Bundle Trust Board Meeting in Public Session 5 April 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 1 March 2022

Chair

Item 5.1 Public Board Minutes March 2022v1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log March 2022.docx

6 Chief Executive Horizon Scan

Chief Executive

Item 6 Chief Executive's Report, 050422.docx

7 Patient/Staff Story

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

7.1 BREAK

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

8.1 Assurance and Risk Report from the Quality Governance Committee

Chair

Item 8.1 QGC Upward report March 2022 v2.doc

Item 8.1 Final QGC Annual Report 2021-22.docx

Item 8.1 App 1 Quality Governance Committee Forward reporting schedule 2021-22.xlsx

8.2 CQC Actions Submission

Director of Nursing

Item 8.2 Board (b) CQC Update - March 2022 - Public Board v1.3.docx

Item 8.2 Board (b) CQC Improvement Action Plan - Appendix 2 as at 10-Mar.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 Workforce and Organisational Development Committee

Chair of People and OD Committee

Item 9.1 POD - Upward Report - March 2022.docx

Item 9.1 Final POD Annual Report 2021-22.docx

Item 9.1 App 1 People and OD Forward reporting schedule 2021-22.xlsx

9.2 Staff Survey Results

Director of People and OD

Item 9.2 TB_NNSS21_FINAL results 5April22.docx

9.3 Anti Racism Campaign

Director of People and OD

Item 9.3 Front Sheet AR 5April22.docx

Item 9.3 AntiRacism_final proposal_Mar2322.pdf

9.4 Establishment Review -Emergency Department

Director of Nursing

Item 9.4 Emergency Department Establishment Review Feb 2022 v5.docx

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

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

Chair of Finance, Performance and Estates Report

Item 10.1 FPEC Upward Report March 2022v1.docx

Item 10.1 Final FPEC Annual Report 2021-22v1.docx

Item 10.1App 1 Finance Performance and Estates Committee Forward Reporting Schedule 2021-22.xlsx

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 March 2022.pdf

13 Risk and Assurance

13.1 Risk Management Report

Director of Nursing

Item 13.1 Trust Board - Strategic Risk Report - April 2022.docx

Item 13.1 Appendix A - TB Details of all active Very high and High risks (15-25).xlsx

13.2 Board Assurance Framework

Trust Secretary

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

Item 13.2 BAF 2021-2022 v29.03.2022.xlsx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 3 May 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 1 March 2022

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Dr Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Mrs Sarah Dunnett, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director
Dr Colin Farquharson, Medical Director
Professor Philip Baker, Non-Executive Director
Mr Simon Evans, Chief Operating Officer
Dr Chris Gibson, Non-Executive Director
Miss Gail Shadlock, Interim 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)
Dr Maria Prior, Healthwatch Representative
Ms Cathy Geddes, Improvement Director, NHSE/I
Mr Jonathan Young, Deputy Director of Finance
Ms Claire Low, Deputy Director of People
Mrs Kathryn Helley, Deputy Director of Clinical Governance
Ms Emma Upjohn, Lead Nurse Womens Health
Mr Simon Hallion, Divisional Managing Director
Dr Suganthi Joachim, Divisional Clinical Director
Dr Max Seabrook, Registrar, Trauma and Orthopaedics

Apologies
Mr Paul Matthew, Director of Finance and Digital/ Director of People and OD

181/22	**Item 1 Introduction**

	The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. The Trust Board continue to hold meetings open to the public through the use of MS Teams live. In line with policy, papers had been published on the Trust website ahead of the meeting and the public able to submit questions. The Chair highlighted that although national Covid-19 restrictions were lifted the NHS continued to operate under the advice of NHS England in regard to Infection Prevention Control measures including the requirement to follow social distancing rules, impacting on the ability to revert to Board meetings in the pre pandemic format. The Trust Board would continue to follow national advice and operate in accordance with procedures that had been implemented during the pandemic.
182/22 183/22	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 Vi King** **Please can I ask the Trust, what is the uptake for theatres at Grantham from the other sites for Elective operations. Are they being used to full capacity?** **Is the timeframe on time for the new theatres that are being built at Grantham. I was aware there was a problem re: water pipe being damaged.** The Chief Operating Officer responded: It was difficult to identify use from other sites due to the use of mixed lists for surgeons operating at Grantham, Lincoln and Pilgrim due to specialities. It is possible however to state that in terms of utilisations sessions were using around 70% capacity which reflected the move out of Wave 4 of Covid-19. The Trust were now starting to build on restoration and to move in to recovery and over the course of the next few weeks there was an expectation to substantially increase additional session. The Trust planned to use the additional three theatres with 75% of the last remaining capacity over the coming weeks. The new theatres at Grantham, disappointingly, would not be in place for April as had been the aim due to a number of issues around water systems and an unfortunate accident. The Trust were now expecting that the Theatres would be in place for June with two additional theatres for greater capacity with consideration of more elective operations taking place. The Chief Operating Officer noted that the Board would be updated through the Committees over the course of the coming months in respect of recovery of services.

	The Chair noted that receiving regular updates to understand how capacity was being built to support recovery would be beneficial.
184/22	**Q2 Jody Clark** **It is good to see improvements in the latest CQC reports, although both Lincoln and Pilgrim require improvement in Urgent and Emergency Care. For those of us in Grantham, who have to heavily rely on these services. What assurances can you give us that either Lincoln or Pilgrim can adequately care for us, as well as their own catchment of patients?** The Chief Executive responded: Both Lincoln and Pilgrim had received much improved ratings from the Care Quality Commission (CQC)including Urgency and Emergency care. The CQC were right to identify that issues remained and required addressing and it was known that some patients had waited longer than would have been liked. Both sites, and Grantham, have the same issues regarding delays on occasion and flow issues. This was not unique to the Trust with many departments across the county experiencing significant pressures on Accident and Emergency. It was hoped that it was clear through other reports presented that, services were monitored, risks tackled and a strong focus on quality, safety and patient experience of those in Accident and Emergency departments. Those patients who were most seriously ill take priority in terms of waiting times and it was important that the public supported the Trust to help those needing to access services to consider the range of options available. Services available to the public include self-care, 111, GPs, Pharmacies and Urgent Treatment Centres. The Chief Executive emphasised however that both Lincoln and Pilgrim Hospitals had emergency services available to those who required them, and people should feel confident in accessing both departments.
185/22	**Item 3 Apologies for Absence** Apologies were received from the Director of Finance and Digital/Director of People and Organisational Development.
186/22	**Item 4 Declarations of Interest** There were no new declarations of interest
187/22	**Item 5.1 Minutes of the meeting held on 1 February 2022 for accuracy** The minutes of the meeting held on 1 February 2022 were agreed as a true and accurate record.

188/22	**Item 5.2 Matters arising from the previous meeting/action log** The Chair noted that all actions on the action log were closed with the exception of 1914/21.
189/22	The Director of Nursing advised that all Emergency Department establishment reviews had been completed and would be presented to the Committees in March followed by the Board in April. Due to operational pressures the endoscopy establishment review had been delayed but would be completed and presented the following month.
190/22	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board noting that the Lincolnshire Health System remained under pressure and as previously noted in the response to the public questions this was not unique to Lincolnshire.
191/22	In respect of access to urgent and emergency care there was a focus on ambulance handover delays, front door issues and a strong focus on the system ensuring safe and effective discharges in order to be able to admit new patients.
192/22	At the Board meeting in February the Trust were about to commence work around Vaccination as a Condition of Deployment (VCOD) however the Government had paused the process. A consultation was being undertaken and subject to legislation the Government intended to revoke this. As such the Trust had stopped actions relating to VCOD.
193/22	It was anticipated that at some point in the immediate future the Government would confirm that this would not be progressed as a mandatory requirement for healthcare staff.
194/22	The Chief Executive noted the recent publication in respect of health and care integration which should be read alongside the original Integrated Care Systems (ICS) White Paper, which was now subject to the Health and Social Care bill. It should also be read in conjunction with the Social Care White Paper issues in December 2021 and the recent Levelling-up White Paper. These papers taken together offer a view of Government policy and will influence the system focus.
195/22	The Chief Executive noted, as a rural and costal area, that the All-Parliamentary Group for Rural Health and Care had published an inquiry which should also influence the system focus over the coming months.
196/22	The Board was advised of the appointment of Sir Andrew Cash as the Interim Chair of the Integrated Care Board (ICB) and Mr John Turner as Chief Executive Officer. The ICB was due to come on stream on 1 July 2022, following the recent 3-month extension.
197/22	The Provider Collaborative, Lincolnshire Health and Care Collaborative (LHCC) were currently developing the alliance agreement between members of the collaborative and included NHS bodies, Primary Care Network colleagues, social care and

	voluntary services. The agreement was being developed along with arrangements on governance and decision making as part of the ICS.
198/22	The Chief Executive noted that there had been recent Covid-19 legislation changes however the NHS continued to operate to previous arrangements in respect of personal protective equipment. This meant that staff were expected to continue to wear masks and visitors and patients were expected to continue to respect previous infection prevention and control (IPC) requirements.
199/22	It was anticipated that further guidance regarding visiting would be available in due course with the Trust keen to have visiting back in place in a safe way. It was recognised that there remained Covid-19 inpatients within the Trust and Covid-19 remained within the Community.
200/22	The Chief Executive noted the Trust update and the financial position noting that the Trust remained on course to deliver the projected year end surplus of £1.8m.
201/22	The Board was advised that the Care Quality Commission (CQC) report would be discussed at the next item however the Chief Executive was pleased to note that the inspection report had been received. Whilst the rating remained the same, Requires Improvement overall, this could not be changed as not all sites and services were inspected. 3 of the 5 domains had been rated good, including well led and effective with caring remaining rated as good.
202/22	The CQC had commented on the significant and widespread improvements in the safety and quality of services provided and noted that this was impressive despite the backdrop of Covid-19. The Trust had been commended for a strong cohesive team with collective leadership at Board level.
203/22	There remained many things to focus on and the Chief Executive noted that the Trust was not complacent about the improvements that had been made however it was good to see the improvements in the ratings.
204/22	The Chief Executive noted that the Integrated Improvement Plan (IIP) had been a key part in the improvement seen in the CQC report and work was now underway on year three of the plan.
205/22	The Board noted the appointment process for leaders of the staff networks and it was hoped that colleagues had seen the press release in respect of the new robotic surgery system. The first operations were now being undertaken and it was good to see Lincolnshire and the Trust at the forefront of new practice.
206/22	The Chair noted the positive report that had been presented and noted the operational pressures on discharge and ambulance handovers. Significant work was being carried out with system partners in respect of discharge however it was noted that, whilst the Trust was taking action, there was a need for system partners to put a full weight of effort in to release patients from hospital as soon as they were fit to do so.

