Bundle Trust Board Meeting in Public Session 5 July 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 June 2022

Chair

Item 5.1 Public Board Minutes June 2022 v1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log June 2022.docx

6 Chief Executive Horizon Scan

Chief Executive

Item 6 Chief Executive's Report.docx

7 Patient/Staff Story

Director of Nursing/ Deputy Chief Executive
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 (maternity appendices to follow)

Chair of Quality Governance Committee

Item 8.1 QGC Upward report June 2022v1.doc

8.2 Safeguarding Annual Report

Director of Nursing/ Deputy Chief Executive

Item 8.2 Front Cover Safeguarding Annual Report 2021- 2022.docx

Item 8.2 Annual report 2021 - 2022 - QGC approved 21.06.2022.docx

8.3 Infection Prevention and Control Annual Report

Director of Nursing/ DIPC

Item 8.3 IPC Annual Report front sheet.docx

Item 8.3 IPC Annual Report 21.22 Draft.docx

8.4 Patient Experience Annual Report

Director of Nursing/ Deputy Chief Executive

Item 8.4 Trust Board PT eXP Annual Report june 22.docx

Item 8.4 Annual Report 2021 - 2022 v5 13.06.22 Final.docx

8.5 CQC Actions Quarterly Report

Director of Nursing /Deputy Chief Executive

Item 8.5 Board CQC Update - July 2022 - Public Board v1.1.docx

Item 8.5 Appendix 1 - CQC Update - 20 June 2022.pdf

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

9.1 Assurance and Risk Report from the People and Organisational Development Committee - No meeting held

Chair of People and OD Committee
No report due to meeting not taking place.

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

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

Chair of Finance, Performance and Estates Committee

Item 10.1 FPEC Upward Report June 2022 v2.docx

10.2 Estates Strategy

Chief Operating Officer

Item 10.2 Board Paper Estates Strategy June 2022.docx

Item 10.2 Estates Strategy 24th June.docx

11 Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing

12 Integrated Performance Report

Director of Finance & Digital

Item 12 IPR Trust Board - Front page.docx

Item 12 IPR Trust Board June 2022.pdf

13 Risk and Assurance

13.1 Risk Management Report

Director of Nursing/ Deputy Chief Executive

Item 13.1 TB - Strategic Risk Report - July 2022.docx

Item 13.1 Appendix A - All active risks rated 15-25.pdf

13.2 Board Assurance Framework

Trust Secretary

Item 13.2 Item BAF 2022-23 Front Cover July 2022.docx

Item 13.2 Item BAF 2022-2023 28.06.2022.xlsx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 2nd August 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 June 2022

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Dr Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Ms Dani Cecchini, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Mr Simon Evans, Chief Operating Officer
Miss Gail Shadlock, Interim Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital/ Director of People and OD
Dr Colin Farquharson, Medical Director
Dr Chris Gibson, Non-Executive Director

Non-Voting Members:
Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Jody Blow, Advanced Care Practitioner, Orthopaedics
Mr Prasad Antapur, Consultant Orthopaedics
Dr Maria Prior, Healthwatch Representative
Ms Emma Upjohn, Lead Nurse, Family Health

Apologies
Mr Andrew Morgan, Chief Executive
Mrs Sarah Dunnett, Non-Executive Director
Ms Cathy Geddes, Improvement Director, NHSE/I

815/22	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting.
816/22	The Trust Board continue to hold meetings open to the public through the use of MS Teams Live however the format of future meetings was being considered following the lifting of national restrictions. The national operating status at NHS National level had also been downgraded however the Trust continued to be cautious in terms of

	access to sites in order to maintain the highest levels of infection, prevention and control. Therefore, the meeting would continue as a live stream to ensure the Trust Board was open and accessible whilst footfall at the hospitals sites was managed.
817/22	The Chair invited those members of the public who had joined the meeting to offer their views on future meeting arrangements.
818/22	In line with policy, papers had been published on the Trust website ahead of the meeting and the public able to submit questions.
819/22	The Chair moved to questions from members of the public. **Item 2 Public Questions**
820/22	**Q1 from Stewart Girvin** **I wrote a letter of complaint to the head of Ophthalmology at Pilgrim Hospital in Boston on 04/03/22. I received a reply from their PALS service saying they had received the letter and forwarded it. I have heard absolutely nothing since the acknowledgement of my e-mail.** **I then wrote a letter to complain about my lack of response, to Ms Baylis via Pilgrim Hospital on 13/04/22. A copy of this letter was also sent to:** **Dr. K. Dunderdale, via Lincoln County Hospital** **Dr. C. Farquharson, via Grantham & District Hospital** **Mr. S. Evan's, via County Hospital Louth** **My questions therefore are rather simple;** **1) What does a patient have to do, to be heard regarding a complaint at a United Lincolnshire Hospital Trust's facility?** **2) Does the trust condone such appalling lack of respect, care and common decency?** **3) Should the e-mail address of the board members be more forthcoming so as to facilitate a better dialogue with their patients?** The Deputy Chief Executive responded: Apologies were extended to Mr Girvin and his family that the case was not handled in the way in which would have been expected and it was noted that as this was a public meeting it would not be appropriate to respond in detail to the concerns raised. The Deputy Chief Executive however noted that on review the case had identified an apparent breakdown in the process between the Patient Advice and Liaison Service (PALS) and the complaints team meaning that this had not been handled in the usual manner. The Deputy Chief Executive noted that a member of the complaints team should now have been in touch with Mr Girvin to make contact and respond to the complaint

	made. Mr Girvin was encouraged to contact the Deputy Chief Executive directly should this contact not have taken place in order that this could be facilitated. It was noted that a recent review of the complaints process had been undertaken and changes were being made to ensure that this was more accessible and responsive with the question posed an example of why the changes were required. The experience of Mr Girvin would be used to identify any further actions to be taken. The Deputy Chief Executive would take a personal interest in the complaint and oversee the response to Mr Girvin. The Chair offered a further apology and noted the recognition that the complaints process required review and strengthening.
821/22	**Q2 from Vi King** **First of all, I would like to thank Simon Evans for sorting ophthalmology out, which was very concerning.** **Please can I ask when people from, Grantham, have to go for any appointments, or procedures, they are only given Louth, Lincoln or Boston. Even though appointments and procedures can be done at Grantham.** **If this is a problem with centralise booking, please can it be explained why Grantham is not being offered.** **It would be beneficial to look into this, if people have been on the list for a while if this is the reason why.** The Chief Operating Officer responded: Thanks were offered for the comments made and it was noted that the service had been addressed by the management team and colleagues and it was pleasing to note that the issue had been resolved. In respect of the broader issue that had been raised the Chief Operating Officer had requested that the Head of Operations look in to and examine where the Trust may not be offering appointments comprehensively where the services were in place. Responses had previously been offered through the public Board meetings regarding the difficulties with fracture clinical and ophthalmology, two services where appointments had been offered with the same clinical team but not on the same site, such as Grantham. This had been resolved however the request had been made to investigate this and consider a broader range of services to understand if a full range of access was not being offered. The Chief Operating Officer noted that some specialist services were only offered on certain sites in order to ensure access to specialist staff and diagnostic services. This would be looked in to and would be discussed at a future Finance, Performance and Estates Committee and upwardly reported to the Board.

	Action: Chief Operating Officer 21 July 2022
822/22	**Item 3 Apologies for Absence** Apologies were received from Mr Andrew Morgan, Chief Executive, Mrs Sarah Dunnett, Non-Executive Director and Ms Cathy Geddes, Improvement Director, NHS England/Improvement.
823/22	**Item 4 Declarations of Interest** There were no new declarations of interest.
824/22	**Item 5.1 Minutes of the meeting held on 3 May 2022 for accuracy** The minutes of the meeting held on 3 May 2022 were agreed as a true and accurate record.
825/22	**Item 5.2 Matters arising from the previous meeting/action log** The Chair noted that all actions were either complete or not yet due. The Board received the action log.
826/22	**Item 6 Chief Executive Horizon Scan** The Deputy Chief Executive presented the report to the Board noting that significant pressure had been seen over the past week and during the Jubilee weekend.
827/22	Plans in place had been enacted over the past 7-10 days however this remained a challenging position for the organisation. The Deputy Chief Executive expressed thanks to all staff who had worked over the bank holiday period and given up time with families to care for patients.
828/22	The Trust continued to work with NHS England and System partners to update the operational plan with a continued focus on closing the financial gap in order to offer the assurance needed through the regional and national teams. It was noted that this was a challenging position for both the organisation and system.
829/22	The Deputy Chief Executive advised that the Trust continued to offer confidence to regional colleagues, as evidence in the latest quarterly system review meeting with the Board noting the feedback from the regional director.
830/22	The Board noted that Lincolnshire Clinical Commissioning Group (CCG) had taken the final Acute Services Review (ASR) decision and a letter of support, offered by the Trust Board, would be noted at item 11.1 on the Board agenda. Work would now commence to develop implementation plans to enact the decision of the CCG in relation to the services concerned.
831/22	The Deputy Chief Executive noted that the Health and Social Care Act 2022 had been passed by Parliament which would abolish CCGs and lead to the creation of Integrated Care Boards (ICB) and Integrated Care Partnerships (ICP) which would

	come into effect on 1 July 2022. This would also lead to the Provider Collaborative, Lincolnshire Health and Care Collaborative formalising from 1 July 2022.
832/22	This would include an alliance and delegation agreement with the ICB with these documents being worked through. It was expected that the Trust Board would consider these documents and be involved in the changes both nationally and as a system.
833/22	The Board noted the publication of the Fuller Report into primary care and ICS's with the report offering recommendations and ideas about the future shape of urgent care. Locally this would inform the system delivery plan with time to be spent considering the recommendations and building these into the system plan.
834/22	The Deputy Chief Executive noted the Month 1 financial position that would be reported through the Finance, Performance and Estates Committee upward report noting that as previously advised the system was working on the 2022/23 plans. As a consequence, the Trust plan would need to revise to be brought in line, the position was very challenging.
835/22	The Deputy Chief Executive had had the huge privilege of opening the first Community Diagnostic Centre (CDC) at Grantham and there was currently ongoing engagement with the public for a second CDC to determine where this should be sited. The Board noted the achievement and effort of all teams involved to achieve the opening.
836/22	It was noted that this was a huge asset to the surrounding population of Grantham and to those patients who now had a choice to receive diagnostic tests provided at the centre. This would offer easier access to patients and not require attendance at larger sites for tests.
837/22	The new Aseptic Unit had been opened and was located at the Lincoln Science and Innovation Park and further developed the relationship between the Trust, Lincolnshire Co-operative and University of Lincoln. This also afforded additional opportunities going forward.
838/22	Thanks were expressed by the Deputy Chief Executive to all involved in the venture and for the dedication in getting both the CDC and Aseptic Units up and running to deliver exceptional services.
839/22	The Deputy Chief Executive noted that the Chief Executive was currently representing the Trust with the Accountable Officer for the CCG in relation to the recovery support programme and the experience of the Trust of being in this and moving from system oversight framework (SOF) level 4 to SOF 3 and the removal of special measures.
840/22	The Employee Assistance Package was now in place with Health Assured who would support staff in a range of ways. The Big Thank You variety show was held at New Theatre Royal on 29 May to honour all of the work of the NHS during the pandemic. The proceeds of the event will be going to the United Lincolnshire Hospitals Charity and will benefit patients and staff.

841/22	The Chair noted the operational and financial challenges as outlined in the paper noting also the celebratory content that was presented.
842/22	The CCG decision on the ASR was welcomed by the Trust Board and it was noted that this had taken a significant amount of the Board's time and had resulted in difficult conversations both by the Board, with colleagues in the Trust and with patients. It was pleasing to see that a decision had been made and that this could now be progressed. The resilience of those involved in the process was worthy of mention.
843/22	The Chair was pleased to note the comments from the quarterly system review meeting as there had not always been positive comments received from regional and national colleagues.
844/22	The Trust Board welcomed the formal establishment of the ICBs and Provider Collaboratives and looked forward to seeing how the developments of the recommendations of the Fuller review would work through. This would have a significant bearing on the Trust.
845/22	Congratulations were offered from the Trust Board on the opening of both the CDC and Aseptic suite as provision of the aseptic suite had been included on the Trust risk register for a significant amount of time. This was a positive step forward in partnerships with Lincolnshire Co-operative and the University of Lincoln.
846/22	Staff were encouraged, following the launch of the employee assistance programme to consider what was included in the programme and to promote this to other staff across the Trust.
847/22	Thanks were offered by the Chair to the cast of the variety show at the New Theatre Royal and to staff for the celebrations held over the Jubilee weekend for staff and patients.
848/22	Dr Gibson noted the opening of both the CDC and Aseptic Unit noting that these were both examples of the transformation of healthcare and development of partnerships. The Trust Board: • **Noted the report and significant assurance provided**
849/22	**Item 6.1 Integrated Improvement Plan Year 3** The Director of Improvement and Integration presented the year 3 Integrated Improvement Plan (IIP) to the Board noting that this was the final version.
850/22	The IIP has been through a process of review over the past two months in order to review the strategy and plans and to consider learning both post Covid-19 and in light of the significant operational challenges being faced.

851/22	Whilst the Trust had seen improvements, such as progress with the Care Quality Commission ratings there remained work to be achieved in order to reach the aspirations set.
852/22	The Director of Improvement and Integration noted the need to consider the level of recovery and the ability to see patients as quickly as possible which would be important as partnership working progressed with the ICB. It was noted that there was an opportunity to start engaging with wider populations in terms of the impact on health outcomes and health inequalities.
853/22	The Board was advised that the Leading Together Forum would be central to continue to progress efforts against discrimination and ensuring there was diverse culture nurtured by values and behaviours of the Trust.
854/22	In light of the challenges being faced a top-down bottom-up approach had been taken with a series of workshops and strategic thinking sessions with senior teams and divisions being held. These sessions reviewed the strategic objectives with the paper presented in line with the discussions held. There had been stakeholder contributions to the narrative and alignment to national priorities and internal challenges.
855/22	The IIP had been presented to the patient panel to gain consensus and engagement to ensure that this was clear and that the priorities were right.
856/22	It was recognised that in order to achieve outstanding care personally delivered, there were a number of priorities across 4 strategic objectives. The Trust wanted to be able to tell a simple narrative in order to be clear on the focus for the year.
857/22	The Director of Improvement and Integration noted that there were 3 elements that would deliver the outstanding care together programme. There were patient safety and experience, reduction of long wait times for treatment and ensuring staff feel valued and supported.
858/22	The Board noted the proposal for the IIP with the Director of Improvement and Integration noting that, if approved, a summary version of the IIP would be used for communication roadshows.
859/22	The Chair thanked the Director of Improvement and Integration for the work undertaken since arriving at the Trust.
860/22	The Director of Nursing advised that the process had demonstrated real engagement of staff and patients in developing the IIP and built on what was already in place but in a simplified way.
861/22	The Director of Nursing recognised that the Trust needed to ensure that patient experience was captured and acted on and referred back to the public question posed by Mr Girvin. This was one of the reasons that the Trust needed to ensure one of the 3 key objectives was about patient safety and, more importantly patient experience. It was pleasing to see that this was so overtly placed in the IIP.

862/22	Miss Shadlock noted that the document was well written and was pleased to see the use of bite sized communications.
863/22	Dr Prior recognised the work taking place in the Trust to increase patient engagement, which was evident within the Quality Account, however this had not translated to improvements in patient experience. It was important to that the translation of engaging with patients was sustained and change embedded and it was pleasing to see that this was included within IIP.
864/22	The Chair supported the comments made noting that this was a journey for the Trust and recognised the need to translate delivery to sustained delivery. The comments were welcomed and taken on Board.
865/22	The Chair noted that the year 3 IIP had been revised meaning this was more focused and explicit however there remained a balance of national and local requirements alongside the importance of patients. It was pleasing to see that the patient panel had been engaged offering an example of how the Trust was working differently with patient and the public to influence thinking. With the wider engagement of the organisation and staff this was not a much-strengthened product.
866/22	The Director of Improvement and Integration noted the points raised by Dr Prior noting that the IIP had been well received by the Leading Together Forum but that similar comments about sustaining improvement had been made. Work was underway with a cross section of colleagues of the forum to consider how this was sustained.
867/22	Ms Cecchini highlighted that the introduction stated the priority of efficiency and cost improvement programme was contrary to the 3 priorities and asked if there was a need to amend the language to avoid confusion.
868/22	The Director of Improvement and Integration noted that if quality and safety were delivered then efficiency and finances would flow from this and having it packaged in this way felt that the right focus was offered.
869/22	The Chair noted the report that was offered to the Board and that the attendant points would be taken forward in terms of publication and promotion of the plan. The Trust Board: • **Received the report** • **Approved year 3 of the Integrated Improvement Plan**
870/22	**Item 7 Patient Story** The Chair welcomed Mr Antapur, Consultant Orthopaedics and Ms Jody Blow, Advanced Care Practitioner, Orthopaedics to the Board for the patient story.
871/22	The Director of Nursing presented the patient story to the Board noting that this offered David's experience of suffering with severe arthritis in both hips and of how a double hip replacement and outcome of the treatment had gone for him.

872/22	The Trust Board, via the video, watched the patient story that described the reasons why David had reached out to Mr Antapur to seek a bilateral simultaneous superpath hip replacement and the improved recovery process experienced.
873/22	The Board noted that this was the first surgery of its type in the UK and was carried out safely under spinal anaesthetic. The length of stay on the surgical unit was 3 days and mainly due to post operative blood pressure control.
874/22	The Chair offered thanks for the presentation noting that it had been an amazingly aspirational patient story. As stated in the video this demonstrated the power of orthopaedics to change peoples lives and this had clearly been the case for David. The Chair sought the view of the Mr Antapur.
875/22	Mr Antapur noted that he had been with the Trust for the past 11 years and had reached a plateau around 2 years ago in relation to what more could be done to improve the service and quality of life with better and faster recovery for patients. It was at this time that the superpath hip replacement surgery had been seen.
876/22	The Board noted that Mr Antapur was one of 4 surgeons on the UK carrying out the surgery noting that traditionally the surgery would see a 15-20cm incision and significant restrictions for the first 3 months post-surgery. The new surgery saw a 5cm incision with the patient having no restrictions post-surgery.
877/22	This allowed patients to regain a quality-of-life post-surgery more quickly and saw the 24 patients in the study not require a blood transfusion and have an average length of stay of 1.1 days at Grantham Hospital. All patients were back driving 2 weeks post-surgery and most back to full time work and duties at 6 weeks.
878/22	The Chair noted that this was not only positive from a patient perspective but that there was also both efficiency and productivity savings.
879/22	Professor Baker noted with interest that the Trust was at the forefront of the initiative and asked why others were not embracing the new approach.
880/22	Mr Antapur noted that this was not a standard hip replacement and noted that there had been a learning curve for him on the first few surgeries. There was not much training for teaching of registrars and fellows across the country or world and being a super specialist procedure, it was expected that surgeons would have completed 1000 hip replacements prior to attempting key-hole surgery.
881/22	The Director of Nursing thanked Mr Antapur and Jody Blow for joining the Board meeting and commented that the power of technology and ability for patients to take control had been demonstrated by David making contact with Mr Antapur through social media. It was clear that all expectations of the patient had been met.
882/22	The Director of Nursing sought to understand the ongoing support in place for patients given the comments offered by David about seeking information from the internet as part of the recovery and wanted to understand the role of the Advanced Care Practitioner.

883/22	Mr Antapur noted that this was work in progress and there had been a need to ensure all allied staff, physiotherapist and occupational therapists, were on board with the approach given that the usual restrictions did not apply. Whilst this had been a work in progress it had taken a year for staff to realise that patients were behaving differently in recovery.
884/22	The Advanced Care Practitioner, Orthopaedics noted that patients were contacted prior to surgery once a date was set and 2 sets of scores were recorded. There were a pain score and the effect on everyday life the pain was having. Patients were contacted on days 2 and 7 post-surgery to assess the pain scores for sitting, lying and standing. A follow up telephone call was made at 6 weeks, again to assess pain scores. There was also a 6 month and year follow up with patients followed for 5 years post-operatively.
885/22	Contact details were offered to the patients should there be any questions and they were also seen face to face at 6 weeks post-operatively by Mr Antapur. There was a good network in place for patients to make contact should they have any queries.
886/22	Mr Antapur noted that a further score for the forgotten joint score was carried out whereby the ability of the patient to forget they had had a hip replacement was measured. It had been found in almost 100% of patients that they had been able to return to normal and had forgotten that they had received a hip replacement.
887/22	Dr Gibson asked if David was typical of the patient's seen and asked if there was a need for patient selection.
888/22	Mr Antapur noted that it had been agreed that this would be for patients under 70 years old due to the implant being uncemented. Going forward it would be possible to expand this as there was a circa £600 saving per patient. Patients over 70 were receiving this surgery in the private sector and in the USA.
889/22	The Director of Improvement and Integration noted the fantastic achievement and offered an offline conversation to support the team to put themselves forward for awards and to capitalise of the service offered.
890/22	Ms Shadlock noted that it would be useful to hear from David a year after surgery to see how he had progressed.
891/22	Mr Antapur noted that there were 24 other patients who had been operated on, 18 of which were more than a year old. It was noted that there was a need to publicise the service being offered across Lincolnshire.
892/22	The Chair offered thanks for the innovative and creative work that was being undertaken at Grantham Hospital.
893/22	Thanks were offered to David for sharing his story and the personal resilience shown was recognised by the Trust Board. The Trust Board: • **Received the patient story**

	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
894/22	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair of the Quality Governance Committee, Dr Gibson provided the assurances received by the Committee at the 24 May 2022 meeting.
895/22	The Committee received the upward report of the Clinical Harm Oversight Group noting that harm reviews were being processed to address the backlog of patients with a number of issues in relation to this agreed.
896/22	It was noted that one group would be excluded from the process due to being subject to medical examiner review with the Committee assured that this would provide all required investigation. With the increasing volume of reviews required these would need different approaches to process as time moved on.
897/22	The Committee received a high level of assurance in regard to Infection, Prevention and Control (IPC) with the Trust having had 2 cases of Methicillin-resistant Staphylococcus aureus (MRSA) in the past year and 59 cases of Clostridium difficile (C-diff), significantly less than trajectory. It was noted that an IPC visit from NHS England/Improvement was undertaken and it was likely that the Trust would move to a green rating.
898/22	The Covid-19 Board Assurance Framework (BAF) was received by the Committee and was appended to the upward report. This was a national document and demonstrated an improved level of compliance to excellent. It was noted that the only elements rated as amber were primarily due to ventilation and rest areas within the Trust's estate, these were however being addressed.
899/22	Dr Gibson noted that the Maternity and Neonatal Oversight Group (MNOG) continued to progress with a number of issues including the Ockenden report and a number of appendices were included for the Board to consider.
900/22	The Committee continued to receive more guidance about the recommendations of the Ockenden report and although there was a process of assessing the action plan it was anticipated guidance would become more detailed as specific. This meant that the action plan would be an evolving process. Whilst some areas were not compliant, which was the same both regionally and nationally, changes would be required hence the action plan in place.
901/22	Dr Gibson noted that the Board were previously assured of the ability to sustain 4 Continuity of Carer Teams in Lincolnshire and whilst this was the default model required by NHS England, an appendix was offered following assessment by the Midwifery Team. This demonstrated the requirements to move to Continuity of Carer across all maternity services and would see an increase from 4 to 18 teams which would be around a 10% uplift in clinical staff.

902/22	The Committee was pleased to note the new project lead appointed for medicines management with integration to the improvement team. The Committee looked forward to significant progress being made.
903/22	The Deputy Director of Safeguarding attended the meeting to offer an update on safeguarding with the Committee noting some remaining issues in respect of child protection information sharing. This was an ICT issue that would be resolved in due course with the implementation of electronic records, moderate assurance was received.
904/22	A higher level of assurance for mortality had been received with an improvement seen in both figures and benchmarking. The Committee would continue to receive detailed quarterly reports going forward.
905/22	Dr Gibson noted the mixed-sex accommodation and the issue of maintaining this due to Covid-19. The Urgent and Emergency Care pathway was affected however a group had been established to reverse the normalised alternative practices. The Patient Experience Group would continue to monitor this on a monthly basis.
906/22	A high level of assurance was received from the Clinical Effectiveness Group upward report and the internal audit review of the clinical audit programme. As a result, there was a recommendation for the assurance rating for objective 1c to improve.
907/22	Dr Gibson noted that, at the time of writing the report, verbal feedback had been received following the Human Tissue Authority (HTA) inspection which had indicated a small number of major issues. These would be considered in more detail through the Private Trust Board however an action plan was in place to address the issues.
908/22	Dr Gibson noted the suggestion to improve the RAG rating of objective 1c from amber to green due to the strong participation in national audit, comprehensive local audits across all divisions and good progress to implement NICE guidelines.
909/22	The Director of Nursing noted that month on month through the Committee more assurance was being offered on varying aspects on the cycle of business. It was noted that the Nursing, Midwifery and Allied Health Professionals Advisory Forum had been cancelled due to staff attending the IIP refresh session.
910/22	Month on month, through the IPC Group there was oversight of the IPC BAF and there had been significant improvements over the last 12 months in IPC. These improvements were supported by the recent visit from the regional IPC Team.
911/22	The Director of Nursing confirmed the point made by Dr Gibson regarding the verbal assurance from the regional IPC Team that the Trust would move to a green rating, formal communication was awaited.
912/22	The Chair noted the supportive commentary and the continued improvement being seen in relation to the IPC BAF. There were 2 amber items which were in regard to environmental constraints which prevented these moving to green.

913/22	The Chair sought an additional understanding of medicines management given the concern noted by the Committee and the assurance received.
914/22	The Medical Director noted that the Medicines Management Task and Finish Group had met two days after the Quality Governance Committee where the new project lead was in attendance. Discussion had taken place in detail regarding the outstanding actions and who would be assigned to take these forward. It was noted that this required support from both divisions and corporate areas in order to fulfil the actions.
915/22	The lack of update was due to the timing of the meeting and it was noted that this had progressed with a comprehensive actions plan and progress in a short time. There was now traction with the issue.
916/22	The Chair noted the safeguarding update and the mixed-sex accommodation breaches and was pleased to note the oversight on this. It was pleasing to note that the approach to clinical harm reviews was being considered as this demonstrated flexibility and forward thinking.
917/22	The Chair requested that the Ockenden review section of the report now be afforded focus.
918/22	The Director of Nursing noted that MNOG brought together not only maternity and neonatal staff from the Trust but partners from the Local Maternity and Neonatal System (LMNS), Clinical Commissioning Group (CCG) and Maternity Voices Partnership.
919/22	The Group had reviewed the initial 8 recommendations from the first publication of Ockenden and at the last meeting had confirmed further compliance with the immediate and essential actions. This meant that the Trust was now compliant with all but 2 of the actions and partially compliant with the remaining 2 and was on track for completion by the end of quarter 2.
920/22	The second report from Ockenden had offered a further 15 recommendations with the appendices to the paper offering the initial benchmarking gap analysis and where the Trust believed itself to be. It was recognised that there was further work to be completed on the plan however this would be reviewed on a monthly basis by MNOG.
921/22	The Board was reminded of the improvement plan in place for maternity and neonatal services for which the recommendations from Ockenden would form part of. The Director of Nursing was clear that there should only be one plan for the service and plans would be amalgamated to ensure there was clarity on actions, where these came from and what recommendations related to.
922/22	The Director of Nursing noted that on the 22 and 23 June the Trust would have the Ockenden insight visit by the regional team, supported by the LMNS and CCG.
923/22	The Chair noted the initial findings of the second Ockenden report and the gap analysis presented to the Board noting that this would be formulated into a single

	improvement plan for clear oversight from the Quality Governance Committee on progress of all recommendations.
924/22	The Lead Nurse, Family Health noted that the actions from the first report had been short term and easier to achieve with the services the Trust offered. Following the release of the second report the Trust had benchmarked against the immediate and essential actions with the team reviewing each section.
925/22	National guidance was awaited on what would be required to deliver on the actions however the Trust was 30% compliant with these. It was known that there would be a significant investment into workforce required in order to deliver further.
926/22	The Lead Nurse, Family Health noted that the Trust was being proactive and considering the recommendations made, what was being done and delivered in the services. This would be overseen by MNOG whilst the national steer was awaited.
927/22	A task and finish group was being established with staff, the CCG and Better Births to consider what was required to achieve the ask.
928/22	The visit from the assurance team would be to considered the first report, released in December 2022, with the team speaking to staff and services users to evidence the immediate and essential actions from the report.
929/22	The Chair stated that it was recognised national guidance was awaited however it was clear that the Trust was not waiting for this was actions being put in train which was inclusive with colleagues both internally and externally. This offered a degree of reassurance to the Board which looked forward to seeing progress.
930/22	Professor Baker noted that the ask was challenging noting the financial recourse to ensure there were individuals capable of running and developing the services. It was noted that amongst the list of actions there were some that did not appear to be workable.
931/22	The Director of Nursing noted that concern had been raised in respect of some of the actions by the Heads of Midwifery and Directors of Nursing across the regional and national networks, hence the need for a clear steer and national guidance.
932/22	It was noted that the Non-Executive Director Maternity Safety Champion was supporting some of those conversations in a similar way and offering a lay person view.
933/22	The Lead Nurse, Family Health agreed with the comments made and the need for clarification, particularly the need for supernumerary staff in clinical areas. There was a need to understand what this would look like.
934/22	Clarity was required from the national team on the direction of travel and how this was delivered to ensure the workforce was available to deliver the services. Work would need to be undertaken with Health Education England to ensure staff were coming in to do this.

935/22	The Chair noted, in the absence of Mrs Dunnett Maternity Safety Champion, that the conversation were ongoing and assurance was being gained with information being offered and represented at the Quality Governance Committee.
936/22	Some of the actions were also applicable to wider parts of the Trust and there was a need to ensure these were considered across all services with any learning and implication considered.
937/22	The Director of Nursing presented the Continuity of Carer paper to the Board noting this had been presented to MNOG and the Quality Governance Committee. This offered some high-level requirements as an organisation to further role out Continuity of Carer.
938/22	In May 2022 the Trust Board had agreed to option 2 of the 3 recommendations offered. This was to pause roll out of the model but to continue with the current model in place and accept appropriate women into the teams as required.
939/22	Whilst it was recognised that this was always the stance of the Trust it had been helpful that a clear direction of travel had been offered. The paper offered detail in terms of further requirements which would need to go through established governance cases to progress. The paper presented offered the quantum of the ask in order to enable the Trust to move to a full Continuity of Carer services.
940/22	The Chair noted that this underlined the decision taken by the Board in May and offered a helpful description of what would be required for full implementation.
941/22	The Director of Improvement and Integration noted that the gap analysis was useful to see and noted that the next challenge would be to understand the deliverability associated with the actions.
942/22	Dr Gibson noted that the Committee was conscious of the public scrutiny on maternity services and the pressure on staff. Thanks were expressed to the Maternity Team for continuing to offer a high level of assurance and offering papers to the Committee.
943/22	The Chair noted the thanks and asked that the Lead Nurse, Family Health offered these back to the team. A recent visit to the services at both Lincoln and Pilgrim had demonstrated how hard the staff were working.
944/22	The Board received the Ockenden benchmarking action plan and Continuity of Carer reports noting the content and understanding the context in which this was offered.
945/22	The Quality Governance Committee would take ownership of reviewing the reports and reportion to the Board as presented through MNOG. There was strong governance in place to ensure appropriate scrutiny was in place in the right parts of the Trust prior to this being presented to the Trust Board.
946/22	The Chair noted the positive position of the Covid-19 BAF and noted receipt of the report from the Quality Governance Committee.

947/22	The Board endorsed the recommendation from the Committee to move objective 1c to a green rating on the BAF. The Trust Board: • **Received the assurance report** • **Received and noted the Ockenden Report and Continuity of Carer update** • **Approved move of Objective 1c to Green assurance rating**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
948/22	**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 10 May 2022 meeting.
949/22	Professor Baker noted that the Committee was made aware through the safer staffing report of the prolonged challenge of unprecedented demand and the association with the increase in the number of patient falls and severity. The Committee was grateful for the ongoing mitigating actions in place and the oversight by the executive leadership team.
950/22	The Guardian of Safe Working attended the Committee and flagged relevant issues pertaining to Junior Doctors in the Trust around facilities and educational support. Professor Baker advised the Board that there had been positive feedback received regarding the recent anti racism campaign with this having been received well by the Junior Doctors across the Trust.
951/22	The Committee received a report regarding the consultation of the restructuring of the People and Organisational Directorate and support was offered to the plans proposed to ensure that the directorate was fit for purpose.
952/22	Professor Baker noted that the Committee discussed at length the 5 reporting groups to the Committee which were either in place or being established. Work was being carried out in relation to the groups to ensure these were functioning to both support the Committee and to cascade initiative throughout the Trust.
953/22	The Committee considered the Board Assurance Framework and continued to remain unable to provide full assurance for the objectives however Professor Baker noting that the Committee felt it would be able to provide this to the Board once the reporting groups were established and functioning.
954/22	Professor Baker advised the Board that there was now a dashboard of metrics considered by the Committee and whilst it was noted that there had not been an upturn in the metrics it was hoped that this would be seen in the near future.
955/22	The Chair invited the Director of Nursing to offer an update in relation to safer staffing and the link to increased patient falls.

956/22	The Director of Nursing noted that limited assurance was being offered on safer staffing, which was triangulated with quality, for the past few months. There had been a decrease in the number of inpatient falls seen over recent months however the associated level of harm was increasing with at least one fall resulting in severe harm or related to a patient death. These incidents were taken very seriously by the Trust.
957/22	The Director of Nursing noted that it had been possible to pull out themes as a result of the incidents of which staff was not directly a cause but had an impact due to the dilution of staffing to support the increasing bed base.
958/22	The Falls Steering Group oversees every fall and root cause analysis of these which are upwardly reported to the Patient Safety Group and to Quality Governance Committee to ensure oversight each month.
959/22	The Director of Nursing stated that there was a clear theme however mitigating actions were in place, associated with each fall and themes associated, this did not however move away from limited assurance being offered to the Committee on staffing, triangulated with quality.
960/22	The Board was advised that pressure ulcers were also an area of focus, with equal intensity, but the degree of harm was a cause for concern.
961/22	The Chair was grateful to receive the detailed update noting that whilst this was not the position desired it was good to note the triangulation between staffing and incidents of harm. The reporting of this to the Committees demonstrated that assurance processes were working in the way in which the Board expected.
962/22	The Chair was pleased to note that the anti-racism campaign had been received in the way it had been and noted the update in relation to the expectation of when the Board Assurance Framework ratings could be reviewed and assurances reflected.
963/22	The Director of People and Organisational Development noted that the shape and work of the Committee, along with how the Directorate looked, was taking longer than anticipated when the caretaker role was taken on. It was noted however that good progress was being made and over the coming months the structure would be in place and benefit would start to be seen as the journey of improvement progressed. The Trust Board: • **Received the assurance report**
964/22	**Item 9.2 NHS Rainbow Badge Reset** The Director of Finance and Digital, as the Executive Sponsor for the Trusts' PRIDE+ Network, presented the report to the Board noting that June was PRIDE+ month and this was felt to be the appropriate time to reaffirm the position of the Trust in respect of Lesbian, Gay, Bisexual, Transgender + (LGBT+).
965/22	The Trust joined the NHS 'Rainbow' Badge in October 2019 with the Director of Finance and Digital noting that some time had passed since, including the pandemic,

	and noted the desire to refresh the view on culture and building an inclusive culture meant that it was important that this was reinforced.
966/22	The Trust wanted staff to feel that they were safe and could bring their whole selves to work with the organisation taking necessary steps to create a sense of belonging and harness diversity to deliver better patient care.
967/22	Appendix 1 offered the pledge made previously by the Trust with the Director of Finance and Digital proposing that the Trust Board reaffirmed the pledge. Staff who choose to wear the badge would identify themselves as someone whom a LGBT+ person could feel comfortable talking to about issues regarding sexuality or gender identity.
968/22	There was a responsibility with the wearing of the badge and staff would be required to apply for the badge and agree to listen and sign post staff and patients where required.
969/22	The Director of Finance and Digital noted that the next step, should the Board reaffirm, would be to undertake a communications campaign identifying the importance of inclusion at the Trust.
970/22	Narrative would be used from the rainbow badge to raise awareness and understanding of LGBT+ staff and patients and to use the badge to highlight the responsibility of staff to promote and improve inclusion, dignity and respect.
971/22	The Chair agreed that this was important noting the impact that had been seen due to the pandemic and other issues at the forefront. This was about valuing the workforce and was the right time to reaffirm the commitment as a Trust Board.
972/22	The Board members supported the initiative. The Trust Board: • **Received the report noting the significant assurance** • **Re-endorsed the Trust commitment to the NHS Rainbow Badge initiative and pledge** • **Approved the next steps**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
973/22	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini provided the assurances received by the Committee at the 30 May 2022 meeting.
974/22	Ms Cecchini noted that the Committee continued to receive limited assurance in respect of reporting from estates however noted improvements which were being seen in relation to staffing and capacity within the estates team.

975/22	The Committee noted that, unfortunately, as Authorised Engineer reports were completed these were highlighting some infrastructure issues, some of which had previously been discussed such as ventilation.
976/22	Ms Cecchini noted the passenger lifts and electrical wiring that had been highlighted as being past a useful state noting that the risks were managed by the estates team and there was the potential to consider reprioritisation of capital schemes to ensure infrastructure issues were dealt with.
977/22	The Committee received good assurance in respect of Low Surface Temperature works with continued work on those parts of the estate not owned by the Trust and were more complicated in terms of resolution.
978/22	Ms Cecchini advised of the moderate assurance that had been received on the Month 1 financial position and reported as £200k adverse variance, according to plan. This was yet to be adjusted however the Committee had received limited assurance regarding Cost Improvement Programme (CIP) schemes with concern noted on the delivery of elective care and the potential loss of income if 104% activity was not achieved.
979/22	The Trust would rely on some Covid-19 reduction in expenditure in the coming months however there was an awareness of the potential for excess inflation to adversely impact the Trust. The Committee noted the requirement to deliver a breakeven position.
980/22	Ms Cecchini advised the Board that staffing was circa £2m adverse to plan which was in non-substantive bank and agency staffing which continued to highlight the issues regarding beds being kept open over the funded capacity. This raised significant concerns.
981/22	The Committee noted that the position could deteriorate depending on the approval of the financial plan which required submission on 20 June.
982/22	The Committee received updated in respect of cyber and from the Information Governance Group. The Committee spent some time considering the Data Security and Protection Toolkit (DSPT) and received the related internal audit report.
983/22	The Committee noted that whilst the task and finish group worked to resolve issues there remained some risks which had been identified in the Trust being fully compliant with the toolkit submission. The toolkit was due for submission at the end of June with the Committee receiving an update at the next meeting.
984/22	Ms Cecchini noted that operational performance continued to see some deteriorations with urgent care continuing to be challenging with issues of overcrowding in the emergency departments impacting on metrics.
985/22	There had been improvements seen in planned care with P2 clearances reducing to 4.7 weeks, down from 8 weeks in the previous month. There remained significant numbers of patients waiting over 52 weeks however.

986/22	The Committee had noted some improvement in 14-day cancer delivery with the 62-day backlog continuing to be a cause for concern.
987/22	The Chair noted the broad range of business undertaken by the Committee and specifically noted the critical infrastructure elements. It was pleasing to note that this was being recognised and that the Committee was seeking further details on this in due course.
988/22	The Chair was pleased to note the continued scrutiny of the low surface temperature works and noted the risks raised in respect of the data security and protection toolkit but noted that there was time for mitigations to be put in place.
989/22	The financial position, whilst this had not yet been confirmed, was part of the wider system plan and there was a need to wait to see how this would flow through however it was clear that risks had been identified.
990/22	A large element of this would be predicated on the number of beds open and the need for system partners to have more open in the community in order to close those open in hospital. There was a consequence to these actions and there was a need to ensure that all parts of the system were fulfilling the requirements upon them.
991/22	Ms Cecchini noted that it would be interesting to understand how the Trust would engage with the system to ensure delivery against the community initiatives as there was concern that the appropriate infrastructure was not in place to support and assurance was required.
992/22	The Chair endorsed the comments made noting that this was required from the Provider Collaborative and whilst this had been promised to be received this was not yet sighted. There was a need for reporting to be received in order to understand the work. The Trust Board: • **Received the assurance report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
993/22	**Item 11.1 ASR Statement of Support – Record of virtual board discussion** The Chair noted that the Board had submitted a letter of support to the Clinical Commissioning Group (CCG) in respect of the Acute Services Review (ASR) decision.
994/22	The Trust Secretary noted that the item acknowledged and captured, in the public meeting, the decision taken by the Trust Board to offer a statement of support to the ASR proposals ahead of the CCG Board meeting at the end of May.
995/22	Due to the timing of the meeting this had been considered by the Trust Board members virtually, outside of scheduled meetings and confirmed for the minutes the response agreed and submitted by the Trust Board members.

	The Trust Board: • **Noted and ratified the statement of support**
996/22	**Item 12 Integrated Performance Report** The Director of Finance and Digital noted that the core items from individual upward reports had been raised to the Board from the Committees and was happy to take questions in relation to the paper for the relevant Executive Director to respond.
997/22	Dr Prior noted, in respect of patient experience, that only 40% of outpatients were seen within 15 minutes of appointment time. This, considering the emphasis of the Trust on improvements in patient experience, appeared to show a lack of respect to patients. Whilst people did not mind the exceptional circumstance of a delay Dr Prior noted that this appeared to demonstrate a cultural issue and lack of punctuality.
998/22	The Chair noted the point that was raised with the Director of Finance and Digital confirming that this was the reason for inclusion as a metric.
999/22	The Chief Operating Officer noted the focus required on outpatients explaining that the Trust was alert to the issue, and it was hoped that improvements would be seen as a result of the initiatives being put in place. It was right that the concern was raised. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
1000/22	**Item 13.1 Risk Management Report** The Director of Nursing presented the monthly report to the Board noting that there were 9 quality and safety risks rated very high, 20 and above with the risk of serious harm from falls raised from 16 to 20.
1001/22	The increase in this risk had been undertaken following a review through the established process and supported discussions held by the Board.
1002/22	The Director of Nursing noted that the risk regarding medicines linked to e-financials had been closed following review and confirmation through the confirm and challenge risk register session.
1003/22	The Board noted 5 quality and safety risks which were high with 1 increasing risk related to the maternity environment. 1 high rated risk had been closed regarding interventional radiology at Lincoln.
1004/22	The Director of Nursing noted that workforce risk remained high within the Trust, particularly in relation to staffing capacity and morale. There were 3 very high risks at present along with staffing capacity risks to the delivery of stroke, oncology and respiratory services.

1005/22	It was noted that there were no very high finance and estates risks however there were 4 risks rated as high. The highest priority finance, performance and estates risk related to the cost of temporary clinical staff, fire safety Trust wide, information governance and the continuity of the water supply at Pilgrim.
1006/22	The fire risk regarding storage of acetylene had reduced substantially since the previous report. The ICT critical infrastructure risk had been reviewed and updated with the most recent report offered to the Finance, Performance and Estates Committee, the risk had been rated at 16, high.
1007/22	The most significant risks within the Trust related to recovery of planned care, emergency care demand, availability of accurate patient information, recruitment of medical and nursing staff, staff morale, patient harms as a result of falls, delays in echocardiograms and the ability to learn lessons from previous incidents.
1008/22	The Director of Nursing advised that the appendices offered with the report detailed the suite of strategic risks as recorded within the risk register.
1009/22	The Board noted that the relevant risks has been presented to the Committees during May.
1010/22	The Chair was pleased with the way in which the report was focused and specific and detailed clear mitigations. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the significant assurance**
1011/22	**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 May 2022.
1012/22	The Trust Secretary noted, as described through the Quality Governance Committee upward report a proposed improvement of objective 1c from amber to green had been made.
1013/22	Work continued to review and update the Board Assurance Framework through the monthly cycle with some discussions ongoing to ensure that this offered the correct focus for the Committees and was fully aligned to the year 3 revision of the Integrated Improvement Plan.
1014/22	The Trust Secretary noted that the document had been presented with colour coding to ensure that, as the transition and alignment was completed, Board members were able to see the changes being made.
1015/22	The Chair noted that the colour coding drew attention to the updates offered and supported read across of the Committee updates.

1016/22	It was noted that work remained in terms of populating the document with a specific need to consider objective 4c - Successful delivery of the Acute Services Review and Recovery Support plans. A conversation would be held outside of the Trust Board as concern was noted in how both the Acute Services Review (ASR) and recovery support plans could be considered together.
1017/22	The recovery support plan required Trust partners to undertake activity that would impact the Trust's ability to deliver, this required consideration.
1018/22	Dr Gibson noted that there was also a cross over with some quality and safety issues in the delivery of the ASR noting that this objective would also requirement assessment by the Quality Governance Committee.
1019/22	The Chair agreed noting that this demonstrated the maturity of the Board when working with the Board Assurance Framework and highlighting the finer points that would not necessarily have been identified previously. How this was pulled through would require consideration.
1020/22	Ms Cecchini also noted that the Finance, Performance and Estates Committee was responsible for new models of care and noted the need again to consider the input from the Committee on the relevant aspects of the objective.
1021/22	It was noted that the Board Assurance Framework offered oversight of the position at a strategic level with the Committees finding the document useful.
1022/22	The Chair thanked the Executive Directors for working through and populating the document noting the maturity and development of the Board in using this to offer assurance. The Trust Board: • **Received the report noting the moderate assurance** • **Agree rating of Objective 1c from amber to green**
1023/22	**Item 13.3 Audit Committee Upward Report** The Chair offered the report to the Trust Board in the absence of the Chair of the Audit Committee noting that this offered a technical report considering the year end position, internal audit and preparation for annual reports and internal audit plan.
1024/22	Dr Gibson advised the Board that the overall head of internal audit opinion was likely to be partial assurance with improvement required.
1025/22	The Chair noted the position advising that this would be formally received in due course. The Trust Board: • **Received the report noting the moderate assurance**

1026/22	**Item 14 Any Other Notified Items of Urgent Business** There were no items of other business.
1027/22	The next scheduled meeting will be held on Tuesday 5 July 2022, arrangements to be confirmed taking account of national guidance.

Voting Members	**1 June 2021**	**6 July 2021**	**3 Aug 2021**	**7 Sept 2021**	**5 Oct 2021**	**2 Nov 2021**	**7 Dec 2021**	**1 Feb 2022**	**1 Mar 2022**	**5 Apr 2022**	**3 May 2022**	**7 June 2022**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	A	X	X	A	X	A	X	X	A	X	X
Geoff Hayward	A	X										
Gill Ponder												
Neill Hepburn	X	A										
Sarah Dunnett	X	X	X	X	X	X	X	X	X	A	X	A
Elizabeth Libiszewski	X	X	X	X	X	X	X					
Paul Matthew	X	X	X	X	X	X	X	X	A	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	A
Mark Brassington	X	X	X									
Simon Evans				X	X	X	X	X	X	X	X	X
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X
David Woodward	X	A	A	X	X	X	X					
Philip Baker			X	X	X	X	X	X	X	X	X	X
Colin Farquharson			X	X	X	X	X	X	X	X	X	X
Gail Shadlock								X	X	X	X	X
Dani Cecchini								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
7 December 2021	1914/21	Action Log	Establishment reviews for endoscopy and ED would be received once considered at Committee in Jan/Feb 2022 Endoscopy review to be received in July	Director of Nursing	~~01/03/2022~~ ~~05/07/2022~~ 02/08/2022	Deferred to August
3 May 2022	688/22	Assurance and Risk Report Quality Governance Committee	Continuity of Carer to be reviewed in respect of Ockenden Final report to consider if option 2 remains appropriate	Director of Nursing	02/08/2022	Agenda item Complete
7 June 2022	821/22	Public questions	Specialist services on certain sites to be discussed further at a future Finance, Performance and Estates Committee and upwardly reported to the Board.	Chief Operating Officer	21 July 2022	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5 July 2022*
Item Number	*Item number 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Dr Karen Dunderdale, Deputy Chief Executive/Director of Nursing*
Author(s)	*Dr Karen Dunderdale, Deputy Chief Executive/Director of Nursing*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to be under significant pressure. This is similar to the NHS across the country. The Trust declared a critical incident on 15 June for 24 hours related to an overcrowded ED, long waits to be seen and limited access to key pathways leading to a compromised elective pathway. This declaration led to enhanced system working which released the Pathway 1-3 discharge capability.

b) The system submitted its updated operational plan on 20th June which included an improved financial position from £32.9m deficit to break-even for 2022/23. The updated plan for Lincolnshire reduces the deficit to £8.6m which sits in the CCG / ICB position as an unmitigated risk in achieving the overall break-even position. The £32.9m deficit has been reduced through a combination of further central funding of £17.7m to cover inflation and other cost pressures, £10.2m of further mitigations identified offset by £3.6m of additional investments and cost pressures. The £17.7m central funding was conditional on submission of a break-even plan.

c) The NHS Lincolnshire CCG Board took the final decision following the public consultation relating to four NHS Services to support the recommendations. The recent Health Overview and Scrutiny Committee has chosen not to refer the outcome to the Secretary of State for Health and commended the process the CCG has gone through. Work has now commenced to develop an implementation plan with ULHT, the public and their representatives on the four services of Orthopaedic surgery countywide, urgent and emergency care at Grantham and District Hospital, Acute Medicine at Grantham and District Hospital and Stroke services countywide.

d) On the 1 July 2022 NHS Lincolnshire CCG's functions were subsumed into the Integrated Care Systems, with the creation of the Integrated Care Board as a statutory body and the creation of the Integrated Care Partnership as a statutory committee.

Trust Overview

e) At Month 2, the Trust reported a deficit of £1.3m against a planned deficit of £0.9m. This is £0.4m adverse to plan. This is against the initial financial plan for 2022/23 of a year-end deficit of £5.8m. This is part of the system planned deficit of £32.9m. Following the submission of the system break-even plan the Trust has in turn resubmitted its plan at break-even which will include a planned surplus in June to offset the initial planned deficit in April and May.

f) As the cost of fuel has continued to rise this has put significant pressure on those staff who are required to travel in their own cars as part of their role. We have temporarily increased the mileage rate to compensate for this whilst

we await the rate to be reviewed nationally. We will continue to review and do our upmost to support these colleagues.

g) The Trust's maternity and neonatal services were visited on 22 June and 23rd June as part of an Ockenden Insights visit by a team led by the regional midwife and comprising of representation from the regional team, LMNS and Maternity Voices Partnership. The visit was a review of our progress against the first Ockenden report published in December 2020 with 7 Immediate and Essential actions. The visit feedback was exceptional across all aspects of the service and even more impressive in the backdrop of a pandemic.

h) Members of the board including the CEO, DoN, COO, NED Maternity Safety Champion and the Clinical Director of Family Health met virtually with the Chief Midwifery Officer (CMO) for England, Jacqueline Dunkley-Bent and her team as part of the CMOs meeting with all boards who provide maternity services. The overall aim of the meeting was to highlight maternity safety and assurance items that will support trusts in the provision of safe, personal sustainable maternity care provision, as well as understanding what may be helpful to the Trust.

i) Across the Trust we have relaxed restrictions in relation to visiting and moved to pre-pandemic arrangements with regard to social distancing in all areas of the Trust and removal of mask wearing in our non-clinical areas. These arrangements are under constant review and when it is safe to do so we will make further changes to the restrictions.

j) The Trust launched a Dress Policy for All Staff and a Dress Policy for All Staff Working in the Clinical Environment in June which aims to ensure an inclusive, consistent and corporate approach to dress ensuring our dress complies with Health & Safety, Infection Prevention & Control and laundry requirements.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	21 June 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 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 2022/23 objectives.
	Assurance in respect of SO 1a Issue: Deliver high quality care which is safe, responsive and able to meet the needs of the population **Clinical Harm Oversight Group Upward Report** The Committee received the report noting the discussion held regarding proposed changes to the clinical harm reviews for 12-hour A&E waits. This would see harm reviews conducted where a trigger was alerted from the incident management system, Datix, of possible harm occurring due to a long wait/delay. A prompt will be embedded in the Datix system to facilitate this. The Committee was assured by the process undertaken that resulted in the proposal being made and accepted by the Group. The Committee supported the recommendations made in respect of monitoring clinical harm. **Serious Incident Summary Report** The Committee received the report noting the number of SIs and overdue actions in month. The Committee was pleased to note the continued reduction in overdue actions and number of open actions associated with Never Events. **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 that there were no items of escalation. **Infection Prevention and Control Annual Report**

	The Deputy Director of Infection, Prevention and Control and Consultant Microbiologist joined the Committee to present the Infection Prevention and Control annual report. The Committee was pleased to note the positive results that had been achieved during this year despite the challenges of Covid-19 and operational pressures. The report highlighted that there had been positive development of policies during the year and the incidence of all reportable infections was under trajectory. Board Assurance Frameworks for infection control and Covid-19 were both satisfactory, although the relatively small numbers of single occupancy side wards in the Trust had influenced nosocomial infections during the pandemic. The Committee recommended the report to the Board and thanked the teams for the significant work undertaken. **Medicines Quality Group Upward Report** The Committee noted that there had been a significant fall in the incident metrics noting that whilst this remained a concern the movement was welcomed. The Medicines Safety Report had now been received by the Trust which would be reviewed in detail at the next meeting of the Medicines Quality Group. The initial outcome had shown a reduction in medication incidents across the Trust however this would result in a number of actions being required. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the upward report appended with the claims scorecard and Perinatal Mortality Report. The Committee noted that further work would be required on the claims scorecard as this had been the first iteration of the report with the need to identify themes and trends. The report offered a significant amount of data which would now be reviewed in order to offer narrative update alongside further analysis. The Perinatal Mortality report was received, and the Committee noted the robust process in place with the LMNS driving forward the agenda, however, the Trust would undertake specific actions. The Committee noted the Ockenden insight visit that would be taking place on 22 and 23 June which would involve stakeholder groups, site walks and interviews with the Director of Nursing, Medical Director and Chief Executive. The regional deep dive into saving babies lives had demonstrated a deteriorating position however this was due to up to date audits not being conducted. It was noted that the midlands region was up to date

	with audits and as such was likely to show a different output when the deep dive concluded. The Committee was pleased to note that the Trust would be exiting the Maternity Safety Programme and progress was being made with tapered support. The Committee raised concern regarding the Nettleham Ward decant required to be undertaken to address environmental issues. It was noted that the delay was as a result of operational pressures and open escalation beds reducing the ability to decant. All appendices offered to the Committee alongside the report are available to Board members in the paperless solution reading room. **Patient Safety Group Upward Report** The Committee noted that due to a critical incident being declared the full meeting had not been held. Discussion had focused on falls, pressure ulcers and diagnostics with the Committee being advised of the commissioned work to understand the position of diagnostic and therapeutic processes. The Committee was pleased to note the significant improvement in duty of candour due to the significant work that had been undertaken by the clinical governance team and clinical staff across divisions. **Medicines Management Task and Finish Group** The Medical Director was pleased to note that the meeting had been positive and was able to advise the Committee that a Project Lead had been established to embed actions. A single action plan had been produced taking into account comments from the CQC and Internal Audit. The group would continue to meet and report to the Committee on a monthly basis to ensure that assurance could be offered on the actions being taken. **Nursing Midwifery and AHP Advisory Forum Upward Report** The Committee took the report as read noting that there were no escalations to be alert to. **Safeguarding Annual Report** The Deputy Director of Safeguarding joined the meeting to present the Safeguarding Annual Report noting that over the past 12 months there had been forward movement on the position within the Trust including the expansion of the safeguarding team. The Committee noted the trends that had been seen over the past year including an increase in child protection, looked after children and safeguarding adults. The Trust had continued to maintain training during Covid-19 and a

	dementia pathway had been rolled out. The Committee noted the positive position of the report and reflected that there would be benefit in understanding the population types against each of the categories reported. The Committee recommended the report to the Board and thanked the teams for the significant work undertaken. **Mental Health, Learning Disability and Autism Group Upward Report** The Deputy Director of Safeguarding presented the upward report to the Committee noting the changes due to come in to place as a result of the Mental Health Act. The Committee noted the progress that had been made in respect of the group over the past 2 years and supported the proposal that the group now become a sub-group of the Safeguarding and Vulnerabilities Oversight Group. **Children and Young People Oversight Group Upward Report** The Committee received a verbal update from the Medical Director noting that there were no issues of concern to escalate. The Committee noted the discussions held in relation to the IIP and how the children and young people issues related to this. The main focus would be the hidden child and children's clinics in main outpatient areas. The Committee would receive a written report to the next meeting. **CLIPS Report** The Committee received the report noting the move to the Patient Incident Response Framework and the positive position of the Trust due to the current reporting in place. The Committee questioned how learning was undertaken as this needed to be wider than incident reporting. It was noted that patient feedback was an element of the IIP regarding areas such as discharge and that the complaints process also addressed this. Work was being undertaken by the Patient Experience Group to categorise learning from various communication routes.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Deputy Director of Nursing joined the meeting to present the report noting that there were no areas for escalation. Mixed sex breaches continued to be monitored and a monthly update received by the group. A task and finish group had been established and

	daily review of the position undertaken. Whilst this remained work in progress positive improvements were being seen. The Committee noted that the group had approved relevant policies and updates had been made to relevant areas of the risk register to ensure risks were clearly articulated. **Patient Experience Annual Report** The Deputy Director of Nursing presented the annual report noting that it had been a difficult year due to the impact of Covid-19, a difficult winter period and staffing and critical incident challenges. The report demonstrated some progress made in year however it was recognised that this was not at the desired pace. The approach to patient experience had matured over the year and the Trust had seen the establishment and embedding of the Patient Panel. The Committee noted the interest in the patient panel from NHS England and that the Trust would be referenced as a case study in the NHS England review of related guidance. The Committee recommended the report to the Board and thanked the teams for the significant work undertaken.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **NCEPOD Report** The Committee received the report noting the continuing development of the information reported. A business partner model approach was being taken in the Clinical Governance team resulting in traction to close actions. It was noted that future reports would provide an update on actions and offer consideration to the level of risk being held along with closure of actions not relevant to the Trust. **Clinical Effectiveness Group Upward Report** The Committee received the report noting that the Trust had flagged for not being able to provide audit data against the National Bowel Cancer Audit. The Committee was assured that reporting issues had been resolved and data could now be provided.
	Assurance in respect of other areas: **Topical, Legal and Regulatory Update** The Committee received the report noting that this was beneficial in offering sight of current and future areas of interest for the Committee. It was noted that the Out of Sight report would need to be considered by the Safeguarding and Vulnerabilities Oversight Group and the outcome of

	this reported upwardly to the Committee. **Performance Review Meeting upward report** The Committee noted the ongoing changes to the PRM process and framework linked to the IIP noting that improved reporting was anticipated from July. **Clinical Audit Internal Audit** The Committee received the internal audit noting that this had been requested by the Trust. The Committee noted the significant assurance achieved and that all identified actions were being implemented. **Integrated Improvement Plan** The Committee received the month 2 report noting continued development of reporting in line with the Executive Scorecards. The Committee noted the benefit of receiving a more detailed report and welcomed future reports that would offer an understanding of the progress being made. **CQC Actions – Full quarterly report** The Committee received the full quarterly report noting that a report would be offered to the Board in July. The Committee was pleased to note the increase in the green and blue actions meaning that these were complete and embedded. A library of evidence was being gathered and maintained to ensure robust assurance of actions. The Committee noted the continued urgent and emergency care pressures resulting in ambulance delays meaning that progress was not being seen at the rate hoped. The Committee was assured on the comprehensive approach being taken to ensure that the actions were taken, completed and embedded, supported by evidence. **Committee Performance Dashboard** The Committee received the performance report noting that the items discussed through the Committee had offered oversight of current performance. The Committee noted concern of the number of serious incident actions not being completed within the timetable, but noted the significant work that had been undertaken over the past year to improve to the current position and the ongoing action that would be taken to continue to address this.
Issues where assurance remains outstanding for escalation to the Board	None

Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register and the addition of 3 new high risks.
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	A	S	O	N	D	J	F	M	A	M	J
Elizabeth Libiszewski Non-Executive Director	X	X	X	A	X	X						
Chris Gibson Non-Executive Director	X	X	A	X	X	X	X	X	X	X	X	X
Alison Dickinson Non-Executive Director							X					
Sarah Dunnett Non-Executive Director (Maternity Safety Champion)	X	X	A	X	X	A		X	X	X	X	X
Neill Hepburn Medical Director	X											
Karen Dunderdale Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Simon Evans Chief Operating Officer	D	D	D	D	X	D	D	X	D	X	D	D
Colin Farquharson Medical Director		X	X	X	A	X	X	X	X	X	X	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

Meeting	*Public Trust Board*
Date of Meeting	*5th July 2022*
Item Number	*Item 8.2*
Safeguarding Annual Report 2021-2022	
Accountable Director	*Dr Karen Dunderdale* *Director of Nursing*
Presented by	*Craig Ferris* *Deputy Director of Safeguarding*
Author(s)	*Craig Ferris* *Deputy Director of Safeguarding*
Report previously considered at	*Quality Governance Committee* *21.06.2022* *Approved*

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

Risk Assessment	*Insert risk register reference: 4145/4146*
Financial Impact Assessment	*Not available at present however LPS will have an impact during the latter part of the 2022 - 2023 financial year*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	The Trust Board is asked to:
	• *Receive the Safeguarding Annual report*
	• *Approve the Plans for 2021 - 2022*

Executive Summary

The purpose of the report is to provide the Trust with a Safeguarding annual report of the work undertaken during 2021 -2022 giving assurance that the Trust is compliant with its safeguarding duties and those responsibilities specified under section 11 of the Children Act 2004, NHS Assurance Framework 2015 and current safeguarding adult legislation.

Present proposed developments for 2022 – 2023 based on local, regional, and national safeguarding agenda

The report demonstrates the continued performance of the trust within the safeguarding arena which covers Safeguarding Children (Child Protection, Domestic Abuse, FGM, County Lines, Allegations against staff), Safeguarding adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and the PREVENT strategy. During 2021 – 2022 the safeguarding portfolio has expanded to further and now includes Dementia, Learning disabilities and Autism, and Mental Health

Whilst managed within the Nursing Directorate the safeguarding agenda threads through all aspects of the Trust business and the trust play an active part within the wider safeguarding multiagency partnerships

Issues to note:

- Liberty Protects Safeguards
- Safeguarding training targets still below required levels however work continues to move training back to a face-to-face delivery process which should ensure compliance levels continue to rise steadily over the coming 12 months

Since 2020 there has been a plan to replace the current Deprivation of Liberty Safeguards with a new process entitled ‘Liberty Protects Safeguards’. Guidance has been delayed on multiple occasions due to the pandemic and at present Draft guidance is out for consultation with a closing date of mid-July 2022.

It is likely that LPS will not now be launched until October 2023 and possibly as late as April 2024. The delay in official guidance has meant that it is it is not possible accurately predict the impact on the trust, but it is widely expected to have a financial and workload effect on the trust.

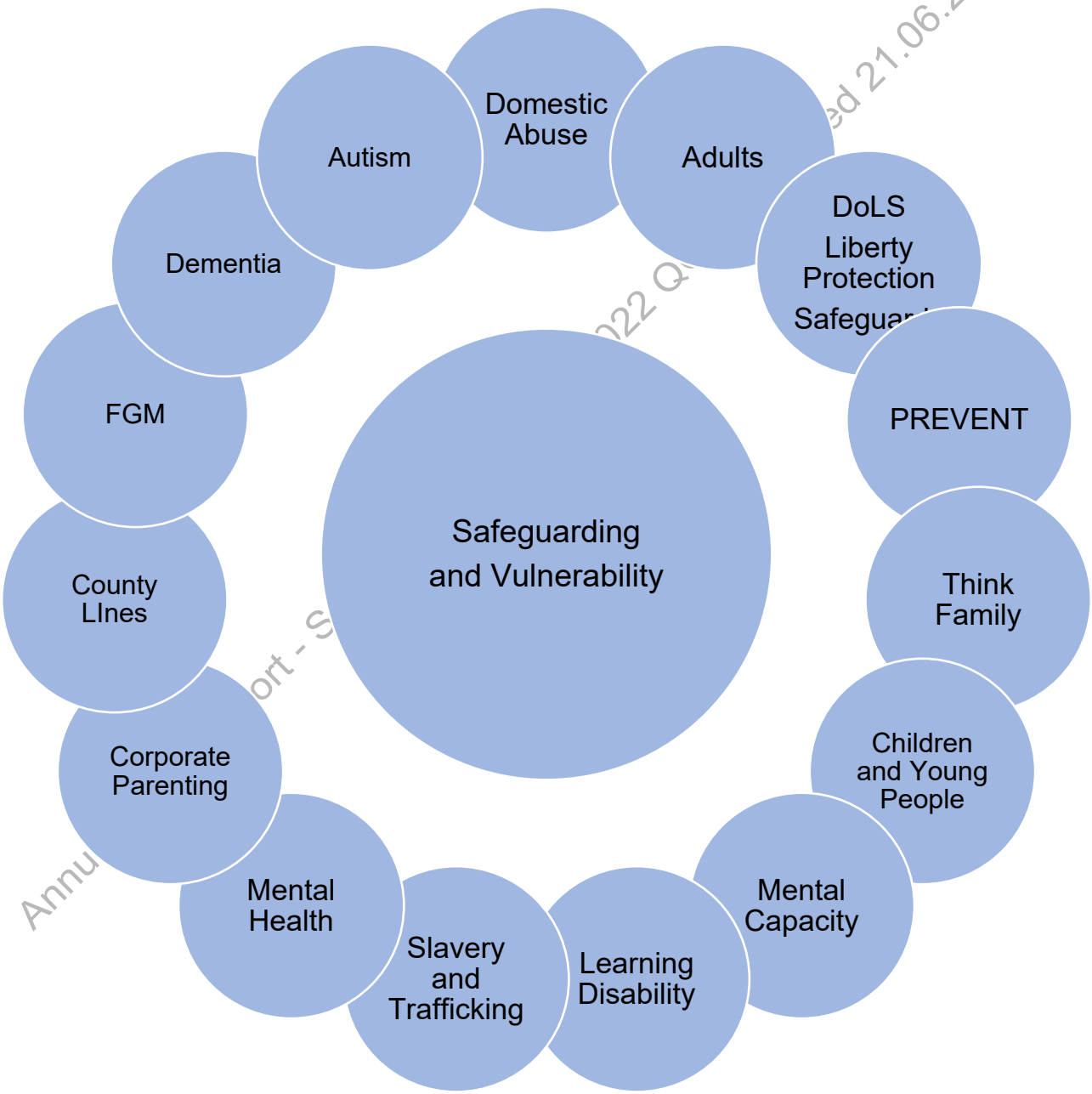
Despite the changing dates a paper has been presented to CRIG with an outline business case (agreed in principle) and a further detailed business case will be submitted once the impact of LPS is more understood

Safeguarding training remains a challenging area and although there is a steady overall rise in compliance this is slower than expected due to the last pandemic therefore this will remain a key focus for 2022 -2023.

NHS
United Lincolnshire Hospitals
NHS Trust

Safeguarding and Mental Capacity Annual Report 2021 - 2022

OUTSTANDING CARE *personally* DELIVERED


Safeguarding and Vulnerability
Domestic Abuse
Adults
DoLS Liberty Protection Safeguar
PREVENT
Think Family
Children and Young People
Mental Capacity
Learning Disability
Slavery and Trafficking
Mental Health
Corporate Parenting
County LInes
FGM
Dementia
Autism

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Foreword

As the Executive Lead for Safeguarding, I am pleased to introduce United Lincolnshire Hospitals NHS Trust's Safeguarding and Mental Capacity Annual Report for 2021/22. Over the past year, the Trust has continued to deliver quality and compassionate care and treatment across the communities in which we provide inpatient, community and emergency services. All of this is against the backdrop of an unprecedented pandemic which started in March 2020.

In February 2022 the Care Quality Commission (CQC) published its inspection findings. The Trust received an overall rating of 'requires improvement' with 'good' for Caring and Good for Well-Led. Without exception staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs. Staff also provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.

The Trust has set out a clear vision, values and strategic objectives through our integrated improvement plan. We aspire to provide outstanding care personally delivered which is of the highest quality in collaboration with everyone who uses and delivers our services. Everything we do involves and prioritises our patients, and their families and carers.

Safeguarding our people and their rights is key to all that we do as a Trust. This report highlights how we achieve this and sets out our commitment to the coming years' Safeguarding agenda.

The Trust Board of Directors are committed to ensuring all patients accessing our services are protected from harm and abuse ensuring that safeguarding remains a priority within the organisation. The Trust's **Safeguarding Statement of Intent 2021-2024** is published on our website.

The Trust has specialist Safeguarding and Mental Capacity staff who lead on and embed the practice of protecting adults and children from abuse, neglect, modern slavery, domestic abuse, and radicalisation and over the last 12 months have taken on the additional specialist areas of Learning Disability/Autism, Dementia and Mental Health. The team work tirelessly to ensure that our frontline staff have the required skills and knowledge to protect people, uphold their human rights and assess capacity.

I would like to thank our caring and compassionate staff, volunteers and Safeguarding team for their commitment and dedication in working alongside and providing protection, guidance and support to people whose circumstances make them vulnerable to abuse, neglect or radicalisation.

Dr Karen Dunderdale

Director of Nursing/Deputy CEO and Executive Lead for Safeguarding

Statement from Lincolnshire Safeguarding Childrens Partnership (LSCP) and Lincolnshire Safeguarding Adults Board (LSAB)

A wide range of Trust staff have a vital role to play in safeguarding and promoting the welfare of children and adults including paediatricians, doctors, nurses and midwives. In addition, there are a number of designated professionals who provide expertise in this important and sensitive area. (e.g., Paediatrician for unexpected deaths in childhood)

It is clear that the Trust has a high commitment to safeguarding and this is demonstrated by their strong engagement levels within the respective partnerships. They are represented at many levels within the overall structures and contribute significantly to the work of the partnerships focussing on strategic priorities and the business plans.

We are grateful to the safeguarding team and all frontline staff for their dedication and look forward to developing this positive way of working together even further.

Mr Chris Cooke Independent Chair of LSCP

Mr Richard Proctor Independent Chair of LSAB

1.0 Purpose of Report

The purpose of the report is to provide the Board with an annual update of the work undertaken in 2021 - 2022 with regard to safeguarding children and adults, Prevent, Mental Capacity and Deprivation of Liberty Safeguards (DOLs), Learning Disability /Autism, Dementia and Mental Health and the proposed areas of development for 2022 - 2023.

2.0 Legislative Background

The NHS Outcomes Framework 2020 identifies that sustainable quality improvements are achieved when the focus is on outcomes, rather than being process driven. The DOH Outcomes Framework sets out five overarching high-level outcome domains for quality improvements.

Domain 1 Preventing people from dying prematurely.

Domain 2 Enhancing quality of life for people with long-term conditions.

Domain 3 Helping people to recover from episodes of ill health or following injury.

Domain 4 Ensuring that people have a positive experience of care; and

Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.

In terms of safeguarding the key domains are:

Domain 4 Ensuring people have a positive experience of care,

Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.

The revised guidance "Safeguarding Children, Young People and Adults at risk in the NHS: Accountability and Assurance Framework (NHS England 2019) sets out the safeguarding roles, duties and responsibilities of all NHS health care organisations.

The Trust has a range of statutory duties including safeguarding children and adults and is required to give assurance to both Local Safeguarding Partners and commissioners of service to demonstrate that we have effective safeguarding arrangements in place.

Safeguarding forms part of the NHS national contract (service condition 32 - Safety and Safeguarding) and the CCG monitors our performance via contract monitoring processes.

NHS England Safeguarding agreed a range of safeguarding programmes which were included in the NHS England Standard Contract for 2021 – 2022.

2.1 Safeguarding Children

Since the statutory inquiry into the death of Victoria Climbié (2003), and the first Joint Chief Inspectors' report on Safeguarding Children (2002) highlighted the lack of priority status given to safeguarding, there has been a consistent process of review and change of legislation.

In 2021 the face of safeguarding children is very different to that of the late 1990s and an emphasis on early help rather than punitive action is what currently drives the system and as such the number of children on plans continues to vary.

Whilst systems change, at a national level we continue to see tragic cases involving child abuse such as Arthur Labinjo-Hughes aged 6 (Solihull) and Star Hobson aged 1 (Keighley) who both died at the hands of the very people who were expected to protect them.

Safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children (2018 – *updated December 2020*) as

- protecting children from maltreatment.
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes

Safeguarding Children is everyone's responsibility, Section 11 of the Children Act 2004 places a duty on key persons and bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

This is a standard requirement within all ULHT contracts of employment

At an organisational or strategic level, key features which must be adopted by NHS organisations (monitored by the Local Children Safeguarding Partnerships and Commissioners) are:

- Senior management commitment to the importance of safeguarding and promoting children's welfare.
- A clear statement of the agency's responsibilities towards children for all staff.
- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children.
- Service developments that take account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families.

- Staff training on safeguarding and promoting the welfare of children for all staff working with or in contact with children and families.
- Safe recruitment procedures in place.
- Effective inter-agency working to safeguard and promote the welfare of children
- Effective information sharing.
- CQC Standard 7: Safeguarding people who use services from abuse

An audit of Section 11 duties is undertaken by the Local Safeguarding Children Partnership (LSCP) and any subsequent action plans will be monitored in line with the current governance arrangements. The most recent section 11 submission took place in February 2021 and the trust reported ***full compliance which was agreed by the LSCP***

2.2 Safeguarding Adults

The passing of the Care Act 2014 has meant significant changes in the way adult safeguarding operates across ULHT. The safeguarding process has now been placed on a statutory footing and the requirements placed on our organisation have become more clearly defined.

The term vulnerable adult has been replaced by “Adult at Risk” and the definition of safeguarding adults has changed to:

“The process of protecting adults (18 years plus) with care and support needs from abuse or neglect”.

In the same section the key role played by public organisations in safeguarding adults at risk is also noted.

The victim in the process is now the “adult at risk”, the perpetrator “the alleged source of risk” and a written “Safeguarding Alert” is now termed a “Safeguarding Concern”

The Act recognises the need to focus on openness and transparency, in the drive to improve the quality of care individuals receive. This segues neatly with our own health service requirement for “Candour” as set down in ULHTs Incident Management Policy (C-P-43) and in line with the Trusts statutory Duty of Candour as defined in Regulation 20 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Act also places the duty on public organisations like ULHT to take action when abuse or neglect is suspected or known and underlines the duty to ensure that all staff are trained in safeguarding proportionate to their roles and responsibilities. Both of these are explicit in ULHTs Safeguarding Policy’s and training plans.

2.2.1 Implications for Safeguarding Vulnerable Adults

The Act sets out the statutory framework for adult safeguarding, including local authorities' responsibilities, and those of the local partners. In many cases the requirements of the Act are already fulfilled and expand across not just safeguarding but also cover some of our more vulnerable clients such as those with dementia and learning disabilities.

Safeguarding Principles

Principle 1 – Empowerment	Presumption of person led decisions and consent
Principle 2 – Protection	Support and representation for those in greatest need
Principle 3 – Prevention	Prevention of neglect harm and abuse is a primary objective.
Principle 4 – Proportionality	Proportionality and least intrusive response appropriate to the risk presented
Principle 5 – Partnerships	Local solutions through services working with their communities
Principle 6 – Accountability	Accountability and transparency in delivering safeguarding

2.3 PREVENT

2.3.1 What is PREVENT?

The Counter-terrorism and Security Act 2015 placed PREVENT on a statutory footing. The Office for Security and Counter Terrorism (OSCT) in the Home Office is responsible for providing strategic direction and governance on CONTEST. As part of CONTEST, the aim of PREVENT is to stop people becoming terrorists or supporting terrorism and again transitions into vulnerable children & adults who are groomed and exploited to carry out acts of violence against others

CONTEST is primarily organised around four key principles. Work streams contribute to four programmes, each with a specific objective:

PURSUE: to stop terrorist attacks

PREVENT: to stop people becoming terrorists or supporting terrorism

PROTECT: to strengthen our protection against a terrorist attack

PREPARE: to mitigate the impact of a terrorist attack.

The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.

PREVENT has 3 national objectives:

Objective 1: respond to the ideological challenge of terrorism and the threat we face from those who promote it

Objective 2: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support

Objective 3: work with sectors and institutions where there are risks of radicalization which we need to address

The Health Sector contribution to PREVENT will focus primarily on Objectives 2 and 3.

PREVENT training undertaken is undertaken in line with the Prevent Training and Competencies Framework - Department of Health and Social Care (2021)

2.3.2 Why Health care staff?

The overall principle of health is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation. PREVENT is also about protecting individuals.

PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence.

3.0 Designated and Named Professionals for the Trust and its Commissioners

3.1 Children

The terms designated and named professionals (children) are clearly defined in Working Together 2018 as professionals with specific roles and responsibilities for safeguarding children.

All Clinical Commissioning Groups are required to have a designated doctor and nurse whose responsibility it is to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the commissioned area, which includes all providers. The designated professionals are also in place to provide professional advice on matters relating to safeguarding children for other professionals, NHS Commissioners, Local Authority children's services and the safeguarding children partnerships. The Designated Professionals for Lincolnshire are employed within the CCG and provide this support to the Trust.

Moving forward there is clear guidance from NHSE/I that the Designated Professionals must remain a key component to safeguarding within the new Integrated Care Partnership and the statutory responsibilities including child safeguarding, SEND, children in care, children in the justice system will be a delegated responsibility delivered via the Integrated Care Board

All NHS Trusts must identify a named doctor, a named nurse and a named midwife (where maternity services are provided) for safeguarding with the focus of the named professional being on safeguarding children within their own organisation. These professionals are in post within the Trust and include a lead anaesthetist for safeguarding children as recommended by the Royal College of Anaesthetists (2012)

3.2 Adults

Following the publication of Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (July 2015) there is now an expectation that Designated (CCG) and Named professionals (ULHT) for safeguarding adults are in place. ULHT have been proactive in the development of the safeguarding adult service and as such the Deputy Director for Safeguarding holds the strategic lead for both children and adults and the Trust has a Named professional responsible for

safeguarding adults and Mental Capacity Act supported by specialist nurses with responsibility for Safeguarding Adults, Learning Disability/Autism and Dementia

4.0 The ULHT Safeguarding Team

The Safeguarding Team has been in place for several years and historically was responsible for Child Protection (ULHT), Adult Protection (ULHT), MCA/DOLS and the PREVENT agenda (ULHT). During 2021 to 2022 the teams remit expanded and now leads on Mental Health, Learning Disability, Autism and Dementia.

During 2022 – 2024 the team will develop and lead on the new Liberty Protection Safeguards which will replace the current Deprivation of Liberty (legislation/guidance pending) *

A full structure of the current safeguarding team can be found at appendix 1

**Presently the national guidance is in a consultation phase (ending July 2022) and until this process is concluded it is not possible to fully understand the impact on the Trust. (See appendix 2 for timeline)*

5.0 ULHT Safeguarding Governance Arrangements

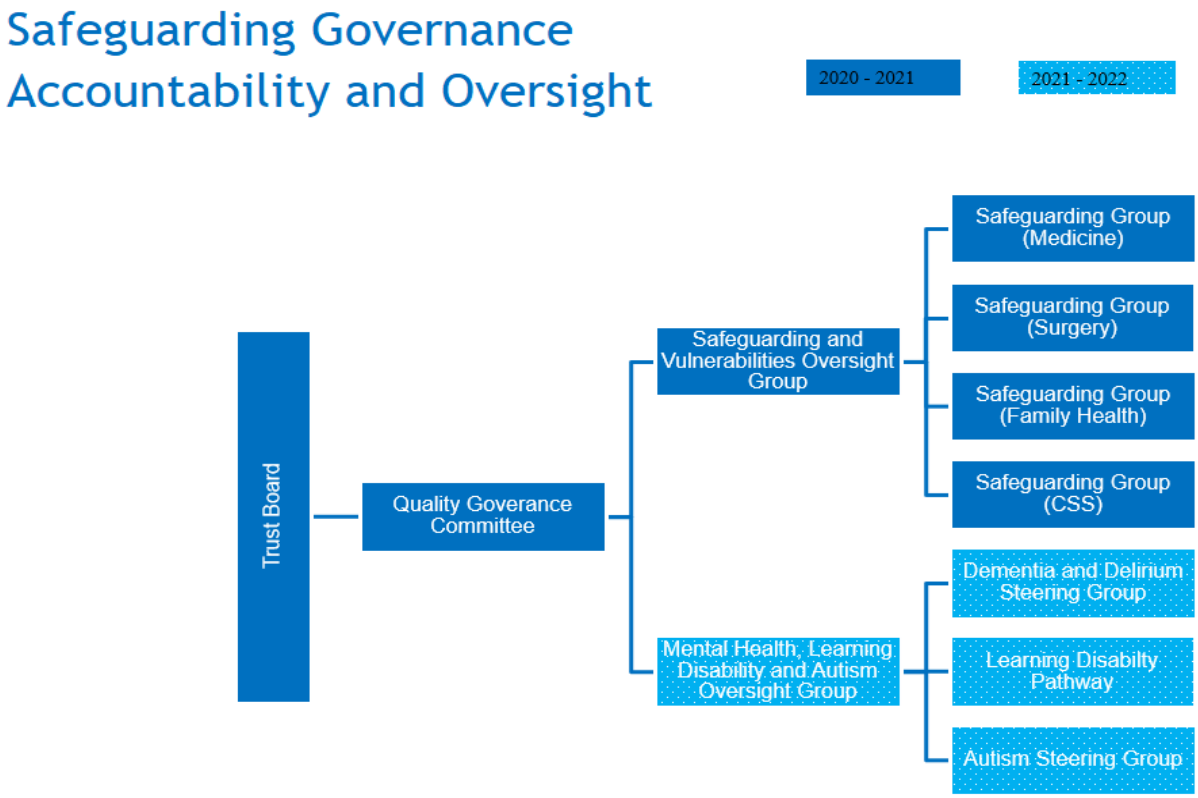
The responsibility for safeguarding rests ultimately with the Chief Executive Officer, supported by the Executive Director with Board responsibility (Dr Karen Dunderdale, Director of Nursing / Deputy CEO) and Dr Chris Gibson - Non-executive Director.

The Trust has in place the following safeguarding specific groups:

Safeguarding and Vulnerabilities Oversight Group (SVOG) which reports to the Quality Governance Committee (figure 1). The group is active in the management of the current action plans / issues within the specialist area. The group is chaired by the Deputy Director of Safeguarding and the divisional groups are chaired by a senior manager within the division.

Mental Health, Learning Disability and Autism Group (MHLDA) which reports to the Quality Governance Committee (figure 1). The group is active in the management of the current action plans / issues within the specialist area. The group is chaired by the Deputy Director of Safeguarding and the sub-groups chaired by the Named Professional for Safeguarding Adult

Figure 1: Safeguarding Governance Accountability and Oversight



6.0 Local Safeguarding Children Partnership Board (LSCP) and Local Safeguarding Adult Board (LSAB)

Safeguarding Children Partnerships and Safeguarding Adults Boards were set up as statutory bodies under a national model led by the local authority until a government review of their role in 2016. This led to changes in relation to Safeguarding children, bringing about a shared responsibility for safeguarding amongst the identified three lead partners (Local Authority, Police and CCG) and the change to Local Safeguarding Arrangements which allow some flexibility based on local needs.

They are a partnership of the relevant statutory, voluntary and community agencies involved in safeguarding and promoting the welfare of all children and young people /adults at risk of abuse. They do this by coordinating the safeguarding work of member agencies so that it is effective; monitoring, evaluating and when necessary, challenging the effectiveness of the work and advising on ways to improve safeguarding performance.

The Local Safeguarding Children Partnership / Adult Board within Lincolnshire both have Independent Chairs and membership has been reviewed ensuring that attendance is at the required levels and members have sufficient seniority

The Trust is represented by the Deputy Director of Safeguarding at the Partnership/Board and there is representation by other key safeguarding professionals on the subgroups.

6.1 LSCP Key areas of action

- Tackling Child Exploitation and understanding emerging themes of abuse
- Enhancing the Emotional Wellbeing of Children and Young People
- Promoting Healthy Relationships
- Working Together to Recognise Risk Making Behaviours
- Identify and Reduce the Impact of Neglect on Children and Young People.
- Identify and Reduce the Impact of Domestic Abuse on Children, Young People and their Families.

LSCP Business Plan 2021 - 2022

6.2 LSAB Key areas of action

- Develop and improve our early help and preventive practice.
- Develop effective community and service user engagement.
- Develop a quality and assurance framework and to measure and demonstrate policy success.
- Continue to develop the ethos and practice of Making Safeguarding Personal (MSP); and,
- Learn from reviews and put service improvements into practice.

ULHT are actively involved in all the above areas by way of delivering the topic areas within training and/or sitting on operational groups to actively target the perpetrators and support the victims of abuse.

Lincolnshire Safeguarding Adult Board Strategy 2018 - 2021

The above LSAB strategy was extended until the end of 2022 due to the Covid Pandemic

7.0 Child Safeguarding Practice Reviews (Previously Serious Case Reviews - SCR) / Serious Adults Review (SAR) / Domestic Violence Homicide reviews (DVHR)

7.1 Children

Child Safeguarding Reviews have been in place for many years and nationally about 100 take place every year. A review is always carried out by the Safeguarding Partnership when a child dies and abuse or neglect is known, or suspected, to be a factor in the death. Working Together (2018) guidance also states that LSCP should consider holding a review where a child has sustained a life-threatening injury through abuse or neglect, serious sexual assault, or through serious and permanent impairment of health or development through abuse or neglect. The purpose of a review is to establish what lessons can be learnt about the way professionals and organisations worked together, how they will be acted upon and what is expected to change in order to improve inter-agency working and improve safeguarding practice to children. Reviews are exercises in learning and improving policy and practice and outcomes for children and young people and are not inquiries into how a child died or who was culpable; this is the business of Coroner's and the Criminal Court.

A review is commissioned by the LSCP and involves setting up a multi-agency review panel of senior and experienced managers, with an independent chair, to ensure objectivity and impartiality. The panel must produce a report to the LSCP on lessons learnt, the LSCP then ratifies the conclusions and recommendations for actioning the lessons.

The report goes to the Trust Safeguarding and Vulnerabilities Oversight Group and Ofsted / CQC and national oversight panel for their scrutiny and response. All relevant agencies are expected to produce and implement an action plan, based on the recommendations, which is overseen by the LSCP Significant Incident Group.

During 2021 - 2022 the Trust has been involved in one new review, which is a combined Child Safeguarding Practice Review (CSPR) and Domestic Homicide Review (DHR) and there were three reviews (JBR2016 / SCR2018H* / SCR2019J) published. **All Trust actions are complete** for all the published Reviews, and at this stage, there are no new actions for the Trust in relation to the combined CSPR/DHR**.**

During this period the Trust has also submitted information to support five Lincolnshire and one bordering LSCP rapid reviews. The outcome of each of the Lincolnshire rapid reviews resulted in a decision that the criteria for undertaking a CSPR had not been met. These decisions were validated by the National Panel. ULHT was not required to participate in the bordering LSCP review, due to lack of relevant in-scope involvement.

**** Reports only remain on the LSCP website for 12 months and are then removed - the Trust hold a copy of the report should board members wish to read it***

7.2 Adults

Safeguarding Adult reviews within the safeguarding adult's process are still relatively new and since 1st April 2015 form part of a statutory process. The criterion for undertaking a SAR is similar to that of the children's review. ULHT is currently involved in no ongoing reviews

7.3 Domestic Violence Homicide Reviews (DHR)

A DHR is very similar in nature to a children's or adults' review however takes place *when a death occurs in a young person (16 & 17 years), or an adult and the cause is linked to Domestic Violence or Abuse*.

Nationally there were 362 domestic homicides recorded by the police in the three-year period between year ending March 2018 and year ending March 2020. This represents 19% of all homicides where the victim was aged 16 years and over during this period.

Of the 362 homicides, 214 (59%) were female victims who were killed by a partner or ex-partner. In contrast 33 (9%) were male victims who were killed by a partner or ex-partner. The remaining 115 (32%) were victims killed by a suspect in a family category.

Since the introduction of the Statutory Domestic Homicide Reviews in April 2011 there have been 26 cases involving 36 deaths (including 4 alleged perpetrators) that have met the criteria for a domestic homicide review in Lincolnshire

During 2021-2022, four new DHRs were commissioned within Lincolnshire. In total, ULHT is currently involved in nine DHRs; two of which were identified in 2020 but commenced in 2021, and three which were ongoing prior to 2020.

The Partnership published two DHRs during 2021-22. (Holly and Peter, Ron and Judith

In addition to the Lincolnshire, DHRs, ULHT is also involved in an out of County DHR, involving submission of a chronology and report for a former patient who was resident in Sunderland at the time of their death..

During 2021-22, the Trust has also submitted information to support three Lincolnshire DHR decision-making panels. The outcome of each of these Decision Panels resulted in a decision that the criteria for undertaking a DHR had not been met

There are no outstanding actions for the Trust relation to the ongoing DHRs.

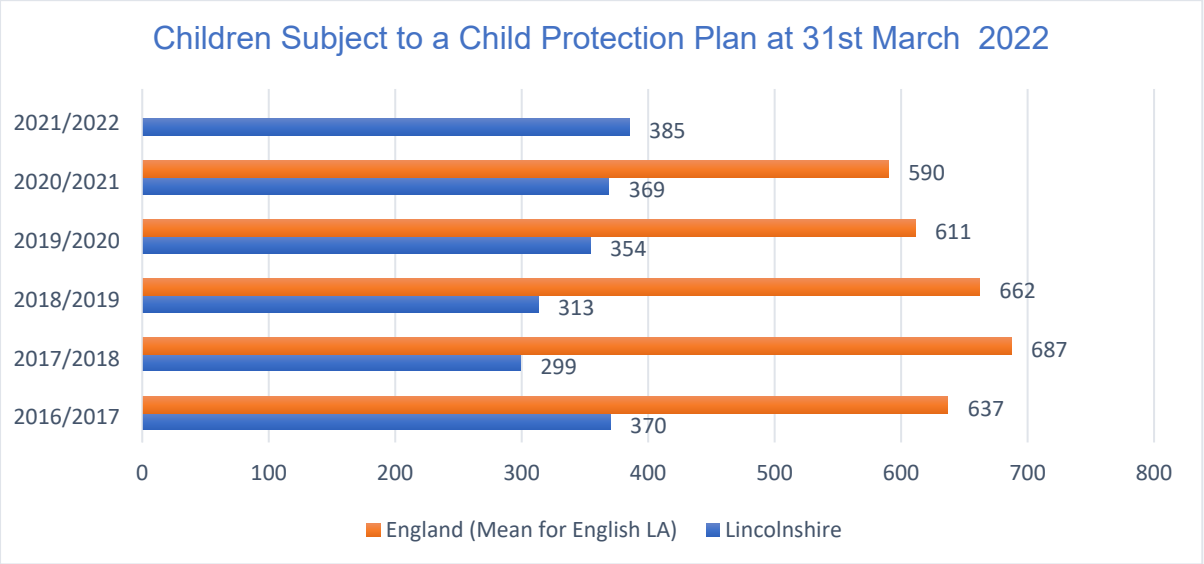
8.0 Child Protection Cases

Lincolnshire holds child protection conferences on each working day and therefore the numbers for children who currently have a child protection plan vary on a daily basis Monday to Friday and can be influenced by families moving in and out of the local authority. Overall, the numbers of children on plans (figure 2) have slowly risen over the last 5 years whereas the mean for England has demonstrated a steady fall in numbers. As yet the impact of the pandemic is not ascertained, and it is not possible to predict if there will be a significant shift in the annual figures.

Children on child protection plans are identified within the trust on Medway and via the Lincolnshire Care Portal.

During this period there has been a noticeable increase in the number of unborn babies who have become subject to child protection / court proceedings and as such there has been a significant impact on the midwifery workload

Figure 2: Number of children having a child protection plan within the Local Authority area who may be receiving services from ULHT (April 2016– March 2022) ***(England Mean 21/22 not available at time of report)***



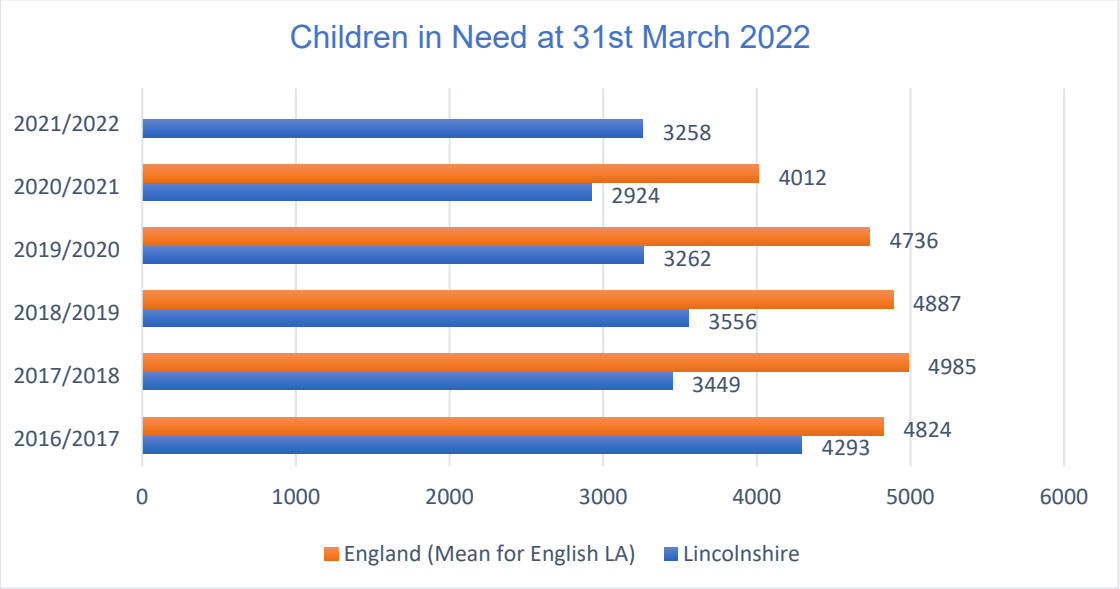
8.1 Child in Need

Some children will not meet the criteria for a child protection plan but still require a service which can be met at a lower level 'children in need' of support. The data in figure 3 demonstrates the number of children in need across Lincolnshire with an increase in numbers over the last 12 months but still remains below the England mean.

Lincolnshire has focused its support offer on 'Early Help' which is designed to assist children and family at an earlier stage and prevent them from reaching the child in need stage

Figure 3: Number of children classed as a Child in Need within the Local Authority area who may be receiving services from ULHT (April 2016– March 2022)

(England Mean 21/22 not available at time of report)



8.2 Children in Care

Children and young people who are looked after are amongst the most socially excluded groups in England and Wales. They have profoundly increased health needs in comparison with children and young people from comparable socio-economic backgrounds who have not needed to be taken into care. These greater needs, however, often remain unmet and as a result, many children and young people who are in care continue to experience significant health inequalities and on leaving care experience very poor health, educational and social outcomes.

ULHT does not directly provide the children looked after health service however many of these children will access the services within ULHT by way of A+E or Paediatrics and research demonstrates that children in care will continue to have a high levels of Adverse Childhood Experiences (ACES) which impact on lifelong health and opportunities and therefore continue to access services long into their adult life.

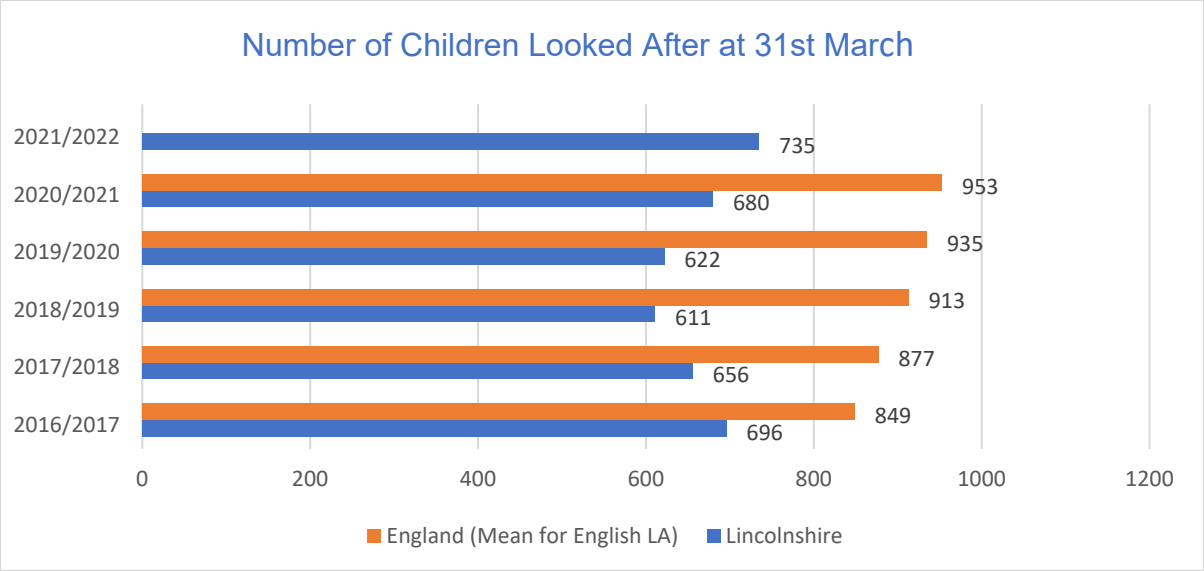
Due to the demographics of Lincolnshire the Trust may also provide services to other young people who are placed in care within Lincolnshire from other Local authority areas.