207/22	The Chair thanked colleagues who had received the Covid-19 vaccination, those who had been hesitant but gone ahead and those who had supported conversations and provided vaccinations. Thanks were expressed on behalf of the Board for the approach taken to keep patients safe irrespective of VCOD being stood down.
208/22	It was noted that the national papers referenced would need to be considered by the Board. This would continue to be done through the provider collaborative however there was a need to understand how this would feed into the Trust. It was inevitable that there would be an impact on the business of the Trust and as such there was a need to influence the direction of travel through the ICS.
209/22	Dr Gibson noted the volume of NHS staff who were from Eastern European countries asking if there was anything further that could be done to support staff who had links to eastern Europe.
210/22	The Chief Executive noted that wellbeing support had been offered to staff through the weekly e-mail for those who had concerns about the situation in Ukraine. It was noted that this was not just about those from Ukraine or Russia but all staff. Access had been made available to wellbeing teams and managers were being encouraged to understand if staff required time away from work or during the day to understand their emotions and offer support as needed.
211/22	The wellbeing team had responded quickly, and a letter had also been issued via the Secretary of State for Health to send to all staff expressing government support. Wellbeing huddles were in place and being taken up by staff. The Trust had employees from many difference nations and was very much a united Trust which wanted to do all it could to support colleagues.
212/22	The Chair, on behalf of the Board, took a moment to reflect on the situation in Ukraine and held those affected in our thoughts. The Trust Board: • **Noted the report and significant assurance provided**
213/22	**Item 6.2 Publication of CQC Inspection Report** The Chair introduced the report noting that it was pleasing and rewarding for the Board to receive.
214/22	The Director of Nursing presented the report to the Board noting that this formally offered to the Board the published Care Quality Commission (CQC) report from 8 February 2022. As stated by the Chief Executive, although the Trust remained as requires improvement, there was recognition from the CQC and NHS England/Improvement of widespread improvements.
215/22	The report presented demonstrated the comparison with the 2019 inspection and current inspection offering the improvements seen across a number of areas. The Trust were due to offer an interim plan to the CQC by 10 March in response to the report with the Director of Nursing noting that the Trust were on track to provide this.

216/22	The Director of Nursing noted, on behalf of all Board members, that this was a fantastic achievement and offered confidence that the Trust was on the right path to reach an outstanding rating by 2025.
217/22	Dr Prior offered congratulations on behalf of Healthwatch, to the Trust for the hard work in the achievements seen, as challenges were seen month on month and it was encouraging to see the good work being acknowledged. There obviously remained some way to go and the Board had spoken of the system issues holding back the responsive domain however it was a pleasing result.
218/22	The Chair thanked Dr Prior for the comments and the contributions made to the Board.
219/22	The Chief Executive noted that the Trust was a visible and high-profile part of the local NHS and was delighted that the CQC had recognised the improvements made. This was not about the Trust seeking ratings but this was good for patients and offered a boost for staff who had delivered the improvements. It was recognised that there remained work to do however this was a good foundation to move forward from.
220/22	Echoing the comments from the Director of Nursing the Chief Executive noted that there had been a clear ambition set by 2025, through the Integrated Improvement Plan, that the Trust wanted to be rated as outstanding. This remained the aim but would not be achieved by chasing ratings but by being outstanding in all domains
221/22	The Chief Executive noted that questions had been raised regarding special measures and the recovery support programme (RSP) however it was noted that this was separate to the CQC inspection process. It was known that discussion was underway regarding the move of the Trust out of RSP and it was hopeful that this could be achieved following the CQC report. This would however be discussed separately in due course however reassurance was offered to the Board that this was underway through another route.
222/22	Dr Gibson noted the positive outcome with no single area rated as inadequate and noted that there was an action plan in place, mostly consisting of should do actions and some must do's however these were already underway and from a quality perspective it was clear things were moving forward.
223/22	The Chair thanked Dr Gibson and Mrs Libiszewski, who was previously a member of the Board, for the approach taken through the Quality Governance Committee to help support the improvements made.
224/22	Mrs Dunnett asked how the recognition would be made to staff and how the Trust would communicate the findings and next steps across the organisation.
225/22	The Director of Nursing noted the importance of communicating the outcome of the inspection to all staff advising that there had been some significant media presence on the 8 February with both the CQC and regional and system colleagues sharing the findings.

226/22	This would be continued on a weekly basis to staff in the organisation to pick up specific areas. There was also a formal structure being built around the response directly to the report. It was important to note that this was not about the CQC rating but taking the learning and feedback from the CQC and others to develop and improve further.
227/22	Continued feedback through all mechanisms was expected both internally and externally constantly featuring the improvements, improvement projects and quality improvement work which would culminate in a further inspection and hopefully the outcome of these should be seen in the result of an inspection.
228/22	Within the organisation, through the Quality Governance Committee, oversight would be maintained on a number of improvements which would form part of the work programme for the Committee and support the other Committees. This would allow the Board to remain informed and ensure overall sight of the improvement journey of which a CQC inspection offered feedback.
229/22	The Chair noted that the report was rewarding and was a great representation of the herculean effort made in improving the quality of care in the organisation since 2019 to benefit patients. The point was well made that this was not about the CQC but the quality of care provided to patients. The tables offered a visual representation across all domains and insight about the improvements made and the commitment of staff.
230/22	This outcome was noted as all the more impressive being undertaken during the course of a pandemic and if this could be achieved in this context then it would be interesting to see what could be done as a new normal was established.
231/22	The Chair paid tribute to the Board members noting that the CQC report, throughout, references the Board of Directors and talked about strong, cohesive and collective leadership. The Chair thanked the Directors for the unfailing leadership and for having belief in the organisation to be able to move forward with improvement.
232/22	The Chair specifically thanked the Improvement Director, NHS England/Improvement for the work carried out with the Trust to hold a mirror up and to hold the Trust to account, this had been done in a helpful and constructive manner. The contribution had been invaluable and central to the achievement.
233/22	The population of Lincolnshire could take great confidence in where United Lincolnshire Hospitals NHS Trust was now in terms of the quality of care provided and the trajectory to become an outstanding Trust by 2025. This was a very real ambition. The Trust Board: • **Received the report** • **Discharged responsibility to the Quality Governance Committee for oversight of delivery of the action plan**
234/22	**Item 7 Patient Story**

	The Director of Nursing presented the patient story to the Board advising that the story detailed online feedback received through Care Opinion. The Director of Nursing offered thanks to Dr Seabrook for the candid feedback that had been offered through the story.
235/22	The Board watched the video presentation that detailed the use of Care Opinion and how this offered an opportunity for patients to interact with the Trust and offer feedback on their experiences. Care Opinion was a public online platform that allowed others to understand the experiences of patients who had received care at the Trust, and other Trusts, who had signed up to use Care Opinion.
236/22	The Board heard the feedback from a patient who had received care from Dr Max Seabrook, Registrar Trauma and Orthopaedic which had been responded to by both the service lead and Dr Seabrook. The video detailed the feelings of Dr Seabrook and his reaction to the feedback that had been received.
237/22	Board members congratulated Dr Seabrook on the positive feedback that had been received noting that his care and compassion offered embodied the Trust's Values and Behaviours.
238/22	The Director of Nursing noted there had been a move away from the traditional collection of patient feedback to one of engagement and hearing voices. The point made in the video about the negative feedback being louder than the positives was well made with the Director of Nursing keen to speak to Dr Seabrook outside of the meeting to understand what could be done across the organisation to tip the balance to positive feedback being the loudest. This would not detract from the feedback where things had not gone well.
239/22	The Director of Nursing noted that a library of stories was being created with care opinion being one element of this. The Director of Nursing was struck by the point made in respect of touching people lives and whilst it was not thought to be exceptional patients do not often compare to other healthcare services but to everything else in day-to-day life. Whilst the comparison may not be drawn to other healthcare experience there was a significant impact made by individuals and the service.
240/22	The Medical Director noted that there should be a balance between the negative and positive comments with negative feedback being acknowledged and dealt with, this should be the same for the positive feedback which could be disseminated.
241/22	Dr Prior noted that part of the role of Healthwatch was to share experiences with providers and whilst there was a lot of negative feedback it would be useful to use this story to show the importance of patients providing Healthwatch and the Trust with positive feedback.
242/22	Mrs Dunnett was aware that the Patient Experience Team scrutinised all patient opinion feedback and responded to this. This presented a real opportunity about how feedback was captured and shared in real time to encourage the positives to be shared across the organisation.