Over the last 4 years the number of children in Care of Lincolnshire Local Authority has risen in line with the England mean.

Children within the trust are identified within Medway and via the Lincolnshire Care Portal.

Figure 4: Number of children classed as a Child in Care within the Local Authority Area who may be receiving services from ULHT (April 2016 – March 2022

(England Mean 21/22 not available at time of report)



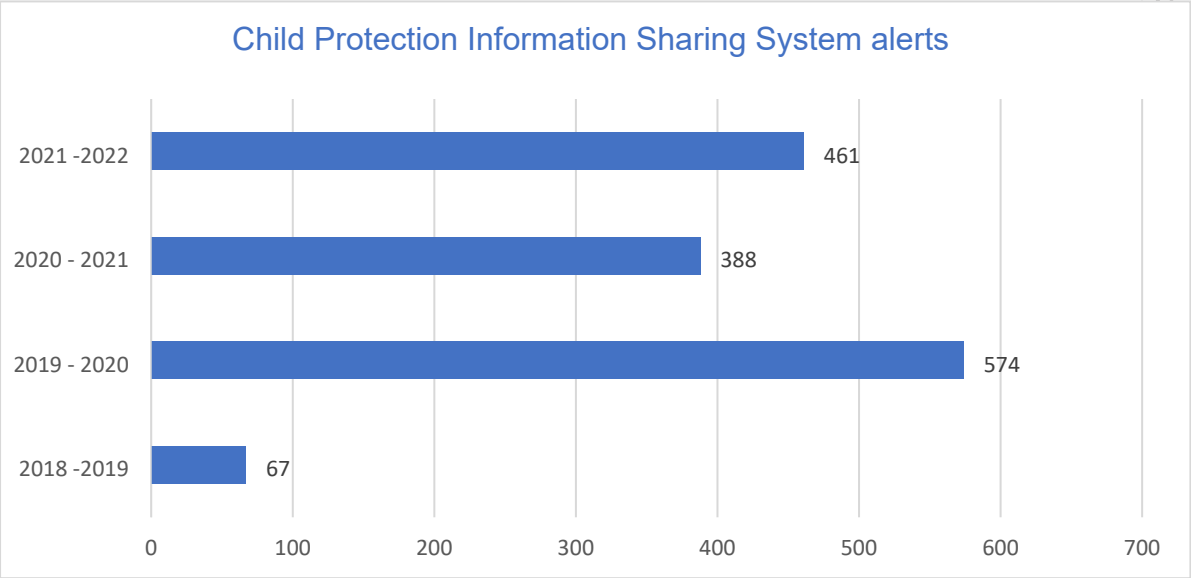
A review of the safeguarding flagging systems in the Trust has taken place during 2021 – 2022 to ensure that information is accurate and shared across as many areas as possible. Because of the large amount of data, it is expected that the process will be completed by the end of 2022

8.3 Child Protection Information Sharing System (CP-IS)

ULHT has in place systems for flagging high risk cases (e.g., Child Protection/Children Looked After/Domestic Abuse and Child Exploitation) within its Admission Systems. Following the development of the National CP-IS system, ULHT completed work with our Local Authority Partners to introduce this system into Unscheduled Care/Maternity settings Trust-wide, in line with NHS Digital's deadline of 31st March 2019. Currently, a CP-IS notification is triggered when an NHS number is entered into Medway; with relevant information being stored within the Lincolnshire Care Portal for clinical staff

to access in order for them to determine the current level of Social Care involvement and facilitate appropriate liaison. Training was provided for clinical staff in line with each of the relevant areas 'going live'; with supplementary pathways and user guides created to support usage. Upon attendance, additional Safeguarding alerts are then placed onto the patient's Medway record to ensure non-scheduled care settings are aware of their Safeguarding status.

Figure 5: The number of attendances for which a CP-IS alert was triggered during 2018 (partial data) - 2022



Comments: During 2020 - 2021 the continued effects from the repeated COVID lockdowns may have contributed to a lower number of attendances than was noted during 2019-20 with 2021-2022 possibly demonstrating a more normal pattern

For future reports, it is hoped that we will be able to demonstrate the ratio/split between CP, LAC and Unborn CP attendances.

During early 2021 an audit was undertaken to assess Practitioner compliance with the CP-IS pathway. The audit demonstrated a degree of noncompliance brought about by staff turnover, impact of the pandemic and lack of staff understanding. A programme of work was planned however, due to the CQC identifying issues with A&E staff members' knowledge of and compliance with the Trust's process for checking the CP-IS status of children and young people, an extended training programme for A&E staff has been implemented and monthly audits have been undertaken. The Trust's Safeguarding Team will continue to monitor compliance via the audit programme reporting to the Children and Young Peoples Oversight Group.

9.0 Adult at risk

Adult protection continues to expand with increasing workload not only within the safeguarding team but impacting on the general roles within the Trust i.e., Complaints/PALS, Matrons, and operational staff.

The number of referrals raised by the Trust varies. There is a greater emphasis on making safeguarding personal and involvement of the patient since the Care Act 2015. In the interests of making safeguarding personal, it is good/expected practice to discuss concerns with the adult at risk prior to a referral being raised in order that consent is gained, and the person's views sought. When this is not completed during the time in hospital opportunities may be missed to ascertain views and wishes whilst when they are alone and in a relatively safe place.

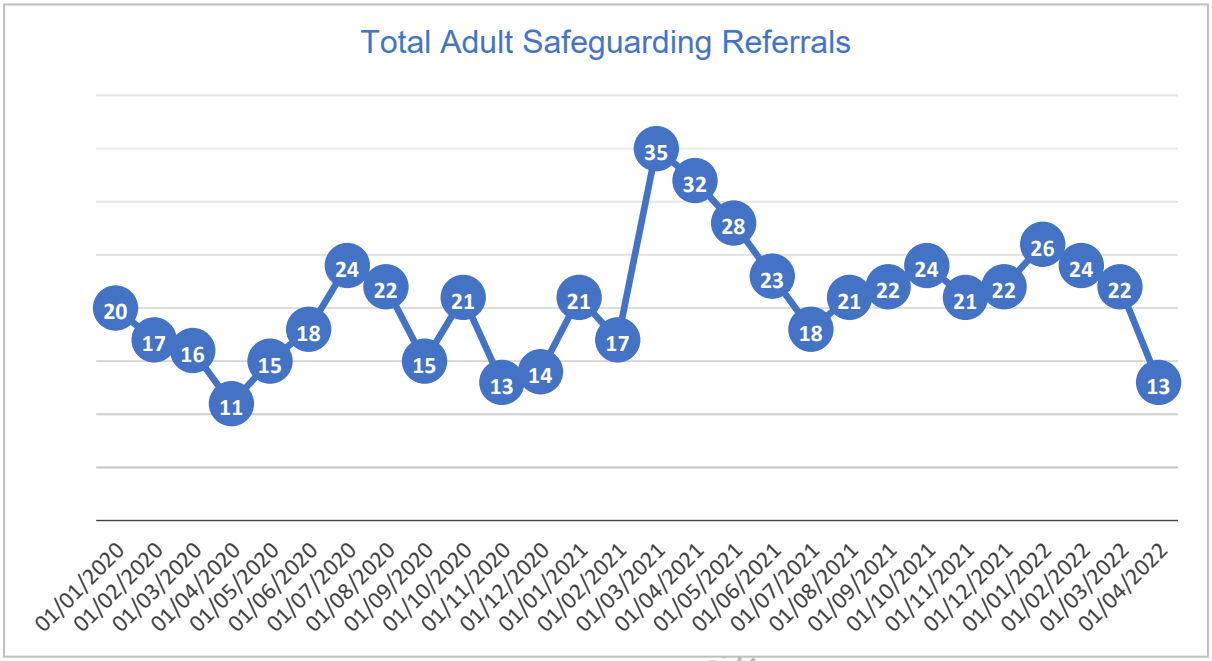
ULHT continues to promote this area of practice as referrals can be rejected as staff do not always meet this requirement and ongoing work is required to ensure compliance with the making safeguarding personal agenda which is re-audited by the LSAB

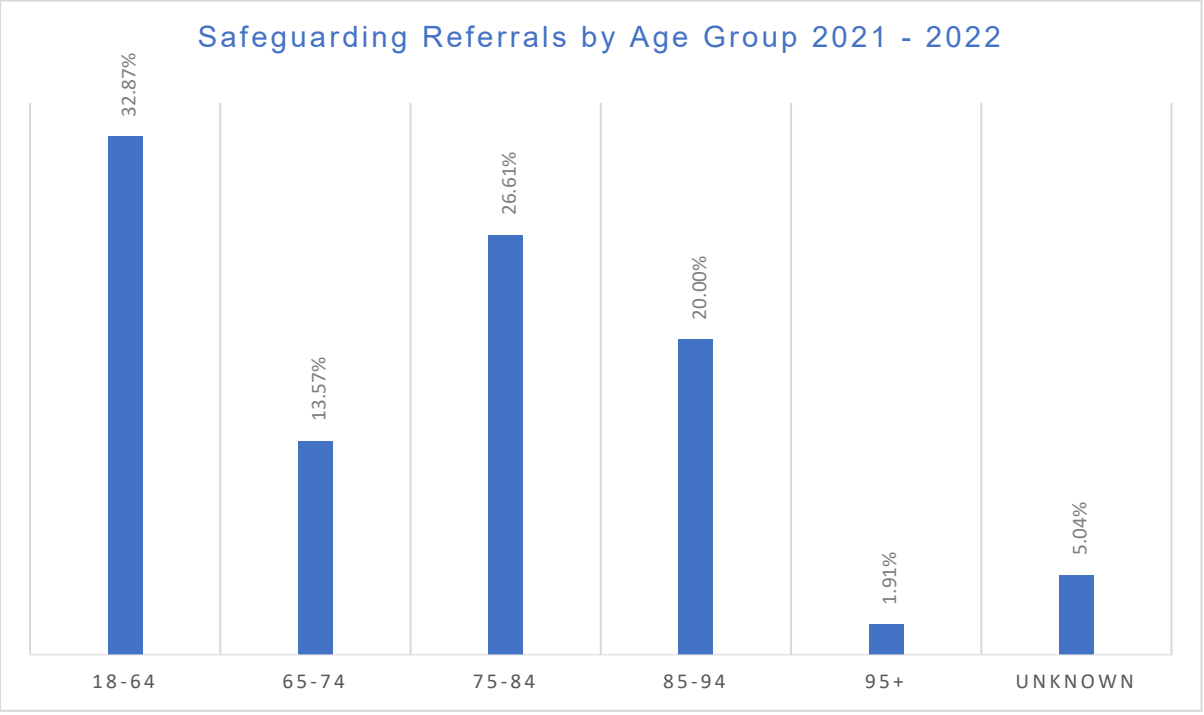
The number of safeguarding adult cases raised against the Trust is also variable in number with several referrals being made against the Trust which do not meet the safeguarding adult criteria as specified by the Association of Directors of Adult Social Services (ADASS) and Care Act 2015. These are therefore re-directed to another suitable avenue of investigation (i.e., PALS / Complaints) or indeed back to the originating referrer

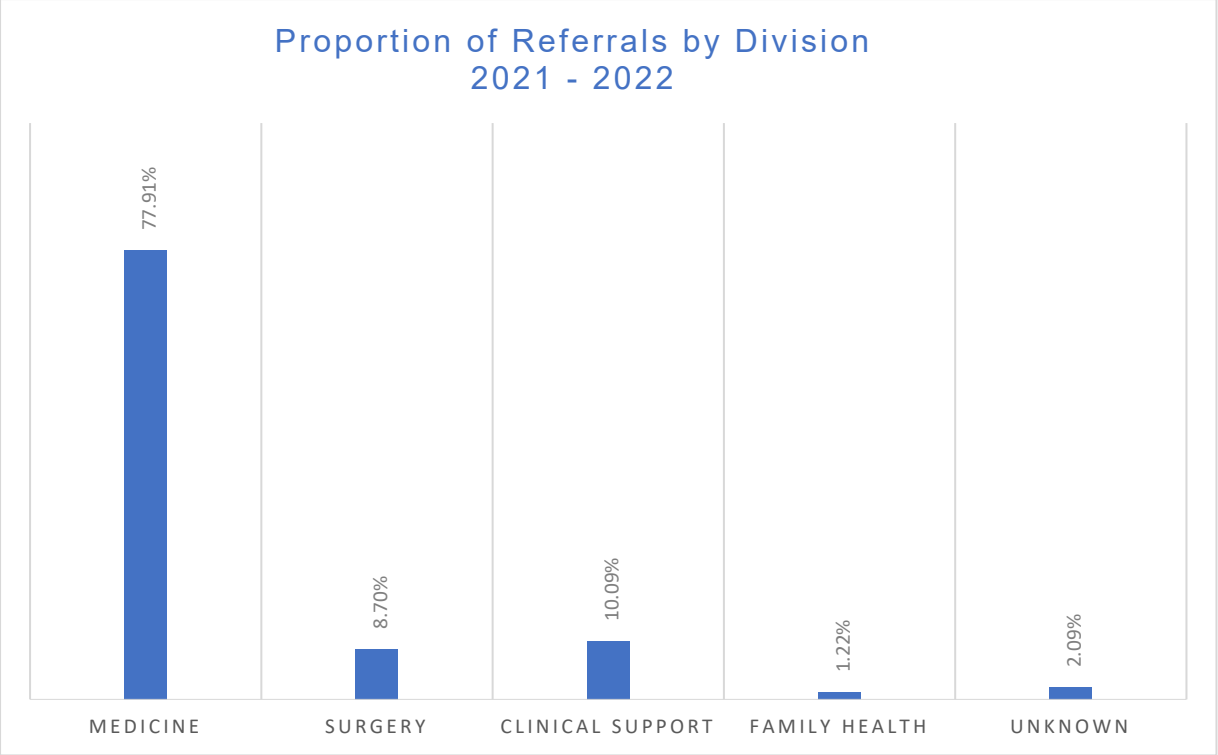
General trends from these investigations highlight issues of variable nursing care, lack of co-ordinated discharge and poor communication / record keeping and pertain to most staff groups. The team undertake monthly audits and undertake focussed work within clinical areas that are identified as requiring further support

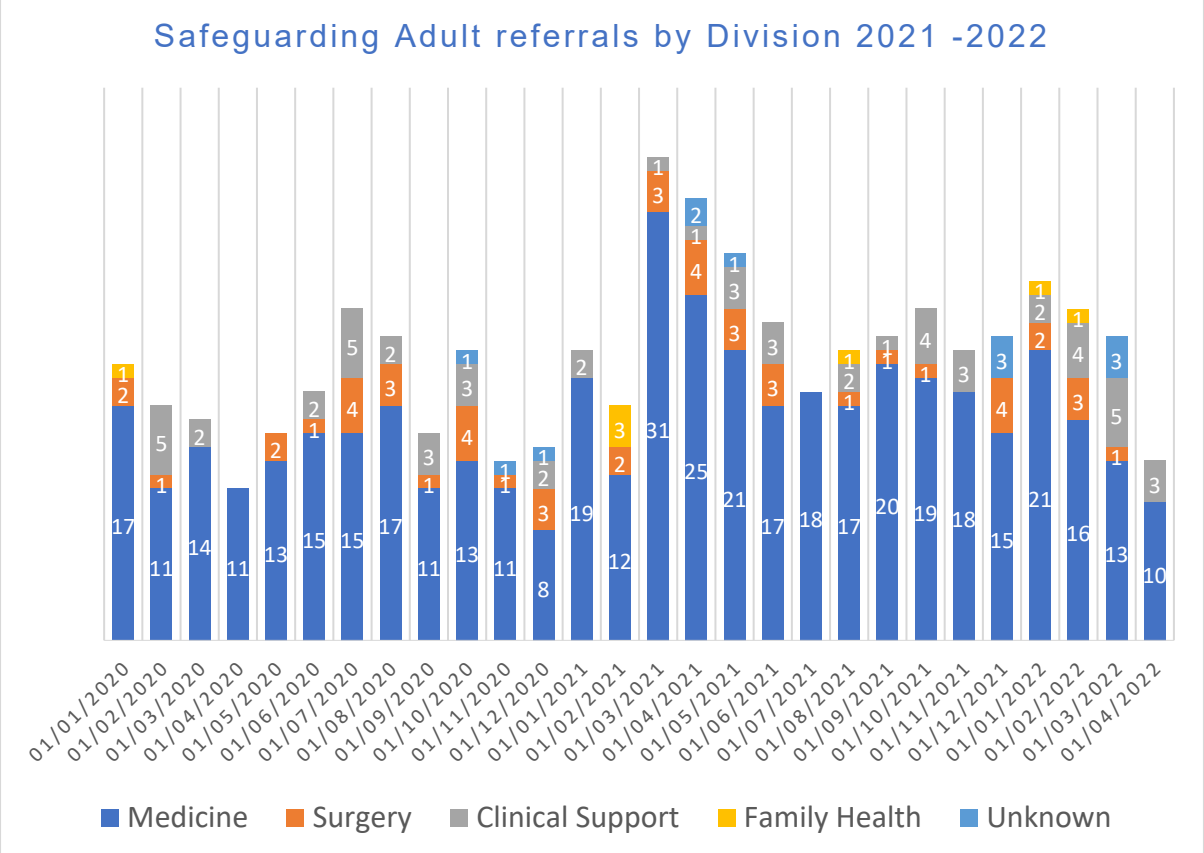
The Named professional meets monthly with the CQC and separately with the CCG and LA to ensure that there is an open and honest dialect maintained and works on the premise of ‘no surprises.

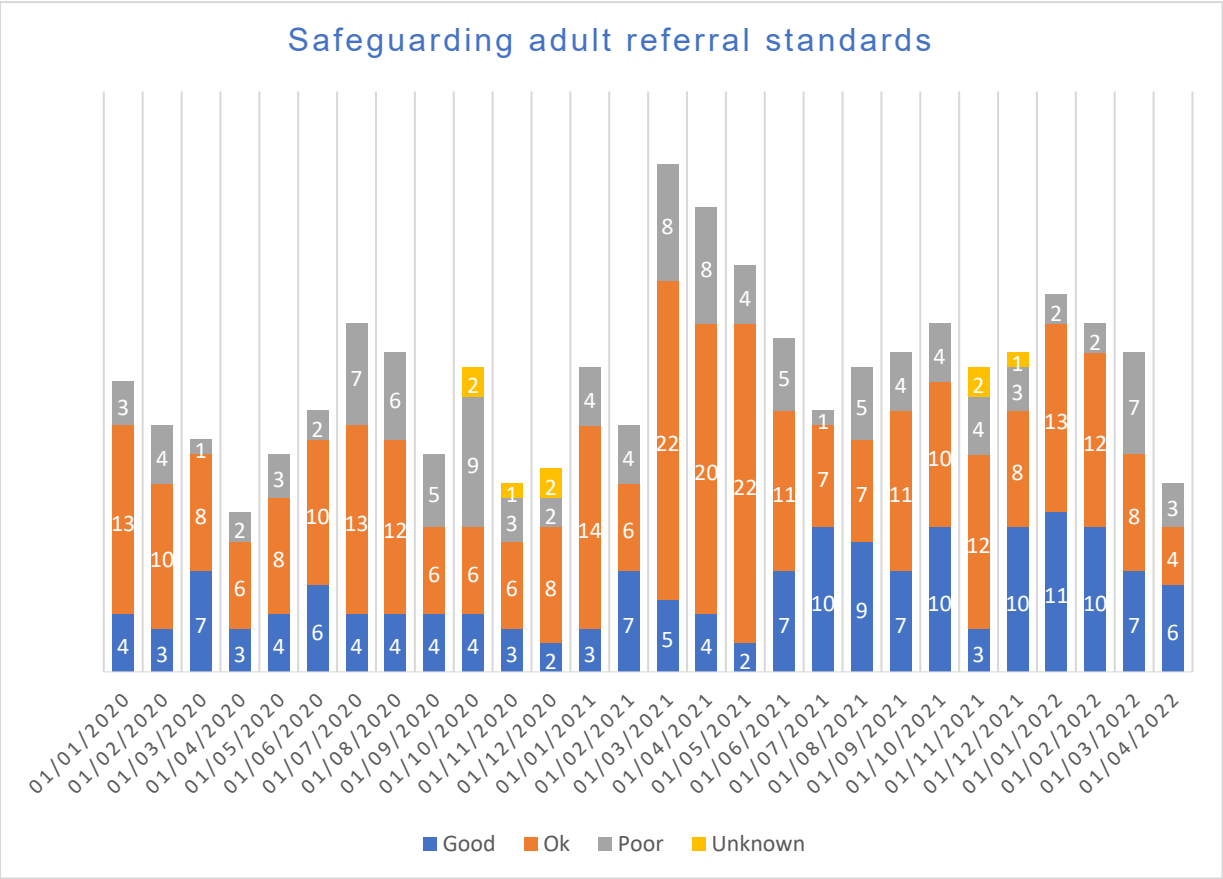
Figure 6: Number of safeguarding adult referrals made by ULHT to the Local Authority (January 2020 – March 2022) including age breakdown and divisional breakdown






Proportion of Referrals by Division
2021 - 2022
77.91%
8.70%
10.09%
1.22%
2.09%
MEDICINE
SURGERY
CLINICAL SUPPORT
FAMILY HEALTH
UNKNOWN


Safeguarding Adult referrals by Division 2021 -2022
01/01/2020
01/02/2020
01/03/2020
01/04/2020
01/05/2020
01/06/2020
01/07/2020
01/08/2020
01/09/2020
01/10/2020
01/11/2020
01/12/2020
01/01/2021
01/02/2021
01/03/2021
01/04/2021
01/05/2021
01/06/2021
01/07/2021
01/08/2021
01/09/2021
01/10/2021
01/11/2021
01/12/2021
01/01/2022
01/02/2022
01/03/2022
01/04/2022
Medicine
Surgery
Clinical Support
Family Health
Unknown



10.0 Legal statements / Court process

The safeguarding team have continued to strengthen and develop its remit of supporting staff in statement writing and court attendance. The current trend to produce more legal statements / requests for records continues and is also impacted on with the growing area of work from the Court of Protection.

The ongoing supportive relationship / process between safeguarding and the legal / data protection team continues to work well however some improvements are in the planning to ensure that court orders are met in a timelier manner and given the ongoing increase in requests, there is a potential risk that the resource within the data protection team will not be able to maintain the timeliness of the process.

Other teams adversely affected by this increase are Paediatrics, Maternity and Emergency Departments across site with pressures being placed on paediatricians and frontline clinicians to provide reports and statements in greater detail and in a much shorter timescale.

The Court of Protection (CoP) is a court in England and Wales that can make decisions on behalf of people who lack the capacity to make their own decisions and the court mainly deals with decisions about a person's welfare, property, or medical treatment.

Whilst the Mental Capacity Act Code of Practice confirms some of the situations when decisions must be taken to the Court of Protection (Section 8.18), not all scenarios are covered including cases where there is a dispute about whether a particular treatment will be in a person's best interests.

The Court of Protection has issued guidance which states that if force or restraint is required an application to court may be required and if the force or restraint amounts to a deprivation of liberty then the authority of the court will be required to make this deprivation of liberty lawful.

ULHT have taken no cases to the CoP in the past year however have sought legal advice on several

During 2021 to 2022 the Trust commissioned a series of Court craft and legal updates for staff which currently continue to November 2022 and cover court skills suitable for children and family / Coroners' Courts as well as updated around the Mental Capacity Act and relevant changes in case law.

11.0 Safeguarding Clinical Supervision

11.1 Children

Effective clinical supervision is important to promote good standards of practice and support individual staff members. Supervision allows time for reflective practice and is a vital component in the protection of children. Supervisors should be available to practitioners as an important source of advice and expertise and may be required to endorse judgements at certain key points in time, and ensure each individual child has an effective plan of action. The Safeguarding team provide direct supervision to professionals (Individual and Group) which includes reflecting on, scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner and providing coaching, development and pastoral support.

During 2020 safeguarding supervision was managed and recorded by the Safeguarding team however a review of this process was undertaken in 2021 and because of this, safeguarding supervision is now mandated to specific staff groups and managed by way of ESR (compliance / noncompliance) making the process more transparent and increasing the governance of this aspect of support.

Compliance is monitored by the Safeguarding team with monthly reports provided to Divisional leads for escalation

11.2 Adults

Whilst less prescriptive, safeguarding supervision for adult protection cases is readily available and provided to staff who require it on a needs lead basis. This is often delivered at source on the clinical areas on a case-by-case basis and during the pandemic has been delivered via teams. As safeguarding adult / MCA is embedded, safeguarding supervision for adult cases is noticeably a bigger part of the work of the team and also recorded via the ESR system.

12.0 Training and learning

Safeguarding training has always been a high priority to the Trust and has been delivered in a variety of ways and at different levels across the organisation. A new training plan was introduced for safeguarding children and safeguarding adults in 2020 to accommodate restrictions imposed by the COVID-19 pandemic and bringing the trust in line with statutory guidance, adding some additional topic areas.

At the beginning of the pandemic all training stopped due to being traditionally delivered via classroom attendance and as a result compliance figures within the trust reduced by approximately 10% and for a period of 6 months remained static. During this period the safeguarding team developed and rolled out e-learning and local podcasts for all topic areas to ensure that where possible, staff could complete training and the trust was able to not only reduce the impact of the pandemic on safeguarding training but improve the level of compliance.

Despite the above and continuous monitoring, the pandemic has had a significant impact on the Trusts ability to significantly improve training compliance across all subject areas however the team have maintained a strong focus on maintaining training, escalating areas needing compliance and supporting staff on this important subject topic.

Despite the ongoing pressures the team have continued to adjust, update and develop new topic areas to ensure that the trust is as compliant as possible, and that new national guidance is actioned.

The reported training levels with the Trust as of 31st March 2022 were as follows

KPI Description *(A measurable value that demonstrates the success of your change, to include trajectory to achieve target)*	**Measures** *(How will this be Measured)*	**Target** *(Desired level of performance)*	**Progress** *(Current progress measured)* *END March 2022 figures*	**KPI Target date as of March 2021**	**Adjusted target date** (due to continued impact of pandemic)
Safeguarding training compliance to reach 90% for Safeguarding children level 1	Monthly training report	90%	89.44% ↑	June 2021	Dec 2022

Safeguarding training compliance to reach 90% for Safeguarding children level 2	Monthly training report	90%	80.66% ↑	Sept 2021	Dec 2022
Safeguarding training compliance to reach 90% for Safeguarding children level 3	Monthly training report	90%	81.58% ↑	Sept 2021	Dec 2022
Safeguarding training compliance to reach 90% for Safeguarding children level 4	Monthly training report	90%	100% ↑	Sept 2021	N/A
Safeguarding training compliance to reach 90% for Safeguarding adults level 1	Monthly training report	90%	88.44% ↑	June 2021	Dec 2022
Safeguarding training compliance to reach 90% for Safeguarding adults level 2	Monthly training report	90%	80.66% ↑	Sept 2021	Dec 2022
Safeguarding training compliance to reach 90% for Safeguarding adults level 3	Monthly training report	90%	81.58% ↑	Jan 2022	Dec 2022
Training compliance to reach 90 % for MCA / DOLS	Monthly training report	90%	80.73% ↑	Sept 2021	Dec 2022
Training compliance to reach 90% for PREVENT basic level	Quarterly training report	NHSE/I target 85% ULH target 90%	89.44% ↑	Sept 2021	Dec 2022
Training compliance to reach 90% for PREVENT Higher level	Quarterly training report	NHSE/I target 85% ULH target 90%	81.58% ↑	Sept 2021	Dec 2022
Mental Health	Monthly training report	90%	94.42% ↑	N/A	N/A
Dementia	Monthly training report	90%	94.11% ↑	N/A	N/A
Learning Disability / Autism Tier 1 **Introduced Dec 2021**	Monthly training report	90%	75.63% ↑	N/A	Dec 2022
Learning Disability / Autism Tier 2 **Introduced Dec 2021**	Monthly training report	90%	72.55% ↑	N/A	Dec 2022

During 2021 the portfolio for Mental Health, Dementia and Learning Disability/Autism has been embedded within the safeguarding team and as such the training topics are now managed within the team.

During 2022 / 2023 Dementia training will be reviewed with plans already underway to develop three levels of training to reflect clinical need.

Learning disability training was introduced in December 2021 and was a need identified across the NHS following the tragic death of Oliver McGowan in November

2016 from substandard health care and the successful campaign by Paula McGowan (Oliver's Mother)

olivermcgowan.org

Uptake and feedback have been very positive with requests for more in-depth training moving forward

An action for 2021 – 2022 was to achieve the original targets set above however during the last 12 months the impact of the pandemic as meant that progress has been slower than expected so a new target date has been set

13.0 Safeguarding issues within Pregnant Women

The Maternity Safeguarding team consists of 2 midwives, the Named Midwife for Safeguarding and a Safeguarding Midwife.

The role of the Safeguarding Midwives is to support clinical and managerial staff in performing their safeguarding duties and responsibilities through advice, escalation of concerns to / from other agencies and effective feedback and support from safeguarding meetings and forums. They provide specialised knowledge, guidance, training and support to all staff within United Lincolnshire Hospitals NHS Trust regarding safeguarding unborn / new-born, children, young people, vulnerable adults and domestic abuse.

The Safeguarding Midwives maintain a Safeguarding Database that all Midwives and Neonatal staff have access to and holds information on each woman / family where there are safeguarding concerns for unborn and/or siblings in order to assist staff to safely care for women and their babies with safeguarding risks.

369 Social Care referrals were made by ULHT Maternity Services in 2021/22 due to safeguarding concerns.

235 unborn babies within the safeguarding database had an allocated Social Worker, 114 were made subject to Child in Need plans, 36 subject to Child Protection plans and the remaining unborn babies were managed with the legal arena under pre-proceedings due to the severity of the safeguarding concerns.

The Safeguarding Midwives attend Strategy Meetings for unborn babies alongside the Police and Social Care in addition to representing maternity services at MARAC, Child in Need meetings, Initial Child Protection Conferences and Core groups.

The Safeguarding Midwives co-ordinate and monitor high risk cases and ensure robust birth plans are in place for all unborn who are subject to Child Protection plans and those within Pre-birth legal proceedings.

The Safeguarding Midwives have made strong working relationships with external agencies; particularly Children's Social Care and the Named Midwife for Safeguarding was instrumental in rewriting the Lincolnshire Pre-birth Protocol, alongside colleagues from the Local Authority.

Once the decision is made that the unborn child will be subject to the pre-proceedings process, the case is managed as Child in Need (s17, CA 1989) within the Pre-proceedings framework and an Initial Child Protection Conference in no longer convened.

This approach avoids any duplication or dual processes for the expectant parents and helps to alleviate stress for the expectant mother, which in turn reduces additional risk to the unborn child.

85 unborn babies were managed within the Public Law Outline pre-proceedings process in 2021/22 with 41 babies being removed on discharge from their mother's care.

10 babies were discharged into Mother and Baby placements and a further 21 were discharged with their mother to a family member's address.

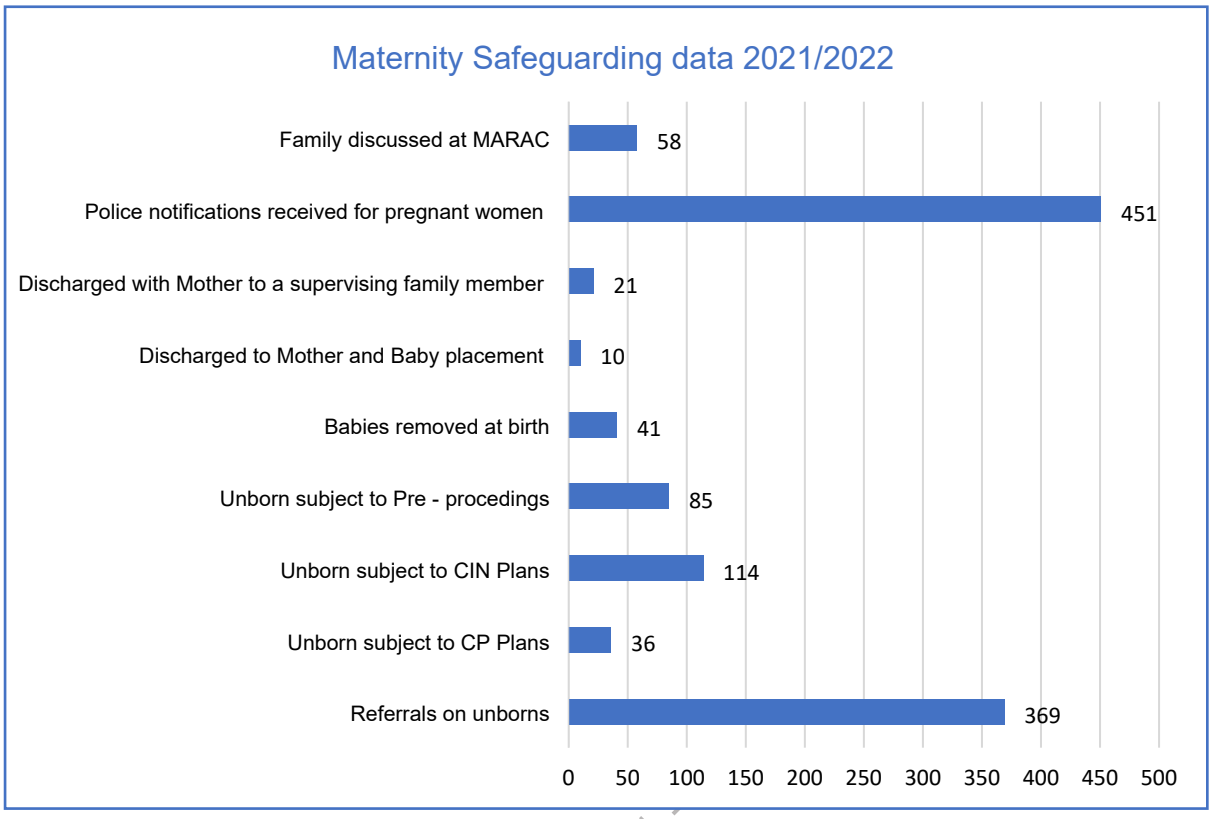
This pre-birth protocol within Lincolnshire is extremely innovative and very different to the majority of pre-birth protocols across other areas of the country. The protocol hopes to offer pregnant women within ULHT a more transparent and less traumatic experience in relation to their pregnancy when there are significant safeguarding concerns which is being managed within the legal arena.

Following a Domestic Homicide within Lincolnshire, the Named Midwife for Safeguarding identified that there was lack of information sharing between Lincolnshire Police and maternity services in relation to Police incidents regarding pregnant women. Following communication with the Police, the Safeguarding Midwives now receive notifications of all Police incidents pertaining to pregnant women, the majority being domestic abuse incidents with 58 pregnant women being heard at MARAC in 2021/22.

The notifications have allowed the Safeguarding Midwives to ensure that any outstanding actions are completed and to monitor on-going safeguarding concerns and make any required referrals to partner agencies.

The Safeguarding Midwives have received 451 Police notification in 2021/22, this is information that maternity services would not have been previously aware of and has allowed for more collaborative working between maternity services and other external agencies and organisations.

Figure 7: Safeguarding Specific Maternity data



14.0 Female Genital Mutilation (FGM)

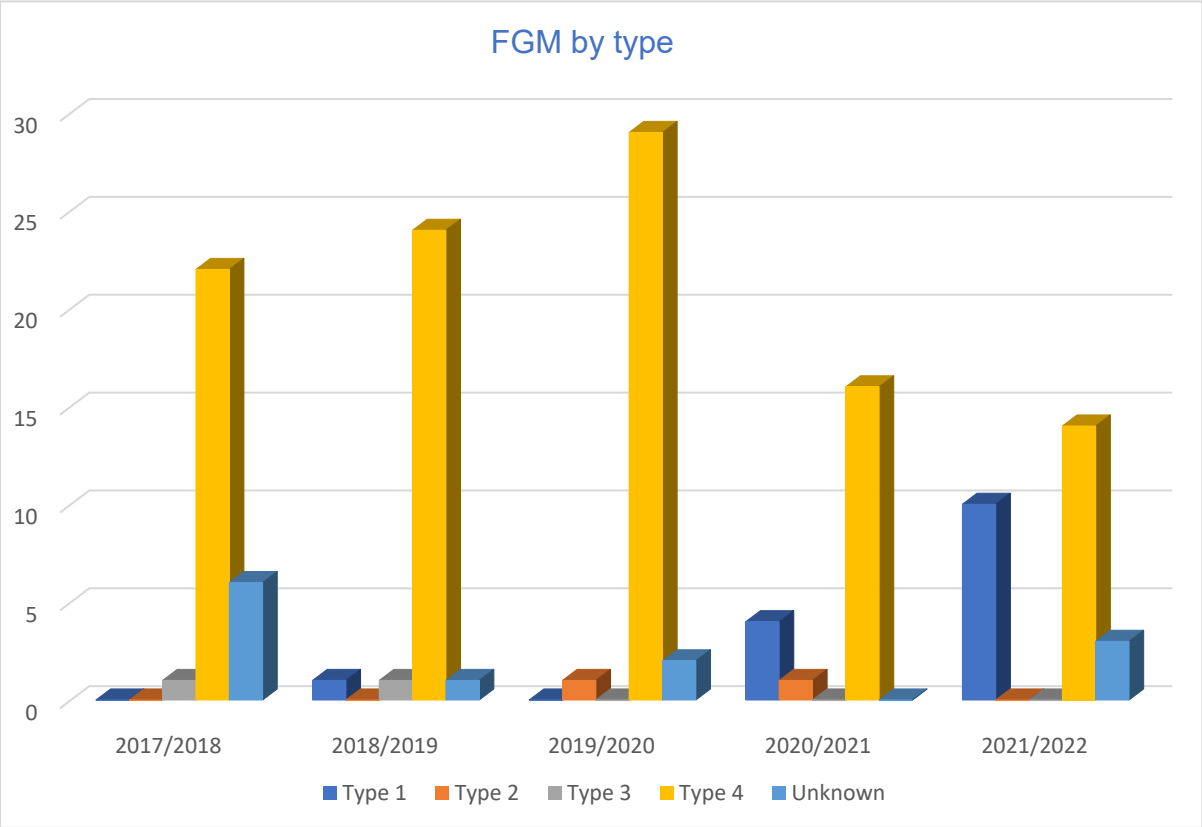
Whilst the issue of FGM affects women / girls across all operational services the midwifery and Gynaecology teams are key within early identification and reporting of this specific area of abuse. The trust has in place an FGM policy and specific working guidance for paediatrics and midwifery.

From 1st April 2015, and in line with National Guidance, the Trust began to routinely submit FGM data. This data is submitted monthly to the Trust's Information Support team for onward submission to NHS Digital.

Between April 2021 and March 2022, the Trust reported 27 cases of FGM: of which 14 were Type 4 (piercings); 10 were Type 1 and 3 were of an unknown type. All cases reported were reported by adults and those reporting Type 1 had undergone the FGM as children in their countries of origin.

For those Type 1 cases, appropriate safeguards were initiated in respect of the unborn: with the Trust also complying with the appropriate NHSE alerting protocols.

Figure 8: FGM specific data by WHO type classification



15.0 Domestic Violence / Multi-agency Risk Assessment Conference (MARAC)

Domestic Abuse costs the country's economy £15.8 billion a year. The cost to health, housing and social services, criminal & civil legal services is estimated at 3.9 billion and of this the NHS spends £1.73 billion.

ULHT is represented at the twice-weekly MARAC meetings by the Safeguarding Specialist Nurses and Safeguarding Midwives and at the Domestic Abuse Operational and Strategic Boards by the Named Nurse for Safeguarding Children and Young People and the Deputy Director for Safeguarding, respectively.

15.1 Key Facts

The Crime Survey for England and Wales (CSEW) recorded a total of 1,459,663 domestic abuse-related incidents and crimes in England and Wales in the year ending March 2021.

Of these, 845,734 were recorded as domestic abuse-related crimes, an increase of 6% from the previous year, representing 18% of all offences recorded by the police in the year ending March 2021.

Domestic abuse has a significant impact upon the communities and public services of Lincolnshire. Estimates from our most recent Crime Survey for England and Wales year ending March 2021 show 5.5% of adults aged 16 to 74 years (2.3 million) experienced domestic abuse in the 12 months prior. This national figure would equate to roughly 30,200 adults aged 16-74 suffering domestic abuse in Lincolnshire (assuming a similar prevalence in Lincolnshire compared to the England and Wales average).

It is estimated that for the year ending in March 2021, 28% of women and 14% of men aged 16 to 74 had experienced some form of domestic abuse since the age of 16.

Domestic abuse remains an underreported issue. CSEW national figures suggest that only 31% of partner abuse victims told someone in an official position about their abuse (i.e., police, health professionals, or local council department). 17% of victims told the police, 18% told a health professional and 5% told a local council department. The majority of partner abuse victims instead told somebody they knew personally about their abuse. 1 in 4 partner abuse victims told nobody at all about their abuse (27%), a much more concerning statistic amongst males where 1 in 2 (49%) told nobody about suffering abuse at the hands of their partner. (Source: Office of National Statistics)

More than one in four women has experienced at least one incident of domestic violence in England and Wales since age 16 (equivalent to 4.8m women)

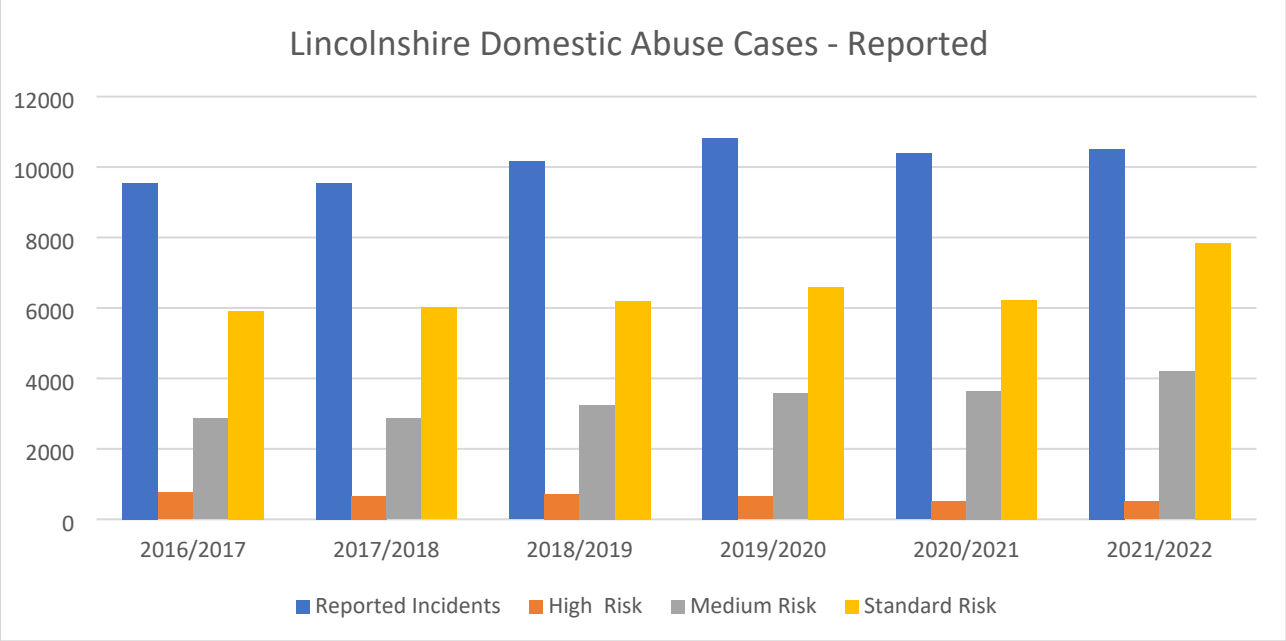
- Approximately **1 million** women a year experience at least one incident of domestic violence, equating to nearly **20,000 women a week**
- On average a woman will experience **35 assaults** before going to the police
- **2 - 3 women a week** are killed by their current or former partner
- **1 in 7 males** will experience domestic violence and abuse
- Domestic violence often starts or intensifies during and after pregnancy
- 3.7 million women in England and Wales have been sexually assaulted at some point since the age of 16
- Around 2,000 women are raped each week. 34% of all rapes recorded are committed against children under 16 years of age
- Estimated 66,000 women in England and Wales have undergone Female Genital Mutilation and over 24,000 girls are estimated to be at risk
- One in four lesbian, gay, bisexual, and transgender people have experienced domestic violence and abuse in their relationship
- Disabled women are twice as likely to experience domestic violence and abuse than non-disabled women and over a longer period of time, suffering more severe injuries as a result of the violence

- Domestic violence and abuse in teen relationships is increasingly recognised as a serious issue. Research now suggests that women between the ages of 16 and 25 are at highest risk.

15.2 Domestic abuse in Lincolnshire

In the last six years, on average there are over 10,000 domestic abuse incidents reported to Lincolnshire Police every year. Of these, circa 6,500 are standard risk incidents, equivalent to around 3 in 5 domestic abuse incidents reported. The proportion of reported incidents that are graded as high risk has been falling, while the proportion graded as medium risk has continued to increase year on year. Improvements in recording practice will have contributed to this.

Figure 9: Domestic Abuse Cases



15.3 Domestic abuse and children

The true number of victims of domestic abuse is likely to be higher when children are included. CSEW figures suggest that 41% of partner abuse victims suffered abuse while their children were in the house, and that 21% of victims disclosed that the children did see or hear what happened. (Source: Office of National Statistics) If only one child was present at each of the 21% of domestic abuse victimisations in Lincolnshire each year, this would mean that 5,500 children witnessed domestic abuse in their home each year. This means that the true number of Lincolnshire residents affected by domestic abuse each year is likely to be upwards of 35,700 adult victims and child witnesses.

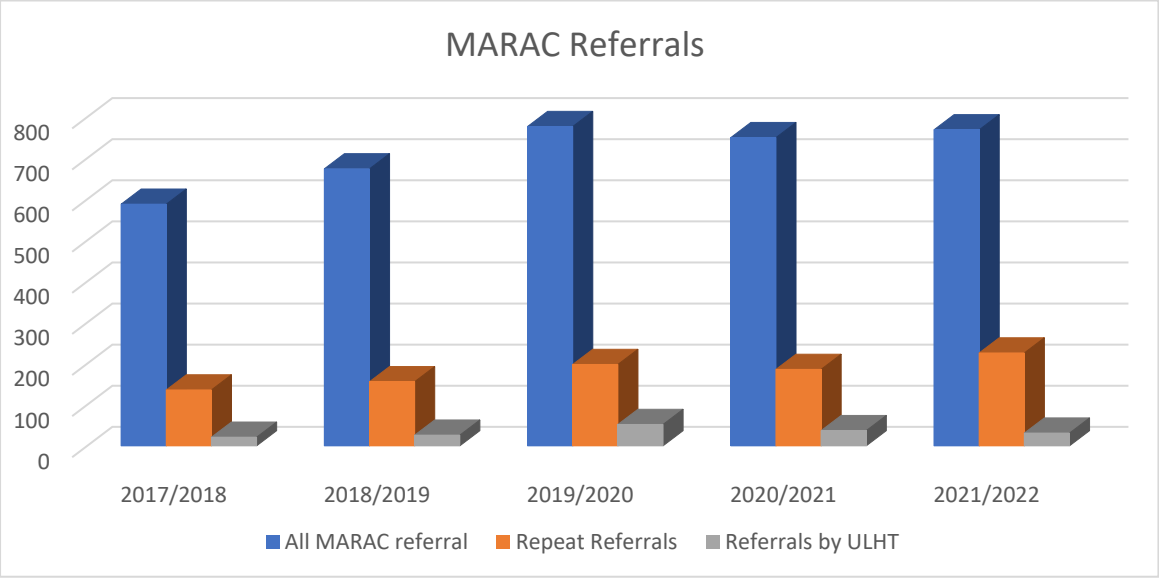
The Domestic Abuse Act (HM Government, 2021) now recognises children and young people living within a Domestically Abusive relationship/household as being victims in their own right.

The relatively high rate at which children are present during partner abuse incidents has a number of consequences. At a basic level it places additional responsibility on those agencies encountering domestic abuse to ensure that appropriate checks, risk assessments and safeguarding referrals are being made for child witnesses as well as adult victims of domestic abuse. Domestic abuse is the single most prevalent assessment factor identified in children's social care assessments. It is more prevalent than the presence of factors such as mental health, alcohol misuse, drug misuse, disability and illness, emotional abuse, physical abuse, or sexual abuse. In Lincolnshire during 2018-19, 55.1% of assessments identified domestic abuse as an issue. This is higher than the national average of 50.6%, and places Lincolnshire 42nd among the 151 local authorities in England that supplied information. (Source: Department for Education) Domestic abuse has also specifically been identified as a factor in 54% of all serious case reviews, which investigate child deaths relating to maltreatment, abuse, and neglect. *(S Framp, Community Safety Analyst, Lincolnshire County Council, May 2021).*

15.4 MARAC cases

There were 769 victims who were at high risk of serious harm or death referred into the Multi Agency Risk Assessment Conference (MARAC) by partner agencies in 2021-2022. On average 263 referrals are made to MARAC every quarter (last three years ending March 2022).

Figure 10: MARAC Referrals – all risk levels



MARAC conferences are held weekly in Lincolnshire on both a Wednesday and Thursday and during the last 12 months the team have continued to attend all MARAC meetings.

Figure 11: MARAC Referrals and Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) assessments made by ULHT Safeguarding Professionals

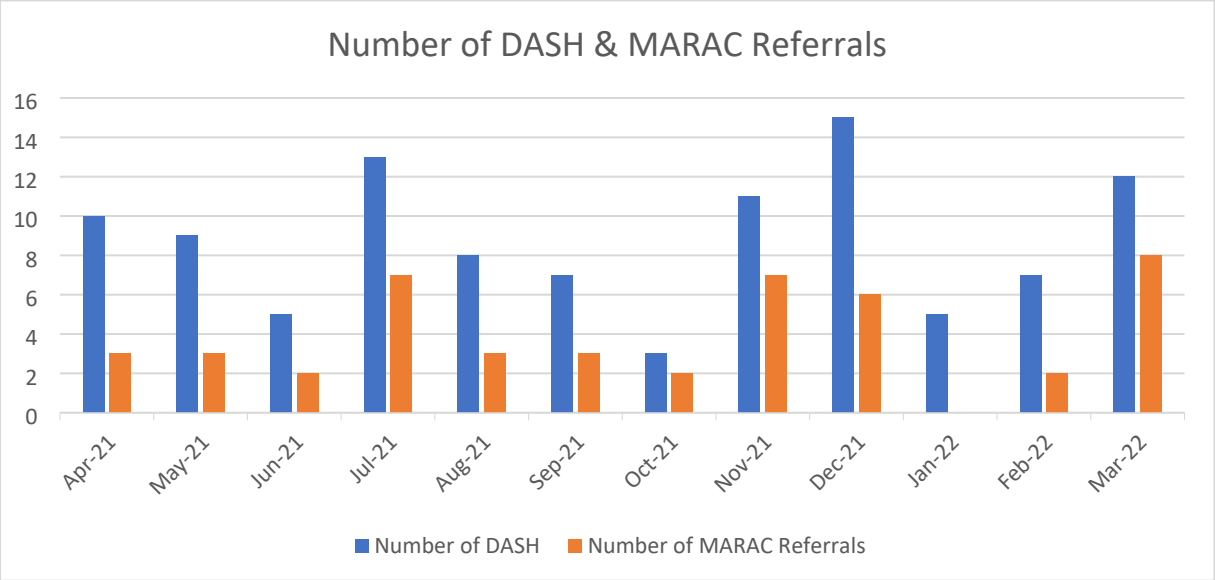
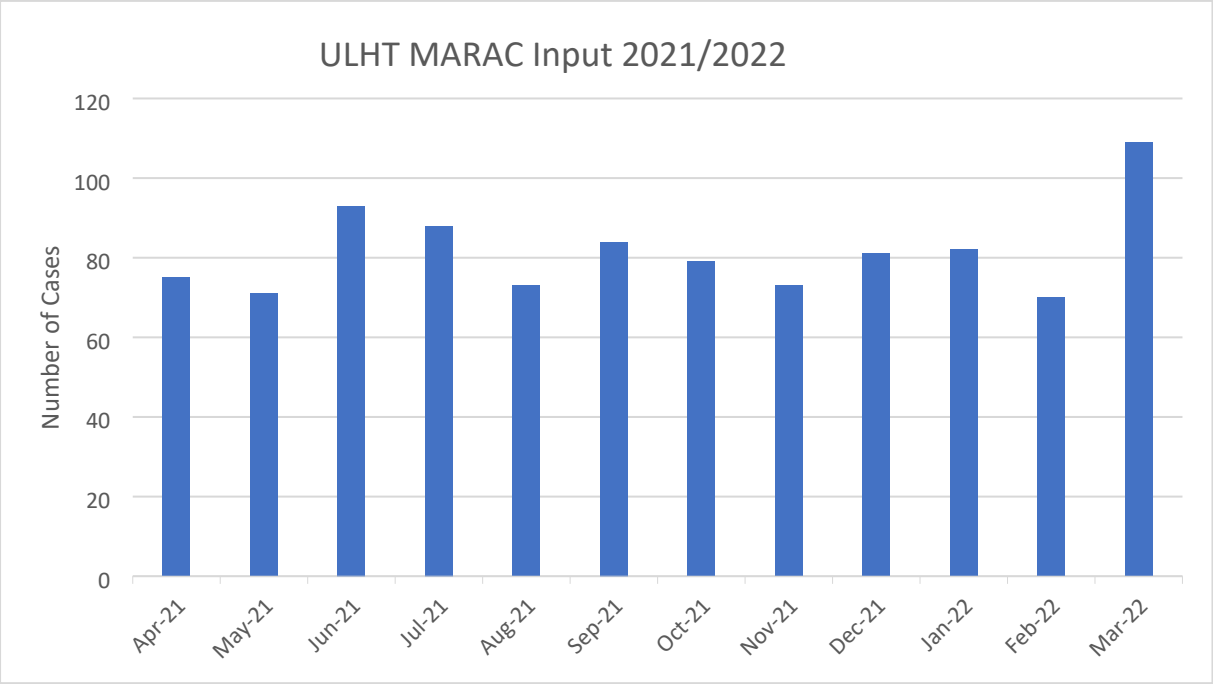


Figure 12: MARAC cases attended by ULHT Safeguarding Professionals



15.5 Domestic Abuse support

Based virtually within the safeguarding team there are 2 Independent Domestic Violence Advocates (IDVA) employed by EDAN Lincs who provide 1:1 work with victims and support staff to manage disclosures of Domestic Abuse. The IDVAs also support staff members who make disclosures of experiencing DA in their personal lives. The IDVAs are based within Pilgrim and Lincoln County Hospitals, but also share support for Grantham Hospital.

Across Lincolnshire there were 3492 referrals for adult victims of domestic abuse to specialist outreach support services in Lincolnshire (provided by EDAN Lincs) during 2021/2022, an increase of 74% on the previous year. As well as referrals there were a further 4712 people who contacted the EDAN Lincs helpline or online chat for one off advice regarding domestic abuse.

16.0 PREVENT Lincolnshire Profile

Lincolnshire is classified as a low-level area however this does not mean that no risk exists.

There has been a drive to ensure Women be equally considered as being as capable and motivated to plan and conduct terrorist attacks as men.

The threat from Islamist extremism remains the most likely source of violent attack in the UK, despite local intelligence and referrals being much lower and within Lincolnshire Right-wing extremism occupies the majority of staff time and is the greatest risk in Lincolnshire despite the national trend.

Attacks by self-initiated terrorists (lone actors working independently to a network) is a national priority, having increased significantly in recent years and reflected a trend towards low-complexity attacks (e.g., bladed weapons and vehicles). The solitary and unpredictable nature of this type of perpetrator, combined with short planning times, means attacks can be difficult to disrupt

Lifestyle changes during the pandemic have most likely led to an increased targeting of young people online. Propaganda based on conspiracy theories can also make for complex assessments.

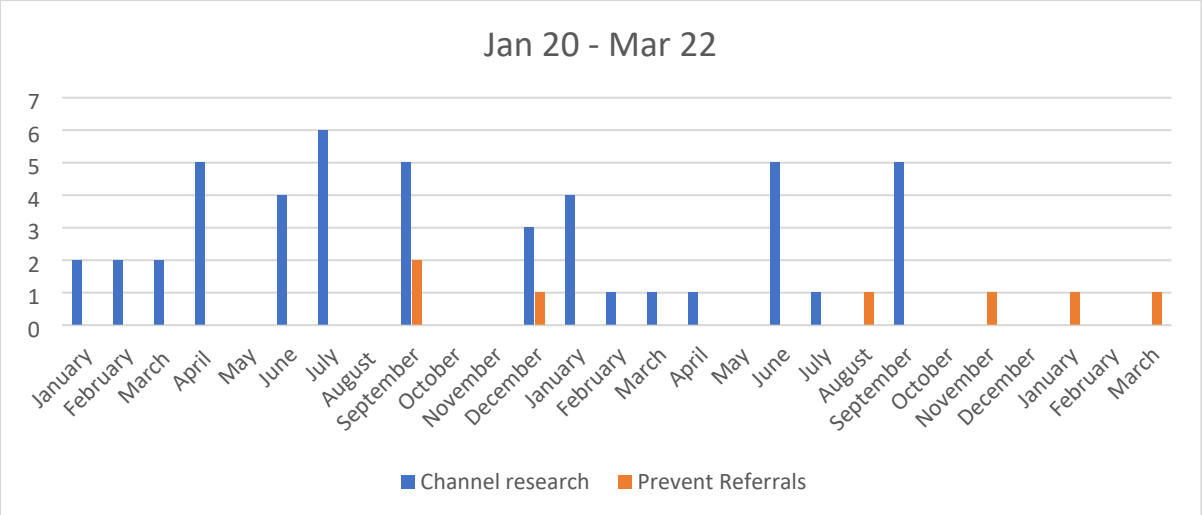
The majority of referrals (37%) related to people with a perceived vulnerability to radicalisation, due to mental ill health, age, abuse etc.

Nearly all referrals related to males, and the highest proportion of subjects were aged between 12 and 16. Female referrals are below the national average. The extent of their involvement in terrorism and extremism represents a significant intelligence gap.

Lincoln, followed closely by Boston, generated most referrals, likely due to population density. Mirroring this trend, Lincoln saw the most hate crime/incident reports

ULHT raised four Prevent referrals in this period.

Figure 13: Number of PREVENT referrals made by ULHT and data analysis cases as part of Channel Process (April 2020 – March 2021)



17.0 Multi-Agency Public Protection Panel (MAPPA)

MAPPA (Multi-Agency Public Protection Arrangements) are a set of arrangements to manage the risk posed by the most serious sexual and violent offenders under the provisions of the Criminal Justice Act 2003.

They bring together the Police, Probation and Prison Services and a number of other agencies are under a Duty to Co-operate (DTC) with the Responsible Authority. These include Social Services, Health Services, Youth Offending Teams, Jobcentre Plus and Local Housing and Education Authorities.

There are 3 categories of MAPPA-eligible offender:

Category 1 registered sexual offenders.

Category 2 mainly violent offenders sentenced to 12 months or more imprisonment or a hospital order; and

Category 3 offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm.

All MAPPA eligible offenders are presently flagged with regards to their assessed risks on Medway with processes in place for potential disclosures based on risk.

Figure 12: Lincolnshire Area MAPPA Eligible offenders on 31st March 2021 (2022 figures are not yet available) *Comparative figures 31st March 2020*

Category 1: Registered Sex offender	857	↑ (+47)
Category 2: Violent offenders	179	↓ (-14)
Category 3: Other dangerous offenders	0	↓ (-5)
Total:	1036	↑ (+28)

18.0 Persons in Positions of Trust (PiPoT)

Each year the Trust receives information which pertains to allegations of abuse / situations of concern about staff member's behaviour that take place both within their working life and their personal life.

Information comes in many forms – via PALS, from statutory agencies or from other members of staff within the Trust.

When this situation arises, several processes take place within the Trust and joint decisions are often made between human resources, operational services and the safeguarding team. As part of this process the safeguarding team will follow the PiPoT process whereby we follow specific safeguarding procedures to ensure that these concerns are shared with and at times investigated by our statutory partners

During 2020 – 2021 the Trust dealt with 10 allegations that proceeded to a formal process

(Specific data is not provided within this report due to the small numbers making the possibility for individuals being identified)

19.0 Mental Capacity Act and Deprivation of Liberty Safeguards - DOLs

19.1 Background

The Deprivation of Liberty Safeguards was introduced in 2009 and are part of the Mental Capacity Act 2005 (MCA). They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves.

The Mental Capacity Act provides the essential framework of guidance for people who need to make decisions on behalf of someone else. It sets out who can take decisions, in which situations, and how they should go about this – making sure they act in the

person's best interests and empowering people to make their own decisions wherever possible.

The Deprivation of Liberty Safeguards is set firmly within the empowering ethos of the Mental Capacity Act (MCA). They encourage all health and social care providers to put liberty and autonomy at the heart of care planning, to avoid wherever possible the need to deprive people of their liberty.

This section of the annual report provides an update to the Trust in respect of compliance with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in line with the CQC's approach to regulation under the Health and Social Care Act.

19.2 Mental Capacity Act

The Mental Capacity Act 2005 (MCA) came into force in October 2007 and provides a legal framework for assessing capacity and making decisions about the care and treatment of adults who lack capacity. This could be due to a mental health condition, a severe learning disability, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident. It also created new protections and powers in respect of the decision-making process. The MCA applies to young people aged 16 and over.

The Mental Capacity Act provides:

A duty to treat an incapacitated person in accordance with their best interests.

Limited ability to restrain an incapacitated person in accordance with their best interests but is only lawful where:

- It is necessary to prevent harm.
- Proportionate to the likelihood and seriousness of harm and in the least prohibitive way.

To lawfully deprive an incapacitated person of their liberty, even in their best interests, the trust must follow the statutory DoLS process and obtain an authorisation in line with the Act

When carrying out acts of care and treatment in the best interests of a person who lacks capacity, staff will be legally protected through Section 5 of the MCA against legal challenges, providing that they:

- Have taken reasonable steps to assess the person's capacity to consent to the act in question.
- Reasonably believe that the person lacks capacity to consent.
- Reasonably believe that the act they are carrying out is in the person's 'best interest'.

The Act is accompanied by a 'Code of Practice' which gives essential guidance on the implementation of the key principles.

Other provisions of the Act include:

- Appointment of Independent Mental Capacity Advocates (IMCAs) to support and represent people without capacity who have no-one to speak for them when decisions need to be made about serious medical treatment or a change in a care home or hospital accommodation.
- The Court of Protection is a specialist court with powers to deal with complex matters affecting adults who may lack capacity to take a particular decision.
- Lasting Power of Attorney (LPA) enable people to appoint one or more people they know and trust to make decisions for them on their behalf relating to Personal Welfare (including healthcare decisions) and property and affairs, an LPA must be registered with the Office of the Public Guardian before it can be used.
- Planning for future care – Advance Decisions are applicable when a person who made it does not have the capacity to consent to or refuse the treatment in question, it refers specifically to the treatment in question and the circumstances to which the refusal of treatment refers are present.

19.2 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards came into effect in 2009 and are part of a legal framework set out in the Mental Capacity Act. They set out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights and freedom of action, and empowering people to make their own decisions wherever possible. The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment.

There is no simple definition of deprivation of liberty and each decision must be made on a case by case, patient-specific basis. Certain key factors can be relevant in identifying whether the steps taken in caring for a patient amount to a deprivation of liberty. These include:

- The use of restraint (including sedation)
- Staff exercising complete and effective control over the care and movement of a person for a significant period.
- Staff exercising control over assessments, treatment, contacts, and residence.
- Decisions being made that the person will not be released into the care of others or permitted to live elsewhere unless the staff considers it appropriate.

- The refusal of a request by a carer for a person to be discharged to their care.
- The person being unable to maintain social contacts because of restrictions placed on their access to other people.
- The person losing autonomy because they are under continuous supervision and control.

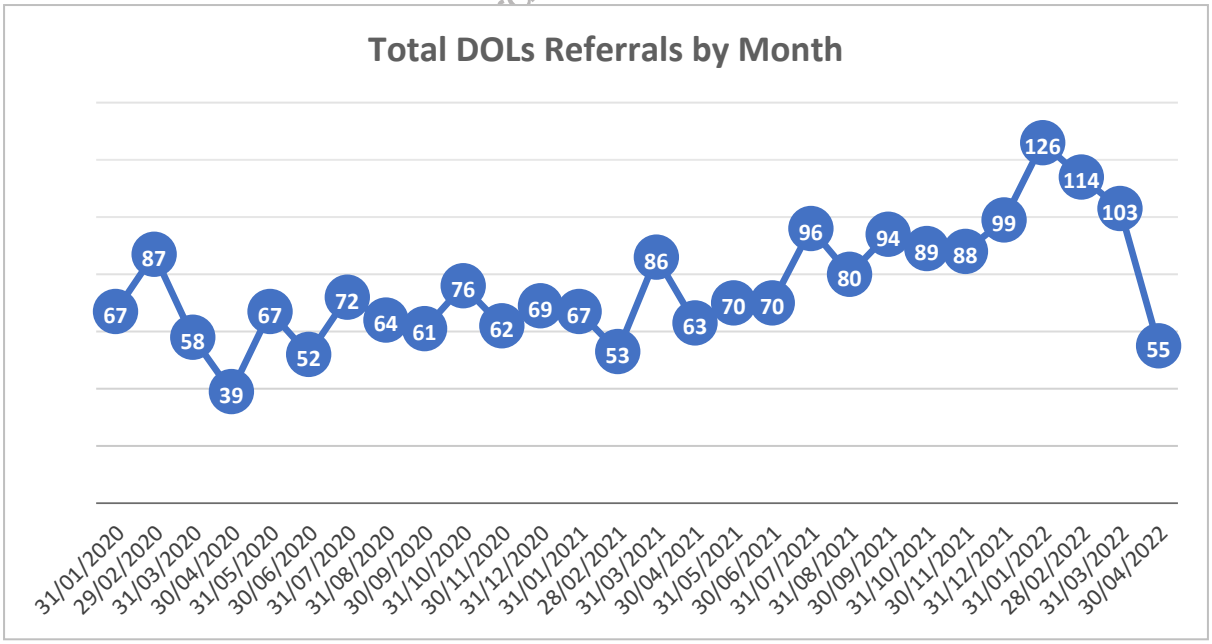
Staff must consider whether the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty.

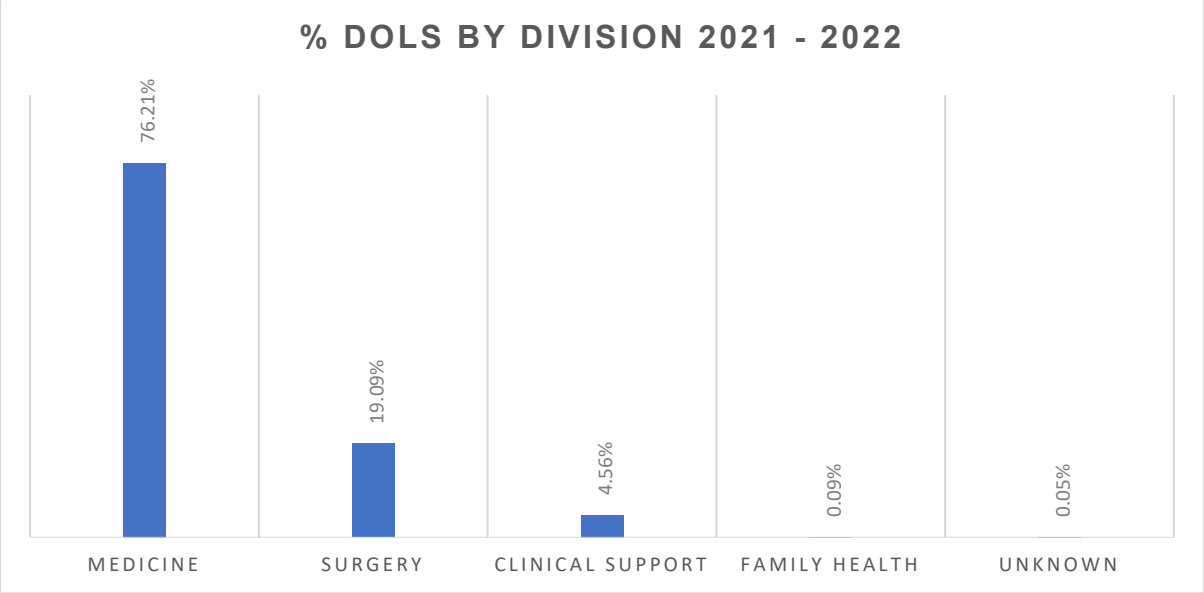
Staff are required to consider the following factors before considering a Deprivation of Liberty Safeguards application:

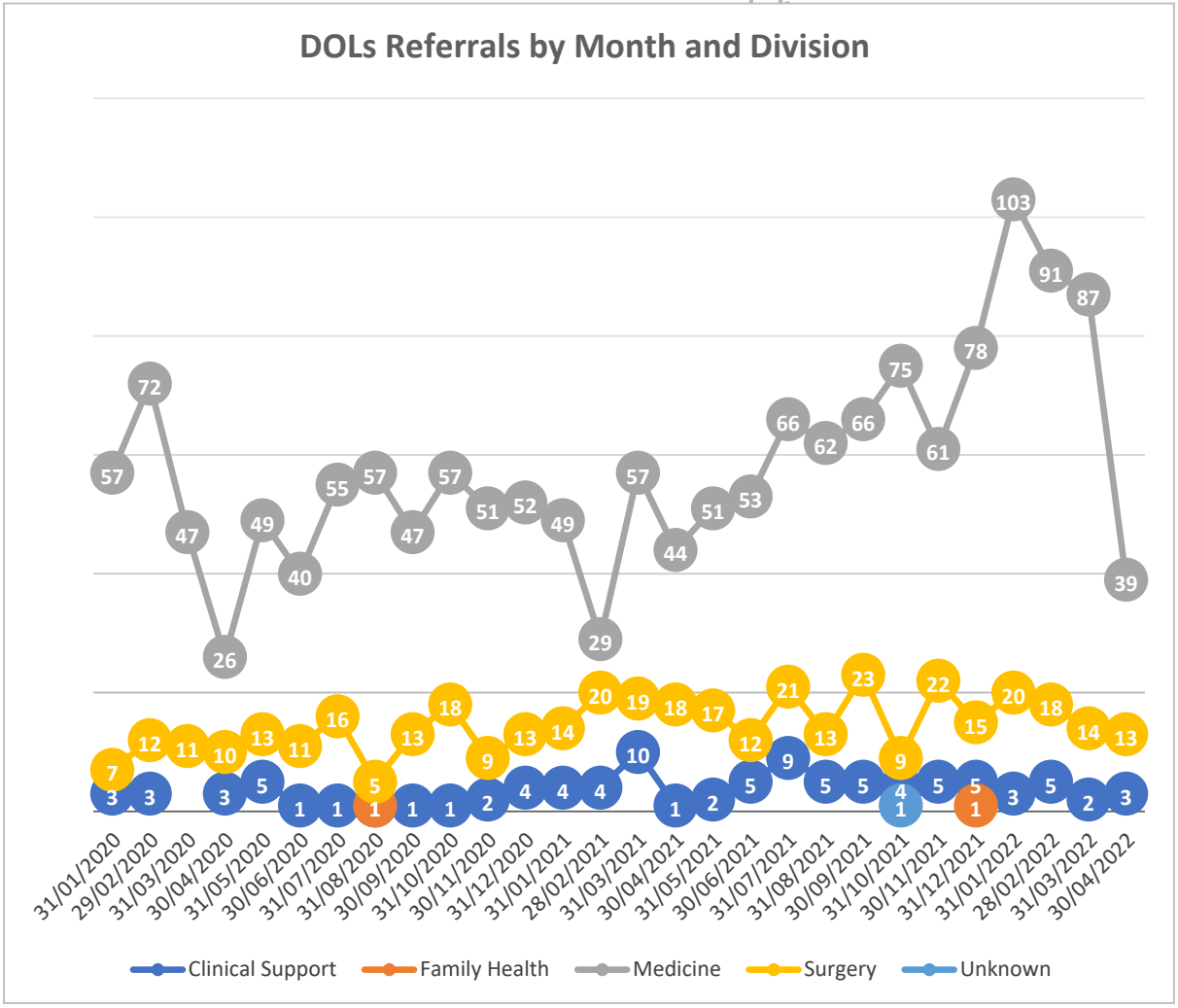
- Can the patient receive the planned care or treatment using a less restrictive but still effective care plan which avoids an unauthorised deprivation of liberty?
- Is the patient receiving treatment for a mental disorder?
- If the patient cannot receive the planned care or treatment with there being a risk of depriving them of their liberty, and all practical and reasonable steps have been taken to avoid a deprivation of liberty, an application for authorisation of deprivation of liberty must be considered.

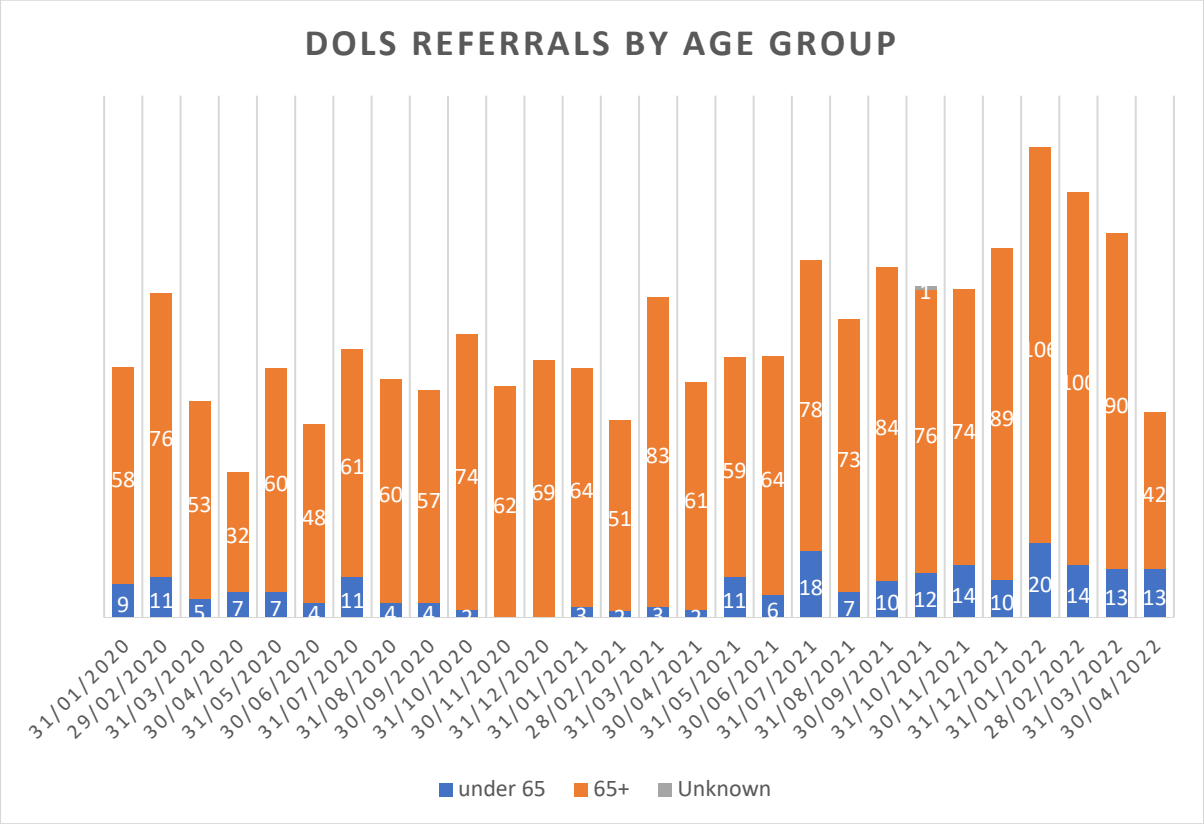
The Trust is responsible for ensuring that it does not deprive a person of their liberty without an authorisation and must comply with the law in this respect.

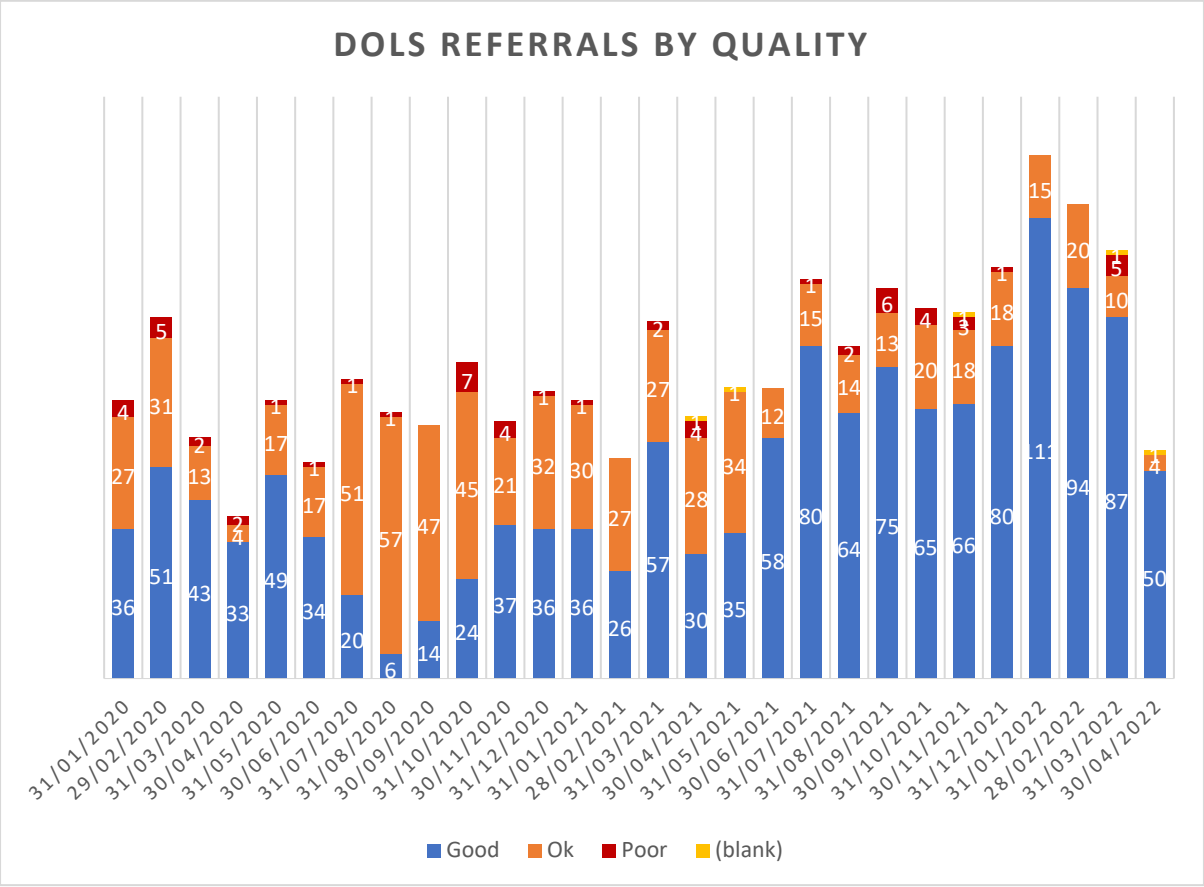
Figure 14: The number of DoLs referral made between January 2020 and April 2022 including a break down for Divisional activity, Quality of completion and Age




% DOLS BY DIVISION 2021 - 2022
76.21%
19.09%
4.56%
0.09%
0.05%
MEDICINE
SURGERY
CLINICAL SUPPORT
FAMILY HEALTH
UNKNOWN


DOLs Referrals by Month and Division
31/01/2020
29/02/2020
31/03/2020
30/04/2020
31/05/2020
30/06/2020
31/07/2020
31/08/2020
30/09/2020
31/10/2020
30/11/2020
31/12/2020
31/01/2021
28/02/2021
31/03/2021
30/04/2021
31/05/2021
30/06/2021
31/07/2021
31/08/2021
30/09/2021
31/10/2021
30/11/2021
31/12/2021
31/01/2022
28/02/2022
31/03/2022
30/04/2022
Clinical Support
Family Health
Medicine
Surgery
Unknown


DOLS REFERRALS BY AGE GROUP
under 65
65+
Unknown


DOLS REFERRALS BY QUALITY
Good
Ok
Poor
(blank)

20.0 Dementia

20.1 What we know about dementia?

Dementia is a worldwide issue, growing significantly every year. It is estimated that over 55 million people have dementia around the world. This figure increases by 10 million annually and is estimated to reach 78 million by 2030 (World Health Organisation (WHO), 2021; Gauthier et al., 2021). In the UK there are currently 944, 000 people living with dementia, of which around 700,000 are in England, these figures are set to increase exponentially over the coming decades (Alzheimer's Research UK, 2021; Wittenberg et al., 2019b).

20.2 The impact of dementia

Dementia has significant psychological, physical, social and economic consequences for the person living with the disease as well as their families, carers, communities and society at large (WHO, 2021). Not only can dementia severely impact someone's cognitive functioning, it also has a debilitating effect on their physical capacity, particularly later in disease progression (Alzheimer's Society, 2021b). The cost implications for health and social care are substantial, in 2019 in England alone the total cost of dementia care was £29.5 billion, of that total cost 14% is attributable to healthcare, 46% attributable to social care and 40% attributable to unpaid carers (Wittenberg et al., 2019a).

Figure 15: Projected costs of dementia for older people (£million), 2019-2040

	2019	2020	2025	2030	2040	% change
England						
Healthcare	4,100	4,300	5,300	6,700	10,600	156%
Social care	13,500	14,500	18,600	24,000	39,200	191%
Unpaid care	11,700	12,200	15,300	19,400	30,100	157%
Other	150	210	260	340	540	254%
Total	29,500	31,200	39,500	50,500	80,400	173%

20.3 Dementia in Lincolnshire

There are an estimated 12,216 people aged 65 and over living with dementia in Lincolnshire – equivalent to 6.8% of the over-65 population and 1.6% of the whole population. This is predicted to increase to 16,558 by 2030 and 18,831 by 2035 (54.15%), which is higher than the expected national increase of 51.21%. This will equate to 7.86% of the over-65 population or 2.3% of the whole population.

The number of people aged 65 or over in Lincolnshire is projected to increase by 60,000 (33.5%) between 2019 and 2035, with the highest proportion of people in this age group who are living with dementia estimated to be in Lincoln, Boston, North Kesteven and South Holland. South Kesteven is expected to see the greatest increase in people with dementia (66.75%), given a predicted shift towards a higher proportion of older people.

The prevalence of dementia increases with age and, due to longer life expectancy, this is higher for women than for men. In 2018, an estimated 61.5% of people in Lincolnshire living with dementia were female.

There were also an estimated 211 people under the age of 65 with dementia in Lincolnshire in 2019.

In 2017, national prevalence of dementia for all ages was 0.8%. At this time, Lincolnshire East and South Lincolnshire were higher than the national figure (1.0% and 0.9% respectively), and Lincolnshire West was the same (0.8%). Southwest Lincolnshire was below the national figure. In the over 65 population, the national figure was 4.33% as at December 2018. Locally, Lincolnshire West had the highest prevalence, which was similar to the national figure (4.37%). Recorded prevalence in the other Lincolnshire areas was significantly lower, and Southwest Lincolnshire had the lowest recorded prevalence in the Central Midlands at 3.59%.

In 2018, the highest rate of dementia diagnoses was in West Lincolnshire (68%), and the lowest rate was in Southwest Lincolnshire (52.1%).

The directly age standardised rate of emergency hospital admissions of people with dementia in Lincolnshire for people aged 65+ (3,095 per 100,000 population) is significantly
lower than the national rate (3,609 per 100,000 population) for 2017/18. This equates to 5,559 emergency admissions.

In 2017, there were 1,703 (948 per 100,000 population) deaths of people in Lincolnshire aged 65 and over, where dementia was mentioned either as an underlying cause of death or a contributory factor. This is a similar figure to the England rate of 903 per 100,000 population.

A number of behavioural and disease factors are known to increase the likelihood of developing dementia and many of these are more prevalent in Lincolnshire than at both regional and national levels, including physical inactivity, being overweight or obese, hypertension, stroke, diabetes, CHD and depression. These factors are not evenly spread across Lincolnshire, which creates inequalities in those populations experiencing deprivation

20.4 Progress in ULHT

In 2021 the trust embedded dementia within the safeguarding portfolio and governance framework and as a result appointed a Safeguarding Adults/Dementia Specialist Nurse within the team who is in the process of rolling out the new dementia pathway and reviewing the dementia training to make it fit for purpose and embed across all staff groups to ensure all staff have at least an awareness of dementia and how they can support that person, or their family, from answering the phone, meeting someone in a corridor, through to how we can meet their needs on our wards and clinical areas as well as being able to support through the discharge process to ensure our patients, and their carers have support.

Rollout has also begun of the dementia and delirium pathways which has included many face to face and teams' sessions to support the staff. Staff are very engaging through training; however, evidence of implementation has been varied.

Relationships have been developed with Dementia Services at LPFT, so that we can work collaboratively and use skills and experience as well as tap into services which will support our patients and their families. This includes encouraging and supporting all staff to refer patients who we are concerned may have an underlying dementia directly through to the memory clinics, rather than requesting GP referral via EDD. We can also refer either patients with a dementia, or their carers to the Dementia Support Services who can help from point of diagnosis all the way through to end of life.

Band 4 dementia support practitioners are now in post at both Boston and Lincoln. They work with patients and their families early into the hospital admission to develop a one-page care plan, based around the 'All About Me' document, to give staff a snapshot of what this patient needs to have a positive experience whilst in ULHT. It also allows staff to have an understanding of the person's background; their likes and dislikes and any triggers of distress, in order to support reminiscence conversations as well as make reasonable adjustments to their hospital admission to reduce the distress and anxiety of being in an unfamiliar environment. The plan is to also develop activity sessions with the patient, and where appropriate family and staff, to engage and maintain skills to prevent deconditioning and aid stimulation which we often find our patients are lacking. Many of the ward areas have asked for support from the Dementia practitioners to develop day rooms, ward areas or activities which will engage the patients.

The Hospital Charity has recently funded 10 CD players and numerous CDs to aid our patients who love music. Hearing favourite songs from their past can have a huge impact on their mood and ability to communicate, which is so important whilst they are in hospital which can be a challenging and distressing environment.

Each ward area at Lincoln and Boston has a Dementia Distraction Box. These are filled with various activities to distract, stimulate, and comfort our patients. We have

fiddle mitts, kindly donated by various knitting groups, games such as dominoes, snap, cards. Larger building blocks and musical instruments as well as colouring packs and puzzles. We often find patients with Dementia are concerned that they cannot afford to pay for their stay or for their meals etc. available in the boxes are small purses and coins to alleviate some of these worries. Our dementia support practitioners also have access to other tools to support patients as required.

RITA (Reminiscence Interactive Therapy Activities) is a tool widely used across ULHT for our cognitively impaired patients to provide stimulation and distraction through reminiscence. The variety of films and music allows our patients to go back in time to periods that they often have happy memories. This can then unlock communication skills and a whole world they are wanting to share with staff and their families. Our Dementia Support Practitioners, through conversations with family or carers can find out what genres they enjoy and build this into the activities, and we can watch their whole persona change. We have also found that with using RITA we can reduce the number of falls, as a patient is engaged in an activity and less likely to look for other distractions. The system currently in place is coming to the end of its life span, a paper is to be presented to CRIG with regards to plan for its update and replacement. Many ward areas are very keen to have the new equipment as they find it hugely beneficial to calm some of our patients. The plan will be that there will be more training in place to ensure that we can utilise RITA to her full abilities for all patients.

Along with support from Patient Experience, we are in the process of setting up a Dementia Carer Expert Reference Group, to be able to hear the experiences that our patients with dementia, and their carers have, when using services in ULHT. This is a really important step forward to mould services to support needs using first person experiences. Following an initial advert during Dementia Awareness Week we have had several applicants and now looking at arranging the first meeting in June 2022.

Sessions have been developed for the HCSW induction programmes to develop their understanding of dementia and delirium and how we should be supporting our patients with Dementia. Looking at skills and trying to give staff the understanding of how these patients will feel in a strange, busy environment with different people coming and going as well as losing the routine that they all thrive on.

21.0 Learning Disability and Autism

A learning disability affects the way a person learns new things throughout their lifetime by affecting the way a person understands and communicates information.

This may mean they can have difficulty with:

- Understanding new or complex information
- Learning new skills
- Coping independently

A visit to hospital can be difficult for anybody, but it is particularly challenging for people who have a learning disability or Autism. Reasonable adjustments to the hospital care of people are not only a statutory duty under the Equality Act 2010 but are also beneficial for all involved

21.1 Learning disability and autism in ULHT

In 2021 the trust embedded Learning disability and Autism within the safeguarding portfolio and governance framework and as a result appointed a Safeguarding Adults/Learning Disability Specialist Nurse within the team who is in the process of developing and rolling out several pathways which make access to the services from ULHT more accessible (at times this will include applications to the Court of Protection).

In December 2021 Learning disability and autism training was launched for all staff groups to ensure staff have an awareness of learning disabilities and autism and know how they can support that person, or their family, from answering the phone, meeting someone in a corridor, through to how we can meet their needs on our wards and clinical areas as well as being able to support through the discharge process to ensure our patients, and their carers have support.

Moving forward the trust will develop the training further to align with the newly legislated 'Oliver McGowan' Training to ensure that we develop a higher level of insight into the needs of this client group.

Since starting in Post the Specialist Learning Disability Nurse has provided additional advice, guidance and support to patients with a learning disability, their carers/ parents, staff within the hospital as well as working collaboratively with health and social care partner agencies to ensure sure a multiagency response to those more complex patients.

The post holder has directly supported patients, and given advice made recommendations to hospital staff and or other health and social care colleagues to approx. 15-20 patients each month since she started in post. This has directly improved patient care and experience and supported ward and clinical areas with understand the needs of people with Learning disabilities, educating staff and role modelling interacting with patient with alternative communication needs.

The post holder has also worked with a number of other patients with learning disability and/or autism while they have been an outpatient, inpatient or as an elective admission. These have involved cases with palliative care needs, cancer patients, 2 week waits and epilepsy.

The post holder has chaired a number of Best Interest Meeting and supported staff to ensure MCA is followed and embedded for patients with learning disabilities. Cases have involved complex, finely balanced and disputed decisions along with planning for cases which have been referred to Court of Protection for approval for care and treatments.

Multi-agency and multi-disciplinary partnership working has been an essential part of the role, establishing strong partnerships with LPFT Learning disability teams especially the Acute Learning Disability Nurses and LCC Learning Disability Social care. A pathway is being developed for this to ensure clear guidance is available to support this joint work. The Trust are now involved in a number of proactive physical health meetings across the Lincolnshire services to ensure ULHT are included in plans for people with learning disabilities. This includes the Epilepsy task and finish group looking at Epilepsy services in light of the Clive Treacey Report and new Purple light took kit and Healthy Lives working Group which is chaired and facilitated by people with learning disabilities,

Current projects are auditing and revising the current Learning Disability Care Bundle which every patient with a learning disability should have completed on admission to a ward. This supports staff to identify and plan how they can meet the needs of people with learning disabilities, including reasonable adjustments.

Bespoke training / Learning Disability awareness onwards departments and in Safeguarding supervision sessions. To share knowledge, offer advice and staff.

Currently Easy read documents are being developed, these have been reviewed by LPFT Experts by Experience and will be added to the External website for everyone to use and added to the Learning disability Folders each ward has.

21.2 Future plans for 2022 – 2023

There are clear challenges with elective admissions for patient with learning disabilities who have complex needs and require a number of reasonable adjustments to ensure they are fully supported on admission. The Post holder will be coordinating the development of the surgical pathway to ensure there is a consistent pathway across all ULHT sites for patients with a learning disability. This involves reviewing the current pathways at this at start of the process, from listing patient for surgery, pre assessment, anaesthetics, theatre scheduling and adapting it to each hospital site with the different physical environments of theatres / admission wards etc. This will include the introduction of sensory box for theatres and recovery area.

LeDeR / SJR and mortality – Review and audit the feedback from LeDeR and the actions from governance group to look at ULHT role in improving the outcomes of people with Learning Disabilities.

Flags and alerts across the trust for people with Autism and Learning disabilities to ensure more meaningful and are ready for an Electronic Patient Record in the future.

Development of the External website to have a Learning Disability section, with resources / information. This will include accessible information about how to access our hospitals, these will include videos of people with learning disabilities acting.

22.0 Safeguarding Risks

The safeguarding team have proactively used the risk register to identify a variety of risks based on current and future predicted changes and have embedded the actions within the day-to-day business of the team.

Figure 16: Summary of current risks and risk scoring

Risk ID	Summary of risk	Risk score
4631	If there is inconsistent compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) requirements it could have a severe adverse impact on the mental health and wellbeing of the patient and may increase the likelihood of subsequent legal proceedings against the Trust. **Risk identified by CQC in 2019 however CQC in 2021 where satisfied that there had been a significant improvement**	LOW
4633	If clinical staff are caring for patients with specific mental health; learning disability; or autism related needs but they have not had the required training or kept their training up to date, there is an increased likelihood that those patients may suffer serious harm. **Learning disability/Autism training was introduced in December 2021 with current uptake at 70+%. Oliver McGowan training will be formally introduced in 2022 once approved in legislation. Mental Health training was already in place however is currently undergoing review**	LOW
4630	If an inspection by the Care Quality Commission (CQC) finds that the Trust is significantly non-compliant with safeguarding regulations and standards it may result in sanctions such as a warning, improvement or prohibition notice, or a financial penalty. **Risk identified by CQC in 2019 however CQC in 2021 where satisfied that there had been a significant improvement. The Trust have significantly invested in the safeguarding team to ensure it is now fit for purpose in relation to the size of the Trust**	LOW
4634	If patients who have been victims of domestic abuse, or are at risk of domestic abuse, are not provided with appropriate care and protection by the Trust they are likely to continue to be at high risk and may suffer serious harm.	LOW

	Whilst the Trust have robust systems in place to identify cases of DV it is wise to maintain this risk given the number of DV cases across Lincolnshire continue to rise.	
4628	If the Trust is found to be in breach of the new Liberty Protection Safeguards (LPS), after they have replaced the Deprivation of Liberty Safeguards (DoLS), it could result in legal action with potential for fines and compensation awards. **This Risk is in anticipation of the rollout of LPS**	MODERATE
4632	If the Trust cares for patients with significant learning disabilities and complex needs in a manner that is not appropriate to their needs (e.g., because there is no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc.) it could lead to sub-optimal care and delays in diagnosis or treatment with an increased likelihood of serious harm or a poor clinical outcome. **Whilst Individual care pathways are put in place there is currently a standard pathway being developed for this specific group of patients**	MODERATE
4627	If a patient becomes agitated and in response the Trust applies sedation, restraint, chemical restraint, or rapid tranquilisation inappropriately it could result in serious harm to the patient; other patients; or members of staff and could lead to subsequent legal or regulatory action **Risk identified by CQC in 2019 however CQC in 2021 where satisfied that there had been a significant improvement**	MODERATE
4910	There is currently no provision to provide de-escalation, clinical holding and restraint training for staff within the trust which could lead to injury of both staff and patients, allegations of assault against staff and reputational damaged to the trust. **Risk identified by CQC in 2019 however CQC in 2021 where satisfied that there had been a significant improvement. Work is ongoing to develop a new training format that is more suitable for the needs of staff and patients**	MODERATE

During 2021 - 2022 the safeguarding team have been actively involved with working against these objectives which are monitored by the Safeguarding Vulnerabilities Oversight Group

23.0 A review of 2021 – 2022

The last 12 to 24 months have been a challenge for everyone across the United Kingdom in a way that no one could have envisaged. Across the safeguarding system new ways of working have been developed to help support our most vulnerable in

society as well as provide a wider level of support to all staff within the trust and external safeguarding teams.

The normal pattern of safeguarding across Lincolnshire has changed and meant that some of its residents did not access services as normal during the first year of the Covid Pandemic.

During 2021 to 2022 however safeguarding activity appears to have increased particularly in relation to patients admitted due to eating disorders/disordered eating and Mental Health related issues as well as cases being more complex in nature.

As expected Nationally there have been several serious children / adult reviews which indicate the negative impact on our ability to safeguarding our most vulnerable during the pandemic.

To try and address this level of invisibility / delayed identification the safeguarding team continued to make the following adjustments based on service and client need:

- Maintain an increased availability of support and supervision to staff via face to face / teams / telephone even when team redeployment was required during COVID
- Created and amended alternative shortened pathways and processes to support staff in managing SG cases during the pandemic
- Acknowledge the difficulties of staff to complete safeguarding training due to the pressures of the pandemic and provide / supplement some of these potential knowledge gaps by providing face to face and bespoke educational opportunities in clinical areas
- Developed high quality alternative training packages to allow staff to maintain their compliance in the absence of classroom-based training sessions
- Developed virtual Trust-wide Safeguarding Supervision Sessions, with specific sessions for the area's most likely to have regular and sustained contact with Children and Young People. The sessions proved successful in terms of facilitating attendance for a larger group of staff members
- Developed IIP/PID projects and progressed same
- Acted as first line contact for our local authority colleagues specifically in the area of MCA and DOLs due to face-to-face client contact not taking please or being limited within the hospital setting
- Maintained and increased our presence in external / partnership processes such as the LSCP / LSAB / strategy meetings / MARAC etc.
- Fully embedded and maintained the Safeguarding governance process across all divisions ensuring that safeguarding remained at the forefront of operation business
- Continued to develop policies and improvements, undertook audits to maintain safety and identify risks
- Successfully appointed to newly developed safeguarding roles within the team to ensure that the Trust is able to deliver a safeguarding service (child

protection / adult protection / MCA / PREVENT/learning disability / autism and mental health) over the coming years

- Support the data protection team in delivering requests made by the judicial system
- Undertook a comprehensive review of the chemical sedation policy
- Supported the MARZIPAN group for eating disorder patients of which the Trust has seen an increase in admissions
- Provided continued support with chairing complex MDT meetings and best interest meetings.
- Produced guidance to support staff members who are required to produce statements for, or attend as a witness in, Family or Criminal Court.
- Facilitated the delivery of quarterly trust wide court craft skills training events and bi-annual Legal updates for staff who are required to attend court delivered by the trust solicitors
- Reviewed and benchmarked safeguarding supervision to ensure that the targets of achievement in this area are not unreasonable and embeds a reportable assurance process that allows monthly reporting
- Developed and rolled out specific training in relation to Learning disability and Autism
- Created a Quarterly PREVENT Newsletter
- Safeguarding team now part of the membership for the pressure ulcer support panels and skin integrity group
- Safeguarding team actively involved in the reviewed of complaints and SI's with a safeguarding or MCA aspect
- Created with A&E a malicious drug intoxication leaflet (spiking)
- Continue to undertake ward spot checks for divisional leads
- Contribute to fire fatality reviews

24.0 Safeguarding Developments for 2022-2023

- Maintain momentum to achieve 90% across safeguarding training areas
- Develop rollout process for Liberty Protection Safeguards (LPS) as guidance allows and identify any risks to the trust that the new legislation may pose.
- Consolidate business case for increased funding in relation to LPS
- Appoint to new team structure in relation to LPS and continue regular review to ensure it remains fit for purpose

Presently the national guidance is in a consultation phase (ending July 2022) and until this process is concluded it is not possible to fully understand the impact on the Trust. (See appendix 2 for timeline)

- Finalise and embed pathways for clients with learning disability / autism across trust services

- Launch the trust wide dementia pathway
- Embed the training of MCA/DOLS ensuring that there is a better understanding of best interest planning, and that staff are able to more readily identify patients who require extra care and have clear plans to follow in line with legislative requirements
- Audit adult concerns submissions to ensure compliance with 'Making Safeguarding Personal'
- Consolidate business case for funding in relation to Clinical/Therapeutic holding training with a provisional launch date of September 2022)
- Consolidate business case for funding in relation to the replacement of RITA (Reminiscence Interactive Therapy Activities) to ensure the system is future proof

RITA is a stand-alone computer system that is used with dementia patients as a therapeutic aid)

- Continue to review and roll out MHA procedures
- Review and embed the new Learning Disability bundle and shared care agreements
- Develop a system of flags and alerts across the trust for people with Autism and Learning disabilities to ensure more meaningful and are ready for an Electronic Patient Record in the future.
- Development of the External website to have a Learning Disability section, with resources / information. This will include accessible information about how to access our hospitals, these will include videos of people with learning disabilities acting.
- Undertake the Lincolnshire Assurance and Assessment Framework to provide assurance for the LSAB
- Approve and roll out the surgical assessment process for patients with a learning disability who requiring a GA
- Roll out the restrictive intervention log for data collection on restraint online with the Mental Health Unit Act 2018
- Continue to support A&E departments in their CQC Must-Do action to fully embed compliance with the Trust's CP-IS process

25.0 Conclusion

This report demonstrates the continued development and increased awareness of safeguarding children and safeguarding adults' issues within the Trust. The Trust continues to respond to the rapid national and local pace of change as well as maintaining an input external to the Trust.

Looking ahead to 2022 – 2023 there will be ongoing work needed to implement the changes to the Mental Capacity Act with the DOLS process being replaced (over the next 12 to 18 months) with the Liberty Protection Safeguards (LPS). Whilst still

awaiting the conclusions from the national guidance consultation event, the trust will aim to ensure that the transition is as seamless as possible and the LPS process will be embedded within the new and progressive safeguarding function of the team

Financially the launch of the LPS will in effect remove the onus and costs of deprivation from the local authority to the Trust and a business case will be concluded as soon as the final guidance is available

The safeguarding governance structures continue to be effective, and the forums are actively managing the current action plans as well as moving services forward however these will be continually reviewed to ensure that the structures remain fit for purpose.

The forthcoming year promises to be full of further developments and challenges for both the team and the Trust

26.0 Recommendations

It is recommended that the Trust Board

i) Receive the safeguarding report

ii) Approve the plans for 2022 - 2023

Appendix 1: Safeguarding Team – Structure April 2021 – March 2024

Safeguarding Team

March 2022

Portfolio:

Safeguarding Children

Safeguarding Adults

Mental Capacity and DOLS > LPS

Learning Disability / Autism

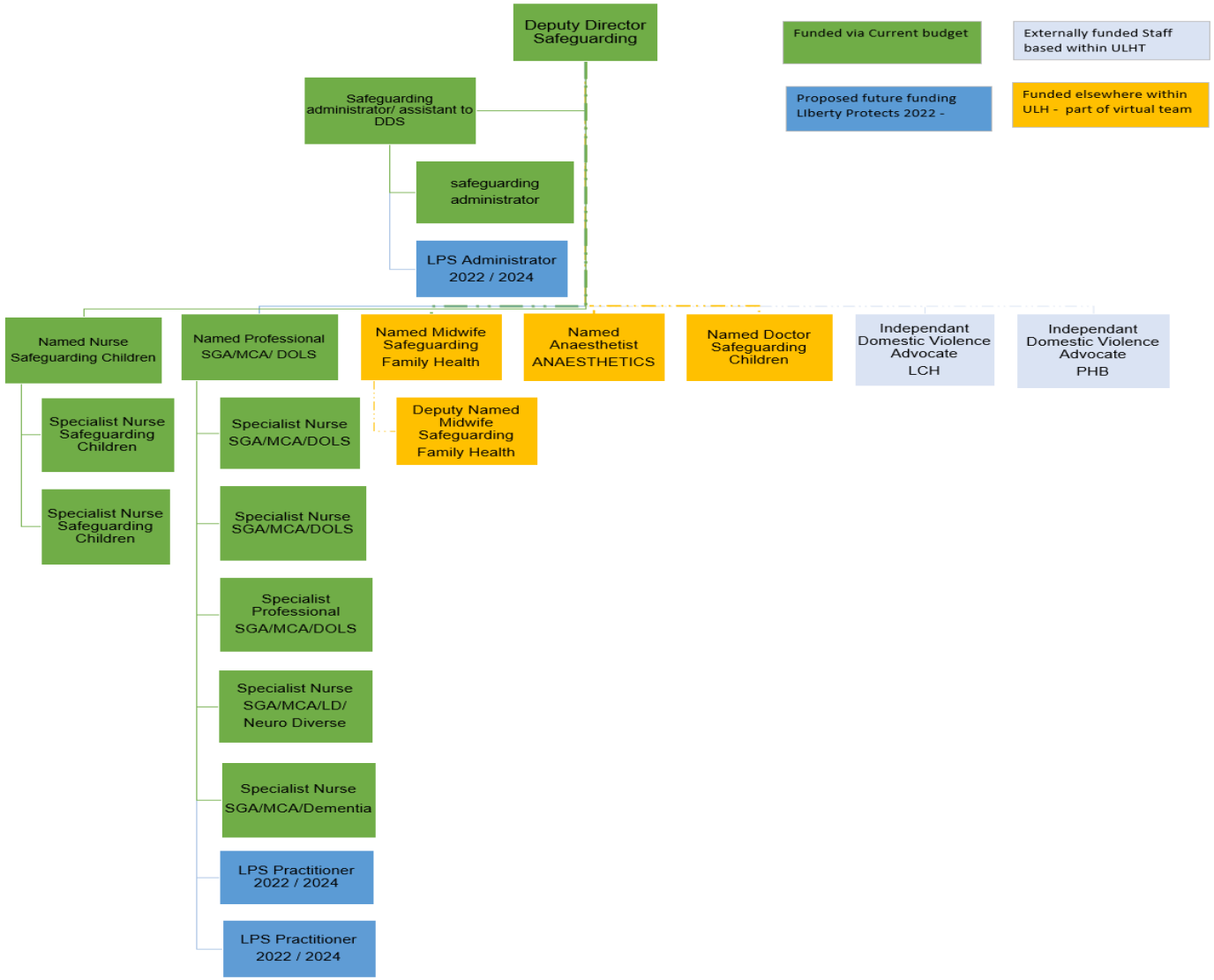
Dementia

Mental Health

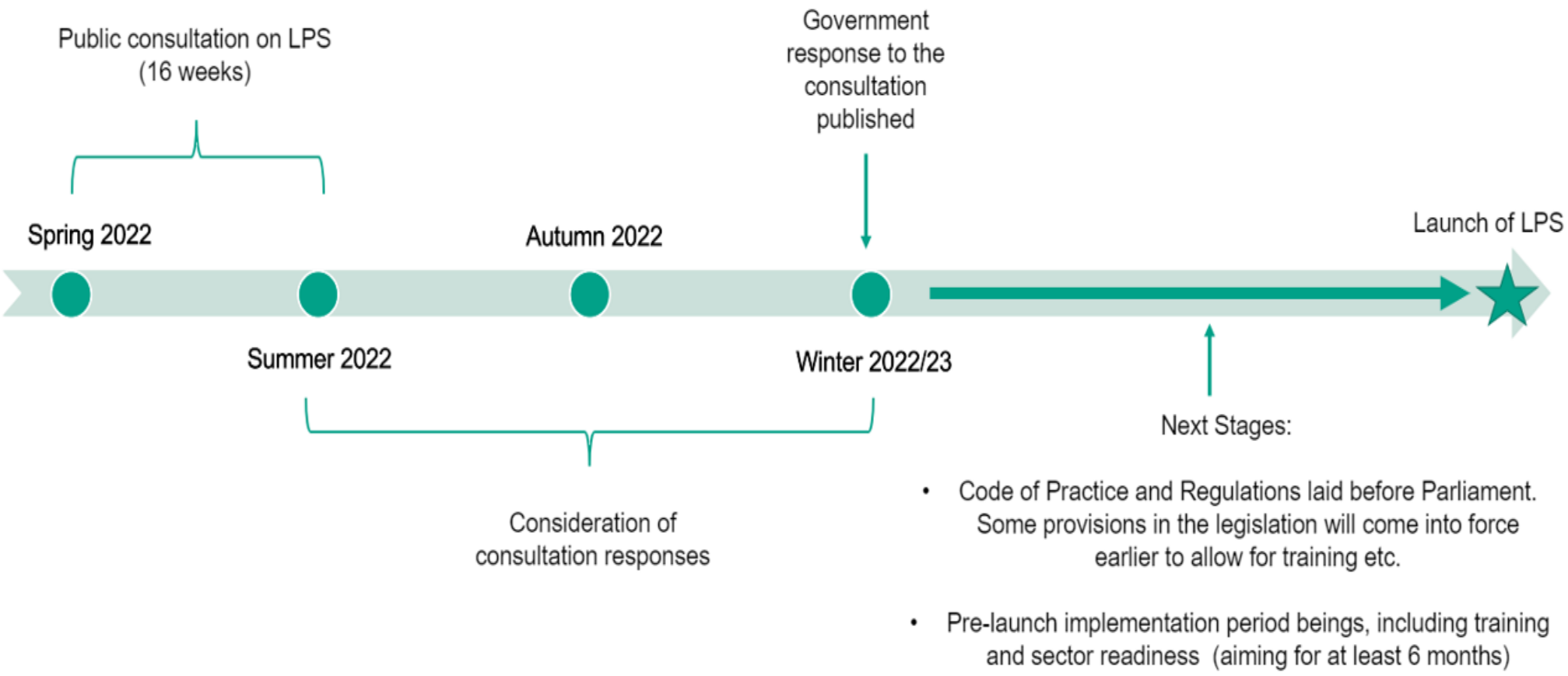
PREVENT

Domestic Abuse

Safeguarding Team - propose structure April 2021 - March 2024 (current position as at 30th March 2022)



Appendix 2: Planned Milestones for Liberty Protection Safeguards



OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5 July 2022*
Item Number	*Item 8.3*
Draft IPC Annual Report	
Accountable Director	*Dr. Karen Dunderdale*
Presented by	*Dr. Karen Dunderdale*
Author(s)	*Mrs. Natalie Vaughan, DDIPC*
Report previously considered at	*Infection Prevention and Control Group 8th June 2022 Approved*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
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	
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	*Moderate*

Recommendations/ Decision Required	•
	•
	•

Executive Summary

The Director of Infection Prevention and Control (DIPC) Annual Report details infection prevention and control performance activities within United Lincolnshire Hospitals Trust (ULHT) for the year 2021-2022.

The report outlines the Trust's continued zero tolerance approach to preventing and reducing the risk of avoidable healthcare associated infection (HCAI) as well as the process and interventions taken to mitigate risk. There is a strong commitment to lead on and support initiatives to prevent HCAI.

Development of the IPC Team structure has foccused on achieving skill set, clinical leadership along with the requirements to provide 7 day cover across sites.

IPC key objectives provide a strategic and structured framework upon which to shape and develop IPC across the organisation.

The IPC Group receives quarterly Board Assurance Frameworks (BAF) for The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and COVID-19 indicating a continued increase in compliance and commitment to sustaining the required IPC key lines of enquiry.

Mandatory reported cases of HCAI were under trajectory and reflective of the organisation-wide commitment and determination to achieve and sustain high standards of IPC. The pandemic effect however may have impacted on the number of cases due to less elective activity and a decrease in the number of blood cultures taken during this period of time.

The COVID-19 pandemic posed a significant level of challenges with the implementation of a robust and risk-based Trust response. There was close monitoring of nosocomial cases and outbreaks of this infection. The local interpretation and response to the plethora of national guidance was enacted to achieve compliance with the required directives.

COVID-19 designated wards and the implementation and embedding of Project Salus principles contributed to the provision of a high level of patient care and safety.

External inspections and visits identified significant improvements along with a responsive approach to strengthen Estates and Facilities governance arrangements and sustain the required IPC practice within inpatient areas. All staff were found to be welcoming and were witnessed to be delivering caring and kind patient care.

Estates and Facilities work has notably progressed in relation to water safety and ventilation as well as development of decontamination-related interventions. There has been significant progress with the interpretation and implementation of the National Standards of Healthcare Cleanliness 2021.

The report furthermore offers an overview of activity and/or development of outbreaks of infection, policies and guidelines, audit programme, antimicrobial stewardship, laboratory service, occupational health and training.

Main Body

Purpose
The publication of this report is a requirement to demonstrate effective governance and public accountability. It highlights in addition the role, function and reporting arrangements of the DIPC and the IPC Team

Key messages

Progress the IPC Key Objectives (table 15) to provide assurance and monitoring of the overarching IPC requirements
Continue to develop compliance with the components of the IPC BAFs
Further IPC service and Team development to further prevent and reduce HCAI and promote patient safety, governance and risk mitigation processes
Prevent and reduce HCAI and progress surgical site infection surveillance
COVID-19: recovery and restoration of IPC elements
Support the implementation of electronic prescribing in relation to antimicrobial stewardship
Support the progression of laboratory-based interventions to achieve enhanced diagnostic and clinical applications for the identification of micro-organisms for medical diagnosis
Provide IPC expertise to progress further compliance with environmental cleanliness, water safety, ventilation and decontamination requirements and directives

It is anticipated the forward plan will offer a range of IPC work to further develop the prevention and reduction of HCAI to achieve a high level of patient safety, governance and mitigation of risk.

Table 15: Infection Prevention and Control Key Objectives 2022-2022

Number	Objective
1	Develop infection prevention and control organisational and Divisional Governance arrangements
2	Continue to progress assessment and gap analysis of The Health and Social Care Act 2008. Code of Practice on the prevention and control of infection
3	Further development of surveillance of healthcare associated infections and performance
4	Investigate and manage the risks posed by novel infectious diseases to promote patient safety and prevent and reduce the risk of cross transmission
5	Investigate and manage the risks posed by the emergence of multi-drug resistant organisms to promote patient safety and prevent and reduce the risk of cross transmission
6	Development of governance arrangements for appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
7	Implement and sustain standards of cleanliness in line with National Standards of Healthcare Cleanliness. Development and implementation of hydrogen peroxide total room decontamination
8	Progress water safety, ventilation and decontamination requirements as sub-groups of the Infection Prevention and Control Group to ensure patient safety requirements

Conclusion/Recommendations

2021-2022 has been another unprecedented year with IPC being at the forefront of the COVID-19 pandemic response.

A wide range of strategic and operational IPC interventions and initiatives are in place and continue to be developed to prevent and reduce HCAI and promote a high level of risk-based patient safety.

There is much commitment to progress development of the IPC service and Team to continue the journey to achieve IPC excellence at all levels in the organisation.

NHS
United Lincolnshire Hospitals
NHS Trust

Director of Infection Prevention and Control Annual Report 2021-2022

OUTSTANDING CARE *personally* DELIVERED

Version Control

Version	1
Type	Annual Report
Directorate	Corporate
Author	Mrs Natalie Vaughan – Deputy Director Infection Prevention and Control
Contributors	Dr Bethan Stoddart - Consultant Microbiologist/Infection Prevention and Control Doctor Mrs Sandra Smirthwaite – Clinical Lead Infection Prevention and Control Mrs Vivien Duncanson – Senior Nurse Infection Prevention and Control Mrs Balwinder Bolla - Consultant Antimicrobial Pharmacist Mr Wayne McIntosh – Estates and Facilities Engagement Lead Mr John Killeen – Associate Director of Estates and Facilities Mr Stephen Kelly – Head of Occupational Health and Wellbeing Mrs Karen Bailey - Estates, Facilities and Decontamination Lead Nurse
Approving Person	Dr Karen Dunderdale - Director of Nursing, Deputy Chief Executive, Director Infection Prevention and Control
Approval Date	Infection Prevention and Control Group 08.06.22

Contents

1. Summary and Highlights

The Director of Infection Prevention and Control (DIPC) Annual Report details infection prevention and control performance activities within United Lincolnshire Hospitals Trust (ULHT) for the year 2021-2022.

The report outlines the Trust's continued zero tolerance approach to preventing and reducing the risk of avoidable healthcare associated infection (HCAI) as well as the process and interventions taken to mitigate risk. There is a strong commitment to lead on and support initiatives to prevent HCAI.

Infection prevention and control (IPC) practice is essential to ensure those who access the Trust's services receive safe care. Effective IPC practices require the hard work and diligence of all clinical and non-clinical staff, with a need for everyone to consistently apply a high level of practice.

The publication of this report is a requirement to demonstrate effective governance and public accountability. It highlights in addition the role, function and reporting arrangements of the DIPC and the IPC Team.

Development of the IPC Team structure has foccused on achieving skill set, clinical leadership along with the requirements to provide 7 day cover across sites.

IPC key objectives provide a strategic and structured framework upon which to shape and develop IPC across the organisation.

The IPC Group receives quarterly Board Assurance Frameworks (BAF) for The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and COVID-19 indicating a continued increase in compliance and commitment to sustaining the required IPC key lines of enquiry.

Mandatory reported cases of HCAI were under trajectory and reflective of the organisation-wide commitment and determination to achieve and sustain high standards of IPC. The pandemic effect however may have impacted on the number of cases due to less elective activity and a decrease in the number of blood cultures taken during this period of time.

The COVID-19 pandemic posed a significant level of challenges with the implementation of a robust and risk-based Trust response. There was close monitoring of nosocomial cases and outbreaks of this infection. The local interpretation and response to the plethora of national guidance was enacted to achieve compliance with the required directives.

COVID-19 designated wards and the implementation and embedding of Project Salus principles contributed to the provision of a high level of patient care and safety.

External inspections and visits identified significant improvements along with a responsive approach to strengthen Estates and Facilities governance arrangements and sustain the required IPC practice within inpatient areas. All staff were found to be welcoming and were witnessed to be delivering caring and kind patient care.

Estates and Facilities work has notably progressed in relation to water safety and ventilation as well as development of decontamination-related interventions. There has been significant progress with the interpretation and implementation of the National Standards of Healthcare Cleanliness 2021.

The report furthermore offers an overview of activity and/or development of outbreaks of infection, policies and guidelines, audit programme, antimicrobial stewardship, laboratory service, occupational health and training.

A forward plan details work and initiatives to be progressed through 2022-2023 in addition to updated IPC key objectives.

2. Infection Prevention and Control Arrangements and Team

The DIPC holds Board level responsibility for all matters relating to the safe delivery of IPC care and practice and is supported by the Deputy DIPC who also provides operational leadership to the IPC Team.

During 2021, a review of the current IPC Team strcture was undertaken. Following a successful business case, there has been additional funding to address the need for investment in strong, consistent clinical leadership to build a one team approach and develop the skills of the team. A focus is to grow our own talent and think differently by utilising different roles, e.g. Nursing Associate to build a team fit for purpose. The need for data analyst support to ensure accurate reporting, identification of themes and trends and subsequently free up clinical time was also built into the proposal.

The progress to date is illustated in diagram 1, with further recruitiment to achieve the IPC Team described in diagram 2. Recruitment into experienced IPC Clinical Specialist posts contuinues to be a challenge and the support from retire and return coilleagues is much appreciated.

Diagram 1: Current IPC Team Structure

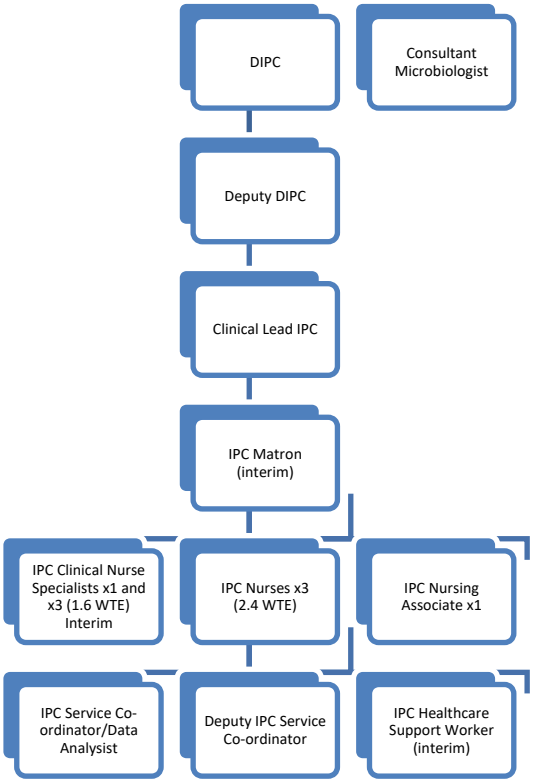
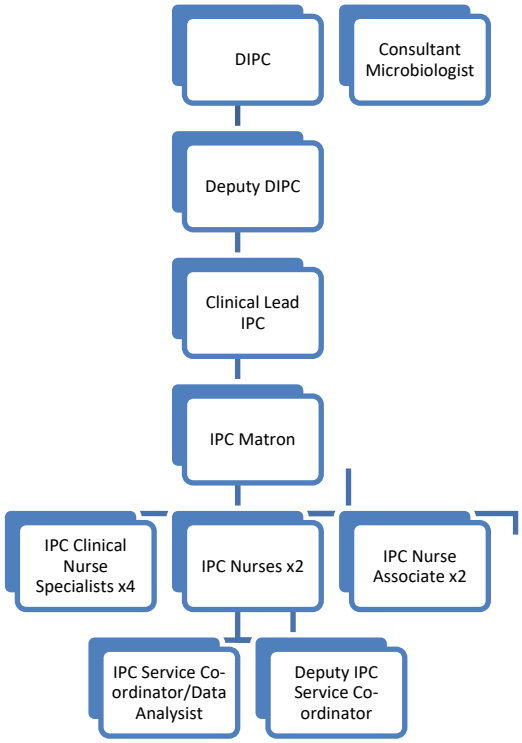


Diagram 2: Proposed/Funded IPC Team Structure



3. Infection Prevention and Control Governance, Assurance and Reporting Structure

The IPC Group meets monthly and provides strategic direction for the prevention and control of HCAI. It performance manages the organisation against the Trust's IPC Key Objectives (table 1) and ensures a risk-based and proportionate response to directives as well as national and local guidance. Upward reporting via a highlight report is to the Quality Governance Committee (QGC) and the Trust Executive Board.

Table 1: Infection Prevention and Control Key Objectives 2021/22

No	Objective
1	Develop infection prevention and control organisational and Divisional Governance arrangements
2	Continue to progress assessment and gap analysis of The Health and Social Care Act 2008. Code of Practice on the prevention and control of infection
3	Further development of surveillance of healthcare associated infections and performance
4	Investigate and manage the risks posed by novel infectious diseases (specifically COVID-19) to promote patient safety and prevent and reduce the risk of cross transmission
5	Investigate and manage the risks posed by the emergence of multi-drug resistant organisms to promote patient safety and prevent and reduce the risk of cross transmission
6	Development of governance arrangements for appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
7	Establish and sustain (new and improved) standards of cleanliness in line with National Standards of Healthcare Cleanliness. Development and implementation of hydrogen peroxide total room decontamination
8	Progress decontamination, water safety and ventilation requirements as sub-groups of the Infection Prevention and Control Group to ensure patient safety requirements

Antimicrobial stewardship, water safety, ventilation and decontamination sub-groups report into the IPC Group with Divisions providing assurance and exception reporting in line with The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections.

3.1 Board Assurance Frameworks

The IPC Group receives quarterly Board Assurance Frameworks (BAF) for The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and COVID-19, with the shared criterions detailed in table 2.

Table 2: The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections: Criterions

No	Criterion Description
1	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
2	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities
8	Secure adequate access to laboratory support as appropriate
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections BAF has been subject to many years of progress monitoring and assurance via a gap analysis framework. There has been a good level of development and overall sustainability of the key lines of enquiry, with 3 criterions continuing to score a partial (amber) rating (table 3).

Criterion 1 identifies a partial rating in respect of the continued IPC service and team development and the need to progress a business case for additional cleaning resource.

Criterion 2 describes excellent implementation of the National Standards of Healthcare Cleanliness 2021 and good progress with estates programmes of work including enhanced monitoring programmes and assessment of risk processes for ventilation and water safety, decontamination, back log and planned preventative maintenance. Poor environmental infrastructure at all sites continues to be a challenge and scores a partial rating.

Criterion 9 reports a position of publication and implementation of the required IPC policies with work progressing to increase the partial rating for the estates and facilities related documents.

Table 3: The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections: Board Assurance Framework Compliance Summary

Compliant

Partial

Criterion	Theme
Criterion 1	Governance
Criterion 2	Environment
Criterion 3	Antimicrobial stewardship
Criterion 4	Information
Criterion 5	Management
Criterion 6	Engagement
Criterion 7	Isolation
Criterion 8	Laboratory support
Criterion 9	Policies
Criterion 10	Workforce

The COVID-19 BAF is a more recent national directive and describes the key lines of enquiry, local systems and processes in place as well as national and local supporting guidance. There has been a very good level of progress and development and of the key lines of enquiry with 2 criterions continuing to score a partial (amber) rating (table 4)

Criterion 2 compliance is reflective of ventilation work to progress including work to upgrade or replace systems.

Criterion 9 has been awarded one partial rating due to Divisions continuing to progress work to look at ways of achieve better spaces for staff break areas/changing facilities.

Table 4: The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections: COVID-19 Board Assurance Framework Compliance Summary

Compliant

Partial

Criterion	Theme
Criterion 1	Governance
Criterion 2	Environment
Criterion 3	Antimicrobial stewardship
Criterion 4	Information
Criterion 5	Management
Criterion 6	Engagement
Criterion 7	Isolation
Criterion 8	Laboratory support
Criterion 9	Policies
Criterion 10	Workforce

4. Healthcare Associated Infection Performance

4.1 Mandatory Reporting

The following infections required by the mandatory surveillance programme facilitated by UK Health Security Agency (UKHSA) continue to be reported:

- Meticillin-resistant *Staphylococcus aureus* (MRSA) blood stream infections (bacteraemia)
- *Clostridioides difficile* infection
- Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia
- *Escherichia coli* bacteraemia
- *Klebsiella* species bacteraemia
- *Pseudomonas aeruginosa* bacteraemia

National criteria were applied to establish whether cases of these infections are attributable to the Trust (hospital onset or healthcare-associated).

4.2 Meticillin-Resistant *Staphylococcus aureus* Bacteraemia

Staphylococcus aureus is a bacterium commonly found on human skin which can cause infection if there is an opportunity for the bacteria to enter the body. In serious cases it can cause blood stream infection (bacteraemia). Meticillin-resistant *Staphylococcus aureus* (MRSA) is a strain of these bacteria that is resistant to many antibiotics, making it more difficult to treat.

Many patients carry MRSA on their skin and this is called colonisation. It is important to screen some high risk patient groups when they come into hospital to identify if they are carrying MRSA.

The Trust in 2021-2022 reported 2 Trust acquired MRSA bacteraemia and nationally there remains a zero tolerance to Trust attributed cases (table 5). This was a decrease from the 4 cases reported in 2020-2021.

For each case a root cause analysis (RCA) investigation was to identify areas of concern, ensure actions were taken to prevent recurrence and the lessons are learnt and shared with the wider health care team.

The first case in July 2021 at Pilgrim Hospital Boston (PHB) in the Medicine Division concluded following patient assessment and a review of further blood culture results

it was most likely a blood culture specimen contaminant. This instigated a review of how the specimen was taken as well as associated procedural education requirements.

The second case in December 2021 at Lincoln County Hospital (LCH) in the Surgery Division was deemed to be unavoidable. The investigation concentrated on a review of IPC practice and reiteration of the importance of accurately recorded visual infusion phlebitis (VIPs) scores, MRSA screening and decolonisation along with antimicrobial prescribing.

Table 5: MRSA Bacteraemia by Site 2021-2022

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Louth	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	1	0	0	0
Pilgrim	0	0	0	1	0	0	0	0	0	0	0	0
Grantham	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	0	0	1	1	1	1	1	2	2	2	2

4.3 *Clostridioides difficile* Infection

Clostridioides difficile (C. difficile) is a bacterium found in the gut of around 3% of healthy adults. It seldom causes a problem and is kept under control by the normal bacteria of the intestine. Certain antibiotics however can disturb the bacteria of the gut and *C. difficile* can then multiply and produce toxins which cause symptoms such as diarrhoea.

Table 6 describes 59 Trust attributable cases of *C. difficile* reported against a trajectory of not to exceed 70 cases. This compares with 66 Trust attributable cases reported in 2020-2021 (decrease of 11%) and 70 cases in 2019-2020.

Table 6: Trust Attributable C. *difficile* Data 2021-2022

2021-2022	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	5	5	6	6	6	6	6	6	6	6	6	6
Actual acute cases	4	3	5	7	6	7	2	4	6	7	3	5
+/- Trajectory	-1	-2	-1	+1	0	+1	-4	-2	0	+1	-3	-1
Acute Cumulative actual	4	7	12	19	25	32	34	38	44	51	54	59

The continued downward trajectory was encouraging and reflects the high level of work to achieve good IPC and antimicrobial practices as well as a high standard of environmental cleanliness. Programmes of audit and monitoring were in place and consistently applied.

There were investigations into 5 periods of incidence (PII) defined as two or more cases of *C. difficile* (occurring > 48 hours post admission, not relapses) in a 28-day period on a ward. There was one PII at LCH and 4 at PHB. IPC interventions such as enhanced cleaning, sending stool samples for ribotyping, weekly antimicrobial audits for a 3 week period as well as RCA investigation and holding PII meetings with clinical colleagues.

The ribotyping did not indicate cross transmission but reviewing IPC practice as part of the PII process put forward the need for prompt patient isolation upon taking the stool sample, review of antimicrobial prescribing and the importance of maintaining high standards of environmental cleanliness.

Cases of Trust acquired *C. difficile* were furthermore subject to a thematic investigation to enable a detailed review. Common themes requiring further work and development included recording of severity score, some suboptimal antimicrobial prescribing, i.e. long-term antimicrobials given without Microbiologist consultation as well as their advice not always followed. Indication for antimicrobial use, duration and a delay in commencing treatment were identified as a concern. On a number of occasions, there was a decrease in environmental cleanliness scores leading up to a positive case. A delay in commencing the *C.difficile* pathway or in some cases not undertaking this as well as best practice audits not carried out for all cases. An action plan was compiled with assurance and monitoring by the IPC Group.

4.4 Meticillin-Sensitive *Staphylococcus aureus* Bacteraemia

Meticillin-sensitive *Staphylococcus aureus* (MSSA) is a strain of these bacteria that can be effectively treated with antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body and in serious cases it can cause blood stream infection (bacteraemia).

Table 7 details the Trust has reported 20 Trust acquired MSSA bacteraemia during 2021-2022 and is unchanged when compared with the cases reported in the previous 2 years (2020-2021; 19 cases and 22019-2020; 18 cases).

Table 7: Trust Attributable MSSA Bacteraemia by Site 2021-2022

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Louth	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	2	0	1	1	0	0	2	0	1	0	1
Pilgrim	3	0	1	0	1	2	0	1	0	0	3	0
Grantham	0	0	0	0	0	0	0	0	0	0	0	1
Total	3	2	1	1	2	2	0	3	0	1	2	2
Cumulative Total	3	5	6	7	9	11	11	14	14	15	18	20

4.5 Gram Negative Bacteraemia

- *Escherichia coli (E. coli)* bacteraemia

E. coli is part of the normal gut flora and can commonly cause urinary, biliary or gastrointestinal tract related infection leading to blood stream infection (bacteraemia).

Some *E. coli* are enzyme producers known as extended spectrum beta lactamase (ESBL) which increase the resistance to multiple antibiotics.

Attention to insertion and care of urinary catheters, audits, education and reporting of catheter associated urinary tract infection are directed to further reduce HCAI and *E. coli* blood stream infection.

For 2021-2022 there was a trajectory of not to exceed 146 Trust attributable cases of *E. coli* bacteraemia and in this period there were 54 cases. This however represents an increase of 59% on the previous year when 34 cases were reported but in line with the 51 reported cases in 2019-2020.

- *Klebsiella* species bacteraemia

Klebsiella species belong to the family Enterobacteriaceae and are commonly associated with a range of healthcare associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis.

For 2021-2022 there was a trajectory of not to exceed 28 cases of Trust attributable cases and in this period there were 24 cases. This represents a decrease of 22% on the previous year when 31 cases were reported.

- *Pseudomonas aeruginosa* bacteraemia

Pseudomonas is a type of bacteria that is found commonly in the environment, including soil and in water. Of the many different types of Pseudomonas, the one that most often causes infections in humans is called Pseudomonas *aeruginosa*, which can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.

For 2021-2022 there was a Trust trajectory of not to exceed 29 Trust attributable cases and in this period there were 8 cases. This represents a decrease of 47% on the previous year when 15 cases were reported.

Mandatory reported cases of HCAI were under trajectory and reflective of the organisation-wide commitment and determination to achieve and sustain high standards of IPC. The pandemic effect however may have impacted on the number of cases due to less elective activity and a decrease in the number of blood cultures taken during this period of time.

4.6 Carbapenemase Producing Enterobacterales (CPE)

Bacteria from the family Enterobacterales live harmlessly in the gut, but can cause significant infections when they get into the wrong place. It is a very large family of Gram negative bacteria, including *E. coli*, and *Klebsiella* and Enterobacter species. They can cause a broad range of infections from urinary tract infections, intra-abdominal infections through to overwhelming sepsis.

Enterobacterales can become resistant to antibiotics through many different mechanisms. One of these is production of various beta-lactamases which destroy some beta-lactam antibiotics before they can kill the bacteria.

The number of Trust attributed cases of CPE is low with 2 reported during the year, one at LCH and the other at PHB.

4.7 SARS-CoV-2 (COVID-19)

Through 2021-2022 the COVID-19 pandemic posed a significant level of challenges. The Trust response continued to highlight robust systems and processes to promote a risk-based IPC approach to monitor and assure the required governance structure was in place.

Nosocomial rates and outbreaks of COVID-19 were closely monitored with measures in place to prevent and reduce the spread of the virus. The emergence of the highly transmissible Omicron variant exacerbated the number of outbreaks of COVID-19 and this is summarised in section 4.8.

IPC cell meetings continued to offer support, guidance, implementation of IPC policy and practice relating to COVID-19, management of outbreaks and has provided assurance to the Trust board.

The local interpretation and response to the plethora of national guidance was enacted in a systematic and consistent manner to achieve compliance with the required directives. The evolution of a COVID-19 BAF (see section 3.1) was welcomed to support this process and moreover provide a framework for assurance and monitoring by the IPC Group with upward reporting to the QGC.

The Divisional response was commended with much engagement and accountability to ensure compliance with COVID-19 interventions to undertake daily audits in all wards and departments to ensure compliance with PPE, physical distancing, environmental cleaning, hand hygiene, ventilation and the wearing of masks by patients. As new guidance was published the ward assurance logs were updated to reflect this. Spot checks and audits continued to be carried out by the Quality Matrons and Divisional Nurses with support from the IPC Team.

The immense effort and work of the cleaning teams to provide 24 hour cleaning as well as enhanced cleaning significantly contributing to keeping our patients and staff safe. The work to interpret and implement the National Standards of Healthcare Cleanliness 2021 offered an opportunity to work in collaboration with the IPC Team to achieve a systematic roll out.

National visiting guidance has been followed in conjunction with local indications such as local COVID-19 prevalence. This offered a risk-based approach with appreciation of end of life, carers and extraordinary circumstances to put forward a safe but compassionate approach.

The cleaning teams expanded to deliver 24 hour service provision with increased cleaning of all touch points along with enhanced cleaning in areas caring for COVID-

19 positive patients or where patients have been in contact with a COVID-19 positive individual.

The COVID-19 designated wards at the LCH and PHB sites remained in situ and provided a high level of patient care and IPC precautions to achieve patient safety and maximise the use of single room accommodation.

The implementation and embedding of the Project Salus principles (launched in January 2021) has successfully via the application of high, medium or low risk categories contributed to safely restore speciality based wards and a resumption of business as usual. This was to move from managing COVID-19 during a pandemic to living with it as endemic in our population.

Despite the implementation of the above the pandemic has continued to impact on flow and bed capacity. The partnership working of the IPC and Operational Teams was a positive example of collaboration to work through risk-based options on a daily basis to optimise patient safety.

Trust wide communications have disseminated relevant, up to date and consistent key messages to ensure an informative and proportionate approach with regards to keeping colleagues, patients and the wider public informed.

A review of 36 probable (8-14 days after admission) and definite (15 or more days after admission) nosocomial COVID-19 deaths during the period February 19 2021 to December 31 2021 identified much good practice with areas completing COVID-19 testing in line with the expected standard, practicing good hand hygiene, overall care of the patient documentation, clear discharge planning processes documentation as well as communication with families and the involvement of other agencies.

There were however some testing delays and increased patient moves. Concerns relating to ventilation, audit processes and documentation may have contributed to the patient acquiring COVID-19 in or hospitals. A further issue was delayed discharge where medically fit or optimised patients remained in hospital and subsequently contracted COVID-19 and died. In almost all cases the patients had multiple co-morbidities, and many were approaching the natural end of their life due to their clinical condition.

Patient pathways have continued to be subject to review as well as the discharge of a medically optimised patient and the documentation of patient moves has been strengthened. A duty of candour process is being developed to support recording on Datix and documentation in a patient's record. COVID-19 ward assurance audits were reviewed and revised as appropriate with plans for enhanced digital solutions,

including for reminding staff when a COVID-19 test is due. Ventilation work has progressed (section 10.3).

4.8 Outbreaks of Infection

- SARS-CoV-2 (COVID-19) cases of nosocomial infection and outbreaks

During the year there were 311 reported cases of nosocomial (probable and definite COVID-19 and 51 outbreaks of this infection across sites (table 8).

Table 8: COVID-19 Nosocomial Cases and Outbreaks 2021-2022

Date	Number of COVID-19 cases: Probable (8-14 days	Number of COVID-19 cases: Definite (15+ days)	Number of Outbreaks of COVID -19
April 2021	0	2	0
May 2021	6	2	0
June 2021	1	0	0
July 2021	3	0	0
August 2021	10	12	4
September 2021	4	4	1
October 2021	3	2	0
November 2021	9	15	3
December 2021	9	15	6
January 2022	30	33	11
February 2022	26	22	10
March 2022	45	58	16
Total	146	165	51

The IPC/Outbreak Cell meeting had oversight of each outbreak and received assurance regarding the investigation of cases, patient isolation, IPC precautions and the monitoring of positive patients and contacts in line with national guidance. Timely patient and staff screening with good co-ordination by Occupational Health

colleagues, visiting restricted as per high risk environment stipulations as well as enhanced cleaning and auditing of the affected areas.

Contributory factors that may have led to onward transmission included limited single room accommodation (and with en suite facility), the number of patients cohorted in an area due to bed capacity constraints, ageing environmental infrastructure, especially ventilation systems and repeated critical incident status due to very high bed capacity. Further exacerbations were the increased number of COVID-19 related admissions due to the highly transmissible Omicron variant as well as decreased staffing capacity due to COVID-19 related illness.

- ## Outbreak of *Stenotrophomonas maltophilia*

In July 2021 an outbreak of *Stenotrophomonas maltophilia* was declare on the Critical Care Unit at PHB. This is a Gram-negative bacterium found in a variety of environments including soil, water and plants. It also occurs in the hospital environment and may cause bloodstream, respiratory, urinary and surgical site infections.

The 6 affected patients were all ventilated on closed circuits and being cared for in different areas of the unit. Outbreak meetings were held and a comprehensive review of practice identified the sputum samples sent to Reference Laboratory for typing were of the same strain. Enhanced environmental cleaning was undertaken despite previous consistent high scores of 98%. There was audit and observation of clinical practice with the implementation of Front Line Ownership (FLO) validation audits. There was also a review of antimicrobial prescribing. The Estates work included water and drain testing and a review of water flushing practice. Hand wash basin taps were replaced.

It was ascertained the most likely infection source was the disposal of used water from a patient wash bowl being disposed of in the hand wash basin leading to contamination. Filling of a wash bowl necessitates contact with the base of the hand wash basin leading to potential contamination. These practices were ceased and waterless bathing was introduced on the unit. Education and a revised standard operating procedure provided direction on cleaning a hand wash basin to negate transference of micro-organisms. Discussion with an external water expert provided assurance that he correct measures were undertaken.

5. Policies and Guidelines

During 2021-2022 the remaining policies to comply with the requirements set out in The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections were written and published. Work has progressed to achieve a complete Estates and Facilities policy portfolio.

The Guidance at a Glance quick reference documents for key IPC practice continued to be a very good quick reference guide with positive colleague feedback.

Posters continued to be developed and made available in all clinical areas detailing IPC messages as well as choosing pertinent topics for the publication of IPC bulletins communicated to all staff.

Utilising these methods of pan-organisation communication have been especially important to provide pertinent and concise information to busy staff.

6. Audit Programme

The IPC programme of audit continued to monitor and assure IPC practice standards across the organisation. Through 2021-2022 the substantial programme provided additional COVID-19 related assurance.

The Front Line Ownership (FLO) audit programme remained the standardised IPC audit tool for all wards and departments focussing on key areas of practice including hand hygiene, general and patients' immediate environment, patient isolation, dirty utility / linen and waste disposal, ward kitchen, sharps safety, storage areas, clean utility and treatment room, patient equipment decontamination and clinical practice.

The audits were undertaken by Divisions on a monthly basis and results with themes and actions reported to the IPC Group for assurance. Senior Divisional staff have provided a detailed overview of IPC practice in their clinical environments. A high level of Divisional responsibility, accountability and engagement to achieve high standards was commended. Each Division was able to identify progress and exception to create bespoke plans of action.

Thematic analysis highlighted the need to focus on the impact of poor environmental infrastructure and continued programmes of enhancement and refurbishment. A hand wash basin and tap replacement roll out in clinical areas was progressed. Supported by the sharps bin manufacturer, there was sharps management and education to staff especially in respect of ensuring the sharps bin temporary closure mechanism is in place.

A summary of Divisional FLO audit results is located in table 9.

Table 9: Divisional Front Line Ownership Audit Scores (%) 2021-2022

Site	Division	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Pilgrim	CSS	97.27%	96.30%	97.07%	94.79%	95.08%	95.00%	95.73%	95.21%	96.43%	95.82%	96.24%	94.95%
Lincoln	CSS	96.85%	97.11%	96.53%	94.65%	96.44%	97.12%	95.84%	96.72%	97.75%	96.48%	97.16%	97.17%
Grantham	CSS	96.25%	97.00%	98.86%	98.45%	97.89%	98.17%	98.75%	98.27%	98.75%	98.47%	98.20%	96.81%
Louth	CSS	96.86%	95.14%	94.14%	92.43%	99.00%	98.17%	97.57%	97.71%	98.86%	98.86%	98.83%	98.00%
Pilgrim	Family Health	95.20%	93.40%	96.20%	96.57%	96.43%	96.71%	97.00%	93.83%	96.00%	96.50%	97.00%	96.60%
Lincoln	Family Health	95.00%	94.43%	96.75%	95.20%	95.63%	96.89%	95.71%	95.25%	96.00%	96.14%	95.75%	96.57%
Grantham	Family Health		96%	89%	95%	95%	92%	95%	99%	90%	93%	93%	94%
Louth	Family Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pilgrim	Medicine	94.10%	93.38%	90.71%	92.50%	95.86%	92.60%	92.73%	93.36%	92.58%	93.64%	92.55%	93.75%
Lincoln	Medicine	90.25%	92.90%	94.00%	90.64%	91.77%	93.08%	93.79%	91.12%	93.40%	93.56%	94.80%	94.44%
Grantham	Medicine		98.00%		92.50%		94.00%	95.50%	91.33%	91.67%	93.25%	95.00%	96.00%
Louth	Medicine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pilgrim	Surgery	94.40%	95.50%	95.75%	93.14%	94.20%	93.50%	94.83%	94.86%	96.00%	91.40%	96.50%	94.11%
Lincoln	Surgery	90.88%	90.33%	93.29%	91.75%	93.29%	93.67%	95.13%	96.67%	94.71%	96.00%	96.43%	91.70%
Grantham	Surgery	96.50%	99.00%	99.33%	99.00%	95.67%	98.33%	98.67%	98.00%	99.00%	96.00%	99.00%	97.00%
Louth	Surgery	N/A	N/A	N/A	98.00%		100.00%	97.00%	97.00%	96.50%	97.00%	97.00%	97.50%

(≤ 84% = red; 85-90% = amber; 91–100% = green)

Effective hand hygiene is the most effective measure to prevent the spread of infection and this has been especially important throughout the pandemic. The results in table 10 indicated overall high compliance with the requirements of the 5 moments of hand hygiene.

Work progressed to review hand hygiene facilities as the current system required updating and refreshing. A decision was made to implement the Gojo system with roll out commencing in the summer of 2022.

Table 10: Divisional Hand Hygiene Audit Scores (%) 2021-2022

Site	Division	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Pilgrim	CSS	99.50%	99.70%	99.75%	99.64%	99.00%	99.00%	99.50%	99.00%	100.00%	100.00%	100.00%	99.00%
Lincoln	CSS	99.85%	99.94%	99.84%	99.83%	99.27%	97.00%	99.39%	99.00%	100.00%	100.00%	99.00%	99.00%
Grantham	CSS	99.57%	100.00%	99.83%	98.16%	99.80%	100.00%	99.82%	100.00%	100.00%	100.00%	100.00%	100.00%
Louth	CSS	100.00%	100.00%	100.00%	100.00%	100.00%	96.00%	100.00%	89.00%	97.00%	100.00%	100.00%	99.00%
Pilgrim	Family Health	99.83%	99.50%	100.00%	99.88%	99.75%	100.00%	99.83%	99.00%	100.00%	100.00%	99.00%	100.00%
Lincoln	Family Health	98.67%	97.50%	98.14%	99.71%	99.44%	99.00%	98.67%	99.00%	100.00%	99.00%	99.00%	98.00%
Grantham	Family Health	99%	100%	100%	100%	99%	92.00%	99%	100%	100%	98%	98%	98%
Louth	Family Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pilgrim	Medicine	97.70%	98.12%	93.57%	96.87%	99.00%	98.00%	98.09%	95.00%	97.00%	97.00%	97.00%	99.00%
Lincoln	Medicine	95.16%	97.11%	97.18%	95.69%	98.33%	99.00%	98.62%	95.00%	98.00%	99.00%	97.00%	99.00%
Grantham	Medicine		99.00%		96.00%		97.00%	99.50%	99.00%	97.00%	98.00%	98.00%	100.00%
Louth	Medicine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pilgrim	Surgery	96.00%	99.33%	97.57%	97.83%	95.60%	97.00%	98.00%	95.00%	100.00%	97.00%	99.00%	98.00%
Lincoln	Surgery	97.13%	98.85%	99.57%	94.13%	98.43%	98.00%	98.38%	95.00%	98.00%	99.00%	100.00%	99.00%
Grantham	Surgery	99.50%	99.50%	99.50%	99.00%	99.50%	99.00%	99.66%	100.00%	100.00%	99.00%	100.00%	100.00%
Louth	Surgery	N/A	N/A	N/A	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

(≤ 84% = red; 85-90% = amber; 91–100% = green)

A COVID-19 ward assurance audit tool proved to be successful as a dynamic check list to provide assurance to the IPC cell outbreak meetings. There was overall good compliance with national directives and guidance. In addition a PPE and social distancing audit tool was undertaken on a regular basis to serve as assurance along with a regular best practice reminder.

The IPC Team carried out compliance assessment tool (CAT) audits on a patient upon identification of organism of clinical significance. The ward was visited to ascertain that best and safe practice is being implemented. Due to COVID-19, a decreased number of audits were undertaken. Support was given to ensure the door of an isolation room was closed, reiterating the importance of thorough commode cleaning and the correct use of the “I am clean” stickers, ensuring patient information leaflets were given to patients and the documentation of a severity score.

7. External Inspections and Visits

In July 2021 there was an NHSE/I visit to LCH, PHB and Grantham District Hospital (GDH) with significant improvements reported to increase from the previous red to an overall amber rating. Estates and Facilities and governance issues put forward issues pertaining to limited assurance on ventilation, water and decontamination. Non-compliance with patient mask wearing documentation was identified, as well as some environmental concerns.

The clinical areas visited without exception achieved a green status with evidence of a high standard of environmental cleanliness and the consistent application of very good IPC practice. All staff were found to be welcoming and were witnessed to be delivering caring and kind patient care.

A repeat visit in February 2022 to the same sites concluded significant Estates and Facilities strengthening of governance arrangements as well as having plans to further embed. Clinical inpatient areas demonstrated sustained improvements, with just a few actions requiring attention. It was noted staff supported each other with compassionate challenge.

A number of outpatient and diagnostic areas highlighted some issues requiring immediate attention. These related to both IPC practice, and the environment.

There was a recommendation the Trust remains on an amber rating with a further review of LCH Outpatient areas scheduled for April 2022.

Action and development plans have been progressed with assurance and monitoring via the IPC Group. An Outpatients Task and Finish Group has also been established to allow a more detailed review to address the concerns.

The CQC inspection visits in October and November 2021 alluded to all areas being clean and had suitable furnishings which were clean and well maintained. Most equipment also appeared to be clean. Monthly audits did not always demonstrate the service met the expected IPC standards. An action plan was in place with monitoring by the IPC Group.

Staff followed IPC principles and were observed using personal protective equipment PPE. Managers conducted regular audits to check compliance with IPC policies. Patients with infections or at risk of harm from infections were clearly identified and isolated as well as having an individual assessment of the level of risk. Some clinical areas required refurbishment with plans in place to progress this work.

8. Antimicrobial Stewardship (AMS)

The Trust Antimicrobial Stewardship Strategy Group (ASSG) has made good progress over the course of the year, despite IPC and critical clinical pressures compromising some attendance. Monthly tracking of progress and actions against the ULHT Antimicrobial Stewardship strategy continued, as well as consumption of antimicrobials surveillance in various parameters to provide some organisational management insight.

East Midlands acute NHS providers bi-monthly benchmarking enabled an understanding of areas of assurance and improvement. The ASSG furthermore promoted antimicrobial focussed multidirectional dialogue with clinicians, speciality teams and non-clinical colleagues.

Progression of wider system working was progressed as per the NHS long term plan and National Strategy against Antimicrobial Resistance with whole economy working alignment. An NHSE/I initiative furthermore brought together pharmacy, medicines optimisation and medicines safety within the Integrated Care System (ICS) developments. Working with the University of Lincoln achieved partnership working in respect of educational initiatives and the future workforce. The AMS Lincolnshire Microguide App was well utilised enabling accessibility of primary and secondary care antimicrobial guidelines as well as the ULHT Antimicrobial Prescribing Policy and outpatient parenteral antimicrobial therapy (OPAT) and sepsis guidelines.

Five Antimicrobial Prescribing Key Performance Indicators for Antimicrobial Prescribing were a significant measure of stewardship standards. They were effective at identifying concerns, benchmarking increasing prescriber engagement along with the provision of audit and quality improvement.

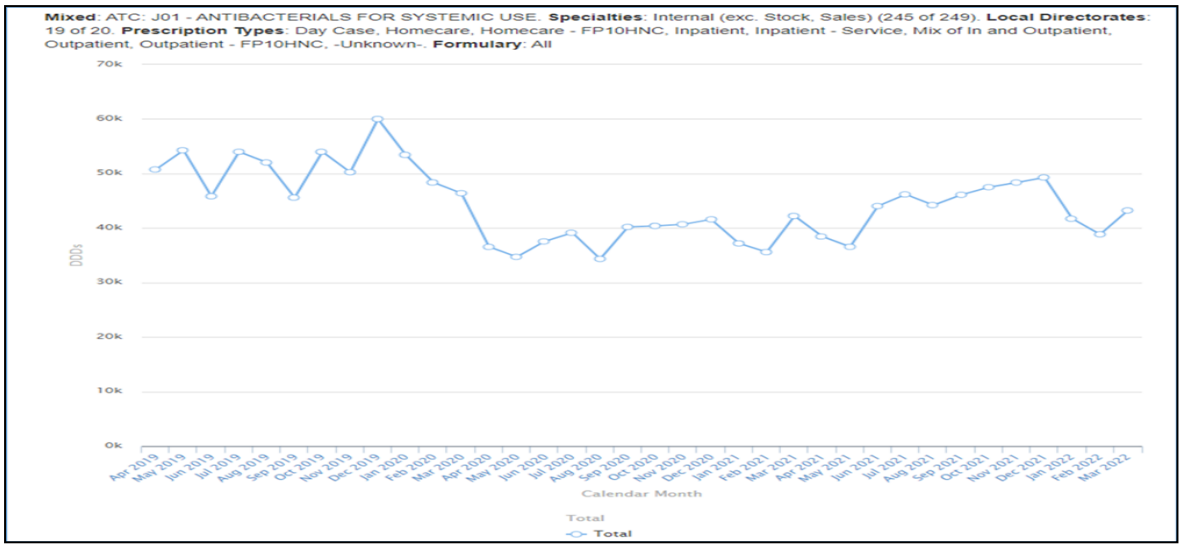
Antimicrobial guidelines continue to be aligned with National Institute for Health and Care Excellence (NICE) recommendations with a ‘Start Smart then Focus’ emphasis, further iterated in educational sessions. The Antimicrobial Stewardship Strategy was supported by Medicines Quality Group, Drug and Therapeutics Committee and the IPC Group and other key forums.

The Antimicrobial Prescribing Policy shaped by local trends, risks and microbiology surveillance advocated total dosing of intravenous (IV) antibiotics, and work to increase awareness and implementation to be boosted by electronic prescribing, as well as educational campaign development. Updating IV Antimicrobial Monographs e.g. infusion set flushing for nurses was supported by Medusa (guidance on the preparation and administration of injectable medicines), inclusion in the Marsden Manual of Nursing and via educational study days.

Restricted antimicrobials were effectively managed with support from the pharmacy department and prescriber quality improvement projects under Antimicrobial Consultant supervision. There continued to be a robust system for the supply of sepsis antibiotics to ensure availability foe immediate use.

The ASSG analysed the surveillance of antimicrobials to identify key trends and associated actions. Overall consumption is slowly increasing from 2020, in line with the Trust recovery plan, as patient flow activity increases. Graph 1 demonstrates consumption remains significantly below pre-pandemic period as activity has not yet fully recovered.

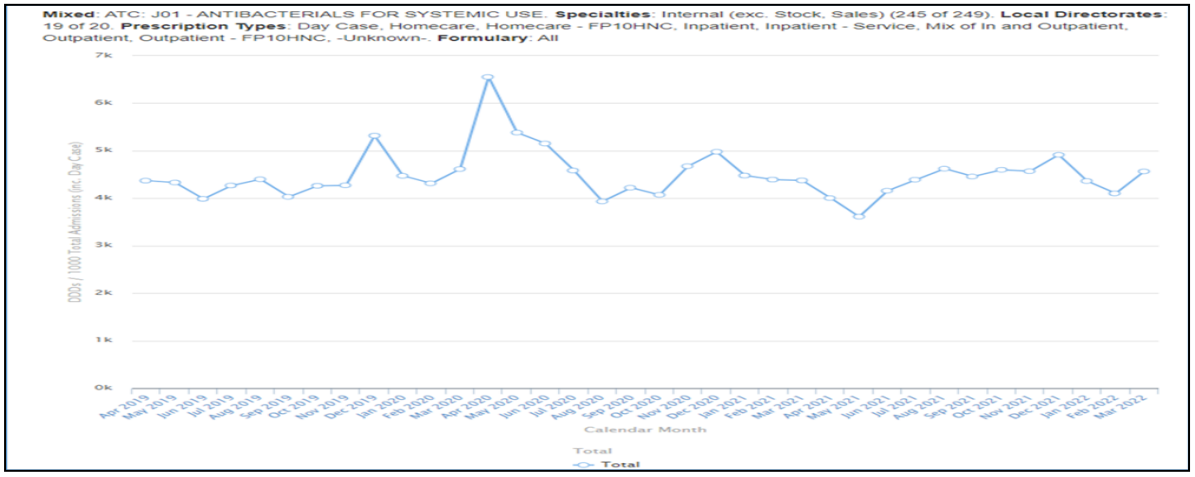
Graph 1: Antimicrobials All Classes and Agents Monthly Consumption Trend Since 2019 (NOT ADJUSTED to Trust activity levels)



When adjusting consumption data to Trust-wide admission activity, there was a spike in antimicrobial use in April 2020 correlating with increased non-elective infection related admissions, in context of the COVID-19 pandemic. By 2021, the prescribing

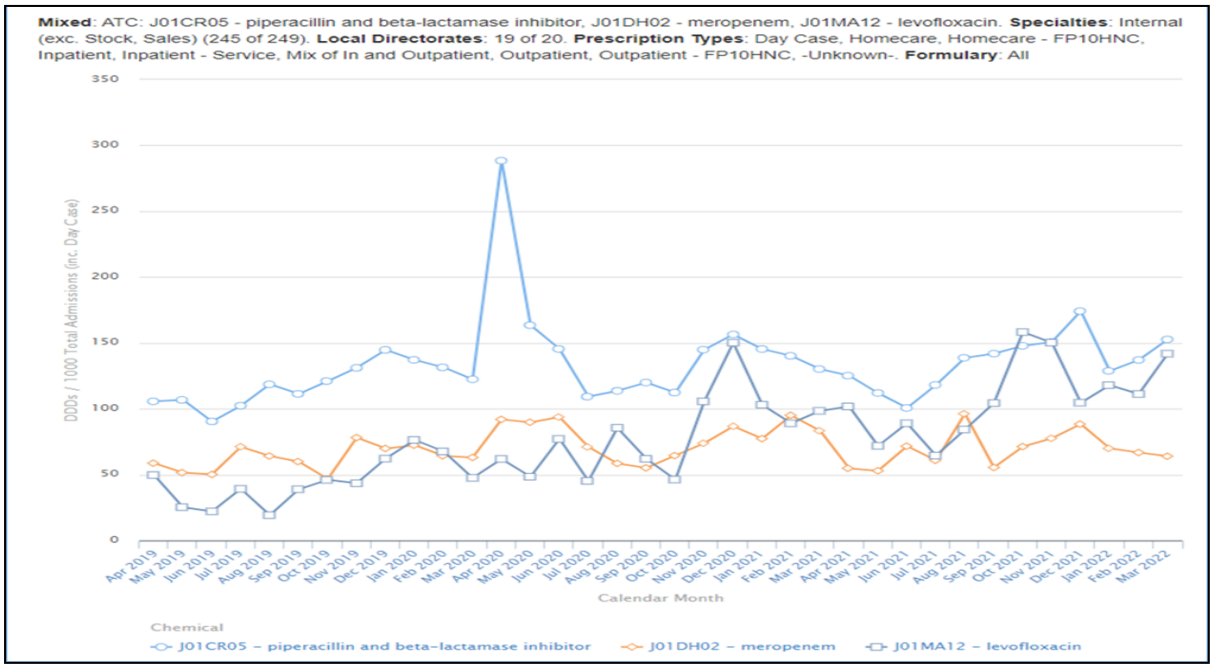
trend stabilised comparably to the pre-pandemic level, with winter month peaks as usual (graph 2).

Graph 2: Antimicrobials All Classes and Agents Monthly Consumption Trend Since 2019 (ADJUSTED to Trust activity levels)



Graph 3 illustrates specific restricted antimicrobials requiring continuous monitoring. Piperacillin tazobactam consumption spiked during the early phase of the pandemic, but normalised with improved understanding and rapid implementation of national guidance around appropriate use of antimicrobials in COVID-19 patients. Levofloxacin use has increased steadily since January 2019 as expected following increased recommendation in the adult antimicrobial guidelines. Meropenem consumption has been stable.

Graph 3: Antimicrobials Top 3 Restricted Monthly Consumption Trend Since 2019 (ADJUSTED to Trust activity levels)



Antimicrobial stewardship audits have been undertaken by doctors, junior pharmacists other with projects tailored to Trust needs and areas of concern. This played an important role in increasing awareness, engagement and encouraged good practice in line with quality improvement with examples described in table 11.

Table 11: Antimicrobial Quality Improvement Audits 2021-2022

5KPIs on MEAU at LCH: understanding prescribing issues in real terms on acute medicines unit. Has led to set up of antimicrobial virtual wards to make a plan for every patient. Expansion of initiative planned to further improve patient outcomes and bed flow.
5KPIs on AMSS at PHB: antimicrobial prescribing a recurring issue as identified by PII audits this Weekly antimicrobial ward visits as an educational feature whilst making interventions for patients in real time to improve outcomes.
Penicillin allergy audit: to ascertain prescription charts completeness and accuracy of penicillin allergy documentation and to identify outcomes of reported incidents. Audit results promoted AMS Lincolnshire to set up penicillin allergy clinics. Will initiate planning, careful co-ordination and investment, and has been added to the system wide long-term plan.
Teicoplanin audit: undertaken as a result of several incident reports and identified the extent of prescribing and monitoring issues. The utilisation of this agent has increased over this year, bringing the complexities to light. Audit findings led to progressing an action plan with communications to prescribers, strengthened dosing and monitoring advice in the ULHT antimicrobial guidelines as well as education and treatment chart discussion.

The Antimicrobial Pharmacy Team continued to be a well utilised service to influence a basic level of antimicrobial stewardship on ward and clinical areas. This included signposting to identify inappropriate or unusual prescribing and other queries.

Prescribers received induction and training in prudent antimicrobial use and regular antimicrobial resistance and stewardship reminders. Audit and surveillance was accompanied with feedback and engagement with clinical teams, with further ambition to increase this activity with the advent of electronic prescribing in the Trust.

Led by Post Graduate Education Centre (PGMEC) colleagues there has been education of antimicrobial topics via bite size videos, sharing of key messages and supporting the recruitment of junior doctors to antimicrobial projects. This year has been the strongest yet in collaborative approach to ensuring antimicrobial stewardship and improving patient outcomes, and given much inspiration for how to progress over the next year. There was training for other staff groups in various formats to allow easier access.

There has been expansion and development of the OPAT service with further plans to offer new opportunities and care pathways to keep our patients safe and support the Trust's recovery plan as well as further ICS collaborative working. The

anticipation of electronic prescribing rollout in late 2022 brings much promise of further developments to guide prescribing, and surveillance.

9. Laboratory Service

The microbiology service is provided by Path Links which is the NHS pathology partnership between ULHT and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). There is the provision of diagnostic services and endoscopy water testing facilities; other environmental testing is undertaken through external laboratories. Path Links has United Kingdom Accreditation Service (UKAS) accreditation to international organisation standardisation (ISO) 15189, and although awaiting the results of the March 2022 laboratories surveillance visits, the assessors' reports have not caused concern with the rectification of minor findings being addressed.

Although during 2021/2022 COVID-19 testing dominated the laboratory agenda, there was a gradual restoration of services until all apart from dermatophyte testing has resumed. The repertoire and volume of rapid COVID-19 testing has increased with rapid testing available is available on all main sites using the GeneXpert, SAMBA and Abbott IDNow platforms.

Projects that had taken a back seat during the height of the pandemic have been reopened, including the introduction of an extended panel respiratory pathogen polymerase chain reaction (PCR), enhanced culture for *E. coli* 0157, and broth culture for Group B *Streptococcus* screening, all of which are now available.

Path Links microbiology standard operating procedures based on the national Standards for Microbiology Investigations (SMI), include procedures for screening and detection of antimicrobial resistance and HCAIs. All specimens are examined at the appropriate laboratory containment level, with a request for clinical details to highlight a sample with an unusual high risk element. Turnaround times for key investigations have been monitored and subject to internal and external key performance indicators (KPIs), and have not caused concern despite the ongoing pressures on the laboratory service.

Procedures were regularly reviewed and updated using the Q-pulse document management system and compliance was overseen by the quality management team, and KPIs monitored during the monthly technical working group meetings. There was a regular laboratory audit programme, undertaking vertical and horizontal audit. The laboratories participated in internal and external quality assurance activities including National External Quality Assurance (NEQAS) to ensure accurate and reliable laboratory results.

The laboratory communicated results of public health significance to UK Health Security Agency (UKHSA) via the electronic Second Generation Surveillance System (SGSS), or by telephone or e-mail for a more urgent situation. Specimen transportation is compliant with current legislation, and the laboratory provided appropriate containers where needed.

Challenges this year have mirrored those across the health system, with clinical and laboratory staff absence through COVID-19, and increased demand exacerbating an already stretched service. We have been grateful to a colleague for his long delayed retirement supporting the clinical service throughout the pandemic, but have sadly been unsuccessful in recruiting to the vacant posts. There have been similar challenges with recruitment of laboratory staff.

There are currently 4.0 WTE substantive consultant microbiologists covering ULHT and NLaG, and in addition a 1.0WTE speciality doctor. There is a nominated IPC Doctor who with the clinical microbiologists cover day to day microbiology advice to IPC where needed for their base sites. There is a 24/7 microbiology clinical rota, which includes IPC advice where needed.

Aspirations for the microbiology service for next year include introduction of a matrix-assisted laser desorption time of flight (MALDI-TOF) to provide enhanced diagnostic and clinical applications for the identification of micro-organisms for medical diagnosis. This has unfortunately for financial reasons been delayed again. Recruitment to vacant clinical microbiology posts, or rethinking how the service might be delivered.

Expansion of the molecular microbiology service to include cerebrospinal fluid (CSF) PCR, with scoping and business cases for PCR for gastrointestinal infections, mycobacterial and toxoplasma PCR; and possibly *C. difficile* PCR if the acute trusts are keen to explore the idea.

10. Estates and Facilities

The Estates and Facilities Team has implemented adapted and changed working patterns and processes to respond to the COVID-19 pandemic as an integral part of the Trust's response.

The ward enhancement programme has continued to undertake vital work to improve the environment for patients and staff. This included the ibnstallation of doors on bays to ensure a COVID-19 secure environment and improve privacy and dignity for patients.

10.1 Environmental Cleanliness

Cleaning support was expanded to provide 24 hour cover to support patient flow and in response to COVID-19. This had a positive impact on patient flow with a business case submitted to continue as the pandemic moved to being endemic in the population.

New cleaning equipment has been procured to ensure effective cleaning can be carried out, and has included the purchasing of scrubber dryers, vacuums and cleaning trolleys.

Cleanliness audits have been undertaken by Facilities with Matrons/Sisters in line with the National Standards of Healthcare Cleanliness 2021 using the Credits for Cleaning Micad audit tool (MiC4C). This audit data has been reviewed and provided assurance regarding with monthly reporting to the IPC Group.

Facilities continued to increase the audit frequency in areas where there were outbreaks of COVID-19 with the provision of Agency personnel to support enhanced cleaning on wards that were caring for COVID-19 cases or contact patients.

Facilities and the IPC Team worked in close partnership to interpret and implement the National Standards of Healthcare Cleanliness 2021. Risk categories were reviewed for all areas and the Trust is using all 6 functional risk (FR) categories from the new standards as well as the cleaning responsibilities and cleaning frequencies for each risk category. Approval was through the IPC Group.

Commitment to cleanliness charters were developed and displayed in the entrances of all public facing areas. New cleaning schedules have been issued for housekeeping cleaned elements for all areas in FR1 to FR5 categories. A business case has been submitted to progress cleaning at the required level in FR6 areas (offices).

There was a move to displaying star ratings instead of percentage scores, and in line with the implementation programme these have for the first 6 months been derived from Cleaning Services elements. From May 2022, the star ratings will be awarded an overall rating that includes Nursing and Estates elements. Table 12 describes the 2021-2022 MiC4C percentage audit scores and demonstrates a good level of compliance.

An efficacy audit programme has been planned for all public facing areas along with an upgrade to the MiC4C system to ensure that audit standards are aligned to the new standards.

Table 12: Site Average MiC4C Audit Scores (%) 2021-2022

	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Grantham	93.72	94.29	95.53	96.16	95.25	95.54	94.79	92.05	92.94	92.89	94.82	94.77
Lincoln	88.27	88.27	89.09	88.44	87.60	88.69	92.05	92.63	91.60	93.16	93.76	91.96
Pilgrim	93.01	88.78	93.38	89.88	89.55	90.75	91.34	91.44	89.69	92.92	92.34	92.82

10.2 Water Safety

During 2021-2022 the Trust has continued to review water safety and systems management. The Water Safety Policy, Water Safety Plan and Written Scheme Plan have been updated. The internal audit programme has been revised and a robust audit programme implemented.

A Water Safety Group is in place and reports into the IPC Group. A senior member of the Estates and Facilities team is a core member of the IPC Group and a monthly report is submitted to the group for assurance.

During the year an external audit of water systems was undertaken by the Trusts appointed Authorising Engineer (AE – Water). A number of actions were identified and the Trust has made good progress implementing these and is committed to deliver assurance in 2022 to deliver a compliant and managed approach.

The approach has reduced reliance on contractors to undertake non-specialised tasks and transfer responsibility to competent estates staff. A programme of training and appointing of staff to ensure compliance with HTM 04-01 has also been completed. Furthermore, a full review of planned preventative maintenance tasks and asset identification has also taken place together with a revised approach to water sampling and flushing. The Water Safety Group (WSG) now provides detailed plans of action to manage and address risks associated.

Water sampling was undertaken across all sites. Where samples identify water borne pathogens remedial actions to ensure decontamination were undertaken as well as the installation of point of use filters as a temporary measure to remove pathogens from the water supply.

A revised process has been developed and implemented across all sites to ensure compliance and assurance with current water regulations.

10.3 Ventilation

Through 2021-2022, the Trust has delivered significant ventilation systems management improvements. A full review of the maintenance strategy and procedures was conducted to enable more robust compliance management in order to validate and assure good practice. Along with this the Estates teams have undergone a review and re training for the maintenance and management of ventilation systems with reviewed roles and responsibilities to provide assurance of a well led and managed service.

Planned Preventative Maintenance continued to greatly improve to provide assurance and a proactive programme of work.

A number of air handling units (AHUs) exceed the standard >20 years end of life cycle. A condition review was undertaken in 2021 enabled the Operations Managers to implement actions to address concerns where reasonably practicable. This allowed the units to continue to perform until refurbishment / replacement is scheduled. Remedial works included the sealing of ductwork to ensure no air leakage, improvements in air flow with recommissioning and balancing of fan units, cleaning of the internal of the systems along with a full review of filtration grades and pressure differentials. The work intended to ensure vent systems are operating at a performance level equivalent of the design characteristics when installed.

In February 2022, an external company was commissioned to review Operating Theatre Building Services Compliance and to make recommendations and cost models to achieve the Health Technical Memoranda (HTM) 03-01 (2021) standard. The report has now been issued to the Trust, to assist in formulating a business case in readiness for approval of funding, achieving a phased approach which has been fed into the capital delivery plan and is under review.

A review of the current Ventilation Policy and associated procedures have been commenced to ensure the Trust has the appropriate local documentation.

10.4 Decontamination

In July 2021, an Estates and Facilities/ Decontamination Lead Nurse commenced in post and has led the review and development of decontamination policy as well as re convening the Decontamination Group.

There is the continued contract with Steris to provide decontamination services with the required contract monitoring in place.

The Decontamination Authorised Engineer has led the work to ensure the endoscopy Institute of Healthcare Engineering and Estate Management (IHEEM) audits are carried out. The Trust has Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation that is awarded for the provision of high quality services. The processes necessitated some remedial work on the fabric of the LCH building.

11. Occupational Health

The Occupational Health Service (OHS) supports the health and wellbeing of staff as well as delivering a programme of staff health assessment to ensure protection against infectious disease by vaccination and on employment screening.

11.1 Vaccination

The OHS is responsible for staff influenza and COVID-19 vaccination programmes. The influenza vaccination campaign ran from September 2021 to February 2022 with 62.5% of frontline staff taking up the offer of vaccination. This compared to 89.9% of frontline staff in 2020-2021. A high level of support was provided by peer vaccinators and clinics as well as flexibility to take into account all shift patterns and weekend working. It is believed staff prioritising COVID-19 vaccination could have attributed to the decrease in uptake, even though there was an opportunity for simultaneous vaccination.

The 2021 winter COVID-19 vaccination programme for front-line staff reports 96.62% of staff received the first dose, 93.88% the second dose and 81.01% have had a booster.

The OHS has provided invaluable support to the Trust and IPC Team to support COVID-19 staff tracking, tracing and testing. This has supported the investigation and management of outbreaks of this infection. Staff counselling support, the provision of testing results and antibody testing were also undertaken. Colleagues in at risk groups were furthermore provided with assessment of risk support and guidance.

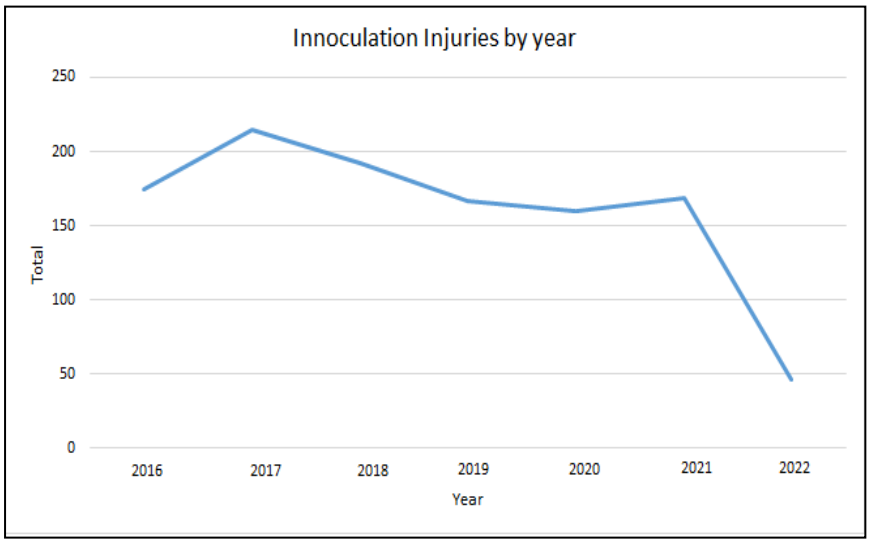
There continues to be a robust service for the delivery of other healthcare worker required vaccinations, e.g. Hepatitis B, Measles, Mumps and Rubella, Chickenpox as well as the control of Pulmonary Tuberculosis in NHS employees. For staff that do not attend there is a follow up process and escalation to line managers.

11.2 Inoculation Injuries

The OHS supports the management of the safe handling and disposal of sharps, and the management of inoculation injury and exposure to bodily fluids. The aim is to reduce the incidence of such injuries and promote the requirement to use safer sharps devices.

All reported inoculation injuries are recorded and table 13 below illustrates the number of reported inoculation incidents from 2016 to 2022 and puts forward a 21% reduction following the introduction of safer sharps.

Table 13: Number of Reported Inoculation Incidents 2016-2022



Year	Number of Inoculation Incidents
2016	175
2017	215
2018	192
2019	167
2020	160
2021	169
2022	46

12. Training

Through 2021-2022 there has been a focus on all aspects of IPC training with a continued emphasis on COIVID-19 education. To meet time and resource constraints as well as responding to the frequently changing national guidance an IPC bulletin approach has continued to be initiated. This provided up to date information to be cascaded in a timely manner in a succinct and easily understandable format. Topics were able to be reiterated, refreshed along with being posted on social media sites to reach a wider audience.

IPC mandatory training was reviewed and the use of work book covering the content have continued to support some colleagues with training in a timely manner whilst

working under the pressures of a pandemic. Trust IPC mandatory training data is located in table 14.

Table 14: Divisional Infection Prevention and Control Mandatory Training Compliance (%) 2021-2022

Division	IPC Mandatory Training Compliance (%)
Medicine	86.26%
Surgery	89.32%
Family Health	87.36%
Clinical Support Services	91.67%
Corporate	90.51%
Estates and Facilities	84.39%
Overall Compliance	88.55%

The IPC Intranet site received a complete update and refresh to offer a range of current and relevant information in a manner to hopefully visually stimulate interest in the content. Steps were taken to ensure easy navigation of the site.

A focus on IPC excellence and fundamentals has continued with an emphasis on non-COVID-19 topics such as other MRSA screening and the care of a patient with other infections. A return to pre pandemic IPC practice has also been communicated, e.g. the rational use of gloves.

13. Forward Plan 2022-2023

The following forward plan details work and initiatives to be progressed through the next year:

- Progress the IPC Key Objectives (table 15) to provide assurance and monitoring of the overarching IPC requirements
- Continue to develop compliance with the components of the IPC BAFs
- Further IPC service and Team development to further prevent and reduce HCAI and promote patient safety, governance and risk mitigation processes
- Prevent and reduce HCAI and progress surgical site infection surveillance
- COVID-19: recovery and restoration of IPC elements

- Support the implementation of electronic prescribing in relation to antimicrobial stewardship
- Support the progression of laboratory-based interventions to achieve enhanced diagnostic and clinical applications for the identification of micro-organisms for medical diagnosis
- Provide IPC expertise to progress further compliance with environmental cleanliness, water safety, ventilation and decontamination requirements and directives

It is anticipated the forward plan will offer a range of IPC work to further develop the prevention and reduction of HCAI to achieve a high level of patient safety, governance and mitigation of risk.

Table 15: Infection Prevention and Control Key Objectives 2022-2022

Number	Objective
1	Develop infection prevention and control organisational and Divisional Governance arrangements
2	Continue to progress assessment and gap analysis of The Health and Social Care Act 2008. Code of Practice on the prevention and control of infection
3	Further development of surveillance of healthcare associated infections and performance
4	Investigate and manage the risks posed by novel infectious diseases to promote patient safety and prevent and reduce the risk of cross transmission
5	Investigate and manage the risks posed by the emergence of multi-drug resistant organisms to promote patient safety and prevent and reduce the risk of cross transmission
6	Development of governance arrangements for appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
7	Implement and sustain standards of cleanliness in line with National Standards of Healthcare Cleanliness. Development and implementation of hydrogen peroxide total room decontamination
8	Progress water safety, ventilation and decontamination requirements as sub-groups of the Infection Prevention and Control Group to ensure patient safety requirements

14. Conclusion

2021-2022 has been another unprecedented year with IPC being at the forefront of the COVID-19 pandemic response.

A wide range of strategic and operational IPC interventions and initiatives are in place and continue to be developed to prevent and reduce HCAI and promote a high level of risk-based patient safety.

There is much commitment to progress development of the IPC service and Team to continue the journey to achieve IPC excellence at all levels in the organisation.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5th July 2022*
Item Number	*Item 8.4*
Patient Experience Annual Report 2021 / 2022	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale*
Author(s)	*Jennie Negus, Head of Patient Experience*
Report previously considered at	*Quality Governance Committee 21.06.22*

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

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

Recommendations/ Decision Required	• *To receive the report*
	•
	•

Executive Summary

Our ambition is for all of our patients to have a positive and meaningful experience of the services and care we deliver, that the care is compassionate and respectful, that they receive the best clinical outcomes for them and that their safety is of paramount importance to us as a Trust.
These three key elements of experience, clinical effectiveness and safety make up the foundation of 'quality'.

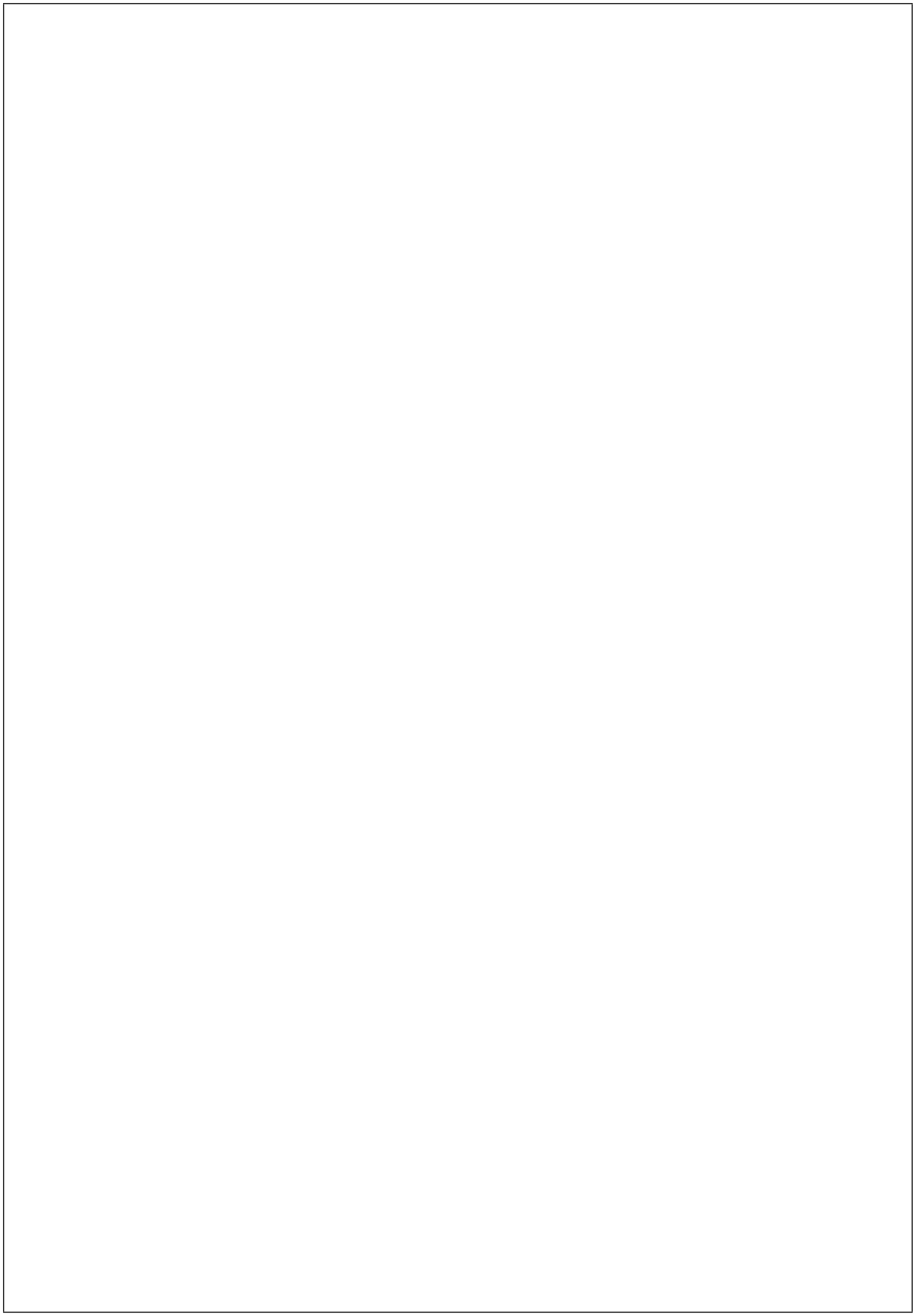
The best way to improve quality in an organisation is by finding out what our patients and carers are saying through their lived experiences. The Trust works hard to ensure that our patients and carers are getting involved in our activities. We offer a number of opportunities for people to be involved including participating in our Patient Panel and emerging Expert Reference Groups, strong stakeholder engagement in Patient Experience Group, sharing stories at Trust board meetings and in other forums as well as being part of interview panels, assurance and assessment visits and volunteering.

We are reaching out across all our communities to ensure that all groups of people are included, that we hear their voices, understand their experiences and learn from their feedback.

We are seeing an increase in our clinical teams using their patient feedback through the use of triangulated data within our SUPERB dashboard. The sharing of learning and best practice through our Patient Experience Group fosters encouraging discussions around areas for continuous improvements.

This Annual Report details our performance and achievements over the last year recognising the significant challenges and extraordinary circumstances that the Covid Pandemic posed to staff and to the patients and families in our care.

The Trust Board is asked to note and receive the Report.



NHS
United Lincolnshire Hospitals
NHS Trust

Patient Experience Annual report 2021 – 2022

Prepared by: Jennie Negus. Head of Patient Experience
Endorsed by: Patient Experience Group – 07.06.22

Quality Governance Committee – 21.06.22

OUTSTANDING CARE
personally DELIVERED

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Patient and carer experience plan 2019 - 2023.

There has been much progress made against the patient and carer experience plan over the last year. Four corporate objectives are set out in this plan and our achievements include:

Establish clear processes and commitment for divisional and service level ownership of patient experience feedback and improvement.

- Divisional assurance reports have been strengthened and Patient Experience Group matured and consolidated.
- Patient Experience Group assurance focuses on the 'so what', the actions taken and their impact as a result of patient feedback and local initiatives and improvements are now being seen more regularly.

Develop SUPERB as the 'core' data intelligence source for Patient Experience metrics.

- SUPERB has continued to develop and now holds FFT, PALs and Complaints, Care Opinion and Compliments data. It triangulates this data across data sets and has a wide range of possible filters to enable drill down analysis.
- The dashboard is widely used by divisions and features as the core data source within assurance reports.

Continuing to champion the Academy of FAB NHS Stuff.

- At practice level, the network of FAB Experience Champions has grown to 83 across the organisation.
- Monthly #FABFact initiative launched in August 2021 providing teams with information and 'grab and go' resources to implement local improvements.
- Engagement with #FabChangeDay has continued throughout the pandemic and in November 2021, we co presented a workshop championing the power of music in health and wellbeing.

Divisions, business units and service level teams have sight, ownership, grip of their patients' experience, and use their data to implement local level actions and improvements.

- Patient Experience Group seeks divisional assurance of learning & improvements.
- SUPERB seen as the 'go to' tool for interrogating and understanding patient experience data. SUPERB graphs and data is routinely used in assurance reports.
- Patient stories are more widely used and have been incorporated into governance meetings, training and assurance reports.

Whilst still in date and many elements still wholly relevant, its strategic direction and vision requires a full review to align with the refreshed strategic objectives. The new plan will ensure incorporation of Year 3 Integrated Improvement Plan, Nursing & Midwifery Framework, national and local Patient Experience imperatives and will be co-produced with patients and carers through our patient panel and expert reference groups.

Patient Experience Group (PEG)

PEG is appointed and established by the Quality Governance Committee and exists to receive, review, scrutinise, challenge and respond to or escalate patient experience related data and information across the clinical activities of the organisation. PEG meets monthly, chaired by the Deputy Director of Nursing with membership from across divisions and services and stakeholders including Healthwatch, Carers First and Maternity Voices. (Full membership list at Appendix 1).

A detailed schedule of reporting (Appendix 2) is in place that encompasses patient stories, data insight, divisional assurance reports, equality, diversity and inclusion and staff experience ensuring patient voice is heard and considered. Feedback is received from and upward reports provided to Quality Governance Committee and to Nursing, Midwifery & Allied Health Professional Advisory Forum (NMAAF) and to Patient Panel.

2021 – 2022 patient feedback received

(Data sources as stated; collated via SUPERB dashboard)

1. Friends & Family Test (FFT)

The FFT question is asked of all patients discharged from across three streams of care; inpatients, outpatients and maternity.

FFT question:

Thinking about [*setting*]…overall, how was your experience of our service?"

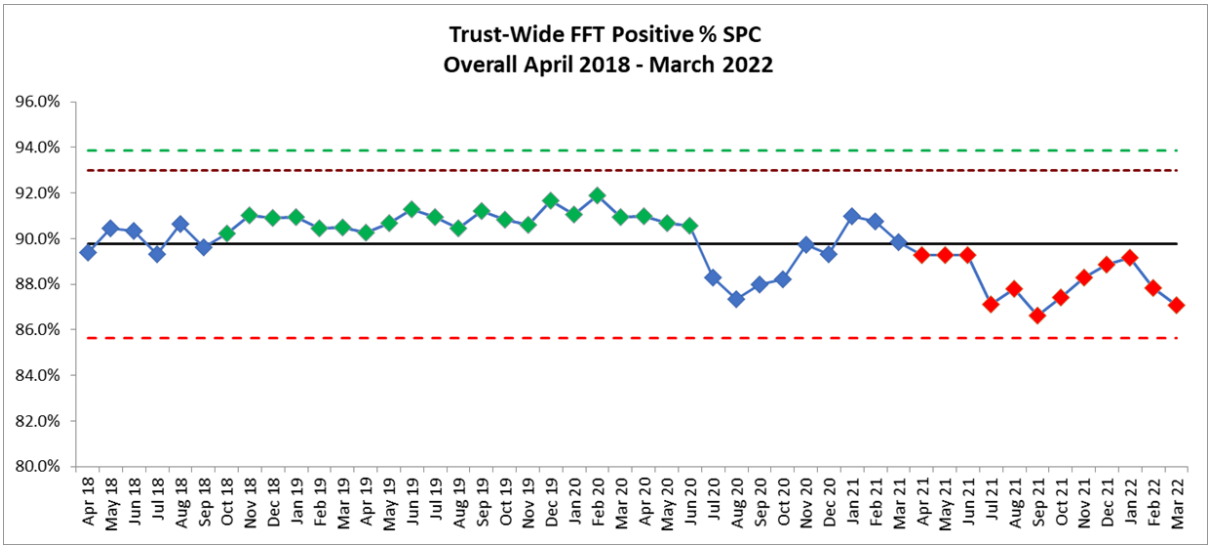
Answer options:

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Don't know

67,796 patients responded to the FFT text survey during the last 12 months. Whilst this response is down on our pre-pandemic rate we have continued to be above the national rates.

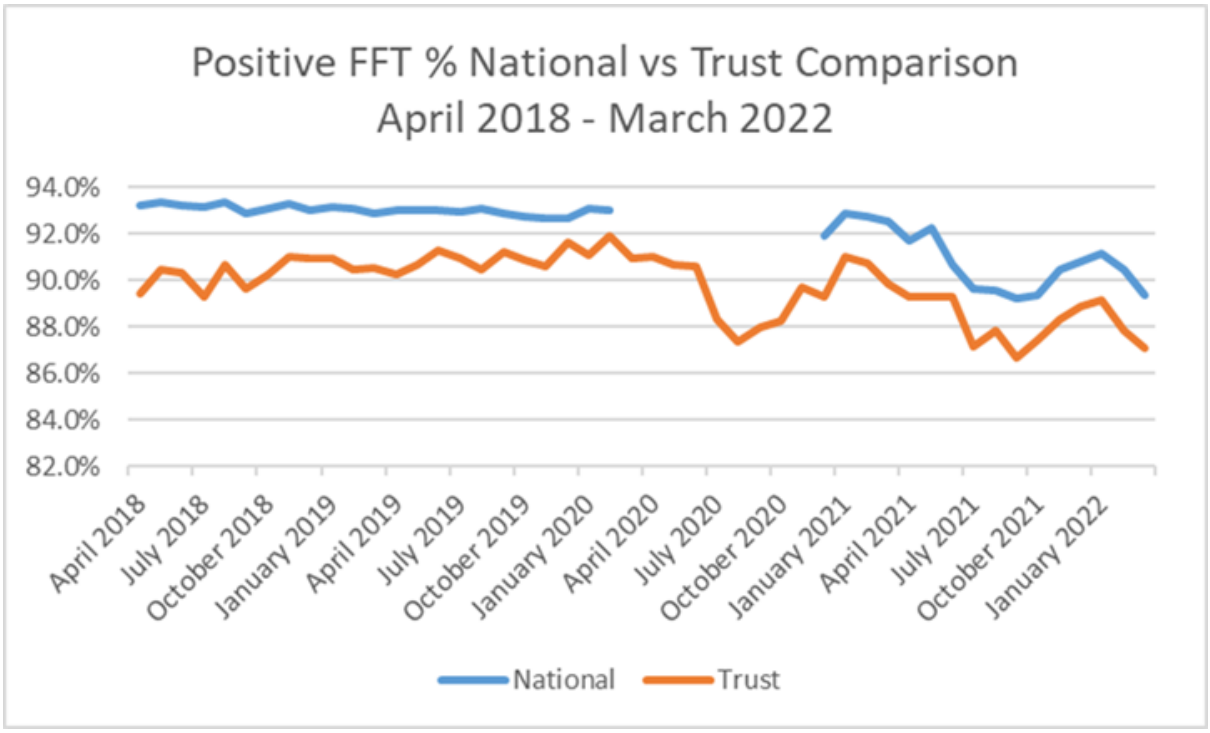
Year	ULHT response rate	National response rate
2020	15.18%	9.57%
2021	13.97%	8.70%
2022	13.91%	9.18%

63,241 (88%) responded positively, choosing either very good or good and 4,555 (6%) negatively choosing very poor or poor.



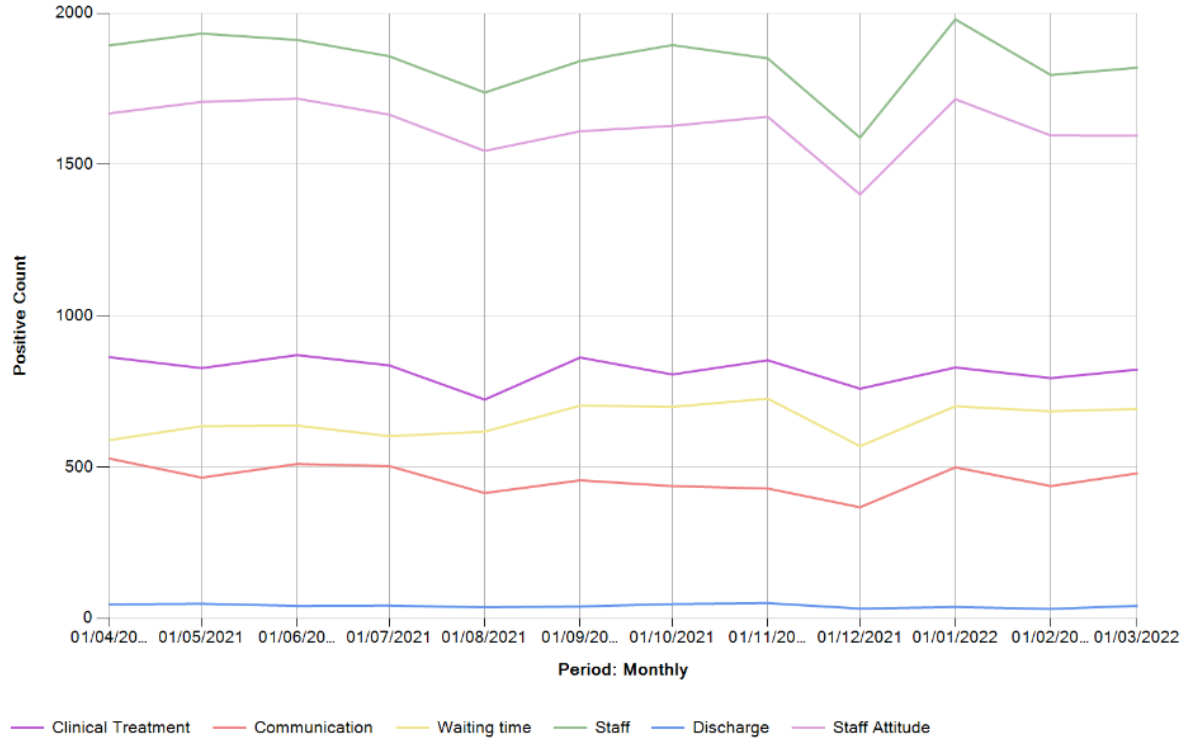
The dip seen from June 2020 onwards aligns with the change in the main FFT question, which may be a factor; however, as national reporting was paused during waves 1 and 2 of Covid, it is harder to establish whether this pattern is mirrored nationally.