243/22	Mrs Dunnett sought to understand how the video could be shared outside of the Board and this was a powerful story that could be shared with a wider audience.
244/22	The Chair noted that conversations had been held with NHS England about how the Trust could scale up patient engagement activity and would ensure that this work was taken forward through the suggestion made by Mrs Dunnett. This would form part of the new approach to patient experience and participation within the organisation.
245/22	Dr Seabrook thanks the Board for the kind comments made in response to the story noting that all that had been said was spontaneous and true. A recent informal poll of a doctors forum had demonstrated that more than 90% of doctors had imposter syndrome and thought colleagues were excellent and they were the odd one out. Where feedback is received this ensures that you are on the right track however Dr Seabrook was unsure of the best way to seek feedback and considered if this should be included within discharge summaries.
246/22	Dr Seabrook noted that he would be happy to work with the Director of Nursing and the team to develop feedback opportunities. The Trust Board: • **Received the staff story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
247/22	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair noted the number of appendices presented in relation to Infection, Prevention and Control (IPC) and maternity and welcomed members of the Family Health Division to the meeting to present the maternity items.
248/22	The Chair of the Quality Governance Committee, Dr Gibson provided the assurances received by the Committee at the 22 February 2022 meeting.
249/22	The Committee had received assurance from the Clinical Harm Oversight Group that considerable work was taking place to assess priority needs of patients on waiting lists noting that there were a number of triggers in place for reviews to take place. This included the prioritisation of patients through the artificial intelligence system. The Committee noted that the Sepsis trigger associated for harm reviews would no longer be used as this was monitored through other routes.
250/22	The Committee noted the increased level of assurance in respect of water safety and ventilation due to the step change in the estates function in recent months as reported through the IPC Group.
251/22	A NHS England/Improvement regional visits had been undertaken and it was noted that sustained improvements were seen with a continued amber rating reflecting the position. A further review would take place in August or September of this year. The Committee noted that the Director of Nursing had been co-opted on to a group to

	support the development of the methodology used by NHS England/Improvement during the visits.
252/22	Dr Gibson noted through the Children and Young People upward report that a bid for charitable funds had been placed to support progression of the paediatric areas for Lincoln as was in place at Pilgrim.
253/22	The Committee had received the Maternity and Neonatal Oversight Group upward report and a number of attachments as presented to the Board. There had been a significant amount of work undertaken by the Maternity Team in relation to the Kirkup and Ockenden reports.
254/22	It was believed that the Trust was now compliant with 117 of 123 Ockenden and 29 of 33 Kirkup actions. There was significant external oversight of maternity services currently with a submission due to be made nationally. The Committee received assurance on the significant progress noting that the 10 actions remaining had an action plan associated to them.
255/22	A detailed report, providing high levels of assurance, was received from the Patient Safety Group and it was noted that the Trust was planning to hold an Aortic Dissection webinar that would involve family representative and representatives from Think Aorta.
256/22	The Medicines Quality Group upward report represented a significant area of interest for the Committee that had expressed concern regarding progress. A task and finish group, led by the Medical Director, had been established and was actively driving this forward.
257/22	Dr Gibson noted that a key area for discussion was for all outstanding actions to be pulled together into a single project plan and the Committee had approved the terms of references for the task and finish group.
258/22	Dr Gibson reminded the Board that it had been 10 yeas since the publication of the Savile inquiry that had led to many recommendations for improving tests and assessments of the presence of individuals within buildings and services.
259/22	The Committee received an updated action plan and noted that some areas offered limited assurance. Whilst many areas were complete and assurance was offered the Committee would continue to review the action plan on a quarterly basis and referred to the People and Organisational Development Committee those matters within its remit.
260/22	The Committee was pleased to see significant improvement in PLACE assessments which was in part due to the recent refurbishment of the Medical Emergency Assessment Unit (MEAU). This had seen a significant increase in results but in particular for disability access which would be taken into account when improvements were made in other areas.
261/22	The Committee received an assessment in to 12-hour trolley waits following a referral from the Finance, Performance and Estates Committee regarding the concern

	nationally about adverse outcomes for long waits. The Committee noted the detailed process for harm reviews in place and the triggers to assess those patients who breached. The Committee noted that there were no specific triggers to escalate to serious incident however requested that the Patient Experience Group consider the outcomes and experience of those patients waiting.
262/22	Dr Gibson noted the request of the Committee for alignment between the Integrated Improvement Plan, Quality Priorities and Board Assurance Framework for 2022/23. The Committee also received a number of other items for information.
263/22	The Director of Nursing presented the IPC letter that offered written formal feedback from the IPC regional visit that had taken place at the beginning of February. This reflected the follow up visit by the regional team and as previously states recognised the significant, sustained improvement, particularly in the highest risk areas.
264/22	No breaches were identified within in-patient areas and there continued to be none in IPC practices since the visit in October 2021.
265/22	There had been some low-level IPC breaches in non-inpatient areas which were dealt with immediately. A follow up visit to these areas would be undertaken in April to demonstrate the actions taken.
266/22	The Director of Nursing noted that the letter was accepted and the Trust supported a full review in to the organisation in August and September with the dates being confirmed nearer the time. The IPC Group had full oversight of all areas with the Director of Nursing also holding other assurance mechanisms for continued oversight.
267/22	The Director of Nursing noted that the visit had been positive and the Trust was grateful for the continued support from the regional team in IPC development.
268/22	The Chief Executive noted the positive report noting that when inspections took place it was useful to understand what success looked like. Feedback would be welcome in respect of the work that had commenced regarding the transparency of the standards that the Director of Nursing was working on with NHS England/Improvement.
269/2	The Director of Nursing noted that this had been asked of the regional team to understand how a green rating could be achieved. Positive conversations had been held and it was recognised that the method of inspection being used was a traditional model of review. The Director of Nursing would be working with the regional team and others to develop and understand the criteria.
270/22	The Chair was pleased that there was engagement with NHS England/Improvement in order that the Trust could understand the questions being asked and to have transparency to ensure the Trust was fully compliant.
271/22	The Director of Nursing moved to present the Ockenden and Kirkup reports to the Board thanking the Triumvirate from Family Health for joining the Board. Members of the Triumvirate had attended the Quality Governance Committee where a review of

	the assessment, 1 year on, from the Ockenden and Kirkup reports had been undertaken.
272/22	The Board were reminded that in December 2020 all NHS Trusts providing maternity care were asked to report to the Board, Local Maternity and Neonatal System (LMNS) and reginal teams, progress on the remaining actions in respect of the Ockenden and Kirkup reports.
273/22	The Maternity and Neonatal Oversight Group was chaired by the Director of Nursing and received the outcome of the self-assessments undertaken in respect of maternity services. This demonstrated that the Trust was meeting 117 of 123, 95% of Ockenden and 89%, 29 of 33 Kirkup actions.
274/22	Of the remaining 10 actions all were in progress or on track with an expectation that these would be complete by the end of quarter 2, with the exception of personalised care and support plans. This required further work and embedding.
275/22	The outstanding actions were captured in progress as part of the maternity and neonatal improvement plan which was reviewed on a monthly basis. The Care Quality Commission had endorsed the appendices presented to the Board for approval ahead of the 15 April submission deadline.
276/22	Mrs Dunnett, as the Maternity Safety Champion, wished to emphasis the significant governance process that had been established for not only the reports but for the whole service. It was noted that the actions formed part of a broader plan for continued improvement and evidence was in place to support the submission. This had been reviewed both internally and externally.
277/22	Mrs Dunnett noted that the team was cognisant of all of the issues in the public arena over the past 4 to 5 years and were constantly reaching out to seek assurance on issues being raised elsewhere to ensure these were captured within the improvement plan.
278/22	The Chair was pleased to note the benchmarking and recognition of the learning that was taking place.
279/22	The Chief Operating Officer sought to understand how the review and evidence related to the Clinical Negligence Scheme for Trusts (CNST) Maternity submission.
280/22	The Director of Nursing noted that the Trust, along with other providers of maternity services, had been asked to undertake a piece of work to cross reference CNST with the position of the original Ockenden self-assessment. This had been undertaken and confirmation received that the Trust had met all 10 criteria for CNST Maternity.
281/22	The Divisional Managing Director noted that the Ockenden and Kirkup actions had been put in the round of the CQC and CNST response as well as the baby friendly improvement with the Trust recognised as one of the few maternity services moving in a positive direction. The Teams had managed to progress a very complex agenda in a short period of time.

282/22	The Chief Executive expressed thanks to divisional colleagues for the collective work that had been achieved and noted the CQC report where services at both Lincoln and Pilgrim had been rated as good overall. It was noted however that the safe domain at Lincoln had decreased and an understanding was requested as to why this was.
283/22	The Director of Nursing noted that whilst the safe domain had decreased this was due to the estate of the maternity block for which capital plans were in place. Secondly, in relation to the environment, this related particularly to the ambient room temperatures for medications being stored.
284/22	The Board noted that there was a lot of work conducted in respect of fridge temperatures and ensuring medications stored in fridges were recorded however it was clear there was not a robust process in place for ambient room temperatures. There was also no clear understanding by staff, consistently, of what should be done if a room temperature became unsuitable.
285/22	Whilst it was important that this had been identified by the CQC these issues were not related to the care or safeness of care provided to ladies and their babies. The care rating across both units was rated as good.
286/22	Professor Baker congratulated the team on the work and progress made and sought to understand the progress being made for a dedicated Foetal Monitoring Lead due to the importance of this issue.
287/22	The Lead Nurse, Women's Health advised that funding has been secured for the role which would shortly be out to advert however this role was currently being provided by Education Midwives with a plan to have the dedicated role in place.
288/22	The Lead Nurse, Women's Health also advised the Board of the work undertaken with the Maternity Improvement Advisor from the Imperial College in London who had been provided external assurance. The advisor had worked with the team during Covid-19 when maternity services had not been able to step down had been required to deliver additional services. The external support had enabled improvements to be made and for this to be reflected in the recent CQC inspection report.
289/22	The Divisional Managing Director noted that approval had been received from the Capital, Revenue and Investment Group to work through a number of business cases to describe what may be required to upgrade accommodation across the services. Appointment to a design team was currently in process in order to support the team.
290/22	Investment had also been secured in order to support delivery of digital maternity improvements with £160k having been spent on new equipment and a partner appointed to develop a business case for an electronic solution.
291/22	The Divisional Clinical Director reflected on the significant amount of work that had been undertaken, supported by the Director of Nursing and Non-Executive Maternity Safety Champion, which would not have been possible 18 months previously.

292/22	Assurance was offered to the Board the CNST was being reinvested into the services and risks were known with recruitment being progressed along with improvements being made to retain staff and improve services.
293/22	The Director of Nursing thanked the Triumvirate for their attendance and the work that had taken place to ensure oversight could be maintained.
294/22	The Chair thanked those in attendance for the items noting that approval was being sought on the Ockenden and Kirkup submission as presented.
295/22	The Board confirmed that it was sighted on the submission with the full report presented. This had been received through the reporting groups and by the Quality Governance Committee for review and discussion.
296/22	The Board was satisfied that residual actions and points to progress had appropriate timescales associated. The Trust Board: • **Received the assurance report** • **Noted the IPC letter** • **Approved the Ockenden and Kirkup submission**
297/22	**Item 8.2 Patient Safety Strategy** The Director of Nursing presented the report to the Board advising that the reports offered an update on the requirements of the National Patient Safety Strategy, Trust progress against the priorities and outlined the role of the Patient Safety Specialist.
298/22	This role was required by all Trusts and the paper detailed how this would be managed across the organisation. The Director of Nursing welcomed the Deputy Director of Clinical Governance to present the papers in detail to the Board.
299/22	The Deputy Director of Clinical Governance noted that the original patient safety strategy had been published in 2019 with the main points included within the paper to remind Board members of the requirements at that time.
300/22	Due to the Covid-19 pandemic it was recognised that progress across the NHS had been impacted and in April 2021 a further paper was published which highlighted short and medium term priorities, which took in to account the national picture. The Deputy Director of Clinical Governance advised the Board of the national network and involvement with this advising of attendance at a meeting in order to understand what the Trust was needed to do to meet requirements.
301/22	The Deputy Director of Clinical Governance noted priority 1, safe to say campaign, noting that this was due to launch at the Trust in March in order to support people within the organisation to feel safe to talk about issues identified. This would offer learning opportunities to improve care and was endorsed by the Director of Nursing as the Lead for Patient Safety and Medical Director as Lead for Patient Safety Culture.