It is noteworthy that in the months since published national results were resumed, the profile of both our own performance and that seen at the national level mirror each other closely. Whilst our performance has dipped, overall this is experienced across the country and s not just a ULHT specific issue.



An important consideration this year is that inpatient FFT is matched to individual wards and with significant upheaval and ward changes due to COVID, ownership of feedback cannot be solely claimed by the last ward someone was on. FFT performance is shared with divisions through monthly infographics (Appendix 3) and SUPERB reports to PEG and teams can access their local data through the Envoy Dashboard where the comments can be accessed giving insight into themes and trends. Performance is also included within the Trust Board Integrated Performance Report. Whilst the scores themselves are important measures the greater intelligence comes from the comments explaining why someone scored as they did. Not all respondents leave a comment but the majority select a core theme. These enable us to triangulate themes with other feedback data and direct actions.

FFT Themes stated against positive scores show staff and staff attitude being the top factors in a good experience.

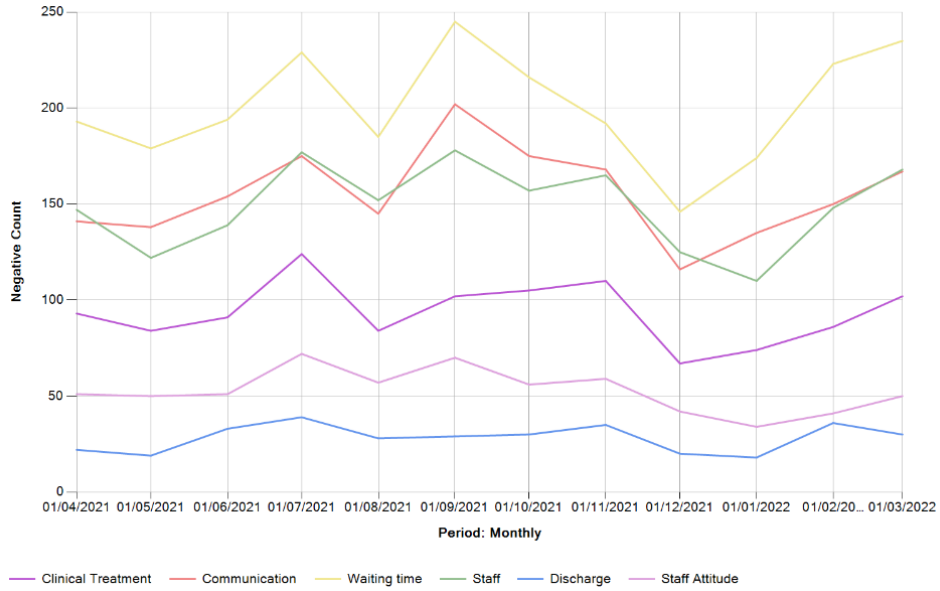


Patient comments against positive scores

“Mainly because of the staff. They were kind, attentive and couldn’t do enough for me. The food was good, the bed was comfortable and I felt cared for.”

“The nurses were so supportive, everything was made clear to me, and I felt relaxed and comfortable. The agency staff were particularly brilliant. The staff were all fantastic. All COVID safe and were all still laughing! I cannot thank them enough!”

Themes reported against negative comments show waiting times in Emergency Departments and communication are the key influences on scores.



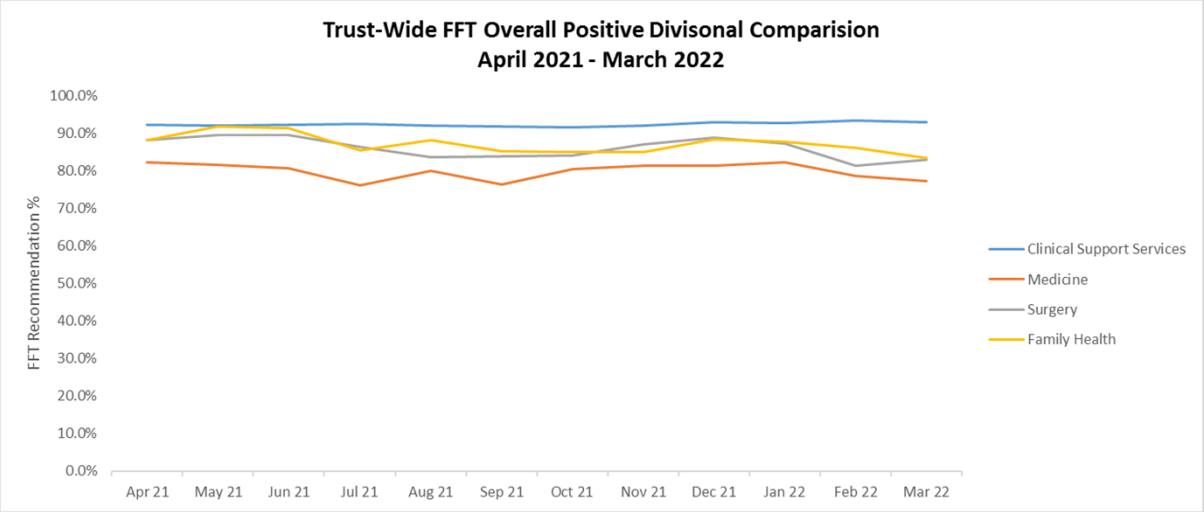
Patient comments against negative scores

“Diabolical waiting time, 3 hours in A&E to see specialist, 6 hour wait for a bed then a further 10 hours to actually get treated by a doctor. Then it took 5 hours to be discharged & wait for meds.”

“No communication with patient or family in what is the most stressful time we have experienced. Staff need to remember to them they are patients. To the family they are a loved one. All that is needed is reassurance from a trained member of staff.”

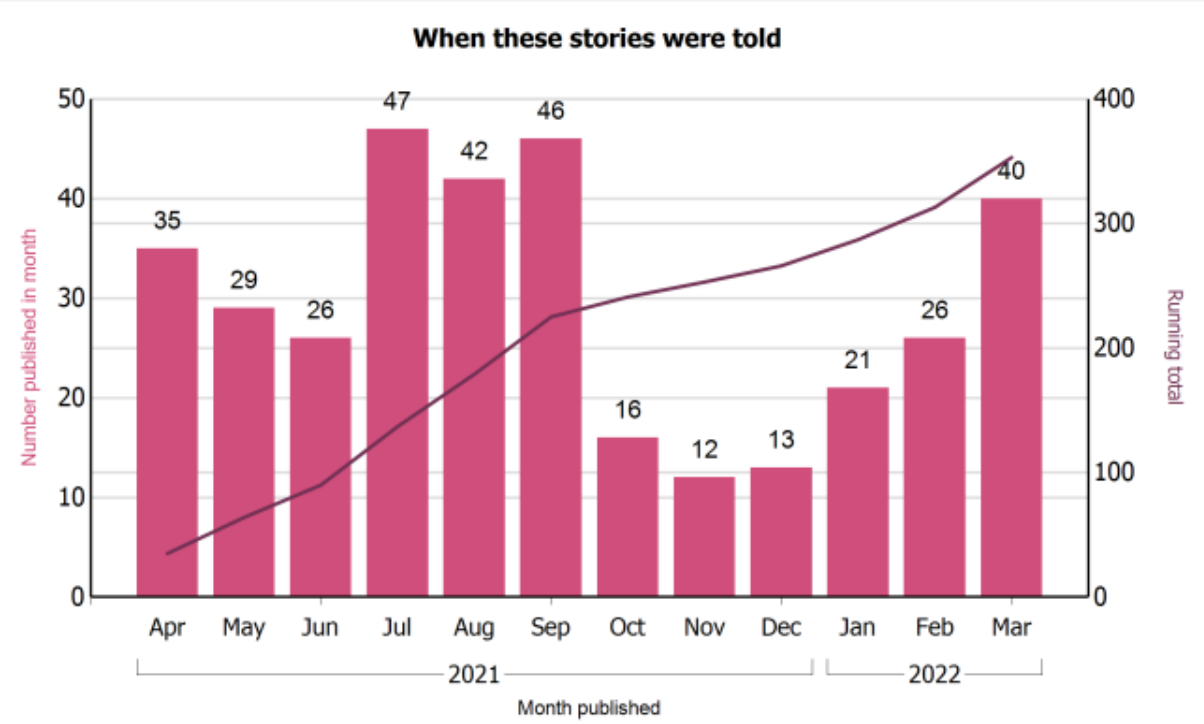
SUPERB enables drill down to divisional level as shown below but also further to CBU and specialty enabling leads to interrogate and identify where improvements need to be focused. Divisional assurance reports to Patient Experience Group require evidence of improvement actions, the ‘so what’, related to patient feedback and examples of actions drawn from these reports include:

- Use of patient stories and sharing of feedback at governance meetings
- Staff communication, values & behaviours training
- Role play for less confident staff
- Updating of information noticeboards and ward information
- Human Factors training
- Local surveys
- Implementation of What Matters to You initiative



2. Care Opinion

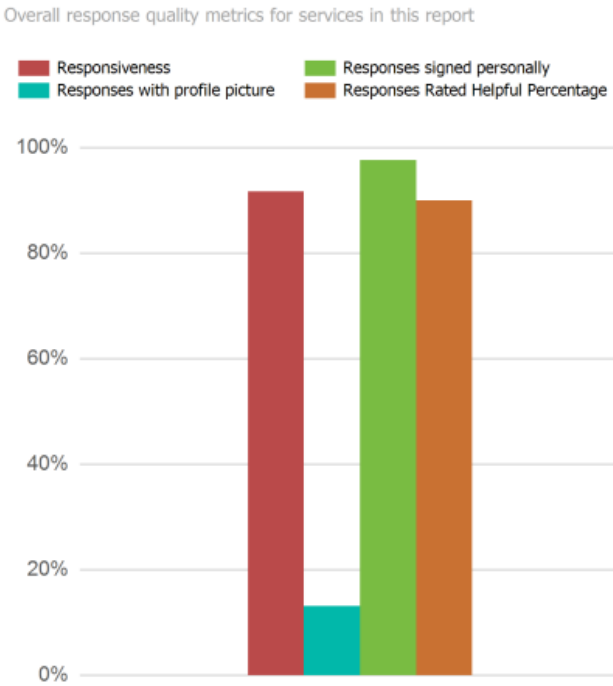
Care Opinion stories have declined nationally since the pandemic started but are slowly on the increase once more. This decline is likely due to a number of factors such as reduced general care activity and fewer visitors. The large majority of stories come from Gynaecology services and wards across the Trust who champion Care Opinion as their key feedback method and receive positive feedback for the most part.



426 stories were posted between 01.04.21 and 31.03.22 and between them were read 23,418 times demonstrating the reach. Typically, negative stories receive the most views though this year of the three most read stories two were positive and one had negative aspects. These can be read, with their responses here:

My Stroke https://www.careopinion.org.uk/886614	LCH Stroke Unit	Read 184 times.
Hysteroscopy clinic https://www.careopinion.org.uk/848715	LCH Gynae outpatients	Read 156 times:
Doctors caring & considerate attitude https://www.careopinion.org.uk/910885	PHB A&E	Read 155 times

Responsiveness to stories has improved significantly with the appointment of a Patient Experience Administrator who reaches out to staff. Our response rate overall through the last 12 months was 96% with all of these being rated as helpful by the storytellers and significantly almost all responses were signed personally by staff demonstrating ownership.



Service	Stories	Responsiveness	Mean time to respond	Profile picture	Personal signature	Responses rated helpful
United Lincolnshire Hospitals NHS Trust	421	92% 386	9 days	13%	98%	90% 81/90
Provides 11 services (6 with stories)						

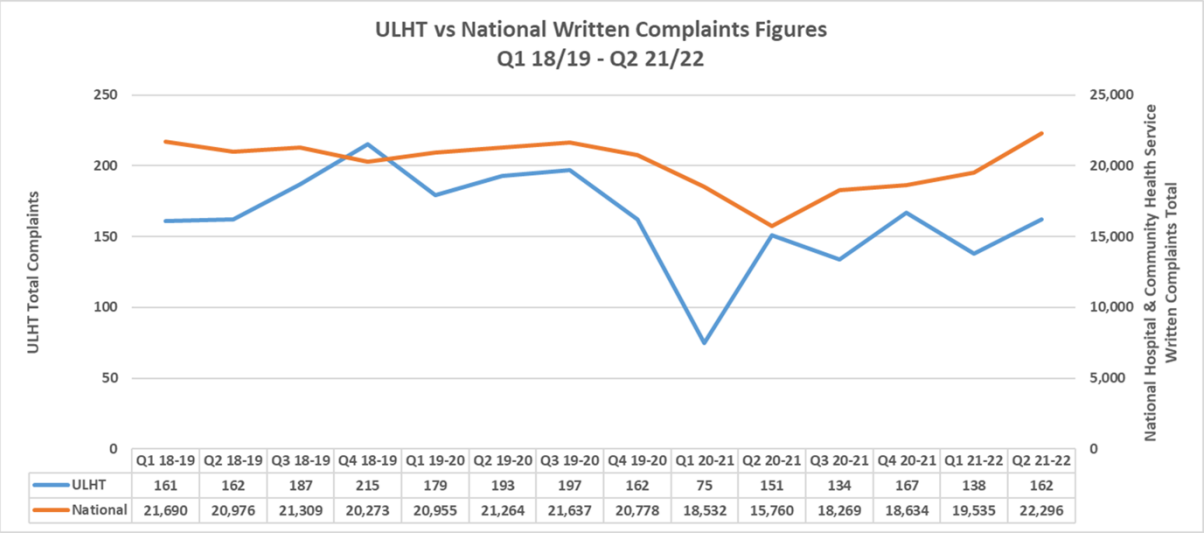
Care Opinion storytellers can add thematic tags to their stories as shown below. These enable alignment and triangulation to other patient experience feedback and once more, we see the same core themes of communication and staff manner and approach.

Most common tags added by authors to these stories

What's good?		*What could be improved?*		*Feelings*	
staff	136	communication	30	at ease	40
Care	67	staff attitude	11	reassured	23
friendly	51	information	8	grateful	21
caring	47	hospital discharge	7	anxious	18
nurses	35	Care	6	put at ease	16
professional	31	conflicting information	6	nervous	14
reassuring	29	explanations	6	supported	13
professionalism	27	kept informed	6	happy	12
explanations	24	diagnosis	5	cared for	11
kindness	24	treatment	5	put off	11

3. Complaints & PALS

Whilst a Complaints Annual Report is produced separately, there is a clear interface between complaints, PALs concerns and patients experiences. As such, complaints and PALs data is included in our reports and is a key data set within SUPERB.

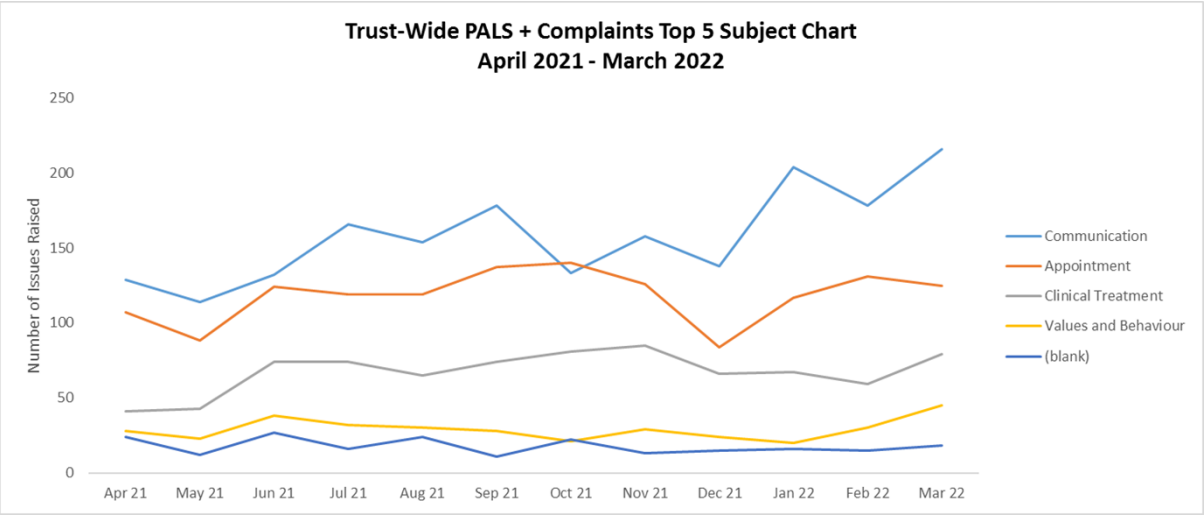


	Q1 18-19	Q2 18-19	Q3 18-19	Q4 18-19	Q1 19-20	Q2 19-20	Q3 19-20	Q4 19-20	Q1 20-21	Q2 20-21	Q3 20-21	Q4 20-21	Q1 21-22	Q2 21-22
ULHT	161	162	187	215	179	193	197	162	75	151	134	167	138	162
National	21,690	20,976	21,309	20,273	20,955	21,264	21,637	20,778	18,532	15,760	18,269	18,634	19,535	22,296

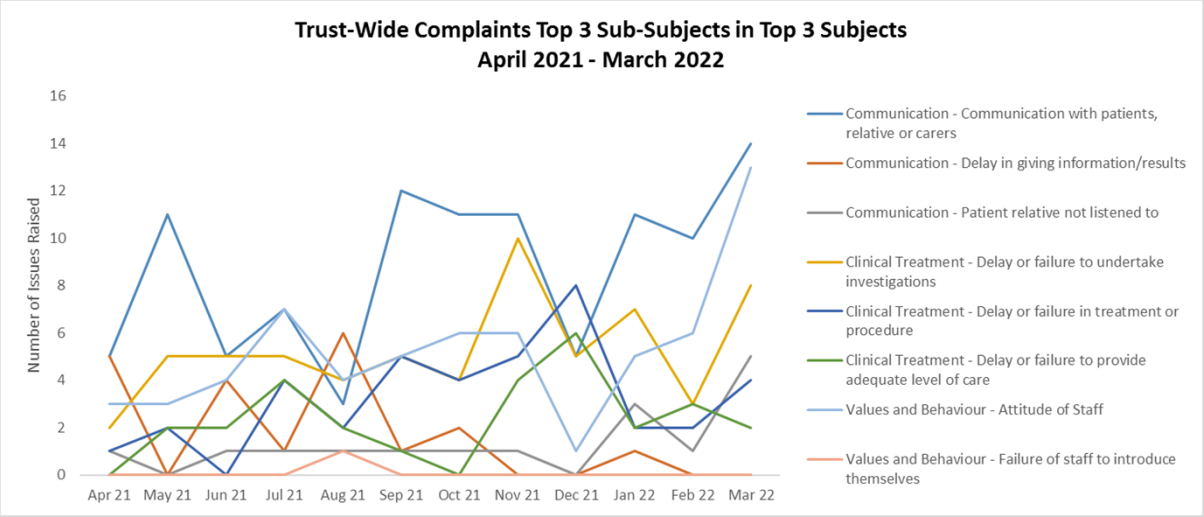
As only Complaints data in any form is available nationally, this comparison takes our own internal Complaints figures, drawn from DATIX and compares those against the 'KO41A Hospital and Community Health Services Complaints Collection' from NHS Digital. These figures are reported quarterly and were available up to Q2 2021-22 only. Complaints are counted as Upheld, Partially Upheld and Not Upheld.

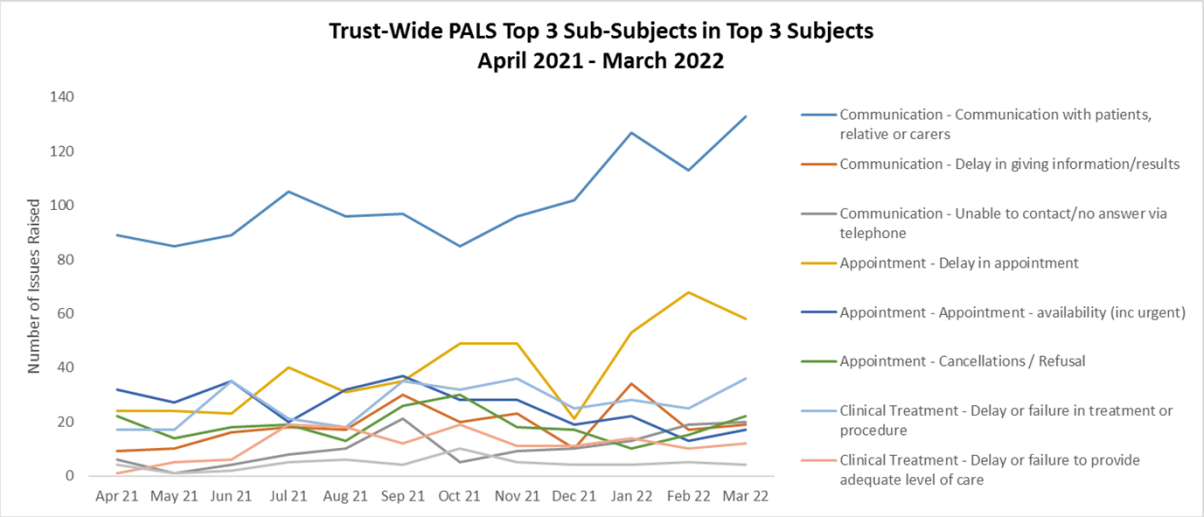
It is noteworthy that while at the national level, aside from a notable dip throughout Wave 1 of the pandemic, complaints in general have stayed at a static level. However, within ULHT whilst there was a marked downward trend they are rising once more. Prior to COVID-19 the Trust received on average 70 complaints a month. During quarter 4 2021-2022 the average was 53; however by March 2022 76 complaints were received., Urgent & Emergency Care have seen the greatest increase and the core themes have been long delays and waiting times in the Emergency Departments coupled with poor communication.

The top five themes shown below mirror the themes already stated within FFT.



SUPERB enables further drill down. Communication for example can mean many things and appointments could relate to scheduling, letters or cancellations. This level of detail is critical to focusing improvement actions.





There is clear evidence that communication is the greatest concern. This is broken down across both complaints and PALs into:

- Communication with patients, relatives and carers
- Delays in giving information and results
- Inability to contact via telephone

Appointments issues primarily sit with PALs, as patients will contact them initially and PALs often resolve these by passing them onto the appointments team to secure a date. Issues include:

- Delays in appointments
- Availability of appointments
- Cancellations

Appointments

Much of the work to address themes from complaints and PALs sits with the divisions and the individual business unit teams, and for appointments in particular are a key component within the overall Trust recovery plan. Actions and progress reported within divisional assurance reports to Patient Experience Group include recruitment plans within Access, Booking and Choice to increase call answering, technical upgrades to the booking system, introduction of Patient Portal and Patient Initiated Follow Up process and a review of letters.

Collectively these will influence patient's experiences not only in relation to appointments but to communication too. The Patient Panel are actively involved in improvements, and an active Outpatient Experience Group that contributes to the overall outpatient transformation programme.

Communication

Whilst communication actions by divisions are most often focused on individuals or individual teams cited in complaints, there has also been a more general review of communication undertaken by the Patient Experience Team and a workgroup and action plan is in place.

Work includes:

Using patient Stories

- Digital patient stories are to be included within the new corporate induction, planned from September 2023to ensure that our patients voices and experiences are ‘front and centre’ in all that we do from the outset of working within the Trust.
- A library of patient stories is under construction within the new intranet. This will archive our stories and thematically categorise them. The ‘shelf’ for communication will have sub-sections relating to different aspects such as communication with relatives or involving patients in care discussions.
- Patient stories are used in several meetings and forums to ensure we remain patient centred in our approach to the services and care delivered.
- The process for developing stories has been updated and circulated and can be found at **Appendix 4.**

Training

- A new Patient Experience induction module was developed and introduced for the August 2021 intake of Junior Doctors. This not only focused on the core domains of patient experience but highlighted perceptions, assumptions and expectations and how communication is at the core of all that we do.
- Although postponed due to the COVID Pandemic and operational pressures an Objective Structured Clinical Examination (OSCE) model for communication training within Trauma & Orthopaedics has been designed. This has been co-produced with the Patient Panel and includes panel members as patient actors in scenarios. The launch is rescheduled for this year.
- A new Patient Experience training programme has been developed and launched in March 2022 which features heavily on perceptions, assumptions, empathy and communication.

Communicating with relatives

- A ‘Family Phone’ project with a dedicated portable phone for relatives to call in on was piloted across wards in Autumn 2021. This was not as successful as planned and has been redesigned and incorporated into a new campaign called ‘Phone a Relative’ where update calls are made proactively to relatives. The pilot started on the Health Care of the Elderly Person wards and is ongoing

and is a co-produced initiative with colleagues from Medway Foundation Trust in Kent. Initial results show a significant improvement in satisfaction from the families and carers of patients and a reduction in the number of complaints regarding this issue. Pilot evaluation will determine next steps.

Patient Information

- A review of ward level information has been completed and new tablemats are being finalised (**Appendix 5**). These have core Trust information for patients but also local ward details. They are laminated and two sided and of a size to be placed on bedside tables. Patient Panel have been involved in the content and design and agreed they will be helpful for patients who may forget something explained on admission and having the information tablemat to hand can refresh their memory.

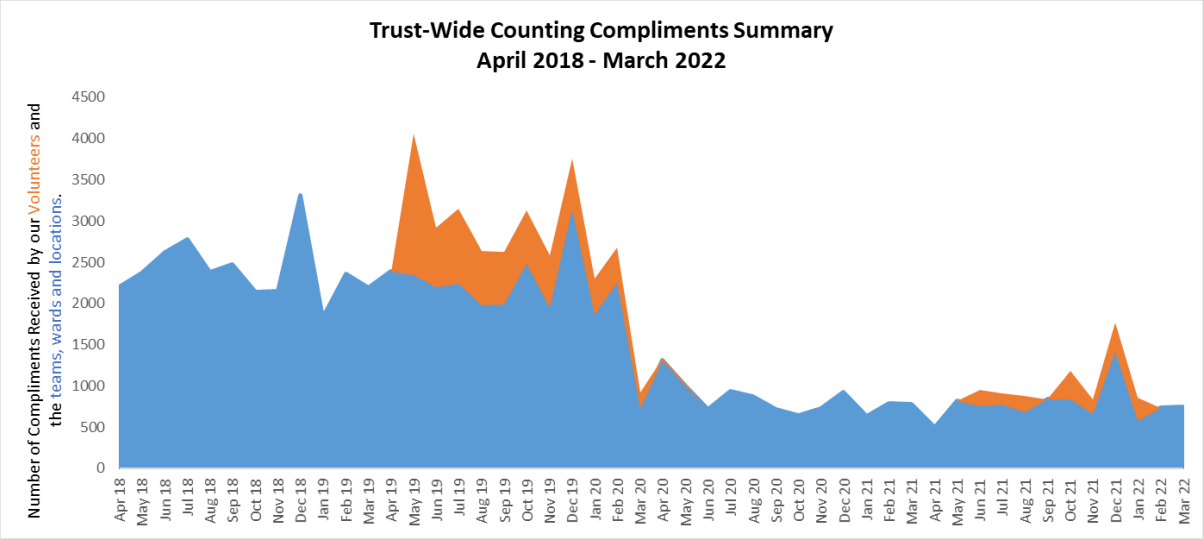
- A full wider review of all patient information has commenced. This includes an audit and appraisal of all existing information leaflets, new branding and development process underpinned by a new policy and approval procedure. This is a large project which will have a working group to undertake the actions required and is included within the CQC action plan.

4. Compliments

Our process for counting compliments is reliant on teams counting the cards, letters, gifts, and messages they receive and sending them through for logging. We know that some areas tend to get more ‘thank you’s’ than others by virtue of their work but Compliments are still a quality indicator that has value.

There was a clear drop-off throughout Wave 1 of Covid, and it is notable that the figures have not recovered and returned to the previously seen levels. This is attributed, in part, to reductions in visitor numbers.

Our volunteers receive many compliments directly and these are also counted and included in the data.



In addition to a pure count, teams provide examples of messages they receive and a selection are shown below.

Absolutely first class from start to finish, totally listened to and accommodated my needs and wishes (and I am an awkward, fussy patient!)	A lady came to follow up clinic after her carotid and said her care had been very good and all staff on the ward and in theatres were very kind and caring.	A patient said he enjoyed reading the new diabetic board, has learned some new info and that it was very well presented.
Thank you to all the staff on Lancaster ward, for all your care, consideration, humour, kindness and professionalism. We thank you from the bottom of our hearts. You have a difficult job in a difficult situation yet you. are considerate of patient needs	I wanted to congratulate you on outstanding service, friendly receptionist and felt completely at ease. Your lovely staff are a shining example of true professionalism	Thank you for being there. Not all angels are in heaven. Some work in the chemo suite
Once the staff realised how serious my condition was they moved with incredibly speed to get me sorted. The teamwork was amazing; I was sorted very quickly and professionally.	You all have made the fantastic family unit that I have felt so secure in this past 10 days and will miss you all so much.	Thank you for making sure that my grandfather had a nice 90th birthday despite being in hospital and being unable to have visitors

5. Healthwatch

We enjoy a strong partnership with Healthwatch who attend the Patient Experience Group and the involvement officer is also a member of Patient Panel bringing views and comments and insight from the wide number of patients they see and speak to.

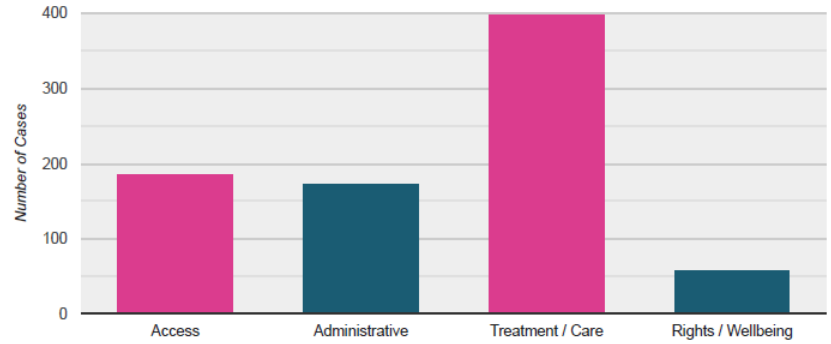
Each month Healthwatch send a report of patient experience feedback raised with them; these are comments, issues and some compliments too. These reports emanate from February 2013, when Sir Francis Keogh produced his review of the Mid Staffordshire Enquiry and cited a number of failings of the system. Under the Mid Staffordshire and Winterbourne reforms, local Healthwatch are considered the local consumer voice with a key role in ensuring the patient voice is heard. We have a statutory requirement to respond to Healthwatch reports within 20 days of receipt.

April 21 - March 22

Statistics

Total cases: 225

Theme Areas



Theme Areas	Cases
Access	186
Administrative	173
Treatment / Care	398
Rights / Wellbeing	58

Sentiments	Cases
Negative	112
Neutral	14
Mixed	59
Positive	39
Unclear	1

Theme Areas	Cases
Access	186
Administrative	173
Treatment / Care	398
Rights / Wellbeing	58

The majority of Healthwatch feedback is negative; however, this is unsurprising, as people tend to approach them if they are unhappy or dissatisfied and staff at Healthwatch have developed a good relationship with the PALs and Patient Experience team to support seeking answers and resolutions swiftly.

Going forward Healthwatch comments received will be entered into DATIX to enable them to be included in our data triangulation.

In addition to the monthly reports, we engage with other events and activities, participate with the quarterly YourVoice@healthwatch sessions, share calls for engagement in surveys, and published reports. Feedback from these sessions and surveys is fed through Patient Experience Group and the relevant business unit; for example, the discharge team attended a Your Voice event related to discharge and they subsequently made local changes within discharge lounges to improve communication.

Patient Stories

In healthcare, storytelling is a powerful tool that helps clinicians provide appropriate care and allows the patients to be part of the healing process. This year we have encouraged and motivated our staff to use stories more; we want stories to illustrate our understanding of what it is like to be a patient in our services, how it felt and how we did. We also want to be able to celebrate and share when we do well and to acknowledge and learn when we could do better.

We have produced a ‘Developing Patient Stories’ document (Appendix 4) to explain purpose and process and have discussed at the Matrons and Sister / Charge Nurse Forums. A story is expected as part of divisional assurance reports to Patient Experience Group as well as Skin Integrity Steering Group and Falls Prevention Steering Group as both of these groups consider patient harms from falls and pressure ulcers attributable to the care received whilst an in-patient at the Trust. Actions taken and learning from the event is shared as part of the patient story.

We have gathered a significant collection of digital stories over the last year as we moved to a virtual Trust Board; the plan this coming year with the launch of the new intranet is to have patient stories in the new Patient Story Library. This format means they can be used in training, are easily accessible and are a lasting legacy.

Stories are filmed by the Patient Experience Team and it may be the patient telling their story on film or staff recounting it on their behalf; it can include slides and photos and the links to the stories this year are listed below and include a short account of the story's impact and learning.

- How innovative use of 3d printing supported a patient with learning disability. https://drive.google.com/file/d/1TwTosfMnqb7R-Qlj0qfDid4C0t5Fo0qW/view?usp=sharing This story highlighted not only innovation but also the importance of making reasonable adjustments to meet a vulnerable patient's needs. It was subsequently shared at the Safeguarding Vulnerable Adults Oversight Group and through safeguarding leads.
- What Matters To You (#WMTY) initiative https://drive.google.com/file/d/1qkI1QpdsmKQYmO2loI51M47kYjHzdwtT/view?usp=sharing Sharing the concept of #WMTY and the approach taken by ward leaders not only celebrated the work to date but kept momentum and awareness active. A number of ward teams came forward seeking further information and the film can be used again as we launch further cohorts of #WMTY training programmes.
- Peter's story – communication and listening to the patient. https://drive.google.com/file/d/1yk72NeWLJGJe3j1vQrG3dlUNsKPbc09W/view?usp=sharing Peter's story led to some dedicated work within Trauma & Orthopaedics and contributed to the development of the OSCE training programme.
- Development of wedding boxes for end of life patients https://drive.google.com/file/d/1s5IE9i00WklbDXrfjXSVZIwPmn8OnFA_/view?usp=sharing. Following an increase in end of life weddings and particularly during the pandemic these boxes were developed to have all the resources necessary to conduct a bedside blessing.
- Hearing it your way; communication within Trauma & Orthopaedics (T&O) https://drive.google.com/file/d/1q8-RjFXejn04tvqOnmQ3by8jP8nQQULq/view?usp=sharing. Linked to Peter's story above this describes the T&O specialty plans for delivering practical and observational communication training to all their staff.
- Gill's story – unable to get through to a ward to find out how her father in law was doing https://drive.google.com/file/d/1CKEgV-wtb97SOW3qawKdN17k8cZ_gYB1/view?usp=sharing. Gills experience of trying to contact a ward for an update on her relative's condition led to the development

of the Communication Working Group and associated workplan and particularly the Family Phone initiative described earlier.

- Collaborative working across paediatric services to support a child with an eating disorder https://drive.google.com/file/d/1_03FiqOFMXrcoCZaTHYChcbA837WU8zJ/view?usp=sharing. A powerful story demonstrating that one provider does not solely deliver their care and the crucial need to work in partnership across acute and community care services.
- Corporate staff go clinical; the experience of staff redeployed during wave 2 of the pandemic https://drive.google.com/file/d/1H_HOW4AQfesiDa97m3x0mTVN00tj5uiG/view?usp=sharing. This story shared the experiences of corporate staff who had been redeployed to support clinical teams in delivering essential care. It was powerfully told by staff who often don't meet patients in their day to day work and their experiences dealing with care needs and in some cases death.

National Survey Programme

The national survey programme is set by the CQC and during 2021-2022; five were running in year at different stages.

	2020 Urgent and Emergency Care Survey	2020 Adult Inpatient Survey	2020 Children and Young People's Survey Inpatient and Day Case	2021 Maternity	2021 Cancer patient experience survey *
Methodology	Traditional paper- only survey	Mixed-mode (online and paper)	*Traditional paper-only survey*	*Mixed-mode survey (paper and online)*	Traditional paper-only survey
Display of posters - During the entire sampling period, posters to be displayed to raise awareness of the survey.	September 2020	November 2020	*November 2020*	*February 2021*	*N/A*
Trusts draw sample, complete DBS checks and Caldicott guardian signs 'sample declaration form'.	October 2020	December 2020	*January 2021*	*March 2021*	*February 2021*
Survey fieldwork.	November 2020 - March 2021	January 2021 – May 2021	*February 2021 – June 2021*	*April 2021 –August 2021*	*April 2021 – June 2021*
Publication of survey results CQC	September 2021 (TBC)	November 2021 (TBC)	November 2021 (TBC)	January 2022 (TBC)	TBC

The 2020 National Inpatient survey, which reported in October 2021, changed on previous years. There were a number of different questions and the CQC created a new ranking system. Whilst there is notice not to directly compare with previous reports there is still the ability to draw conclusions internally.

Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.

Comparison with last year's results

Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month. More information on this is available in the survey development report.

The Adult Inpatient 2021 benchmark reports will include an overview of the number of questions at which your trust's performance has significantly improved, significantly declined, or not significantly changed compared with your result from the previous year.

We can see that seven questions scored worse than other Trusts and the remaining ranked as about the same as other Trusts. The seven worse questions are as follows and further detail can be found at Appendix 6.

- Did staff explain the reasons for changing wards during the night in a way you could understand?
- To what extent did hospital staff take into account your family or home situation when leaving hospital?
- Were you given enough notice about when you were going to leave hospital?
- Before leaving hospital were you given any written information about what you should or should not do after leaving hospital?
- Before you left hospital did you know what would happen next with your care?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- After leaving hospital did you get enough help from health or social care services to help you recover or manage your condition?

Grantham site did not feature at all as a site on these seven worse than questions. Indeed, they had eight questions ranked as somewhat better or better than other Trusts, and 16 questions ranked as much better than other Trusts and as such the Trust is extremely proud of the result.

Somewhat better or better than expected	Much better than expected
Keeping in touch with relatives during COVID	Noise at night from patients
Enough nurses on duty	Noise at night from lighting
Enough information about treatment	Enough to drink
Privacy of conversations	Doctors answering questions in way could understand
Explanation about how treatment had gone	Confidence & trust in doctors
Involved in decisions about discharge	Doctors not talking over
Who to contact of worried after discharge	Nurses answering questions in way could understand
	Confidence & trust in nurses
	Nurses not talking over
	Consistency between clinicians
	Involved in decisions
	Help with worries and fears
	Privacy during examinations
	Pain control
	Respect & dignity
	Overall experience

Whilst the surveys have their 'home' division, there are clearly overlaps and equivalent questions and experiences across the suite. We looked across all the surveys to identify themes that indicate a whole Trust action response.

These core themes and actions were drawn together into one action plan. Going forward into 2022-2023 one overarching national survey plan is being created so a concerted, Trust-wide approach can be taken to address the required actions. This will form part of the patient experience teams work programme for 2022 – 2023.

Actions taken include:

- Discharge – the issues shown above in the latest inpatient survey feature across all specialties and improvement actions are part of an overall transformation plan that link in with operational management and patient flow, zero pathway discharges, services including pharmacy and diagnostics and locally with teams driving improvements in care planning, ward and board rounds and team communications.
- Involvement in decisions – as a Trust we are championing the What Matters to You initiative and a first cohort of 12 nursing teams undertook the QSIRv quality improvement programme to support them in implementing the principles and programme. Cohort 2 was postponed due to the COVID Pandemic and operational pressures but will commence again in the summer of 2022.
- Communication, attitude and behaviours – as detailed above communication has been a key feature across all our data sources and a workgroup is taking a number of improvement schemes forward including:
- Privacy, dignity and respect – dignity and respect has been the subject of a number of discussions and after working with patients, staff across the Trust

and key stakeholders including Healthwatch new Dignity Pledges have been developed which are being launched in the coming year.

These actions and their resultant outcomes are shared within Patient Experience reports, newsletters, and divisional reports.

Internal Audit

In spring of 2021, an internal audit was undertaken within patient experience looking at the following:

- Arrangements in place for collecting public and patient feedback.
- The collection and reporting of public and patient experience data in line with national requirements.
- Arrangements for collecting feedback being inclusive and meet with equality requirements.
- Triangulation of data is undertaken.
- Quality Improvement milestones to improve public and patient experience are fully implemented and embedded.
- There is sufficient evidence to demonstrate how feedback is communicated throughout the Trust's services and adequate ownership at a divisional level.
- The Trust demonstrates how learning from feedback is used to improve patient care.

Partial level of assurance with improvement required

The audit found that we had made good progress in establishing an environment in which public and patient experience is gathered and used to improve and develop services and that whilst the key elements for recording and monitoring feedback are in place, there is still some embedding required, particularly at a divisional level. As shown right, significant assurance was achieved across 3 areas. An action plan was created for where improvements were identified and has been completed.

Objectives	Assurance rating
Inadequate or ineffective arrangements are in place for collecting public and patient feedback.	Significant assurance
The Trust does not collect and report its public and patient experience data in line with national requirements.	Significant assurance
Arrangements for collecting feedback may not be fully inclusive or meet with equality requirements.	Significant assurance with some improvement required
Insufficient triangulation of data is undertaken.	Significant assurance
The Trust's Quality Improvement milestones that were developed to improve public and patient experience are not fully implemented and embedded.	Significant assurance with some improvement required
There is insufficient evidence to demonstrate how feedback is communicated throughout the Trust's services or inadequate ownership at a divisional level.	Partial assurance with improvement required
The Trust does not demonstrate how learning from feedback is used to improve patient care.	Partial assurance with improvement required

Integrated Improvement Plan (IIP)

Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers

There are three main streams to this project:

- Development of a Patient Panel
- Development of Experts by Experience
- Reaching out to hard to reach communities

This report is based upon the Year 2 IIP. It is recognised that the plan is currently being refreshed and this project will be updated accordingly for 2022 – 2023.

Patient Panel

The Panel was established to enable our patients to be involved in Trust developments and improvements through receiving, reviewing, commenting, challenging and responding to proposals and discussions that support the organisation to deliver its strategic objectives in relation to Objective 1e: Patient experience reflects our ambition as a Trust to put patients and safety first.

The purpose is to drive, deliver and demonstrate Trust wide measurable improvement and continuous learning in outcomes, delivery, performance,

sustainability and transformation in Patient Experience. Patient Panel milestones included at **Appendix 7**.

- The Patient Panel members are ambassadors for the trust, ensuring patients, the public and relevant other stakeholders are well informed about the workings and strategic direction of the Trust.
- To provide a diverse forum for influencing and contributing to discussions and planning of the most effective health services for the local population.
- To support the Trust in its aim to ensure that all communication and engagement is fit for purpose, appropriate and accessible to all relevant groups e.g. patient information.
- Terms of Reference were developed and approved by Patient Experience Group and were reviewed and updated August 2021.
- All members are signed up as Honorary Volunteers and undertake DBS checks and mandatory training (Safeguarding, ED&I, COVID and Information Governance).
- Meetings have been held through MS Teams monthly since September 2020 with the exception of April 2021 due to operational pressures and all meetings last 2 ½ hours.
- An average of 16 panellists have been present at each meeting.
- An additional 6 workshop sessions have been held to focus on single topics with an average of 7 panellists in attendance.
- A number of panellists represent the panel on subgroups including Patient Experience Group, Outpatient Experience Group and the ePMA digital cabinet

Panel achievements 2021 - 2022

- 39 discussions have been presented.
- 48 staff have attended to present.
- Of these 4 have returned to have follow up discussions.
- Meeting notes include a transcript of all questions asked to enable staff attendees to take the discussions back to their work and ensure consideration is given to the panellist's views and comments.
- Through the workshops co-production has been undertaken including the development of:
- Revised Dignity Pledges
- Visiting restrictions – information for patients and visitors.
- Patient Moves – principles for discussing with patients.
- Signage Audit (underway)
- Patient Panel masterclass session held for the #WMTY QSIRv cohort.

1. Self Service Booking
2. Outpatient improvements programme
3. Temporary Changes to services due to COVID-19. Quality & Equality impact assessments
4. Temporary Changes to services due to COVID-19 Quality & Equality impact assessments.
5. Acute paediatric service
6. Recommencing planned surgery at Louth
7. Temporary rehabilitation ward at Grantham for medically fit patients that who are not able to go home.
8. Transitioning to 7 day working
9. Re-brand of all ULHT hospital sites.
10. How we can include patient voices in our improvements
11. Charitable Funds Strategy
12. Video Consultations
13. Hybrid mail and self-service - outpatient improvements update
14. Digital letters update
15. Self Service booking
16. Outpatient Letters
17. ENT and OMF Outpatient Improvement programme
18. Pre-Operative Assessments
19. CEO update
20. ED Project Update
21. Patient Initiated Follow Up (PIFU)
22. Project Salus
23. Experts by experience
24. Outpatient Improvement Programme
25. Pilgrim Emergency Department
26. Dermatology
27. Improving Respiratory Services Programme
28. Patient Safety Culture
29. EPMA –Electronic Prescribing and Medicines Administration
30. Urology Hospital Services
31. EHR Electronic Patient Records
32. Patient Information mats
33. PIFU – Patient Initiated Follow Up Proposals
34. Falls Initiative
35. ULHT Patient E Referral acknowledgement letter
36. Rebook Automation and Digital Outpatient Appointment Letters
37. Developments in Dermatology
38. Complaint Action 22290
39. Wellbeing – How we are supporting our staff

An evaluation was undertaken at 10 months with very positive feedback and two recommendations:

- Increase the numbers of panel members and introduce a wider range of demographics – achieved – further 13 members recruited bringing the total membership to 33.
- Devise a robust system to allow feedback on projects/topics to be routinely feed back to the panel members - all presenters asked to complete a survey following their session and to return with updates.

There has been national interest in the success of the Patient Panel and a best practice case study requested by NHS England to support the national document refresh of Statutory Guidance on Working with People and Communities 2022.

Developing Experts by Experience

Experts by Experience are people who have recent personal experience (within the last five years) of using or caring for someone who uses health, mental health (MH) and/or social care services. There is rich evidence that people who have experience of using services are uniquely placed to help plan and develop those services and demonstrates the importance and impact of working in partnership with people with lived experience. It also demonstrates how engaging with our patients and carers, learning from them and working with them leads to better outcomes for all involved.

As an organisation, we have masses of patient experience data, primarily ‘feedback’ that is information about the reaction of experiencing care or treatment and we use this as a basis for improvement. We have a number of local / specialty engagement events such as patient forums or focus groups and bespoke surveys….again largely ‘feedback’. What is missing is that earlier involvement and patients experiences being considered throughout.

The Patient Panel has demonstrated the value of engaging with and involving a broad range of patients experiences, specialty services could benefit not only from this but also from patients with lived experience of specific conditions.

To build the process and concept of using lived experience, we aimed to develop Expert Reference Groups, supported by the Patient Experience Team.

The first group has been the Sensory Loss Expert Reference Group with five members, people who live with sight or hearing loss or those who care for and support them. This group has met a number of times and undertaken two co-production production projects:

- Introducing bedside symbols for people with sight or hearing loss so that anyone approaching their bed space is aware of their need to adjust their communication accordingly.
- Reviewing supporting patients with assistance dogs, moving away from just Guide Dogs to acknowledging there are now a range of assistance dogs. The group has developed a policy and have designed dog walk areas on each hospital site and the launch is planned for summer 2022.
- A Breast Mastalgia Expert Reference Group, functioning more as a task and finish group has been integral in the development and design of a new pathway for patients with breast pain. The group contributed to discussions about the challenges, gave their views and comments and suggestions on pathway design and contributed also to the patient information design and content at the point the new pathway went live.
- Progress has also been made in the creation of a Cancer Patients Expert Reference Group in partnership with the Lincolnshire Cancer Board with its first meeting scheduled for May 2022; a Dementia Carers Expert Reference Group; a Youth Forum and Expert Family Group in paediatrics are being discussed.

These are exciting developments and we are confident that they will bring some powerful, valuable experience to our ongoing service developments and improvements.

Reaching Out Project

How to diversify patient and public engagement and involvement has been discussed within the patient experience community for many years. Often our patient representatives and contributors are from a similar demographic; white, highly educated, retired and often female. While their views are valuable, it is also vital to have feedback from patients with varied backgrounds so patient experience intelligence reflects the true breadth of lived experience.

The notion 'hard to reach' is a contested and ambiguous term that is commonly used within the spheres of health and social care and in patient experience it can be argued that the issue is less that some patient groups are hard to reach and more that our methods of reaching them are inadequate or inappropriate. The objective is to have a collective understanding of our patient's experiences through seeking out their voices and a collaborative approach to being involved in service developments and improvements. The established Patient Panel will be seen as the central hub and satellite groups as spokes to provide an overall picture. As we have now identified some key 'hard to reach' groups we need to engage with, it would be remiss not to include them here at the outset though for some it may be that we can work in partnership with other agencies and providers.

- Sensory Loss group established.
- Contact made with traveller community
- Learning Disability & Autism Spectrum Disorder – new ULHT lead nurse appointed and links established.
- Mental Health – good links with LPFT, co-production options to be discussed.
- Children & Young People – youth forum being discussed.
- Carers – good relationship & stakeholder engagement with Carers First.
- BAME – yet to be progressed.
- LGBTQ+ - yet to be progressed.
- Older People & Dementia – Dementia Carers Group in development.
- Eastern European community – not yet progressed.
- Maternity & Neonatal voices – MVP engagement through PEG and maternity services; neonatal voices links still to be established.
- Cancer Collaborative – cancer Expert Reference Group about to launch.

Visiting

Throughout the pandemic the Patient Experience Team have been responsible for managing visiting precautions. This has included reviewing national guidance and ensuring internal procedures are safe and risk based whilst also considering the importance of visiting.

Throughout all levels of restrictions support has been provided for compassionate and exceptional situations. Alternatives to visiting established during 2020 when the

pandemic first took hold included supporting video calls and Letters to a Loved One both of which continue.

Although we know many of our patients and families appreciated technical solutions such as supporting video calling we also know through feedback that the visiting restrictions had several mainly negative consequences, for the patient's health, and the health and wellbeing of family members. Mental wellbeing suffered as patients and families experienced loneliness and increased anxiety which when seen in addition to reduced staffing levels and subsequent impact on answering of phones has resulted in complaints and concerns being raised.

Visiting restrictions also placed extra burdens on staff by increasing the need for communication with family members, reducing access to relevant information about the patient’s pre-admission condition or abilities and the introduction of risk assessments and booking systems to manage visit appointments.

The core development was the model of Controlled Visiting, in line with the Trusts ‘Salus Principles’ of high, medium and low infection risk. When prevalence and incidence was of a higher risk visiting was either suspended or tightened with a ‘Controlled +’ model with fewer people permitted. (Appendix 8)

All procedures and supporting documents such as risk assessments and booking sheets were created with input and feedback from staff and considering the feedback from patients and families too, to ensure a balance of risk and proportionality. For example, introducing a mealtime support appointment for patients with poor nutritional intake where a visitor could be permitted to support and in the same way as end of life visits have been supported throughout the pandemic specific guidance on supporting carers was developed. A timeline of all decisions has been maintained that has enabled reflection and assurance.

Board assurance framework (BAF) and Risk Register

The BAF is a key mechanism for our Trust Board to achieve the level of assurance they need to assess the quality of care and it recognises patient experience as one of the core elements. The BAF is reviewed and updated monthly, with particular focus on actions taken to address control gaps. In year, such actions have included

a review of PEG terms of reference, revised templates for divisional assurance reports and increasing diversity of patient engagement

Following a full review, the corporate risk register now details three patient experience risks:

1. If we do not listen to the voices of our patients, carers and families through not seeking out, hearing and appreciating their experiences and then acting on them, we will fail in our ambition to deliver patient centred care.
2. Patient engagement can inform service design and evaluation as well as enhance its delivery and governance. It is the process of building the involvement of patients, families and carers, supporting their active involvement in order to enhance their care, care experience, safety, quality and patient-centredness. If we do not build the expectation to engage with our patients then we will not achieve patient centred care and if we do not reach out to 'hard to reach' groups our intelligence will fail to be diverse and inclusive.
3. Codesign shifts the traditional design process where a health care team is independently coming up with ideas for problems. Co-design involves the patients in the design process and works with them to understand their met and unmet needs. If we do not involve our patients and their carers from the outset with our service design and evaluation then we will not achieve our ambition of person centred care.

These risk updates have only recently been approved and in the coming year will provide a structure for assurance.

Summary

We all recognise that patient experience is and should be central to all that we do. Despite considerable challenges through the last 12 months, the Patient Experience Annual Report demonstrates the wide-ranging variety and breadth of inclusion and involvement of our patients in their care and service delivery. The latest CQC Inspection Report (2021) noted that the patient was at the heart of everything we do and recognised this as a significant shift from their previous inspection. This is extremely positive feedback and is an acknowledgement of the work being undertaken to ensure that the patient voice and engagement with our patients becomes embedded into the work of ULHT.

We have good intelligence across the Trust that is triangulated and analysed enabling focused attention where it is identified, to ensure we focus our efforts onto those things, which matter most to patients and their carers.

Our Patient Experience team has been strengthened through additional resource into the team and this reflects the Trust recognition of the important work the Patient Experience do to support this wide-ranging agenda. The Patient Experience Group has matured in year seeing greater assurance provided from the divisions and services around their practice, service developments and learning, which focus on patient experience.

We have built strong links with Organisational Development and Equality, Diversity & Inclusion teams to ensure that our thinking joins up both patient and staff experience, which we know directly impact on each other and most importantly with our patients through the successful Patient Panel and emerging Expert Reference Groups. Their input has been and continues to be invaluable.

Our strategic objectives clearly set out our organisation vision.

Integrated Improvement Plan	Nursing & Midwifery Framework
by 2025, we will deliver high quality, safe and responsive patient services, shaped by best practice and our communities	Our patients and clients will be treated with compassion, dignity and respect at all times and will be encouraged to participate in all aspects of their care planning and delivery. We will improve the care we provide by actively listening to patients and their carers to better understand their needs, concerns and wishes..

Our new refreshed Patient & Carer Experience Plan embodies these strategic aims and will provide a framework and workplan for the coming year, as we continue to build on our successes and further develop the improvements seen and needed to embed our mind-set of placing the patient at the heart of everything we do.

The year ahead

In the coming year we have a number of focus areas:

- Publishing our revised Patient & Carer Experience Plan in July. This will have an associated workplan and milestones that essentially provide the blueprint for the Patient Experience Team.
- Continuing our delivery against the IIP with a particular focus on the development of expert reference groups and reaching out to our seldom-heard patients, working alongside the Equality, Diversity & Inclusion teams.
- Driving the roll out and embedding of ‘What Matters to You’ as our patient centred methodology for involving our patients and carers in discussions and decisions about their care and treatment.
- Through our Communication Action Plan improving how we communicate with our patients and carers, listening to what they tell us about their experience of our services and what matters to them about the way we do things.
- Launching our Patient Story library and implementing real time surveying enabling teams to have rapid intelligence on how patients experience their care.
- Evaluation and anticipated roll out of Phone a Relative (We Care to Call) programme Trust wide.
- Proactive visible Patient Experience Team presence across the sites.

Appendices

Appendix 1 | Patient Experience Group Membership

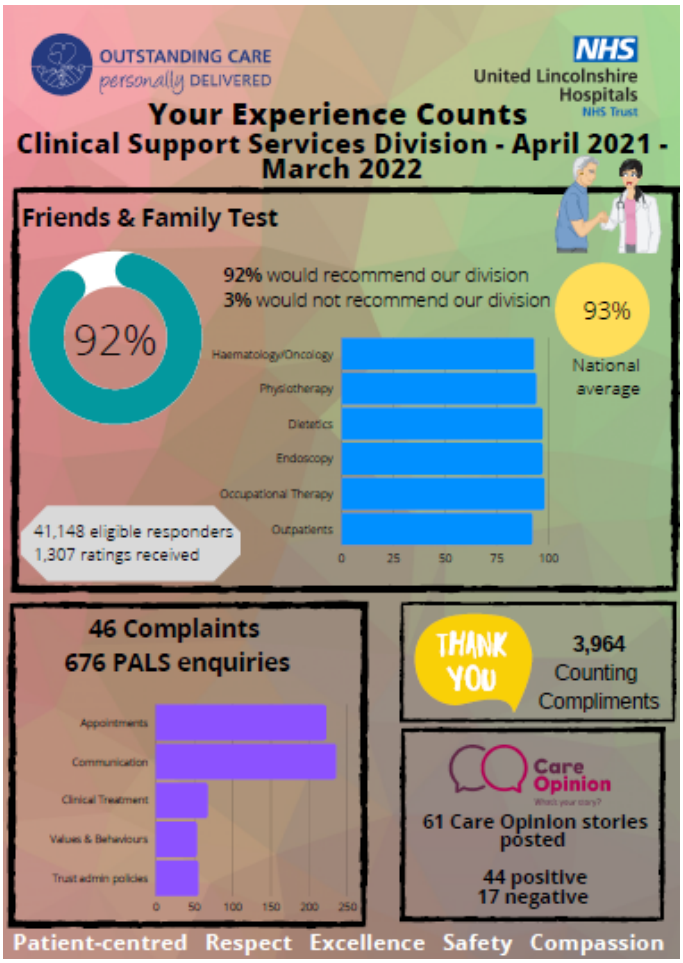
4.1 The members of the **Patient Experience** Group are:

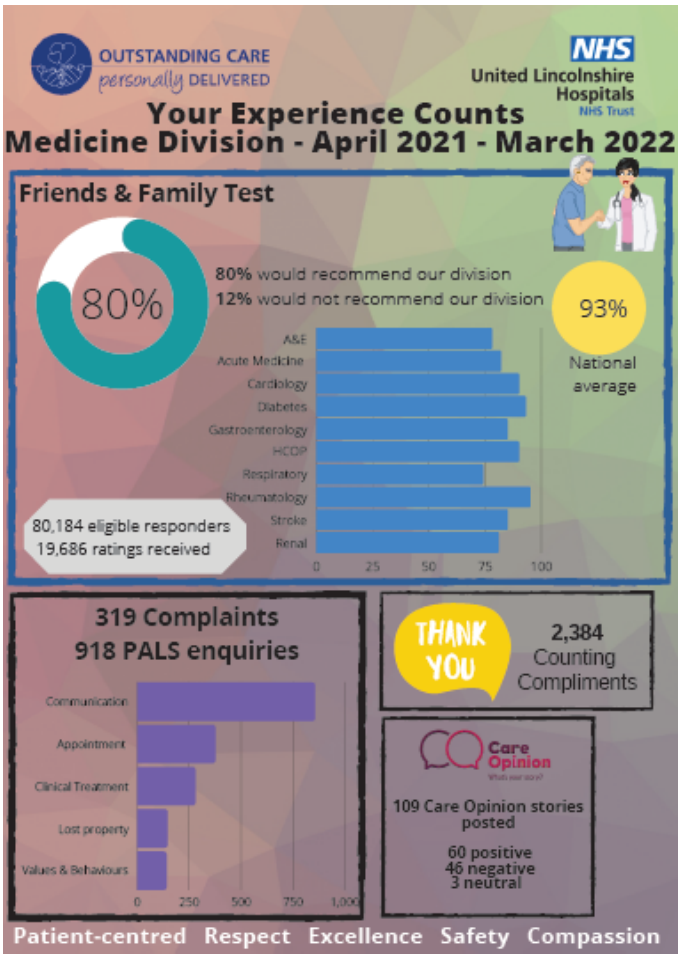
- Deputy Director of Nursing (chair)
- Head of Patient Experience (vice chair)
- Divisional representatives – Lead or Deputy Lead nurses:
  - Medicine & Urgent Care
  - Surgery
  - Clinical Support Services
  - Family Health
    - Head of Midwifery
    - Lead Nurse for Paediatrics
- Patient Experience Managers
- Patient Experience Data Insight Manager
- Assistant Director of Clinical Governance
- Organisational Development representative
- Senior Chaplain and Bereavement Services Manager
- Equality, Diversity and Inclusion Lead
- Quality Matron (Patient Experience)
- Complaints & PALS manager
- Voluntary services manager
- Therapy representative
- Facilities representative
- Communications team representative
- Stakeholder representatives:
  - Patient Panel
  - Healthwatch
  - Carers First
  - Young Carers
  - Maternity Voices
  - Neonatal Voices
- Open invitation to service level FAB Experience Champions (recognising unlikely to attend all meetings)

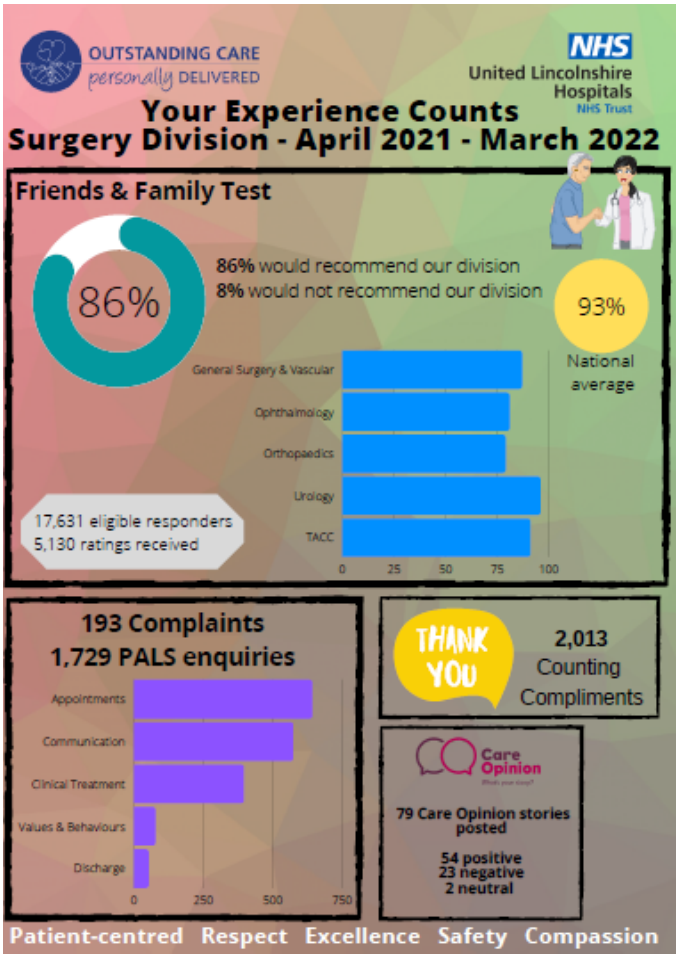
APPENDIX 2 | Patient Experience Group – Reporting Schedule

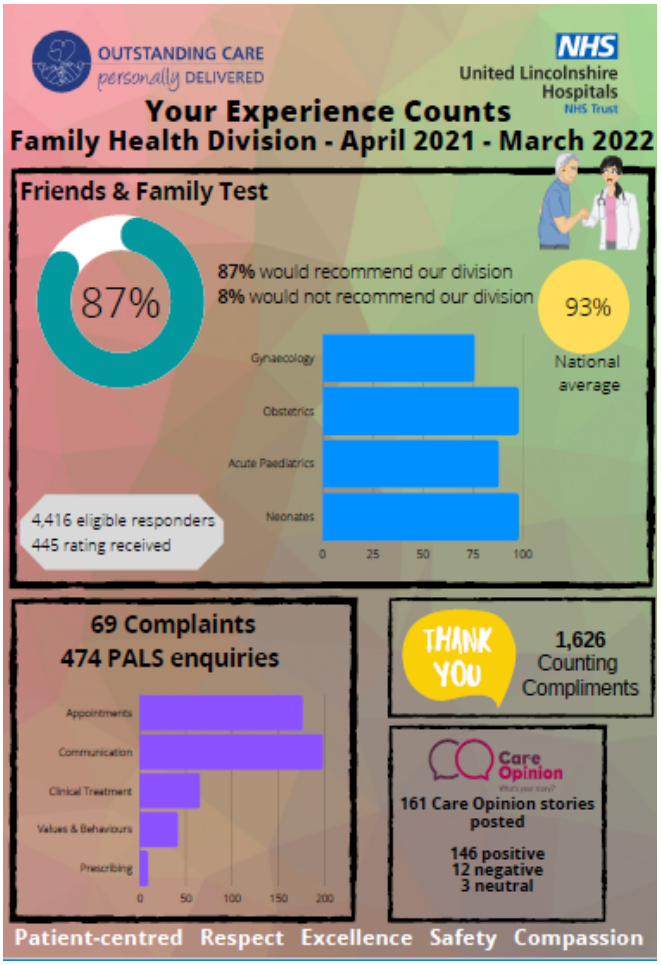
		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Agenda Item	**Lead**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Business Items													
Group Terms of Reference (Draft & Final)	Deputy Director of Nursing	X											X
Forward Reporting Schedule (Draft & Final)	Deputy Director of Nursing	X											X
Reporting Group Terms of Reference and Forward Reporting Schedules (Draft & Final)	Deputy Director of Nursing	X											X
Group (Patient Experience) Performance Dashboard	Deputy Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Matters Referred													
Matters Referred by QGC or other QGC sub-groups	Deputy Director of Nursing	**To be added to the agenda as required**											
Risk and Assurance													
Board Assurance Framework (Improve Patient Experience)	Deputy Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Patient Experience Risk Register Report	Deputy Director of Nursing			X			X			X			X
Internal Audit Reports (Patient Experience)	Deputy Director of Nursing	**To be added to the agenda as required**											
Strategic Objective 1 - To deliver high quality, safe and responsive patient services, shaped by best practice and our communities													
Objective 1b - Improve Patient Experience													
Patient Experience Report - (including inclusion, equality & diversity from a patient perspective)	Head of Patient Experience		X			X			X			X	
Complaints Report	Complaints Manager		X			X			X			X	
Complaints Annual Report	Complaints Manager			X									
National In-patient Survey (In-patient, Cancer, Maternity)	Patient Experience Manager				X Cancer	X In-patient						X Maternity	
PLACE Lite Report	Deputy Director of Estates and Facilities	X			X			X			X		
PLACE Annual Report	Deputy Director of Estates and Facilities						X						
Mixed Sex Accommodation (MSA) Assurance Report**	Deputy Director of Nursing		X										
Patient Story (from Divisional reports)	Deputy Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Upward Highlight / Exception Reports from Groups reporting to the Patient Experience Group (including any identified areas of focus for 2021/22)													
Chaplaincy / Bereavement service report	Senior Chaplain		X			X			X			X	
Stakeholder Updates	Stakeholder Representative	X	X	X	X	X	X	X	X	X	X	X	X
Integrated Improvement Plan progress reports	Head of Patient Experience	x			x			x			x		
SUPERB	Patient Experience Manager	X	X	X	X	X	X	X	X	X	X	X	X
Voluntary services service report	Voluntary Services Manager			X			X			X			X
National surveys action plans	Patient Experience Manager			X			X			X			X
Patient Experience Plan progress report	Head of Patient Experience		X			X			X			X	
Fab Champions reports	Divisional Lead	X			X			X			X		
Maternity Voices	Maternity Voices Representative	X	X	X	X	X	X	X	X	X	X	X	X
Staff Experience	OD/HR Representative			X			X			X			X
Fab Academy update	Patient Experience Manager		X			X			X			X	
Reporting from Divisions:													
Clinical Support Services (CSS)	Divisional Triumvirate - CSS			X			X			X			X
Medicine	Divisional Triumvirate - Medicine	X			X			X			X		
Surgery	Divisional Triumvirate - Surgery		X			X			X			X	
Family Health	Divisional Triumvirate - Family Health	X			X			X			X		

APPENDIX 3 | Patient Experience Feedback – infographics






OUTSTANDING CARE
personally DELIVERED
NHS
United Lincolnshire Hospitals
NHS Trust
Your Experience Counts
Surgery Division - April 2021 - March 2022
Friends & Family Test
86%
86% would recommend our division
8% would not recommend our division
93%
National average
General Surgery & Vascular
Ophthalmology
Orthopaedics
Urology
TACC
0
25
50
75
100
17,631 eligible responders
5,130 ratings received
193 Complaints
1,729 PALS enquiries
Appointments
Communication
Clinical Treatment
Values & Behaviours
Discharge
0
250
500
750
THANK YOU
2,013
Counting Compliments
Care Opinion
79 Care Opinion stories posted
54 positive
23 negative
2 neutral
Patient-centred Respect Excellence Safety Compassion


OUTSTANDING CARE
personally DELIVERED
NHS
United Lincolnshire Hospitals
NHS Trust
Your Experience Counts
Family Health Division - April 2021 - March 2022
Friends & Family Test
87%
87% would recommend our division
8% would not recommend our division
93%
National average
Gynaecology
Obstetrics
Acute Paediatrics
Neonates
0
25
50
75
100
4,416 eligible responders
445 rating received
69 Complaints
474 PALS enquiries
Appointments
Communication
Clinical Treatment
Values & Behaviours
Prescribing
0
50
100
150
200
THANK YOU
1,626
Counting Compliments
Care Opinion
161 Care Opinion stories posted
146 positive
12 negative
3 neutral
Patient-centred Respect Excellence Safety Compassion

APPENDIX 4 | Developing Patient Stories

DEVELOPING PATIENT STORIES

Introduction

Stories have been used to hand down learning and knowledge for thousands of years. A good story engages our curiosity, emotions and imagination and the art of storytelling is instilled early on, when children are tucked in for the night with a bedtime story. However, storytelling does not just happen during bedtime or around campfires. Stories are part of our daily lives, from books, we read, movies we watch, and stories we tell our friends. In healthcare, storytelling is a powerful tool that helps clinicians provide appropriate care and allows the patients to be part of the healing process.

Stories have a transformative power that allows us to see the world in a different way. When someone tells us their story, it helps us connect, allows us to walk in their shoes and offers a better narrative that has more meaning and is more engaging than when presented simply in data. The *'lady in bed 6 with confusion'* becomes more than a bed number or a condition when we know her story. She becomes a person, a mum, a wife, a grandma, a good friend.

At ULHT we want to use stories more; we want stories to illustrate our understanding of what it is like to be a patient in our services, how it felt and how we did. We want to be able to celebrate and share when we do well and to acknowledge and learn when we could do better.

Stories are an extremely powerful element within training, and in keeping with many Trusts, we also share them at our Board meetings. The purpose of using stories to illustrate experience at Board level is to:

- Forge a connection between the experience of patients and staff and the leadership of the Trust and its role in establishing the right strategic context for improvement and change.
- Provide insight into how such stories can influence improvements in quality and patient experience.

What do patient stories tell us?

Stories provide feedback, from patients themselves, in their own words and voice on what *actually happened* in the course of receiving care or treatment, both the objective facts and their subjective views of it. The factual element is useful in comparing what people say they experienced against what an agreed care pathway or quality standard says should happen. The opinion element tells you how patients felt about their experience and helps to corroborate (or otherwise) other quality measures.

Our Trust vision and values highlight what we know are important to us as both caregivers and care receivers:

- Being patient and staff centred; being involved in decisions & valued.
- Being treated with genuine respect, 'respect me as an individual and for what I bring'.
- Striving for outstanding care, personally delivered; contributing to our organisational goals and being encouraged to make changes.

When we say 'I' and 'My' we can lose the sense of 'We' and 'Our' and so understanding what we each feel and experience and how our patients and families feel when we care for them, can help us to ask that NHS Leadership question; 'what is it like to be on the receiving end of me?'

Why stories matter

From a patient perspective:

- The quality of patients' experiences is central to an organisation's reputation and productivity, making it a major risk-management issue but also an opportunity. These risks and opportunities will not diminish even as we come out of special measures as an organisation, rather they will remain and new ones will appear; it is the nature of healthcare. The current pandemic is an example of this.
- The ability to demonstrate excellent feedback from patients, carers and families is a very good marketing tool in a climate of increasing choice and competition. Shortcomings or failures, however, may lose custom and confidence unless we openly and honestly demonstrate how we respond to these and that we are a learning organisation.
- Understanding and acting to improve patients' experiences is core business for the NHS. It is an important motivator for staff and part of the statutory duty of quality for board members – a 'must do' and the right thing to do.

From a staff perspective, our staff survey asks specific questions that provide the colour and backdrop to a patient's experience and staff stories can help us to paint that picture. For example if our staff are not satisfied will our patients be.

Storytelling Process:

- We are developing a digital library of stories accessible on the Intranet to all staff. Having them in this format also means they can be used in training and are a lasting legacy.
- Stories are filmed by the Patient Experience Team and it may be the patient telling their story on film or staff recounting it on their behalf; it can include slides and photos and it runs automatically with some gentle music in the background.
- In total we try and keep it to under 10 minutes; here are some recent examples:

Falls prevention
https://drive.google.com/file/d/1DQeR1IMCPTOZZGx1xeUfhHR3NmOyIlpz/view?usp=sharing

Care Opinion story
https://drive.google.com/file/d/1cXkSCpQ7SwhoQolac2LkopfDSCYE_MoB/view?usp=sharing

Eat Well; nutrition & hydration campaign
https://drive.google.com/file/d/1ECNvF5EKoBRS1hdDSiZWYP0fUamcweb6/view?usp=sharing

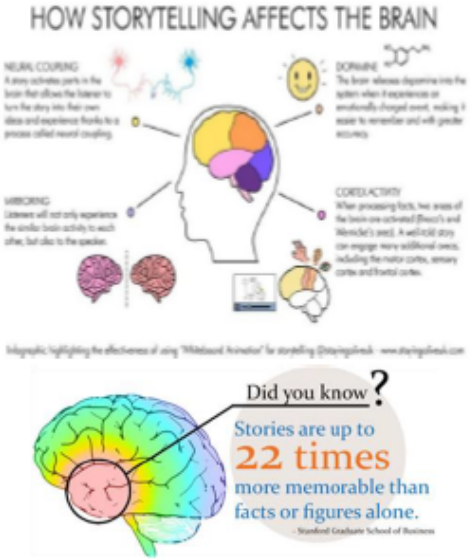
- *In all cases, even if the story it being anonymised, consent from the patient and the staff involved must be sought.* This is of particular importance of the story is to be shown at Trust Board as it is shared during the public section and anyone can join that meeting. The Patient Experience Team can help with this.
- The Patient Experience team will support this process from initial story thoughts through to presentation, as we know that it can cause some nerves on the day.

Structuring your story:

- Stories need to consider a *message*, for example:
  - A lesson learned following an incident or complaint.
  - A story of innovation or improvement.
  - A story of achievement and pride.
- Stories ideally need to be *complete* and demonstrate:
  - What the issue, situation or problem was; how this made the people involve feel.
  - What was done about it and how
  - What the outcome was and how this made the people involved feel.
- For stories going to Trust Board, there may be times when a story is *incomplete* and the point of it is to raise this with the Board to seek their assistance or support or to provide assurance that improvements are ongoing.
- Stories relating to current, unresolved complaints should not be told until an outcome has been reached.

Sharing the stories

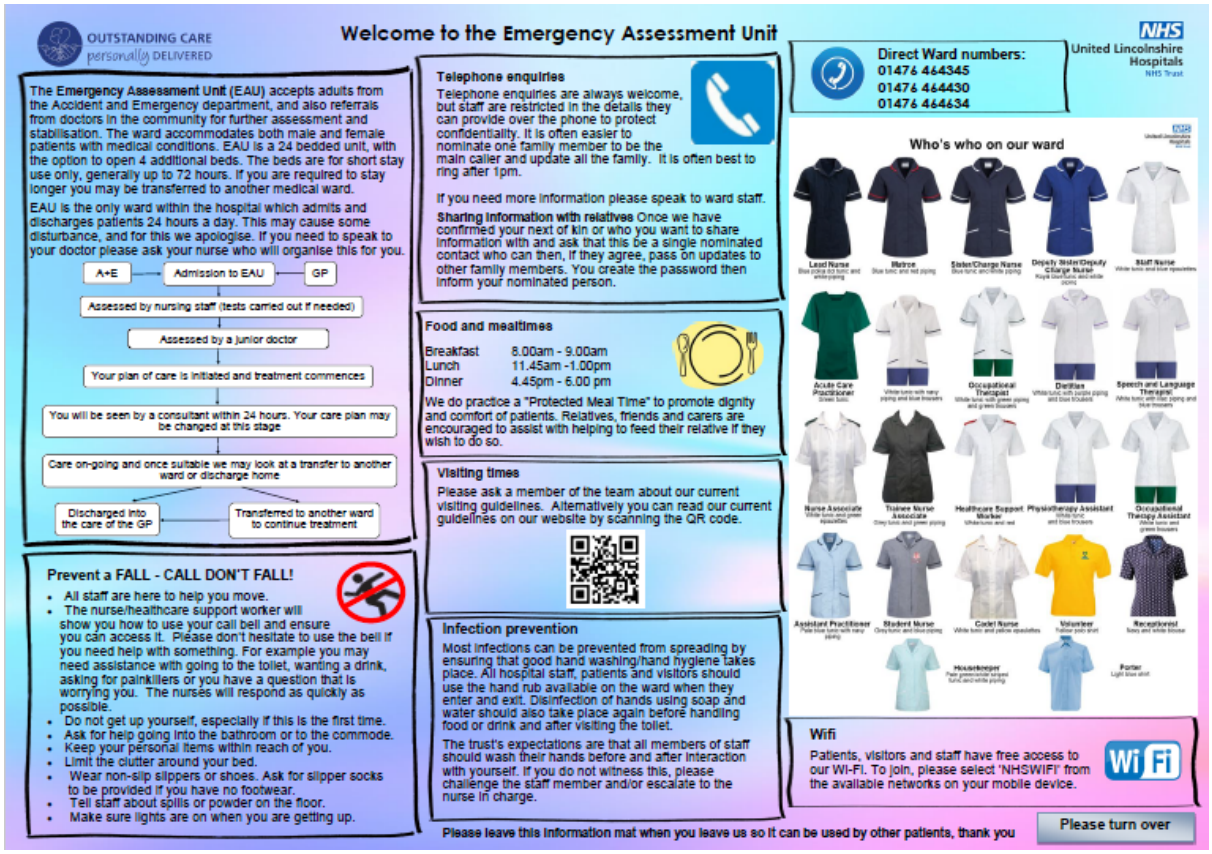
We want the stories to be shared, for as many staff as possible to hear and watch them, for that is their power. Following presentation to Trust Board the story will be saved within the new Story Library on the Intranet and then shared, as appropriate through existing channels such as Roundup and newsletters.



Let us help you to capture your patient's stories. We can support you to draw it together and create it into a format that can be shared.
Get in touch at: patient.experience@ulh.nhs.uk

Jennie Negus
Head of Patient Experience. May 2022

APPENDIX 5 | Ward information tablemats (A3 size)



OUTSTANDING CARE personally DELIVERED

Welcome to the Emergency Assessment Unit

NHS United Lincolnshire Hospitals NHS Trust

The **Emergency Assessment Unit (EAU)** accepts adults from the Accident and Emergency department, and also referrals from doctors in the community for further assessment and stabilisation. The ward accommodates both male and female patients with medical conditions. EAU is a 24 bedded unit, with the option to open 4 additional beds. The beds are for short stay use only, generally up to 72 hours. If you are required to stay longer you may be transferred to another medical ward.

EAU is the only ward within the hospital which admits and discharges patients 24 hours a day. This may cause some disturbance, and for this we apologise. If you need to speak to your doctor please ask your nurse who will organise this for you.

A+E → Admission to EAU ← GP

Assessed by nursing staff (tests carried out if needed)

Assessed by a junior doctor

Your plan of care is initiated and treatment commences

You will be seen by a consultant within 24 hours. Your care plan may be changed at this stage

Care on-going and once suitable we may look at a transfer to another ward or discharge home

Discharged into the care of the GP | Transferred to another ward to continue treatment

Prevent a FALL - CALL DON'T FALL!

- All staff are here to help you move.
- The nurse/healthcare support worker will show you how to use your call bell and ensure you can access it. Please don't hesitate to use the bell if you need help with something. For example you may need assistance with going to the toilet, wanting a drink, asking for painkillers or you have a question that is worrying you. The nurses will respond as quickly as possible.
- Do not get up yourself, especially if this is the first time.
- Ask for help going into the bathroom or to the commode.
- Keep your personal items within reach of you.
- Limit the clutter around your bed.
- Wear non-slip slippers or shoes. Ask for slipper socks to be provided if you have no footwear.
- Tell staff about spills or powder on the floor.
- Make sure lights are on when you are getting up.

Telephone enquiries

Telephone enquiries are always welcome, but staff are restricted in the details they can provide over the phone to protect confidentiality. It is often easier to nominate one family member to be the main caller and update all the family. It is often best to ring after 1pm.

If you need more information please speak to ward staff.

Sharing information with relatives Once we have confirmed your next of kin or who you want to share information with and ask that this be a single nominated contact who can then, if they agree, pass on updates to other family members. You create the password then inform your nominated person.

Food and mealtimes

Breakfast	8.00am - 9.00am
Lunch	11.45am -1.00pm
Dinner	4.45pm - 6.00 pm

We do practice a "Protected Meal Time" to promote dignity and comfort of patients. Relatives, friends and carers are encouraged to assist with helping to feed their relative if they wish to do so.

Visiting times

Please ask a member of the team about our current visiting guidelines. Alternatively you can read our current guidelines on our website by scanning the QR code.

Infection prevention

Most infections can be prevented from spreading by ensuring that good hand washing/hand hygiene takes place. All hospital staff, patients and visitors should use the hand rub available on the ward when they enter and exit. Disinfection of hands using soap and water should also take place again before handling food or drink and after visiting the toilet.

The trust's expectations are that all members of staff should wash their hands before and after interaction with yourself. If you do not witness this, please challenge the staff member and/or escalate to the nurse in charge.

Direct Ward numbers:

01476 464345
01476 464430
01476 464634

Who's who on our ward

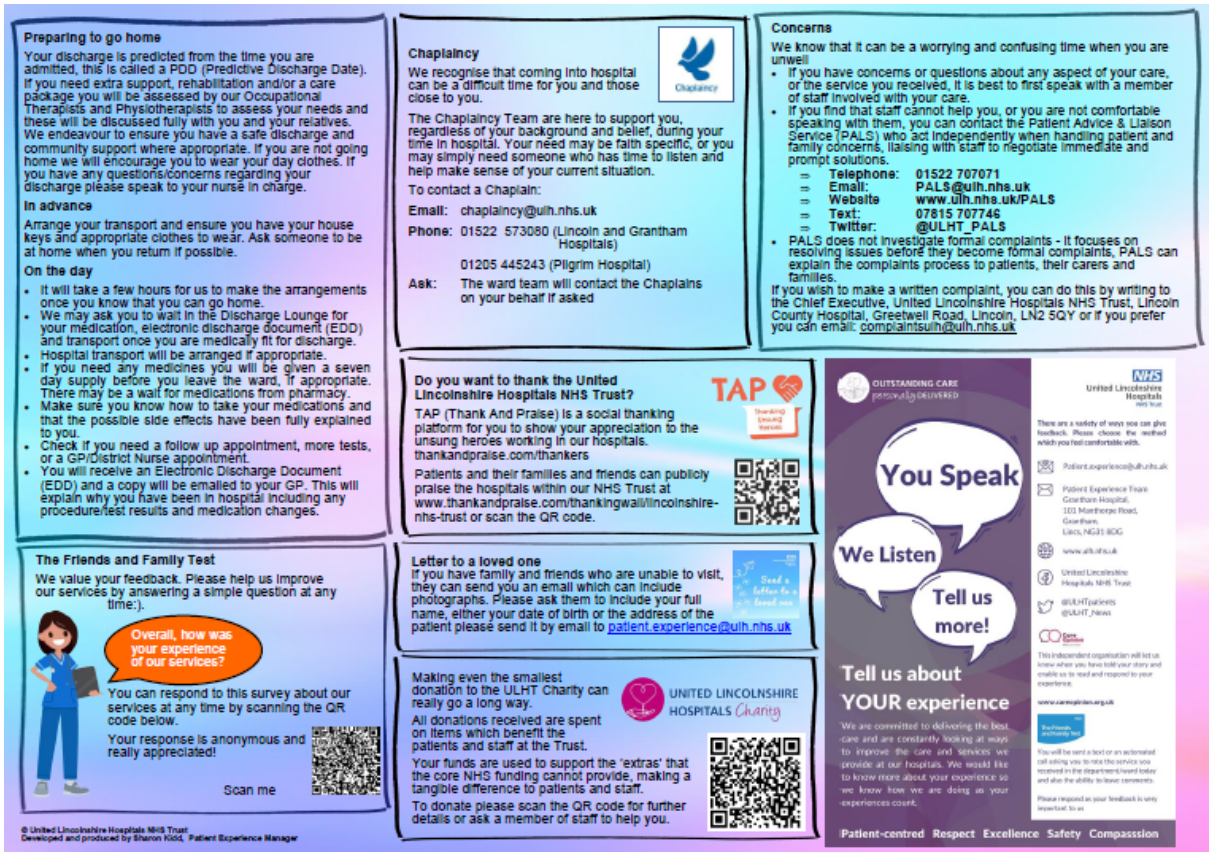
Lead Nurse · Matron · Sister/Charge Nurse · Deputy Sister/Deputy Charge Nurse · Staff Nurse · Acute Care Practitioner · Occupational Therapist · Dietitian · Speech and Language Therapist · Nurse Associate · Trainee Nurse Associate · Healthcare Support Worker · Physiotherapy Assistant · Occupational Therapy Assistant · Assistant Practitioner · Student Nurse · Cadet Nurse · Volunteer · Receptionist · Housekeeper · Porter

Wifi

Patients, visitors and staff have free access to our WI-FI. To join, please select 'NHSWIFI' from the available networks on your mobile device.

Please leave this information mat when you leave us so it can be used by other patients, thank you

Please turn over



Preparing to go home

Your discharge is predicted from the time you are admitted, this is called a PDD (Predictive Discharge Date). If you need extra support, rehabilitation and/or a care package you will be assessed by our Occupational Therapists and Physiotherapists to assess your needs and these will be discussed fully with you and your relatives. We endeavour to ensure you have a safe discharge and community support where appropriate. If you are not going home we will encourage you to wear your day clothes. If you have any questions/concerns regarding your discharge please speak to your nurse in charge.

In advance

Arrange your transport and ensure you have your house keys and appropriate clothes to wear. Ask someone to be at home when you return if possible.

On the day

- It will take a few hours for us to make the arrangements once you know that you can go home.
- We may ask you to wait in the Discharge Lounge for your medication, electronic discharge document (EDD) and transport once you are medically fit for discharge.
- Hospital transport will be arranged if appropriate.
- If you need any medicines you will be given a seven day supply before you leave the ward, if appropriate. There may be a wait for medications from pharmacy.
- Make sure you know how to take your medications and that the possible side effects have been fully explained to you.
- Check if you need a follow up appointment, more tests, or a GP/District Nurse appointment.
- You will receive an Electronic Discharge Document (EDD) and a copy will be emailed to your GP. This will explain why you have been in hospital including any procedure/test results and medication changes.

The Friends and Family Test

We value your feedback. Please help us improve our services by answering a simple question at any time:).

Overall, how was your experience of our services?

You can respond to this survey about our services at any time by scanning the QR code below.

Your response is anonymous and really appreciated!

Scan me

Chaplaincy

We recognise that coming into hospital can be a difficult time for you and those close to you.

The Chaplaincy Team are here to support you, regardless of your background and belief, during your time in hospital. Your need may be faith specific, or you may simply need someone who has time to listen and help make sense of your current situation.

To contact a Chaplain:

Email: chaplaincy@ulh.nhs.uk

Phone: 01522 573080 (Lincoln and Grantham Hospitals)

01205 445243 (Pilgrim Hospital)

Ask: The ward team will contact the Chaplains on your behalf if asked

Do you want to thank the United Lincolnshire Hospitals NHS Trust?

TAP (Thank And Praise) is a social thanking platform for you to show your appreciation to the unsung heroes working in our hospitals.
thankandpraise.com/thankers

Patients and their families and friends can publicly praise the hospitals within our NHS Trust at www.thankandpraise.com/thankingwall/lincolnshire-nhs-trust or scan the QR code.

Letter to a loved one

If you have family and friends who are unable to visit, they can send you an email which can include photographs. Please ask them to include your full name, either your date of birth or the address of the patient please send it by email to patient.experience@ulh.nhs.uk

Making even the smallest donation to the ULHT Charity can really go a long way.

All donations received are spent on items which benefit the patients and staff at the Trust.

Your funds are used to support the 'extras' that the core NHS funding cannot provide, making a tangible difference to patients and staff.

To donate please scan the QR code for further details or ask a member of staff to help you.

UNITED LINCOLNSHIRE HOSPITALS Charity

Concerns

We know that it can be a worrying and confusing time when you are unwell

- If you have concerns or questions about any aspect of your care, or the service you received, it is best to first speak with a member of staff involved with your care.
- If you find that staff cannot help you, or you are not comfortable speaking with them, you can contact the Patient Advice & Liaison Service (PALS) who act independently when handling patient and family concerns, liaising with staff to negotiate immediate and prompt solutions.
  - ⇒ **Telephone:** 01522 707071
  - ⇒ **Email:** PALS@ulh.nhs.uk
  - ⇒ **Website** www.ulh.nhs.uk/PALS
  - ⇒ **Text:** 07815 707746
  - ⇒ **Twitter:** @ULHT_PALS
- PALS does not investigate formal complaints - It focuses on resolving issues before they become formal complaints, PALS can explain the complaints process to patients, their carers and families.

If you wish to make a written complaint, you can do this by writing to the Chief Executive, United Lincolnshire Hospitals NHS Trust, Lincoln County Hospital, Greetwell Road, Lincoln, LN2 5QY or if you prefer you can email: complaintsulh@ulh.nhs.uk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

You Speak

We Listen

Tell us more!

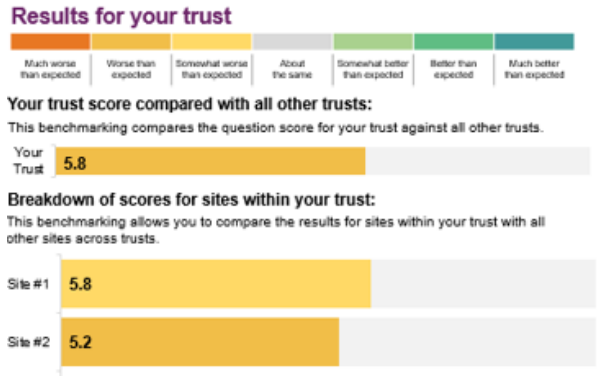
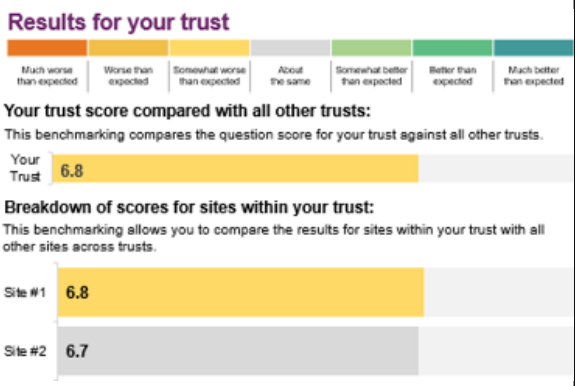
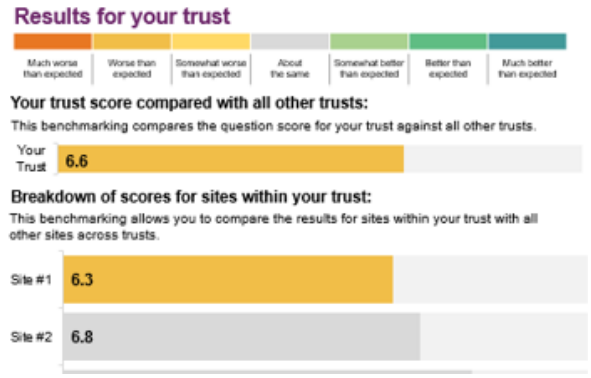
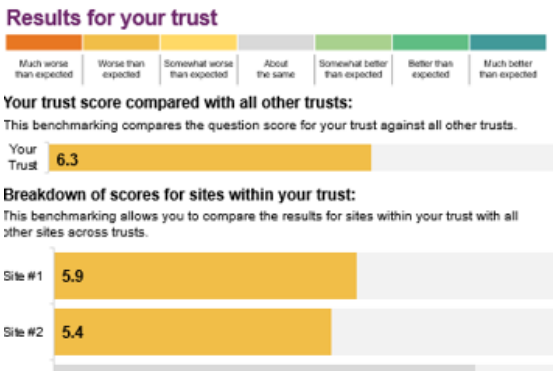
Tell us about YOUR experience

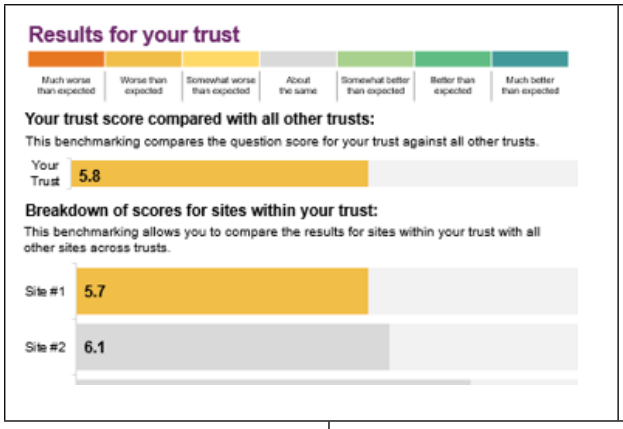
We are committed to delivering the best care and are constantly looking at ways to improve the care and services we provide at our hospitals. We would like to know more about your experience so we know how we are doing as your experiences count.

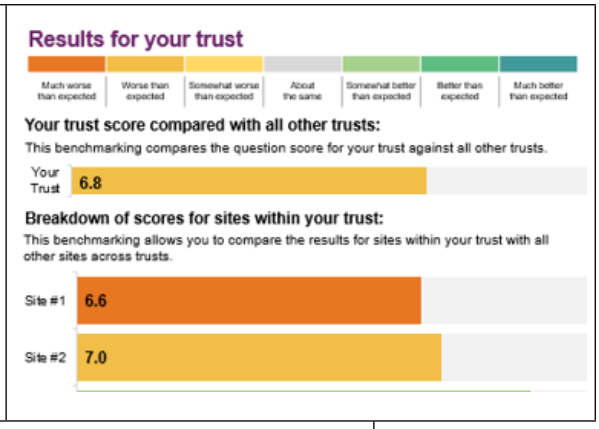
Patient-centred Respect Excellence Safety Compasssion

APPENDIX 6 | National inpatient survey 2020. Worse scoring questions

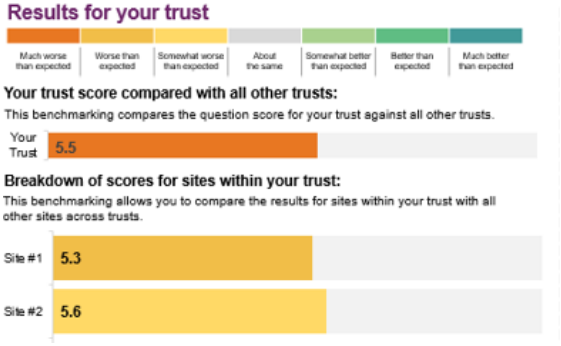
(site #1 = Lincoln, site #2 = Pilgrim)

Did staff explain the reasons for changing wards during the night in a way you could understand? 	To what extent did hospital staff take into account your family or home situation when leaving hospital? 
Were you given enough notice about when you were going to leave hospital? 	Before leaving hospital were you given any written information about what you should or should not do after leaving hospital? 
Before you left hospital did you know what would happen next with your care?	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?





After leaving hospital did you get enough help from health or social care services to help you recover or manage your condition?



APPENDIX 7 | Patient Panel IIP milestone plan

	Objective	Actions	Target milestone	Completion
1	Develop Patient Panel terms and process	Develop Model & Terms of Reference	Aug-20	Aug-20
2	Recruit pannelists	Engage with Trust Membership & HW	Aug-20	Aug-20
		Develop Honorary Volunteer packs	Aug-20	Aug-20
		DBS checks	Sep-20	Oct-20
		e-learning (Safeguarding, COVID, ED&I, IG)	Oct-20	Oct-20
3	Launch Panel	Schedule meetings & agendas	Sep-20	Sep-20
4	Evaluate Panel	Design pannelists survey	May-21	Jun-21
		Design presenters survey	May-21	Jun-21
		Undertake survey	May-21	Jun-21
		Report & make recommendations	May-21	Sep-21
5	Implement evaluation recommendations	Agree recommendations with pannelists	Jun-21	Sep-21
6	Recruit new members	Engage with Trust Membership & HW	Jul-21	Jul-21
		Calls to those interested	Jul-21	Jul-21
		Sign up as Honorary Volunteers	Sep-21	Sep-21
		DBS checks	Sep-21	Sep-21
		e-learning (Safeguarding, COVID, ED&I, IG)	Sep-21	Dec-21

APPENDIX 8 | Visiting precautions

A range of documents were developed to support the various levels of restrictions and precautions

- Visiting Procedure
- Ten Steps to Safe Visiting
- Ward booking templates
- Visitor Information
- Exceptions risk assessment
- Carers risk assessment
- SOP for patient property
- Carers & companions in OPD
- Carers & companions in ED

Visiting precautions timeline

Apr-21	ULHT visiting suspension continues	· Meeting held re: LFT for EoL visitors and decided not to implement.
		· Guidance updated to reflect that all visitors would be encouraged to undertake home LFT prior to visiting.
		· EIA / QIA re: LFT for EoL completed.
		· Procedural updates and preparations completed in readiness for reintroducing.
May-21	Controlled visiting introduced	· From 3rd May controlled visiting introduced.
Jun-21	Roadmap delayed; controlled visiting con	· 30th – review meeting held in anticipation of new 'Freedom Day' 19.07.21
Jul-21	Controlled visiting continues	· 9th – proposal presented to Gold to increase visiting opportunities; agreed to continue to develop and consider closer to 19th July.
		· Gold decision to continue with controlled visiting following national guidance that precautions continue in hospital settings despite national precautions being lifted.
Aug-21	Visiting suspended from 11.08.21	· 5th – proposals to Gold to in light of increased community prevalence & staff absences. Agreed to continue controlled visiting & move to IPC led decision on local suspensions.
		· 6th – decision to suspend visiting from 11.08.21; review in 4 weeks.
		· 24th Proposal for increased visiting opportunities presented to Gold in preparedness of lifting suspension.
Sep-21	Controlled visiting (Salus Principles) reintroduced 09.09.21	· Procedure and associated documents reviewed and updated to reflect risk based approach to ward bays.
Oct-21	Controlled visiting continues	
Nov-21	Controlled visiting continues	
Dec-21	ULHT visiting suspension 16.12.21	In light of Omicron variant visiting suspended other than exceptional circumstances; risk asessmets reviewed and updated. Carers & Companions to OPD and ED reviewed and updated.
Jan-22	01.01.22 new national visiting guidance published	Requirement to introduce proof of negative LFT prior to visiting. Process agreed commencing 31.01.22
	20.01.22 Gov. Announcement that Plan B stepping back to Plan A.	Guidance, risk assessments and procedures in place including: - Controlled visiting aligned to Salus principles. - Strengthened Exceptions guidance for EoL and Carers. - ED & OPD carers & companions guidance reviewed December 21. - Proof of negative LFT process agreed and commencing 31.01.22.
	26.01.22	Introduced 'Controlled +' Visiting - Reduced numbers permitted per bay at a time – as per graphic. - Permit sharing of a slot between 2 people but both must have negative LFT check.
Mar-22	ULHT visiting suspension 30.03.22	Due to rising cases and staff absences.

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NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*05 July 2022*
Item Number	*Item 8.5*
Update on CQC Improvement Action Plan in Response to 2022 Inspection Report	
Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Jeremy Daws, Head of Compliance*
Report previously considered at	*Relevant 'cuts' of the CQC plan are shared with: Executive Leadership Team; Trust Leadership Team; Quality Governance Group, Finance & Performance & Estates Committee; People and Organisational Development Committee*

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

Risk Assessment	*Not Applicable*
Financial Impact Assessment	*Not Applicable*
Quality Impact Assessment	*Not Applicable*
Equality Impact Assessment	*Not Applicable*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	*Trust Board is asked to:-* • *note the update report on progress against the 2022 CQC Inspection actions* • *note (section 4) for assurance purposes the current oversight and assurance and escalation reporting to remove any barriers to progress*

1. Background

- Following the unannounced CQC core-service inspection and the announced Well-Led inspection during the months of October and November 2021, CQC published their findings on the 8 February 2022. The Trust has responded to the CQC with a copy of our intended improvement plan.
- The CQC improvement action plan has been developed with divisions and is updated with divisional owners at regular intervals.
- This paper is designed to summarise for the Trust's Board progress against the CQC improvement action plan.
- Included in the scope of this paper are the actions being taken in response to the 'must-do' or 'should-do' requirements from the 2022 published inspection report. The full CQC improvement action plan is attached as appendix 1.

2. Executive Summary

- **Appendix 1** provides the CQC improvement action plan in response to the 'must-do' and 'should-do' actions from the published 2022 inspection report.
- In total there are 54 improvement actions that relate to the 2022 published inspection report. These are all open and underway.
- Within most of the 54 improvement actions there are a series of underpinning sub-actions. As at 20 June 2022, there are 166 underpinning sub-actions currently detailed within the improvement action plan.
- **NB:** The CQC improvement action plan is a 'live' document, being reviewed and updated throughout the month. As part of this process, the number of underpinning sub-actions may be subject to change, as progress is made resulting in closure or inclusion of additional sub-actions.
- As at the 20 June 2022, the following progress is reported:

2022 Inspection Report: CQC Improvement Action Plan:		
	Jun-22	
Number of CQC Improvement actions:	54	
Number of CQC sub-actions:	166	
BRAG Rating Matrix:		
Blue [Completed and embedded]	26	15.66%
Green [Completed but not yet fully embedded/evidenced]	45	27.11%
Amber [In progress/on track]	62	37.35%
Red [Not yet completed/significantly behind agreed timescales]	30	18.07%

  - 71 or 43% have been completed or are in the process of being embedded;
  - 30 or 18% of sub-actions are currently rated as 'Red' or overdue.
  - For greater detail, please refer to section 3 of this report and appendix 1 for the full action plan.
  - **NB:** 3 of the 166 sub-actions have been closed as no longer relevant and replaced with more relevant actions.

- **Focus on 'Must-Do' Actions:**
- From the 2022 inspection report, there were 5 'must-do' actions that the Trust must take in order to comply with its legal obligations, to demonstrate compliance with Regulation 12 and 13 of the Health and Social Care Act 2008.
- In summary, as of the 20 June, the following progress is reported:

2022 CQC Inspection Report: Focus on the 5 'Must-Do' Actions		
	Jun-22	
Number of CQC Improvement actions:	5	
Number of CQC sub-actions:	30	
BRAG Rating Matrix:		
Blue [Completed and embedded]	7	23.33%
Green [Completed but not yet fully embedded/evidenced]	13	43.33%
Amber [In progress/on track]	2	6.67%
Red [Not yet completed/significantly behind agreed timescales]	7	23.33%

  - 20 or 67% have been completed or are in the process of being embedded;
  - 7 or 23% of sub-actions are currently rated as 'Red' or overdue.
  - For greater detail, please refer to section 3 of this report and appendix 1 for the full action plan.
  - **NB:** 1 of the 30 sub-actions has been closed as no longer relevant.

3. Detailed Progress Update:

3.1 Focus on: Must-do actions:

3.11: CQC2021-01 & CQC2021-04: *The trust must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.*

- There are zero sub-actions red rated as overdue.
- All (100%) relevant staff with the Emergency Department (ED) have received training in using the child protection information system (CP-IS) and have access to this.
- Two pilots have been undertaken to review and refine the process for reviewing CP-IS and recording this within the ED record. Following evaluation of the two processes, all departments have now standardised the process with Safeguarding team input.
- The Trust approach was standardised in June and will be evaluated through audit and further action will be informed from the audit findings.

3.12: CQC2021-02 & CQC2021-05: *The service must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. [Patients waiting on ambulances should be reviewed by medical staff within an hour and within 30 minutes where the national early warning score is five or more or requiring prioritisation]. Regulation 12 Safe care and treatment.*

- There are 5 sub-actions red rated as overdue. These actions relate to:
  - The ED Casualty Card documentation has been amended to include additional detail for assurance purposes relating to where a patient is assessed. This revised document is currently being approved through Governance for use. This presents a low risk.
  - The Trust's Standard Operating Procedure (SOP) has been revised so that it outlines processes to mitigate the risk posed from waiting in ambulances due to capacity constraints within the department during times of peak pressure. This has been communicated to staff within the department. The process to evidence compliance, for assurance purposes, has now commenced but is not robustly in place at this time. This data will be used to inform practice and be overseen by the ED Governance group. This will be further embedded into the departments electronic Nurse in charge assurance process. However, the Trust's standard practice of identifying incidents should they occur remains in place. This presents a low risk.
  - The revised SOP has not yet been incorporated into the Trust's Clinical Operational Flow policy. Work is underway to finalise the policy by the end of June in line with the System action plan and NHSE/I guidance. This presents a low risk.

3.13: CQC2021-03: Lincoln: *"The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment."*

- There are 2 sub-actions red rated as overdue. These actions relate to:
  - Review of options available to support mitigate, in the short term, some of the environmental challenges identified within the maternity block relating to raised temperatures in rooms where medicines are stored. The service have undertaken all actions to mitigate this as far as possible and have now enlisted the help of the Trust's Estates team. A comprehensive programme of refurbishments are planned and will provide the longer term resolution to this challenge. This presents a medium risk.

3.2 Focus on: Should-do actions: Rated as overdue:

Corporate: 2021-11: 'Should-do' *The trust should ensure they are using timely data to gain assurance at board. [**Trust wide**]*

- An options appraisal paper needs to be considered by the Finance, Performance and Estates Sub-Committee of the Board to address this CQC 'should-do'. This presents a low risk.

Corporate: 2021-13: 'Should-do' *The trust should ensure it has access to communication aids and leaflets available in other languages. [**Trust wide**]*

- A number of actions have been agreed with regards improving patient information provision.

- Further work is underway to understand the differences in information for patient provision and how the Trust accesses translation facilities.
- A revised policy has been approved at the Patient Experience Group that seeks to bring greater clarity to the processes in place for information for patients.

UEC: 2021-35: 'Should-do' *The trust should ensure deteriorating patients are identified and escalated in line with trust policy. [**UEC, Pilgrim**]*
And
2021-33: 'Should-do' *The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances. [**UEC, Pilgrim**]*

- The actions are the same as those related to the 'Must-do', specifically ensuring robust assurance on compliance with the revised and reissued Standard Operating Procedure (SOP). Assurance evidence has now become available, work is underway to ensure this is robust and regular to inform compliance and provide assurance. This presents a low risk.

UEC: CQC2021-13: 'Should Do' *The trust should ensure it has access to communication aids and leaflets available in other languages. [**UEC, Trust**]*

- Recognising the particular needs of the department which is accessible 24/7, a specific meeting between UEC and the Patient Experience team is being organised to understand the needs and determine what the current gaps are.

UEC: CQC2021-31: 'Should Do' *The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to. [**UEC, Pilgrim**]*

- A revised cleaning checklist linked to the Nurse in charge booklet has been implemented at Lincoln. Further understanding is required to determine if this has also been launched at Pilgrim and Grantham. This presents a low risk.
- Recognising the challenge of providing assurance that bed spaces are kept clean throughout the busy department, the team are scoping out how best to demonstrate this and provide robust assurance evidence. This presents a low risk.

CYP: CQC2021-12: 'Should Do' *The trust should ensure all patient records and other person identifiable information is kept secured at all times.* ***[Trust]***

- Additional scoping of actions is required to ensure the consistency of learning and communication to medical staff regarding the importance and practical steps to support improvement information security within the ward environment.

CYP: CQC2021-14: 'Should Do' *The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.* ***[Trust]***

- There are some shortfalls in the estate relating to worn surfaces and flooring within the Children's Ward at Lincoln County Hospital. Timescales for resolution of these issues are in the process of being provided.

CYP: CQC2021-19: 'Should Do' *The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy. [**CYP, Lincoln**]*

- Thermometers for undertaking daily ambient temperature checks have been installed in all sites Theatre departments. The assurance evidence to demonstrate these are

being used in line with Trust policy is in the process of being developed using the Matrons audits with a feed into the divisional performance meeting.
- Theatres are also one of the pilot sites for the roll-out of remote temperature monitoring probes.

Maternity: CQC2021-29: 'Should-Do' *The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff.* ***[Maternity, Lincoln]***

- Assurance paper received through MNOG which demonstrated revised compliance trajectories. Current competence rates are: LCH - 47%; PBH - 75%. Trajectory for competencies to be achieved is Nov 22 and July 22, respectively for each hospital site. In the interim to ensure patient safety, the following steps have been taken:
    - Every shift is covered by a member of staff who is trained in general anaesthesia recovery.
    - Patients are kept in theatre until extubated and conscious, therefore care is provided in such instances by Theatre Recovery staff. This model is considered by the Trust to be best practice with midwifery support to Theatre Recovery Teams. This presents a low risk.

CYP: CQC2021-41: 'Should Do' *The trust should consider all key services being available seven days a week.* ***[CYP, Pilgrim]***

- The CBU are in the process of identifying any gaps in services available and quantifying the scale of issues (and scoping mitigations).

CYP: CQC2021-42: 'Should Do' *The trust should consider routine monitoring or auditing of waiting times for children to have a medical review as per the Royal College of Paediatrics and Child Health (RCPCH).* ***[CYP, Pilgrim]***

- Previously the Trust had in place a programme of audits to seek assurance data on waiting times for children. The Trust is planning on reinstating this programme of audit assurance data.

Medicine: CQC2021-14: *The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.* ***[Trust]***

- Estates and environmental issues are identified through monthly audits with monthly divisional reporting to an oversight group (IPCG). Routine meetings take place with Estates and Facilities to create "snag lists" of issues that need to be addressed. In addition there are some ward areas with estate-related challenges. Options are being considered to address issues identified. This presents a low risk.

4.0 Trust CQC Assurance Process:

4.1 Assurance and Escalation:

- The Trust's CQC Assurance Process includes the following steps to seek assurance and escalate any actions not meeting set timescales:
    - Sub-committees of the Board now receive their own 'cut' of the CQC improvement action plan outlining progress against timescales set.
    - Escalation reporting to the Trust's Executive Leadership Team (ELT) and the Trust Leadership Team (TLT) focussed on any areas of concern or 'red' rated overdue actions.

- Inclusion within the divisional performance meetings a slide outlining key areas of progress against the CQC improvement action plan and escalation of any areas of concern and ‘red’ rated, overdue, actions to enable escalation of risks and issues.
- Executive Director CQC Assurance Meetings with the Director of Nursing and Medical Director seek assurance from divisions on any actions with blockages to progress identified and those actions ‘red’ rated as overdue.

4.2 Next steps:

- The Executive-Led Assurance meeting will consider during July the first updates from corporate owned CQC action owners.
- Actions from the first two Executive-Led Assurance meeting, including agreed communications plans will be acted upon.

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 20/06/2022

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-06	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure that staff complete mandatory training in line with trust targets. Including but not limited to the highest level of life support, safeguarding and mental capacity training.	All	The Trust's established process for overseeing and targeting improvement around mandatory training and appraisal rates will be strengthened as a result of an increased focus through the Performance Review Meetings (PRM) with increased assurance reporting to the People and Organisational Development Sub-Committee of the Board. Improvement trajectories will be set via the PRM process with divisions. Target to achieve is 95% to have completed mandatory training. Key performance indicators to be included to summarise progress along with highlight reporting.	Claire Low (Deputy Director of People)	31-Mar-23	Amber		(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.	(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.		Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)
CQC2021-07	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.	All	The Trust has already established work streams focussed on ensuring sufficient nursing and medical staff. The Nursing work stream includes the process for twice daily oversight arrangements, annual nurse staffing reviews for all ward areas led by the Director of Nursing and reporting through to Trust Board. This is supported by the Trust's 5-year workforce plan which includes new and emerging roles. Key performance indicators to be included to summarise progress along with highlight reporting.	Helen Clark (Assistant Director of Nursing for Workforce & Education) Claire Low (Deputy Director of People) Lisa Geraghty (HR)	31-Mar-23	Amber		(1) Reporting to PODC committee on progress with workforce plans; (2) Progress with key workforce indicators.	(1) Reporting to PODC committee on progress with workforce plans; (2) Progress with key workforce indicators.		Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)

CQC2021-08	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure there are mechanisms for providing all staff at every level with the development they need through the appraisal process.	All	The Trust's established process for overseeing and targeting improvement around mandatory training and appraisal rates will be strengthened as a result of an increased focus through the Performance Review Meetings (PRM) with increased assurance reporting to the People and Organisational Development Sub-Committee of the Board. Improvement trajectories will be set via the PRM process with divisions. Target to achieve is 90% to have an appraisal. Key performance indicators to be included to summarise progress along with highlight reporting.	Claire Low (Deputy Director of People)	31-Mar-23	Amber		(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.	(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.		Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Divisional/CBU Leads (see Divisional / CBU CQC Improvement Action Plans)	31-Dec-2022	Amber		(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met; (3) Oversight through PRM process.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-10	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.	All	The Trust have an established improvement programme of work in place to review and manage the work required to improve medicines management. Medicines management related themes and findings from the CQC inspection have been included within this programme of work. The Medical Director chairs the Medicines management T&F group to oversee delivery of this work. Key performance indicators will be scoped and included to summarise progress along with highlight reporting.	IIP Improvement Project focussing on Medicines Management	Various	Amber		(1) Assurance reporting from IIP programme of work; (2) Assurance reporting into QGC sub-committee.	(1) Assurance reporting from IIP programme of work; (2) Assurance reporting into QGC sub-committee.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
CQC2021-11	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they are using timely data to gain assurance at board.	All	Provide a paper to FPEC considering options available in response to CQC Should-do action. Establish additional milestones in response to actions agreed at FPEC.	Shaun Caig (Associate Director of Performance & Information)	30-Apr-2022	Red		(1) Paper to FPEC summarising options; (2) Actions agreed in response.	(1) Board reporting of performance.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	All	Update Trust provision of information to patients policy (ULHT-NUR-PPI-PDWPI) to include process for escalation to PEG should 'information owners' not update existing information resources in line with periodic, 2 yearly review dates.	Sharon Kidd (Patient Experience Manager)	31-Mar-22	Green		Revised policy in draft.	Evidence from information resource register showing ongoing work to update information with escalation to PEG for those overdue review; Evidence that overdue information is being risk stratified and escalated accordingly to PEG.	The Trust policy has been updated to reference reporting through to PEG and escalation steps where steps in the Trust policy are in danger of not being followed.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Approve new policy at PEG.	Sharon Kidd (Patient Experience Manager)	10-May-22	Green	08-Jun-22	(1) Minutes of PEG demonstrating approval of policy.	None.	Revised policy has been submitted to PEG and approved.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Refine quarterly PEG update report regarding patient information to include escalation of specific areas/owners of overdue patient information.	Sharon Kidd (Patient Experience Manager)	30-Apr-22	Red		Revised PEG update; Minutes from PEG when update received.	Evidence from information resource register showing ongoing work to update information with escalation to PEG for those overdue review; Evidence that overdue information is being risk stratified and escalated accordingly to PEG; Outcome evidence: reducing numbers of overdue patient information.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

						All	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	Divisional CQC action plan owners (with support from FAB champions).	Set with divisions.	Amber		Evidence of listening opportunities from divisions to identify information resources required by local population.	Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Divisions to assign 'information owners' to provide information resources in response to feedback from local patients.	Who: Divisional CQC action plan owners to nominate lead 'information owners'.	To confirm on completion of divisional scoping.	Amber		Evidence of information resources completed in response to listening events with patients; Evidence of these resources being entered onto the information resource register (held by Patient Experience team).	Metrics for ongoing assurance: Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Divisions to undertake a walk-around/audit of current patient information resource available and being provided to patients within the division and compile a register, to include what languages the information is available in.	Divisional CQC action plan owners to nominate action leads.	Set with divisions.	Amber		Register of locally held patient information resources being provided to patients.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Patient Experience team to update the Trust central register with findings from the walk-around/audit and compare and contrast with Trust standards for patient information and determine if further action is required to update the information being provided (i.e. update/refresh the information - Divisional lead required; or update the format - Patient Experience team).	Scope out action needed on completion of audit and scope of work better understood.	Set on completion of audit and scope of work better understood.	Amber		Updated central register of patient information available and work required as a result of audit/updated register.	Evidence from Patient Experience team that patient information in use is in keeping with Trust approved standards and formatting through ongoing reporting to PEG/links to electronic information available in multiple languages via MS Edge.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Refresh Patient Experience strategy and determine KPIs relating to the provision of patient information.	Jennie Negus	30-Apr-22	Red		Refreshed patient experience strategy with KPIs to support delivery.	Update reporting on progress with strategy to PEG and measurement against agreed KPIs.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Patient Experience team to work with Maxine Skinner and Denise to ensure communication aids and resource folders are available in the department and agree further actions to ensure these resources are communicated with the wider team and made use of.	Sharon Kidd (Patient Experience Manager)	31-Mar-22	Red		Copies of resource available; Scope out further milestones required/timescales/leads at this time.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Patient Experience team to determine with UEC leads how communication with patients/carers whose first language is not English is currently facilitated and determine what resources would support this to be more effective.	UEC leads with support from Patient Experience Team.	30-Apr-22	Red		Scoped out detail of what resources would support improved communication with patients presenting in UEC; Scope out further milestones required/timescales/leads at this time.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Patient Experience team to liaise with specialist teams (i.e. Learning Disability CNS) and review patient/service user feedback to determine if further information in easy read is required, and scope additional milestones/timescales accordingly.	Sharon Kidd (Patient Experience Manager)	30-Mar-22	Red		Scoped out detail of what resources are required and a plan to deliver; Scope out further milestones required/timescales/leads at this time.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Scope out plan for translation of internal information resources into different languages.	Jennie Negus (Head of Patient Experience); Sharon Kidd (Patient Experience Manager)	30-Apr-22	Green		(1) Plan for translation of patient information resources.	None.	There is a plan to enable current information resources to be made more accessible on a public facing internet site to enable service users to access these resources, using their own devices to translate or make more accessible.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Upload all known patient information resources (approximately 300) to the Trust's public facing website.	Sharon Kidd (Patient Experience Manager)	30-Sep-22	Amber		(1) Trust website updated with information resources for patients to access	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Develop communication plan to ensure that clinical areas know where to access information resources and are able to signpost service users to. Include within this messages relating to the use of QR codes to enable easier access.	Sharon Kidd (Patient Experience Manager)	TBC	Amber		(1) Plan for communications; (2) Evidence of communications used.	(1) Public facing communications to enable patients locate information resources and download these.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Review outcomes from the walk-around audit completed in Family Health and agree next steps to support timely information provision.	Sharon Kidd (Patient Experience Manager)	TBC	Amber		(1) Plan for next steps needed following the audit.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.	All	Service specific actions relating to the estate (i.e. the £37m development of a new Emergency Department at Pilgrim) are outlined within the service level improvement action plans.	For further detail see the service level improvement action plans.	For further detail see the service level improvement action plans.	Amber			For further detail see the service level improvement action plans.	For further detail see the service level improvement action plans.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

						All	Undertake a 6-facet survey to refresh the Trust's understanding of current estate conditions to further support the Trust to take a risk based approach.	Michael Parkhill (Director of Estates & Facilities)	31-Dec-22	Amber		(1) Evidence of findings from 6-facet survey; (2) Evidence of inclusion of key areas from the 6-facet survey into the Trust's estate plans.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
						All	The Trust is continuing to focus on strengthening its Planned Preventative Maintenance (PPM) regime with ongoing assurance reporting through the Trust's Finance, Performance and Estates Committee. This is supported by the appointed Authorising Engineers (AEs) across the Trust focussed on all aspects. The Premises Assurance Model (PAM) provides a key assurance function as part of this process. This is a business as usual action.	Michael Parkhill (Director of Estates & Facilities)	31-Mar-23	Amber		(1) FPEC assurance reporting of progress with planned preventative maintenance regime; (2) FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; (3) PAM assurance reporting into FPEC; (4) FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; (5) AE reporting from key subgroups (i.e. water, fire, electrical).	(1) FPEC assurance reporting of progress with planned preventative maintenance regime; (2) FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; (3) PAM assurance reporting into FPEC; (4) FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; (5) AE reporting from key subgroups (i.e. water, fire, electrical).		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

NHS
United Lincolnshire Hospitals
NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 20/06/2022

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URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating BRAG	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes
CQC2021-01	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	UEC	The flowchart describing the correct process has been reinforced within ED. This will be supported by the Safeguarding team who have commenced education work with key staff as part of team huddles and supervision sessions. This education work will be completed by 30 November 2021. A record of staff trained will be maintained for assurance.	Elaine Todd (Named Nurse for Safeguarding Children and Young People); Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie Peet and Sharon Laverton / Vikki Hoadley (ED Clinical Educators)	31-Mar-2022	Green	20-Jun-2022	(1) Training records for ED staff; (2) Evidence of this being added to UEC risk register.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.	Confirmation received from ED that all relevant staff have now completed CPIS training.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-04	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Must Do	The service must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	UEC	A compliance audit was already planned by the Safeguarding team, this will be undertaken as planned on this process retrospectively and will be completed by 5 November 2021. A re-audit will be undertaken following delivery of educational sessions. This will be completed by 31 January 2022.	Elaine Todd (Named Nurse for Safeguarding Children and Young People)	31-Jan-2022	Blue	31-Jan-22	(1) Audit findings / report; (2) Action plan in response.	(1) Monthly audit to be undertaken to test compliance.	A monthly schedule of audits has been agreed by which the Safeguarding team will support the ED team by undertaking these assurance audits.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	A list of those who cannot access care-portal within ED is needed and then access needs to be requested from IT.	Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie and Sharon (ED Clinical Educators)	31-Mar-2022	Green	09-Jun-2022	(1) Evidence of access arrangements to Care Portal being in place for existing staff.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.	Staff automatically have access to Care Portal via their permissions provided to them once given systems access on commencing their role within the department.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Include within ED nursing competencies Safeguarding and access to the National Child Protection Register spine to ensure this training/education is provided on a routine and regular basis.	Maxine Skinner (Lead Nurse Urgent & Emergency Care) Ellie and Sharon (ED Clinical Educators)	31-Mar-2022	Green	09-Jun-2022	(1) Inclusion of Safeguarding training as part of induction programme for new starters; (2) Inclusion of access to the Care Portal system as part of the induction programme for new starters.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.	Assurance provided by the department that CP-IS training has been included within the departments local induction process to ensure new nursing/medical staff receive this training on commencement of their employment in the Department.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Implement monthly audit process to monitor compliance and to provide assurance that process is fully embedded.	Tracey Wall (Divisional Nurse); Craig Ferris (Head of Safeguarding)	31-Mar-2022	Green	31-Mar-2022	(1) Monthly audit data; (2) Action plan in response; (3) Findings from audit demonstrate compliance.	(1) Monthly audit data demonstrating compliance; (2) Reporting to appropriate UEC governance arrangements; (3) Upward report to CYP Oversight Group.	Monthly audit results are now being provided for assurance purposes to demonstrate performance with checking the Nationally Approved Child Protection Register.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Monthly audit results do not show improvement. Review performance and agree plan of improvement actions.	Denise Dodd, (UEC Matron)	31-May-2022	Green	20-Jun-2022	(1) Agreed action plan for improvement on monthly audit findings.	None.	Standardised process agreed following pilot project supported by audit evaluation.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Undertake compliance audit of June 2022 following standardising CP-IS process across the Trust and determine action needed as appropriate from the audit findings.	Denise Dodd, (UEC Matron)	TBC	Amber		(1) Agreed action plan for improvement on monthly audit findings.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-02	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.	UEC	Assurance data that patients waiting in ambulances are seen by a doctor.	Cheryl Thomson (General Manager)	01-Nov-2021	Green		(1) 30-Sept-21 Information report which shows first location and time seen; (2) Ambulance handover SOP: Section 2.5; (3) S.31 CQC full assurance report; tab 1 'triage times'; tab 9 '60 mins'.	(1) Information reports from ED system detailing time seen and location first seen; (2) CQC full assurance documentation – tab 1 focus on triage; (3) ED S.31 Assurance Tool focussing on time to be seen by a Doctor.	The evidence supplied provides assurance that patients waiting in ambulances, due to capacity bottlenecks with the Emergency Department, are seen and assessed by a doctor whilst in the ambulance. This mitigates the risk of harm to patients waiting outside of the Emergency Department.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-05	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Must Do	The service must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Patients waiting on ambulances should be reviewed by medical staff within an hour and within 30	UEC	Inclusion of additional field into the Harm template to ensure this is more clearly evidenced from harm reviews.	Cheryl Thomson (General Manager)	01-Nov-2021	Blue	01-Nov-2021	(1) Email request for the UEC harm reviews to include a specific field to capture the time patients receive their first assessment; (2) Copy of amended harm template.	(1) Random, snapshot sample of UEC Clinical Harm reviews	This additional field makes it easier, at the time of undertaking a harm review, for harm to be accurately assessed related to waiting times/locations.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	

					minutes where the national early warning score is five or more or requiring prioritisation. Regulation 12 Safe care and treatment.	UEC	PHP log not felt to be best solution, amendments to CAS card instead have been made that include location of the patient when handed over.	Blanche Lentz (Clinical Services Manager UEC)	31-Aug-2022	Red		(1) Amended casualty card.	(1) Audit evidence of the new CAS card being used in practice and recording where patient has been seen – including ambulance.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Aug-22. This will remain as 'RED' rated.
						UEC	Develop clinically led standardised admission pathways guidance to support ED teams identify: • The primary specialty to take ownership for the ongoing care from the ED • If necessary, and additional MDT input required, this will be undertaken by the primary speciality. These have been agreed by the group, this was ratified during May and June 2021.	Urgent Emergency Care Clinical Standards Group		Blue	01-Oct-2021	(1) Copy of the standardised admission pathway guidance; (2) Minutes from the Urgent Emergency Care Clinical Standards Group evidencing approval of guidance.	(1) Copy of the standardised admission pathway guidance.	Clinically agreed guidance exists to support the Emergency Department consult and seek assistance from specialties for patients waiting in the department. The guidance includes a commitment for specialties to pull patients out of the Emergency Department. Evidence of impact from these standardised admission pathways is now needed.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Review and update the 'Management of Reducing Ambulance Delays in the Emergency Departments' SOP. Ensure this includes links to wider corporate policies and SOPs (i.e. Full Capacity Protocol and the Ambulance Turnaround Protocol) and includes all relevant roles (i.e. Pre-Hospital Practitioners (PHP) and Hospital Liaison Officers (HALO)) and makes it clear that patients are being seen regardless of location (i.e. on ambulances during extreme pressures).	Cheryl Thomson (General Manager)	31-Mar-2022	Blue	05-May-2022	(1) Revised SOP completed and approved.	(1) Evidence that SOP has been added to the Trust's controlled documents procedures and is available for staff to access easily to guide them; (2) Evidence that SOP has a timely review date to ensure guidance remains updated and fit for purpose.	The Pre-Hospital Practitioner SOP has been re-written and agreed at UEC CBU Governance. This SOP outlines actions for patients waiting on ambulances and outlines when these should be reviewed by medical staff and criteria for prioritisation. This has now been added to the Trust's document control system as a corporate document with a review date of 6-months.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Add the Reducing Ambulance Handover Delays SOP into the Clinical Operational Flow Policy.	Michelle Harris (Deputy Chief Operating Officer)	30-Jun-2022	Red		(1) Revised SOP included within the Clinical Operational Flow Policy.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 30-Jun-22. This will remain as 'RED' rated.
						UEC	Revised SOP to include effectiveness measures to track progress with key metrics: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking to provide ongoing assurance against SOP.	Cheryl Thomson (General Manager)	31-Mar-2022	Green		(1) Evidence of effectiveness measures for ongoing monitoring of performance against key metrics.	(1) Evidence that performance with key metrics, as part of revised SOP, are being used for ongoing monitoring of performance against key metrics; (2) Evidence of audit data being used for improvement purposes.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	In the interim, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) ≤ 15 minutes; (b) Doctor assessment ≤ 1 hour; (c) Doctor assessment ≤ 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Jul-2022	Red		(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit; (2) Evidence of audit data being used for improvement purposes.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.

						UEC	Scope out the inclusion of performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking as part of the Trust's Clinical Audit Programme to provide further external assurance.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	30-Apr-2022	Green	06-May-2022	(1) Development of Clinical Audit Project plan.	None.	Project plan drafted for the audit of compliance with the revised SOP and key measures.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Undertake first Quarterly audit project of compliance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	30-Jun-2022	Amber		(1) Audit findings from first audit.	(1) Evidence of ongoing audit for assurance purposes.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Develop an audit tool to obtain this assurance with key milestones. Feed into monthly CBU governance reporting process (escalations to divisions and PRM).	Jeremy Daws (Head of Compliance)	31-Jul-2022	Green	09-Jun-2022	(1) Completed audit tool; (2) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	The audit tool has been developed and approved at ED Governance. This has been used as part of the NIC booklet during the month of June and first data from the audit will be availble during the w/c 13 June 2022.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Add into Harm Review proforma - Has patient been seen within 1 hour. Review in 3 months to see if this is giving assurance needed.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-Mar-2022	[Abandon & Replace]	20-Jun-2022	(1) Email request for the UEC harm reviews to include a specific field to capture this; (2) Copy of amended harm template.	(1) Random, snapshot sample of UEC Clinical Harm reviews	UEC proposal to CHOG regarding a change in process in undertaking the Clinical Harm Review Process results in this sub-action relating to inclusion of ambulance wait question within the process being no longer relevant.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Provide a monthly overview of performance against these key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking. In addition to other related metrics (i.e. time to first assessment etc.) to Governance meeting process.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-Jul-2022	Red		(1) Ongoing monthly assurance reporting.	(1) Ongoing monthly assurance reporting.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Build monthly assurance reporting of key milestones into one of the standard ED assurance processes so this becomes a standard feature of the ED assurance process.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-May-2022	Red		(1) Ongoing monthly assurance reporting.	(1) Ongoing monthly assurance reporting.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-35	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure deteriorating patients are identified and escalated in line with trust policy.	UEC	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Jul-2022	Red		(1) Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; (2) Performance against deteriorating patient audits (sepsis); (3) ED Daily Assurance Tool.	(1) Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; (2) Performance against deteriorating patient audits (sepsis); (3) Ongoing monthly assurance reporting as part of S.31 response process; (4) Completed harm reviews.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.

CQC2021-33	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.	UEC	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Jul-2022	Red		(1) Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; (2) Performance against deteriorating patient audits (sepsis); (3) ED Daily Assurance Tool.	(1) Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; (2) Performance against deteriorating patient audits (sepsis); (3) Ongoing monthly assurance reporting as part of S.31 response process; (4) Completed harm reviews.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Understand performance with DoC at CBU Level and ensure reliable data is available to feed into monthly Clinical Governance processes.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Green	31-Mar-2022	(1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements; (2) Inclusion within the Divisional PRM process.	(1) Ongoing regular reporting of DoC into CBU Governance; (2) Ongoing inclusion within the Divisional PRM process.	Division have confirmed that this is a compliance issue and not a data qualtity issue. UEC performance is being monitored on an ongoing basis.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Review DoC performance data and, through CBU Governance, scope additional improvement actions to be taken.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Green	31-Mar-2022	(1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements.	(1) Use of data to inform improvement action plans.	Duty of candour is now brought through to the strenthened CBU governance meeting for the group's review of latest performance data and to provide regular updates on action being taken and the effectiveness of improvement actions.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Achieve 100% compliance within UEC with verbal and written duty of candour.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-Jul-2022	Amber		(1) Performance reporting of DoC compliance within UEC.	(1) Ongoing assurance of DoC performance for UEC.	Duty of candour is now brought through to the strenthened CBU governance meeting for the group's review of latest performance data and to provide regular updates on action being taken and the effectiveness of improvement actions.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Matrons audits in place currently that monitor this, but this is a recurrent problem. Senior Sisters and Lead Nurse to meet to refine the contents of the B7 daily assurance process which will support proactive action to address performance issues.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Blue	09-Jun-22	(1) Meeting to approve content of the revised NIC assurance process.	None	Paper reviewed and approved at ED Governance for inclusion of this and other topics of relevance to the 2021 inspection visit to be included in the NIC Assurance Process.	Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	
						All	Agreed at ED Governance for this to be added to the NIC Assurance Tool. Task and Finish group established and working with Informatics team to develop draft NIC Assurance Tool for approval and commencement within the department to obtain improved assurance of daily oversight.	Denise Dodd (Matron, Urgent & Emergency Care)	TBC	Amber		(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in the security of records observed.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	

						All	Review availability of CAS card trolleys availability at Pilgrim.	Holly Carter (Senior Sister, ED)	30-Apr-2022	Green	30-Apr-22	(1) Evidence of a review of note storage controls and identification of any gaps.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in the security of records observed.	Additional medical records storage trolley obtained for use in Fit to Sit area to support the change in process at PBH of greater assessment of patients within the area.	Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	UEC	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards). Include patient information as part of the UEC Governance agenda.	Cheryl Thomson (General Manager)	31-Mar-22	Green		(1) Inclusion of patient information within the UEC Governance meeting process/schedule.	(1) Inclusion of patient information within the UEC Governance meeting process/schedule.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Undertake a review of the patient information and identify any gaps where additional information is required.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	30-Jun-22	Green		(1) Evidence of undertaking review of information resources currently available; (2) Review at Governance of review and any gaps identified where further resources are required.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Collate a register of information resources in use within UEC and submit this to the Patient Experience Team to support the strengthening of internal document control processes in relation to patient information.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	30-Jun-22	Amber		(1) Register of information resources currently available.	(1) Ongoing review of information resources available and at UEC Governance as evidenced by document control register.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Patient Experience team to work with Maxine Skinner and Denise to ensure communication aids and resource folders are available in the department and agree further actions to ensure these resources are communicated with the wider team and made use of.	Sharon Kidd	31-Mar-22	Red		(1)Copies of resource available; (2) Scope out further milestones required/timescales/leads at this time.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Patient Experience team to determine with UEC leads how communication with patients/carers whose first language is not English is currently facilitated and determine what resources would support this to be more effective.	UEC leads with support from Patient Experience Team.	30-Apr-22	Red		(1) Scoped out detail of what resources would support improved communication with patients presenting in UEC; (2) Scope out further milestones required/timescales/leads at this time.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. (UEC Specific)	UEC	As part of the LCH work to expand resus area, make other improvements in environment; specifically: (1) Secure paediatric area through installation of swipe card access points. This will prevent unauthorised access (i.e. from fit to sit waiting area that is in close proximity; (2) Improved segregation of Paediatric resus from adult resus areas; (3) Expansion of mental health room capacity (additional room); (4) Improved storage of medicines including premises for IV.	Jemma Bowler (Senior Sister, ED)	30-Sep-2022	Amber		(1) Evidence of improvements made to the environment.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						UEC	Scope out employment for a play specialist for ED area.	Jemma Bowler (Senior Sister, ED)	30-Sep-2022	Amber		(1) Scoped out plan for recruitment of a play specialist.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						UEC	Review arrangements for 1:1 supervision of patients with mental health needs at Lincoln ED.	Jemma Bowler (Senior Sister, ED)	30-Sep-2022	Amber		TBC	TBC		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						UEC	Consider addition of the mental health room (location and staffing oversight) to the departmental risk register.	Jemma Bowler (Senior Sister, ED)	30-Apr-2022	Green	30-Apr-22	(1) Evidence of risk scoping and mitigation actions considered.	None.	Consideration of whether this was a risk that required inclusion within the ED risk register.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

						UEC	New ED at Pilgrim which is valued at £37m and is at the full business planning stage. This is scheduled for Trust Board approval in April, and then for final approval by NHSE/I. Enabling works (included decant of staff) have begun. Build to progress over the next 2 years. Determine if dementia friendly aspects have been included in the plans.	Holly Carter (Senior Sister, ED)	31-Mar-2022	Green	31-Mar-2022	(1) Confirmation that plans for new ED include dementia friendly considerations.	(1) Evidence of dementia friendly considerations included compared with NHS planning guidance for build works.	Confirmation received from ED Manager that Dementia Friendly elements have been built into the new PBH ED plans.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						UEC	13-Apr-22: Attended meeting with ED design and building team, chaired by Grant. Designs for ED shared. Agreed to review specific details of relevance to CQC and get formal responses back to specific subjects of interest in line with the following: 1) Dementia friendly - inc. application of standard NHS Planning Guidance in the process; 2) Paediatrics area of ED - security, segregation from the adult area; RCPCH standards; 3) Anti-ligature rooms.	Grant Holley (Senior Capital Projects Manager)	TBC	Amber		(1) Confirmation of greater detail of plans in place for new ED at PBH and how they support the Trust in terms of providing care in line with CQC KLOE.	(1) Evidence of dementia friendly considerations included compared with NHS planning guidance for build works.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2021-15	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that falls and mental health risk assessments and transfer documentation are in place for patients when they are required and that completion risk assessments and transfer documentation are audited.	UEC	Process for assessing falls risk has been changed to being assessed on entry to ED by the PHP. Once identified as at risk of falling, yellow socks, yellow wristband and falls risk assessment document completed. Meeting with Senior Sisters, Matron and Lead Nurse to be held to incorporate this into the B7 daily assurance review process.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Blue	09-Jun-2022	(1) Meeting to approve content of the revised NIC assurance process.	None	Paper reviewed and approved at ED Governance for inclusion of this and other topics of relevance to the 2021 inspection visit to be included in the NIC Assurance Process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agreed at ED Governance for falls and mental health risk assessments to be added to the NIC Assurance Tool. Task and Finish group established and working with Informatics team to develop draft NIC Assurance Tool for approval and commencement within the department to obtain improved assurance of daily oversight.	Denise Dodd (Matron, Urgent & Emergency Care)	TBC	Amber		(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with falls risk assessments; (3) Improvements in performance with mental health risk assessments.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-34	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.	UEC	A review of the transfer document has been held with UEC and Quality Matrons. The UEC transfer documentation has been merged with the Trust's transfer documentation and SOP. Transfer documentation has been replaced with a sticker, in SBAR format, to be applied to the CAS card and completed in ED before the patient is transferred. Limited supplies of the sticker are available, to launch pilot when there is a greater stock of stickers.	Jemma Bowler & Holly Carter (Senior Sister ED)	31-Mar-2022	Green	31-Mar-2022	(1) Launch of pilot utilising the newly fashioned transfer stickers; (2) Copy of revised sticker; (3) Evidence of communications to staff regarding pilot.	None.	The transfer sticker has been used in practice and well received by staff within the ED. No formal review or audit has been undertaken, rather the view of those using the documentation is positive. A more formal evaluation is now needed.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Review effectiveness of pilot to determine if supportive of improved documentation.	Jemma Bowler & Holly Carter (Senior Sister ED)	30-Apr-2022	Green	31-Mar-2022	(1) Evidence of performance with completion of transfer sticker documentation; (2) Additional actions if needed to support improvements.	(1) Ongoing evidence of audit outcomes demonstrating improved recording and documentation of transfer information via the sticker.	The transfer sticker has been well received by staff within the ED. No formal review or audit has been undertaken, rather the view of those using the documentation is positive. A more formal evaluation is now needed.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agreed to include the transfer sticker information within the new CAS card, to scope out measuring of effectiveness.	Jemma Bowler & Holly Carter (Senior Sister ED)	31-Aug-2022	Amber					Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agree an audit/evaluation process to review the impact and effectiveness of the transfer sticker/revised section of the CAS card. Agree process (i.e. evaluate on IAC/MEAU on arrival of the patient or undertaken snapshot compliance review within ED).	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	TBC	Amber					Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Meeting with Senior Sisters, Matron and Lead Nurse to be held to incorporate mental health risk assessment completion into the B7 daily assurance review process.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Blue	09-Jun-2022	(1) Meeting to approve content of the revised NIC assurance process.	None.	Paper reviewed and approved at ED Governance for inclusion of this and other topics of relevance to the 2021 inspection visit to be included in the NIC Assurance Process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agreed at ED Governance for falls and mental health risk assessments to be added to the NIC Assurance Tool. Task and Finish group established and working with Informatics team to develop draft NIC Assurance Tool for approval and commencement within the department to obtain improved assurance of daily oversight.	Denise Dodd (Matron, Urgent & Emergency Care)	TBC	Amber		(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with mental health risk assessments.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-16	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure, the paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).	UEC	Provide written clarification with evidence to CQC on the following points: • The Paediatric area within the ED, whilst moved to a distinct part of the department, is retained within the UEC management and governance structure. • There is a 24/7 nominated lead doctor, detailed within the rota. • Close links with the CYP team with cross divisional learning and close working between CYP and UEC matrons. Shared with CQC as part of Pilgrim U&E 86 and Pilgrim CYP 49.	Denise Dodd, (UEC Matron) Rebecca Thurlow (CYP Matron)	01-Dec-2021	Blue	15-Nov-2021	(1) 24/7 Paediatric named lead clinician rota; (2) Nursing rota demonstrating nurses on duty 24/7 with paediatric competencies.	(1) 24/7 Paediatric named lead clinician rota; (2) Nursing rota demonstrating nurses on duty 24/7 with paediatric competencies.	A written narrative has been provided to CQC that outlines the functionality of the Emergency Department and how it operates, how systems and controls have been established to care for children within the department. The Trust were concerned that CQC inspectors thought that the Trust had a dedicated Paediatric Emergency Department, when it does not.	Paul Matthew, Director of Finance and OD	People & Organisational Development Committee (PODC)	
CQC2021-36	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure the, paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).	UEC	Review and confirm RCPCH standards for ED departments in ULHT and staffing requirements from the guidance.	UEC CBU Leads	30-Jun-2022	Amber		(1) Completed assessment of the impact on ULHT through a review and gap analysis; (2) Highlight reporting to the Children's and Young People Board.	(1) Highlight reporting to the Children's and Young People Board (and inclusion on the UEC risk register if required).		Simon Evans, Chief Operating Officer	People & Organisational Development Committee (PODC)	
						UEC	Complete workforce review for nursing and medical staff on the back of the gap analysis and draft a business case for additional recruitment to close the gaps (if any).	Cheryl Thomson (General Manager)	30-Jun-2022	Amber		(1) Completed assessment of the impact on ULHT through a review and gap analysis; (2) Highlight reporting to the Children's and Young People Board.	(1) Evidence of a plan to close gaps identified; (2) Clarity on mitigations in place if gaps identified; (3) Highlight reporting to Children's and Young People Board		Simon Evans, Chief Operating Officer	People & Organisational Development Committee (PODC)	
						UEC	Draft a business case based on staffing needs based on demand and capacity work.	Cheryl Thomson (General Manager)	TBC	Amber		(1) Draft business case; (2) Submission for approval.	(1) Evidence of a plan to close gaps identified; (2) Clarity on mitigations in place if gaps identified; (3) Highlight reporting to Children's and Young People Board		Simon Evans, Chief Operating Officer	People & Organisational Development Committee (PODC)	
CQC2021-17	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.	UEC	Refresh CBU Governance process and arrangements for 2022/23 with renewed TOR for UEC Governance and Cabinet meetings.	Cheryl Thomson (General Manager)	31-Mar-2022	Blue	04-Apr-2022	(1) Approved TOR; (2) Minutes evidencing approval of TOR.	None.	ED Governance arrangements have been reviewed and strengthened. Assurance metrics agreed to test impact of strengthening arrangements throughout the year. This approach includes within it the governance arrangements relating to children.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	

CQC2021-39	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.	UEC	Strengthen the UEC Governance processes in line with the revised and approved TOR.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	31-Dec-2022	Amber		(1) 80% of CBU governance meetings achieved; (2) 75% attendance at meetings; (3) Recognising implications of operational pressures - escalate if more than 2 meetings are cancelled to divisional governance; (4) Addition to CBU risk register if operational pressures lead to cancellation of arrangements.	(1) Evidence that Governance meetings are being held; (2) Regular highlight reporting from UEC to Children's and Young People (CYP) Board.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-18	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	UEC	CBU Risk Register has been refreshed. Embed regular review of risk register at strengthened Governance meeting process.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	30-Apr-2022	Green	30-Apr-22	(1) Evidence that risks on the register have a named owner; (2) Risks should be clear and concise; (3) Risks should be reviewed in line with timescales within Trust (new) policy: Very high (20-25): Monthly review; High risk (15-16): review quarterly; Moderate risk (8-12): review quarterly; Low/very low (4-6; 1-3) review 6-monthly; (4) Datix version of risk register to be updated after every review.	(1) Ongoing evidence of Risk Register review; (2) Evidence from meeting documentation that risk register is being reviewed and is effectively capturing risks.	CBU Risk Register has been refreshed and is regularly reviewed at the strengthened Governance meeting process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-40	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	UEC	Include within the UEC risk register the risk around the control of policies and SOPs.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	30-Mar-2022	Green	30-Mar-22	(1) Addition of risk to risk register.	(1) Addition of risk to risk register.	Assurance received that this has been included within the UEC risk register.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-31	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.	UEC	Revised cleaning checklist has been developed. To implement this on a shift by shift basis. To review how this roll-out to be communicated and completion of revised checklist to be completed.	Jemma Bowler & Holly Carter (Senior Sister ED)	31-Mar-2022	Red		(1) Flo-audit completion data; (2) Mattress audits; (3) Matrons audit contains IPC checks.	(1) Flo-audit completion data; (2) Mattress audits; (3) Matrons audit contains IPC checks.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Review completion of domestic cleaning checklist with domestic supervisor and identify any gaps that require further action.	Jemma Bowler & Holly Carter (Senior Sister ED)	30-Apr-2022	[Abandon & Replace]		TBC	TBC	20-Apr-22: On review in greater detail of the context behind this 'Should-do' action and a review of the process within ED, this action has been abandoned and replaced as it is not relevant to the bedspace cleaning process within the department, and therefore unhelpful in addressing the root cause of the issue identified in the CQC report. This has been replaced with a new action focussed on improving the evidence of bedspace cleanlieness within the ED.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	The process for cleaning bedspaces within the department is followed, but is difficult to evidence given the throughput of patients through the ED when under pressure. Scope out and agree appropriate and realistic action in response to be able to better demonstrate and provide assurance that bedspaces are clean.	Denise Dodd (UEC Matron); Jemma Bowler & Holly Carter (Senior Sister ED)	31-May-2022	Red		TBC	TBC		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-32	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure patients at risk of self harm or suicide are cared for in a safe environment meeting standards recommended by the Psychiatric Liaison Accreditation network (PLAN) and mental health risk assessments and care plans are completed for all patients at risk.	UEC	Room 15 has been identified as a suitable room that can be used to assess mental health patients with some modifications. The room has 2 doors meaning suitable access / egress and is situated away from the 'plaster room'.	Blanche Lentz (Clinical Services Manager UEC)	TBC	Amber		(1) Quote for modifications; (2) Photographic evidence of modifications made to Room 15.	(1) Audit evidence of appropriate access/use by MH patients; (2) Ligature risk assessment completed for refurbished MH room.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						UEC	In the interim, until the modifications to room 15 are complete, any patient with mental health conditions requiring use of the room will have 1:1 supervision from a sitter. The staffing template for the unit will enable this in most circumstances, and in situations where this is more challenged, escalation will be made to Site Management Team to support backfill arrangements. This arrangement has been communicated to all the team.	Denise Dodd (UEC Matron)	01-Nov-2021	Blue	01-Nov-2021	(1) Evidence of communication cascade.	(1) Audit to be undertaken in Nov-21.	The need for a 1:1 sitter for patients cared for within room 15 has been communicated to the team and assurance that this is maintained will be included in a regular assurance audit.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

						UEC	The Trust's Estates team have been contacted to fit locks to cupboard doors in the clean procedures room to ensure that there is not easy access to sharps.	Estates	01-Dec-2021	Blue	01-Dec-2021	(1) Photographic evidence of pin locks fitted and in use.	(1) Audit/walk-around visits.	The Trust's Estates team have fitted locks to cupboard doors in the clean procedures room to ensure that there is not easy access to sharps.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						UEC	An audit will be undertaken during November 2021 to test this arrangement and the quality of record keeping. Evidence from this audit will made available for sharing with CQC.	Denise Dodd (UEC Matron)	29-Nov-2021	Blue	20-Jan-2022	(1) Audit findings / report	None	An audit has been completed which demonstrates that all patients with mental health needs who have been cared for in Room 15 within Pilgrim ED have had a 1:1 sitter with them to mitigate the fact that the room has not yet had the required alterations to make this ligature free.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						UEC	Agree a schedule of audits to provide ongoing assurance that enhanced care is provided where needed, including for patients with identified mental health needs.	Holly Carter (Senior Sister, ED)	31-Mar-2022	Green	31-Mar-2022	(1) Evidence of scheduled audits being undertaken; (2) Appropriate action in response to the audit findings.	(1) Ongoing assurance that audits are continuing.	Audits underway monthly at PBH demonstrate that each time room 15 has been used for a patient with Mental Health conditions, a 1:1 sitter has been assigned and supervised the patient whilst in the room.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2021-37	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to investigate incidents in a timely manner and identify and share learning from incidents to prevent further incidents from occurring.	UEC	Backlog of incidents has re-occurred linked to extreme operational pressures. Strengthened governance meetings will include regular ongoing oversight of this area. Theme and trend all backlog of incidents to enable sharing of lessons learnt.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	30-Jun-2022	Amber		(1) Resolution of the backlog; (2) Evidence of learning from the analysis of themes and trends being shared with staff.; (3) Sustained compliance with timescales for Serious Incident Reporting and investigation.	(1) Ongoing oversight of incident reporting metrics to measure effectiveness of the process and assurance that a backlog position does not again appear; (2) Ongoing oversight of Serious Incident Reporting and investigation timescales.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Review the effectiveness of current learning lessons processes in UEC and strengthen if needed.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	30-Jun-2022	Amber		(1) Completed review and evidence of action in response.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups.	Helen Shelton (Assistant Director of Clinical Governance / Patient Safety Specialist)	TBC	Amber		(1) Trust level understanding of mechanisms in use to share learning; (2) Evidence of action in response.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-38	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure clinical pathways and policies are updated in line with national guidance.	UEC	Undertake service by service review to identify and catalogue all SOPs and Policies currently being used or referred to within UEC.	Cheryl Thompson (General Manager)	31-Jul-2022	Amber		(1) List of SOPs and Policies in use; (2) Clear local policy for approval of SOPs and Policies within UEC that includes process to review documents at a scheduled and timetabled point to ensure they remain up-to date and evidence based.	(1) Addition of all SOPs and Policies in use to central register for tracking and control process.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	
						UEC	Review, update and approve all UEC SOPs and Policies and ensure registered as controlled documents, in approved Trust format and stored in the CBU U drive and accessible via the intranet.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	31-Dec-2022	Amber		(1) Evidence that all SOPs and Policies have been reviewed and approved.	(1) Ongoing process to track compliance with the control of SOPs and Policies in use with reference to Trust document control processes.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 20/06/2022

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes
CQC2021-03	Maternity	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.	Maternity	Action taken at the time of the inspection. Trolleys with medications were moved to a secure area.	Dr Suganthi Joachim (Division Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Divisional Managing Director)	31-Oct-2021	Green	31-Oct-2021	(1) Evidence submitted as part of core service evidence request; (2) Evidence of communications to team; (3) Evidence of more security for trolleys (locker type trolley).	(1) B7 Assurance process (weekly) includes an assessment of security of medications.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Wall thermometer ordered. Daily check added to the daily check list. Staff aware of escalation process if needed.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Oct-2021	Green	31-Oct-2021	(1) Wall thermometer in place; (2) Daily check added to the daily check list; (3) Audit of the process.	(1) Review of daily checks; (2) Survey of staff regarding action needed if temperature too high; (3) B7 Assurance process (weekly) includes an assessment of this point; (4) Pharmacy pro-forma outlines process of what to do with out of range temperatures in relation to medicines storage.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Map out across Maternity at both sites locations where medicines (drugs rooms (inc. fluids), medication fridges, mobile trolleys) are stored	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue		(1) Map of locations within Maternity at both sites outlining where medicines are being stored.	(1) 6-monthly review to determine if any changes in process/location for storing medicines.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Undertake gap analysis audit against Trust's Medicines Management Policy that relates to storage and security (i.e. have locations that store medicines got digital thermometers?)	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue		(1) Completed audit, by location, outlining controls in place/gaps.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks; (2) 6-monthly review to determine if any changes in process for storing medicines to determine compliance against policy.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Develop audit tool for use by Maternity Matrons to undertake gap analysis against medicines storage section of medicines management policy.	Jeremy Daws (Head of Compliance)	03-Mar-2022	Blue		(1) Completed audit proforma.	None.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Plan out action in response to audit to close any gaps identified (i.e. order digital thermometers).	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Green		(1) Action plan collating all actions in response to gap analysis audit.	(1) Evidence that all gaps have been closed and that actions have been completed; (2) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Identify any risks from audit undertaken (i.e. rooms where ambient temperature is routinely 25 degrees or above and take advice from pharmacy around mitigations.	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Green		(1) Action plan outlining mitigations to identified risks, in line with policy with Pharmacy advice (inventory of medicines; any with specific sensitivities; stock rotation - how long kept? Insulin length of time stored?) (2) Evidence of mitigations being in place.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	

						Maternity	Understand mitigations to environmental challenges in storage of medicines (i.e. age of estate at Lincoln maternity with a lack of air-conditioning/ventilation).	Simon Hallion (Divisional Managing Director)	30-Apr-2022	Red		(1) Mitigating actions scoped out in relation to environmental issues (i.e. ventilation and temperature management).	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Red		(1) Evidence of PRM escalation; (2) Addition to divisional risk registers of medicines storage matters.	(1) Ongoing escalation reporting to PRM.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Suganthi Joachim (Divisional Clinical Director); Simon Hallion (Divisional Managing Director); Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	Amber		(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Matrons audits assess security and storage of records, but main focus will be in relation to nursing documents. The Doctor's office is currently a shared room that doubles as a staff room. The doctor's office is moving to opposite the nurses station. As part of this move incorporate a door closure mechanism to ensure the door is not left open.	Carol Hogg (Ward Manager)	30-Apr-2022	Green		(1) Evidence of door closure device being added to the Doctors Office door.	(1) Ongoing monitoring as part of the Matron's audit process.	The Doctors office relocation to opposite the nurses station improves the ongoing oversight and assurance that medical records are stored securely. The door closure mechanism supports address the human factors elements of staff forgetting to secure the door when moving around the ward area.	Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	
						All	Scope out with Dr Amol Chingale additional actions in relation to medical staff raised awareness regarding information governance matters and other key messages (i.e. IPC).	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Red		(1) Evidence of raising awareness with medical staff.	(1) Programme of work to raise awareness for medical staff.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	

CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	CYP / Maternity	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	Carol Hogg, Hayley Warner, Emma Young, Kristie Rennison, Karen O'Connor, Kay Probert (Sisters/Clinical Educators/Play Specialists) C/O Rebecca Thurlow (Lead Nurse, CYP) Matrons within Maternity, C/O Emma Upjohn (Deputy Head of Midwifery/Lead Nurse Breast/Gynae)	30-Apr-2022	Green	18-May-22	(1) Evidence of divisions identification of currently available information resources and any additional resources that are felt to be needed.	(1) Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).	Findings from the audit undertaken have been collated and shared back to the Patient Experience team to determine next step actions needed in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP / Maternity	Divisions to undertake a walk-around/audit of current patient information resource available and being provided to patients within the division and compile a register, to include what languages the information is available in.	Carol Hogg, Hayley Warner, Emma Young, Kristie Rennison, Karen O'Connor, Kay Probert (Sisters/Clinical Educators/Play Specialists) C/O Rebecca Thurlow (Lead Nurse, CYP) Matrons within Maternity, C/O Emma Upjohn (Deputy Head of Midwifery/Lead Nurse Breast/Gynae)	30-Apr-2022	Green	18-May-22	(1) Register of locally held patient information resources being provided to patients.	(1) Maternity: Maternity Voices Partnership (MVP) have done a review of information provision within maternity. Track outcomes from future iterations for assurance.	Findings from the audit undertaken have been collated and shared back to the Patient Experience team to determine next step actions needed in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP / Maternity	Divisions to assign 'information owners' to provide information resources in response to feedback of information for patient needs.	Divisional CQC action plan owners to nominate lead 'information owners'.	To confirm on completion of information availability scoping.	Amber		(1) Evidence of information resources completed in response to listening events with patients; (2) Evidence of these resources being entered onto the information resource register (held by Patient Experience team).	(1) Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Scope out additional communication aids for use in CYP in British Sign Language and Makaton with Charitable funds.	Rebecca Thurlow (Lead Nurse, CYP)	01-Aug-22	Amber		TBC	TBC		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust wide	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. [Family Health Specific]	CYP	Understand from Rainforest Ward if the following issues have been reported to Estates: * Entrance flooring; * Some surfaces in poor repair in bathrooms/toilets; * Worn flooring; * Broken equipment (only 1 item - Immediately repaired); * Equipment needing repair	Carol Hogg (Ward Manager)	30-Apr-2022	Red		(1) Evidence that environmental issues have been reported to Estates; (2) Evidence of Estates action in response; (3) Escalation if no action yet taken.	(1) Environmental audits evidencing that issues requiring escalation are identified and appropriately reported.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Charity funds are being secured through a major fundraising for a total refurbishment of the Rainforest Ward. Potential to incorporate Safari into ward footprint. Scope out timescales and more detailed plans.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		(1) Refurbishment plans; (2) Evidence of completed works.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Replacement of 'Z' beds with new reclining chairs/beds to support decluttering of Rainforest ward with replacement of tables and lockers to support improved environment for patients and parents.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		(1) Evidence of replacement of old equipment with new; (2) Review of the effectiveness of decluttering of ward environment.	(1) Environmental audits to identify any estates issues; (2) Evidence that environmental issues have been escalated appropriately for remedial action.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

						CYP	Scope out the development of an internal Family Health 15-steps process to provide 'fresh eyes' on the environment.	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Green	18-May-22	(1) Evidence of plan being scoped out.	(1) Roll-out of internal 15-steps challenge methodology.	Plan agreed for how to undertake a local programme of 15-steps reviews for CYP clinical areas to better enable gaps in relation to the fabric of the environment, that affect the patient experience, to be proactively picked up and addressed to support other controls in place to mitigate.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Undertake phase 1 of the 15-steps roll-out plan within CYP with Healthcare Support Workers (HCSW) / Reception staff undertake review in their own areas of work and report findings to newly in post CYP Matron.	Rebecca Thurlow (Lead Nurse, CYP); Sandy White (Matron, CYP)	31-Jul-2022	Amber		(1) Findings from phase 1 of the 15-steps rollout plan.	(1) Scheduled activity to ensure regular programmed events for ongoing assurance purposes.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Understand the ULHT Trust process for undertaking, recording and frequency for undertaking ligature risk assessments.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Blue	04-May-2022	(1) Clarification Trust processes.	None.	Clarity obtained in the process expected for Trust Ward areas in respect of ligature risk assessments.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Scope out assurance available that Ligature Risk Assessments are undertaken annually in line with Trust Policy on CYP ward areas.	Rebecca Thurlow (Lead Nurse, CYP)	31-May-2022	Green	18-May-2022	(1) Plan to obtain assurance that ligature risk assessments are a programmed activity within CYP.	None.	Agreed plan for frequency of ligature risk assessment reviews with built in reminder process.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Scope out assurance available that Ligature Risk Assessments are undertaken annually in line with Trust Policy on CYP ward areas.	Rebecca Thurlow (Lead Nurse, CYP)	31-Nov-2022	Amber		(1) Plan to obtain assurance that ligature risk assessments are a programmed activity within CYP.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Continue to scope out additional steps for CYP in relation to risk mitigation for children with mental health concerns linking in with LPFT and ULHT Safeguarding team.	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Green		(1) Agree approach with system partners and stakeholders to review care and environment for children requiring Mental Health services.	TBC		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	The Trust have identified the latest GIRFT findings and recommendations pertaining to Children and Young People's Mental Health Services, issued in April 22. Scope out how the Trust, alongside key partners, can use this to review current service provision with a view to improving environment and care processes for CYP.	Rebecca Thurlow (Lead Nurse, CYP)	30-Jun-2022	Amber		(1) Scoped out plan for next steps in reviewing current practice against GIRFT publication.	TBC		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Review and seek assurance that routine weekly fire checks are being undertaken on Safari ward.	Carol Hogg (Ward Manager)	30-Apr-2022	Green	30-Apr-22	(1) Evidence of weekly fire checks being undertaken.	(1) Assurance of processes in place to maintain this going forward; (2) Evidence of weekly fire checks (spot checks).	Evidence obtained demonstrating regular weekly fire safety checks are being undertaken on Safari ward. The Fire Safety Team further write to divisional teams if there are no completed fire safety checks recorded as being completed.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

CQC2021-25	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider adding specific action plans to the service risk register.	CYP	Revised risk register format now being used. Continue to embed the use of this in strengthened governance structures.	Dr Suganthi Joachim (Divisional Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Managing Director).	31-Mar-2022	Green		(1) Maternity risk register in new style format and updated; (2) Evidence of the risk register being reviewed within Maternity meeting structure; (3) Evidence risk register is maintained in line with Trust (new) policy: Each risk has a named owner; Risk register entries are clear and concise; Risks should be reviewed in line with timescales: Very high (20-25): Monthly review; High risk (15-16): review quarterly; Moderate risk (8-12): review quarterly; Low/very low (4-6; 1-3) review 6-monthly; Datix risk register to be updated after every review.	(1) Evidence of the risk register being reviewed within Maternity meeting structure and updated as per Trust policy.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-19	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.	Surgery	Theatre safety bulletin to be devised and disseminated to all theatre staff outlining roles and responsibilities in monitoring of ambient temperatures alongside why this is a requirement.	Lisa Pim (Divisional Nurse, Surgery)	04-Mar-2022	Blue	26-May-22	(1) Completed Safety bulletin; (2) E-mail evidence of dissemination	None.	Guidance shared with Theatre teams on need to record temperatures, roles and responsibilities and action in case of temperature deviation.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Thermometers to be ordered for all Anaesthetic Rooms	Jason Green (Matron, Surgery)	02-Mar-2022	Blue	31-Apr-22	(1) Written confirmation by Theatre Matrons that Thermometers are in place; (2) Practice has been commenced.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Daily Temperature Checks Sheets to be installed in all Anaesthetic rooms	Jason Green (Matron, Surgery)	02-Mar-2022	Blue	31-Apr-22	(1) Practice has been commenced; (2) Temperature check sheets are used to record temperatures.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Daily Temperature Checks to be instituted by Theatre Teams	Jason Green (Matron, Surgery)	02-Mar-2022	Blue	31-Apr-22	(1) Practice has been commenced; (2) Temperature check sheets are used to record temperatures.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Implement remote temperature monitoring probes within Theatres with Clinical Engineering and Pharmacy input.	Jason Green (Matron, Surgery)	30-Jun-2022	Amber		(1) Remote temperature probes in place.	(1) Matrons audit findings; (2) Band 7 audit findings.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	SOP to be devised outlining procedure to be undertaken and actions to be undertaken in the case of a temperature breach.	Lead Nurse/Matron for Health Safety	02-Mar-2022	[Abandon & Replace]				There is no need for a separate SOP as the Trust's Medicines Management policy covers off the actions required wen temperature identified as being out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Band 7 Weekly Quality and Safety Audit	Matrons/Band 7 Practitioner for Theatre	02-Mar-2022	Red		(1) Audit document with additional checks	(1) Ward accreditation process		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Monthly Matrons Audit	Matrons for Theatre	02-Mar-2022	Blue	31-Apr-22	(1) Audit document with additional checks	(1) Ward accreditation process	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	As this is a new process - compliance will be reported at monthly CBU PRM	Lead Nurse TACC	01-Apr-2022	Red	31-Apr-22	(1) Monthly PRM Slide Deck	(1) CBU PRM Quality Process	have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2021-20	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure an interpreter is used as per trust policy to ensure all young people, parents or guardians are able to consent to care and treatment and fully understand clinical conversations.	CYP	Reminders provided to staff around the availability of interpreting services.	Rebecca Thurlow (Lead Nurse, CYP)	01-Nov-2021	Blue	01-Nov-2021	(1) Communication messages shared with the team; (2) Addition (during Nov 21) of this to the monthly matrons audit.	(1) Message of the month schedule; (2) Monthly Matron Audit data.	Work undertaken to proactively remind staff of the availability of translation services for patients/families whose first language is not English.	Paul Matthew, Director of Finance and OD	Quality Governance Committee (QGC)	
						CYP	To include within the message of the month schedule reminders to act as an aide memoir to support staff continue to make good use of the interpreting services.	Carol Hogg (Ward Manager)	31-Dec-2021	Green		(1) Addition to the message of the month schedule.	(1) Message of the month schedule; (2) Monthly Matron Audit data.		Paul Matthew, Director of Finance and OD	Quality Governance Committee (QGC)	
						CYP	Nursing admission document being revised, currently in development by Shared Decision Group, with a prompt and space documentation relating to interpreting services booked	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		(1) Completed nursing admission document.	(1) Message of the month schedule; (2) Monthly Matron Audit data.		Paul Matthew, Director of Finance and OD	Quality Governance Committee (QGC)	

						CYP	Section to be added in Matrons monthly assurance audit. To ensure this practise is embedded and monitored – evidence received	Rebecca Thurlow (Lead Nurse, CYP)	01-Dec-2021	Blue	01-Dec-2021	(1) Addition (during Nov 21) of this to the monthly matrons audit.	(1) Monthly Matron Audit data.	Matrons assurance audit has been updated to include assessment of interpreting service being used. This will support ongoing compliance and continual reminders being provided to staff.	Paul Matthew, Director of Finance and OD	Quality Governance Committee (QGC)	
CQC2021-21	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure cleaning records are completed as per trust policy.	CYP	Embed use of new cleaning schedules that have been introduced through Nurse In Charge taking a lead role in ensuring this is completed at the end of each day.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		(1) Evidence from cleaning schedules assurance metrics.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Scope out action needed in relation to Neonatal cleaning records.	Rebecca Thurlow (Lead Nurse, CYP)	31-Aug-2022	Amber		(1) Evidence from cleaning schedules assurance metrics.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-22	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.	CYP	Scope out further actions in response to inclusion of patients/parents in service provision whose first language is not English. Set up meeting with Lead Nurse CYP; Equality & Diversity Trust Lead and Patient Experience Lead. [Include within this availability of information for patients whose first language is not English, communication aids and proactive communication relating to cultural issues that impact on mixed sex accommodation]	Jeremy Daws (Head of Compliance)	30-Apr-2022	Blue		(1) Meeting held and further actions needed scoped and included within CQC Improvement Action Plan.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	To include this and wider cultural issues to the Shared Decision Making group within CYP to scope out tangible improvement actions to support this action.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber					Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-23	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider the use of a communication tool to support staff working with children who have additional needs.	CYP	Work is underway in participating in the Trust trial of 'This is me' document. To be included in the next wave. Aiming to link in with CAMHS and work on this in partnership with LPFT to ensure an integrated approach. To scope out additional details and timescales. D/W Becky - action plan	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		TBC	TBC		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-24	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that a patient's food and fluid intake is accurately recorded.	CYP	New tool/risk assessment has been drafted specifically for CYP in collaboration with Dietetics and Clinical Education team. Awaiting ratification and approval of the document to then roll-out. Scope out additional detail and timescales and include further milestones to test implementation and embedding of documentation.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		TBC	TBC		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-28	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	Maternity	The incident 'Trigger List' has been provided to all staff and discussed at team meetings. On the back of this link in with the Trust piece of work looking at mapping of the various processes that share learning across both sites.	Paula Izod (Risk Midwife)	31-Mar-2022	Green		(1) Survey of staff using Survey Monkey to ascertain further staff understanding of incidents;	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						Maternity	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups.	Helen Shelton (Assistant Director of Clinical Governance / Patient Safety Specialist)	TBC	Amber		(1) Trust level understanding of mechanisms in use to share learning; (2) Evidence of action in response.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						Maternity	Review the corporate assurance tools to understand what questions are regularly asked of staff and determine if further assurance relating to incidents could be included within these (i.e. ward accreditation review process).	Jeremy Daws (Head of Compliance)	30-Jun-2022	Amber		(1) Review of corporate assurance tools.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

CQC2021-29	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff.	Maternity	Midwives whose training / sign off of competence is outstanding to have obtained competencies. In the interim, where there is a case and a midwife who has not received the training for GA recovery, the theatre recovery nurses will remain in attendance. *NB: Original action planned to have fully completed competence for those midwives outstanding by Dec-21. However, to attain competence requires a full-day in Theatres and there is insufficient capacity in Theatre rotas for these staff to be attain competence until end of the financial year 21/22 (an average of 1-2 midwives a week can attend).* *16-Mar-22: Timescale reset from 31-Mar-22 to 30-Apr-22 (PHB) and 31-Oct-22 (LCH).*	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-Apr-2022 (PBH); 31-Oct-2022 (LCH).	Red		(1) Assurance provided to CQC directly; (2) Clinical Education team have all the records – reviewed each year during Mandatory training.	(1) Progress against trajectory for outstanding midwives whose training / sign off of competence is outstanding, who work on labour ward; (2) Database of competences is maintained by Education team and consultant midwife; (3) Strengthened reporting to Maternity Neonatal and Oversight Group.		Simon Evans, Chief Operating Officer	People and Organisational Development Committee (PODC)	
						Maternity	Look at further strengthening, reduce the likelihood still further, by including this competency as part of roster planning. Scope out during October 2021. *Action amended subsequently to being provided to CQC:* *The majority of midwives on the labour ward are B6 and therefore have, for the most part, obtained necessary competencies as part of their training at B5 level*	Libby Grooby (Divisional Head of Nursing and Midwifery)	01-Dec-2021	Green	01-Dec-2021	(1) Rotas that evidence staffing on the unit and higher ratio of B6 nurses to B5.	(1) Rotas that evidence staffing on the unit and higher ratio of B6 nurses to B5.		Simon Evans, Chief Operating Officer	People and Organisational Development Committee (PODC)	
						Maternity	Monitoring of compliance and assurance through the Maternity and Neonatal Assurance Group.	Yvonne McGrath (Consultant Midwife)/ Emma Upjohn (Interim Deputy Head of Midwifery)/Lead Nurse Breast/Gynae	31-Mar-2022	Blue		(1) Update provided in the Maternity and Neonatal Assurance Report to the Maternity & Neonatal Oversight Group in November 2021.	(1) Formal reporting on compliance against the agreed trajectories to be included within the Maternity and Neonatal Assurance Report; (2) Include within next MNOG report.		Simon Evans, Chief Operating Officer	People and Organisational Development Committee (PODC)	
CQC2021-30	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should improve the completion of safety, quality and performance audits to ensure these are consistently completed effectively, to enable safety and quality concerns to be identified and acted upon.	Maternity	BAU: Ongoing review and assurance that environmental audits do assess the estate and escalate appropriately into MNOG.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	Green		(1) MiCad audits focus on cleanliness; (2) Matrons audits pick up estate issues.	(1) MiCad audits focus on cleanliness; (2) Matrons audits pick up estate issues; (3) Evidence of onward escalation reporting into MNOG.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-41	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider all key services being available seven days a week.	CYP	Scope out and define key clinical support services needed by CYP over a 7 day period by urgency (i.e. routine management vs. seriously unwell).	Dr Suganthi Joachim (Divisional Clinical Director)	31-Mar-2022	Blue		(1) Defined list of key services and when needed in terms of urgency.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Identify availability of key clinical support services over a 7 day period, by urgency and identify any gaps.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	31-May-2022	Red		(1) Key services availability and identification of any gaps.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Apr-22, moving to the 31-May-22. This will remain as 'RED' rated.
						CYP	Outline a plan for mitigating any gaps in available clinical support services and define risks.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	31-May-2022	Red		(1) Risk stratification of gaps; (2) Plan in place to mitigate gaps.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Add any risks to divisional risk register.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	30-Jun-2022	Amber		(1) Evidence that risk has been considered and added to the risk register as necessary.	(1) Evidence of ongoing risk mitigation as part of risk register process.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-42	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider routine monitoring or auditing of waiting times for children to have a medical review as per the Royal College of Paediatrics and Child Health (RCPCH).	CYP	Review RCPCH guidance to determine specific requirement as to what waiting times need auditing and then discuss further with Lead Nurse and Clinical Lead for CYP.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Green		(1) Evidence of detail for the audit being scoped out.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

						CYP	Plan a prospective audit to log and record the details, a set number of times a year (to scope). Co-ordinators to collect data. Scope of wards included would be 4a/Safari/Rainforest. To be led by Dr Chingale and Becky.	Dr Chingale (Clinical Lead); Rebecca Thurlow (Lead Nurse CYP)	30-May-2022	Red		(1) Plan for the audit.	(1) Schedule for the audit to be undertaken throughout the year.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 20/06/2022

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating BRAG	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes:
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Anita Parmar (Deputy General Manager); Claire Spendlove (Lead Nurse); Michael Bland (General Manager); Donna Gibbins (Deputy Divisional Nurse)	31-Dec-2022	Amber		(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Review assurance evidence available from existing metrics to determine if additional action is required, other than the ongoing education work resulting from ongoing assurance work.	Clare Spendlove (Lead Nurse); Donna Gibbins (Deputy Divisional Nurse)	30-Apr-2022	Green	30-Apr-22	(1) Matrons audit data in relation to security of patient records/information (systems etc.).	(1) Matrons audit data in relation to security of patient records/information (systems etc.).	Audit data reviewed and agreed that further action is required as compliance audits show room for improvements.	Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	
						All	Scope and agree improvement plan to support improved compliance and evidence using the matrons audits.	Katy Mooney (Divisional Lead Nurse)	31-May-2022	Green	24-May-22	(1) Agreed action plan	None.	Action plan agreed in relation to monitoring compliance with security of personal information from unsecured casenotes and/or computer workstations.	Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	
						All	Order and put into use medical records storage trolleys within the Cath Lab.	Claire Spendlove (Lead Nurse Cardiovascular)	TBC	Amber		(1) Notes trolley(s) available in Cath Lab.			Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	
						All	Monitor evidence from the following assurance sources to demonstrate compliance with Information Governance Requirements: * IG mandatory training compliance (reported through to Medicine PRM); * Matrons audit data - compliance at ward level.	Katy Mooney (Divisional Lead Nurse)	TBC	Amber		(1) IG Training Compliance within Medicine; (2) Compliance with IG questions contained within the Matrons audit.	(1) IG Training Compliance within Medicine; (2) Compliance with IG questions contained within the Matrons audit.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)	
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	All	Medicine Cabinet to scope out how to determine what information resources are required that do not currently exist (including UEC and advice cards) and catalogue information currently available and in use.	Katy Mooney (Divisional Lead Nurse)	31-Mar-2022	Green	18-May-22	(1) Agreed action plan	None.	Plan agreed within medicine on how best to approach this audit/data collection exercise.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	To first undertake review of information for patients kept and provided at ward level. Discuss with weekly sisters meeting and develop clear plan to undertake this audit of information available.	Katy Mooney (Divisional Lead Nurse)	TBC	Amber		(1) Agreed action plan with clear timescales for ward areas.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. [Medicine specific]	Medical	Review evidence that estates issues are being identified as part of the Ward/department environmental audits and FLO audits and determine mitigations in place to safeguard quality of service provision.	Clare Spendlove (Lead Nurse); Donna Gibbins (Deputy Divisional Nurse); Maxine Skinner (UEC).	30-Apr-2022	Red		(1) Environmental audits / FLO audits demonstrating that estates issues are being identified; (2) Evidence of escalation / mitigation of estates related issues by risk.	(1) Environmental audits / FLO audits demonstrating that estates issues are being identified; (2) Evidence of escalation / mitigation of estates related issues by risk.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Medical	Scope out opportunities to better plan routine replacement programme for equipment with Trust's procurement team.	Clare Spendlove (Lead Nurse).	30-Apr-2022	Red		(1) Understand options available.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2021-26	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that safety checks of new ward environments are fully completed before moving patients.	Medical	Standardise and merge out-of-hours checklist with Divisional checklist and ensure this is accessible and version controlled as part of the Trust's documentation control processes and procedures. Katy to chair a meeting of matrons and lead nurses across divisions and with OPs team.	Katy Mooney (Divisional Lead Nurse)	31-May-2022	Green	18-May-22	(1) Draft Revised checklist for opening a ward.	(1) Assurance evidence the checklist is in use when opening a ward.	Draft checklist developed, now being consulted on to develop final draft for approval and implementation.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Medical	Agree final draft of the merged Surgery/Medicine checklist and agree group to approve the revised checklist and agree frequency of review (6-monthly) to ensure the document adapts in line with changing nature of the service/reflects new challenges.	Kathyrn Mayer (Matron, Surgery); Sophie Rudge (Matron, Medicine)	30-Jun-2022	Amber		Final draft checklist for opening a ward; (3) Inclusion within the Trust's document control processes.	(1) Assurance evidence the checklist is in use when opening a ward.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-27	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.	Medical	With support from the Trust's audit department, embed the process that all national audits are participated in, presented at the respective audit meetings, discussed at Governance and an action plan agreed.	National Audit leads (with support from Trust Audit Team)	31-Mar-2023	Amber		(1) CEG Quarterly Report; (2) CQC Insights data.	(1) CEG Quarterly Report; (2) CQC Insights data.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2021-43	Medical care (including older people's care)	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider giving ward managers direct access to training systems for their areas in order to monitor and action mandatory training needs of their teams on a more regular basis.	Medical	Scope out with HR/ESR level of access Ward managers have already to ESR which provides oversight in relation to training compliance levels within their teams.	Katy Mooney (Divisional Lead Nurse)	30-Apr-2022	Red		(1) Understanding of difficulties in obtaining information from ESR.	None.		Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)	

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	23 June 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 2022/23 objectives.
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 that this offered limited assurance due to a number of risks associated with critical infrastructure. The Committee noted that weekly performance meetings were being held in the estates to ensure focused discussions and performance improvements were achieved. It was noted that there were green shoots of improvement in performance. The Committee noted the concerns raised by Lincolnshire Fire and Rescue, following attendance at site as a result of the fire at Lincoln County, regarding the condition of corridors and storage. A working group had been established to address the concerns which would be monitored through the Fire Safety Group. The Committee requested consideration of future reporting to streamline the report. **Emergency Planning – incident debrief** The Committee received the incident debrief report following the fire at Lincoln County Hospital noting that the workshops had been held virtually and physically with good stakeholder engagement. The feedback from the debrief was positive and areas for improvement identified. A copy of the incident debrief had been made available to Board members in the paperless board solution reading room. **Low Surface Temperature Report** The Committee received the report noting the significant assurance that had been provided.

	50% of the works at Louth County Hospital had been completed and work continued to progress to determine the course of action following the work to identify locations where the Trust was a tenant.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital and CRIG Upward Report** The Committee received the finance report noting the month 2 position, reported against the plan submitted at the end of April with a £5.8m deficit, was YTD £917k deficit with an actual of £1.3m meaning the Trust was £400k adverse to plan. The Committee noted the update plan that had been submitted on 20 June and the breakeven position that had been put forward. The revised YTD plan would include an adjustment in June to reflect the new plan phasing and overall position. The Committee was concerned that the Trust was currently reporting off plan, particularly in respect of Cost Improvement Programme (CIP) delivery as achievement would become more difficult as the year progressed. The Committee was reassured that actions were in place to address the identification of CIP programmes however noted that there remained £20m to be identified. The Committee noted the contracting position and the need for these to be finalised and signed ahead of the 1 July. It was noted that risk and gain share would be considered as part of the 'long stop' aspect of the contract which should be concluded by August. An update regarding Pilgrim ED business case was offered to the Committee and it was noted that this case would be taken to the national Joint Investment Sub-Committee (JISC) on 11 July where it was anticipated that the schemes would be approved. It was not yet clear if this meeting would address the requirement for additional funding. The Committee received and noted the update from the Capital, Revenue and Investment Group. **Financial Plan final submission** The Committee received, for completeness, the financial plan submission that had been received by the Board at the June meeting. The Committee noted the discussions held regarding risk and mitigation through the Finance Report and noted the moderate assurance offered.
	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Hospital Group Upward Report**

	The Committee received the upward report noting the discussions that had been held by the group and the escalation of the Ophthalmology ePR practice variation. It was noted that discussions would be held to address the level of variation with work being undertaken by the Chief Nursing Information Officer. The Committee were made aware of the Brachytherapy case of need which would require investment outside of plan for the year, It was noted that work was being completed to understand the required investment and once complete a review of the capital programme would take place. **Data Security Protection Toolkit Submission** The Committee received the update noting that a full review of all elements of the toolkit with a significant number moving to green. The Committee noted the limited assurance that was offered and the areas of concern in respect of achieving compliance with training levels and the completion of data flow mapping. The Committee was assured that action was being taken to address the areas of risk ahead of the 30 June submission deadline. Moving forward the Committee noted the intention that the toolkit would be considered throughout the year and updates provided on a regular basis to the Committee.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the combined report which offered an update on urgent, planned and cancer care and noted the limited assurance that had been offered. The Committee noted that whilst flow issues continued to be present across the Trust there were some green shoots seen recently with a reduction in overcrowding within A&E departments. The Committee was updated on the recent Multi-Agency Discharge Event (MADE) that had taken place as a result of the recent critical incident and had seen a reduction in occupancy rates in EDs, no 4-hour handover delays and no 12-hour trolley waits. It was noted that taking the approach through MADE had a significant positive impact on the Trust however this was not currently sustainable. The Committee noted that there would be benefit in future reports offering a bed bridge to demonstrate beds open, closed and associated cost.

	With regard to planned care the Committee noted the work to synthesise the submitted system plan and the need to populate indicators within the scorecard. Concern was noted regarding 52 week waits and the increasing waiting list. It was noted that outpatient bookings and waiting rooms had reverted to pre-pandemic with some elements maintained such as mask wearing. This would see 30% more activity in a week. Concern continued regarding echocardiograms due to the physical space issues for scanners. Work was being completed with an external company to maximise slot utilisation. The Committee was pleased to note the reduction in turnaround times in the P2 category with the Trust being amongst the best in the region. Theatre utilisation could be improved and work was underway to identify additional efficiencies. The Committee received the cancer update noting that the progress made on the 62-day backlog had been lost with more work to be undertaken to recover the position. It was noted however that improvements were being seen in the 14-day waits.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 4a Establish new evidence based models of care No items received
	Assurance in respect of other areas: **Topical, Legal and Regulatory Update** The Committee received the report for information noting that this was a helpful report to offer oversight of current areas of interest for the Committee. The Committee noted the need to withdraw from contracting with Russian companies and assurance was offered that work had been completed to confirm that the Trust did not directly or materially indirectly through major suppliers, contract with Russian firms. **Board Assurance Framework 2022/23** The Committee received the Board Assurance Framework and undertook a detailed discussion regarding the current position and outlining expectations to update the current content.

	The Committee noted that the risk register confirm and challenge sessions being held to update the risk register would support and align to the BAF with controls and assurances being clearly aligned. The Committee expected to receive a much updated and focused version of the BAF to the July meeting ahead of presentation to the Board in August. **Internal Audit – Core Financial Controls – Phase 2 Host Ledger/Trust Final** The Committee received the internal audit on the host general ledger noting that the reduction in the Better Payment Practice Code (BPPC) had declined as a result of the change to the ledger. It was noted however that the position had resolved as the new ledger came online. Payments against the BPPC would be monitored through the recognised governance processes and alerted to the Committee should this drop. **CQC Action Plan** The Committee received the action plan noting the position reported and reflected that a number of the actions were being addressed through the PRM meetings. Whilst it was recognised that there remained further work to be undertaken there was good oversight and progress being made. The Committee noted the need for there to be clarity on the purpose of receiving the report in order to avoid duplication of effort as these actions were being addressed in other forums. **Data Quality Update** The Committee received the update in relation to data quality noting the moderate assurance being offered. The paper responded to the concerns raised through the CQC action plan in respect of data flow in the organisation and the timeliness of data. The Committee noted that the paper offered a response to the position of data flow and timeliness and were assured that the processes in place were sufficient and allowed escalations to take place to the Board either directly or through upward reporting of the Committee. There were no concerns within the organisation of the effectiveness of data flow or the ability to escalate where required. **Committee Performance Dashboard** The Committee received the report noting that work would be undertaken to reintroduce the finance reporting elements to the main Integrated Performance Report (IPR).

	The Committee noted that there would be some overlap between the IPR and IIP with the need to finalise the trajectories and tolerances within the scorecard and dashboards. The Committee noted that whilst the scorecard continued to develop there were signs of improvement being seen in some areas. **PRM Upward Report** The Committee received the report noting the moderate assurance being offered and recognised that work continued to develop the format of the meetings and scorecards for use by the Divisions. Once the scorecards and dashboards were fully populated with the metrics, trajectories and tolerances it would be possible for the divisions to be held to account and for performance to be monitored. **Integrated Improvement Plan** The Committee received the IIP noting that this outlined the 4 domains and 3 priorities for the 2022/23 year. The Committee felt that the format of the report offered a clear update however noted that further assurance could be received once this was better populated and baselines were in place. The Committee noted the limited assurance being offered through the report as a result of the current position at the end of Q1 and the need to complete the scorecard development. **Improvement Steering Group Upward Report** The Committee noted the first of the ISG meetings had taken place on the 20 June with the report noting that the majority of programmes were not achieving expected levels. Work was required during July to undertake reprioritisation and development of mitigation plans to demonstrate actions to be taken to address the position. The Committee noted the need to align the programmes of work to the CIP programme to demonstrate where there would be financial advantage. The Committee agreed that limited assurance had been received and noted the need to receive updates that offered the impact and timeline of achievement.
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 very high risks as presented and the completion of the Finance deep dive which would be presented in July.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 July 2022*
Item Number	*Item 10.2*
ULHT Estates Strategy 2022	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Simon Evans, Chief Operating Officer*
Author(s)	*Claire Hall, Associate Director of EFM*
Report previously considered at	Finance, Performance and Estates Committee

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	
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	3720 3520 3688 4403 3690 are some of the entries that relate to strategic estates risks
Financial Impact Assessment	Capital plans are developed that describe the initial stages of funding for this strategy however future years are dependant and capital availability
Quality Impact Assessment	Substantial Improvements are described within the strategy that mitigate Quality Risks and support improvements in service experience and in some cases safety
Equality Impact Assessment	N/A
Assurance Level Assessment	• Significant

Recommendations/ Decision Required	• Approve the Interim Estates Strategy

Executive Summary

Summary/Key Points:

The Interim Estates Strategy has been developed to provide a two year strategy for United Lincolnshire Hospitals NHS Trust whilst work is undertaken to develop the Integrated Care System Strategy.

In the short term, immediate investment into the ULHT estate is required. This document maps out the short-term strategy for the maintenance, management and capital priorities for the Trust's estate over the next two years.

It focusses on areas to be addressed as a matter of urgency, and those required in order to maintain the hospital sites prior to the delivery of the Integrated Care System transformation strategy.

The 0-2 year strategy is split into three sections:

Where are we now? Starting with analysis of the current Integrated Improvement Plan (IIP) 2020-2025 with the four strategic objectives of Patients, Services, People and Partners to achieve Outstanding Care, Personally Delivered. This report initially looks at the size and physical condition of the current estate summarised as follows:

- Six-facet survey published in 2017 and primary infrastructure surveys updated in 2019 identify that conditions have deteriorated below condition B -increasing from 82% to 88% by block.
- Critical Infrastructure Risk (CIR) based on High and Significant risk is currently £31.1m (net build cost)
- Total backlog (including CIR) is currently £68.2m (net build cost)

Where do we want to be? The integrated care vision with a 'left shift' is a system-wide approach and encompasses acute sector, community, primary care and home care. This report also considers travel plans, Trust priority spend, COVID-19 strategy, the 10 year estates strategy, Modern Methods of Construction and Net Zero Carbon as part of the strategy.

How do we get there? Included in this report are strategic design strategies for each hospital, identifying proposals for refurbishment and new build supported by engineering strategies. The strategies are complemented by a Development Control Plan, identifying a programme of priority works to describe the journey.

NHS
United Lincolnshire Hospitals
NHS Trust

United Lincolnshire Hospitals NHS Trust Estates Strategy 2022

OUTSTANDING CARE
personally DELIVERED

Chapter 1

Executive Summary

1.0 Executive Summary

In the short term, immediate investment into the ULHT estate is required. This document maps out the short-term strategy for the maintenance, management and capital priorities for the Trust's estate over the next two years.

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Where do we want to be? To develop a long-term strategy for the provision of fit for purpose buildings and infrastructure to support the delivery of patient care. The integrated care vision with a 'left shift' is a system-wide approach and encompasses acute sector, community, primary care and home care. This report also considers travel plans, Trust priority spend, COVID-19 strategy, the 10-year estates strategy, Modern Methods of Construction and Net Zero Carbon as part of the strategy.

How do we get there? Included in this report are strategic design strategies for each hospital, identifying proposals for refurbishment and new build supported by engineering strategies. The strategies are complemented by a Development Control Plan, identifying a programme of priority works to describe the journey.

1.1 Introduction

The Trust was in financial special measures from September 2017 to 2022. An ageing and dilapidated building infrastructure previously contributed to the adverse financial position of the Trust, specifically relating to difficulties in recruitment, significant hard facilities management estates costs and clinical inefficiencies resulting from poor clinical adjacencies and patient flow.

Backlog Maintenance (BLM) - The removal of existing backlog maintenance will result in one-off backlog avoidance savings of c.£37m, of the existing £75m shown on ERIC (estates return information collection). Based on six-facet surveys, the total outturn cost of delivering the £75m BLM is estimated at £275m – of this, the backlog avoidance for this scheme will eradicate £125m in backlog outturn costs.

Although this paper focuses on the strategy for years 0-2, it also needs to be cognisant of the longer-term ICS strategy. The Lincolnshire Health Infrastructure Programme is Lincolnshire Integrated Care System's (ICS) overarching scheme for the transformation of the whole NHS estate in Lincolnshire. This seeks to address specific local challenges, including the fact that all of our sites serve areas of deprivation, there is a history of under-investment in healthcare infrastructure and the fact that Lincolnshire is one of the most rural counties in the UK. Poor road infrastructure means that services cannot be easily centralised, leading to a need for a large healthcare estate.

Expressions of interest - The Trust has submitted three expressions of interest (EOIs) under the New Hospitals Programme, which are under consideration, totalling £480m for the following:

- Lincoln County Hospital
- Grantham and District Hospital
- Pilgrim Hospital, Boston

Transformation is underway, developed with clinical leaders across the system. There is recognition of the many external factors that may change direction during this journey such as the outcomes of the EOI's above and emerging clinical strategies that may change current design solutions.

The purpose of this strategy is to outline how we can deliver the best environment for staff, patients and their families and carers. Delivering infection prevention excellence and using Modern Methods of Construction and other sustainable approaches (e.g. efficiency gains due to reduced travel by staff, patients and visitors)

will help ensure progression towards Net Zero Carbon (NZC) targets. This paper focuses solely on the acute proposals for the three hospital sites of Lincoln County Hospital, Pilgrim Hospital Boston and Grantham and District Hospital, where the Trust is striving for “best in class” environments for the provision of services to patients and staff.

Chapter 2

Where are we now?

2.1 Profile of the Trust

United Lincolnshire Hospitals NHS Trust (ULHT) is situated in the county of Lincolnshire and is one of the biggest acute hospital trusts in England, serving a population of over 760,000 people.

The Trust provides a broad range of clinical services including community services, population-screening services, and a comprehensive range of planned and unscheduled secondary care services including specialised services for stroke, vascular and cardiac services.

The Trust's services are provided from three principal hospital sites:

- Lincoln County Hospital
- Pilgrim Hospital, Boston
- Grantham and District Hospital.