302/22	It was noted that there was an active human factors faculty within the Trust that continued to train staff in relation to human factors but also support teams to consider what may be impacting on care delivery on a day to day basis.
303/22	The Deputy Director of Clinical Governance noted that work underway in respect of the patient safety incident response framework which would be a major change for how the Trust would manage investigations. National guidance was awaited on the expectation of implementation. It was recognised that it would likely take 6 months to implement due to the changes however updates would be offered as this progressed.
304/22	It was noted that there was a requirement to appoint 2 patient safety partners by July 2022 and it was hoped a paper would be put forward to the Quality Governance Committee and the Board about the role and how this would be used within the Trust.
305/22	There was a national move to develop national patient safety training at 5 different levels, level 1 and 2 had been published with an expectation but not a requirement that all staff would undertaken level 1 training. Work was underway to determine how this could be rolled out and it was hoped this would commence in April 2022.
306/22	The Chair noted that this would see a significant change in how the organisation would move forward noting that this was a welcomed approach however there was a need to understand the transition to ensure there were no risks or gaps in response.
307/22	Dr Gibson sough to understand if there were any known IT issues in the transfer of the framework of if this would align to the existing framework.
308/22	The Deputy Director of Clinical Governance noted that in respect of the Patient Safety Incident Response Framework (PSIRF) this was about identification of trends and investigating differently. There would however be changes to uploading into the national system. The Trust had signed off the move to Datix Web which was a different monitoring mechanism and would allow the translation of incidents from the Trust system to the National system.
309/22	The Deputy Director of Clinical Governance offered the NHS England/Improvement presentation to the Board noting the expectation that this was received by all Board in order to be sighted on patient safety specialists. There was a requirement for all Trusts to have a specialist in post and this had been outlined in the August 2020 published paper.
310/22	The Board noted the requirement to appoint a safety expert into the organisation working full time on patient safety however noted that the guidance stated this would be more than one person making up a full time post. The Deputy Director of Clinical Governance was the Lead Patient Safety Specialist who was ably supported by other members of the team to lead on patient safety.
311/22	A Safety Champion Network was being established in order that other staff in the organisation, who supported agendas such as medicines safety and medical devices, could consider initiative to work across the organisation to deliver the national requirements.

312/22	The Deputy Director of Clinical Governance noted the key deliverables detailed within the presentation noting that some of these had changed due to the national agenda and Covid-19 issues. It was noted however that the Trust was on track to deliver all of these within the organisation.
313/22	A number of early milestones were presented with the Board noting that there were over 700 patient safety specialists across the NHS with the Trust tied into the network and attending regular meetings to ensure all requirements were met.
314/22	The patient safety priorities had been briefly outlined for the Board and would continue to be updated to the Quality Governance Committee as this progressed. There were Executive support requirements, in particular the awareness and support of the Board to the Patient Safety Specialist, a requirement for NHS England/Improvement to be made aware of who this was within the Trust. NHS England/Improvement had been notified.
315/22	The Deputy Director of Clinical Governance noted that the Director of Nursing was the Executive Lead for Patient Safety meaning that there was direct contact and a lead up to the Board as required.
316/22	The Chair noted that this was a major shift for the Trust noting the need to ensure there was clarity on the Board retaining oversight and how this was reported through Quality Governance Committee, particularly through the transition.
317/22	The Director of Nursing reinforced the point made about the roles for the Medical Director and Director of Nursing and the representation and oversight for patient safety and patient safety culture being overseen through the respective offices.
318/22	The team was starting to develop around the Deputy Director of Clinical Governance who would drive work forward and maintain oversight through the relevant groups and Quality Governance Committee.
319/22	The Medical Director noted that this was an integral part of a learning organisation to maintain high levels of patient safety and embed the culture within the organisation. Week commencing 14 March was patient safety week with a number of events planned across the Trust.
320/22	Dr Gibson noted the role of the Patient Safety Specialist to link with a Non-Executive Director noting that this could be done through his role as Chair of the Quality Governance Committee and asked if it had been foreseen that there would be a need for an internal network of safety champions as part of the safety culture work.
321/22	The Deputy Director of Clinical Governance noted that this was being discussed as part of the initial conversations with the safety champions about how the role out across the organisations could take place. This role should not be seen as an extra responsibility but was something that should be done every day. People needed to be supported to ensure they felt able to move forward with improvements and feel able to speak out. It was imagined that programmes of work would come from the Patient Safety Champion Network.

322/22	The Chief Executive noted the need for alignment with other pieces of work such as the Culture and Leadership Programme, improvement work and national staff survey. Reassurance was offered to the Board that safety was the business of all across the organisation.
323/22	The Chair noted that reporting would be received through the Quality Governance Committee however noted that escalations should be raised with the Board if required. The Trust Board: • **Received the report and noted the moderate assurance**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
324/22	**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 15 February 2022 meeting.
325/22	Professor Baker noted that the safer staffing report had highlighted concern in the increase in both the number and severity of falls that was thought to be associated with reduced staffing. This would continue to be monitored carefully in subsequent months.
326/22	The Committee received the initial staff survey results noting that once benchmarking had been received this would be an item for attention of the Committee and a subsequent discussion for the Board.
327/22	The report received from the Guardian of Safe Working in respect of Junior Doctors raised a number of issues including rest rooms, access to hot food and most concerning issues of racism.
328/22	The Committee discussed this at length noting the zero tolerance approach however noted that action throughout the Trust was required to ensure that this was delivered.
329/22	Professor Baker noted that the dashboard had offered greater clarity and visibility of key metrics noting that sickness, mandatory training, turnover and appraisal rates were not where would be expected. This linked into the discussion held by the Committee in respect of the priorities for the leadership of the directorate and the challenges to address the issues reported.
330/22	The Committee discussed in detail part 2 of the priorities that were presented along with a detailed suite of actions and timescales.
331/22	The Committee wished to escalate to the Board the need to ensure consistent focus on some of the issues being discussed through the Committee noting that the current operational pressures had impacted on progress in some areas.

332/22	The Chief Executive recognised the pressures and noted that some delay was understandable. Progress was now being made and the concerns raised were noted.
333/22	In respect of racial discrimination against colleagues the Chief Executive advised the Board that further information had been sought and clarity was offered that this was about patient discrimination against colleagues. On occasion there had been instances where patients had refused treatment based on skin colour or race.
334/22	This had been discussed by the Executive Leadership Team and would be discussed further however it was noted that there would be clear messaging across the Trust as to what was and was not acceptable. Colleagues would be supported to report instances of discrimination as it happened and support would be offered to them.
335/22	The Chief Executive noted the clear and simple message that if a patient declined care from one member of staff, then this would be declining care from any staff members. The Trust would not tolerate abuse of colleagues based on skin colour or race and patients would be welcome to seek treatment elsewhere.
336/22	The Board endorsed the strong view offered by the Chief Executive with the Chair noting the need to remind others that there were criminal offences that covered some of the behaviour described and there should be no hesitation to use this where appropriate and in consultation with staff members involved.
337/22	The Chair noted the position reported to the Board in respect of performance and noted that the updates reported to the Board demonstrated strength and depth in the right areas from the People and Organisational Development Directorate. The Trust Board: • **Received the assurance report**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
338/22	**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 21 February 2022 meeting.
339/22	Ms Cecchini noted that the estates report continued to improve along with the governance in place within the directorate. There were a number of Authorised Persons who had been recruited to and improvements were also being seen in respect of fire safety and the low intervention reports from the fire service. The Committee were pleased to see the progress that had been made with fire safety notices.

340/21	The Committee received good assurances on the 2021/22 financial position however concerns were raised regarding the recurrency of the cost improvement programmes and the inclusion of this in to planning for the next year.
341/22	Ms Cecchini advised that Board that there remained a number of capital schemes which required delivery before the year end with the report offering an understanding of some of the risks to this. It was however believed that it would be possible to deliver the majority of the schemes.
342/22	The Committee received the Patient Level Costing and Costing Strategy papers noting that the finance team were looking for cross organisational engagement in costing. This would offer a helpful mechanism and framework to support the productivity and efficiency programme.
343/22	The performance report was received with the Committee noting an expected deteriorating position due to the data reported being for January 2022. The Committee noted the major incident that had occurred during January and assurance was taken on the actions in place to mitigate this.
344/22	The Committee were pleased to note the success of multiagency discharge events however noted that was more to be done in respect of discharge noting that this linked to planning.
345/22	Mrs Cecchini noted that the Committee had received a planning report which detailed the structures being put in place within the organisation and the establishment of a Planning Steering Group to help the organisation delivery the integrated plan. The plan would integrate quality and safety with finance, workforce, performance and levels of activity.
346/22	It was noted that this work was complex as this needed to link to system planning and a focus would need to be based on national guidance, maximising elective activity, reducing long waits and restoring cancer. All whilst managing emergency and urgent care.
347/22	The Board was advised of the plan being required for submission in April and once submitted the organisation would commence a 3-year planning cycle moving forward.
348/22	The Chair noted the extensive agenda of the Committee however was pleased to note the detail and wide-ranging focus that had equally focused on performance in addition to planning and finance.
349/22	Mrs Dunnett sought assurance that the new integrated finance system would be ready for the end of the financial year.
350/22	The Deputy Director of Finance noted that the system had gone live during December with a full go live date of 1 January 2022. Whilst there had been some initial issues as the provider organisations were merged on to one system these had been resolved and the transition to business as usual undertaken.