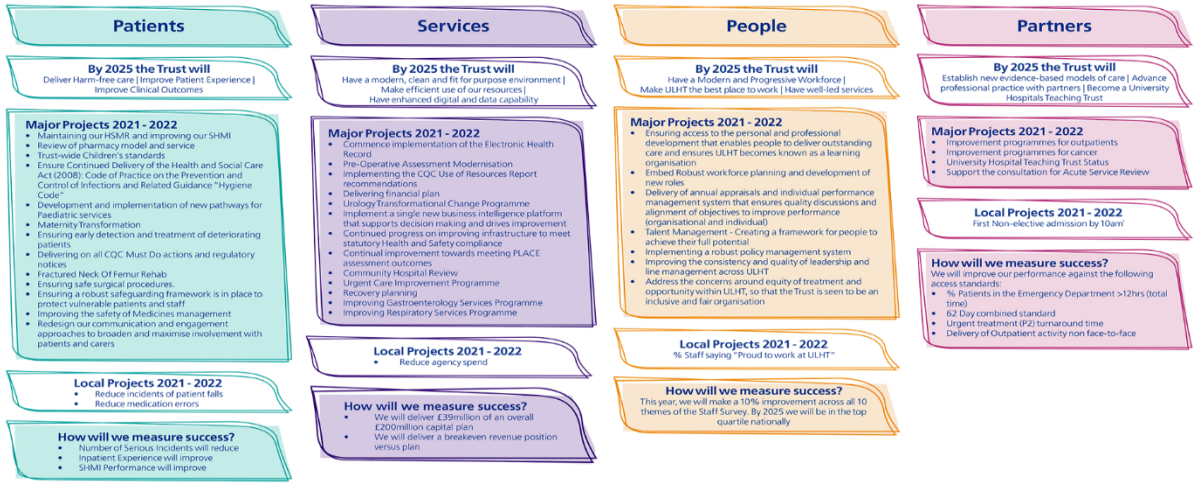
In addition, a number of services are provided from community hospitals closer to patients' homes at Louth County Hospital; John Coupland Hospital, Gainsborough; Johnson Community Hospital, Spalding and Skegness and District General Hospital. In an average year, the Trust treats more than 120,000 accident and emergency patients, over 600,000 outpatients, over 120,000 inpatients and delivers over 4,000 babies.

The Trust is the only acute provider of the four member organisations of the Integrated Care System (ICS), which also includes one CCG, a community trust and a mental health trust. ULHT has worked with partners on a single system plan for 2019/20 and beyond.

2.2 Integrated Improvement Plan

The Trust is in the third year of its Integrated Improvement Plan (IIP) which has been developed through conversations with the divisional teams, executive leads, system partners and national bodies. Its purpose is to ensure the Trust delivers meaningful change in quality and the safety and effectiveness of services for patients, colleagues and partners.

The Trust's Integrated Improvement Plan 2020-2025 sets out four strategic objectives for the organisation: Patients, Services, People and Partners. Each strategic objective has a set of five-year priorities, with strategic metrics to measure improvement. Delivery of this will enable the Trust to deliver its vision: Outstanding Care, Personally Delivered.



The IIP process has helped the Trust to determine its priorities going forward and is set out as follows.

Some key areas of focus are:

- Enhanced data and digital capability - a third of outpatient appointments should be digital consultation focused
- Modern, clean and fit for purpose environment
- Reduction in pressure on the emergency pathway
- Maximising capacity in space leased off the main acute sites
- Better patient and staff experience for elective and trauma care
- Refurbishment and reconfiguration of family health wards and services at Lincoln and Boston, including labour wards
- Explore the feasibility of Midwifery Led Units at Lincoln and Boston

- Refurbishment of Trustwide mortuaries
- Refurbishment/new build endoscopy ward at Lincoln
- Supporting the Community Diagnostic Hubs

It is clear from the above that the quality of the estate, its safety and effectiveness will play a critical part in delivering these priorities.

The previous (2020) ULHT Estates Strategy set out how the Trust would ensure that it has a fit for purpose estate that enables and supports the delivery of its clinical strategy and the organisation's longer-term strategic plans.

The 2020 strategy, however, did not take into account the impact of the COVID-10 pandemic and its consequential impact on the clinical service strategies. Therefore, as a consequence, and being fully cognisant of their clinical importance, the Trust will review further development decisions against the development control plan (DCP) and the estates strategy when it has been developed.

This strategy does not cover the following properties under leasehold or freehold by ULHT: County Hospital Louth, John Coupland Hospital, Gainsborough, Skegness Hospital, Johnson Hospital, Spalding, Boole Technology Park – Lincoln University. Although we acknowledge these are important delivery sites for our clinical services.

2.3 Current Estate: Size

The Trust operates across three sites in Lincolnshire; Lincoln County Hospital, Pilgrim Hospital Boston and Grantham and District Hospital. The estate has a total floor area of 467,000m2, consisting of a building stock of varied ages, design, configuration and condition.

Areas	**Unit**	**Lincoln County Hospital**	**Pilgrim Hospital Boston**	**Grantham and District Hospital**	**Total**
Gross internal site floor area	m²	73,095	56,880	27,453	157,428
Site land area	m²	212,900	169,600	84,500	467,000

(Information in table above taken from ERIC data 2020/21)

2.4 Current Estate: Physical Condition

In 2017, Monaghan's carried out a six-facet survey (HBN 00-08 Facet 1 – Physical Condition Survey (Fabric & M&E) Facet 2 – Statutory Compliance Audit (inc. Fire) Facet 3 – Space Utilisation Facet 4 – Functional Suitability Review Facet 5 – Quality Audit Facet 6 – Environmental Management Audit. At the time of collating the report, it identified that the square meterage of estate falling below the required Condition B standard was between 88-94% by floor area and 77-82% by block across all three sites. In early 2019, the Trust carried out a visual review and attended a series of workshops to review and update the six-facet information block-by-block on each site. The result of that exercise was that over a three year period the estate had reduced further in condition, due to minimal investment and increased backlog across the sites, reducing the amount of estate at Condition B further. The Trust is considering the benefits of commissioning a full six-facet refresh and a targeted review of key areas. The tables below show the results from the workshop involving Consultants and Estates carried out in 2019.

Lincoln County Hospital

Condition	Total Number of Building Blocks
Condition A	0
Condition B	8
Condition B/C	2
Condition C	35
Condition C/D	0
Condition D or D (X)	12
Total	**57**

Table 1: Consultants Workshop Review with Trust Estates 2019 for Lincoln County Hospital

Pilgrim Hospital, Boston

Condition	Total Number of Building Blocks
Condition A	0
Condition B	5
Condition B/C	3
Condition C	15
Condition C/D	0
Condition D or D (X)	4
Total	**27**

Table 2: Consultants Workshop Review with Trust Estates 2019 for Pilgrim Hospital Boston

Grantham and District Hospital

Condition	Total Number of Building Blocks
Condition A	0
Condition B	0
Condition B/C	3
Condition C	8
Condition C/D	2
Condition D or D (X)	4
Total	**17**

Table 3: Consultants Workshop Review with Trust Estates 2019 for Grantham and District Hospital

2.5 Overview of Backlog

By their very nature, unless adequately maintained with considerable investment in upgraded facilities, all healthcare estates deteriorate over time and will eventually become untenable. Qualities and characteristics of the Trust's existing built environment may not be fit for purpose, and in some instances over time can become dangerous. Ageing buildings that remain a part of existing estates may not be capable of adaptation and modernisation through refurbishment to meet the needs of modern acute services, and there could be a need for rationalisation or decommissioning.

The Trust backlog maintenance costs as per published Trust ERIC 2020/21 data are summarised in the table below. Backlog maintenance, as defined in the 'Best Practice Guidance – A risk-based methodology for establishing and managing backlog' is the cost to bring estate assets that are below Condition B in terms of their physical condition and/or compliance with mandatory fire safety requirements and statutory safety legislation up to Condition B. The risk categories are defined as:

- Low risk elements can be addressed through agreed maintenance programmes or included in the later years of your estate strategy.
- Moderate risk elements should be addressed by close control and monitoring. They can be effectively managed in the medium term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety. These items require expenditure planning for the medium term.
- Significant risk elements require expenditure in the short term but should be effectively managed as a priority so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- High risk elements must be addressed as an urgent priority to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.

ULHT Backlog ERIC Data 2020/21	Lincoln County Hospital	Grantham and District Hospital	Pilgrim Hospital Boston	Totals
High Risk	£23,068	£29,471	£1,058,488	£1,111,027
Significant Risk	£7,839,108	£6,783,742	£15,407,545	£30,030,395
Moderate Risk	£4,916,230	£5,000,668	£5,458,391	£15,375,289
Low Risk	£9,199,144	£2,981,637	£9,503,985	£21,684,766
Total	£21,977,550	£14,795,518	£31,428,409	£68,201,477

The backlog cost stated above is the cost to bring the estate assets that are below Condition B up to Condition B. The backlog out-turn costs would be significantly higher and include a number of other costs (list could vary and is Trust-specific) such as:

- Professional fees
- Planning contingency
- Optimism bias
- Inflation
- Decant and phasing costs
- VAT

As part of the process to establish backlog maintenance, the Critical Infrastructure Risk (CIR) is also calculated. CIR is the total of the high and significant risk backlog maintenance. It represents the amount of capital investment needed to eliminate safety and resilience risks from the operational estate.

The risks are made up of three categories:

- Non-compliance with statutory and mandatory requirements;
- Patient, staff and visitor safety issues;
- Infrastructure works to ensure continuity of services.

The CIR based on the ERIC return high and significant risks equates to £31,141,422.

The table below identifies the latest total backlog maintenance costs for the estate using information as per the Trusts ERIC data return 2020/21

Description	**ULHT Backlog ERIC Data 2020/21**
Area (less service voids)	157,428m^2
Backlog Cost £/m^2	£433.2/m^2
Total Backlog	£68.20m

The capital investment for the priority capital projects will progressively reduce both the total backlog and risk-adjusted backlog over the two-year period of the works, but it will not eliminate backlog completely. This is due to the existing estate continuing to age and an increase in floor area due to additional new builds. Therefore, as the condition of the Trust's assets are constantly changing, it is advised that an annual review of survey findings and risk assessments be carried out and fed into the annual investment planning process.

2.5.1 Backlog maintenance high risk item themes

When analysing the high risk, high-cost backlog maintenance items at Grantham, Pilgrim and Lincoln hospitals from the six-facet survey there are some common themes:

- Fire safety
- Electrical infrastructure
- Water safety
- Asbestos
- Theatre ventilation
- Building fabric

2.6 Existing Primary Infrastructure

In 2020, a Mechanical and Electrical (MEP) review carried out a review of the current primary infrastructure across all three sites, building on the 2017 six-facet survey. This has been summarised below. Since this review was carried out, the Trust has spent £9.6 million addressing critical infrastructure risk across the three sites. Refer to table 4.6 for details of critical infrastructure works that are within the 0-2 years proposed capital spend.

2.6.1 Lincoln County Hospital (2020 MEP reports)

Infrastructure Item	Status	Action in Year 0-2
HV Network	Trustwide scheme to review and increase capacity and resilience. Feasibility studies are being undertaken at all sites to address the under capacity issues, improve network resilience and replace obsolete infrastructure.	Feasibility study
Generators	Obsolete and past life expectancy. Issues with maintainability of change-over contactors. Within the scope of the Trust wide scheme relating to high voltage (HV) to cover electrical infrastructure overall. Some Generators and controls have been replaced, part of the wider electrical feasibility study will look at suitable generator capacity.	Feasibility study

Steam mains	Generally in a good condition. This technology will become obsolete to meet NZC targets	Incorporate in NZC study
Gas Mains	No issues	No action
Medical Gas	O2 VIE plant capacity and resilience issues. Trust Wide scheme to review and increase capacity and resilience. Feasibility stage complete.	Feasibility Study
Building Management System (BMS)	Large parts of the BMS are obsolete, with limited environmental controls or strategies, leading to over/under heating of areas or poor temperature control.	Feasibility Study
Chillers	No issues	No action
Potable Water	There are significant issues with the water systems. Pipe failures are frequent and Chlorine Dioxide has been turned off due to its corrosive nature, therefore large sections of pipework require replacing. It is noted that a new Urgent Treatment Centre (UTC) was constructed 2020-2021 and it is not understood at this time the impact to the infrastructure this capital project had.	Infrastructure survey
Resus Unit	Impact on infrastructure not known, this will form part of the brief for the infrastructure survey.	Infrastructure Survey
Modular ED ward	Impact on infrastructure not known, this will form part of the brief for the infrastructure survey	Infrastructure Survey
Ward refurbishment	During 2020/2021, 14 wards Trustwide received ward enhancements of immediate redecoration and IPC enhancement. Due to time constraints and COVID-19, key backlog infrastructure was unable to be addressed. Key wards to be addressed include Family Health at Lincoln and Boston.	Infrastructure survey

2.6.2 Pilgrim Hospital, Boston (2020 MEP reports)

Infrastructure Item	Status	Action in Year 0-2
HV Network	Peak demand over that of the Authorised Supply Capacity would occur should the Combined Heat & Power (CHP) be offline. Additionally, the HV infrastructure is at the end of its life expectancy and some HV switchgear is subject to switching restrictions due to ageing, failure, and non-	Feasibility study

	availability of spare parts. Trustwide scheme to review and increase capacity and resilience.	
Generators	The resilience of generator 5 is very weak as it is a standalone generator which has completed over 14,000 run hours yet supports ICU, endoscopy and the medical air plant. Issues with maintainability of change-over contactors.	Feasibility study
Steam mains	Issues with steam mains and frequent leaks, including access due to confined space limitations and the presence of asbestos.	Incorporate in NZC study
Gas Mains	Issues with steam mains and frequent leaks, including access due to confined space limitations and the presence of asbestos.	No action
Medical Gas	O2 VIE plant resilience issues. Trustwide scheme to review and increase capacity and resilience. Feasibility stage complete.	No action
Building Management System (BMS)	Large parts of the BMS are obsolete, with limited environmental controls or strategies, leading to over/under heating of areas or poor temperature control.	Feasibility Study
Chillers	Decentralised system. Some R22 refrigerant noted as still in use	No action
Potable Water	There are significant issues with the water systems. Pipe failures are frequent and Chlorine Dioxide has been turned off due to its corrosive nature, therefore large sections of pipework require replacing. It is noted that a new UTC was constructed 2020-2021 and it is not understood at this time the impact to the infrastructure this capital project had.	Infrastructure survey
ED Refurbishment	ED was enhanced during 2020 and it is not understood at this time the impact to the infrastructure this capital project had.	Infrastructure Survey
Ward refurbishment	During 2020/2021 14 wards Trustwide received ward enhancements of immediate redecoration and IPC enhancement. Due to time constraints and COVID-19, key backlog infrastructure were unable to be addressed. Key wards to be addressed include Family Health at Lincoln and Boston.	Infrastructure survey

2.6.3 Grantham and District Hospital (2020 MEP Report)

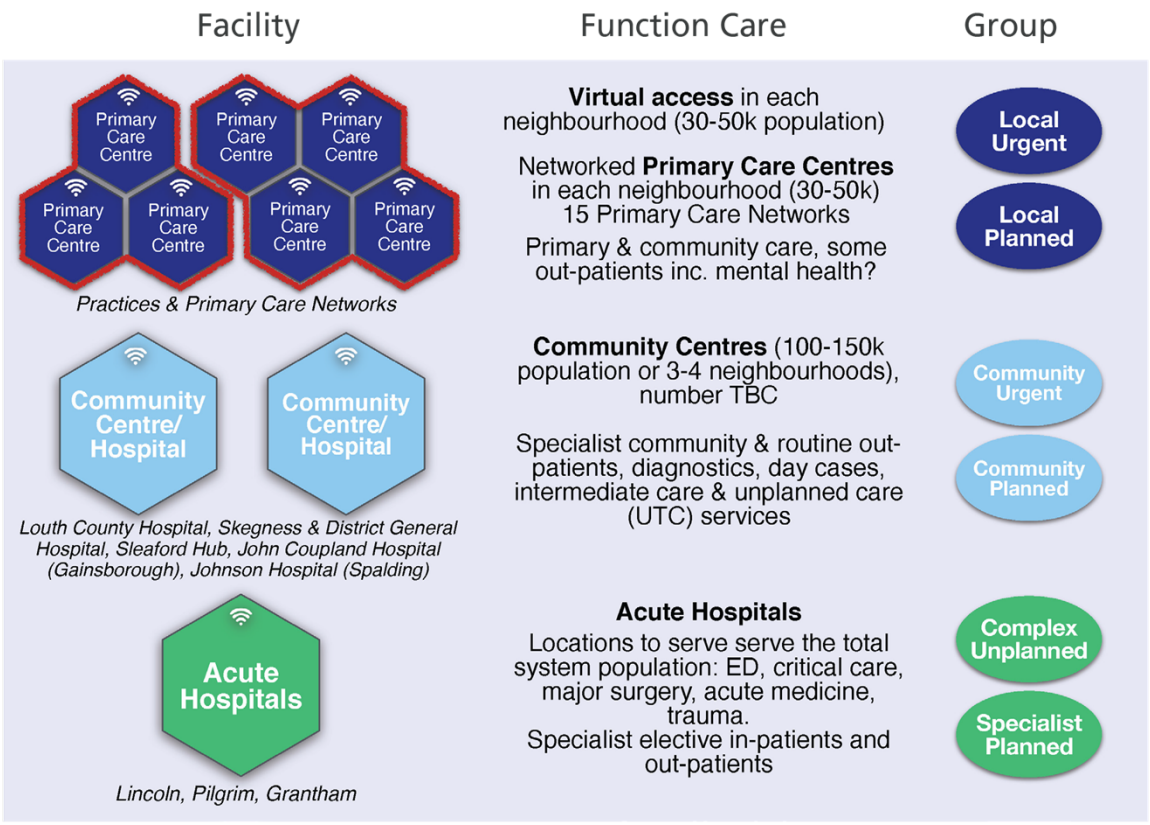
Infrastructure Item	Status	Action in Year 0-2
HV Network	Configured as a number of radial circuits giving resilience issues.	Feasibility study
Generators	Issues with resilience and maintainability of change-over contactors. Trustwide scheme relating to HV to cover electrical infrastructure overall.	Feasibility study
Gas Mains	No noted issues	No action
Medical Gas	No noted issues.	No action
Building Management System (BMS)	Large parts of the BMS are obsolete, with limited environmental controls or strategies, leading to over/under heating of areas or poor temperature control	Feasibility Study
Chillers	Decentralised system. No noted issues	No action
Potable Water	Heating and domestic water upgrades required. Heating and water systems have significant issues as per Lincoln. There are frequent failures of the heating system with around 80% of pipework in need of replacing. Some works being undertaken in 2021/2022.	No action

Chapter 3

Where do we want to be?

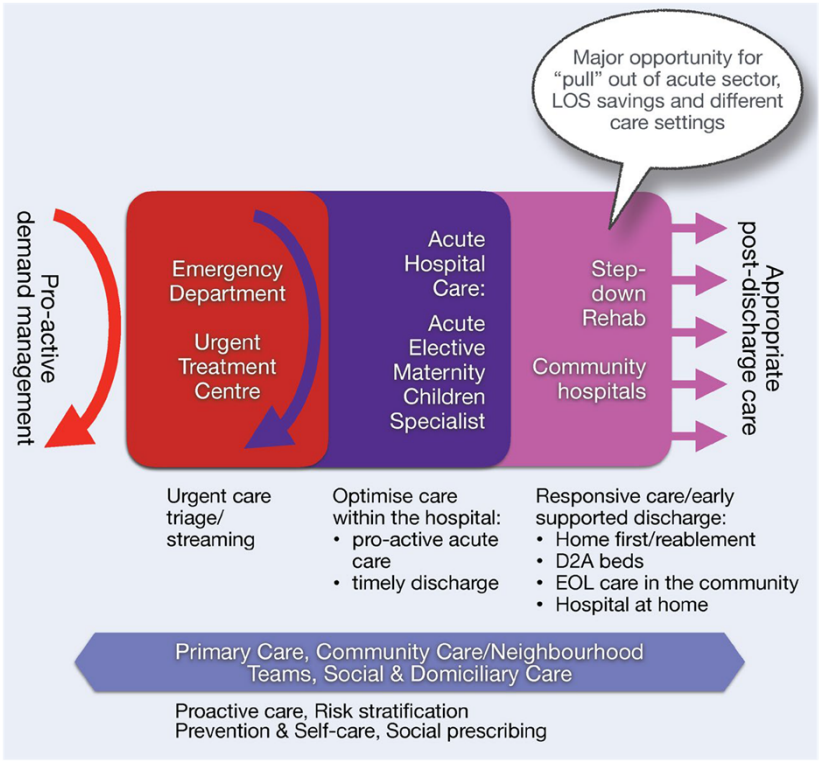
3.1 Integrated Care Vision

The integrated care vision is a system-wide approach and encompasses the acute sector, community, primary care (including mental health) and home care. The below diagram shows the facilities required within the Lincolnshire integrated care vision and model of care, all of which are subject to further consultation.



Integrated System Facilities

Overarching vision….



Integrated Model of Care

3.2 High Level Planning Assumptions/Activity and Capacity Planning

This following provides a summary of the high-level planning assumptions that have informed the demand and capacity modelling used to develop the ICS Estates Strategy (2019). The high-level planning assumptions and activity and capacity planning has been developed to include all areas of the ICS strategy, however for the purposes of this presentation the below are the operational assumptions and activity shifts for the acute hospital requirements only.

Acute Activity

Shifts are based on the Optum resource maps…

Acute POD	Currency	Optum Left Shift %	Delivery Mechanism	Proportion %	Future POD	Future Site
ED	Attendance	27.50%	Hear & Treat, Mobile Rapid Response, Support at Home, Office-based activities.	60%	Comm NFTF	Community Site N/A
			Primary Care based activities: FU PC, care co-ordination, LTC & Frailty management	22.50%	Primary Care FTF	Community Care Site
			Transitional Care: Beds & EOL	7.50%	Community Admission	Community Hospital
NEL	Spells	10%	Rapid Response, Support at Home, Office-based activities.	70.00%	Comm NFTF	Community Site N/A
			Primary Care based activities: FU PC, care co-ordination, LTC & Frailty management	20.00%	Primary Care FTF	Community Care Site
			Transitional Care: Beds & EOL	10.00%	Community Admission	Community Hospital
EL	Spells	12%	Community Services	60.00%	Comm FTF	Community Care Site
			Self Management	40.00%	Self Care	Community Site N/A
OP	Contacts	21%	Community Services	20.00%	Comm FTF	Community Care Site
			Self-Management	15.00%	Self Care	Community Site N/A
			Primary Care based activities: FU PC, care co-ordination, LTC & Frailty management	55.00%	Primary Care FTF	Community Care Site
			Mental Health OP	10.00%	MH FTF	MH Site

Acute Operational Assumptions

Key parameters ('high' scenario)

Growth		
Activity Growth	As per ONS Projections, by age band, by CCG.	
Outpatients		
POD	Face to Face	Non- Face-to-Face
Sessions / Week	12	12
Weeks / Annum	48	48
Session Length	240 minutes (4 hours)	300 minutes (5 hours)
Appointment Length	22.5 minutes	15 minutes
Utilisation	75%	90%
Inpatients		
Bed Ocupancy	92% overall target (varies by zone)	
Decant Beds	One Ward per site in addition to modelled beds	
Day Cases	7 days/week (or equivalent)	
Assessment	7 days/week (or equivalent)	
Theatres		
	Elective & Day Case	Non-Elective
Session Length	240 minutes (4 hours)	240 minutes (4 hours)
Sessions / Week	12	14 (CEPOD will be 24-hour)
Weeks per Annum	48 (to allow for down-time)	48 (to allow for down-time)
Utilisation	75% (needle to skin)	75% (needle to skin)

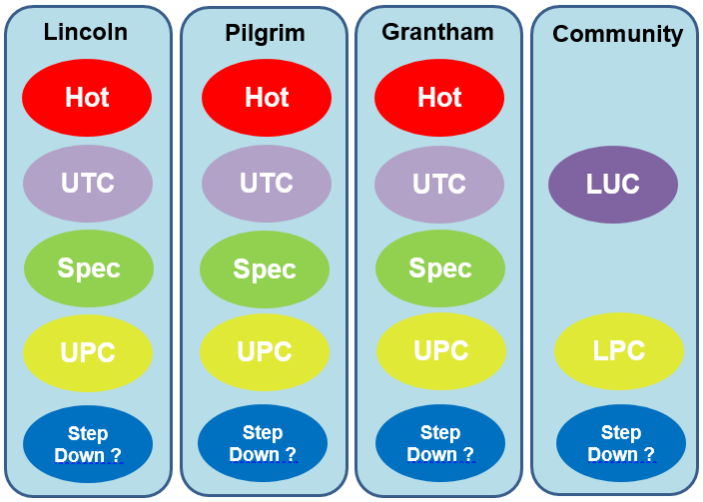
As part of the options review at ICS level, it was agreed that Option 1 was the preferred option. This aligns with the expressions of interest submitted by each sector under the 2021 Health infrastructure Plan (HIP) bid process, which has been used to develop design strategies and development control plans as shown in the following chapters.

Acute Clinical Building Blocks

Service vision for each component of care…

Hot	**Hot**: Emergency Centre inc. ED (resus, majors), critical care, main theatres, acute medicine, cancer surgery, trauma, stroke/HASU etc. Includes CLU maternity & children
UTC	**Urgent Treatment Care**: inc. urban urgent care, requires access to diagnostics (x-ray, pathology)
LUC	**Local Urgent Care**: eg in health centre, primary care
Spec	**Specialist Elective In-patients & Diagnostics**: inc. orthopaedics, short-stay elective surgery, specialist out-patients, specialist diagnostics etc
UPC	**Urban Planned Care**: routine out-patients, out-patient procedures, surgical day cases, medical day procedures, therapies etc
LPC	**Local Planned Care**: routine out-patients, procedures eg in health centre, primary care
Step Down	**Step Down Beds**: long-stay patient care, in a community or home setting

Acute Option 1



Sized Brief*

Metric	Lincoln	Pilgrim	Grantham	Total
Beds (IP & DC, SD)	646	371	69	1,085
OPD C/E	56	34	16	106
Theatres	9	5	7	21
ED Exam/Treat	25	21		46
Imaging Room	16	10	3	29
Cases (all PODs)	404,417	255,068	94,647	754,132
Size m2	85,076	48,165	13,630	146,871

*Sized Brief identifies total future beds

3.3 Disposal of Land

As part of a Government initiative, the National Audit Office (NAO) first published a report in June 2015 entitled Disposal of Public Land for New Homes on behalf of the Department for Communities and Local Government. Following this, the ministry of Housing, Communities and Local Government published a paper entitled Public Land for Housing Programme 2015-2020, which was recently updated in February 2020. The aim of the programme was to identify and release surplus central Government land in England for 160,000 new homes by the end of March 2020 and contribute to the aim to achieve £5bn in land property receipts by 2020, including disposals of land and property where there is no potential for housing. Data shows that by the end of March 2020 c69,000 homes had been delivered. The land disposals within the scope of this programme included NHS Trusts and Foundation Trusts.

Public bodies can adopt a range of approaches to structure disposals to promote early development with departments using one or more of the following approaches:

- Direct sale of land;
- Sale and leaseback;
- Clawback provisions;
- Profit sharing through overage provisions;

- Delaying transfer of land via licensing;
- Partnering for site preparation; and
- Joint-venture arrangements.

The sale of surplus land, either with or without planning permission, generates a one-off capital receipt. Many Trusts and other public bodies are considering alternatives to outright disposal and a capital receipt, and as an alternative retaining an interest in the land, and/or buildings and converting that interest into a long-term revenue stream for the Trust. If land identified as part of the development control plan (DCP) is not considered for sale to other parties it will be reviewed with the ICS to potentially reuse in the wider integrated care system for community care, mental health or primary care facilities.

3.3.1 Potential disposal of land

The Trusts land disposal strategy will be developed alongside the clinical strategy.

3.4 Green Plan

3.4.1 Green Plan

"While the NHS is already a world leader in sustainability, as the biggest employer in this country and comprising nearly a tenth of the UK economy, we're both part of the problem and part of the solution.

That's why we are mobilising our 1.3 million staff to take action for a greener NHS, and it's why we have worked with the world's leading experts to help set a practical, evidence-based and ambitious route map and date for the NHS to reach net zero."- Sir Simon Stevens, former NHS Chief Executive

United Lincolnshire Hospitals NHS Trust (ULHT) is proud to share the Trust's Green Plan, which seeks to embed sustainability and low carbon practice in the way vital healthcare services are offered and help the NHS to become the first health service in the world with net zero greenhouse gas (GHG) emissions.

The climate crisis is also a health crisis. Rising temperatures and extreme weather will disrupt care and impact the health of patients and the public, especially the most vulnerable in society.

People with mental health issues may experience a higher degree of 'climate anxiety', and there may be co-morbidities associated with the physical impacts of climate change and a deterioration in mental health.

ULHT has a central role to play in reducing health inequalities and helping the NHS to reach net zero.

This Green Plan serves as the central document for ULHT's sustainability agenda and provides the rationale for sustainability at the Trust. Through this Green Plan, ULHT will work with staff, patients and partners to take powerful sustainable development and climate action as part of the Trust's commitment to offer the highest quality care to the Lincolnshire community.

The Trust will establish a Sustainability Committee that will meet regularly and project manage the delivery of Green Plan activities by multiple teams. The Green Plan will be incorporated as a part of the Sustainability Committee agenda, reviewed annually, and updated where necessary to ensure continual improvement.

3.4.2 Travel Plan

The travel plan is an important tool, which will also support future planning applications for new developments across the three hospital sites. The implementation of a robust travel plan has the potential to reduce or negate the need for costly improvements and/or planning conditions relating to any planning approval. In light of this, it is crucial that the Trust's travel plan which is under development is not only implemented but also kept up to date. The Trust has recently made a major commitment to continued development of the 2014 travel plan by employing a Trustwide Travel Plan Co-ordinator, whose role it is to source and implement attractive measures to promote alternative travel options for staff and visitors.

A living framework travel plan is being developed, together with site-specific plans on an online platform, where initiatives and actions are updated to meet the targets and objectives that the Trust has set. The objectives include working with partners, including local authorities and service providers, to support the local transport strategies and local transport plans. As one of the largest employers in the county, the Trust is committed to reducing CO2 emissions, improving the local environment and improving air quality. The travel plan will be utilised when progressing with the emerging estates strategy and development control plan.

3.5 Commercial Estate Strategy

The commercial strategy for maintenance of existing buildings will be developed in line with projects identified in 4.6 of this report. They will include any new buildings, as per the Development Control Plans in section 4.4. and will be in accordance with Trust approaches of using tried and tested framework suppliers alongside in house maintenance teams.

3.6 Trust Priority Spend Year 0-2 (Phase 1)

The Estates and Facilities Team has reflected on the issues raised in the 2020 Estates Strategy and has produced this interim Estates Strategy and DCP over two years for consideration and approval, which is in line with the ICS strategy.

The strategy will allow the Trust to develop its estate in the short term in a planned manner to meet the urgent clinical configuration and critical infrastructure needs, without any conflict with the ICS strategy.

With regards the short-term vision for the estate, the Trust has a clear set of aims to support the quality, safety and effectiveness metrics:

- To develop a two-year plan to upgrade the overall condition of the estate and reducing further deterioration and risk. (Critical Infrastructure Risk)
- To ensure any immediate/ urgent clinical and service developments are facilitated.
- To ensure any estate physical solution to these service developments are, as far as possible, in accordance with the Trust's emerging clinical strategy, system acute services plan and dovetail into the development control plan and overall ICS strategy.
- To create an energy infrastructure plan to upgrade the Trust's supply plant and equipment. Investment has already been secured to ensure improvements, through successful bids for Department of Health and Social Care grants and using interest-free loans.
- To review the efficiency of the estate and facilities services, taking all opportunities to reduce cost and align with the model hospital metrics and the Lord Carter report.
- To rationalise the estate and generate capital from the sale of surplus land and assets, as well as improving the utilisation of space and prioritising clinical services.
- To deliver substantial improvements in car parking facilities across the sites.
- To ensure any previous or short-term capital investment is not wasted.

The Trust's 0-2 year priority spend has been reviewed against the ICS reconfiguration to ensure alignment. The following chapters have reviewed the design strategies and resultant development control plans against a list of priority works, which have been provided by the ULHT Estates Department.

This has allowed us to demonstrate how these projects align with the DCP and ICS strategy for years 2-10.

3.7 NHS Estate in response to COVID-19

The COVID-19 pandemic has had significant impact on hospital estates and clinical services countrywide. Therefore, when developing the 0-10 year estates strategy and development control plan, the strategy will be to provide a flexible, optimised and effective healthcare estate with a key focus on IPC excellence. This will include the examination of physical space and utilisation, the digital future with more video consultations, a review on closer to home care and review of clinical space and facilities for flexible use. This means that the ability to reconfigure the estate must be taken into account from the beginning. The Trust also has to reconsider its service plans in light of the COVID-19 pandemic.

3.8 Ten Year Estates Strategy

Following on from Phase 1 priority works years 0-2, this estates strategy is about improving the clinical environments in our hospitals, to make them fit for purpose in delivering quality, reliable care to the people of Lincolnshire, as well as providing a state-of-the-art environment for our staff to deliver care from. This is part of the broader Lincolnshire Health Infrastructure Programme to transform the provision of healthcare across Lincolnshire.

The 10 year estates strategy is split into two phases.

Phase 2 includes enabling works and key infrastructure and a number of new build developments. This is based on a detailed design strategy and estates review, seeking to minimise service disruption and spread capital costs. (See section 4.4 for details)

Lincoln County Hospital, Phase 2:	**Pilgrim Hospital, Boston, Phase 2:**	**Grantham and District Hospital, Phase 2:**
Women's and Children's	Inpatients	Women's and Children'
Hematology and Oncology	Women's and Children's (W&C)	Inpatients
Endoscopy and Therapies	New ward block	Hematology and Oncology
	Refurbishment of existing ward block	Imaging
	Theatres and Critical Care	Outpatients, including Day Surgery, Cardiac, Endoscopy, Therapies
	Hematology and Oncology	Support services
	Outpatients including Cardiac and Endoscopy	
	Imaging	

However, the hospital sites and some of their facilities are no longer fit for purpose. In order to maintain the sites prior to the delivery of the 10 year strategy there are a number of schemes/developments which have been identified which require priority investment within the 2022-2025 capital programme to address critical infrastructure risks and ensure clinical services can continue to deliver safely without disruption. **See Section 4.4 for Development Control Plan**

Chapter 4

How do we get there?

4.1 Design Strategy - New build and refurbishment to existing site - Lincoln County Hospital

The below design strategies have been developed by using the demand for space from schedule of accommodation which has been generated from the activity and capacity planning. These demonstrate how each of the building blocks will be supplied through various levels of refurbishment or new build. These strategies form part of the ICS overarching strategy for the three acute sites.

Building Block	Low Refurbishment	Medium Refurbishment	High Refurbishment	New Build	Demolition
Women's and Children's			W&C @ 8,196 sq.m (plus 1,600 sqm plant)	W&C @ 8,196 sqm (plus 1,600 sqm plant)	8,354 sqm
Urgent and Emergency Care				Assessment Beds @ 3200 sq.m (plus 640 sq.m plant)	
Inpatients			IP Theatres @ 1,955.4 sqm	IP Wards @ 10,526 sqm (plus 2,000 sqm plant)	
			IP Therapies @ 443.2 sqm		
			Critical Care @ 2,451.3 sqm		
			IP Wards @ 7,148 sqm		
Haematology and Oncology				IP & OP @ 5,588 sqm (plus 1,200 sqm plant)	
Imaging			IP & OP @ 3,939 sq.m		
Outpatients	OPD @ 2,238 sq.m		Day surgery unit @ 2,500 sqm Cardiac day unit @ 650 sqm	Therapies @ 500 sq.m (plus 100 sq.m plant)	
				Endoscopy @ 975 sq.m (plus plant 200 sqm)	

Building Block	Low Refurbishment	Medium Refurbishment	High Refurbishment	New Build	Demolition
Support Services		Pathology (incl Mortuary) @ 2737 sqm Research @ 547 sqm		CT Scanner HASU @ 150 sqm (plus 50 sqm plant)	Demolition part pathology @ 1,000 sqm
	Pharmacy @ 821 sq.m	Hospice @ 400 sqm		FM @ 1,642 sqm (plus 328 sqm plant)	
	CSSD @ 1,000 sqm				
	Catering and Restaurant @ 1,500 sqm				

4.1.1 Design Strategies - New build and Refurbishment to existing site – Lincoln County Hospital

Building Block	Low Refurbishment	Medium Refurbishment	High Refurbishment	New Build	Demolition
Plant and Comms	Utilise Existing			2,535 sq.m	Included above
Infrastructure	Increased electrical Supply Capacity to new build developments (new builds likely to utilise electrical source for heating and hot water)				n/a
Infrastructure	Replace aged HV electrical infrastructure				n/a
Infrastructure	Replace local LV generators and change-over contactors				n/a
Infrastructure	Refurbishment projects to incorporate CEF guidance with regards to demand reduction of the following: Chillers and HVAC - Fabric Insulation - Heat Distribution and Boilers - LED Lighting - Variable Speed Drives - Voltage Optimisation - Water Efficiency - Behavioural Management - Building Management Systems - Contract & Performance Assurance				n/a
Infrastructure	500 space MMC multi storey car park				n/a
TOTAL	**67,760 sqm**				**9,354 sqm**

4.1.2 Engineering Strategy - New build and refurbishment to existing site - Lincoln County Hospital

In line with NHS Roadmap to Net Zero Carbon, new build developments are likely to utilise electrical source for heating and hot water. Trust projects are underway to review, and upgrade electrical capacity.

High Level Refurbishment – Incorporate CEF guidance with regards to demand reduction includes:

- Chillers and HVAC - Fabric insulation - heat distribution and boilers - LED lighting - variable speed drives - voltage optimisation - water efficiency - behavioural management - building management systems - contract and performance assurance

https://www.carbonandenergyfund.net/wp-content/uploads/2021/03/CEF_Practice-Guide_Demand_Reduction.pdf

Medium and Low Level Refurbishment – Incorporate sensible measures from above list, variable speed drives, LED lighting, improved BMS controls, occupancy detection etc.

Infrastructure – Improve and upgrade infrastructure:

- New modular self-contained ICT data server rooms
- Medical gas upgrade works
- Theatre ventilation upgrades
- Electrical upgrade works
- Water (heating and domestic) upgrade compliance works
- New water supply for W&C unit
- BMS upgrades
- Review infrastructure loads from recent capital projects:
    - UTC
    - Resus
    - Modular ED

4.2 Design Strategy - New build and refurbishment to existing site - Pilgrim Hospital Boston

Building Block	Low Refurbishment	Medium Refurbishment	High Refurbishment	New Build	Demolition
Women's and Children's		Gynae clinic area		5,017 sqm	6,820 sqm
Urgent and Emergency Care					
Inpatients			IP Support @ 1,800 sqm	* IP Theatres & Critical Care @ 3,199 sqm plus 640 sqm plant)	
			IP Beds & Therapies @ 8,716 sqm		
Haematology and Oncology				1,058 sqm (plus 211 sqm plant)	1,275 sqm
Imaging				2,205 sqm (plus 30 sqm plant)	2,231 sqm
Outpatients		Day Theatres @ 1,500 sqm		OPD, Cardiac day unit, Endoscopy, therapies @ 3,005 sqm (plus 600 sqm plant)	
Support Services	Pathology (incl. Mortuary) @ 1,166 sqm			Pathology/Mortuary @ 325 sqm (plus 65 sqm plant)	
	Pharmacy @ 685 sq.m			New Entrance @ 740 sqm (plus 148 sqm plant)	
	FM @ 1,000 sqm				FM 900 sqm
	Catering & Restaurant @ 1,500 sqm				
	Education @1,500sq.m				Education 1,000 sqm
	Research @ 291 sqm				

4.2.1 Design Strategy - New build and refurbishment to existing site - Pilgrim Hospital Boston

Building Block	Low Refurbishment	Medium Refurbishment	High Refurbishment	New Build	Demolition
Plant and Comms	Utilise existing			3,471 sqm	Included above
Infrastructure	Replace generator 5				n/a
Infrastructure	Replace central medical air plant				n/a
Infrastructure	Increase in heat demand				n/a
Infrastructure	Replace existing aged plant within the calorifier plant room				n/a
Infrastructure	New substation to be installed to serve the Theatres project				n/a
Infrastructure	New energy centre - incorporating net zero carbon initiatives				n/a
Infrastructure	Refurbishment projects to incorporate CEF guidance with regards to demand reduction of the following: Chillers and HVAC - Fabric Insulation - Heat Distribution and Boilers - LED Lighting - Variable Speed Drives - Voltage Optimisation - Water Efficiency - Behavioural Management - Building Management Systems - Contract & Performance Assurance				n/a
Infrastructure	500 space MMC multi storey car park				n/a
TOTAL	**38,872 sqm**				**12,226 sqm**

4.2.2 Engineering Strategy - New build and refurbishment to existing site

In line with NHS Roadmap to Net Zero Carbon, new build developments are likely to utilise electrical source for heating and hot water. Trust projects are underway to review, and upgrade electrical capacity.

High Level Refurbishment – Incorporate CEF guidance with regards to demand reduction include:

- Chillers and HVAC - Fabric Insulation - Heat Distribution and Boilers - LED Lighting - Variable Speed Drives - Voltage Optimisation - Water Efficiency - Behavioural Management - Building Management Systems - Contract & Performance Assurance

https://www.carbonandenergyfund.net/wp-content/uploads/2021/03/CEF_Practice-Guide_Demand_Reduction.pdf

Medium and Low Level Refurbishment – Incorporate sensible measures from above list, Variable Speed Drives, LED Lighting, Improved BMS controls, occupancy detection etc

Infrastructure – Improve and upgrade infrastructure:

- New modular self-contained ICT data server rooms
- Medical gas upgrade works
- Theatre ventilation upgrades
- Electrical upgrade works
- Water (heating and domestic) upgrade compliance works
- BMS upgrades
- New energy centre
- Review infrastructure loads from recent capital projects
    - ED refurbishment

An action still to be undertaken is an updated maintenance strategy for Pilgrim Hospital, Boston. The strategy will be based on the priorities set out in the updated six- facet survey and focus on maintaining a Category B status for all buildings and not allowing deterioration below this level.

4.3 Design Strategy - New build and refurbishment to existing site - Grantham and District Hospital

Building Block	Low Refurbishment	Medium Refurbishment	High Refurbishment	New Build	Demolition
Women's and Children's				449 sqm	
Inpatients				5,351 sqm	
Haematology and Oncology				372 sqm	
Imaging				315 sqm	
Outpatients				OPD, Day surgery, Cardiac unit, endoscopy, therapies @ 4,483 sqm	
Support Services				2,000 sqm	
Sub Total				12,970 sqm	27,315
Plant and Comms				4,863. sqm	Inc above
Infrastructure	Increased electrical authorised supply capacity to new build developments (new builds likely to utilise electrical source for heating and hot water)				n/a
Infrastructure	New energy centre – incorporating net zero carbon initiatives				n/a
TOTAL	**17,833 sqm**				**27,315 sqm**

4.3.1 Engineering Strategy- New build and refurbishment to existing site - Grantham and District Hospital

In line with NHS Roadmap to Net Zero Carbon, new build developments are likely to utilise electrical source for heating and hot water. Trust projects are underway to review, and upgrade electrical capacity.

Infrastructure – Improve and upgrade infrastructure:

- New energy centre
- Theatre ventilation upgrades
- Electrical upgrade works
- Water (heating and domestic) upgrade compliance works first phase at Grantham
- BMS upgrades
- Radiant panel replacements

4.3.2 Maintenance Strategy- Legacy, new build and refurbishment - Grantham &and District Hospital

An action still to be undertaken is an updated maintenance strategy for Grantham and District Hospital. The strategy will be based on the priorities set out in the updated six-facet survey and focus on maintaining a Category B status for all buildings and not allowing deterioration below this level.

4.6 Programme of Projects

Working with the Trust's Estate and Facilities team we have reviewed the programme of projects and have analysed these against the ICS strategy and reviewed against the resultant DCP for each acute site, the results of which are described below. This has enabled us to produce a priority list of capital projects for years 0-2.

Risk Rated Key: High Moderate Low Developmental

Project/Works	Critical Infrastructure or Statutory Requirement (YES or NO)	Clinical Need (YES or NO)	In line with DCP (YES or NO)	In line with ICS Strategy (YES or NO)	Business Case (YES or NO)
Critical theatre refurbishment, compliance and ventilation rolling programme of upgrade works - 2 theatres per location @ All sites	YES	YES	YES	YES	Planned works as part of E&F risk prioritised capital
Maternity block upgrade works @ Lincoln	YES	YES – Patient Environment Improvements	YES	YES	Planned works as part of E&F risk prioritised capital
Trustwide HV reconfiguration and upgrade works	YES	YES	YES	YES	Planned works as part of E&F risk prioritised capital
ICU expansion @ Lincoln and Pilgrim to create extra beds (COVID-19 related)	NO	YES	YES	YES	NO
Mortuary refurbishment @ Lincoln and Pilgrim	NO	YES	YES	YES	NO
New modular ITsServers @ Lincoln and Pilgrim. Relocation of existing servers to provide two at Lincoln and one at Pilgrim	YES	YES	YES	YES	YES
Trustwide lift upgrade works @ All sites	YES	NO	YES	YES	Planned works as part of E&F risk prioritised capital

Project/Works	Critical Infrastructure or Statutory Requirement (YES or NO)	Clinical Need (YES or NO)	In line with DCP (YES or NO)	In line with ICS Strategy (YES or NO)	Business Case (YES or NO)
Medical gases 02 VIE compounds @ Lincoln and Pilgrim	YES	YES	YES	YES	Planned works as part of E&F risk prioritised capital
Public toilet upgrade and improvement works @ all sites	NO	Patient Environment Improvements	YES	YES	Planned works as part of E&F risk prioritised capital
Endoscopy upgrade works (infection control improvement) @ Lincoln	NO	YES – jag accreditation	YES	YES	NO
Trustwide signage – patient experience improvement	NO	NO	YES	YES	NO
Asbestos removal in second, third and fourth floor @ Pilgrim	YES	NO	YES	YES	Planned works as part of E&F risk prioritised capital
Water upgrade works – heating and domestic @ All sites. First phase of works to take place at Grantham	YES	YES	YES	YES	Planned works as part of E&F risk prioritised capital
Women's and children's main entrance enhancement and refurbishment/reconfiguration works to maternity block @ Lincoln and Pilgrim	YES	YES	YES	YES	NO
New water supply for domestic water to maternity @ Lincoln	YES	YES	YES	YES	Planned works as part of E&F risk prioritised capital
Roof replacement and upgrade works @ All sites	YES	NO	YES	YES	Planned works as part of E&F risk prioritised capital
Asbestos removal programme where required @ all sites	YES	NO	YES	YES	Planned works as part of E&F risk prioritised capital

Project/Works	Critical Infrastructure or Statutory Requirement (YES or NO)	Clinical Need (YES or NO)	In line with DCP (YES or NO)	In line with ICS Strategy (YES or NO)	Business Case (YES or NO)
Energy Centre Strategy @ Pilgrim and Grantham (Pilgrim timeline 12-18 months)	YES	NO	YES	YES	NO
Full six facet survey @ all sites	YES	NO	YES	YES	NO
Project 'Spring Clean' – Improvements of patient and staff areas to enhance experience including white rock to walls, painting, ceiling replacement, improvements to main entrances. Improvements addressing infection control and CQC comments. Blocks will be enhanced in line with the DCP @ all Sites	NO	Patient Environment Improvements	YES	YES	NO
Ward refurbishment and improvements addressing infection control and CQC comments. @ Lincoln and Pilgrim. (Critical Care @ Lincoln, 7a, 7b, ACU and 8a @ Pilgrim)	NO	YES – Patient Environment Improvements	YES	YES	Planned works as part of E&F risk prioritised capital
Refurbishment of ward washroom facilities to IPC excellence standards @ all sites	NO	YES	YES	YES	NO
OPD enhancement and refurbishment works to improve overall environment and address infection control and CQC comments @ Lincoln and Pilgrim	NO	YES	YES	YES	NO
Space Management Strategy – Demand for space requirements to be addressed following COVID-19 to meet the need of the clinical teams.	NO	NO	YES	YES	NO
Off-site premises lifecycle costs – capture costs of maintaining services off site (including CDH @ Moy Park and Louth, Aseptic relocation to University of Lincoln)	NO	YES	YES	YES	YES
Provision of a Day Surgery Unit @ Lincoln and Pilgrim. Aspiration and longer term plan which will be developed alongside the clinical strategy.	NO	NO	YES	YES	NO

Project/Works	Critical Infrastructure or Statutory Requirement (YES or NO)	Clinical Need (YES or NO)	In line with DCP (YES or NO)	In line with ICS Strategy (YES or NO)	Business Case (YES or NO)
Grantham theatres – enabler to allow critical infrastructure and ventilation works to existing theatres to commence	NO	YES	YES	YES	YES
Digital consultation – relocation of digital consultations to non-clinical space to enable face-to-face pre op consultations to take place. Priority for the organisation due to delay in patient surgery due to lack of pre op consultation space.	NO	YES	YES	YES	NO
Fire upgrade works @ all sites	YES	NO	YES	YES	
Ingham Ward upgrades to improve privacy and dignity and address infection control and CQC comments @ Lincoln	NO	YES	YES	YES	NO
Window replacement programme. To address backlog and safety issues @ all sites	YES	NO	YES	YES	NO
Radiant panel replacement due to scalding issue @ Grantham	YES	NO	YES	YES	Planned works as part of E&F risk prioritised capital
Trustwide BMS upgrade @ all sites	YES	YES	YES	YES	Planned works as part of E&F risk prioritised capital
Net Zero Carbon @ all sites. Aspiration and longer term plan for the Trust.	Refer to Energy Centre Projects	NO	YES	YES	NO
CPU – Kitchen refurbishment – Trustwide and to be decided in line with catering review.	YES	YES	YES	YES	NO
Storage strategy - Trustwide and to be decided in line with storage review.	NO	NO	YES	YES	NO

4.7 Year 0-2 Programme of Capital Projects

Utilising the full project list, the priority project spend has been extracted and put in the table below. This has utilised indicative values provided by ULHT estates department around the proposed capital budget for each financial year.

Estates Strategy Capital Projects 2022 to 2025

No	Project/Works	Total Budget (million) inc VAT	2022/23 - Year 0 (million) inc VAT	2023/24- Year 1 (million) inc VAT	2024/25- Year 2 (million) inc VAT
		£m	£m	£m	£m
1	Critical theatre refurbishment, compliance and ventilation rolling Programme of upgrade works to address the infection control ventilation - two theatres per location @ All sites	£18.0	£6.0	£6.0	£6.0
2	Trust wide HV reconfiguration and upgrade works	£4.6	£1.4	£1.6	£1.6
3	Scoping budget for capital projects – to maintain forward planning and procurement of capital projects	£0.9	£0.3	£0.3	£0.3
4a	Maternity block upgrade works @ Lincoln - to improve patient experience and address infection control and CQC comments	£6.4	£3.6	£2.8	
4 b	New labour ward @ Boston	£6m	£.3.0	£3.0	
4c	New MLU units@ Lincoln and Boston	£4m		£2.0	£2.0
5	ICU expansion @ Lincoln and Pilgrim to create extra beds (COVID-19 related) – funded expected by NHSE	£3.5	£3.5	£0.0	
6	Modular car parks (decked car parks) @ Lincoln and Pilgrim to provide additional capacity and free up real estate for disposal or construction	£6.6	£3.6	£3.0	
7	Trust wide mortuary refurbishment @ Lincoln and Pilgrim	£2.4	£1.2	£1.2	
8	New modular IT servers @ Lincoln and Pilgrim. Relocation of existing servers to provide two @ Lincoln and one @ Pilgrim	£2.9	£2.9	£0.0	

No	Project/Works	Total Budget (million) inc VAT	2022/23 - Year 0 (million) inc VAT	2023/24- Year 1 (million) inc VAT	2024/25- Year 2 (million) inc VAT
9	Trust wide lift upgrade works @ All sites	£6.0	£3.0	£3.0	
10	Medical gases 02 VIE compounds @ Lincoln and Pilgrim - to improve patient experience	£3.6	£1.8	£1.8	
11	Public toilet upgrade and improvement works @ All sites	£0.2	£0.1	£0.1	
12	Ward refurbishment @ Lincoln and Pilgrim (Critical Care @ Lincoln, 7a, 7b, ACU and 8a @ Pilgrim) – to improve patient experience and address infection control and CQC comments	£7.7	£3.8	£3.8	
13	Endoscopy upgrade works @ Lincoln – to maintain JAG accreditation	£6.0	£0.0	£6.0	
14	Fire upgrade works @ All sites	£2.4	£1.2	£1.2	
15	Full six-facet survey @ All sites	£0.3	£0.3	£0.0	
16	Trust wide signage	£0.6	£0.3	£0.3	
Total		£82.1	£36.0	£36.1	£9.9

The next step will be to develop the estates strategy for years 2-10 in line with the ICS overarching strategy.

4.8 Six- Facet Survey

Since the previous 2017 six-facet survey conducted, the Trust has invested significantly in some of its buildings and infrastructure. However there is still significant backlog maintenance concerns and therefore in 2022-23 a full six-facet survey will be undertaken to establish the current situation and inform future investment plans. Part of this survey will include the utilisation of space review which has been identified as a significant pressure for the organisation post COVID-19.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	5th July 2022
Item Number	Item 12
Integrated Performance Report for May 2022	
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 has been 1 fall in May resulting in moderate harm and 3 falls resulting in severe harm. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. An organisational falls quality improvement project development and implementation group has been established with multidisciplinary representation from divisional and corporate teams. Outline business case for a Falls Prevention Service team will be presented to CRIG in June.

Pressure Ulcers

The number of category 2 PU is 37, category 3 PU is 1 and category 4 PU is 1 for the month of May. The incidents are currently being validated through the incident management205789 process and the appropriate level of investigation will be instigated. The Tissue Viability Team will be delivering a focus on device related pressure damage during June and will also share lessons learned at Ward Leader and Matron Forums.

Never Event

There has been 1 Never Event declared within May that is currently under investigation. This has been reported as a low harm incident relating to the incorrect removal of both ovaries. Patient had only consented for unilateral oophorectomy. A number of actions have already been undertaken whilst the investigation is underway.

Medications

For the month of May, the number or incidents reported in relation to omitted or delayed medications equated to 26% a decrease from the previous two months. A Medicines Management project group has now commenced and aims to raise the profile of medicines management and ultimately reduce the number and potential severity of medicines incidents.

SHMI

The Trust SHMI is 108.32, a slight decrease from the last two reporting periods. The Trust remains in Band 2 with 'As expected'. The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.

eDD

The Trust achieved 90.2% with sending eDDs within 24 hours for May 2022 against a target of 95% with 94.3% being sent anytime within the month. A proposal has been developed and agreed to how eDDs will be managed going forward within the Trust. This will be in collaboration with our system partners.

Sepsis compliance – based on April data

Screening / IVAB / inpatient child - Screening compliance for inpatient paediatrics was 84.7%, screening compliance for paediatrics in ED was 80%, with the administration of IVAB for inpatient paediatrics 87.5% and 28% in ED for April 2022. Screening compliance for adult in ED was 87.4%. Clinical Harm reviews continue as indicated and actions to recover can be seen further within this report.

Duty of Candour (DoC) – April Data

Verbal compliance for April was 82% against a 100% target and 82% for written against a target of 100%. The Clinical Governance team are now notifying clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

Operational Performance

As we move from pandemic to endemic, a number of restrictions have been lifted and the guidance for Infection, Prevention and Control measures have become a 'moveable feast'. At the time of writing this executive summary (10th June 2022), the Trust has 18 positive inpatients. There is 1 patient requiring Intensive Care interventions.

This report covers May's performance, and it should be noted the demands of Wave 4 have significantly decreased, the Trust has moved at pace into the *Recovery* and *Restoration* of services This signifies to teams across the organisation transition to 2022/23 and the recovery of waiting times and return towards pre-Covid access.

A & E and Ambulance Performance

Whilst the summary below pertains to May's data and performance, the proposed new Urgent Care Constitutional Standards continue to be adopted and run-in shadow form. Performance against these will be described in the supplementary combined operational performance FPEC paper.

4-hour performance improved slightly against April's performance of 63.08% being reported at 63.63% in May.

There were 680 12-hr trolley waits, reported via the agreed process. This represents a decrease of 8.73% from April. Sub-optimal discharges to meet emergency demand remains the root cause.

Performance against the 15 min triage target in May demonstrated an improvement of 0.83%. 84.17 in May verses 83.17% in April.

Overall Ambulance conveyances for May were 4080, an increase of 281 conveyances in April (3,799). This represents a 6.89% increase against March. There were 748 >59minute handover delays recorded in May, a decrease of 71 from April, representing an 8.37% decrease. Delays experienced at LCH and PHB have seen increased levels of overcrowding in EDs made more difficult whilst continuing to manage pathways with differing levels of infection risk. May demonstrated a decrease in >120mins handover delays compared with April, 334 in May compared with 461 in April, representing a 27.55% improvement. >4hrs handover delays decreased, particularly at LCH. A total of 76 in May compared to 118 in April. This represents a 35.60% decrease.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 5.05 days against an agreed target of 4.5 days The average bed occupancy for May 2022, was an average of 95%. 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 not been able to meet the demand and is a large contributor to increased LoS. All delays of greater than 24hours are escalated within the System. Elective Length of Stay is now with the agreed parameters.

Elective Length of Stay against the agree target has not been met for May. The average LOS for Elective stay has increased from 2.70 days in April to 3.85 days in May. This is an increase of 1.15 days and represents an increase of 29.88% and can be solely attributed to case complexity.

Referral to Treatment

It is important to view Referral to Treatment standard in the context of the current National Covid Recovery 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.

April demonstrated a further decrease in performance of 1.34% to 49.88%. The Trust reported 4,694 incomplete 52-week breaches for April end of month compared to 4,177 in February. The Trust 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 52+ and 78+ week patients on the 18-week monitoring lists.

At the end of April, the Trust reported 19 patients waiting longer than 104weeks. This is a reduction of 4 patients reported in March and the trust is still on track to only have 1 by the end of June which relates to patient choice.

Waiting Lists

Overall waiting list size has decreased in April to 66,320 compared to February to 66,539, a decrease of 219. Work continues between Outpatient department and the Clinical Business Units regarding returning better access to our bookable services for primary care and patients' choice.

The recovery plan for ASIs has been developed, including a recovery trajectory. May demonstrated an increase (984 verses 596 in April). As of 12th June, ASI numbers have increased to 1042 and is above the agreed trajectory of 550. Additional resource has been directed to resolving missing outcomes which is having an adverse effect on the bookings team being able to move the ASIs to open referrals.

DM01

DM01 for May reported a 57.66% compliance against the national target of 99%. A negative variation of 41.34% against the national target and a 1.63% improvement on the April outturn. Whilst the main area of concern remains Echocardiography, DM01 was significantly impacted by the fire at LCH.

Cancelled Ops

This indicator has not been met since July 2021. The compliance target for this indicator s 0.8%. April demonstrated a 1.58% compliance. A negative variance of 0.78% against the agreed target but an improvement of 0.51% on March.

The target for not treated within 28 days of cancellation is zero. May experienced 22 breaches against this standard verses 33 in April. An improvement of 33.34%

A review of the effectiveness of the 6:4:2 theatre scheduling meetings continues and ICU capacity as a response to internal and external pressures is improving so it is likely that performance will continue to improve.

Cancer

Of the ten cancer standards, ULHT achieved one in April. Nationally only one was met.

Trust compliance against the 62day classic treatment standard is 48.2% (against 85.4% target.) This demonstrates a deterioration in performance of 5.97% since the last reporting period.

Up to 43.2% of the 14-day standard performance can be attributed to the Breast Service. A previous deep dive paper presented to FPEC describes the recovery trajectory across 2022/23.

The impact of COVID-19 on the delivery of the cancer pathways remains evident for 31 day and 62-day standards although as per previous statements Cancer pathways remain the highest priority in the recovery of services and the ring-fencing of capacity.

104+ day waiters were reducing in line with the trajectory, maintaining a level below trajectory until Easter where the impact of multiple Bank Holidays, with associated annual leave has shown a significant deterioration. There are currently 144 patients waiting >104 days against a target of <10.

Workforce

Mandatory Training – Mandatory training rates have remained constant over the past 3 months however shows a slight increase from 89.27% to 90.26%. Staffing challenges and the lack of protected time while on shifts being cited as the main reasons for staff not completing their core learning. In addition some technical issues have had an impact on courses accessibility and record of learning which may have skewed the outcome to which a solution is currently being worked on.

Sickness Absence – The sickness rate increased by 0.05% in May, however we are continuing to see a decrease in Covid absences.

Work is continuing to support the recording and monitoring within the Absence Management System (AMS) which is identifying managers need to ensure that the data recorded in the system is accurate and up-to-date as this will and does affect the system reporting on 'unknown' and 'no reason' absences being recorded. This continues to have a positive impact in reducing the 'blank' reasons.

Work has started on People Management Essentials (PME) training, which cover a section on AMS and management responsibilities. Currently undertaken by Medicine and Estates and Facilities, this will continue across all divisions.

The Employee Assistance Programme (EAP) service provides a complete support network that offers expert advice and compassionate guidance 24/7, covering a wide range of issues. We strongly believe in providing an EAP service that offers not only reactive support when someone needs it but also proactive and preventative support to deliver the best possible outcomes.

Staff Appraisals – The OD team completed a deep dive into appraisal completion rates which was presented to the senior leaders in HR/OD for discussion and next steps. The WorkPAL contract is under discussion with the vendor. Ongoing service pressures and staffing challenges in the Trust have impacted appraisal completion rate over the past 6 months. Return to normality rates will be slow due to backlog. This month we see an increase of 3.56pts from 54.06% to 57.62%

Staff Turnover – Turnover has remained at over 14.5% for the past 3 months. Operational pressures, staffing and culture challenges meant that an increasing proportion of staff are looking for other avenues outside the Trust. The OD team offers face to face / Teams exit interviews to gather deeper insights on the reasons for leaving (in addition to ESR / EF3 form results).

Finance

The Trust submitted a financial plan for 2022/23 of a £5.8m deficit; the plan is inclusive of a £25m cost improvement programme.

A further financial plan submission is required in June to take account of expected additional national funding for 'excess' inflation and pressures - the additional funding comes with the expectation that systems and organisations within them will further improve their plan positions.

The Trust delivered a £0.7m deficit in May (£0.2m adverse to a planned deficit of £0.5m), and YTD the Trust delivered a £1.3m deficit (£0.4m adverse to a planned deficit of £0.9m; CIP savings of £1.9m have been delivered YTD (0.5m adverse to planned savings of £2.4m).

Capital funding levels for 2022/23, agreed through Trust Board & FPEC, show a plan of c£41.0m; capital expenditure incurred YTD equated to c£1.2m.

The May 2022 cash balance is £76.7m, which is a decrease of £11.6m against the March year-end cash balance of £88.3m.

Paul Matthew
Director of Finance & Digital & (interim) People
June 2022

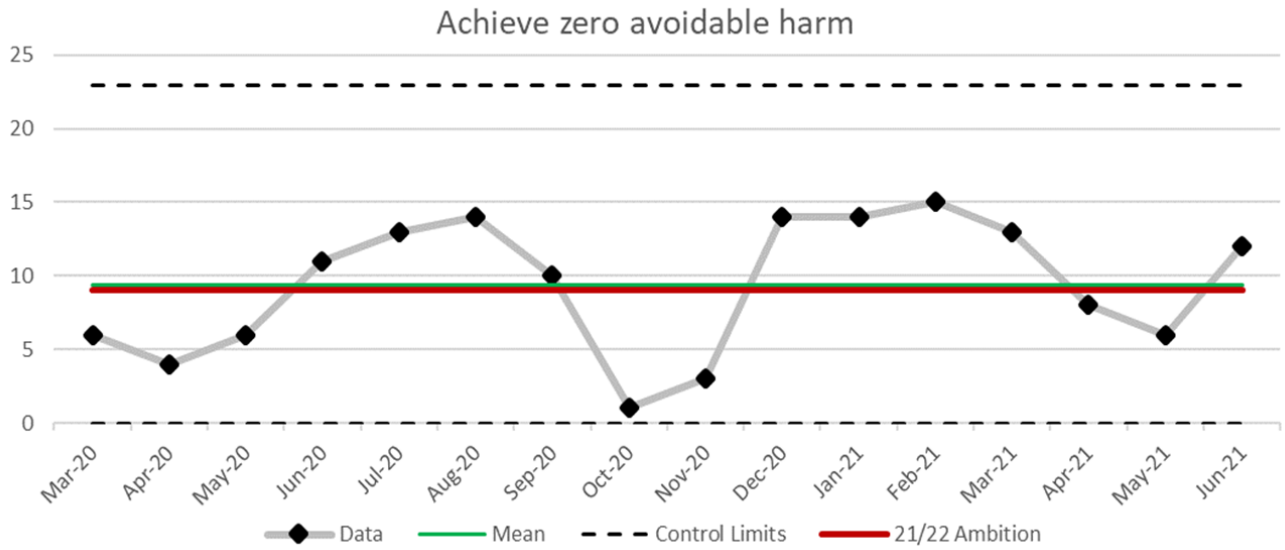
Statistical Process Control Charts

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

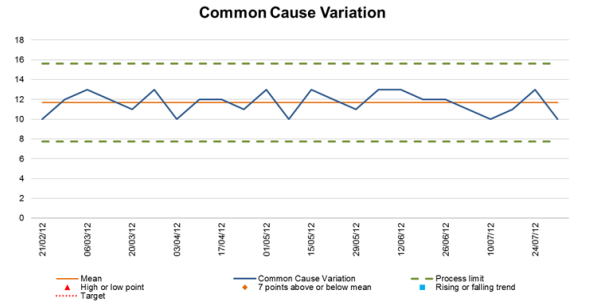
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

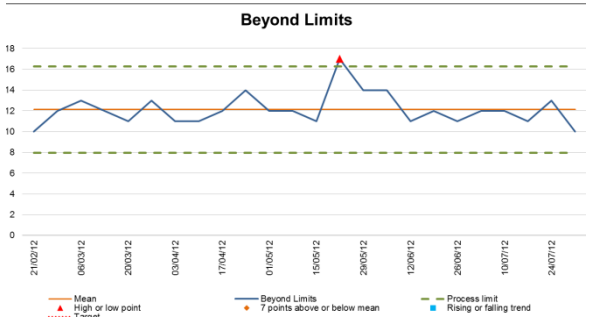
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



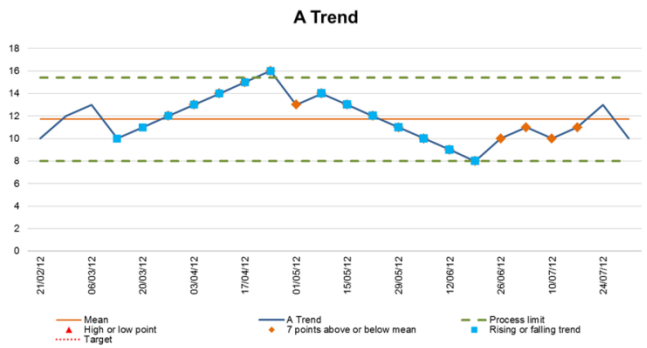
Extreme Values

There is no Icon for this scenario.

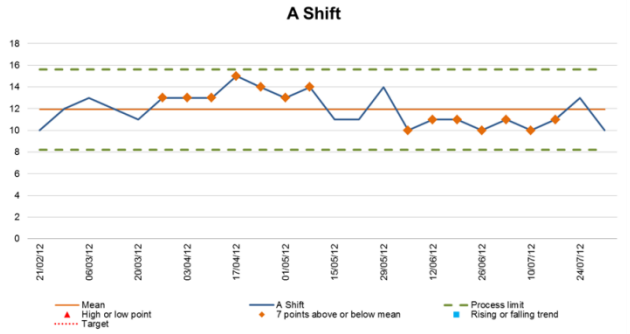


Statistical Process Control Charts

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

Measure ID	Domain	Measure	Measure Definition	Baseline	2022/23 Ambition	£'000	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Latest month pass/fail to ambition	Trend variation
1	Patients	Implementation of the SAFER bundle												
2	Patients	SHMI performance	Summary Hospital-level Mortality Indicator				4th Quartile (110.20) (105th of 122)	4th Quartile (110.73) (106th of 122)	4th Quartile (111.20) (108th of 122)	4th Quartile (111.23) (108th of 122)	4th Quartile (109.48) (107th of 122)	4th Quartile (108.32) (102nd of 122)		
3	Patients	Reduction in moderate and severe harm and death incidents	Serious incidents (including Never Events) of harm - Moderate, severe and death				2	5	4	6	12	14		
4	Patients	Maternity (compliance with Ockenden recommendations and compliance with CNST)												
5	Patients	Reduction in medication incidents leading to moderate & severe harm or death	Medication incidents reported as causing harm (moderate /severe / death), as a percentage of total medication incidents.				3.57%	1.40%	2.10%	1.18%	2.91%	0.00%		
6	Patients	Reduction in DKA incidents resulting in moderate & severe harm or death												
7	Patients	Achievement of the IPC BAF												
8	Services	Financial Plan				£'000								
9	Services	Percentage of patients spending more than 12 hours in department	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.				14.30%	17.43%	21.43%	19.69%	20.28%	19.16%		
10	Services	Percentage of patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more as a percentage of total incompletes.				3.66%	4.50%	5.21%	6.28%	7.08%			
11	Services	28 days faster diagnostics	Number of patients diagnosed within 28 days or less of referral as a percentage of total Cancer pathways.				48.55%	39.50%	53.14%	58.86%	52.63%			
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.				11.18%	10.64%	10.24%	10.36%	10.55%	10.31%		
13	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.				52.40%	53.03%	53.63%	54.30%	54.06%	57.62%		
13	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups				88.94%	88.82%	89.41%	89.59%	89.27%	90.26%		
14	People	Improved Pulse Survey results (Quarterly staff survey)												
15	Partners	Health inequalities and Core20PLUS indicators												
16	Partners	Increased recruitment/academic posts (across the ICS)												
17	Partners	Risk and gain share (provider collaborative)												
18	Partners	Early Warning Discharge Indicators												

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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	Mar-22	Apr-22	May-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	5	4	6	10	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.00	0.13	0.07		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.02	0.01	0.35	0.18		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1						
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.20	0.27	0.05	0.16	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	2	1	1	2	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	1	1	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	2	2	7	9	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	95.54%	95.35%	95.16%	95.26%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	1	1	2	F	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.5	5.73	5.17	5.45	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	27.8%	20.9%	9.9%	15.40%	P	

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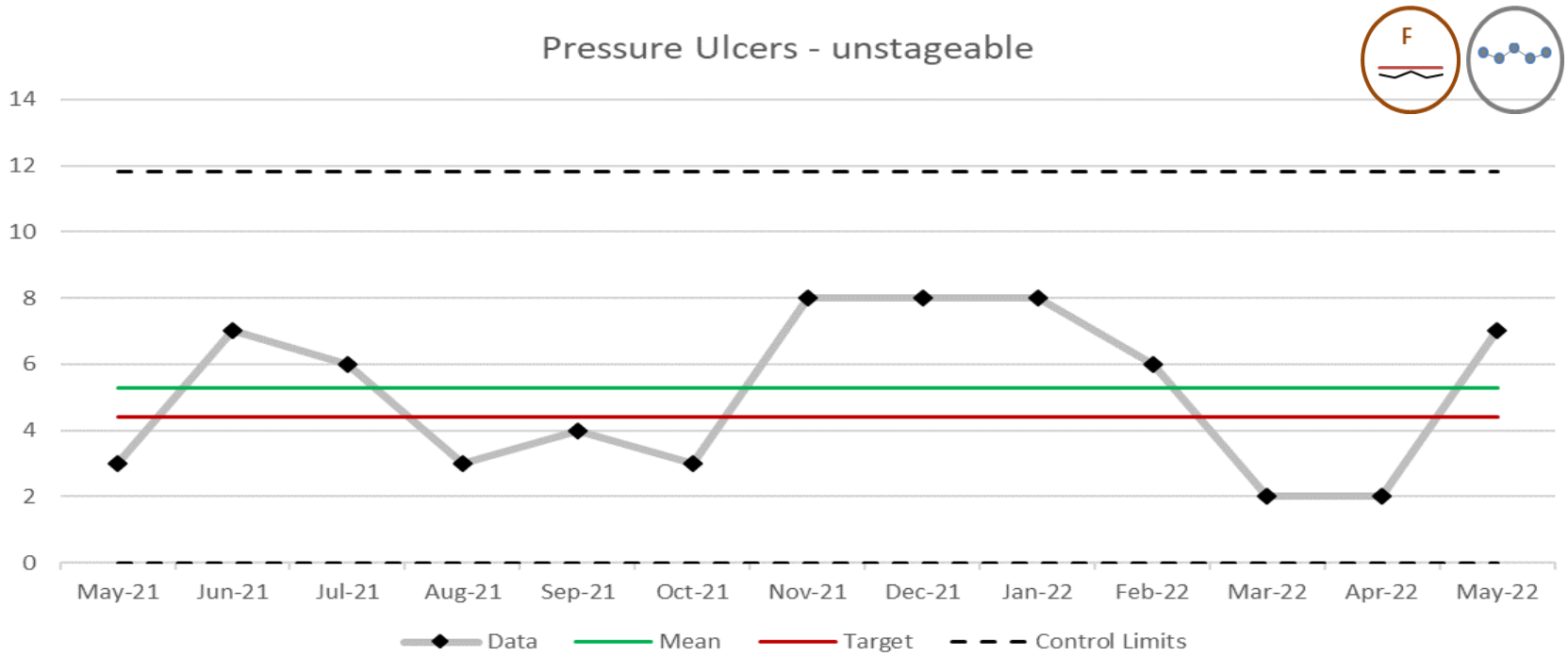
NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-22	Apr-22	May-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	None due	None due	None due		P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	98.10	94.19	92.60	93.40	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	111.23	109.48	108.32	108.90	F	
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	100.00%	100.00%	P	
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	88.20%	88.60%	90.20%	89.40%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	88.6%	94.8%		94.80%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	81.8%	84.7%		84.70%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.6%	98.2%		98.19%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	75.0%	87.5%		87.50%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	90.0%	87.4%		87.40%	F	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	83.5%	80.0%		80.00%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	93.8%	92.3%		92.34%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	100.0%	28.0%		28.00%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	3.03	3.43	3.23	3.33	P	
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%	89.00%	82.00%		82.00%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	71.00%	82.00%		82.00%	F	



May-22
7
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.4
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
Pressure Ulcers Unstageables.

What the chart tells us:
We are currently at 7 against a target of 4 per month an increase of 5 from April.

Issues:
There has been an increase of 5 incidences from last month. PHB and LCH have both reported an increase of 2 incidents each in comparison to April.

On review of the incidents, 3 were identified as a deterioration of existing hospital acquired skin damage.

Two incidents related to patients who were receiving end of life care. There was a delay in implementing a dynamic air mattress and obtaining Tissue Viability advice for one patient.

Two incidents were related to orthopaedic devices.
.

Actions:
Quality Matron and Tissue Viability (TV) team will work collaboratively with Palliative/End of Life team to review best practice and identify any further actions that can be undertaken.

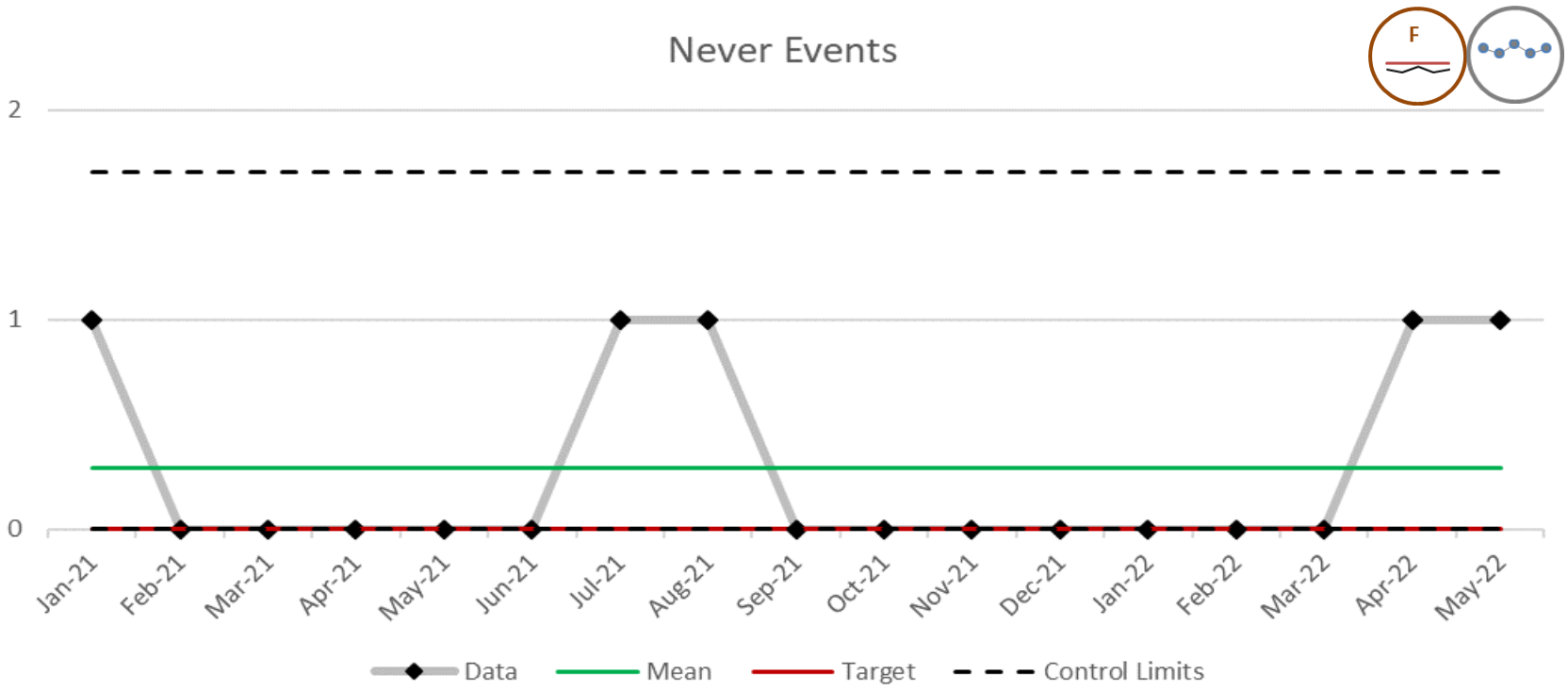
A review of the orthopaedic collar care management pathway is being undertaken with support from the TV team.

The Skin Integrity Group have undertaken a time out session to review its effectiveness and identify additional areas of focus. Outcomes from the session will be discussed at SIG in June.

Mitigations:
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.

Quality | Operational Performance | Workforce | Finance



May-22
1
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
There was 1 Never Event declared in April 2022 and 1 declared in May.

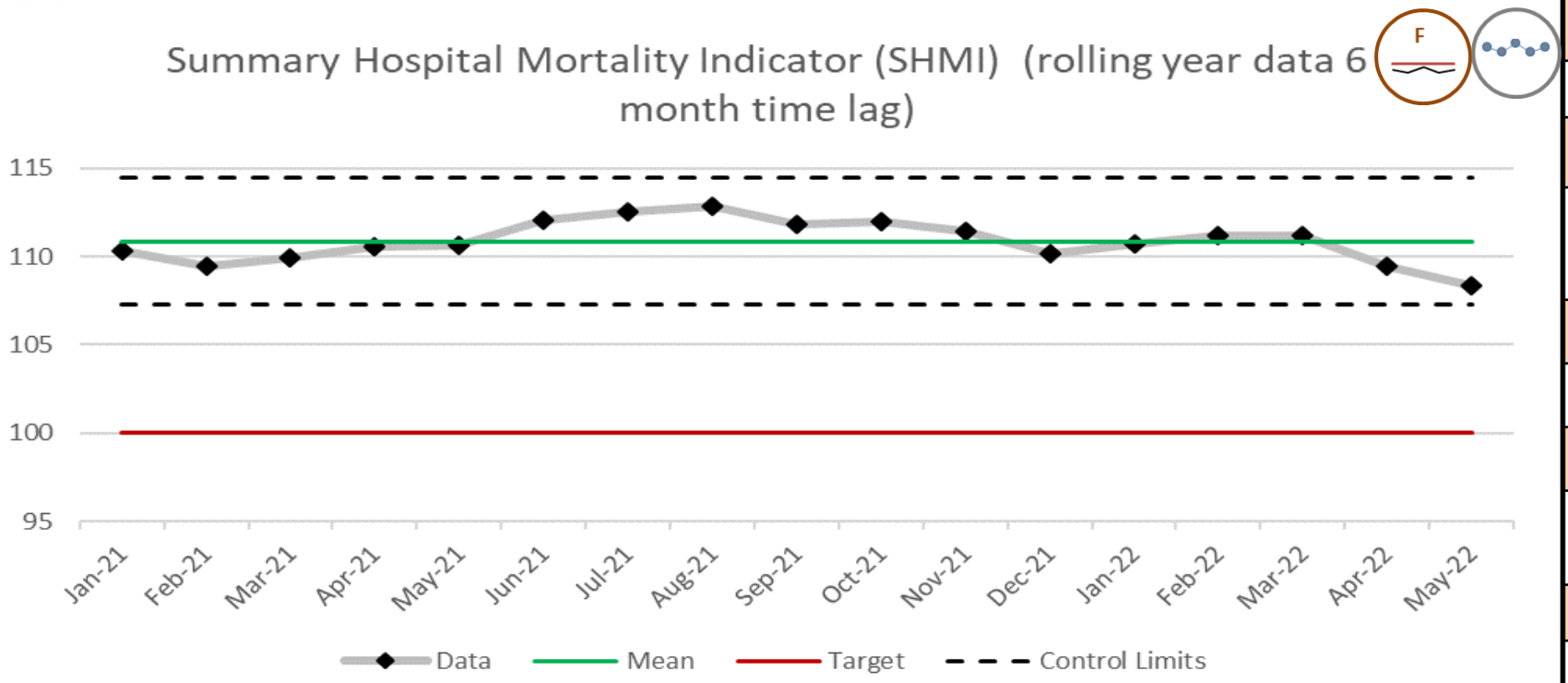
Issues:
The incident declared in April relates to an anaesthetic block performed on the incorrect side prior to a Total Knee Replacement.
The incident declared in May relates to a gynaecology surgical procedure, where consent was given for the removal of 1 ovary but both were removed.

Actions:
Serious Incident procedure initiated leading to local investigation and rapid review – declared to commissioners as SI within approved timeframe
Immediate actions have already been recognised and implemented by the Surgical Division and Family Health Division.

Mitigations:
Investigation teams identified and Risk & Governance support assigned.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



May-22
108.32
Variance Type
Metric is currently experiencing Common Cause Variation
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:
ULHT SHMI is 108.32; a decrease of 1.16 from the last reporting period. The Trust has remained in Band 2 with an 'As expected'.

Issues:
The COVID-19 pandemic has impacted on the Trusts SHMI. The data period is reflective from Dec 20 – Nov 21.

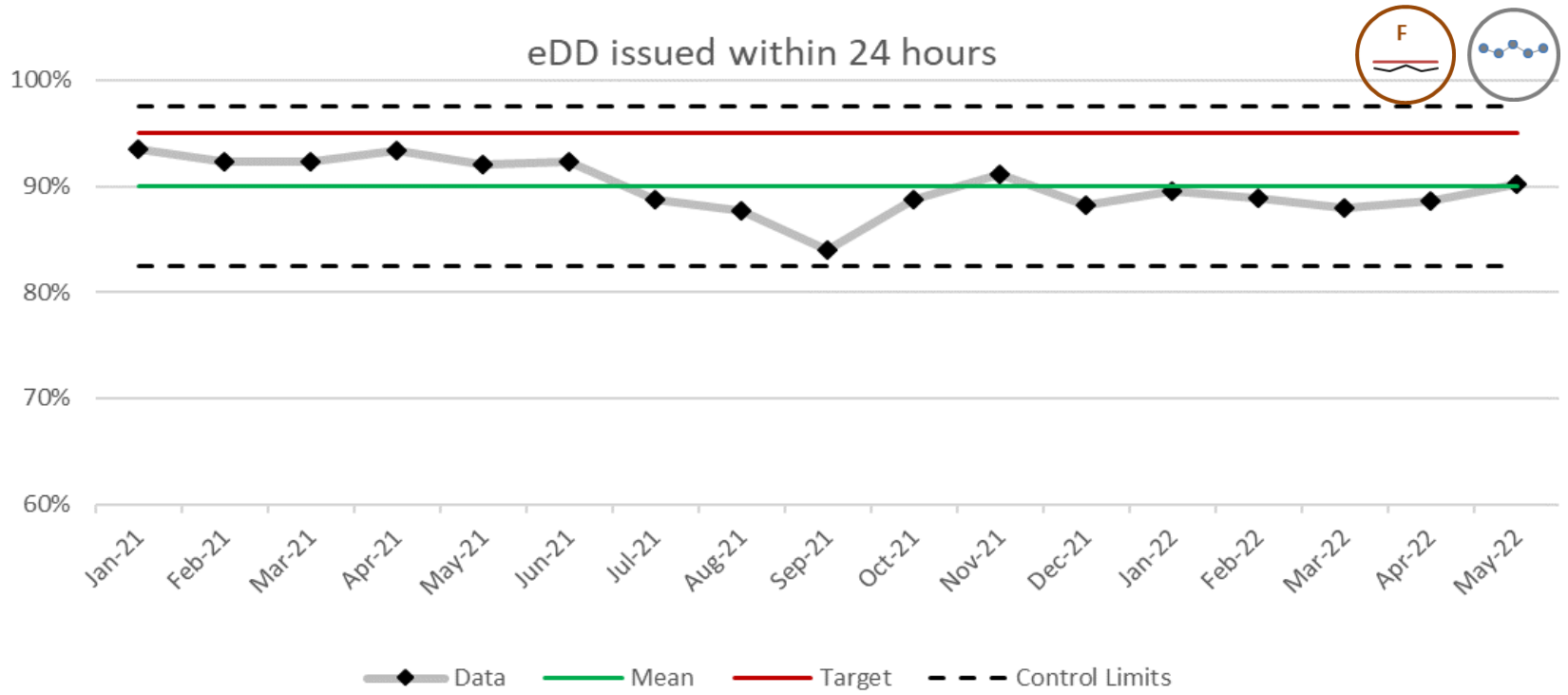
Actions:
Any diagnosis group alerting is subject to a case note review.

The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths and are currently in the pilot phase. This will enable greater learning on deaths in 30 days post discharge.

Mitigations:
The MEs will commence reviewing all deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified.

Learning is shared at the Lincolnshire Mortality Collaborative Group which is attended by all system partners.

HSMR is 92.6 - within expected.



May-22
90.20%
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 May the Trust achieved 90.2% for this standard. The Trust however achieved 94.3% for eDDs sent anytime within the month of May.

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

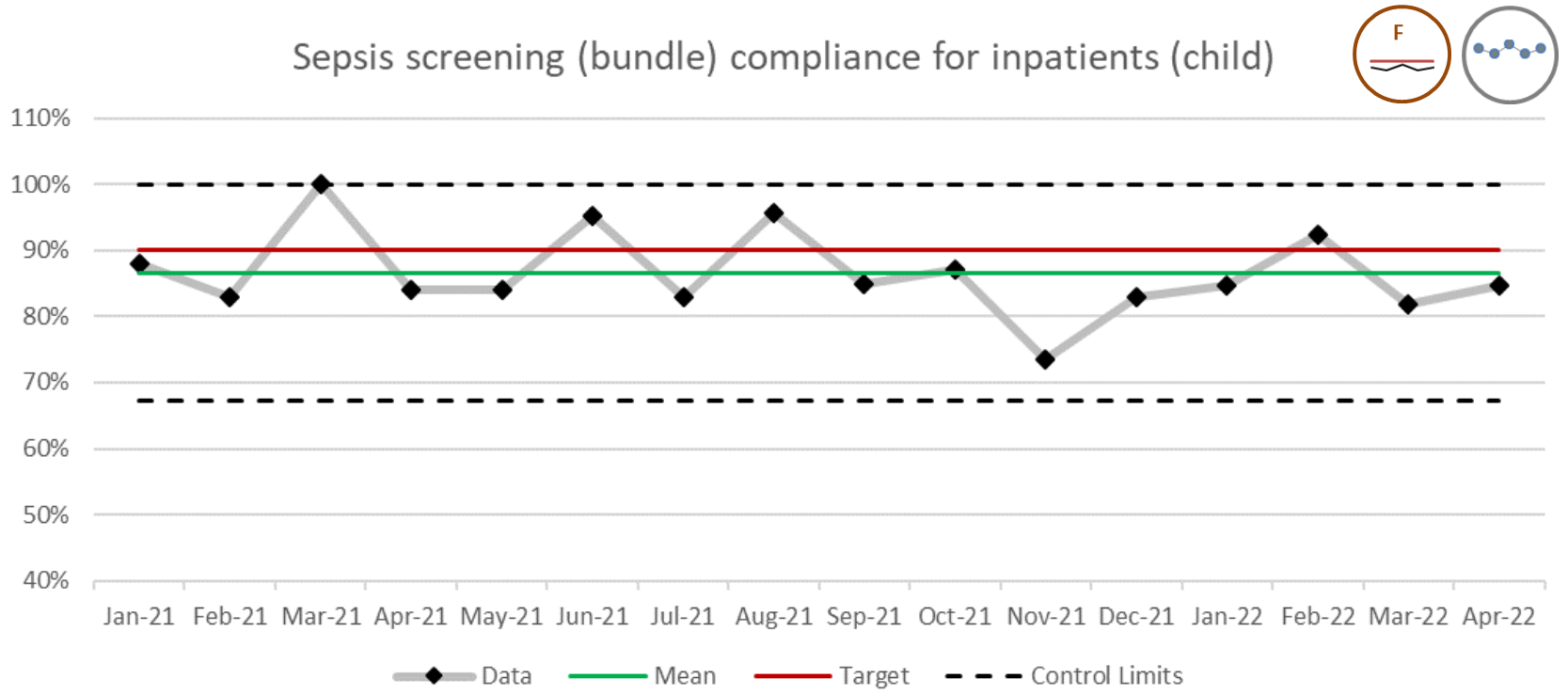
The highest proportion of eDDs not sent within May were from Lincoln Discharge Lounge and Family Health.

Actions:
A dashboard has therefore been developed to highlight compliance at both ward and consultant level, which can then help to highlight areas of suboptimal compliance to help focus targeted work to address this.

Mitigations:
A proposal has been developed and agreed to how eDDs will be managed going forward within the Trust.
Each Division will review their performance at their Performance Review Meetings.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-22
84.7%
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 inpatients (child).

What the chart tells us:
The current compliance is at 84.7% against a target of 90%. This is for 39 out of 46 patients.

Issues:
There were 7 patients found to have not had a screen completed. 6 of these were found to have a viral cause and 1 had observations entered in error giving wrong PEWS score to a patient – No harm found.

Actions:
Educator at Lincoln is currently doing harm reviews for missed screens the aim is that the link nurse at Pilgrim will take on this role too.
The Medical team at Lincoln had training on Monday 23rd May 2022.
There are plans to roll out this training out to Paediatric Drs across site.
Sepsis training Simulation also took place on 18th May 2022.

Mitigations:
The Educator on wards at Lincoln is doing harm reviews and is able to address issues with staff as she finds them. There has been no harm found from April reviews.
Ongoing meeting between Ward sisters, Clinical educators and Sepsis practitioner at both sites in order to highlight any issues or training needs.
Sepsis practitioner visiting wards regularly in order to offer support.

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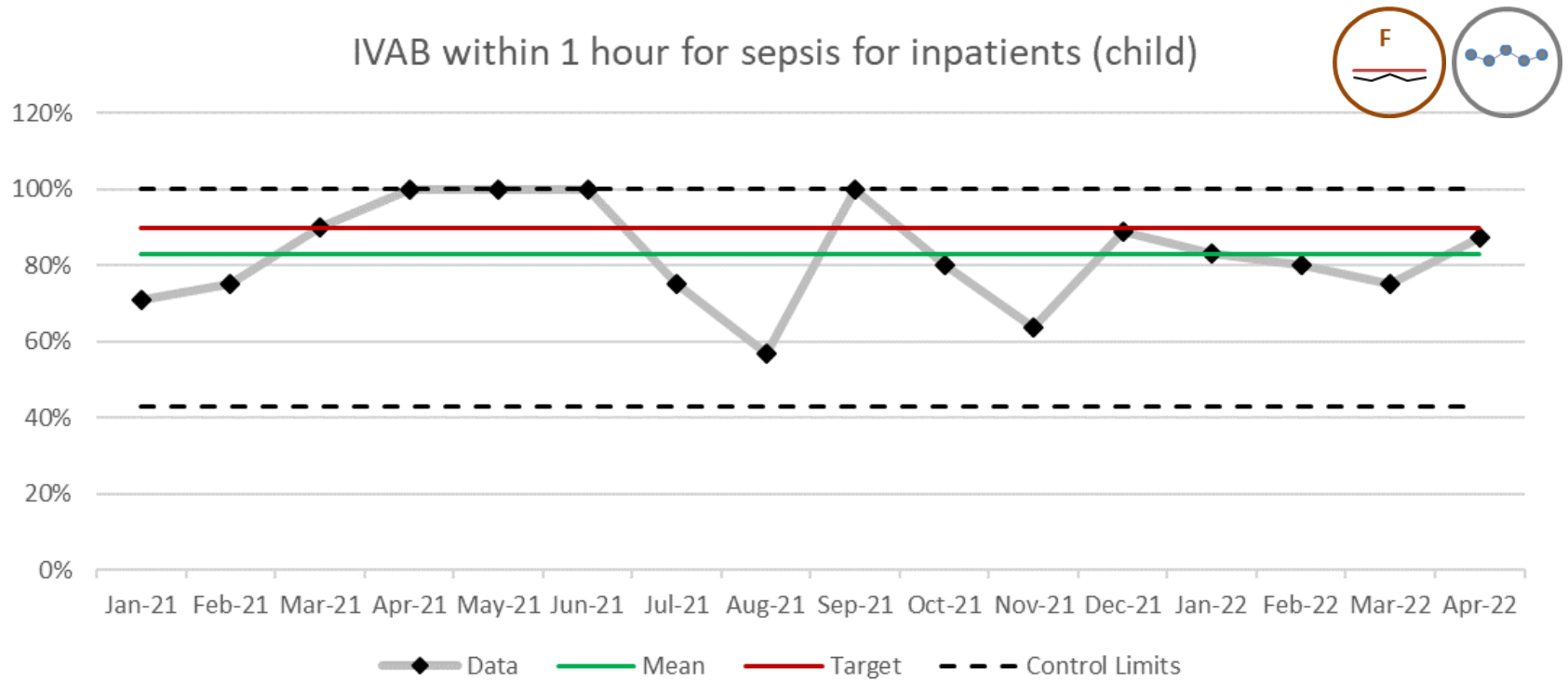
NHS United Lincolnshire Hospitals NHS Trust



Apr-22
87.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The current compliance is at 87.5% against a target of 90%.
There were 7 out of 8 patients that received antibiotics within the one hour time frame.

Issues:
There was one patient who had delayed antibiotics. The harm reviews showed that there was no harm to patients from the delay. This delay was due to difficulties getting IV access for the patient. Antibiotics were given as soon as IV access obtained.

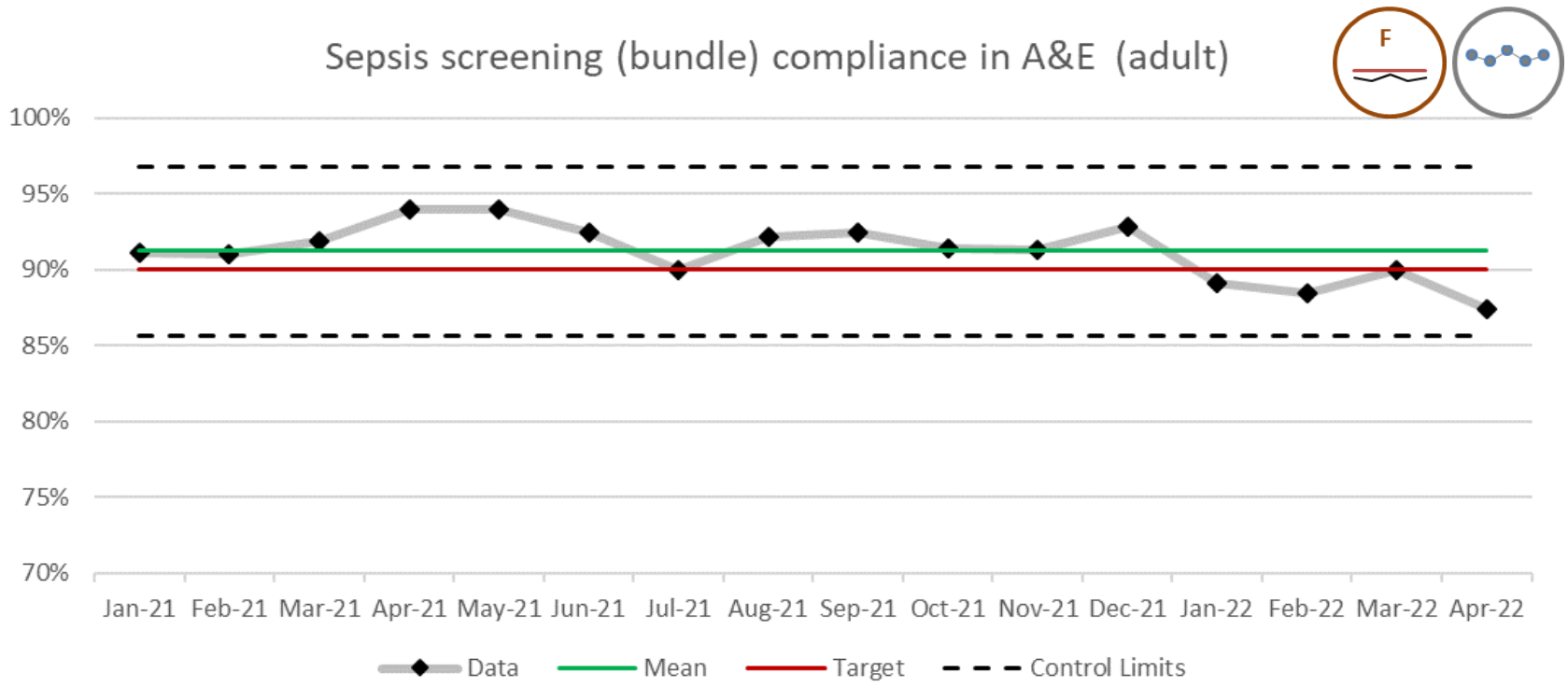
Actions:
Discussions are being held regarding further staff having cannulation training.
Simulation training has happened on both main sites and generated good discussion.
The Sepsis practitioner carried out training for Paediatric Doctors at Lincoln and plans to carry this out across sites.

Mitigations:
Regular meetings taking place between CYP Practitioner, Ward Sister and Clinical Educators to highlight issues early and formulate action plans.
There are also plans for increased MDT meetings regarding Paediatric Sepsis to encourage engagement.
CYP Practitioner is also meeting with Ward Drs to discuss any issues around sepsis.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-22
87.4%
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 (adult).

What the chart tells us:
Screening compliance in ED is 87.4% against a target of 90%. This represents 702 of 803 patients screened within the hour.

Issues:
The fall in compliance is attributable to Lincoln ED where the monthly figures were 80%. Compliance was achieved at PHB and GDH although monitoring continues fortnightly to provide continuing support. Thematic analysis reveals a shortcoming in Agency nurse compliance and issues at the point of handovers of care.
E-learning requires improvement but is on hold due to vacancies on the core learning panel.

Actions:
Weekly meetings with key ED staff and the sepsis practitioners have commenced and this has already led to increased engagement and adoption of different ways of working.
Additional support of a clinical educator at Lincoln to reflect PHB is required and recruitment is underway appoint to this key role.

Mitigations:
All missed screens are subject to a harm review by the respective sepsis practitioners for that site and this will continue with reporting to the focus group each fortnight.
Additional assurance is provided by the establishment of a group of key staff focusing on local improvements for Lincoln ED.
Barriers to improvement are reported to the Deteriorating patient group for escalation and includes the issues around e-learning.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

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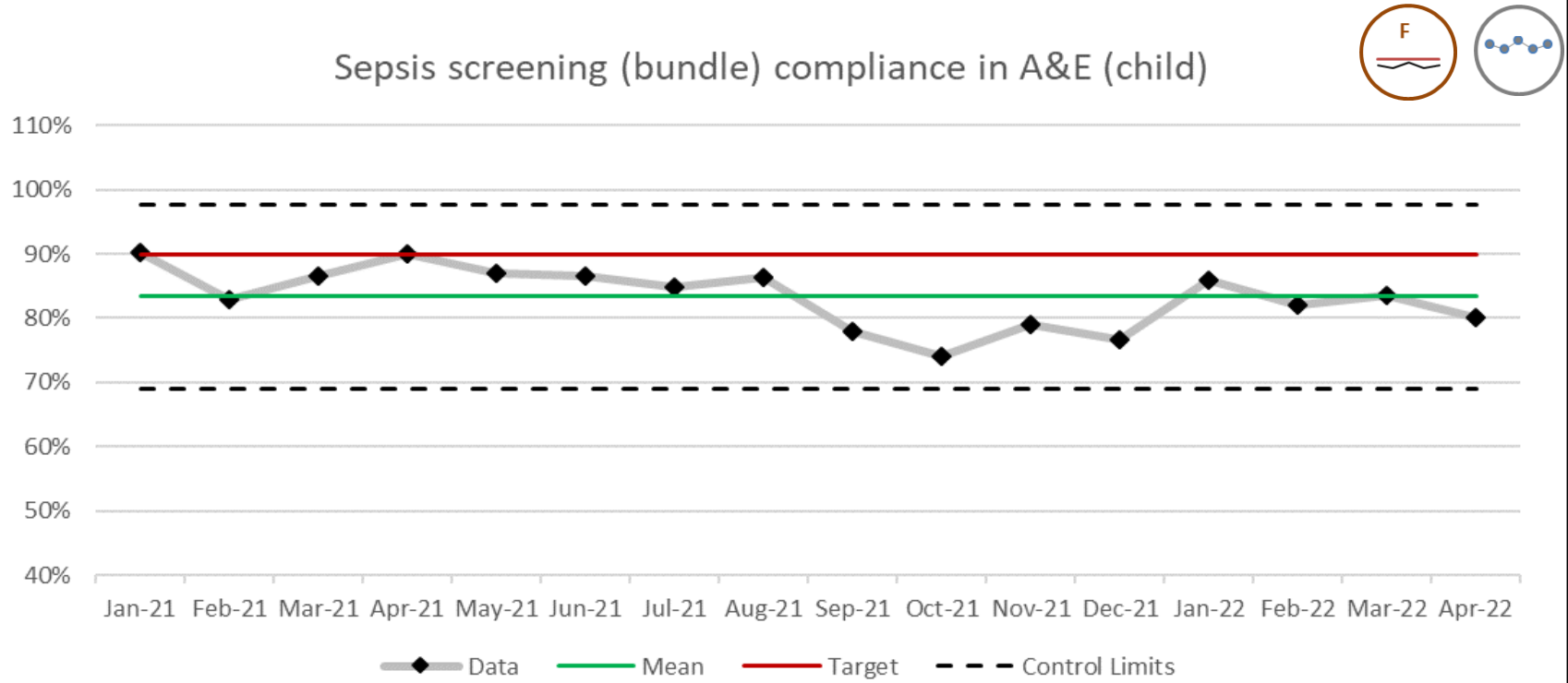

Apr-22
80.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance in ED is 80.0% which is below the 90% target. 139 of 173 patients received screening for sepsis within the hour.

Issues:
ED has recently seen a large turnover of staff. Staff have reported that they are struggling with the Paediatric workload as a single Paeds Nurse in the ED department.
There was a drop in screening and treatment in this month's data.

Actions:
Sepsis Practitioners are currently doing increased walk rounds in the department and offering any assistance if needed. Harm reviews are carried out for all delayed / missed screens.
A member of medical team has been identified as a link at Lincoln. A nurse has also been identified as a link nurse
Two nurses in ED have been shown how to pull data so they can observe this throughout month.

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.
There is also a plan for increased meetings between the link Nurse and Dr in ED and Sepsis Practitioner.

Quality | Operational Performance | Workforce | Finance

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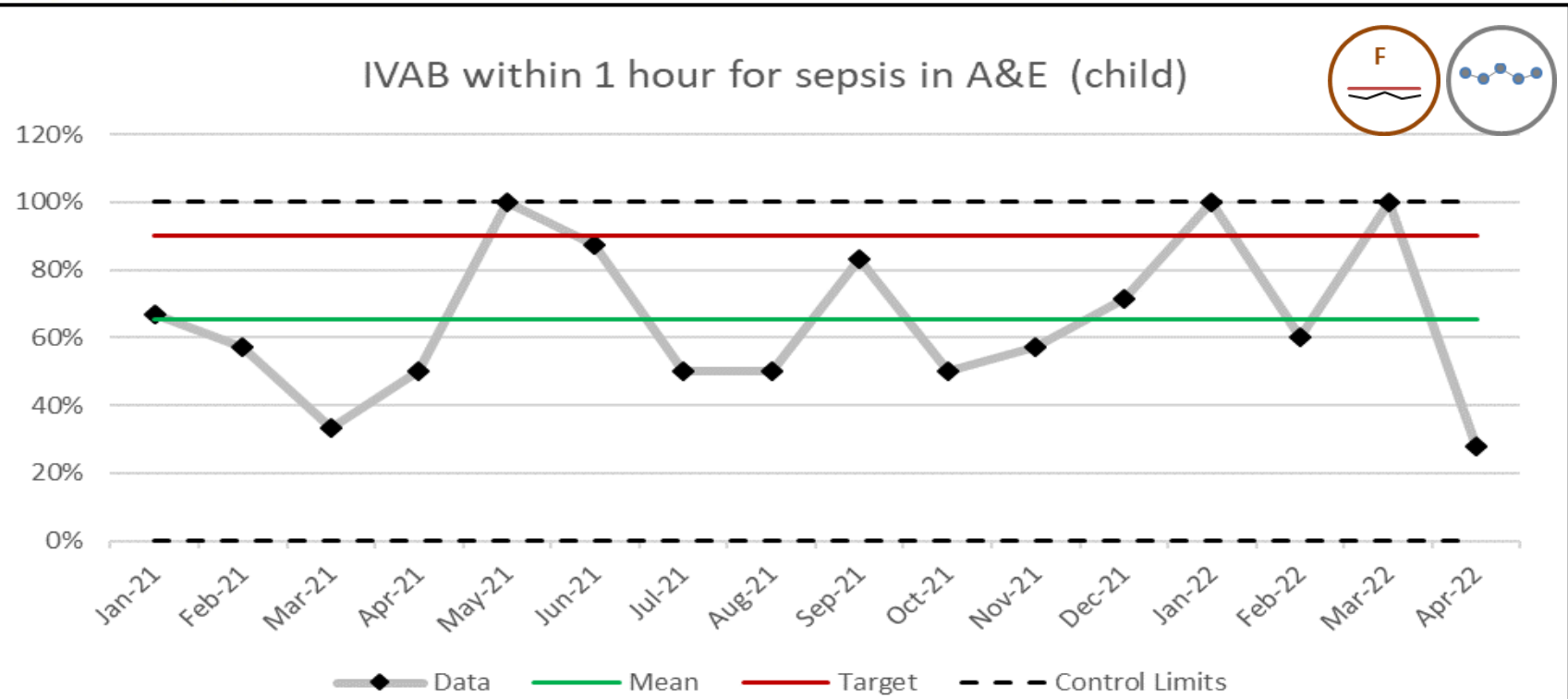

Apr-22
28.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The data this month shows that the IVAB compliance was 28.0%, which is 2 of 7 patients, and is well below the 90% target.

Issues:
There were 5 patients in ED this month that were delayed in receiving antibiotics. Four of these were babies under 3 months of age. The 5th patient was delayed due to Paediatric doctors wanting to review the patient on the ward before deciding whether to treat.

Actions:
Due to this drastic drop in compliance urgent meetings were held between the Link Nurse and Dr in ED for Paediatric Sepsis.
IR1's were completed for all patients as well as harm reviews. There are some learning points from both of these. No harm found.

Mitigations:
IR1's were completed for all these patients so that they could be investigated thoroughly and any learning points can be taken forward.
Harm reviews completed for all patients. No Harm found. 4 out of 5 were treated within a 3 hour timeframe.

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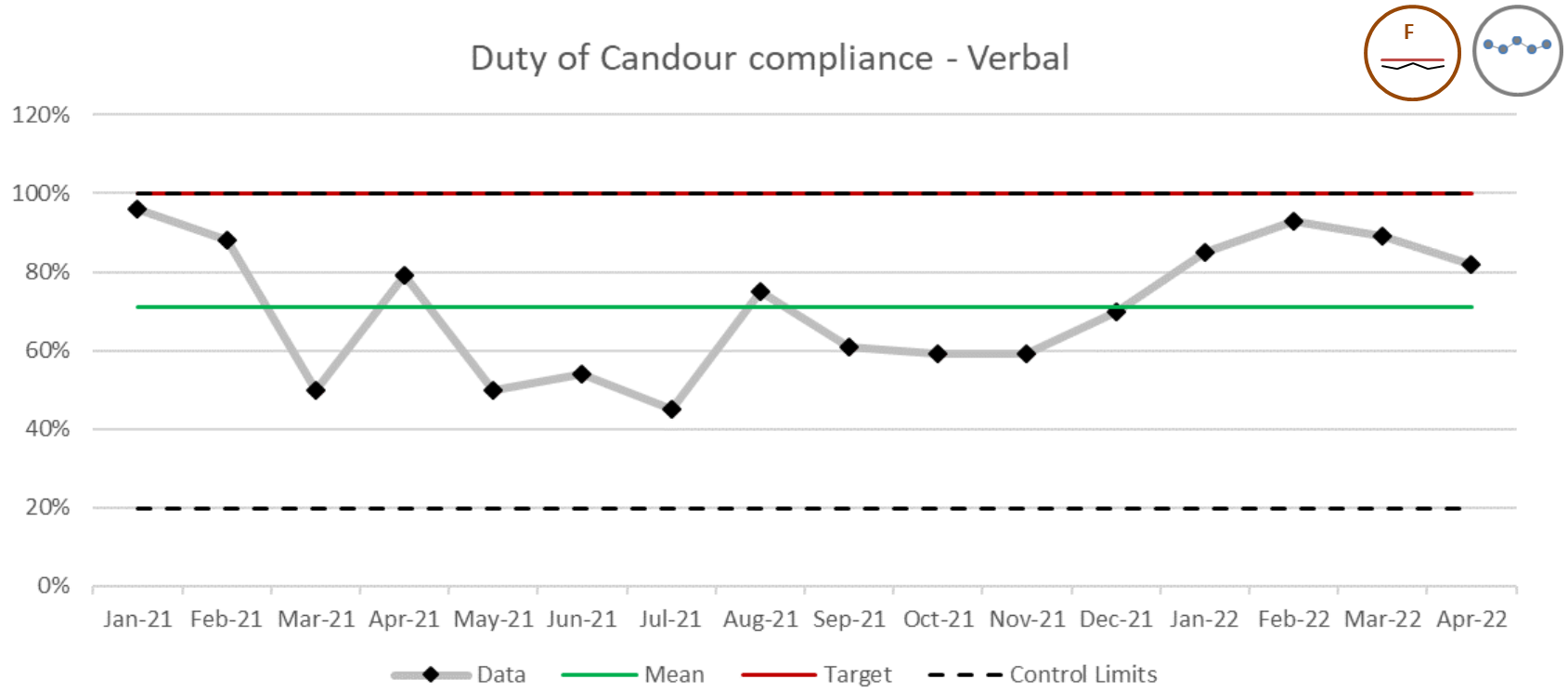

Apr-22
82%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Compliance with the NHS requirement for verbal Duty of Candour, which applies to all patient safety incidents where harm is moderate or above.

What the chart tells us:
Compliance has improved in the last 4 months but is still not reaching 100%.

Issues:
Duty of Candour is frequently completed in person but not recorded on Datix. There are also issues with incidents that are reported retrospectively, where responsibility for Duty of Candour is not always clear at time of reporting.

Actions:
The Clinical Governance team are now liaising directly with clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's.

Mitigations:
Series of briefings on Duty of Candour delivered by external provider in October / November 2021 and again in April 2022.

Completion rate for Duty of Candour Core Learning is consistently above 95%.

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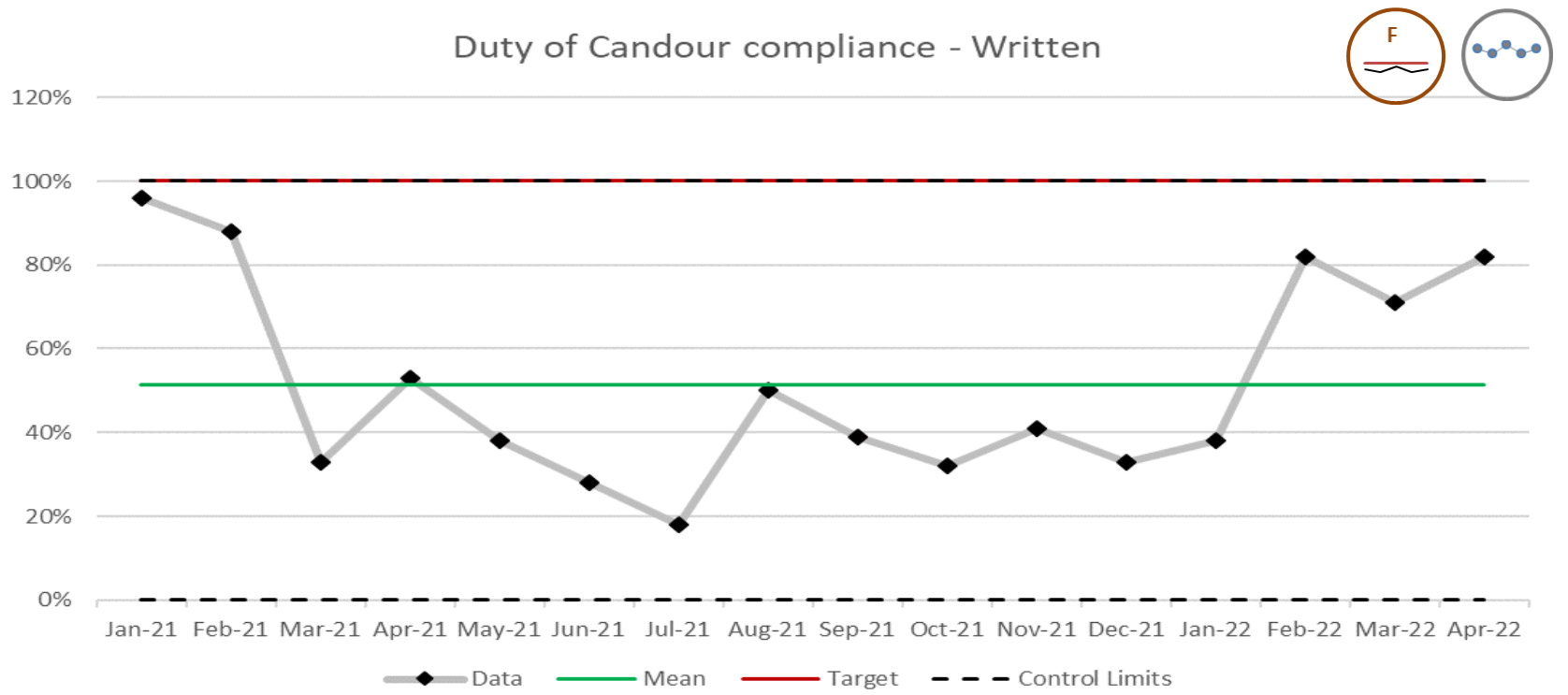
NHS United Lincolnshire Hospitals NHS Trust



Apr-22
82%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Compliance with the NHS requirement for written Duty of Candour, which applies to all patient safety incidents where harm is moderate or above.

What the chart tells us:
Compliance has improved in the last 3 months but is still not reaching 100%

Issues:
Written Duty of Candour is sometimes completed but not recorded on Datix. There are also issues with incidents that are reported retrospectively, where responsibility for Duty of Candour is not always clear at time of reporting.

Actions:
The Clinical Governance team are now notifying clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's.

Mitigations:
Series of briefings on Duty of Candour delivered by external provider in October / November 2021.

Completion rate for Duty of Candour Core Learning is consistently above 95%.

Datix prompts have been added, reminding users to attach copies of Duty of Candour letters.

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	Mar-22	Apr-22	May-22	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%	0.09%	0.06%	0.07%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	61.71%	63.08%	63.63%	63.35%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	834	745	680	1425	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	81.18%	83.34%	84.17%	83.75%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	4177	4694		4,694	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	51.22%	49.88%		49.88%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	66,539	66,320		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	54.17%	48.20%		48.20%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	73.90%	66.80%		66.80%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	9.30%	13.60%		13.60%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	89.29%	91.10%		91.10%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	98.11%	97.10%		97.10%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	77.78%	70.97%		70.97%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	98.25%	94.30%		94.30%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	28.57%	81.25%		81.25%	90.00%			

OUTSTANDING CARE personally DELIVERED

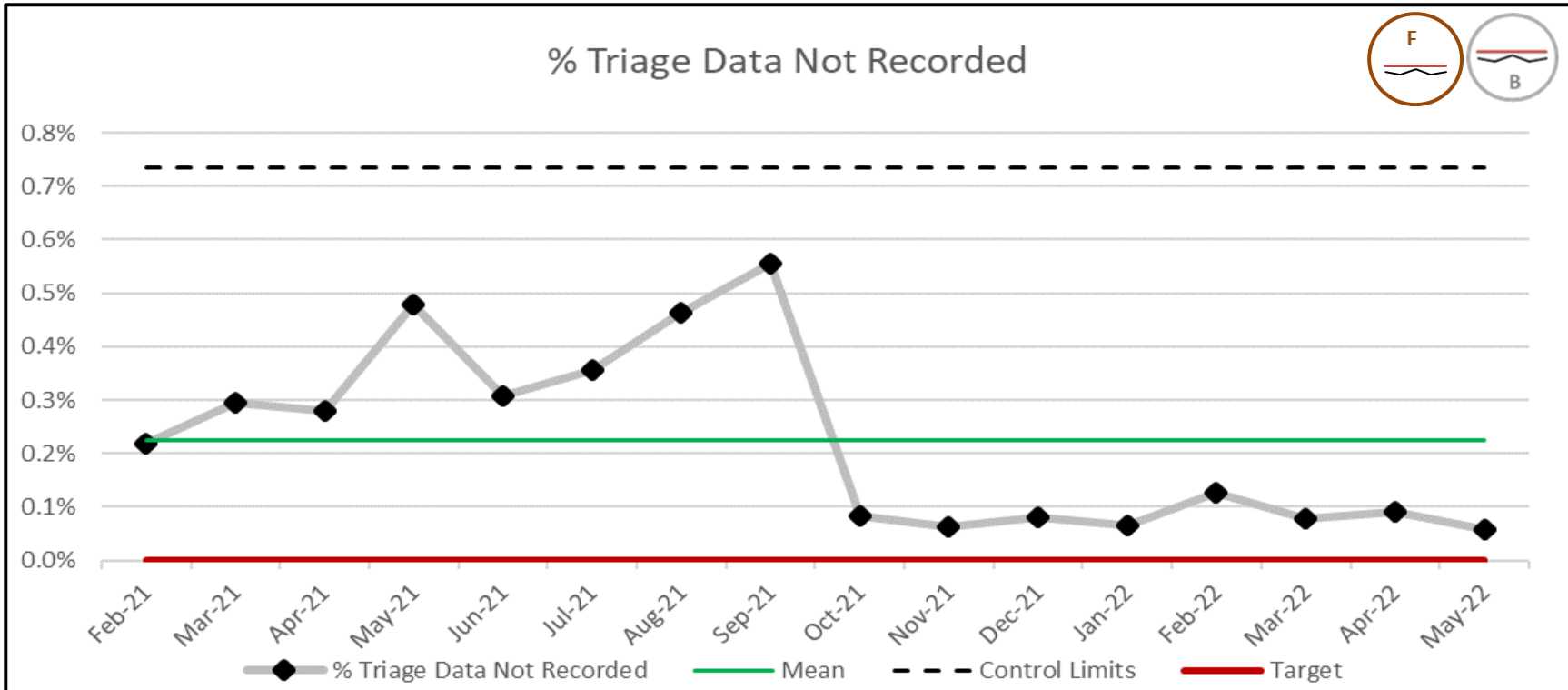
NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Mar-22	Apr-22	May-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	68.82%	66.10%		66.10%	85.00%			
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	62.26%	56.03%	57.66%	56.84%	99.00%			
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	2.43%	2.09%	1.58%	1.84%	0.80%			
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	22	33	20	53	0			
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	83.13%	71.95%	76.71%	74.33%	90%			
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	63.86%	45.12%	53.42%	49.27%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,872	3,799	4,080	3,940	4,657			
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	816	819	748	784	0			
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	111	132	144	276	10			
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.55	2.70	3.82	3.26	2.80			
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	5.17	5.02	5.05	5.04	4.5			
	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	22,327	23,562	22,856	23,209	4,524			
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	39.10%	43.90%	43.28%	43.57%	70.00%			
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	40.42%	36.54%	39.56%	37.95%	45.00%			

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



May-22
0.06%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
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%.
May reported 0.06% data not recorded verses 0.08% in April.
May demonstrated a 0.02% positive variation compared with March.
This metric is below target.

Issues:

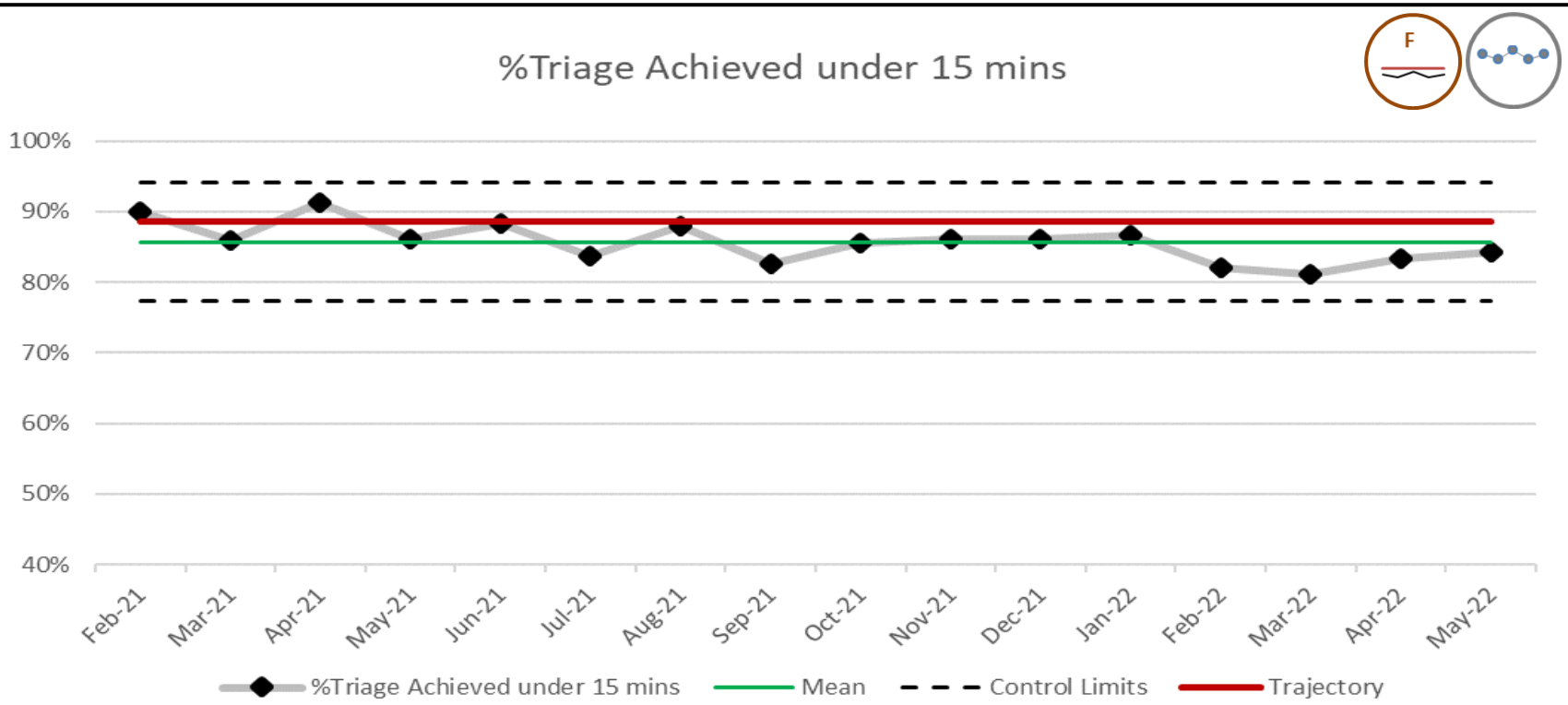
- Timely inputting of data.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been less problematic at all three sites.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP) but a slight improvement in rostering has been seen.
- Staffing gaps, sickness 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 confirmation via a bespoke UEC daily updates.
- 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).



May-22
84.17%
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%.
May outturn was 84.17% compared to 83.34% in April.
This demonstrated an improvement in performance of 0, 83% compared with March.
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.
- There is a recording issue for UTC transfers of care to ED that skews that data.
- 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:

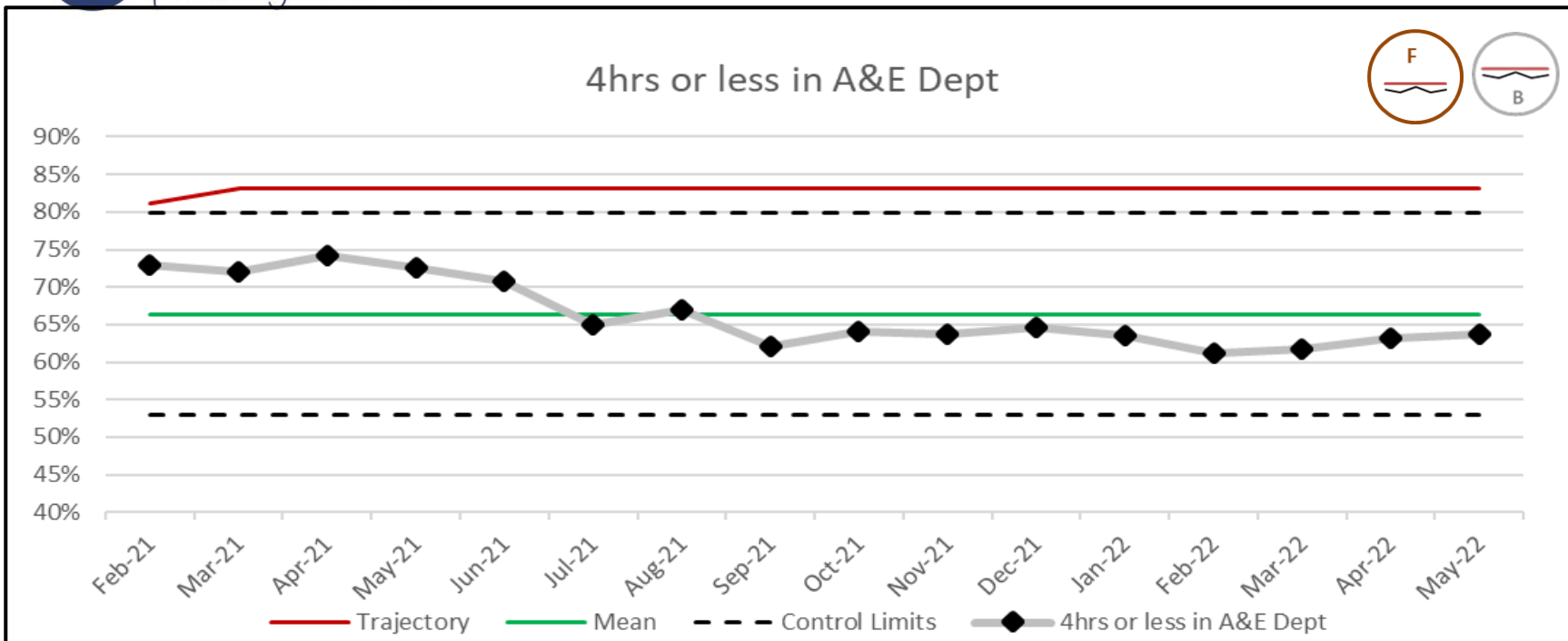
Most actions are repetitive but remain relevant.
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



May-22
63.63%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

The national 4-hour standard is set at 95%. The agreed trajectory for compliance for ULHT is set at 83.12%. This target has not been reset since April 2021.

What the chart tells us:

The current 4-hour transit target performance for May was 63.63% compared to 63.08% in April which is an improvement of 0.55% but is 19.47% below the agreed target.

Issues:

The Emergency Departments saw an 8.4% increase in attendances in May (1,530 patients) compared to April 18,223 combined attendances (ED and UTC) in May compared to 16,693 combined attendances in April.
Of the 18,223 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 12,023 and type 3 accounted for 6,200. This is an increase 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:

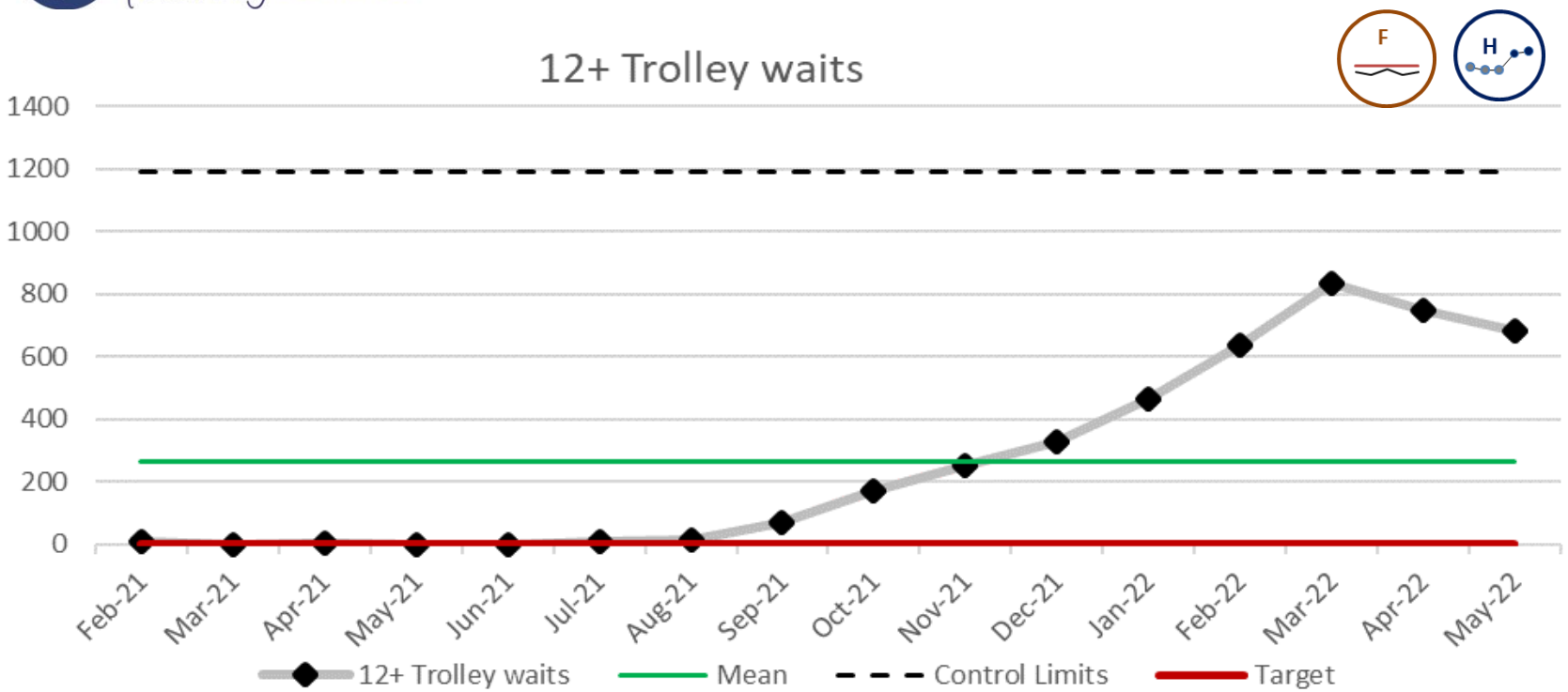
The actions are repetitive but still relevant
Reducing the burden placed upon the Emergency Departments further will be though the continued development of Same Day Emergency Care (SDEC) Services.
Direct EMAS conveyance to SDEC services has commenced and CAD now updated with destination.
Maximising the 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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



May-22
680
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:

May experienced 680 12-hr trolley wait breaches. This is the unvalidated position. This a reduction of 65 12-hr trolley wait breaches compared to April. This represents a decrease of 8.73%. This equates to 5.65% of all type 1 attendances for May.

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.

March has experienced an increase in incidental positive covid cases and nosocomial transmission, which as restricted the use of several inpatients' beds, impacting further on flow.

March saw a significant increase in the number of new positive covid cases akin to wave 1 and 2 peaks.

To prevent nosocomial transmission, the use of boarding areas as per the Full Capacity Protocol areas has been problematic.

Actions:

The Trust continues to work closely with national regulators in reviewing and reporting these breaches.

Due to the number of 12hrs trolley waits breaches currently, harm reviews are completed by the UEC team, DATIX are completed and escalations to the CCG and NHSE/I are in place.

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.

A substantial programme of work out of hospital is in place with system partners to reduce delayed discharges which are upwards of 15% of all beds at times.

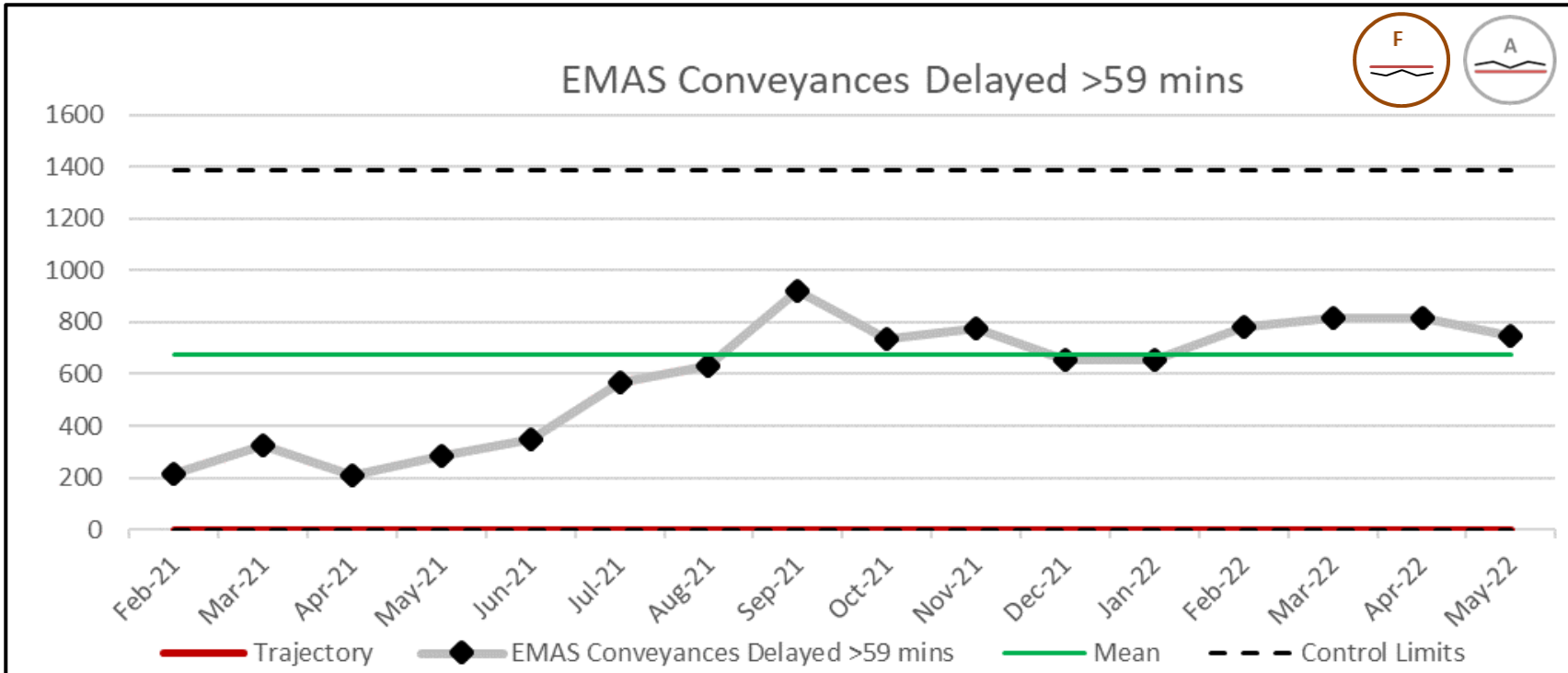
Internal actions on admission avoidance are focussed on Same Day emergency Care and recent developments have shown a 100% increase in some areas.

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 demonstrates 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.



May-22
748
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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:

May demonstrated a slight decrease in greater than 59 minutes' handover delays 748 in May compared to 819 in April. This represents an 8.37% decrease.
What the chart does not tell us is the increase of >2hrs in May 2022 (334 in May vs 461 in April) and the decrease in >4hr delays (76 in May compared to 118 in April).

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.
An increasing number of category 1 and 2 patients being conveyed.
Inadequate flow and sub-optimal discharges continue to result in the emergency departments being unable to de-escalate due to an increased number of patients waiting for admission.

Actions:

All ambulances approaching 30 minutes without a plan to off load is escalated to the Clinical Site Manager and then 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.
May saw a decrease in formal requests from EMAS 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.

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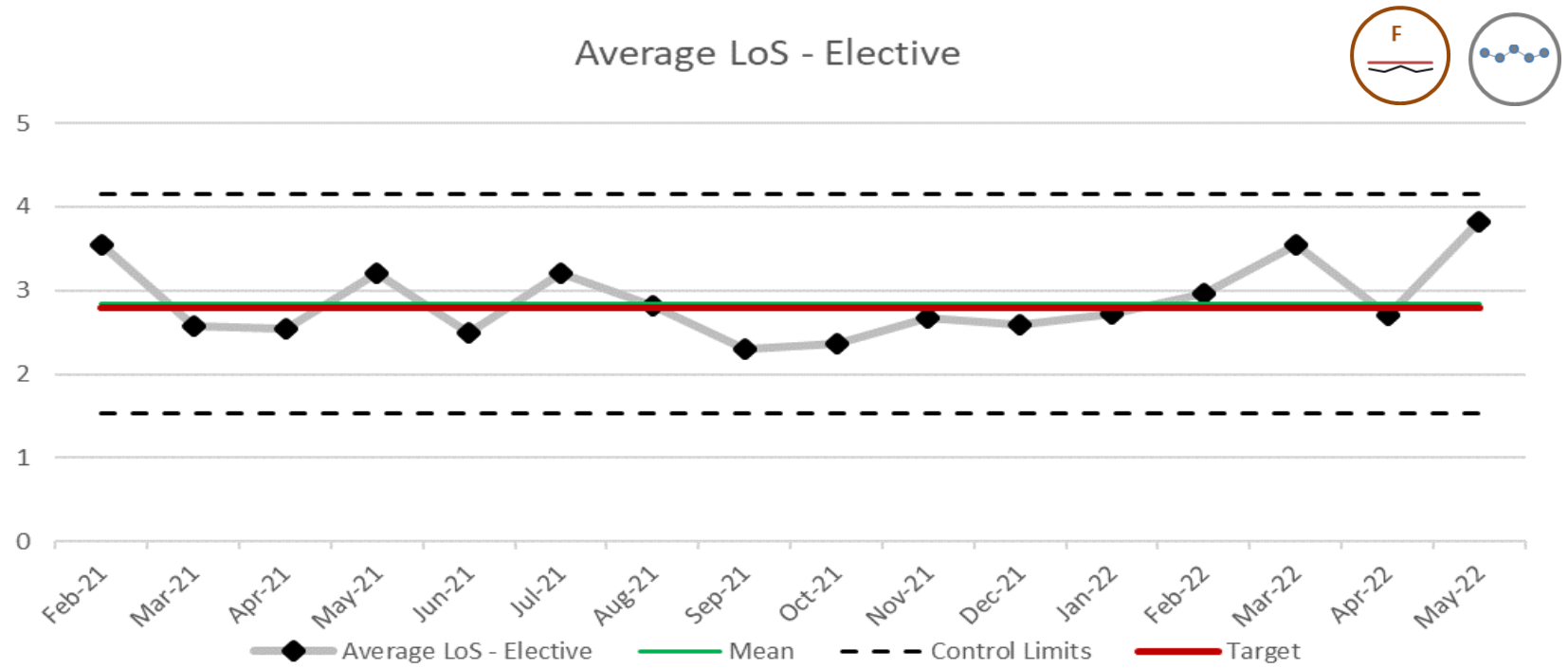

May-22
3.82
Variance Type
Metric is currently experiencing Common Cause Variation
Target
2.8
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for Elective inpatients

What the chart tells us:

The average LOS for Elective stay has increased from 2.70 days in April to 3.85 days in May. This is an increase of 1.15 days and represents an increase of 29.88%.
The trajectory for Elective LOS is 2.8 days.

Issues:

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

Actions:

The reduction in waiting times is being monitored weekly.
Focus on speciality waiting lists where patients have been identified as having increased morbidity which will impact of increased LOS.
Timely ITU 'step down' of level 2 care to level 1 'wardable' care.
The complete review and allocation of 'P' codes.
Work is in train to include an ALOS predictor against procedure normal LOS vs patient specific indicators when scheduling patients for theatre.

Mitigations:

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

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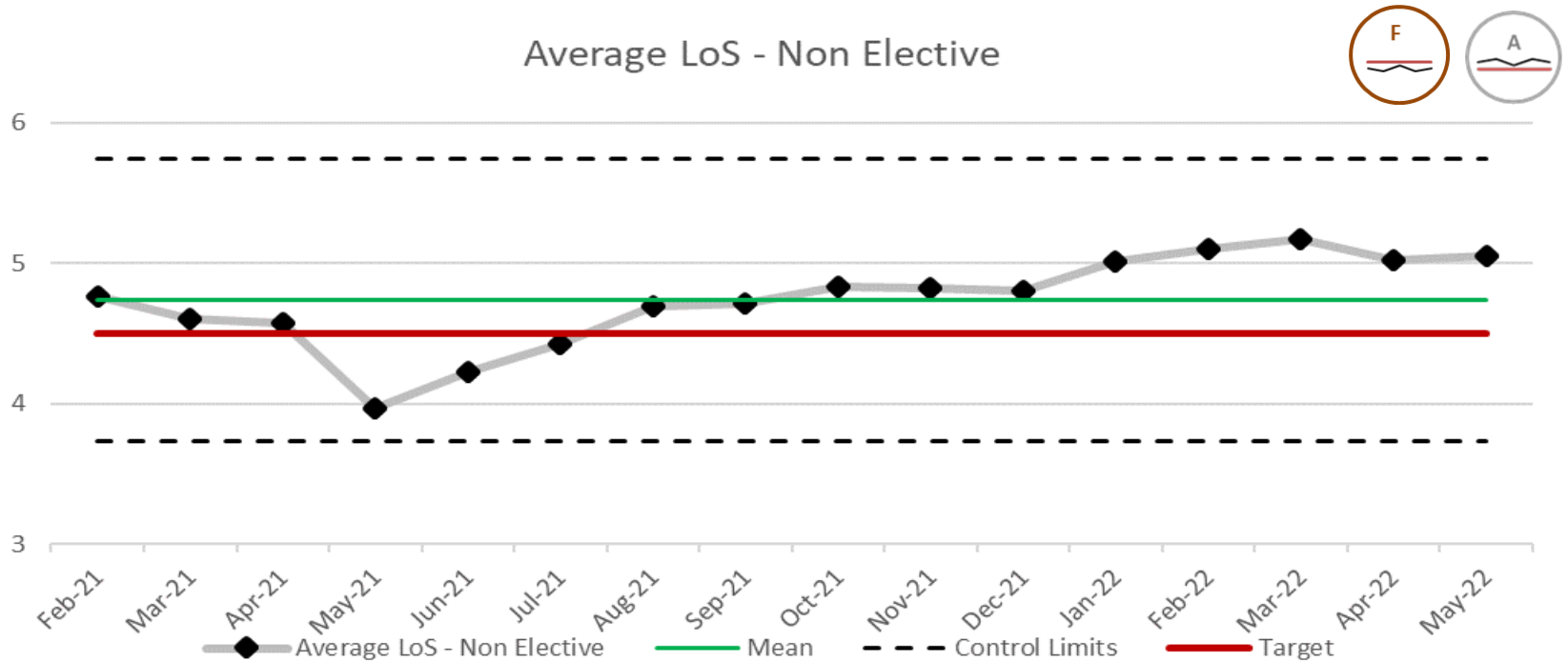

May-22
5.05
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 5.05 days in May vs 5.02 in April. This is an increase of 0.03 days
compared with April
This is a 0.55 variance against the agreed target.

Issues:

Numbers of stranded and super stranded pts continues to increase.
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 but there remains insufficient capacity to meet the increasing demand.
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.
Reluctance of Care Homes to admit at the weekends and to accept patients with a positive covid status or contact until the 14-day isolation is complete.

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.
A new rolling programme of MADE has been agreed and the frequency has been agreed as an 8 week rolling programme.

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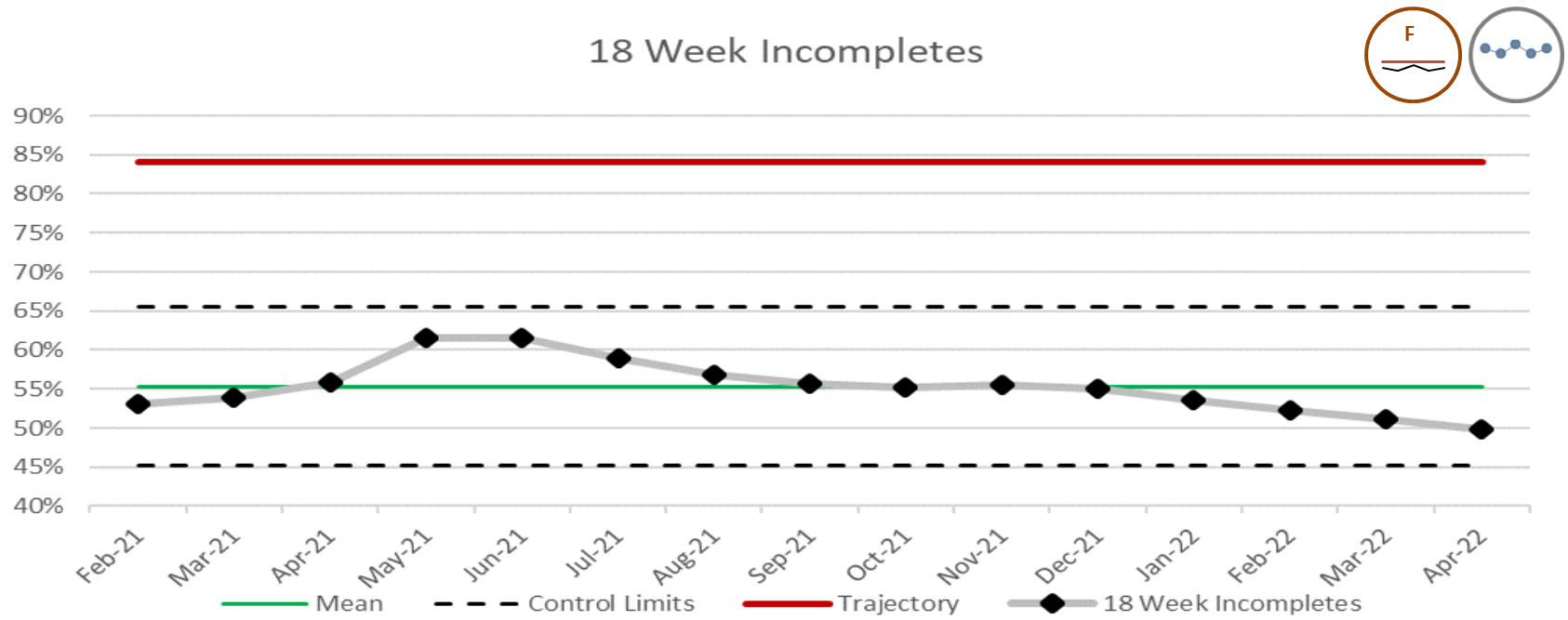

Apr-22
49.88%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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. April saw RTT performance of 49.88% against a 92% target, which is 1.34% down on March.

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 – 5552 (increased by 296)
- Gastroenterology – 3424 (increased by 12)
- Dermatology – 3077 (decreased by 147)
- Gynaecology – 2832 (decreased by 22)
- General Surgery - 2261 (increased by 122).

Actions:
Planned routine elective work remains challenging. Available capacity is being focussed on cancer, long waiting patients, paediatrics, day cases and patients classified as being P2. Following last month's IPC update relating to vaccination status and isolation for admitted patients, there has now been an update regarding Outpatients. IPC are now supportive of Outpatient areas dropping the 2m rule and all areas will go back to full capacity. This will increase Outpatient capacity by 30-40% in some areas.

Mitigations:
Admitted 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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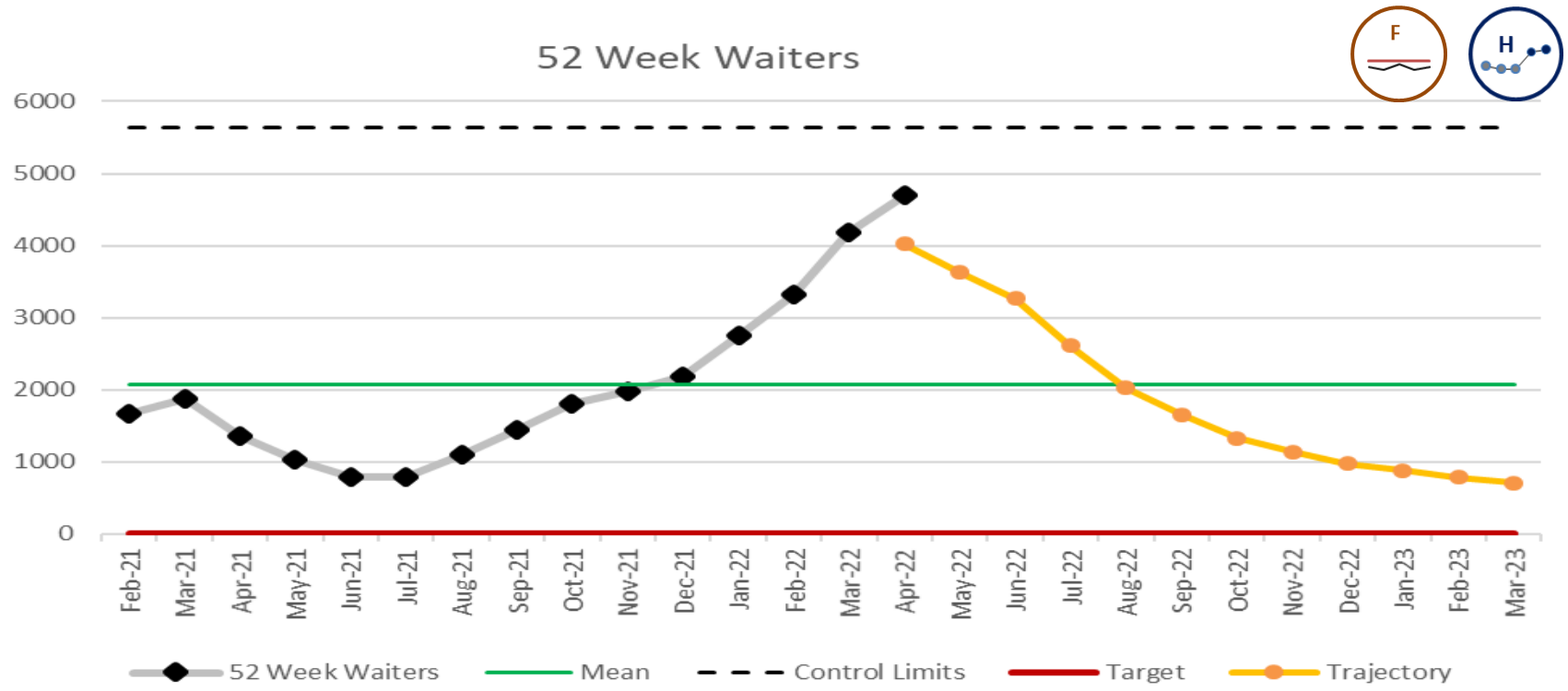

Apr-22
4694
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 4694 incomplete 52-week breaches for April. An increase of 517 from March.
The number of 52-week breaches has increased considerably since August.

Issues:
Both the admitted and non-admitted position remains very challenging. Current capacity challenges and staffing issues are all impacting on service delivery, which is, in turn, detrimentally affecting the 52-week position. Our regional position remains strong. ULHT have been asked to support regional colleagues with their 104 week waiters and this is to be prioritised over our 52 week positions.

Actions:
Admitted patients are individually graded and allocated a priority code. The introduction of C2AI appears to be having a positive effect on the efficiency and effectiveness of this process. All patients waiting more than 52 weeks are required to have a harm review completed. The harm review process is discussed at the Clinical Harms Oversight Group with a new piece of software being developed in-house to better enable monitoring and recording.

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. Recent IPC changes to admitted and Non admitted pathways will support increased activity and a reduction in long waiters.

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Apr-22
66,320
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 decreased from March, with April showing a decrease of 219 to 66,320.
The incomplete position for April 2022 has increased by approximately 28,294 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 March are:

- ENT + 164
- Respiratory Medicine + 114
- Vascular Surgery + 89
- Maxillo/Oral + 80
- Colorectal Surgery + 76

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

- Dermatology – 278
- Community Paediatrics - 193
- Urology - 189
- Gastroenterology - 129
- Gynaecology - 51

The Trust reported 11,580 over 40 week waits; an increase of 815 on March. Patient numbers waiting over 26 weeks increased by 984.

Actions/Mitigations:
The longest waiting patients at 78w+ are monitored and discussed at a weekly PTL meeting and also with system partners at a weekly ICS meeting.
Transferring of appropriate admitted patients to ISP's continues. Non admitted patients in two of the most pressured specialities continue to be transferred out. Medical specialities are also looking at a possible external clinical validation company for their non-admitted patients.

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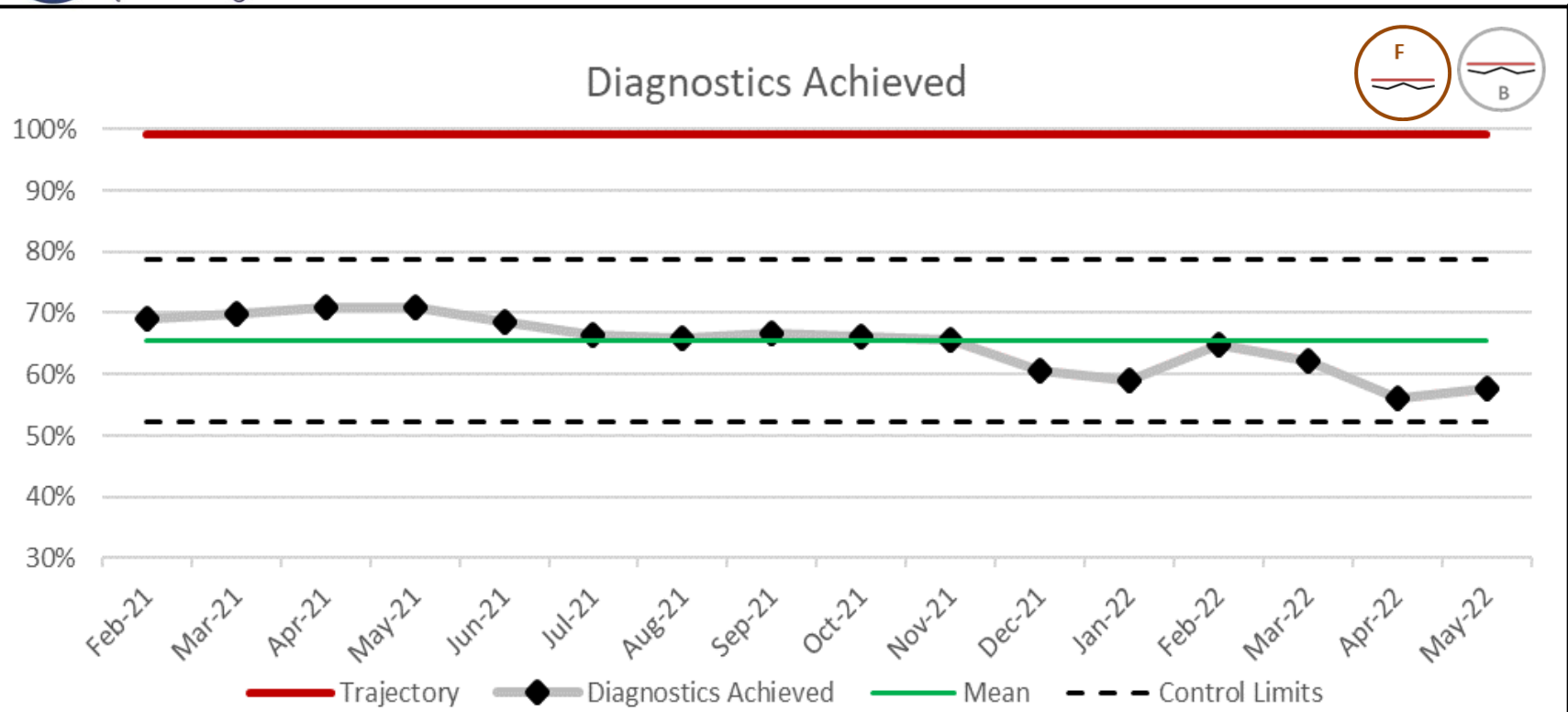

May-22
57.66%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 57.66 for May 2022 against the 99.00% target.
CT, MRI, lost capacity and caused breaches due to the fire.

Issues:
CT, MRI Dexa have lost capacity due to the LCH fire, All areas have lost capacity due to social distancing, demand is still higher than capacity for some procedures so causing increased backlogs for some specialities and increasing the number of breaches declared each month for those specialities. Increase demand in Ultrasound due to Mediscan being stopped by the CQC this has caused an additional 3000 scans in Feb 2022 compared to Feb 2021 AQP, Cardiac Echoes have a considerable backlog due to a lack of capacity. Mobile inpatient scanners have reduced capacity compared to the internal scanner.

Actions:
Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes. Additional US lists are happening but not enough to deal with the additional 2000- 3000 scans. Additional support is being sought by A plan to extend Mobile scanners is being discussed with finance to aid recovery (CT, MRI). Cardia echo have an additional 4 locums from June and have reduced slot time to 30 minutes.

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

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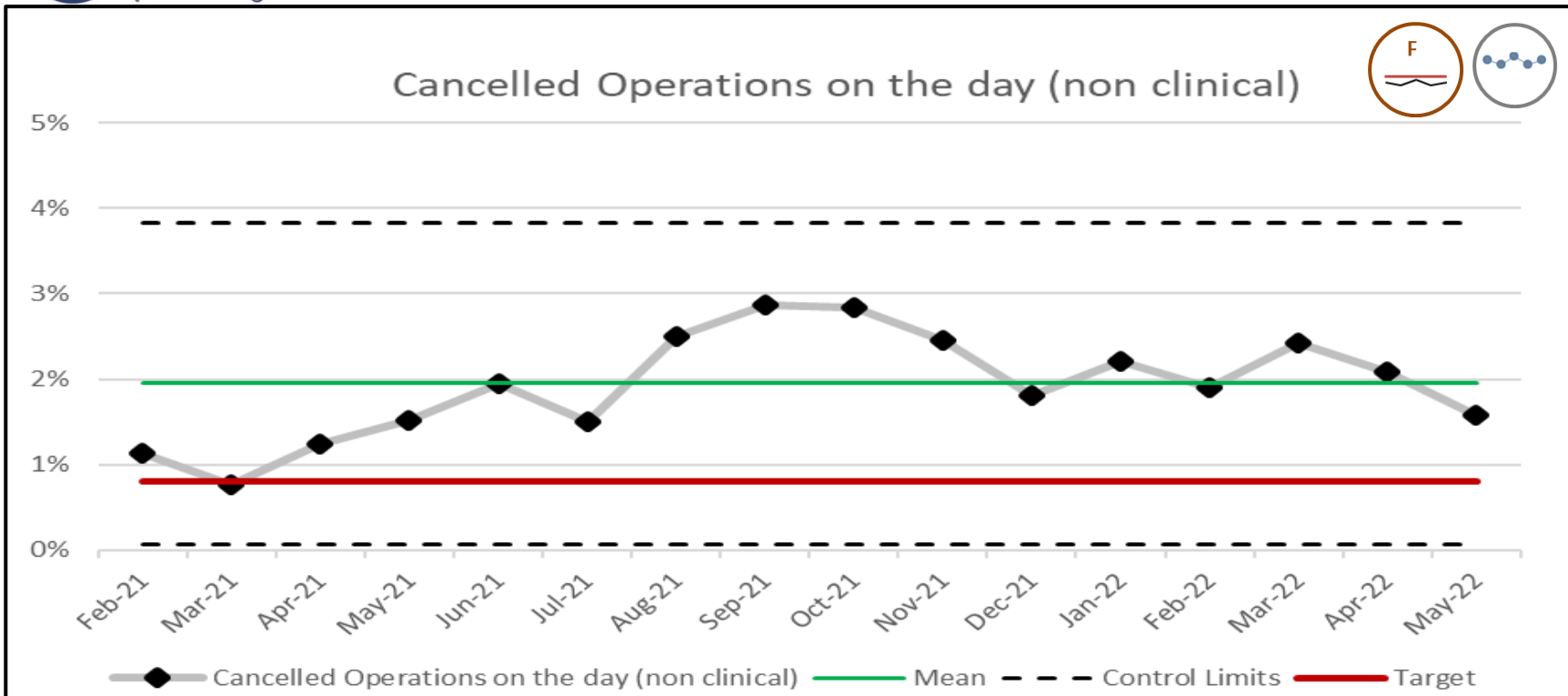


May-22
1.58%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
This shows the number of patients cancelled on the day due to non-clinical reasons during the month of May.

What the chart tells us:
May shows a decrease, of 0.51%, in patients who have had their operation cancelled on the day of surgery however remains above the agreed trajectory of 0.8%.

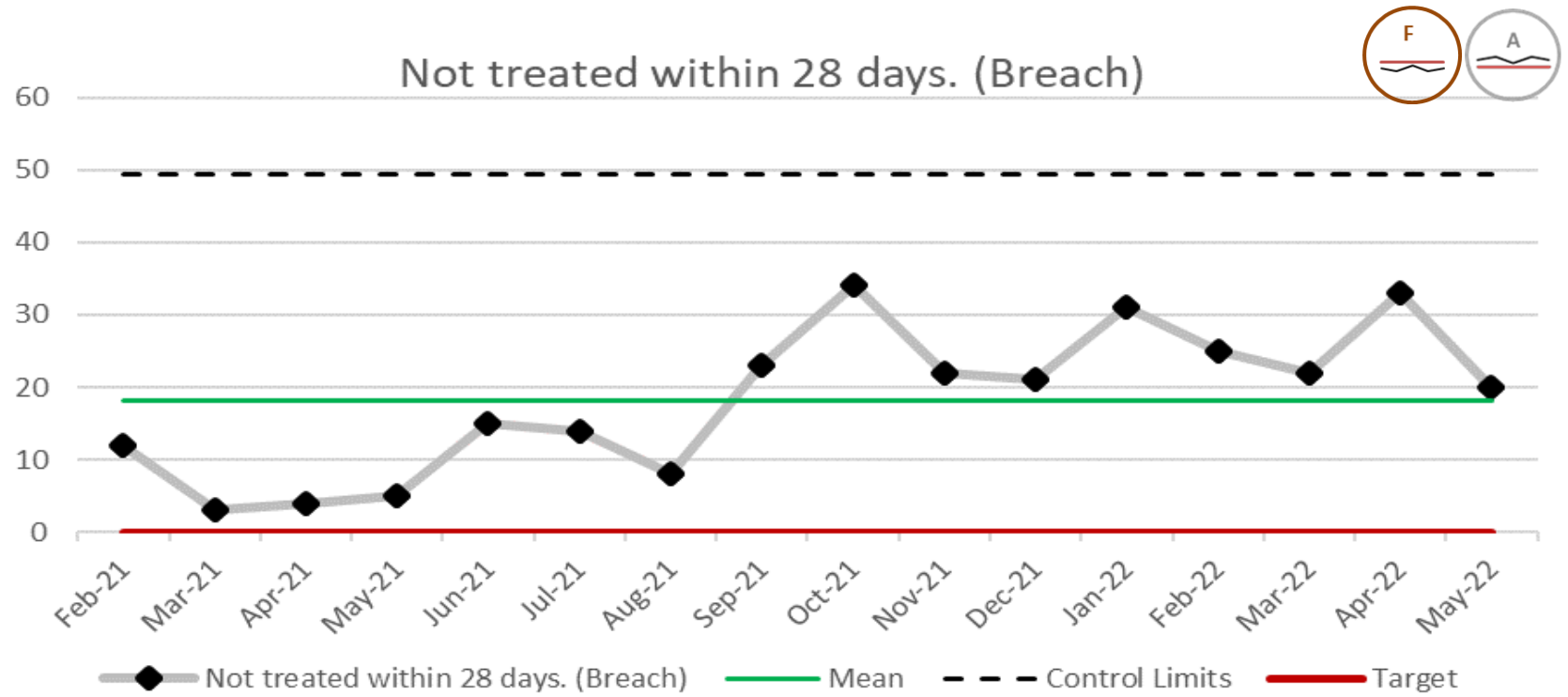
Issues:
The top 3 reasons for same day non-clinical theatre cancellations for May are identified as

- Lack of time;
- Equipment unavailable;
  Equal split of bed and staffing shortage;

Actions:
The theatre team are auditing reasons behind late starts in theatres, as this will have a negative impact on the number of patients being cancelled due to lack of time.

As part of the audit outcome there is focused work with the admitting ward team, theatre team, surgeons and anaesthetists focusing on reducing unnecessary.

Mitigations:
Implementation of the ring fencing of beds on both our day wards and HDU areas took place in early 2022, however it has proved challenging to maintain this due to the high number of inpatients admitted to the wards and the reduced flow.



May-22
20
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
This chart shows the number of breaches during May 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 May is 20, which is a significant decrease from 33 in April.
The agreed target of zero has not been achieved.

Issues:
Difficulty in rebooking patients due to clinician availability remains a concern. This is further exacerbated by limited pre assessment availability, which causes delays for rebooking.

Short time length of MRSA swab results means patients need a swab no more than 6 weeks old, which is significantly shorter than a large number of NHS Trusts.

Actions:
Within the Surgical Division the teams continue to work together to reschedule patients who have experienced any on the day non-clinical cancellations, identifying any requirement for additional capacity.

There is an increased focus on outsourcing appropriate patients, which will enable improved capacity within the Trust.

Mitigations:
The Pre Assessment team are in contact with IPC to identify if there is an opportunity to extend the MRSA swab lifespan.

They are also working with colleagues across the Trust to increase their clinical availability.

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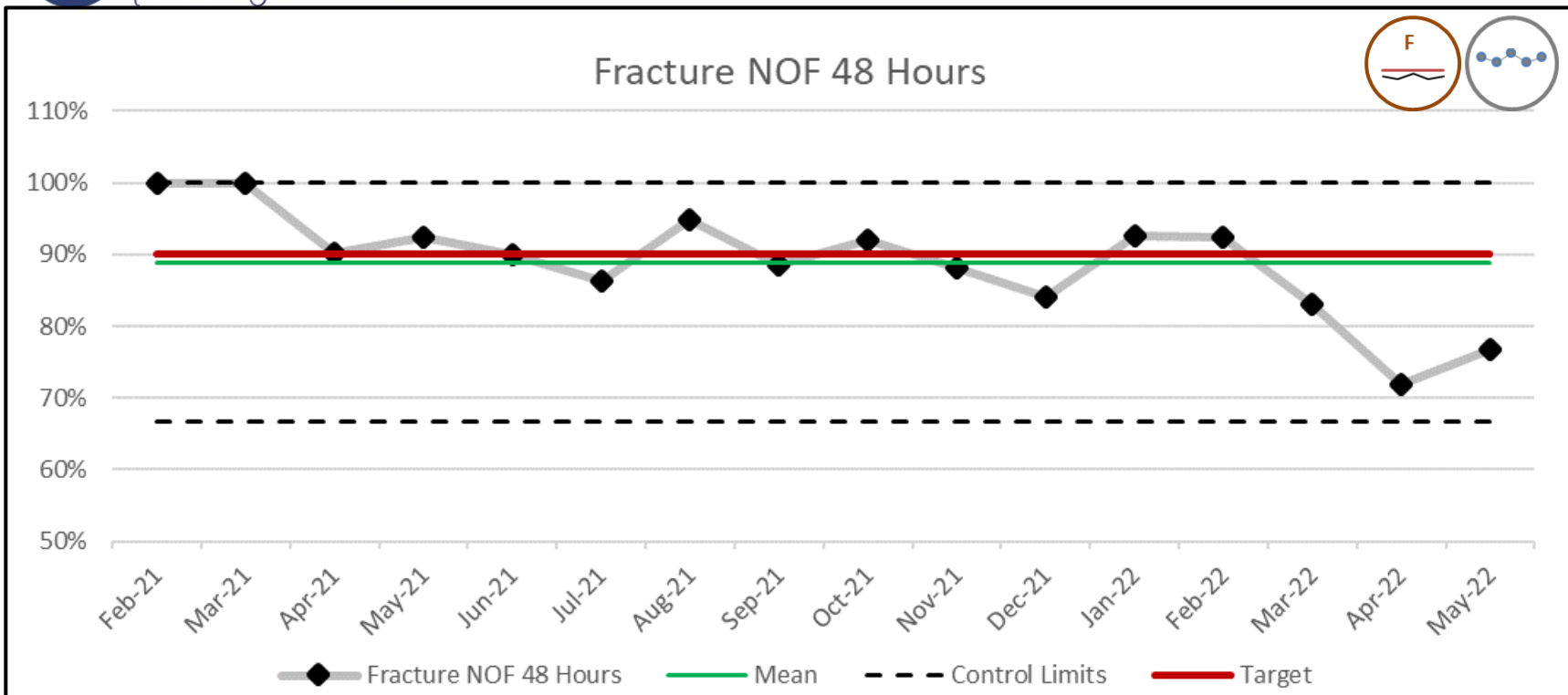

May-22
76.71%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

May performance out turned at 76.71% against the agree target of 90%.

Both sites underperformed with PHB at 85% and LCH 66.67% which has led to deterioration in performance, although this is overall improved from April 2022.

Issues:

Increase in trauma demand over recent months, particularly during BH weekends in May
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 due to complexities.
UTAH hub not in place which will support quicker turnaround of diagnostic needs for NOF patients.
This will also help create ring fenced NOF beds.
Loss of Radiology support for additional lists creating trauma backlogs.

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.
Additional Specialty Trauma lists identified to Theatre to ensure prioritisation of Theatre staffing ensuring minimal cancellations and backlog of trauma.
Additional trauma lists continue to be identified over/pre and post BH weekends for future BH dates to ensure capacity maximised.

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.
Once daily additional CBU review of trauma and plans to ensure capacity maximised for clinical priority.

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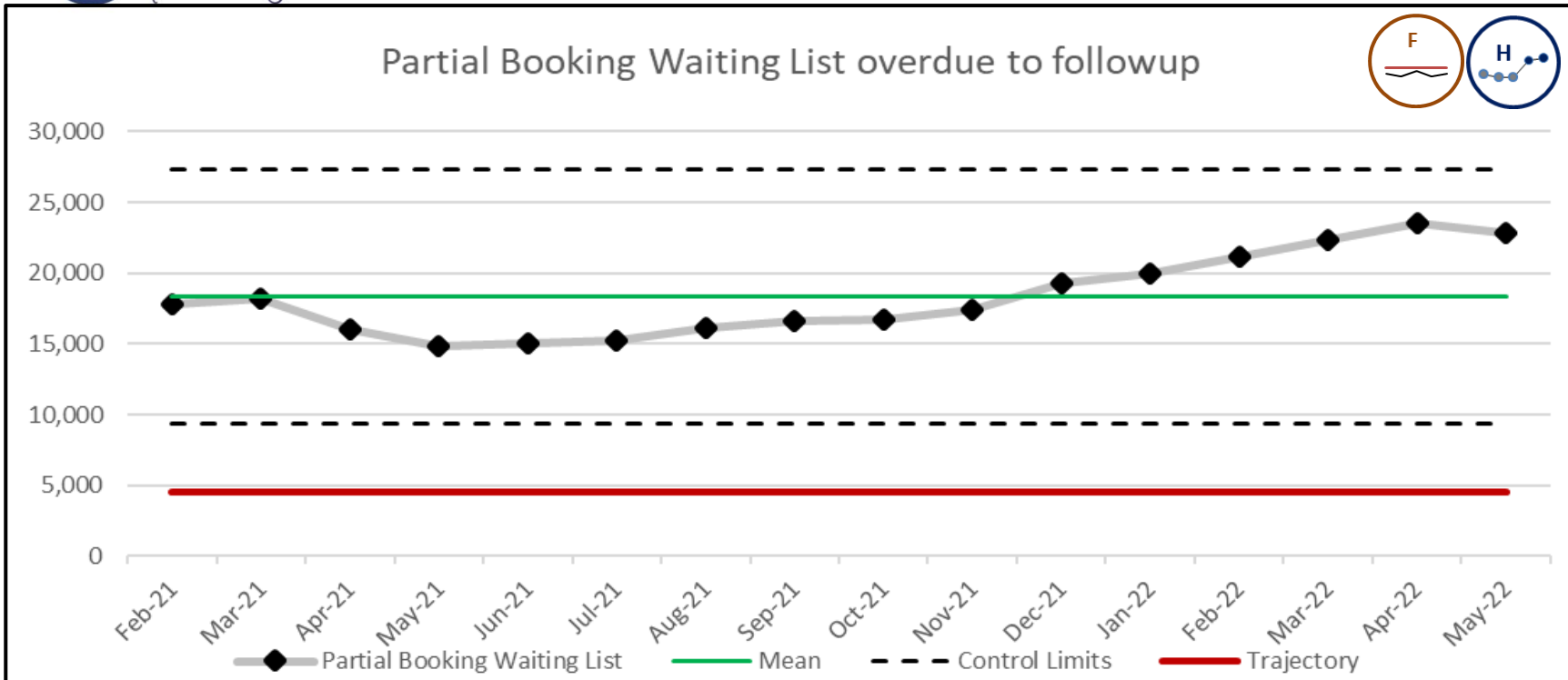

May-22
22,856
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 22,856 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 increased on an upward trend since July 2021.This month is the first month that has not been on an upward trend.

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. The Trust is working through a recovery of diagnostic capacity for outpatients since the fire in the diagnostic area, which has also had an impact on capacity.

Actions:
Specialities have made plans to increase activity for 2022/23 which will improve their PBWL position and reduce patient waits. Outpatients are reviewing current waiting area capacity to allow an increase clinic templates. Further work with validation, clinical triage, technological solutions and PIFU will be included in the Personalised Outpatient Plan. Update on plan - the Trust is out to procurement for a validation team to review the PBWL patients and discussing priorities for this team.

Mitigations:
Supporting organisational priorities in ED and urgent care taking individual outpatient clinics down, if support required across the sites (site/patient flow and theatres) or so a clinician can support the wards at short notice.

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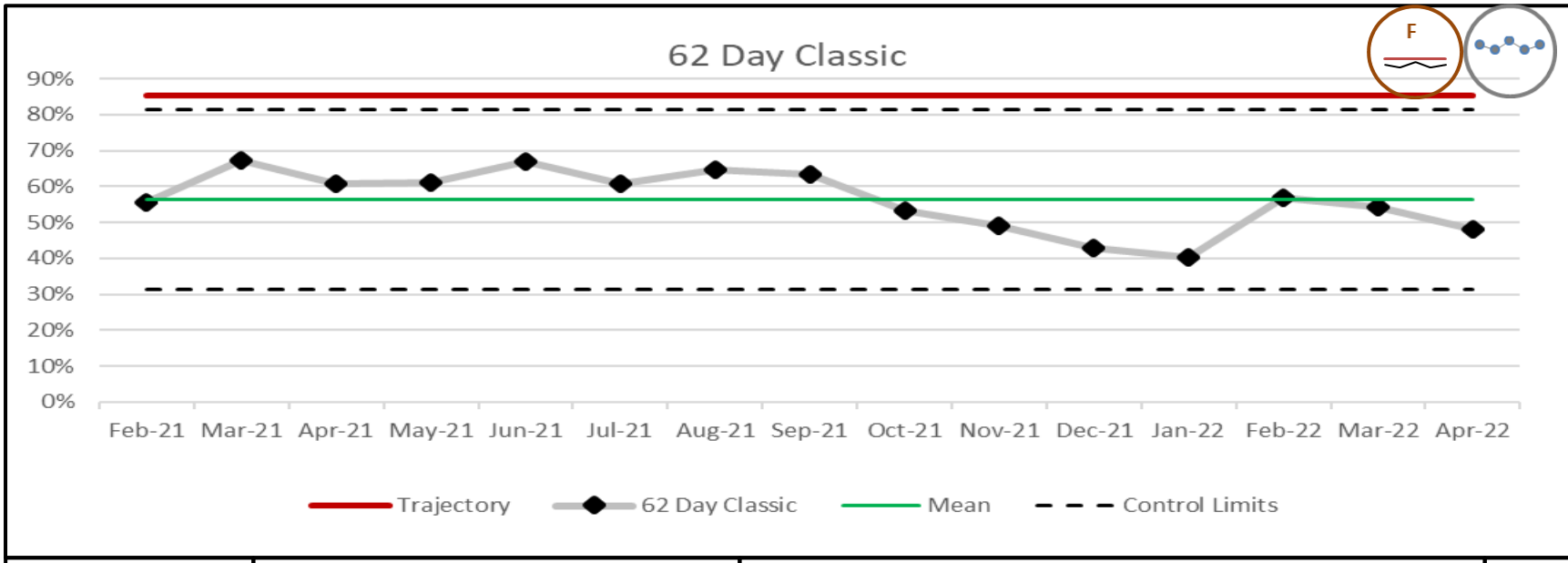

Apr-22
48.20%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 48.20% against an 85.4% target.

Issues:

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

Pressure on diagnostic services following the fire in Radiology at LCH.

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 'effectiveness' period), though this is continuing to reduce. 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, Head and Neck and Upper GI.

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.

Limited theatre capacity continues to impact cancer pathways across the Trust, with all Specialties vying for additional sessions.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program. One Locum Medical Oncologist Locum is due to commence in post on 04/07/2022 covering both UGI and LGI specialties. Other posts are still going through recruitment processes. There is a significant lack of consultants nationally and very few available from agency.

Endoscopy's review regarding endoscopy staffing is now at the point of recruitment. The intention is 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.

Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity.

Mitigations:

Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at Grantham and will alleviate capacity issues once up and running.

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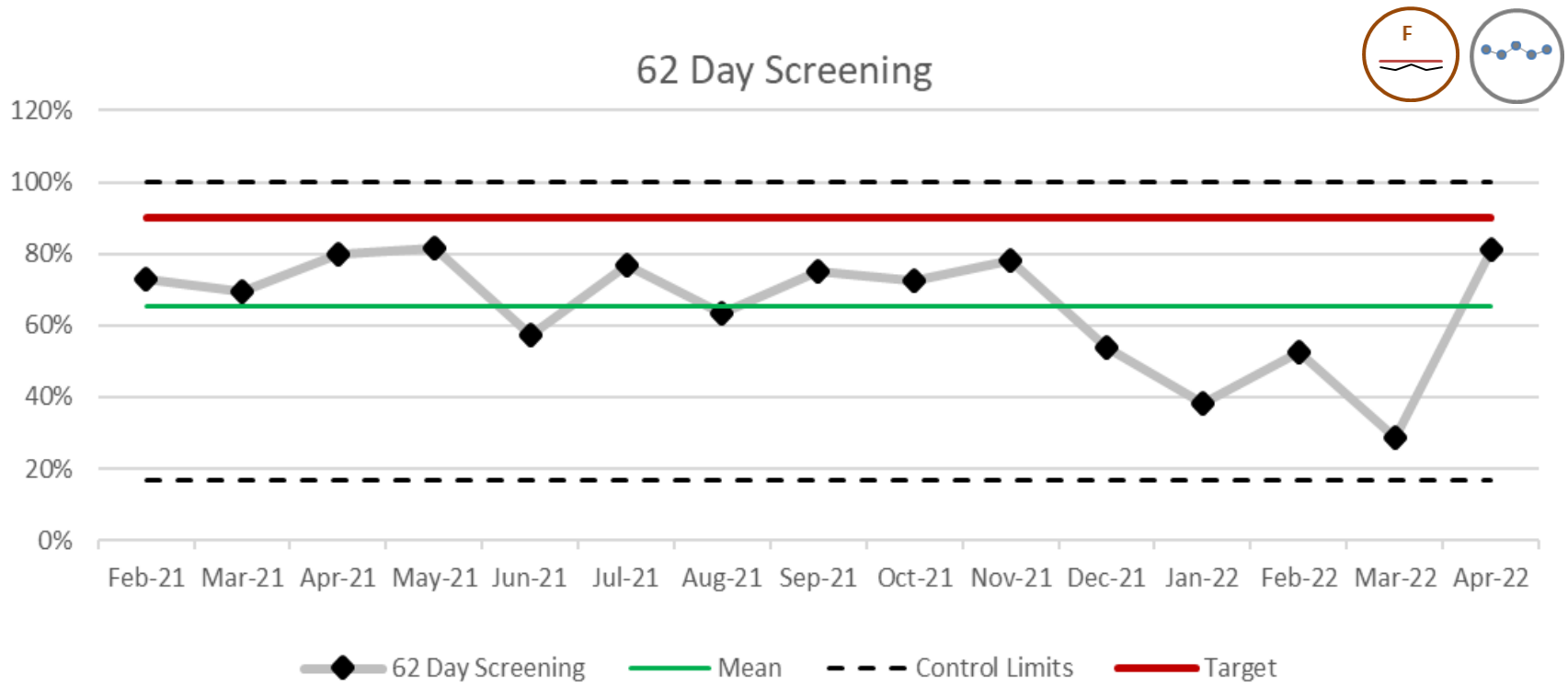


Apr-22
81.25%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

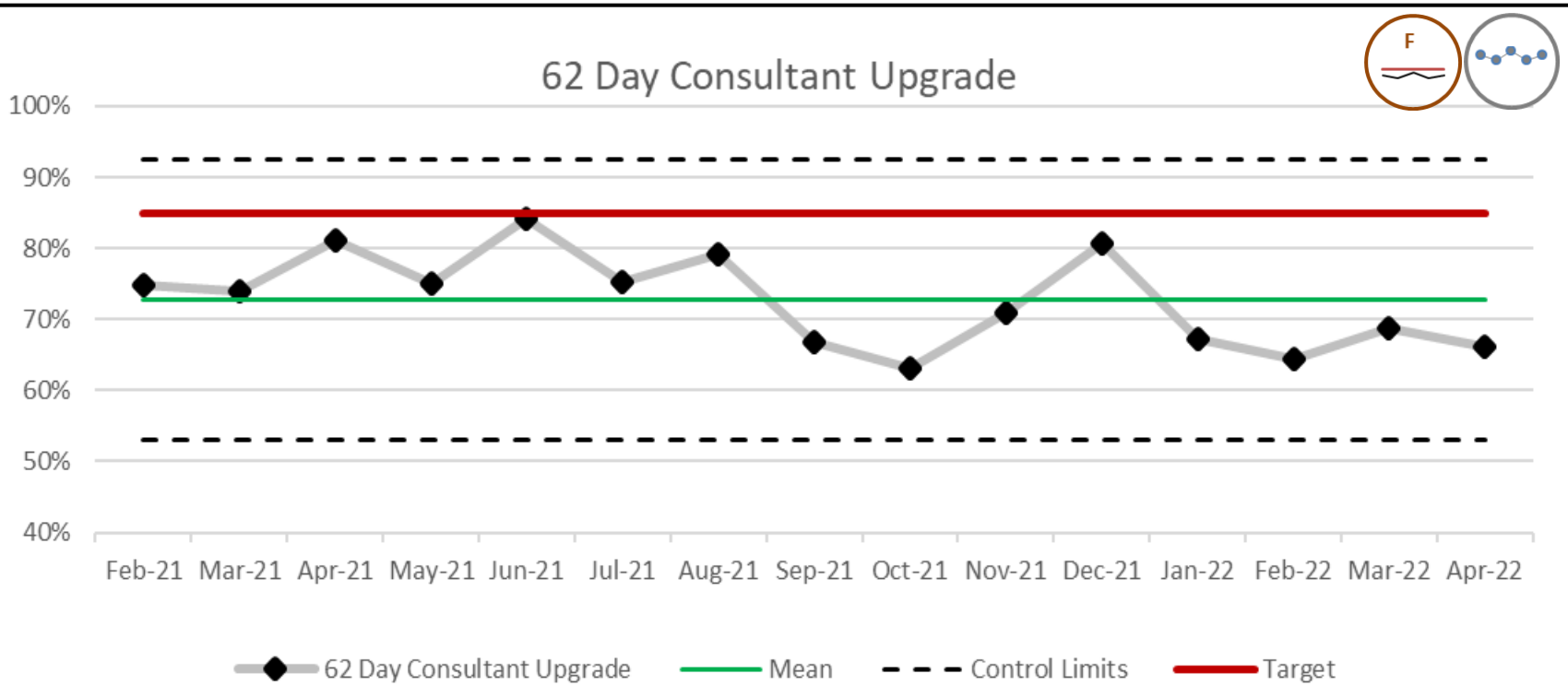
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 81.25% 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.



Apr-22
66.10%
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 66.10% against an 85% target.

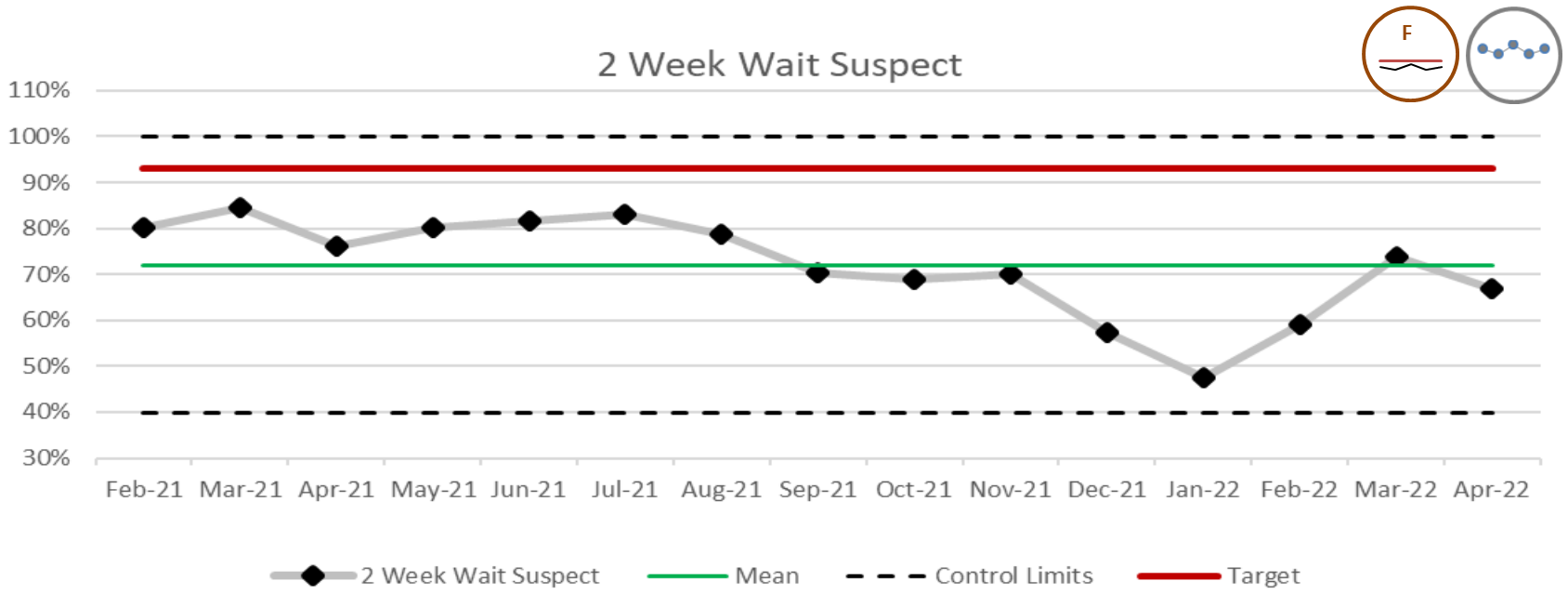
Issues:
See issues on previous page – 62 day classic.

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



Apr-22
66.80%
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 66.80% against a 93% target.

Issues:

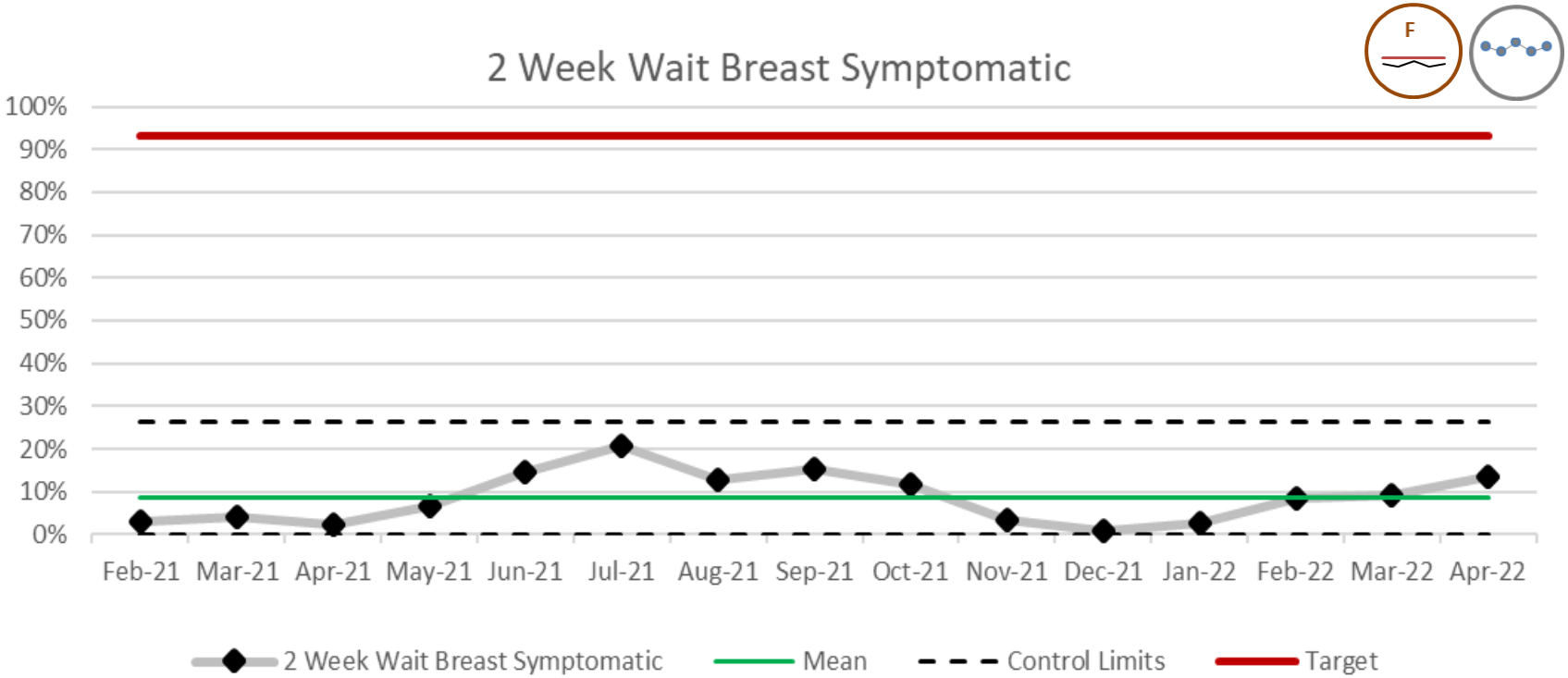
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with Breast performance being 13.6%: -43.2% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Lung (26.0%), Gynaecology (47.4%), and Urology (53.2%)
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. 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 and Upper GI at the earliest opportunity. A pathway review for gynaecology and a direct access ultrasound pathway has also been identified as a priority for 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/support.
Overseas recruitment is underway for gastroenterology consultants / Specialty Doctors. 2 posts are in place to commence from June '22.
A Gynae review of specialist nurse workforce and oncology strategy meeting scheduled for mid-July with a plan to resolve through longer term appointment of consultants to mitigate capacity gap.
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:

A Respiratory locum consultant post has been appointed to for 12 months at PHB with a provisional start date in August. Agreement in process for Radiology to discharge normal scans on the FReD pathway – to start from August when new staff are in place following model in place at SFH. Work is ongoing to move Spirometry into Community Diagnostic Centres.
Additional weekend Urology clinics continue to be set up to resolve capacity issues. Work is being undertaken with Endoscopy to increase capacity across sites and ensure efficient utilisation of current clinic capacity. Recruitment for CBU booking clerks is underway.



Apr-22
13.60%
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 13.60% against a 93% target.