351/22	Year end was now being progressed with Internal Audit engaged to offer a position of assurance. The audit would cross all provider organisations and feed into the external audit.
352/22	The Chair noted there would likely be some learning from this as more collaborative working was undertaken. 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
353/22	No items
354/22	**Item 12 Integrated Performance Report** The Deputy Director of Finance presented the report to the Board noting that the reports from the Committees had offered updates to the Board in respect of performance.
355/22	The Chair noted that there were no further discussions to be held in relation to the paper inviting Board members to accept the report as presented. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk, Governance and Assurance
356/22	**Item 13.1 Risk Management Report** The Director of Nursing presented the report to the Board noting that this was the second time the report had been received following the reconfiguration of the risk register. The report to the Quality Governance Committee had included a number of risks reviewed by the Board.
357/22	The Director of Nursing noted one very high risk that was under review in respect of managing emergency demand and one regarding delays in planned care. These would be reviewed and reported back through the Committees and the Board the following month.
358/22	The Board noted that there were 6 very high risks relating to objective 1, 2 very high risks relating to objective 2a and 1 very high risk for objective 2b.
359/22	Deep dives were being undertaken against each division and directorate on a monthly basis through the new risk register confirm and challenge meetings. As a result of this process there may be changes made to the risks presented on a monthly basis.

360/22	The Director of Nursing advised that to date there had been a review of corporate nursing, maternity, fire, communications and digital risks. Whilst there remained some significant risks related to the Covid-19 pandemic, particularly in regard to the impact on employees and staffing levels, the new risk register was also highlighting other areas of concern.
361/22	There were more traditional risks in relation to recruitment and retention of nursing and medical staff, workload management, staff morale and accuracy and availability of clinical information. These would start to be presented through the risk register as the confirm and challenge sessions were held.
362/22	Some specific risks had been highlighted through the divisions in relation to non-invasive ventilation, delays in processing echocardiograms and the renewal of the Joint Advisory Group (JAG) accreditation, particularly for Lincoln, which had been reviewed in detail at the Quality Governance Committee.
363/22	The risk due to the level of emergency demand, including overcrowding and limited bed availability, along with delays in planned case as a result in changes in services made during the pandemic, were recognised as significant and would be reassessed in order that appropriate actions could be taken to mitigate risks.
364/22	The Director of Nursing noted that the appendices offered with the report offered each risk that was recorded as high and very high.
365/22	The Chair noted that the report was now developing to be more focused and was pleased to see that planned care and emergency departments, which had featured for some time, were due to be reviewed. Reassurance was sought however to ensure that risks were being managed and mitigated during the transition of the risk register.
366/22	The Director of Nursing confirmed that risks were being managed and mitigated noting that the February confirm and challenge session had considered a number of individual risks with the Medicine Division. It was noted that there was a need for the wording to be amended rather that mitigating actions being required.
367/22	The Chair thanked the Director of Nursing for the leadership on the development of the risk register and hoped that this would further strengthen assurance as progress was made. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
368/22	**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 February 2022 advising that the report should indicated the reporting period as February. The RAG status updates offered were for January and February 2022.

369/22	The Trust Secretary noted that work had commenced in relation to the development of the 2022/23 Board Assurance Framework noting the links to the planning and objective setting work being completed by the Director of Improvement and Integration.
370/22	The Chair noted the extensive agenda of the Board and sought to understand from members of the Board if there should be any changes made to the assurance ratings. It was acknowledged that there were no changes required however the number of amber ratings was indicative of the hard work undertaken to move the organisation forward.
371/22	The Chair noted that planning was currently behind however noted the importance of having a Board Assurance Framework for 2022/23 as early into the new financial year as possible. Assurance was sought from the Director of Improvement and Integration that a plan was in place that would allow the construction of a Board Assurance Framework to use from April.
372/22	The Director of Improvement and Integration noted that work had commenced on the development of the year 3 Integrated Improvement Plan including divisional level meetings. This would ensure alignment across the organisation and consideration of objectives and key risks.
373/22	The Director of Improvement and Integration noted the intention to hold a meeting with the Trust Secretary to discuss the draft version for 2022/23.
374/22	The Chair was reassured that this was in progress noting the requirement for a draft document to be presented to the Board through a development session ahead of the April Board meeting. The progress made in respect of the Board Assurance Framework, as noted by the Care Quality Commission, needed to be maintained. The Trust Board: • **Received the report and noted the moderate assurance**
375/22	**Item 13.3 Board Committee Arrangements** The Trust Secretary presented the report to the Board advising of the changes to the Board Committee Arrangements following the appointment of new Non-Executive Directors to the Trust.
376/22	The paper clarified the roles of the Non-Executive Directors and indicated the chair for each of the Committees. The Trust Board: • **Received the report noting the changes**
377/22	**Item 14 Any Other Notified Items of Urgent Business** There were no items of other business.

378/22	The next scheduled meeting will be held on Tuesday 5 April 2022, arrangements to be confirmed taking account of national guidance

Voting Members	**2 Mar 2021**	**16 Mar 2021**	**6 Apr 2021**	**4 May 2021**	**1 June 2021**	**6 July 2021**	**3 Aug 2021**	**7 Sept 2021**	**5 Oct 2021**	**2 Nov 2021**	**7 Dec 2021**	**1 Feb 2022**	**1 Mar 2022**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	A	X	X	X	X	A	X	X	A	X	A	X	X
Geoff Hayward	X	X	X	A	A	X							
Gill Ponder	X	X	X	A									
Neill Hepburn	X	X	X	X	X	A							
Sarah Dunnett	X	X	A	X	X	X	X	X	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X		
Paul Matthew	X	X	X	X	X	X	X	X	X	X	X	X	A
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X	X
Mark Brassington	X	X	X	X	X	X	X						
Simon Evans								X	X	X	X	X	X
Karen Dunderdale	X	X	A	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
Colin Farquharson							X	X	X	X	X	X	X
Gail Shadlock												X	X
Dani Cecchini												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	Director of Nursing	~~01/03/2022~~ 05/04/2022	ED Est Review Agenda Item.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the NHS in Lincolnshire continue to operate under significant pressure. This includes an increase in COVID workload. The focus remains on reducing ambulance delays both in the community and in relation to hospital handovers; ensuring that patients are seen and treated in the right place by the right people; and on ensuring there is good flow through the hospital sector.
b) The results of the National Staff Survey 2021 will be published at the end of March. The survey was undertaken in late 2021. The results are presented by organisation and are presented in the context of the best, average and worst scores for organisations in the same sector. The results will be presented aligned to the seven NHS People Promises. These are – We are compassionate and Inclusive; We are recognised and rewarded; We each have a voice that counts; We are safe and Healthy; We are always learning; We work flexibly; We are a team. There are also scores for staff engagement and morale. Each organisation will be presenting their results to their own Board.
c) The draft Planning Submission for 2022/23 was submitted to NHS England on 17th March. This covers the planning to deliver the priorities for 2022/23 and contains information relating to activity, finance and workforce. Further work is being done to refine the submission prior to finalisation during April.
d) The Government has confirmed that it has now revoked the Vaccination as a Condition of Deployment (VCOD) regulations.
e) Work is continuing to deliver the key components of the system Strategic Delivery Plan. This is the plan linked to the action to assist the system in moving out of SOF 4 and thus exiting the national Recovery Support Programme.
f) A number of CEOs in the system have participated in roundtable discussions with General Sir Gordon Messenger who is leading the Government's review into leadership in health and social care. The review is expected to report shortly.
g) A positive Quarterly System Review Meeting (QSRM) with NHSE was held on 2nd March 2022. Whilst it was acknowledged that the system has many challenges, there is increased confidence in the system's ambition, self-confidence and delivery.

Trust Overview

a) Following the positive CQC inspection report published in February 2022, NHSE has confirmed that the Trust has moved out of System Oversight Level 4 into Level 3. This means that the Trust has been removed from both quality and finance special measures. The trust was placed into special measures (now known as the Recovery Support Programme) in 2017.
b) At Month 11, the Trust reported an in-month breakeven position, with a year to date position of a surplus of £1.923m. The forecast year end position remains a surplus of £1.8m.

c) The public consultation on the future provision of the Nuclear Medicine Service has commenced. This is a twelve week consultation running until 23rd May. The consultation involves both virtual and face to face meetings and a survey. The public are able to propose alternatives to the two options put forward in the consultation, to either provide services at just Lincoln County Hospital or at both Lincoln County Hospital and Pilgrim Hospital Boston.

d) Boston Borough Council has granted planning permission for the plans to transform Pilgrim Hospital's Emergency Department. The Full Business Case can now be submitted to NHSE. The expectation is that this will receive national approval in July.

e) As part of National Patient Safety Awareness Week in March, the Trust launched its 'Safe to Say' campaign aimed at encouraging and supporting staff to raise issues related to patient safety. This campaign needs to be viewed alongside the work being done as part of the NHS Culture and Leadership Programme and the action linked to the results of the NHS Staff Survey.

f) At the time of writing this report, the Trust had just declared a Major Incident in relation to a fire at Lincoln County Hospital. This resulted in the temporary closure of some services on the site including the A&E department. Further details will be provided at the Board meeting.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	23 March 2022
Chairperson:	Chris Gibson, Non-Executive Director
Author:	Jayne Warner, Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives.
	Assurance in respect of SO 1a Issue: Deliver harm free care **Clinical Harm Oversight Group Upward Report** The Committee received the upward report noting an increased number of 12 hour trolley waits and therefore more reviews to complete in relation to these. The Committee noted that the Group was completing a piece of work triangulating the various harm processes to ensure nothing was missed. The assurance report in relation to this would be considered at the next group meeting and then by Quality Governance Committee. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report noting the increased assurance being received through the divisions and directorates. The Committee noted that a review had been completed of 21 of the 22 clostridium difficile cases. Themes had been identified from the review and action plan put in place. The Committee noted that the Group had considered the UKHSA changes to guidance in respect of low risk planned procedures and had shared a number of recommendations which were being put forward in response to this. The Group reported significant assurance in respect of the ventilation systems work. IPC Ownership Audits had resulted in high levels of assurance for Medicine, Surgery and Family Health Divisions. CSS had achieved moderate assurance and plans had been put in place in response to this.

	The Director of Nursing provided assurance that follow up actions highlighted from the NHSE/I IPC Visit were also being actioned. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the report noting the discussions held by the Group and were offered an update by the Director of Nursing in respect of the Ockenden Review. The Committee noted that it had been a year since the report was published and there continued to be scrutiny of maternity services. The self assessment had been submitted to Trust Board in March and was with the LMNS for final sign off. It was noted that the publication of the second Ockenden report had been delayed and was now expected 30 March 2022. The Committee were advised that the Group had been initially established with an 18 month timeframe. The Group were keen to continue the group as the benefits of holding had been clear. This position was supported by the Quality Governance Committee. The Non Executive Maternity Safety Champion noted the progress with the consolidated Improvement Plan and that issues raised during visits were all known and being addressed. **Safeguard Group Upward Report** The Committee received the report noting the discussions held by the Group. The Group had noted that there was still no date for the rollout of the Liberty Protection Safeguards but the Trust had presented a business case to the Capital and Revenue Investment Group. The Group received assurances in relation to current safeguarding regulations and standards. **Nursing Midwifery and AHP Advisory Forum** The Committee received the report noting the discussions that had been held by the Group. The Group were able to offer limited assurance in relation to falls because the level of evidence required was not presented to the Group. Work was underway to address this. The Committee were alerted to the Nutrition and Hydration Campaign which was ongoing in the Trust and supported this detailed and comprehensive campaign. **Patient Safety Group Upward Report** The Committee received the report noting the update offered and sought assurance in relation to the remaining backlog of field safety notices. A plan was in place.

	The Group reported on the launch of the Safe to Say Campaign. The Committee asked how assurance would be received on the safety culture work and noted this would come through the Patient Safety Group. **Serious Incident Summary Report** The Committee received the report noting the number of SIs and overdue actions in month. The Committee receive the Complaints, Legal Claims, and Inquests, Incidents and Patient Advice and Liaison Service which offers triangulation of the data. **High Profile Cases** The Committee received the report noting the content.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Complaints** The Committee received the quarterly complaints report. **Duty of Candour update** The Committee received the monthly update noting that work continued to support improvement. Verbal compliance had improved but written compliance continued to be a concern. The Committee noted the continued review in place to ensure all written compliance was being recorded. The Committee would continue to receive monthly updates. **Patient Story – Learning from Complaints** The Interim Trust Lead for Occupational Therapy presented their experience of learning from complaints, leading to the development of a revised framework for making and documenting joint decisions with patients and their carers. The Committee commended the improved clarity of record keeping and especially the support for patients to make the best decisions for their care. **Patient Experience Group Upward Report** The Committee received the report and were pleased to note the results of the Maternity Survey which they identified for upward escalation to the Trust Board. The Group had sought assurances on actions taken in respect of the ED&I Internal Audit and these would be considered at a future meeting. The Group would produce an annual report to present to the Quality Governance Committee in May.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes

	Clinical Effectiveness Group Upward Report The Group noted that the Trust remained an outlier in the National Bowel Cancer Audit and this was under review.
	Assurance in respect of other areas: **Committee Self-Assessment methodology** The Committee held discussed the self-assessment methodology reflecting that this supported the Annual Report of the Trust and the Annual Governance Statement. Work would be undertaken in 2022/23 to develop the currently used framework to ensure each of the Board Committees was able to conduct an appropriate self-assessment in respect of governance. **Annual Report – Committee Effectiveness** The Committee approved a final version of the annual report. The report would support the production of the Trust Annual Report and Annual Governance Statement **PRM Upward Report** The Committee received the report noting that the Performance Review Meetings would continue to develop alongside reporting to the Committee in order that assurance could be provided. **Integrated Improvement Plan** The Committee received the report which offered the position to the end of January 2022 noting some metrics were reported on an annual basis. **Actions arising from CQC Inspection** The Committee received the report noting that the final report had been published by the CQC and responses to the actions were in place to address those areas requiring attention. Moving forward the Committee would receive those actions within it's remit monthly. **IR(ME)R Report** The Committee received the report noting the content and progress in respect of the improvement plan. The Committee also had sight of the final issued report which had been shared at Trust Board. **Committee Performance Dashboard** The Committee received the report noting the performance presented in the report and reflected those discussions during the meeting that had offered detail of the reported position.
Issues where assurance remains outstanding	None

for escalation to the Board	
Items referred to other Committees for Assurance	The Committee wished to refer to the People and Organisational Development Committee actions pertaining to workforce within the Savile action plan requesting that this be received and added to the cycle of business to maintain oversight.
Committee Review of corporate risk register	The Committee noted the risk register and was pleased to receive the revised format of the risk register which offered greater clarity and understanding of the risks presented. The Committee noted six very high and four high risks within the Committee Objectives
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee noted the assurance provided in relation to the Trust being taken out of special measures for both quality and finance.
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. The Committee agreed that significant assurances were being received in respect of strategic objective 1a Deliver Harm Free Care and agreed that they would recommend to Trust Board that the Assurance Rating for this objective be moved to GREEN.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

United Lincolnshire Hospitals NHS Trust

Annual Report to the Trust Board from the Quality Governance Committee 2021/22

ROLE OF THE COMMITTEE

In 2021/22, in line with all other Committees of the Board, the Terms of Reference were reviewed, amended. Under the agreed terms of reference, the Quality Governance Committee was tasked as follows:

The Quality Governance Committee will:

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

Deliver Harm Free Care:

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

Improve patient experience:

- Greater involvement in the co-design of services working closely with Healthwatch and patient groups

- Greater involvement in decisions about care
- Deliver year three objectives of our Inclusion Strategy
- Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers

Improve clinical outcomes:

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

MEETINGS

The Committee met monthly during the year and after each meeting provided an assurance report to the Trust Board.

Due to the Trust continuing to respond to the Covid-19 pandemic and subsequent operational pressures the Committee, at times, to support the delivery of patient care worked to a reduced agenda and length of meeting during 2021/22.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2021/22 the Committee was chaired by Mrs Liz Libiszewski until the end of her tenure on 31 December 2021. The Committee has been chaired by Dr Chris Gibson for the remainder of 2021/22.

Details of the Committee's membership and attendance during 2021/22 is set out below:

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

Voting Members	20 Apr 2021	18 May 2021	22 June 2021	20 July 2021	24 Aug 2021	21 Sept 2021	19 Oct 2021	23 Nov 2021	21 Dec 2021	18 Jan 2022	22 Feb 2022	22 Mar 2022
Non-Executive Director (Mrs Libiszewski, Chair)	X	X	X	X	X	X	A	X	X			

Non-Executive Director (Dr Gibson)	X	X	X	X	X	A	X	X	X	X	X	
Non-Executive Director (Maternity Safety Champion)	X	X	X	X	X	A	X	X	A	X	X	
Medical Director	X	X	X	X	X	X	X	A	X	X	X	
Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	
Chief Operating Officer	C	X	D	D	D	D	D	X	X	D	X	

A denotes Apologies given
D denotes Deputy in attendance
C Director supporting response to Covid-19
X denotes attendance

External members including representation from the Clinical Commissioning Group and NHS Improvement also attend the Committee to provide external challenge and review.

The Committee is regularly attended by the Deputy Director of Clinical Governance and Trust colleagues are co-opted onto the Committee to offer expert opinion and assurance when required, such as Deputy Director of Safeguarding, Head of Patient Experience, Deputy Medical Director.

A rolling programme of reporting group chair attendance at the Committee on a monthly basis is in place allowing the Chairs to offer upward reports and raise escalations to the Committee as appropriate.

REVIEW OF BUSINESS

The Quality Governance Committee work programme for 2021/22 is set out as an appendix (1) to this report.

The Quality Governance Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2021/22:

- Objective 1a Deliver Harm Free Care
- Objective 1b Improve Patient Experience
- Objective 1c Improve Clinical Outcomes

During 2021/22 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF.

The strategic objectives at the beginning of the year were rated as follows:

Objective 2a – **RED**
Objective 2b – **RED**
Objective 4b – **RED**

Through the year the Committee had continued to receive reports offering assurance against the strategic objectives resulting in the objectives being rated as follows at the end of the year:

Objective 1a – **AMBER**
Objective 1b – **AMBER**
Objective 1c – **AMBER**

OVERVIEW

The Quality Governance Committee has continued to, over the last twelve months, improve the assurance it can give to the Board that there is an effective system of quality governance and internal control across the clinical activities of the Trust. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan, as defined by the terms of reference through this annual report.

Following the commissioned review, by the Director of Nursing, of the arrangements for Clinical Governance undertaken during 2020/21 the Committee has continued to receive improving assurance from the reporting groups. The Committee receive monthly assurance/exception reports from the reporting groups offering assurance on effective quality governance within the Trust.

The Trust, at times, during 2021/22 was required to work to a reduced agenda and length of meeting in order to support the response to the continued Covid-19 pandemic and subsequent operational pressures experienced by the Trust. During these meetings, where the reporting groups had not met in order to release clinical time, the Committee received Chair's reports from the groups. This enabled the Committee to continue to receive a level of assurance throughout the year on all aspects of quality governance. As a result of a reduced agenda, patient stories have not been received to the Committee on a monthly basis. The Committee has also not received as much assurance as would have been liked in respect of Patient Experience due to the reduced agendas.

The Committee has been well attended by members during the year with a rolling programme in place for the Chair's of the reporting groups to attend the Committee and offer assurance on the relevant aspects of work.

The Chair and Executive Lead meet monthly to agree the forthcoming committee agenda in line with the work programme.

Key areas of focus of the Committee have included:

- CQC Inspection reports and outcomes
- Mortality
- Harm Reviews
- Never Events
- Serious Incident Reviews
- Quality Impact Assessments
- Quality Account
- Infection, Prevention and Control
- CNST Maternity Scheme
- Maternity and Neonatal
- Medicines management
- Safeguarding arrangements

The Committee continued to have a focus on Maternity and Neonatal services following the introduction of the Maternity and Neonatal Oversight Group in 2021/22 with attendance from the Non-Executive Director Maternity Safety Champion. Detailed upward reporting was offered to the Board to ensure assurance on progress of the service and response to national reports was provided.

In order to address issues effectively that had been identified, including Maternity, Children and Young People and Medicines Management that Trust had established suitable task and finish groups led by Executive Directors. The Maternity and Neonatal Oversight, Medicines Management and Children and Young People Oversight Task and Finish Groups, in year, reported directly to the Committee to ensure a sufficient level of assurance was offered.

The Committee continued to receive detailed reports in relation to harm reviews and during the year received upward assurance/exception reports from the Clinical Harm Oversight Group. The Committee were able to receive assurance on the process in place to review clinical harm during the Covid-19 pandemic.

The Committee has paid particular attention to 12-hour trolley waits with work undertaken to respond to a referral from the Finance, Performance and Estates Committee to offer assurance the harm reviews were being undertaken as a result of reduced performance.