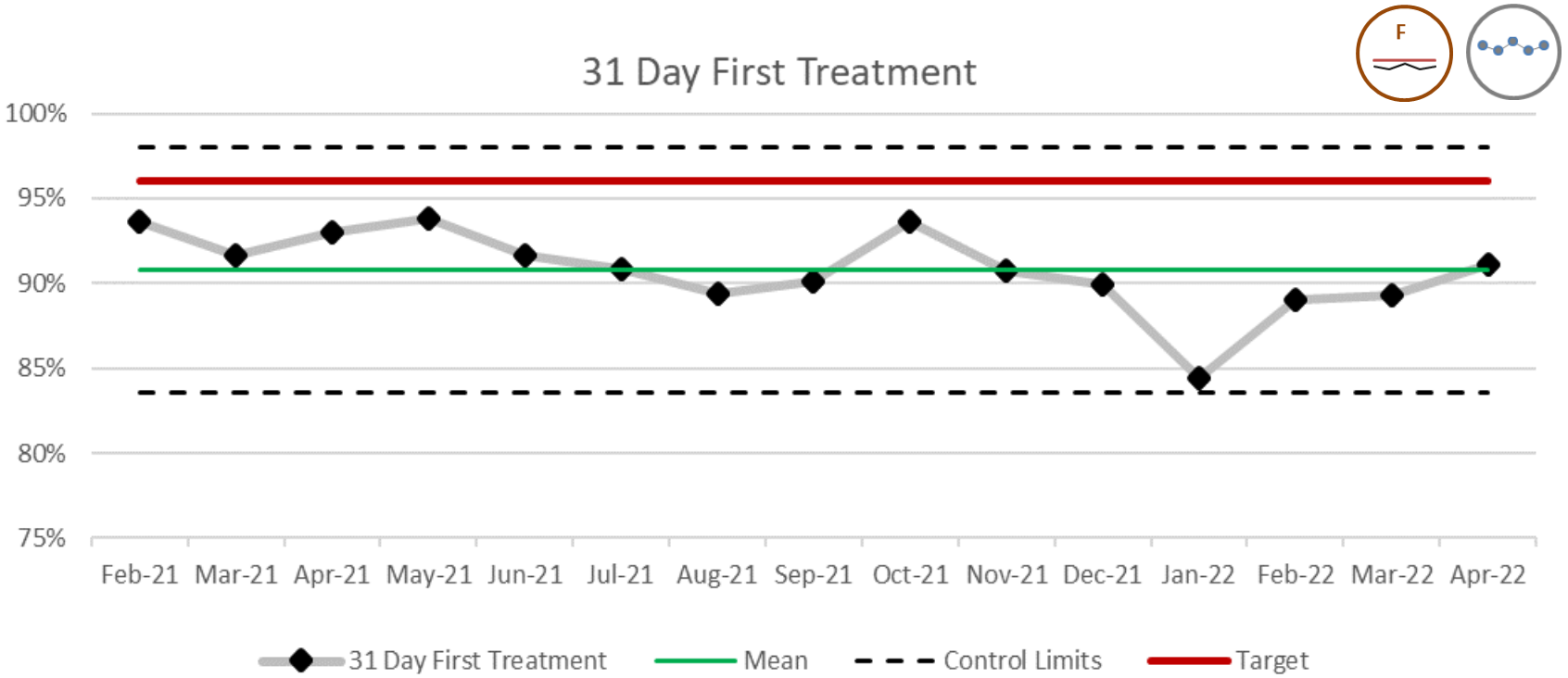
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.

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

Mitigations:
A mastalgia pathway is now up and running 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



Apr-22
91.10%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

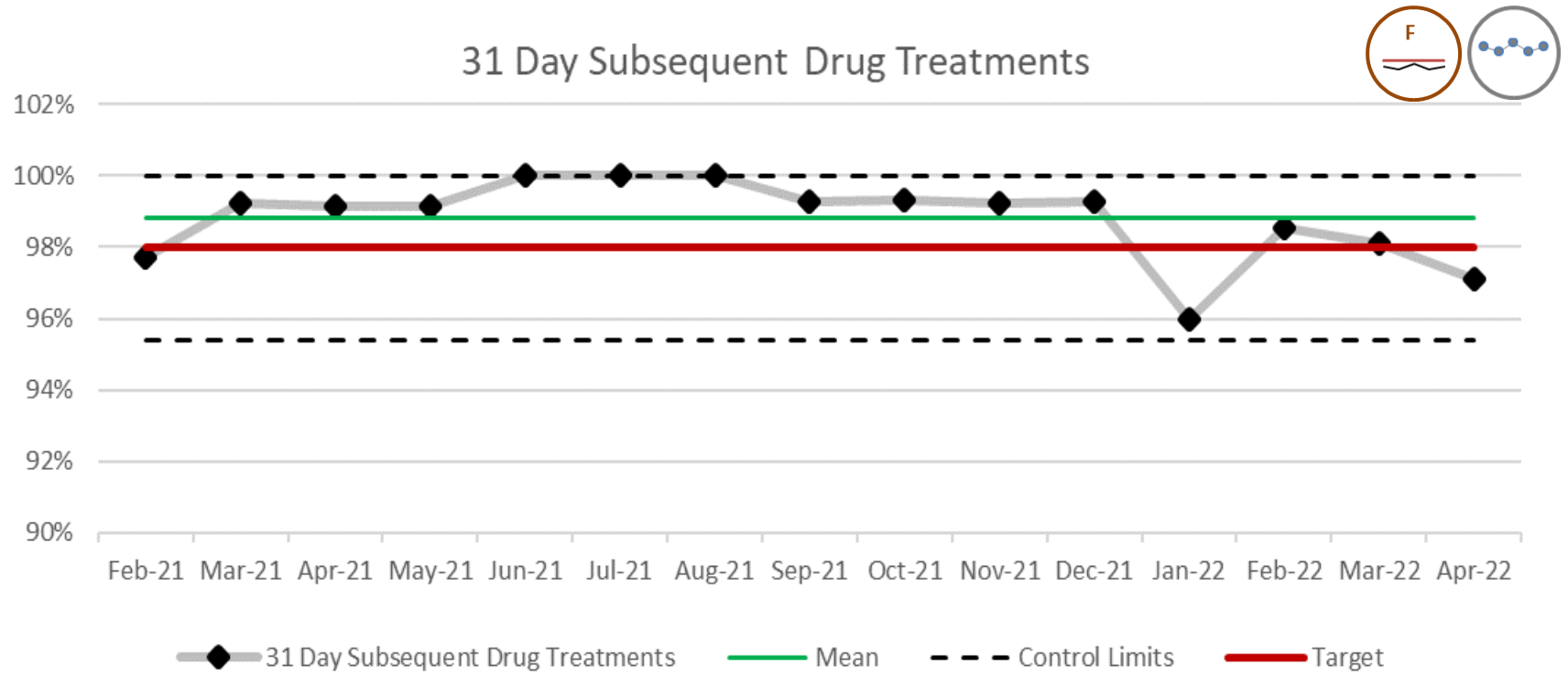
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 91.10% against a 96% target.

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

Actions:
Oncologist recruitment is ongoing. A Locum Medical Oncologist has been appointed and is due to comment in post 04/07/2022 (Covering UGI and LGI specialties)
Work has commenced on building the new theatres at Grantham.
For Colorectal, a Deep Dive and pathway analysis is underway, supported by CCG colleagues.

Mitigations:
Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity.



Apr-22
97.10%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

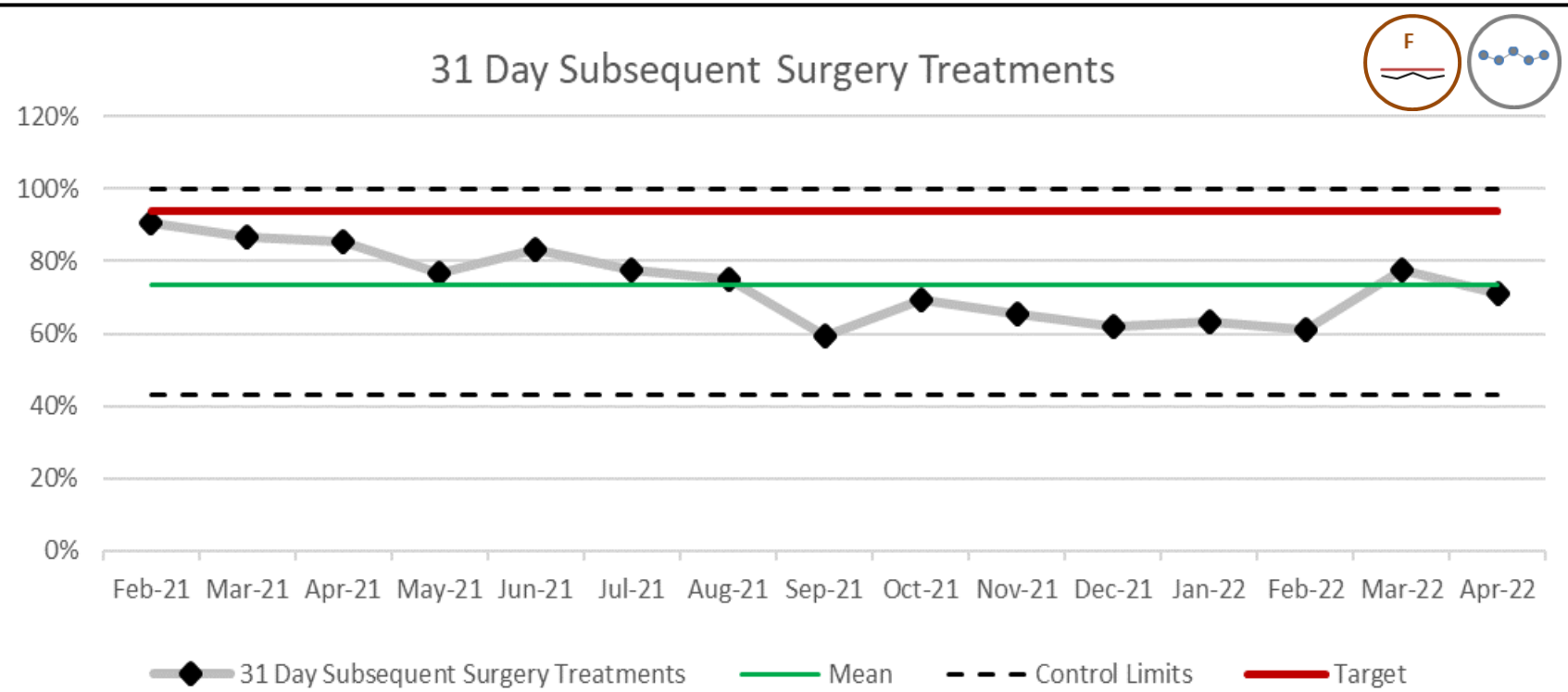
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was drug treatments.

What the chart tells us:
We are currently at 97.10% against a 98% target.

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

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

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



Apr-22
70.97%
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 70.97% against a 94% target.

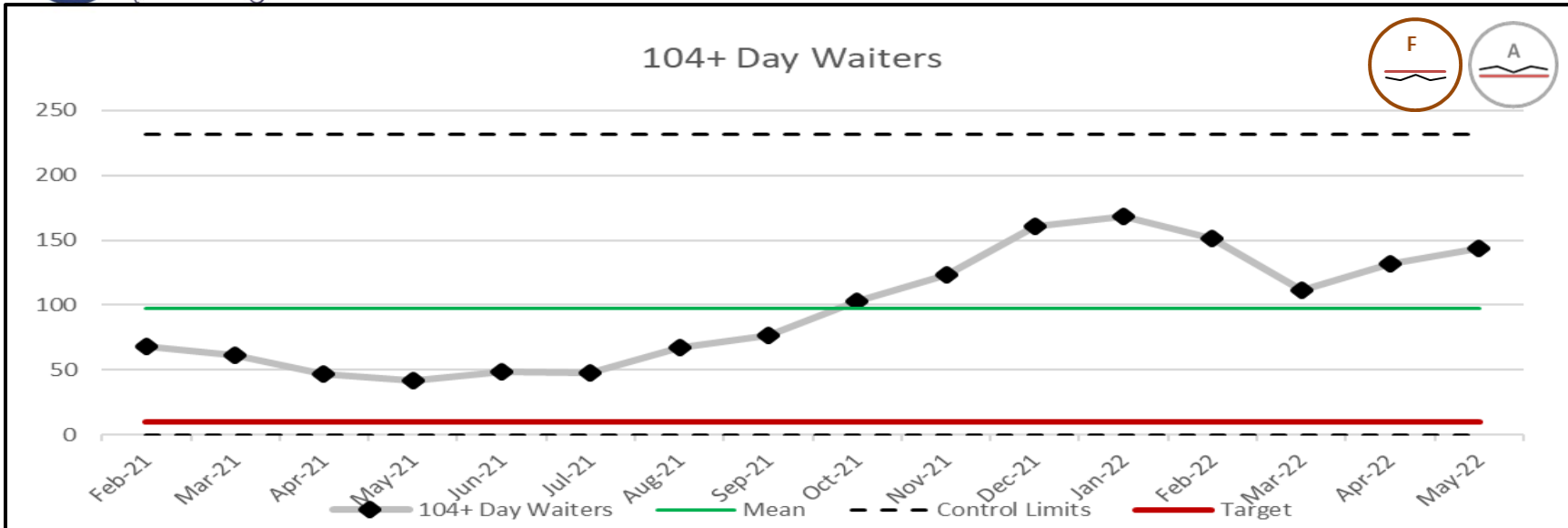
Issues:
The inability to deliver the 31 Day standards was primarily attributed to the reduction in theatre capacity. For the subsequent standards the Trust was successful in the Radiotherapy standard, failing in the Surgery standard and narrowly missing the Drug standard at 97.1%.

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



May-22
144
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Number of cancer patients waiting over 104 days.

What the chart tells us:

As of 16th June the 104 Day backlog was at 144 patients. The agreed target is <10.

The current position by tumour site is as follows: -
86 Colorectal
21 Urology
15 Upper GI
10 Lung
6 Head and Neck
3 Gynaecology
1 each Haematology, CUP and Skin.

Issues:

The impact of critical and major incidents on Trust activity and patient pathways.
Pressure on diagnostic services following the fire in Radiology at LCH.
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 'effectiveness' period) – this is starting to improve.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. 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, Upper GI, Lung, Head and Neck 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 17% 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. Oncologist recruitment is ongoing. A Locum Medical Oncologist has been appointed and is due to comment in post 04/07/2022 (Covering UGI and LGI specialties)
Endoscopy's review regarding endoscopy staffing is now at the point of recruitment. The intention is to increase administrative support by converting fixed term into substantive posts.
For Colorectal, a Deep Dive and pathway analysis is underway, supported by CCG colleagues.

Mitigations:

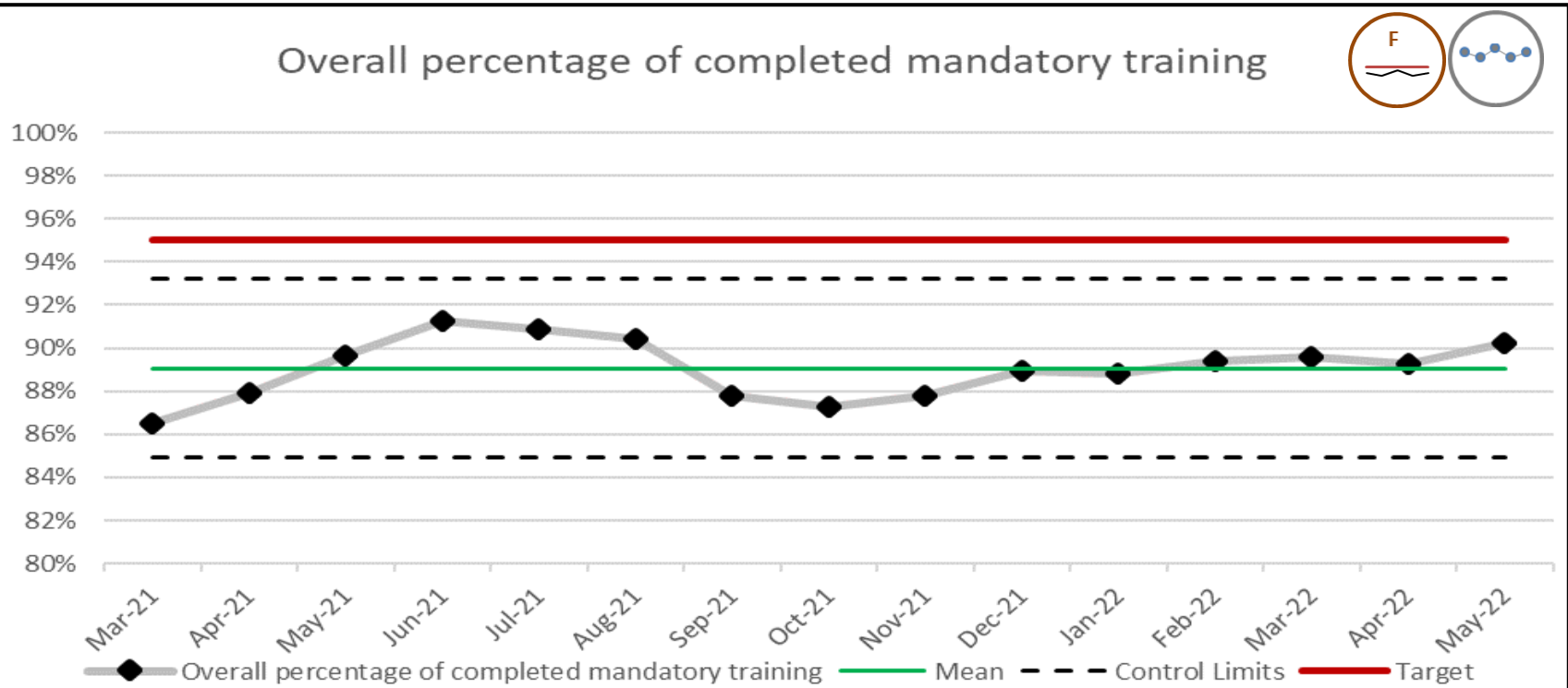
Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity.
A process is currently being designed to 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	Mar-22	Apr-22	May-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	89.59%	89.27%	90.26%	89.76%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	10.36%	10.55%	10.31%	10.43%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.11%	5.21%	5.26%	5.23%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	14.42%	14.67%	14.58%	14.62%		F	H	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	54.30%	54.06%	57.62%	55.84%		F	B	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



May-22
90.26%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Mandatory training has seen a slight increase over the past month however the overall rate can mask poor compliance in some areas.

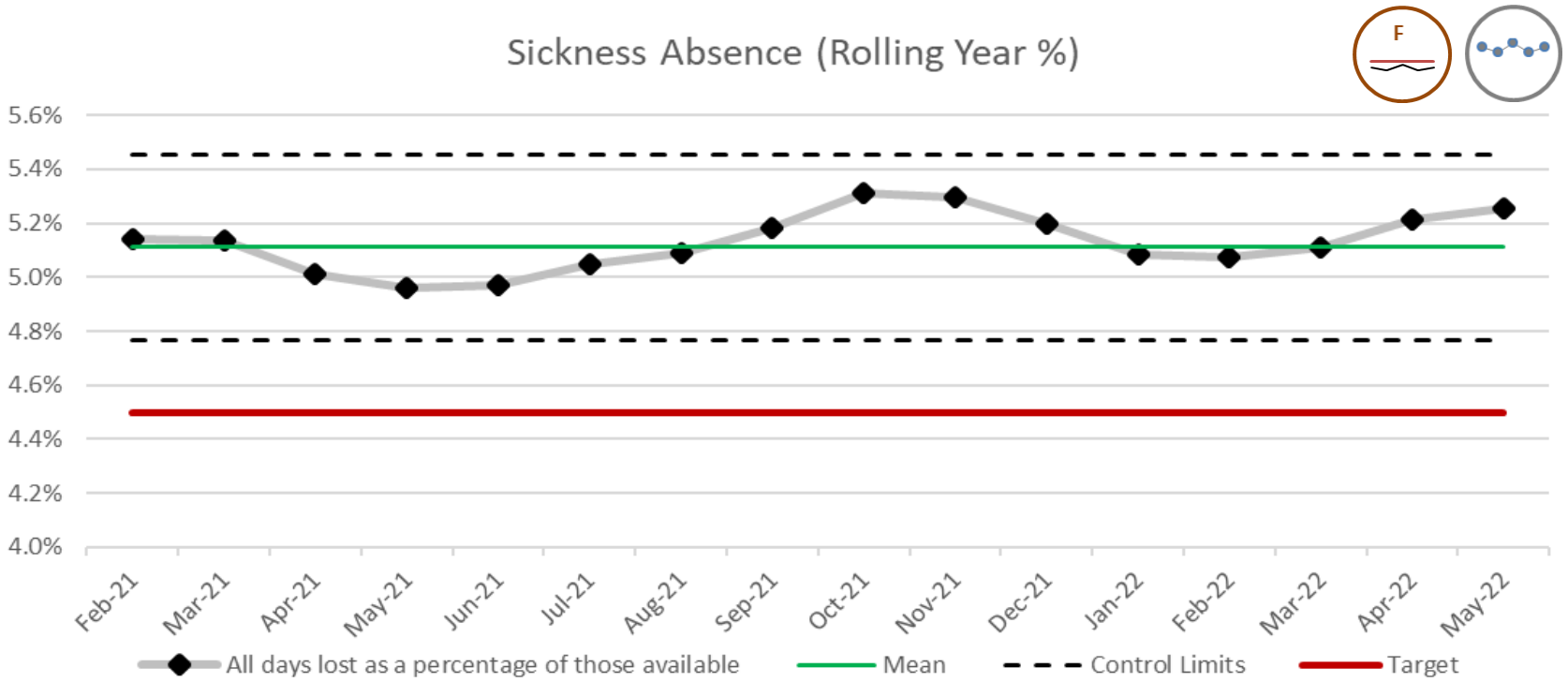
Issues:
- Protected time for learning continues to be a challenge for staff – especially front line staff.
- Anecdotal feedback reports lack of time to access core learning while on shift and difficulties to access from home devices.
- Issues of proper recording of learning by ESR cited as having an impact on rates
- Core learning suite too large.

Actions:
- The lack of a central learning and development team has been added on the risk register.
- Discussion around protected time for training has not progressed.
- SHRBP's continue to work with their Areas and support compliance.
- Work continues with regards to single contract Bank staff and mandatory training/payment for training.

Mitigations:
Messages from The Director of Finance and Digital in April and May has helped in reinforcing protected time off for completion of core learning. These messages need to be repeated over the next month. Issues of access and recording of learning to be addressed by digital team.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



May-22
5.26%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The trend has increased by 0.05% to 5.26% which is still above the target of 4.5%.

Issues:
- The COVID absences are starting to show a decrease.
- Lack of engagement of using the AMS system requires managers to become re-engaged.
- Capacity in the HR team to support case management sooner.

Actions:
- Extensive work is continuing to get full engagement of using Absence Management System (AMS) Trust wide.
- SHRBP's and ER Team continue to work with divisional leads to ensure that the system is being used to log absences correctly, support the wellbeing of employees and monitor attendance.
- All cases in Case Manager are being reviewed and all data is being cleansed in AMS.
- The introduction of LTS Absence meetings with HRBP's, ER Advisers, Divisional Leads and Occ Health have commenced.
- E&F and Medicine Divisions has start the learning journey through a People Management Essentials (PME) sessions. This covers a section on AMS and management responsibilities.

Mitigations:
Support from Empactis has been given to all Divisions.

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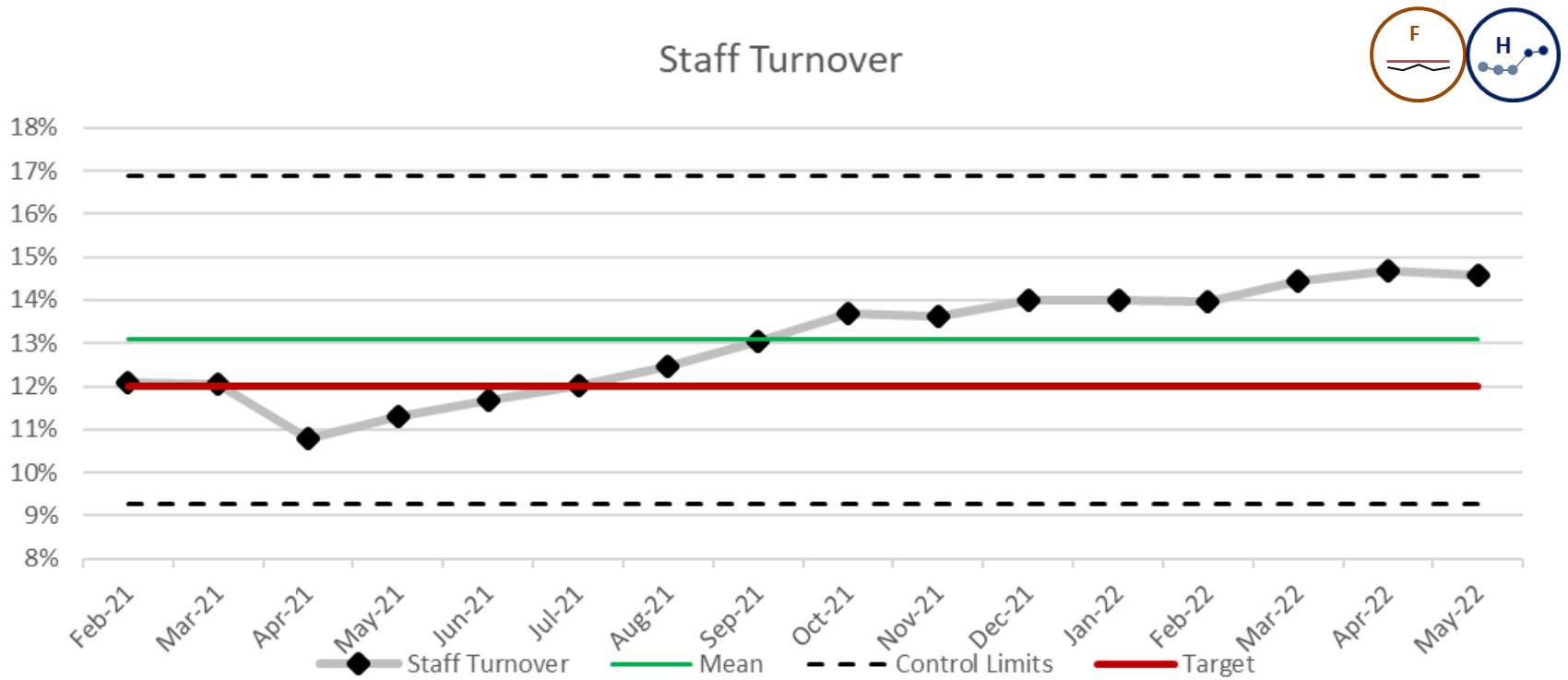
NHS United Lincolnshire Hospitals NHS Trust



May-22
14.58%
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
12%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

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

What the chart tells us:
Turnover rates have stabilised over the past 3 months but still higher than expected as per other partners in the system and Trusts regionally.

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

- Lack of support from managers, development opportunities, flexible working opportunities and relocations, continues to be one of the main reasons for people leaving.

The reasons are the same month on month.

Actions:

- A Culture and leadership OD manager has been appointed and should start in July 22.
- A People Promise Manager started in May 22.
- A new suite of leadership and management training is being introduced in June 22. Flexible working clinics offered by OD to all managers.

Mitigations:
See actions

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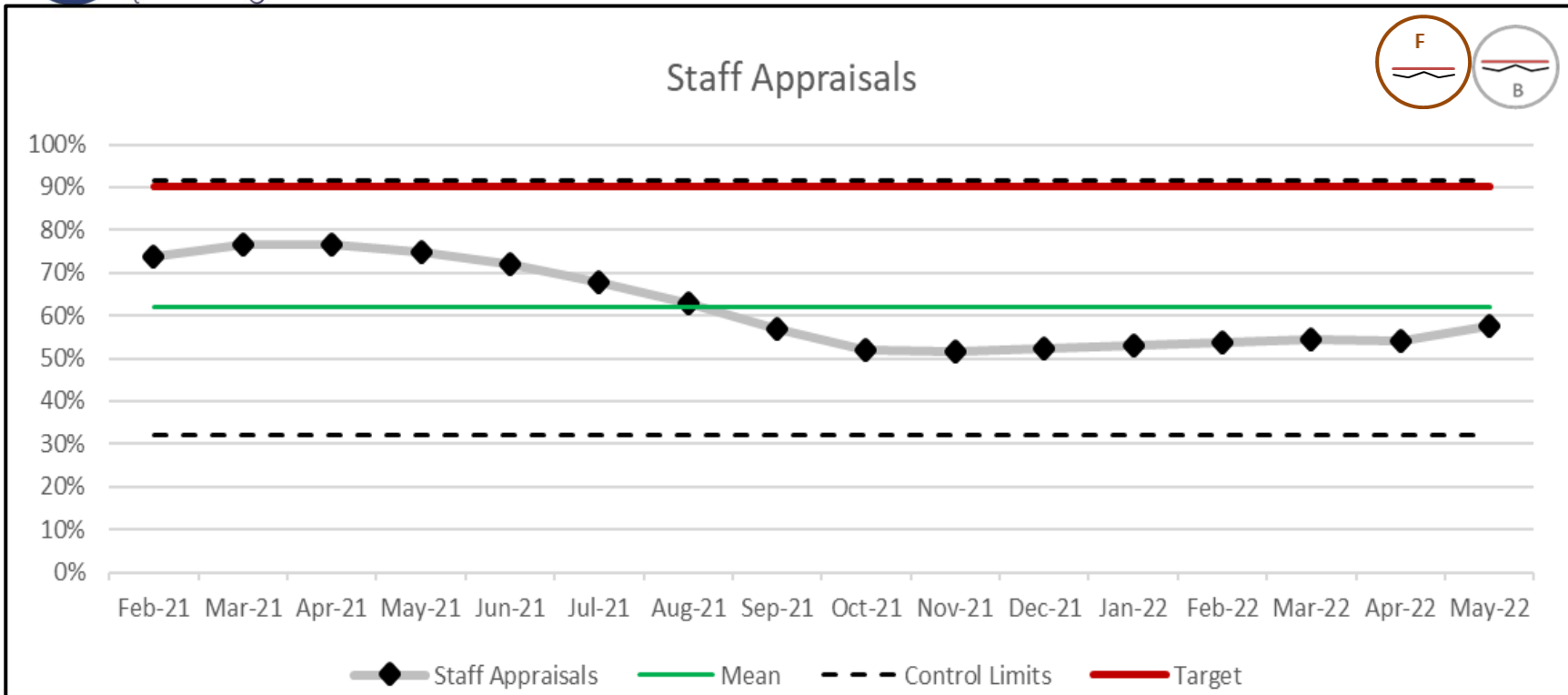
NHS United Lincolnshire Hospitals NHS Trust



May-22
57.62%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 57.62%.

What the chart tells us:
Operational pressures and staffing challenges continue to impact appraisal completion rates. The completion rate slightly increased in May 22.

Issues:
- Operational pressures are causing an impact on completion.
- Appraisal discussions stood down in previous months still felt in April 22 due to back log.
- Staffing issues and increased turnover impact availability of staff to attend appraisals with manager working clinically.

Actions:
- Appraisal completion to be focussed through the divisions regardless of operational pressures Od and HRBPs to continue to prioritise message to divisions
- Appraisal clinics offered by OD to all who require support. Specific focus for Estates and facilities to bring rates up in May 2022 will show in June 22.
- Managers training from June 2022.

Mitigations:
See actions

Financial Position Month 02 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

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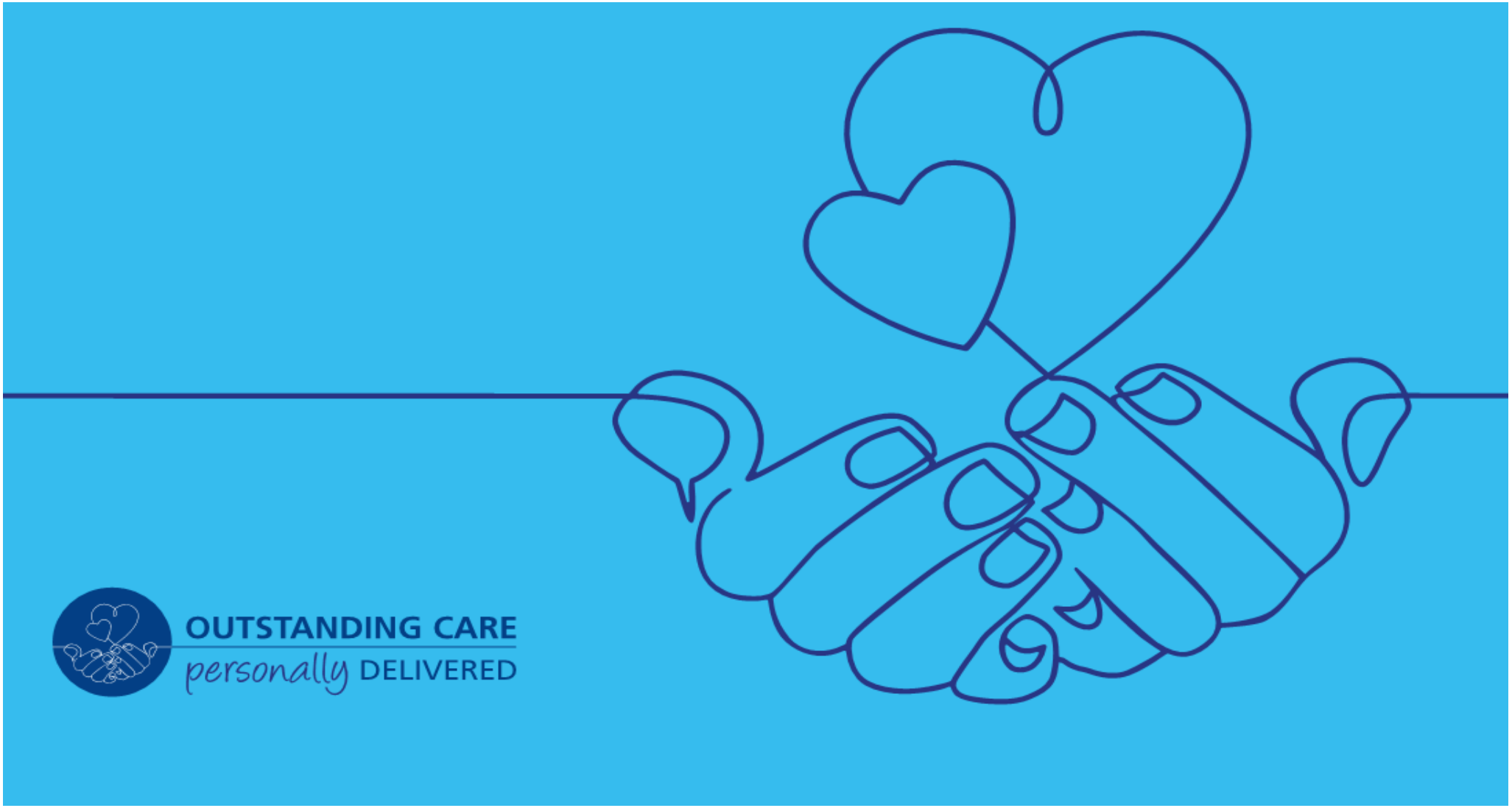
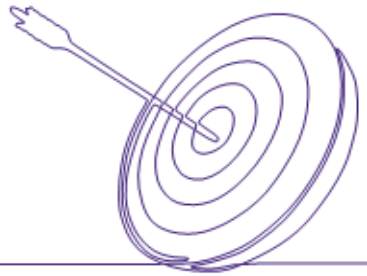


Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)



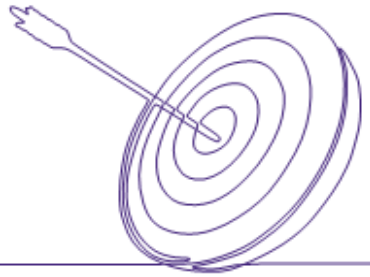
United Lincolnshire Hospitals NHS Trust

	Current Month			Year To Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Patient Care Activities Income	52,549	52,801	252	105,042	105,394	352
Other Operating Income	2,907	3,770	863	5,722	7,097	1,375
Substantive Staff	(30,220)	(30,113)	107	(60,488)	(60,399)	89
Agency Staff	(2,968)	(4,187)	(1,219)	(6,110)	(8,122)	(2,012)
Bank Staff	(2,905)	(3,880)	(975)	(5,874)	(7,901)	(2,027)
Apprentice Levy	(143)	(143)	0	(292)	(286)	6
Non Pay	(17,433)	(16,521)	912	(34,401)	(32,713)	1,688
Depreciation	(1,617)	(1,823)	(206)	(3,287)	(3,268)	19
Net Financing	(657)	(670)	(13)	(1,286)	(1,259)	27
Other Gains / Losses	0	0	0	0	0	0
Surplus/Deficit	**(487)**	**(767)**	**(280)**	**(974)**	**(1,457)**	**(483)**
Below Line Adjustments	2	54	52	57	107	50
Adjusted Surplus/Deficit	**(485)**	**(713)**	**(228)**	**(917)**	**(1,349)**	**(432)**

- The Trust submitted a financial plan for 2022/23 of a £5,811k deficit, and the above table shows that the that the Trust delivered a £713k deficit in May (£228k adverse to plan) and YTD has delivered a £1,349k deficit (£432k adverse to plan). Actual CIP savings of £1,925k have been delivered, such that YTD CIP savings delivery is £534k (21.7%) adverse to plan.

- A further plan submission is required in June to take account of expected additional national funding for 'excess' inflation and pressures - this funding comes with the expectation that systems and organisations within them will further improve their plan positions.

Finance Spotlight Report (Key areas of focus - Income)



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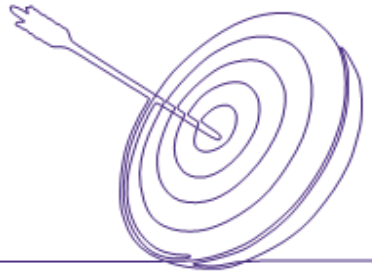
The Income position is £1.7m favourable to plan; this includes:

- **Radiology fire - favourable variance of £0.5m**; the financial plan did not include the I&E impact of the Radiology fire; this favourable income variance offsets an adverse variance of £0.5m in expenditure (mainly in Non Pay in relation to hire of clinical equipment).
- **NHS Patient Care income contract - favourable variance of £0.3m**; this includes £0.4m of accrued income for CDC and Ockenden (both of which are currently outside of the current contract value) to offset related expenditure; these favourable variances to plan have been reduced by under delivery on pass-through income which is reflected in the Non Pay variance.
- **Pay Recharges - favourable variance of £0.3m**; this favourable income variance offsets an adverse variance of £0.3m in Pay.
- **Bad debt provisions - favourable variance of £0.2m**; this reflects a one off change in month 2 which is offset by an adverse variance of £0.2m in Non Pay.
- **Various income lines – favourable variance in total of £0.2m**; including £68k on non patient care recharges, £52k on Research & Development, £46k on Education & Training, £30k on Injury Cost Recovery Unit and £12k on Covid-19 reimbursement.
- **Notional income re the apprenticeship levy - favourable variance of £0.1m**; this favourable income variance offsets an adverse variance of £0.1m in Non Pay.

Finance Spotlight Report (Key areas of focus - Pay)



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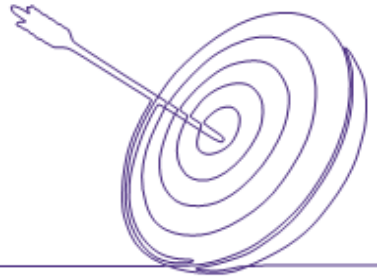
The Pay position is £3.9m adverse to plan; expenditure on non-substantive pay is of particular concern:

- **Substantive pay is £0.1m favourable to plan**
  - Expenditure of £30.1m in May is £0.2m lower than expenditure of £30.3m in April; the reduction of £0.2m was driven by one fewer Bank Holiday in May compared to April.
  - The substantive pay position would be £0.3m lower if it were not for higher than planned expenditure on substantive staffing in relation CDC, Ockenden and other Pay Recharges.
- **Agency pay is £2.0m adverse to plan**
  - Expenditure of £4.2m in May is £0.3m higher than expenditure of £3.9m in April; the increase was driven by higher agency expenditure on Registered Nursing, Midwifery & Health Visitors.
  - The agency pay position would be £0.3m lower if it were not for higher than planned agency expenditure on agency staffing in relation CDC, Ockenden and other Pay Recharges.
  - The financial plan assumed YTD that savings of £1.1m in Agency Pay would be delivered; the adverse position suggests that any savings made YTD have been offset elsewhere in Agency expenditure; the position reflects higher than planned bed numbers, sickness levels & vacancies.
- **Bank Pay is £2.0m adverse to plan**
  - Expenditure of £3.9m in May is £0.1m lower than expenditure of £4.0m in April; Bank expenditure (like Agency Pay) reflects higher than planned bed numbers, sickness levels and vacancies.

Finance Spotlight Report (Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

Non Pay

- The Non-Pay position is £1.7m favourable to plan; the Non-Pay position would be £2.7m favourable to plan if it did not include £1.0m of expenditure for which there is a favourable variance to plan in the income position.

- Non Pay savings delivered of £1,641k are £291k above plan, such that the majority of the favourable variance is being driven by lower than planned activity levels (including pass-through expenditure).

CIP

- The financial plan assumed that the Trust would deliver CIP savings of £25,124k (3.6%) in 2022/23.

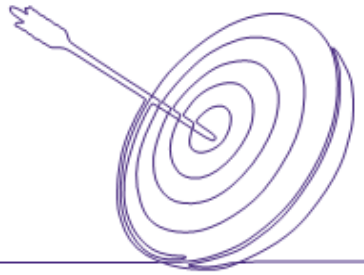
- The financial plan assumed CIP savings delivery of £2,459k by the end of Month 2.

- Compared to planned YTD savings of £2,459k, actual savings of £1,925k (78.3%) have been delivered, such that YTD delivery is £534k (21.7%) adverse to plan.

Capital

- Capital funding levels for 2022/23 agreed through Trust Board & FPEC, show a plan of c£41.0m. Capital spend incurred YTD equates to c£1.2m.

Finance Spotlight Report
(Key areas of focus – Other cntd)



United Lincolnshire Hospitals NHS Trust

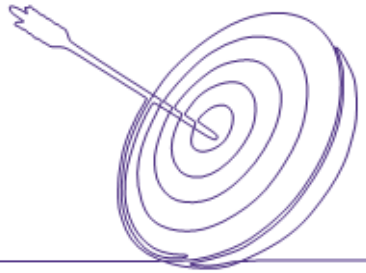
Cash

- The May 2022 cash balance is £76.7m which is a decrease of £11.6m against the March year- end cash balance of £88.3m. This is driven by multiple factors, the most significant being the reduction in year end capital creditors from £22.6m to £9.7m.

BPPC

- BPPC performance is 80% / 78% by value / volume of invoices paid for May 22 (appendix 5d). The YTD performance is 84 % / 76%, this compares to the full year in 2021/22 of 89% / 83%. While performance has started to improve following the introduction of the new finance system in December 2021, a backlog remains and can be seen in the heightened level of trade creditors and has manifested through the reduced performance against the BPPC target.

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

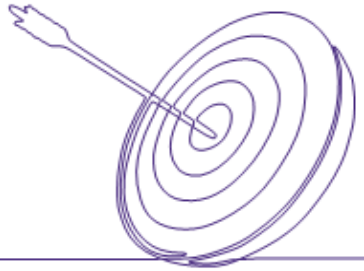
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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 ending:				Actual
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	MAY 2022
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.87
Capital service cover rating	4	4	4	1	2
Liquidity metric	(98.73)	(128.28)	3.71	2.50	1.30
Liquidity rating	4	4	1	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.20%)
I&E margin rating	4	4	2	2	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]
Agency rating	4	4	4	4	[illegible]
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(0.40%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	2

*The Trust Agency Ceiling upon which the Agency Metric is dependent has not yet been released in 2022/23

Balance Sheet



United Lincolnshire Hospitals NHS Trust

	31-Mar-22	31-May-22	
	£000	Plan £000	Actual £000
Intangible assets	7,675	7,319	7,319
Property, plant and equipment	267,753	268,319	266,363
Right of use assets	12,961	10,668	12,621
Receivables	1,848	1,848	1,810
Total non-current assets	**290,237**	**288,154**	**288,114**
Inventories	6,006	6,006	6,113
Receivables	15,520	23,002	22,276
Cash and cash equivalents	88,297	65,770	76,727
Total current assets	**109,823**	**94,778**	**105,116**
Trade and other payables	(89,017)	(75,614)	(80,399)
Borrowings	(2,591)	(3,149)	(2,629)
Provisions	(8,774)	(8,895)	(8,699)
Other liabilities	(1,130)	(1,130)	(4,943)
Total current liabilities	**(101,512)**	**(88,788)**	**(96,670)**
Total assets less current liabilities	**298,548**	**294,144**	**296,560**
Borrowings	(14,264)	(11,571)	(13,906)
Provisions	(3,182)	(3,152)	(3,090)
Other liabilities	(11,572)	(11,488)	(11,488)
Total non-current liabilities	**(29,018)**	**(26,211)**	**(28,484)**
Total assets employed	**269,530**	**267,933**	**268,076**
Financed by			
Public dividend capital	704,180	704,180	704,180
Revaluation reserve	29,294	27,638	29,175
Other reserves	190	190	190
Income and expenditure reserve	(464,134)	(464,075)	(465,470)
Total taxpayers' equity	**269,530**	**267,933**	**268,076**

Note 1: The closing balance sheet for 2021/22 has been restated for the impact of the introduction of IFRS16.
The impact in balance sheet terms is to recognise 'Right of Use' assets with the offset being an increase in Borrowings (£12,83m) and the I&E reserve (£0.13m).

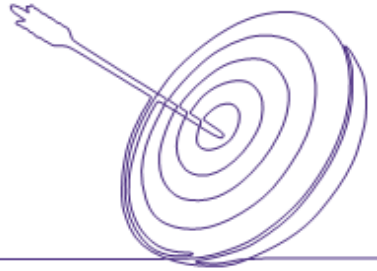
Both the plan and actual for 2022/23 are stated on an IFRS 16 basis.

Note 2: Payables, Receivables and Cash have each been impacted by the migration to the new finance system and disruption to BAU processing. Whilst now operating at close to normal levels, these elements of working capital are expected to return to 'normal' business levels in the next few months.

Note 3: Trade and other receivables continue to be supressed below pre-pandemic levels and will remain so throughout 2022/23 with the continuation of block contract payments. See Appendix 5a-b

Note 4: Trade Payables and other payables remain circa £10m higher than would be normally be expected. This being driven by the heightened level of capital creditors associated with the 2021/22 programme and also the remaining finance system 'backlog.'
The payables balance of £80m is broadly split between:
Staff related creditors £18m, Trade Payables / accruals £36m, Capital creditors £10m and Tax / Superannuation £16m.
BPPC and aged creditor performance is reported at Appendix 5c-d.

Cashflow reconciliation – April 2022– March 2023



NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-22	31-May-22	
	£000	Plan £000	Actual £000
Operating surplus / (deficit)	549	312	(197)
Depreciation and amortisation	15,736	3,287	3,268
Impairments and reversals	7,340	-	-
Income recognised in respect of capital donations	(27)	-	-
Amortisation of PFI deferred credit	(503)	(84)	(84)
(Increase) / decrease in receivables and other assets	11,261	(7,482)	(6,816)
(Increase) / decrease in inventories	504	-	(107)
Increase/(decrease) in trade and other payables	9,745	(2,063)	3,031
Increase/(decrease) in other liabilities	(457)	-	3,813
Increase / (decrease) in provisions	5,860	122	(128)
Net cash flows from / (used in) operating activities	**50,008**	**(5,908)**	**2,780**
Interest received	34	-	92
Purchase of intangible assets	(994)	-	-
Purchase of property, plant and equipment	(35,132)	(16,283)	(14,054)
Proceeds from sales of property, plant and equipment	148	-	-
Net cash flows from / (used in) investing activities	(35,944)	(16,283)	(13,962)
Public dividend capital received	26,610	-	-
Capital element of finance lease rental payments	-	(320)	(368)
Interest paid	(1)	-	-
Interest element of finance lease	-	(16)	(20)
PDC dividend (paid)/refunded	(6,418)	-	-
Net cash flows from / (used in) financing activities	20,191	(336)	(388)
Increase / (decrease) in cash and cash equivalents	**34,255**	**(22,527)**	**(11,570)**
Cash and cash equivalents at 1 April - brought forward	54,042	88,297	88,297
Cash and cash equivalents at period end	**88,297**	**65,770**	**76,727**

Note 1: Cash held at 31 May was £76.7m against a plan of £65.8m.

Note 2: Principle reasons for the cash variance to plan of £11.0m are:
- An increase in NHS deferred income associated with quarter 1 payments from Health Education England income and also block payments made by NHS England.
- The backlog of trade payables associated with the ledger implementation not being reduced as anticipated.

Note 3: Underlying cash balances remain significantly increased on 2019/20 levels primarily due to:
- The continued block payment regime
- The remaining backlog associated with the implementation of the new finance system.
- Receipt in March 21 of £7.1m to cover future outgoings associated with accrued annual leave.
- Increased levels of capital creditors.
- Increased levels of provisions to offset risks associated with current litigation and contractual obligations.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*July 2022*
Item Number	*Item 13.1*
Strategic Risk Report	
Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Paul White, Head of Risk & Governance*
Report previously considered at	*Not Applicable*

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

Risk Assessment	*Not Applicable*
Financial Impact Assessment	*Not Applicable*
Quality Impact Assessment	*Not Applicable*
Equality Impact Assessment	*Not Applicable*
Assurance Level Assessment	*Significant, with some improvement required (based on Internal Audit Report – March 2022)*

Recommendations/ Decision Required	*The Trust Board is invited to review the content of the report.*

Executive Summary

This Strategic Risk Report focuses on the highest priority risks to the Trust's objectives as defined within the Board Assurance Framework (BAF). All references to the risk register concern risks that have previously been reported to the lead assurance committee.

There are 9 quality and safety risks currently rated Very high (20):

- Delays to planned care pathways for admitted, non-admitted and cancer patients
- Delays to handover from ambulances to A&E
- Potential serious harm from patent falls
- Provision of echocardiograms
- Learning from patient safety events
- Use of hard copy documents for patient records and medication details

There are also 5 quality and safety risks with a current rating of High (15-16); this includes 1 increased rating (Maternity environment) and 1 closed risk (interventional radiology suite at Lincoln).

There are 3 Very high workforce risks (scoring 20-25) at present:

- Recruitment and retention of registered nurses
- Recruitment and retention of consultants and middle grade doctors
- Low morale amongst the workforce

A complete review and refresh of the People and OD directorate risk register has been undertaken and an initial draft was presented for discussion at the Risk Register Confirm & Challenge Group (RRC&CG) in May. Due to cancellation of the June People 7 OD Committee these changes have yet to be approved and updated on the risk register.

There are 0 active finance, performance and estates risks that are rated Very high (20-25) at present and 5 that are rated High (15-16):

- Cost of reliance upon temporary clinical staff;
- Fire safety Trust-wide;
- Potential for critical failure of the digital infrastructure;
- Information governance; considerations within system change; and
- Continuity of water supply at Pilgrim Hospital.

The Finance risk register has been completely refreshed and was presented to the RRC&CG in June. Details of the revised risks will be presented to the next meeting of the Finance, Performance and Estates Committee. This includes additional significant risks in relation to:

- Delivery of the CIP programme
- Potential loss of income
- Reducing costs introduced as a result of Covid

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). Details of all active Very high and High risks (15-25) are provided in **Appendix A**, organised by strategic objective and current risk rating however a summary of Very high risks is provided below in sections 2.3-2.13. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level.

1.2 The Risk Register Confirm and Challenge Group continues to meet on a monthly basis, reviewing all High and Very high risks as well as receiving presentations from clinical and corporate business areas on a rotational basis to enable constructive feedback to be provided.

1.3 Active risks that have a performance, service continuity and reputation impact as well as a quality of care impact are reported to the Quality Governance Committee as the lead for assurance. In addition, the Finance, Performance & Estates Committee now receives regular updates on progress with managing these risks so as to maintain oversight from a performance and reputation perspective.

1.4 Similarly, the People and Organisational Development Committee receives a regular report on workforce risk as assurance lead, with a summary of Very high workforce risks that have a potential quality and safety impact also being reported to the Quality Governance committee for information.

1.5 This report is an amalgamation of the most recent reports to each of the assurance committees of the Trust Board. Any changes to the risk register that have not yet been reported through the appropriate committee are not included.

2. Trust Risk Profile

2.1 There 248 active risks currently recorded on the Trust risk register. There are 12 risks with a current rating of Very high (20-25) and 13 rated High (15-16).

2.2 **Table 1** shows the number and proportion of active risks by current rating, change since last month's report, and proportion of the overall Trust risk profile:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
1 (0%)	**33** (14%)	**189** (76%)	**16** (5%)	**12** (5%)

Strategic objective 1a: Deliver harm free care
Assurance lead: Quality Governance Committee

2.3 There are currently 7 Very high risks and 5 High risks to this objective. A summary of the 7 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4877	If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (non-admitted / outpatients) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	Being reviewed by new Risk lead
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	Being reviewed by new Risk lead
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	Being reviewed by new Risk lead
4803	If there are substantial delays to patient handovers from ambulances then it could lead to patients being treated in an area that is not appropriate for patient care, resulting in failure to meet the national standard for ambulance handovers which impacts on the wider system and may lead to regulatory action, also potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	- Early intelligence of increasing EMAS demand to allow 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.	23/03/2022

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	13/06/2022
4624	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.	Very high risk (20)	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents, monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	13/06/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm and a poor clinical outcome	Very high risk (20)	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	28/04/2022

Strategic objective 1b: Improve patient experience
Assurance lead: Quality Governance Committee

2.4 There are currently no Very high risks and 2 High risks to this objective.

Strategic objective 1c: Improve clinical outcomes
Assurance lead: Quality Governance Committee

2.5 There are currently 2 Very high risks and 1 High risk to this objective A summary of the 2 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4828	If information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a reduced likelihood of a positive clinical outcome and possibly causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust.	22/06/2022
4731	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could lead to delayed diagnosis and treatment, reducing the likelihood of a positive clinical outcome and possibly causing serious harm	Very high risk (20)	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	21/06/2022

Strategic objective 2a. A modern and progressive workforce
Assurance lead: People & OD Committee

2.6 There are 2 Very high risks and 3 High risks to this objective. A refreshed version of the workforce risk register has been drafted by the People & OD Directorate for presentation to the committee in June, however the meeting was cancelled therefore a summary of current Very high risks is provided below:

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.	23/05/2022 (included in full refresh of People & OD risk register)
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.	23/05/2022 (included in full refresh of People & OD risk register)

Strategic objective 2b. Making ULHT the best place to work
Assurance lead: People & OD Committee

2.7 There is 1 Very high risk to this objective, a summary of which is provided below:

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)	Decision taken not to have a separate People Strategy. Will 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.	23/05/2022 (included in full refresh of People & OD risk register)

Strategic objective 2c. Well-led services
Assurance lead: Audit Committee

2.8 There are no active Very high risks or High risks to this objective.

Strategic objective 3a: A modern, clean and fit for purpose environment
Assurance lead: Finance, Performance & Estates Committee

2.9 There are no active Very high risks and 2 High risks to this objective.

Strategic objective 3b: Efficient use of our resources
Assurance lead: Finance, Performance & Estates Committee

2.10 There are no active Very high risks and 1 High risk to this objective. A comprehensive refresh of the Finance directorate risk register has been carried out this month and was presented for discussion at the next meeting of the Risk Register Confirm and Challenge Group. The revised risk register will be presented to the next FPEC meeting and will include the following significant risks:

- Breach of the agency staff spending cap due to reliance on temporary staff to maintain services (currently rated Very high, 20)
- Delivery of the CIP target for 2022/23 (rated High, 16)
- Substantial, unplanned reduction in income (rated High, 16)
- Reduction of costs introduced as a result of the Covid-19 pandemic (rated High, 16)

Strategic objective 3c: Enhanced data and digital capability
Assurance lead: Finance, Performance & Estates Committee

2.11 There are currently no Very high risks and 2 High risks to this objective.

Strategic objective 4a: Establish new evidence based models of care
Assurance lead: Finance, Performance & Estates Committee

2.12 There are currently no Very high or High risks to this objective.

Strategic objective 4b. To become a University Hospitals Teaching Trust
Assurance lead: People & OD Committee

2.13 There are currently no Very high or High risks to this objective.

3. Conclusions & recommendations

3.1 The most significant risks within the Trust at present relate to:

- the recovery of planned care pathways;
- ambulance handovers to A&E;
- the availability of accurate patient and medication records;
- serious patient harm from falls;
- the provision of echocardiograms;
- the ability to learn lessons from previous patient safety incidents.
- the recruitment of medical and nursing staff; and
- staff morale

3.2 The Trust Board is invited to review the content of the report, no further escalations at this time.

Appendix A - Quality and Safety risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective						**1a. Deliver Harm Free Care**																			
4879	Physical or psychological harm	Evans, Simon	Carter, Mr Damian		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Cancer Centre		If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	23/03/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	30/04/2022
4877	Physical or psychological harm	Evans, Simon	Carter, Mr Damian		28/03/2022	20	Risk assessments	Surgery				If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care admitted pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	23/03/2022	Extremely likely	High	Very high risk	20	Planned care recovery plan (non-admitted / outpatients) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	30/04/2022
4878	Physical or psychological harm	Evans, Simon	Carter, Mr Damian		28/03/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU		Trust-wide	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care non-admitted pathway & booking systems / processes (outpatients) - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Outpatient Recovery Group; Reports through Divisional PRMs (for performance), and FPEC and System Planned Care Group - Clinical Harm Oversight Group	2ww first O/Ps back within national target Urgent 1sts 90% <13 weeks by 31.03.23 Time critical follow ups (452/2657 overdue) – target to eliminate (mainly neurology, cardiology, rheumatology) by 31.03.23 RTT non-admitted: Clear >104wws by 31.03.22 Clear >78wws by 31.03.22 (with few remaining by 30.06.22) Clear >65wws by 30.09.22 Clear >52wws by 31.12.22	23/03/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	30/04/2022

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ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4803	Physical or psychological harm	Evans, Simon	Skinner, Maxine	Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there are substantial delays to patient handovers from ambulances then it could lead to patients being treated in an area that is not appropriate for patient care, resulting in failure to meet the national standard for ambulance handovers which impacts on the wider system and may lead to regulatory action, also potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	ULHT policy & procedure: - 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 fed back 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.	- Ambulance handover times: increase of >2hrs in January 2022 (261 in January vs 238 in December) and decrease in >4hr delays (35 in January compared to 39 in December) - Clinical harm reviews / incidents linked to ambulance handover delays: 3 serious harm incidents reported this quarter (under investigation)	23/03/2022	Extremely likely	High	Very high risk	20	- Early intelligence of increasing EMAS demand to allow 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.	January saw formal requests from EMAS to enact the rapid handover protocol. Risk discussed at Risk Register Confirm & Challenge Group 23 March 2022, current rating increased from 16 to 20.	Low risk	30/09/2022	30/06/2022	30/04/2022
4624	Physical or psychological harm	Davies, Angela	Addlesee, Sarah	Patient Falls Steering Group	08/11/2021	16	Aggregation of Incident/Claims & Complaints/PALS	Corporate Nursing Directorate	Corporate Nursing	Trust-wide		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.	National policy: - NICE Clinical Guideline CG161: Assessment and prevention of falls in older people (2013) - PHE Falls and fracture consensus statement: Resource pack (2017) ULHT policy: - Falls Prevention and Management Policy (approved April 2021, due for review March 2023) ULHT governance: - Lead Quality Matron - Weekly Falls Investigation Panel / Training package tiered approach / Weekly spot check audits / Monthly Quality Metrics Dashboard meetings /ward review visits - Patient falls steering group / Nursing, Midwifery & AHP Forum / Quality Governance Committee	Frequency, location and severity of patient falls incidents reported: - The numbers of reported falls incidents are demonstrating an increasing upward trend therefore will not achieve the strategic objective to achieve harm free care. - Operational pressures have resulted in patients having prolonged periods sitting in Emergency Departments whilst waiting assessment and for inpatient beds to become available. This may contribute to an increase in some patients overall frailty level and subsequent deconditioning which increases the vulnerability to an individual falling. - Longer length of stays have demonstrated a correlation to risk of a patient falling whilst in the care of the Trust. Patient falls reported April 2021-March 2022 Total -1916 Moderate harm -22 Severe -12 Death -4 Patient falls reported April 2022-May 2022 Total -344 Moderate harm -7 Severe-4 Death-1	07/06/2022	Extremely likely	High	Very high risk	20	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	Initial business case for a dedicated falls team resource to be presented to CRIG in June 2022. A Falls QI Project Development and Implementation Group has been established which has multidisciplinary representation from divisional and corporate teams. Dedicated support is being provided by the Improvement Academy. Oversight and monitoring will be provided by FPSG who will receive monthly updates on actions being taken and progress made by the QI group. A schedule of face to face falls prevention and Flojac training commenced in April 2022 delivered within clinical areas by the Quality Matron and Health & Safety teams. Wards identified as having higher falls occurrences are being prioritised. The Chief Nursing Information Officer (CNIO) has been working with the Quality Matron team to identify how the identification and handover of patients vulnerable to falling can be improved through the support of digital applications. Falls Prevention Steering Group time out session planned 23/06/22 which will provide an opportunity to review the work programme of the group to ensure all the of the right questions are being asked and the right areas of focus are being looked at effectively.	Low risk	31/12/2021	31/03/2023	31/07/2022
4789	Physical or psychological harm	Evans, Simon	Ratcliff, Carl	Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	25/05/2022	Extremely likely	High	Very high risk	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	Echo backlog remains high. Meridian re-engaged to support service. Number of measures being undertaken to increase capacity. Progress being reported into planned care board. Discussed at Risk Register Confirm & Challenge Group on 25 May 2022. Agreed that this is a broader quality of care and experience risk potentially impacting on a large number of patients, rather than a specific risk of serious harm.	Low risk	31/03/2022	31/03/2023	30/06/2022

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ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4622	Patient safety (physical or psychological harm)	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group	09/04/2018	20	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	If the Trust fails to learn lessons when patient safety incidents occur, so that changes can be made to policies and procedures, there is an increased likelihood of similar incidents occurring in future which could result in serious harm affecting a large number of patients.	National Policy: - NHS National Patient Safety Strategy - NHS National Reporting and Learning System (NRLS) ULHT Policy: - Analysing and Learning from Patient Safety Incidents, Complaints, Claims and Coroners Inquests Policy (approved April 2019, due for review April 2022) ULHT governance: - Trust Board assurance through Quality Governance Committee (QGC) and sub-groups"	- Recurring themes in patient safety incidents, complaints, PALS & claims (e.g. patient falls SIs; pressure ulcer incidents; DKA incidents) - Recurring themes in audits / reviews of risk / incident / complaints / claims management"	09/05/2022	Extremely likely	High	Very high risk	20	- Establishment of Patient Safety Improvement Team - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previoulsy called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ - Prepare for implementation of new Patient safety Incident Response Framework (PSIRF) in 2022 (replacement for Serious Incident Framework)	- Patient Safety Improvement Team now established within Clinical Governance - Datix CloudIQ has been approved for connection to the new national learning system - Case of need for Datix CloudIQ approved in principle; implementation to be planned Directorate review (May 2022) - agreed that this would remain Very high (20) subject to learning lessons work being completed and evidence that repeated incidents are reducing	Low risk	31/01/2019	31/03/2023	30/06/2022
4646	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Patient Safety Group	14/12/2021	20	Policy/Protocol Issues, Risk assessments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with 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.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21	23/03/2022	Quite likely	High	High risk	16	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.	New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB scheduled from Feb / Mar 22. Risk discussed at Risk Register Confirm & Challenge Group on 23 March 2022. Still inconsistencies with timeliness against BTC standards, particularly at Lincoln, and inability to ring-fence beds. Agreed that risk remains high but has reduced. Recommendation for rating to change from 20 to 16.	Low risk	30/09/2022	30/09/2022	30/06/2022

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ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors.	1. IV medicines ready to use (pre-prepared in clinical area) kept for 24 hours. 2. To minimise the risk of microbiological contamination and minimise the risk of infection, administration of injections and infusion prepared in a clinical area should be performed immediately after preparation and ideally within 30 minutes of preparation. 3. To minimise the risk of wrong dose/drug/patient errors, the identity of all injectable medicines must be assured. If the preparation (syringe or IV bag) leaves the hands of the person who prepared it and/or the entire injection or infusion process is not under the direct supervision of that person, the syringe or IV bag must be labelled. Infusion Labels must include as a minimum: - the name & dose or strength of the drug and diluent (including units of measurement) - the date and time of preparation - the name of the person who prepared it. Bolus Labels must include as a minimum: - the name & dose of the drug.	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	17/05/2022	Quite likely	High	High risk	16	1. Use of tamper proof boxes/trays being purchased. 2. The only control to prevent the risk is to prepare the injections prior to administration (within 30 minutes) as per guidance (National and Trust). 3. If the practice is to continue, the prepared products should be labelled to include the recommended information. A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day.	Following a Datix (ref no: 255637), it has been identified that intravenous medication required for a Lower Segment Caesarean Section (LSCS) is being prepared in advance of the procedure in case of an emergency. The Lead Obstetric Anaesthetist has discussed the practice with the team and the consensus is that for safety the drugs need to be prepared in advance for potential emergencies. The team has sourced tamper proof drug trays to store the drugs once prepared. This risk assessment has been done for Pilgrim Hospital, Boston. However, the practice seems to replicate at Lincoln County Hospital. Full risk assessment is attached to Datix. 17/5/22 No change	Low risk	30/09/2022	30/09/2022	30/06/2022
4779	Physical or psychological harm	Evans, Simon	Ratcliff, Carl	Clinical Effectiveness Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	29/04/2022	Quite likely	High	High risk	16	defined plans to address backlog for at risk areas	Plans in place to address backlogs across all areas. Significant area of risk for TIA.	Low risk	31/03/2022	30/06/2022	30/05/2022
4790	Service disruption	Evans, Simon	Spendlove, Mrs Clare	Patient Safety Group	16/01/2022	15	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		Major risk to service delivery (cardiology diagnostic tests and reports) due to current system no longer being supported. Supplier only able to support on best endeavours basis. Frequent loss of service resulting in adverse impact on service provision. Urgent replacement of system required	Best endeavours agreement in place with supplier procurement process to be undertaken for replacement system	volume of system failures/ability to reinstate	25/05/2022	Quite likely	High	High risk	16	new system procurement to be expedited	System procurement completed .Implementation plan in place. Risk to be re-assessed once new system has been implemented. Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Agreed that the current level of risk is High and acceptable risk is Low (not Moderate).	Low risk	31/12/2022	31/12/2022	31/08/2022
4935	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha	Patient Safety Group	26/05/2022	16	Workforce Metrics	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care		Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale).	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Rotas (gaps). Agency spend - financial risk. Number of Datix incidents recorded.	06/06/2022	Quite likely	High	High risk	16	Recruit to vacant posts.	Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review	Low risk	31/10/2022		30/06/2022
Strategic Objective						**1b. Improve patient experience**																			

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4701	Reputation	Grooby, Mrs Libby	Upjohn, Emma		13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	13/04/2022	Reasonably likely	Extreme	High risk	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15	Low risk	31/03/2025	31/03/2025	30/09/2022
4724	Physical or psychological harm	Lalloo, Yavenuscha	Cooper, Mrs Anita		13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, then once COVID funding ends it will leave services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	22/03/2022	Extremely likely	Medium	High risk	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.	Business cases completed for all areas.	Low risk	30/11/2021	31/03/2023	30/06/2022
Strategic Objective						**1c. Improve clinical outcomes**																			
4731	Physical or psychological harm	Evans, Simon	Parkin, Mr Lee	Medical Records Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	12/05/2022	Extremely likely	High	Very high risk	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Digital Hospital Group. 120522 - Review of policy is underway – sent to h/recs managers for amendments before being sent for sign off to Lee and via the CRG	Low risk	30/06/2018	31/03/2023	30/06/2022
4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	If information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	17/05/2022	Extremely likely	High	Very high risk	20	Planned introduction of an auditable electronic prescribing system across the Trust.	Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. 17/5/22 No change	Low risk	31/03/2022	30/09/2022	30/06/2022

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ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4905	Physical or psychological harm	Cooper, Mrs Anita	Bradley, Mrs Lesley		22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on acute wards, delayed discharges, delayed referral to response times. Patient reviews delayed for botox treatment.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Prioritisation guidelines.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service.	28/04/2022	Extremely likely	Medium	High risk	15	Getting locums and bank staff in place. Good use of relocation allowance. Actively managing the waiting lists and dealing with urgent cases to avoid harm eg telephone contact with patients. Case of need for GDH orthopaedic staffing. Case of need for rehabilitation consultant post. Case of need for upper GI dietician. Case of need for Neuro Psychology staff on Ashby. Case of need for OT staff at PHB and LCH in ITU. Over recruitment of band 5s in dietetics. Competency frameworks and preceptorship.		Moderate risk	30/06/2023		30/06/2022
Strategic Objective						**2a. A modern and progressive workforce**																			
4669	Service disruption	Paul Matthew	Karen Taylor	Workforce Strategy Group	12/01/2022	25	Workforce Metrics	Corporate	People and Organisational Development	Operational HR	Trust-wide	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	ULHT policy: - Nursing workforce planning processes - Nursing recruitment framework & associated policies, training & guidance - Nursing rota management systems & processes - Nurse Bank & agency temporary staffing arrangements - Workforce management information ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Nursing vacancies & turnover rate. Nursing staff survey results relating to job satisfaction / retention.	02/11/2021	Quite likely	Extreme	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.	Workforce supply is a workstream in the Integrated Improvement Plan reflecting the priority within the NHS National People Plan. Programmes have been delayed by COVID. However vacancy rates have reduced over the last three months. The Director of Nursing has initiated a Nurse Transformation Programme to look at demand and supply issues around nursing.	Moderate risk	31/03/2022	31/01/2023	31/03/2022
4670	Service disruption	Paul Matthew	Karen Taylor	Workforce Strategy Group	12/01/2022	25	Workforce Metrics	Corporate	People and Organisational Development	Operational HR	Trust-wide	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	ULHT policy: - Medical workforce planning processes - Medical recruitment framework & associated policies, training & guidance - Medical rota management systems & processes - Medical staff locum temporary staffing arrangements - Workforce management information ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Medical staff vacancies & turnover rate. Medical staff survey results relating to job satisfaction / retention.	02/11/2021	Quite likely	Extreme	Very high risk	20	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	Plan for every medical post in place. Pre-COVID was strong pipeline for medical recruitment. Focus of IIP. We are restoring recruitment processes and using Teams to run AAC panels. Vacancy rate for medical staff reducing.	Moderate risk	31/03/2022	31/03/2023	31/03/2022

Appendix A - Quality and Safety risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4671	Service disruption	Paul Matthew	Claire Low	Workforce Strategy Group	12/01/2022	16	Workforce Metrics	Corporate	People and Organisational Development	Operational HR	Trust-wide	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	National policy: - Government policy / guidelines on Covid testing and isolation ULHT policy: - Working Safely - Covid-19 Policy (Health & Safety Policy), approved July 2021 - Temporary staffing processes (bank / agency / locum) - Emergency planning processes and workforce contingency arrangements for Major, Critical and Business Continuity Incidents ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group; Health & Safety Group - Operational workforce governance arrangements	Frequency of workforce-related Major / Critical / Business Continuity incidents. Staff absence rates (Covid-related). Temporary staff usage rates.	02/11/2021	Quite likely	High	High risk	16	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.	Re-launch of staff health and well-being offer. Empactis launched with corporate staff in August and rolled out through to February 2020. Sick leave cover due to Covid is currently one of the top 4 reasons for use of temporary staff.	Moderate risk	31/03/2022	31/03/2023	31/03/2022
4741	Service disruption	Colin Farquharson	Aurora A Sanz Torres	Patient Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	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)	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements	Monitoring tumour site performance data	26/11/2021	Quite likely	High	High risk	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements.	Low risk	31/03/2022	30/09/2022	31/03/2022
4780	Service disruption	Simon Evans	Anita Parmar	Workforce Strategy Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		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	Ongoing recruitment activity to attract perm and locum resources. No success with overseas or local tertiary centre recruitment Temporary Service change during COVID has consolidated to a single site hyper-acute service- approved by Executives in December 2019 Protocol in place for access to Thrombolysis Trolley on each site. Acute Care Practitioners (ACP's) appointed and undergoing Masters Level Education and Training currently. Integrated into Cardiology ACP Workforce to ensure supported management & education. Business case being developed to secure funding for ACP workforce	monthly service review in place primarily assessed on rota gaps / ability to maintian services across both sites	12/11/2021	Quite likely	High	High risk	16	Monthly review of provision in place ongoing recruitment campaigns for vacancies expansion of ACP workforce (business case beig developed) to increase medical capacity to support consultant workforce	ongoing deficit in Stroke Consultant staffing. Recruitment to substantive posts unsuccessful. Only 2 substantive consultants out of 6 in post. National Market shortage .Increased reliance on agency locums with significant financial impact Increased pressure on current workforce as service demands have not reduced ASR consultation adding pressure due to lack of uncertainty on outcome. Increase in staff turnover due to service instability daily ward round commitments amended to every other day to create capacity	Moderate risk	31/03/2022	30/09/2022	31/03/2022
Strategic Objective					**2b. Making ULHT the best place to work**																				

Appendix A - Quality and Safety risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4667	Service disruption	Paul Matthew	Claire Low		11/01/2022	25	Risk assessments	Corporate	People and Organisational Development	Operational HR	Trust-wide	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.	Staff Charter & Personal Responsibility Framework Staff engagement strategies & plans. Internal communications platforms (intranet; bulletins; forums). Staff survey process and response planning. People management & appraisal policies, processes, systems (e.g. ESR) training & monitoring. Core learning programmes. Leadership development and succession planning processes. Management of change policies, guidelines, support and training. Partnership agreement with staff side representatives. Occupational health & wellbeing arrangements for staff.	Staff survey results. Staff 'pulse check' results. Staff absence rates. Staff turnover rates. Complaints received regarding staff attitude / behaviour.	03/11/2021	Quite likely	Extreme	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.	Some improvement in the results of the staff survey. Still below average for acute trusts. Less than 50% of staff would recommend ULHT as a place to work. Considerable work still to be done on morale, but this is the thrust of the Integrated Improvement Plan and a number of workstreams within it. Progress on projects delayed owing to COVID, but as part of managing the incident we have introduced new approaches to interacting with staff and feedback has been positive.	Low risk	31/03/2022	31/03/2022	31/03/2022
Strategic Objective						**3a. A modern, clean and fit for purpose environment**																			
4648	Physical or psychological harm	Evans, Simon	Davey, Keiron	Fire Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	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.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit /	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	04/04/2022	Reasonably likely	Extreme	High risk	15	- Statutory Fire Safety Improvement Programme based upon risk. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Capital investment programme for Fire Safety being implemented on the basis of risk. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	New Fire Alarm installed within Lincoln maternity Tower Block. Automatic openable vents for smoke removal to be installed by End of Jan 2022. Fire Risk assessments being undertaken on basis of risk priority. Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. Damper installation within ICU, Rainforest, Lancaster, Ashby to be completed Mid December 2021. Following incident at Lincoln A&E / X-ray in March 2022, risk assessments for fire and security are being reviewed.	Moderate risk	31/03/2022	31/12/2022	30/09/2022
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant diruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	10/02/2022	Reasonably likely	Extreme	High risk	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	Scheme of work and design currently being produced.		30/10/2020	31/03/2023	30/06/2022
Strategic Objective						**3b. Efficient use of our resources**																			

Appendix A - Quality and Safety risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4664	Finances	Matthew, Mr Paul	Young, Jonathan		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	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.	ULHT policy: - Financial strategy - Annual budget setting process - Capital investment planning process, programme delivery & monitoring arrangements - Key financial controls - Financial management information ULHT governance: - Financial review meetings held monthly with each Division - Divisional performance & accountability framework	Budget monitoring - temporary agency / locum staff	26/10/2021	Quite likely	High	High risk	16	Financial Recovery Plan schemes: recruitment improvement; medical job planning; agency cost reduction; workforce alignment	Impact of COVID on services, staff and subsequently the cost base, including increased use of incentive rates, agency staff and high cost consumables and drugs. COVID cost forecasts included in financial planning to provide oversight, control and governance.	Moderate risk	31/03/2022	31/03/2023	31/03/2022
Strategic Objective						**3c. Enhanced data and digital capability**																			
4641	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	23/11/2021	16	Risk assessments	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	19/05/2022	Quite likely	High	High risk	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	Risk reviewed, description amended to reflect broader range of threats to the digital infrastructure. Current score increased to 16. Have purchased a significant number of Radios, to allow communication in the event of failure. We've completed a Network Core Switch replacement at Pilgrim new Data (DC3) at Pilgrim to provide resilience at site backup across site has been improved. Recovery Vault is in the process of implementation The Metro-Cluster is in the process of implementation.	Low risk	31/03/2023	31/03/2023	18/08/2022
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		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)	National policy: - Data Protection Act 2018 - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy (approved May 2018, due for review May 2021) & supporting appendices ULHT governance: - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group - Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles	Internal audit review of data protection / PIA processes	24/03/2022	Quite likely	High	High risk	16	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process.	Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues. Reference to DPIAs in Data Security and Awareness mandatory training. Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required. Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data.	Low risk	31/03/2022	31/01/2023	30/06/2022

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 July 2022*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2022/23	
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 2022/23 BAF were presented to all Committees during June and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives with the exception of the objectives which are new for 2022/23. Supporting controls and assurances are still being reviewed in respect of these objectives. Assurance ratings provided have been confirmed by the Committees.

Through the review process the Board Committees have requested a detailed review and update of the BAF by the Executive leads and reporting groups. The review and updates offered will feed into the July Committees and upwardly to the Board in August.

The additions of the objectives have been highlighted in the Board Assurance Framework in green text with updates offered to the Committees highlighted in blue text to enable a clear view of the changes at the beginning of the year.

Red text has been presented in the Board Assurance Framework to demonstrate items proposed for removal, which no longer feature as a project/priority within the year 3 IIP. Through the detailed review process the changes will be confirmed.

The following assurance ratings have been identified:

Objective		Rating at start of 2022/23	Previous month (May)	Assurance Rating (June)
1a	Deliver harm free care	Green	Green	Green
1b	Improve patient experience	Amber	Amber	Amber
1c	Improve clinical outcomes	Amber	Amber	Green
2a	A modern and progressive workforce	Red	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	Amber	Amber	Amber

3b	Efficient use of resources	**Amber**	**Amber**	**Amber**
3c	Enhanced data and digital capability	**Amber**	**Amber**	**Amber**
3d	Improving cancer services access			
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards			
4a	Establish new evidence based models of care	**Amber**	**Amber**	**Amber**
4b	To become a University Hospitals Teaching Trust	**Red**	**Red**	**Red**
4c	Successful delivery of the Acute Services Review and Recovery Support plans			

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2022/23 - June 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 new 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 - Programme of work in place to implement the requirements of the National Patient Safety Strategy (culture and systems)(PSG) Human Factors faculty in place and face to face training restarted. Commencing next steps of cultural work with external agency. Pascale survey work continues to be undertaken. Safe to Say Campaign launched.			Safety Culture Surveys Action plans from focus groups and Pascal survey findings. Regular update reports to the Patient Safety Group and upwardly reported to QGC and through TLT. Theatre Safety Group reporting progress against a Quality Improvement plan to PSG.	Surgery currently reporting into the Theatre Safety group on progress against Safety Culture. Other divisions due to commence upward reporting to PSG but not yet in place.	Where possible, safety conversations have been taking place with staff.		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)			Upward reports from QGC sub-groups 6 month review of sub-group function Annual review of QGC takes place.				
						Effective sub-group structure and reporting to QGC in place (CG)			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 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 decontamination 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 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.	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.		

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
						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 - this is not across all Divisions, good practice exists and is demonstrated through the mortality group. 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 Mortality team to the Divisions. Following the success in UTOO for ACP's contributing to the SJR reviews, further training is going to be rolled out to the MDT.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Dr Foster data on depth of coding. Dr Foster data is now available.	Gap identified in the ability to draw learning from SJR's due to ongoing delays with completion	Local data sources are used where possible. Gaps in learning mitigated by ME process and escalation of concerns via incident management processes.		
			Failure to manage demand safely Failure to provide safe care Failure to provide timely care			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 Recognition of a skills gap for investigations at different levels of the organisation	Implementation of a Clinical Harm Delivery Group reporting into the Clinical Harm Oversight Group which is a sub-group of QGC. Appointment of a Clinical Harm and Mortality Manager Investigation training will be addressed as part of the implementation of the PSIRF and National Patient Safety Strategy. Plan to refocus PRM with a specific focus on quality and safety.	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 Strong divisional reporting to MORALs	Divisional reporting to PSG has commenced although this is not yet embedded.	Divisions present focussed pieces of work to PSG on issues that arise based on the data received. There is strong Divisional representation at PSG each month.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust although progress is now being made within all four Divisions. Operational pressures continues to impact on delivery.	Individual Divisional meetings now in place; quarterly reporting to PSG Additional support provided to medicine from the Patient Safety Improvement Team	Audit of compliance	Audit of compliance not currently in place - under development at present.	Review will occur through the Divisional meetings with quarterly reporting to PSG. Links now in place with the Clinical Audit team to progress.	Quality Governance Committee	**Green**
						Medicines Quality Group in place with a focus on reducing medication errors Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit	Lack of e-prescribing leading to increase in patient safety incidents due to medication errors COVID / operational pressures have impacted on the pace and progress of delivery of the agreed improvement actions	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Medical Director led Medicines Management Task & Finish Group convened to ensure the required pace and progress of delivery of the Improving the Safety of Medicines Management IIP. Divisional representation at the Task & Finish Group confirmed as Divisional Clinical Director or Divisional Nurse. Action / Delivery Group also in place and meeting fortnightly to progress actions and reporting to the Task & Finish Group.	Upward Report from the Medicines Quality Group to QGC Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group	Medicines Quality Group have not been receiving reports regarding progress with the medicines management IIP; there has been a lack of Divisional attendance at the Medicines Quality Group	Divisional representation at Medicines Quality Group reinforced by Medical Director and Director of Nursing and template for divisional reporting of BAU medication safety activities in to Medicines Quality Group developed and in place		

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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)	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 being 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. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training occurs 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. 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 (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 ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at 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	Identified at PSG that further work is required to breakdown incident categories pertaining to the deteriorating patient.	Deep dive commissioned at PSG for presentation to the April meeting.		
						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	Small business case paper being submitted for funding decision at the end of March 2022 - if successful plan to start training delivering in July 2022. Adhoc session being delivered to Security providers to ensure appropriately trained Datix being monitored by safeguarding team to ensure review of any restraint incidents		

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						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. Improvement demonstrated in the number of overdue alerts	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads(CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	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				
						Enhance patient safety by learning from incidents, specifically:- • Maternity Services (Personalised Care) • Medication Management • Diabetes Management (DKA) • Infection Prevention and Control • Urgent and emergency care			• SHMI Performance • Reduction in moderate & severe harm and death incidents • Maternity (Compliance with Ockenden recommendations and compliance with CNST) • Reduction in medication incidents leading to moderate & severe harm or death. • Reduction in DKA incidents resulting in moderate & severe harm or death. • Achievement of the IPC BAF				

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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, e.g., 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 in-reach to provide support.		
						Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging Sensory Loss group upwardly reports to Patient Panel.	Upward reports and minutes to the Patient Experience Group IIP reporting to Support & Challenge group.	Diversity of patient engagement and involvement.	CCG exploring dev of a Health Inequalities cell to combine efforts in reaching out. Date not yet secured. ULHT Experts by Experience project progressing with Mastalgia Expert ref group (ERG)established, Cancer Board recruiting 2022 discussions continue with Gastro & CYP (Expert Families).		

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						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Inconsistency in applying end of life visiting exceptions.	Exceptions guidance re-issued. Monitor through complaints & PALs.	Report to PEG through complaints & PALs reports; upward reports from Visiting Review working group. Visiting experience section within complaints & PALs reports.		Complaints/PALs reports to include visiting concerns; div ass 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.		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients							
			Failure to provide effective and			Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust			Effective upward reporting to QGC from reporting groups.	Divisional reports still in their infancy.	Verbal updates provided by divisional representatives at the group.		
						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)	GIRFT activity continues to be reduced nationally due to the pandemic.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Current reporting has tended to focus on process rather than improved outcomes.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						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 Job role description for Clinical Audit Leads has been developed and workshops planned with leads, led by the Medical Director.	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 meaning that reporting to QGC is not as up to date as expected.	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate Meeting to take place with Medical Director and Audit Leads to discuss role and expectations, however attendance has been impacted by operational pressures.		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	National and Local Audit programme in place and agreed (CEG) - 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 Reports identify where practice has improved but also where it has not improved.	None identified	None identified	Quality Governance Committee	**Green**
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	None identified		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)	None identified.	None identified.	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down during COVID-19	National reports to be presented at Governance Meetings once produced		
						Process in place for implementing requirements of the CQUIN scheme.	Currently stood down	Currently stood down	Currently stood down	Currently stood down	Currently stood down		
						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.					
						Enhance clinical effectiveness by ensuring that care delivered to patients is based on evidence based, best practice leading to improved clinical outcomes			Implementation of the SAFER bundle				

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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 & five 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 (quarterly) Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan Setting priorities 22-23 - away day (18/03)		Presentation of system progression and oversight being delivered to PODC on 15th March 2022. A day planning session has been held for the 22/23 priorities which are being presented at the next People Board for signoff in April 2022. Priorities for 22/23 agreed and approved at People Board in April. Consideration for PODC whether this is still 'red' rating from an assurance perspective suggest that its is medium.		
						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. Current workforce planning being undertaken in conjunction with our SHRBP and finance colleagues. Draft narrative have been prepared to support the workforce requirements for the Trust, further work is required to align to activity demand and capacity before the final submission date. A review of the first draft submission has taken place with Adrian Tams leading this piece of work on behalf of workforce. Further work moving forward to pull together a workforce planning process and stakeholder to ensure a more seamless and HR/recruitment approach moving forward. A Tams now on secondment for 6 months with ULHT from NHSI/E.		

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2a	A modern and progressive workforce	Director of People and Organisational	Vacancy rates rises Turnover increases Sickness absence rises Under-investment in education & learning	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		Recruitment deep dive continues with the support of the new Head of Recruitment. Additional resource has also been brought into the recruitment team with NLAG providing additional training support. Support is being received from NHSI/E and additional capacity has now been recruited to support the cohort recruitment of HCSW. A review of the process around how we recruit consultants to the Trust has also commenced. Additional training has been provided for the Recruitment team from NLAG and training from TRAC is due to take place in April.	People and Organisational Development	Red
						Focus on retention of staff - creating positive working environments System retention role secured (8a) appointment pending	IIP projects on hold	IIP Projects (subject to review further to IIP reset) 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 (to be discussed 4/5/22)	Regional Midlands Talent Board Model Employer ambition appraisal/mandatory training compliance	Appraisal and training compliance levels not at expected level Appraisal Improvement Plan (Apr'22) to address low compliance / improve quality of conversations and process - proposal for ELT/TLT - May'22			
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff - To be discussed following review of development offer (on hold)					

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		Development	Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce		CQC Effective	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. AMS Project is being relaunched with a training roll-out plan and SHRBP support. The AMS project has been relaunched and additional capacity identified. Training has started to be rolled out with divisions and a position paper is currently being prepared. Reporting will start to feature as part of the Workforce Cell meetings and monthly one to ones with key HR staff. Work continues with the training and roll-out previously hindered by COVID and being stood down.	Committee	
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Agreed - establish ULHT Learning, Education and Development service Proposed Education/Learning service - under review	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 Mandatory training improvement plan (pending subject to proposed Education&Learning team) System LEAD (Learning, Education and Development) Board to provide system oversight (proposed)				

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						Creation of robust Workforce Plan • Values based recruitment and retention • Maximising talent management opportunities • Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn'			Improved vacancy rates				
						Improve the consistency and quality of leadership through:- • Improved mandatory training compliance • Improved appraisals rates using the WorkPal system • Developing clear communication mechanisms within teams and departments			Appraisal rates and training development				
						Providing a stable and sustainable workforce by:- • Ensuring we have the right roles in the right place through strong workforce planning • Reducing vacancy rates and ensuring that posts are filled through a positive and values recruitment approach • Reducing our agency staffing levels/spend • Strengthening the Medical Workforce Job Planning processes							
						NHS People Plan & System People Plan & five 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)			Linked to delivery of the system People Plan agenda		

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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	Reset and alignment of Trust values & staff charter (with safe culture) Resetting ULH Culture & Leadership Reset ULH Culture & Leadership underway - first assurance meeting 10 March	Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Programme Group upward report	Delivery of agreed output	Improved function of group and reporting to be in place for November report	People and Organisational Development Committee	Red
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc. 'Themed' You Said, We are Doing campaign		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey scores: morale / engagement / recommend as place to work and place to receive care / care prioritised / 7 people promise themes				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT)		L&M programme reset from April - piloting new programme (subject to approval)	Pulse surveys - " Have your say"		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 Anti Racism Strategy	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 Following recruitment of new SN Chairs - agree Universal Terms of Reference Support groups in developing strategic objectives for the next 12 months	Protect our staff from bullying, violence and harassment - measure through National Staff Survey		Governance for EDI Recruitment process for SN Chair/VC - Feb'22		
						Demonstrate that we care and are concerned about staff health and wellbeing		EAP approved - implementation from May'22	System Health & Wellbeing Board Linc People Board	OH KPIS to be agreed (for reporting to PODC) System Hub activity Wellbeing activity (upward report to PODC)	Commence reporting from 2022		

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						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		Junior Dr Survey results (alignment with NNSS21 findings)		
						Embed a compassionate leadership approach through our Culture & Leadership Programme			Improved Pulse survey results				
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	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

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			review out of date or policies which are not fit for purpose			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 management 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							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						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 Strategy 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.		

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	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.	Finance, Performance and Estates Committee	**Amber**
						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 commence as part of HIP Bid (Referral in Estates Strategy)		
						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 Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions 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				
						Implement Year 1 of our Estates Strategy							

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3b	Efficient use of our resources	Director of Finance and Digital	Efficiency schemes do not cover extent of savings required. Continued reliance on agency and locum staff and use of enhanced bank rates to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure (as a result of unforeseen events)	4664	CQC Well Led CQC Use of Resources	Delivering £25m CIP programme in 22/23	Operational ownership and delivery of efficiency schemes Detailed delivery plans supported by clear timelines and metrics	Divisional Financial Review Meetings - PRMs improvement steering group	Delivery of Improvement steering group CIP	Ability of clinical and operational colleagues to engage due to service pressures.	Gaps are being reviewed monthly with Divisions through FRMs	Finance, Performance and Estates Committee	**Amber**
						Delivering financial plan aligned to the Trust and Lincolnshire System financial plan / forecast for 2022/23	Urgent and unplanned Restore and Covid related costs	Lincolnshire ICS financial plan Lincolnshire System collective management of financial risk Savings plan, monitoring and reporting. Risk/gain share mechanism at ICS level	Delivery of the Trust and System financial plans for 22/23	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the ICS reporting structure including Finance Leadership Group Reporting to ICS CEOs		
						Reduce agency spend through workforce programme	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans.	Through the Medical and Nursing Workforce Transformation Groups and through Improvement Steering Group		
						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. Supported by refreshed costing strategy.	SLR and PLICs information	Ability of clinical and operational colleagues to engage due to service pressures.	Improvement in the CQC Use of Resources is part of the Trust 22/23 IIP		
						Implementing the CQC Use of Resources Report recommendations	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust from Q1 22/23. Supported by refreshed costing strategy.	SLR and PLICs information	Ability of clinical and operational colleagues to engage due to service pressures.	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 22/23.	Urgent and unplanned Restore and Covid related costs	Lincolnshire System financial plan Lincolnshire System collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for 22/23	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the ICS reporting structure including Finance Leadership Group upwards to the CEOs		
						Detailed workforce and activity modelling aligned to resource requirements to support Trust and System Restoration.	Impact of covid and increasing acuity of NEL patients creating bed and staffing resource pressures to deliver planned care plan.	Trust Restoration plan. Lincolnshire System activity plan Lincolnshire System collective management of restoration of planned care activity	Reporting against the Trust and System Restoration plan and national Trajectories.				

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						Collaboratively work to develop an evidence based approach to more efficient services							
3c	Enhanced data and digital capability	Director of Finance and Digital	Approval of OBC for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure		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		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 Development and approval of OBC		Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of OBC		EPR OBC to be approved by NHSE/I OBC requirements being worked through 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 for 22/23. Completed for Jan 2022	Steady implementation of PowerBI through specific bespoke dashboards and requests.		
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues						
						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.		
3d	Improving cancer services access	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Cancer Care	Recovery post COVID and risk of further waves Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Percentage of patients waiting 52 weeks or more 28 Day Faster Diagnostics			Finance, Performance and Estates Committee	
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Planned Care	Recovery post COVID and risk of further waves Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Percentage of patients waiting 52 weeks or more 28 Day Faster Diagnostics			Finance, Performance and Estates Committee	

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SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish collaborative models of care with our partners	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 Operational pressures and other planning priorities puts an added constraint on time, capacity and headspace to engage with the ICS agenda. Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor institutions		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 Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority speciliaties for service reviews by July 2022.	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 Elective Theatre Programme 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/Improvement Steering Group (ISG) which commences on 20/06/22. Programme Manager recruited and due to start in June 2022. Aligns to Line 31 of the BAF which is specifically relateed to Cancer.		
						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 - complete reconfiguration is complete and new models of care implemented but financial benefits outstanding	CIP Benefit is not fully realised	CIP progress being managed within BAU within the Surgcial Division	Board report July 2021	CIP Beneifts realisation	Being reported through Surgery FPAM and FPEC		
						Pre op Assessment Modernisation	Engagement exercise required to seek further views regarding the proposed revised model	Pre assessment project group	IIP report to FPEC - monthly				
						Support Creation of ICS - Lincolnshire designation July 2022	Delay to review and adoption of legislation Clarity of roles and responsibilities as part of the ICS	Weekly ICS meetings Provider Collaborative Steering Group	SLB reports and upward reports by CEO / Chair	Impact of ICS and our role within it	key role as part of the provider collaborative steering group. Active stakeholder management of key roles.		
						Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team	Awaiting outcome of themes from consultation	Attendance at Consultation Steering Group by Deputy Director of Strategy and Planning, leading the ASR work on behalf of ULHT	SLB reports and upward reports by CEO / Chair	Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational	Flexible engagement approach from Strategy & Planning Team to allow for detail to be captured around operational demands at times when		
						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.	ELT/TLT oversight Board / system reporting	Weekly team meetings- reflected in IIP reports	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh		

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						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution an play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration ULHT anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Scope what a good effective partnership look like Stakeholder mapping & engagement plan Develop appropriate comms for the Lincolnshire ICS and our provider collaborative	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS		
						University Hospital Teaching Trust Status Developing a business case to support the case for change	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee		R&I remain a key stakeholder on the project and are engaging with the University of Lincoln Research Team through meetings to ensure that can move towards a potential joint research office function if required (in line with UHA Guidance). R&I Team will continue to review their strategy in line with any changes to this effect. This will also include any changes of direction as a direct result of the Business Case outputs.		
						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 Funding for Clinical Academic posts	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position The meeting schedule for 2022/23 is being finalised in May 2022, and will be inclusive of R&I, HR and Finance.		

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4b	Becoming 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	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		Ongoing work within the Medical Education Centre nearing final stages of overall completion (as per Trust regular communications updates) and this will then provide a better learning environment for students on a sustainable basis. This will be evidenced with our application.	People and Organisational Development Committee	**Red**
						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	Drafts in place which broadly cover joint research and teaching approach across the organisations, unable to outline in strategy financial commitment	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group The meeting schedule for 2022/23 is being finalised in May 2022, and will be inclusive of R&I, HR and Finance.		
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	Evidence bound by UHA requirements	Portfolio of evidence is being captured and is available on the shared drive	Roadmap developed to identify required evidence for portfolio	Clear understanding of rigidity of UHA requirements	Discussions being held to clearly identify opportunity for movement within guidance		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	HRBP at ULHT is part of the Steering Group to assist with working through the contractual issues	ULHT healthcare roles plan increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible.		

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4c	Successful delivery of the Acute Services Review and Recovery Support plans		Outcome of ASR review and any subsequent challenge may delay implementation of the first phase of fragile services Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data) Engage with services to develop plans as to how best to approach a clinical review, Provide feedback on Public Consultation of ASR	Clinical service strategy and heat map currently being developed Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy	Process being developed to identify services for review. This includes the development of a HEAT Tooll to identify areas where services are not meeting targets, such as RTT, Cancer, Finance data.	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning Publish ULHT clinical service strategy end of 2022/23 Flexible engagement approach from Strategy & Planning Team to allow for detail to be captured around operational demands at times when Divisional Teams are available on an ad hoc basis. This is to ensure delivery of the ask with regards to collation of ASR public consultation feedback and subsequent implication. ASR Public communication ongoing and support within Strategy & Planning as required still in place.		

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