The Committee was pleased to receive, in year, continued assurances against Infection, Prevention and Control against the backdrop of Covid-19 alongside noting the continued governance improvements. Improvements in practice had limited nosocomial transmission of Covid-19 and where outbreaks had been experienced these were contained.

Risks

The BAF and Corporate risk register have been updated and reviewed at the committee on a monthly basis identifying where updates have been required based on assurances received at the Committee.

During 2021/22 the Director of Nursing undertook a review and reconfiguration of the Risk Register resulting in the Committee receiving a revised report. The reconfiguration and revision of the risk register has allowed the Committee to be more clearly sighted on risk within the organisation and receive assurance on the mitigations in place.

Performance Review

The Committee reviews performance against the agreed quality Key Performance Indicators and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover harm free care, improving patient experience and improving clinical outcomes.

The Committee have actively ensured that the KPIs requiring monitoring by the Committee were reported. At each of the meetings during 2021/22 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

During 2021/22 the Committee noted the ongoing impact of Covid-19 on the Trust with a deterioration seen in respect of Duty of Candour. Actions were put in place to support clinical staff and recover the position.

The Committee noted throughout the year some patterns of positive performance however this was coupled with deterioration due to Covid-19 and increased levels of activity alongside continued delivery of elective care.

It was noted however that there was a significant period of the year where there was no correlation between staffing levels and patient harm reported meaning that the level of care offered remained despite staffing challenges.

Of particular note during the year 2021/22 was performance related to infection, prevention and control (IPC) with additional measures, put in place to respond to Covid-19, continuing to be maintained. The Trust had seen the positive outcome of an IPC inspection from NHS England/Improvement resulting in the overall rating for the Trust moving from red to amber with no breaches in IPC practice in the in-patient areas.

The Trust completed a Quality Account for 2020/21 however due to the national stand down this was not subject to audit.

During 2021/22 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals to the Committee and from the Committee were made during the year offering opportunities for the Quality Governance Committee to seek further assurances.

The Quality Governance Committee is an essential element of the Trust's corporate governance structure. It works closely with the Audit Committee and the Chair of the Quality Governance Committee is also a member of the Audit Committee. The Committee received all internal audits relevant to its remit for consideration of the actions and oversight of the completion of these.

United Lincolnshire Hospitals NHS Trust

United Lincolnshire Hospitals NHS Trust

Quality Governance Committee Forward Reporting Schedule 2021/22

				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Agenda Item	**Oversight Group****	**Executive Lead**	**Lead for Reports**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Business Items															
Committee Self Assessment		Trust Secretary	Deputy Trust Secretary										X	X	
Annual Report - Committee Effectiveness		Trust Secretary	Deputy Trust Secretary										X (draft)	X	X
Committee Terms of Reference		Trust Secretary	Deputy Trust Secretary	X (Final)											X (Draft)
Forward Reporting Schedule		Trust Secretary	Deputy Trust Secretary	X (Final)											X (Draft)
Reporting Group Terms of Reference and Forward Reporting Schedules		Director of Nursing / Medical Director	Deputy Director of Clinical Governance	X (Final)											X (Draft)
Committee (Quality & Safety) Performance Dashboard		Director of Nursing / Medical Director	Deputy Director of Clinical Governance	X	X	X	X	X	X	X	X	X	X	X	X
Topical, legal and regulatory update		Trust Secretary	Deputy Trust Secretary			X			X			X			X
Committee Development Session		Trust Secretary	Deputy Trust Secretary						X						
Integrated Improvement Plan		Director of Improvement and Integration	Assistant Director of Improvement			X	X	X	X	X	X	X	X	X	X
Matters Referred															
Matter referred by Trust Board or other Board Sub-Committees		Trust Secretary	Deputy Trust Secretary	**To be added to the agenda as required**											
Risk and Assurance															
Board Assurance Framework		Trust Secretary	Deputy Trust Secretary	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Report		Director of Nursing	Deputy Director of Clinical Governance	X	X	X	X	X	X	X	X	X	X	X	X
Quality Priorities & Quarterly Progress Reports		Director of Nursing	Deputy Director of Clinical Governance			X			X			X	X (Draft)	X	X (Final)
Quality Account (Draft & Final)		Director of Nursing	Deputy Director of Clinical Governance		X (Final)										X (Draft)
Quality Impact Assessments (QIA) Report*		Director of Nursing / Medical Director	Assistant Director of Improvement	X	X	X	X			X			X		
Review of relevant external reports/inquiries including (As Required): - CQC - IR(ME)R		Trust Secretary / Director of Nursing / Medical Director	Deputy Trust Secretary / Deputy Director of Clinical Governance	X	X	X	X	X	X	X	X	X	X	X	X
Savile Action Plan (Quarterly)		Director of Nursing	Deputy Director of Clinical Governance											X	
Review of relevant internal & external audit reports		Trust Secretary	Deputy Trust Secretary	**To be added to the agenda as required**											
CCG Feedback		CCG Representative	CCG Representative	**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 1a - Deliver Harm Free Care															
Clinical Harm Review Report**	PSG	Medical Director	Deputy Director of Clinical Governance	X	X	X	X	X	X	X	X	X	X	X	X
Board to Ward Assurance - Quality & Safety**	NMAAF	Director of Nursing	Deputy Director of Nursing	X			X			X		X	X		
Executive/ Non-Executive Visits		Trust Secretary	Deputy Trust Secretary	X			X			X	X		X		
Safeguarding Annual Report**	SG	Director of Nursing	Deputy Director of Safeguarding			X									
Mortality Summary Report**	PSG	Medical Director	Deputy Director of Clinical Governance	X	X	X	X	X	X	X	X	X	X	X	X
Medicines Management Annual Report**	MQG	Medical Director	Chief Pharmacist				X								
IPC Annual Report**	IPCG	Director of Nursing / DIPC	Deputy Director Infection Prevention & Control			X									
NatSSIPs & LocSSIPs Report**	PSG	Medical Director	Deputy Director of Clinical Governance	X			X			X			X		
Patient Safety Alerts Report**	PSG	Director of Nursing	Deputy Director of Clinical Governance			X			X			X			X
Incident Analysis Report **(will evolve into Aggregate Analysis (Incidents, Complaints / PALS / Claims & Inquests & Learning Report)****	PSG	Director of Nursing	Deputy Director of Clinical Governance			X					X			X	
Serious Incident Summary Report**	PSG	Director of Nursing	Deputy Director of Clinical Governance	X	X	X	X	X	X	X	X	X	X	X	X
High Profile Cases Report**	PSG	Director of Nursing	Deputy Director of Clinical Governance	X	X	X	X	X	X	X	X	X	X	X	X
Claims & Inquests**	PSG	Trust Secretary	Head of Legal Services			X				X			X		
Objective 1b - Improve patient experience															
Patient Experience Report (including inclusion, equality & diversity from a patient perspective)**	PEG	Director of Nursing	Deputy Director of Nursing		X			X			X			X	
Complaints Report**	PEG	Director of Nursing	Deputy Director of Clinical Governance		X			X			X			X	X
Complaints Annual Report**	PEG	Director of Nursing	Deputy Director of Clinical Governance			X									
National Surveys (In-patient, Cancer, Maternity)**	PEG	Director of Nursing	Deputy Director of Nursing				X (Cancer)	X (In-Patient)		X (In-Patient)				X (Maternity)	
PLACE Lite Report**	PEG	Chief Operating Officer	Deputy Director of Estates & Facilities	X			X			X			X		
PLACE Annual Report**	PEG	Chief Operating Officer	Deputy Director of Estates & Facilities						X						
Mixed Sex Accommodation (MSA) Assurance Report**	PEG	Director of Nursing	Deputy Director of Nursing		X										
Patient Story	PEG	Director of Nursing	Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Objective 1c - Improve clinical outcomes															
GIRFT Report (via CEG upward report)	CEG	Medical Director	Assistant Director of Improvement				X						X		
NICE Report**	CEG	Medical Director	Deputy Director of Clinical Governance		X			X			X			X	
PROMS (via CEG upward report)	CEG	Director of Nursing	Deputy Director of Clinical Governance				X						X		
CQUINS Report**	CEG	Director of Nursing	Deputy Director of Clinical Governance		X			X			X			X	
Confidential Enquiries (via CEG upward report)	CEG	Director of Nursing	Deputy Director of Clinical Governance	X											
Clinical Audit Report (Local & National Audits)**	CEG	Medical Director	Deputy Director of Clinical Governance		X			X			X			X	
Clinical Audit Annual Report (May) & Forward Programme (March)**	CEG	Medical Director	Deputy Director of Clinical Governance		X										X
Upward Highlight / Exception Reports from Groups reporting to the Committee (including any identified areas of focus for 2021/22)*:**															
Safeguarding Group (SG): • MCA & MCA DOLS Compliance		Director of Nursing	Deputy Director of Safeguarding		X A		X		X		X		X		X
Infection Prevention and Control Group (IPCG): • Hygiene Code • IPC BAF		Director of Nursing	Deputy Director Infection Prevention & Control	X	X	X A	X	X	X	X	X A	X	X	X	X
Medicines Quality Group (MQG) • Medicines Management 'Roadmap'		Medical Director	Chief Pharmacist	X		X		X		X A		X		X A	
Patient Safety Group (PSG) • Developing & Embedding a Safety Culture • Medical Devices		Director of Nursing	Deputy Medical Director	X	X	X	X A	X	X	X	X	X A	X	X	X
Patient Experience Group (PEG)		Director of Nursing	Deputy Director of Nursing	X	X	X	X	X	X	X	X	X	X A	X	X
Children & Young People Oversight Group (CYPOG) **(Trust Focus)**		Medical Director	Divisional Triumvirate - Family Health	X		X		X		X		X		X	
Maternity & Neonatal Oversight Group (including LMNS / Maternity Voices Partnership Update) Maternity Assurance Framework: - Maternity Dashboard - CNST - Serious Incidents including HSIB - Response to National recommendations e.g. Ockenden		Director of Nursing	Divisional Triumvirate - Family Health	X	X	X	X	X	X	X	X	X	X	X	X
Clinical Effectiveness Group (CEG)		Medical Director	Deputy Director of Clinical Governance	X	X	X	X	X	X	X A	X	X	X	X A	X
Nursing Midwifery and AHP Advisory Forum (NMAAF)		Director of Nursing	Deputy Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Reporting from Divisions:															
PRM Upward Report		Director of Finance	Head of Information	X	X	X	X	X	X	X	X	X	X	X	X
Notes:															
Frequency to revert to bi-monthly or quarterly once systems and reporting are embedded															
****In some instances reporting and assurance to QGC will happen via the oversight group upward reports. Where appropriate, reports submitted directly to QGC will however have been considered and be supported by the upward report from the relevant oversight sub-group; specifically key highlights and any required escalations. This will help to avoid duplication of discussion and actions***															
*****Where relevant the upward reports from reporting sub-groups will be aligned on the agenda to the relevant strategic objective supporting both the flow of the meeting and supporting the process of triangulation and assurance***															
Sub-group chairs will attend the Committee on a cycle throughout the year to present upward reports, attendance will be indicated by an A within the work programme against the relevant group															
Deferred items subsequently received by the Committee have been denoted with a X															

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*05 April 2022*
Item Number	*Item 8.2*
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	*Executive Leadership Team; Trust Leadership Team; Quality Governance Group*

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 final actions in response to the CQC 'must-do' requirements* • *note the divisional and corporate actions in response to 'should-do' actions as demonstrated in appendix 2, approved with divisions* • *note the mapping of some CQC actions to existing work streams and the plans to provide regular status updates* • *note the planned next steps*

1. Background

- Following the unannounced Care Quality Commission (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 responded to the CQC on the 10 March 2022 with a copy of our improvement plan.
- Also approved at this time was a revised approach for the Trust to obtain Assurance in relation to CQC. One of the approved recommendations was to ensure that Board sub-committees receive a 'cut' of the Trust's CQC Improvement Action Plan relevant to their area of focus. Sub-committees will begin to receive this during March and April. As part of this, the Quality Governance Committee (QGC) will receive the full improvement plan on a quarterly basis to undertake a stock take on progress being made.
- Trust Board will receive the full CQC improvement action plan in response to the 2022 inspection report. This is attached as appendix 2.

2. Executive Summary

- **Appendix 1** summarises the full list of CQC required actions following the recent inspection. There were 5 'must-do' actions that the Trust must take in order to comply with its legal obligations. These are illustrated in more detail in section 3 of this paper.
- **Appendix 2** provides the Trust's improvement action plan in response to the 2022 inspection report, broken down by service/corresponding CBU/Division.

3. Detailed review of ULHT 'Must-do' Improvement Actions

- 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. These are detailed as follows:
- **Regulation 12: Safe Care & Treatment:**
- **Urgent & Emergency Care:**
- **CQC2021-02: Lincoln:** *"The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment."*
- **CQC2021-05: Pilgrim:** *"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."*
- **ULHT Improvement Action Plan:**
    - 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).
    - Complete by **31-Mar-22**, referencing the NHS England and NHS Improvement Document (October 2021) 'Managing ambulance conveyances to hospital'.
    - Add the SOP into the Clinical Operational Flow Policy by **31-Mar-22.**

- Track effectiveness of SOP with audit of key metrics. Commence audit by **31-Mar-22 and undertake monthly**. This will be a manual snapshot audit.
- Additional milestones will likely be added on completion of the SOP.

- **Maternity:**
- **CQC2021-03: Lincoln:** *"The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment."*
    - Map out locations across maternity (at both sites) where medicines are stored. **Due on 15-Mar-22.** ***[NB: This action has now been completed]***
    - Undertake gap analysis, against medicines management policy key standards for security and storage. **Due on 15-Mar-22.** ***[NB: This action has now been completed]***
    - Identify gaps across maternity and ensure mitigating actions in response planned. **Due on 31-Mar-22.**
    - Understand risks related to routine ambient storage temperatures exceeding 25 degrees and develop risk based mitigation plan with Pharmacy team. **Due on 31-Mar-22.**
    - Escalation of estate related challenges to storage of medications into estate/division plans for building works. **Due on 30-Apr-22.**
    - Ensure escalation reporting relating to medicines storage/estate issues feature within PRM content. **Due on 31-Mar-22.**

- **Regulation 13: Safeguarding service users from abuse and improper treatment:**
- **Urgent & Emergency Care:**
- **CQC2021-01: Lincoln:** *"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."*
- **CQC2021-04: Pilgrim:** *"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."*
    - Ensure ED staff have received training in accessing and acting on information from the national system. **Due on 31-Mar-22.**
    - Ensure ED staff can access the Care Portal system to access the national system. **Due on 31-Mar-22.**
    - Build training into ED nursing competencies to ensure new staff are trained. **Due on 31-Mar-22.**
    - Undertake monthly audits of compliance. The first audit has been completed, and repeat monthly assurance audits are commencing **during March 2022**.

4. Mapping of the CQC Improvement Action Plan to existing work streams to avoid duplication

- A number of the CQC 'Should-do' actions reference areas with existing mechanisms to oversee, escalate and take improvement action. In these instances, to avoid duplication, the CQC Improvement Action Plan cross-references these as separate work streams.

- In many instances, these areas are long-term pieces of work to overcome particularly difficult challenges and obstacles (i.e. provide 'sufficient staffing'; staff complete mandatory training in line with Trust targets; estates challenges and continued improvement of medicines management within the Trust).
- It is planned in these instances to keep CQC updated with the progress being made towards completion throughout the year, with regular progress updates being written up by accountable owners, approved internally via the appropriate groups and sub-committees. A schedule to plan these throughout the year is being developed to support this aim.
- The following areas are mapped within the CQC Improvement Action Plan (in appendix 2) to existing internal mechanisms to oversee and take improvement action:
    - ***2021-06: 'Should-do'*** *"…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. [**Trust wide**]*
    - ***2021-08: 'Should-do'*** *"…providing all staff at every level with the development they need through the appraisal process."[**Trust wide**]*

      Given operational pressures, performance has been impacted, divisions need a recovery plan for performance during 2022/23 towards the Trust aim of 95% and 90% compliance respectively.
    - ***2021-07: 'Should-do'*** *"…provide sufficient numbers of nursing and medical staff…[**Trust wide**]*
    - ***2021-09: 'Should-do'*** *"…ensure the requirements of duty of candour are met." [Trust wide]*
    - ***2021-10: 'Should-do'*** *"…review and manage the work required to improve medicines management across the organisation."[**Trust wide**]*

      The response to the CQC 'should-do' has been linked to medicines management Integrated Improvement Plan (IIP) improvement work being led on by the refreshed task and finish group to prevent duplication. The Medical Director is chairing a medicines management task & finish group.
    - ***2021-14: 'Should-do'*** *"…ensure the design, maintenance and use of facilities, premises and equipment keep patients safe."[**Trust wide**]*

      This action is linked to the Business as Usual work to develop the Trust's estate and mitigate gaps identified. This reports through to Finance, Performance and Estates Committee (FPEC). Divisional specific actions in relation to the estate are also captured in service level action plan.
    - Going forward, issues relating to the Trusts estate that hamper progress with CQC actions or that risk patient safety will be flagged and reported on (escalation: Performance Review Meetings & Trust Leadership Team; assurance: Finance, Performance and Estates Committee) in line with revised CQC Assurance Process. This is a significant risk area given the size and age of the Trust's estate. The Trust needs to be able to demonstrate mitigation when resolution by capital works is not immediately possible.

5. Next steps

- The Trust Board will receive regular updates and any risks to delivery and how these are being mitigated. Progress will be tracked using the Trust's established BRAG ratings. Identified risks to delivery of actions, including those that have elapsed planned timescales, will be escalated into the Trust's Performance Review Meetings and reporting through Executive and Trust Leadership Team meetings.

- A revised approach to obtaining assurance linked to CQC has recently been approved. This will now be implemented for all elements of the Trust's monitoring and management of action in response to the 2022 inspection report, as well as other improvement actions identified from the wider context of the inspection report (that did not result in 'must/should-do' actions and also elements of the 2019 inspection report where further embedding is required.
- The approved process includes the following elements:
    - Investment in time across all Divisions to develop / strengthen process for the delivery of clinically led improvement actions, with regular update meetings with the compliance team and integration of escalation/assurance reporting into established governance arrangements;
    - Establishment of a divisionally led 'assurance' process to sign off action(s)/milestone(s) as complete, based on robust collation of evidence. Additionally, through regular engagement with and supported by the Compliance team, Divisions to retain oversight and seek ongoing assurance that improvement work remains embedded; or take appropriate remedial action to recover improvement plans;
    - Development of effective and regular communications to teams, within Divisions and the wider Trust, to share and celebrate improvements and achievements;
    - Establishment of a formal Executive 'assurance' process (Director of Nursing and Medical Director) to strengthen internal assurance of completion and closure of improvement actions and form a gateway to enable regular and robust updates to external regulators on progress with improvement actions and sharing of progress updates for improvement activities against difficult/challenging issues;
    - Review and strengthen escalation and assurance reporting linked to CQC/external regulators through existing channels:
        - Trust's Performance framework;
        - Executive Leadership Team / Trust Leadership Team;
        - Sub-committees/Trust Board;
        - Quality Governance Committee (QGC) oversight and taking a periodic 'stock-take' of progress.
    - Linked to the CQC external updates, will be a regular internal update for ULHT staff to ensure a 'CQC said, we did' communications feed.

Appendix 1: Full list of CQC 'Must' & 'Should-dos':

URN	Core Service	Trust/ Site	'Must-Do'	CQC Requirement
CQC2021-01	Urgent and emergency care	Lincoln County Hospital	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.
CQC2021-02	Urgent and emergency care	Lincoln County Hospital	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.
CQC2021-03	Maternity	Lincoln County Hospital	Must Do	The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.
CQC2021-04	Urgent and emergency care	Pilgrim Hospital	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.
CQC2021-05	Urgent and emergency care	Pilgrim Hospital	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 minutes where the national early warning score is five or more or requiring prioritisation. Regulation 12 Safe care and treatment.

URN	Core Service	Trust/ Site	'Should-Do'	CQC Requirement
CQC2021-06	Trust wide	Trust	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.
CQC2021-07	Trust wide	Trust	Should Do	The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.
CQC2021-08	Trust wide	Trust	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.
CQC2021-09	Trust wide	Trust	Should Do	The trust should ensure the requirements of duty of candour are met.
CQC2021-10	Trust wide	Trust	Should Do	The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.
CQC2021-11	Trust wide	Trust	Should Do	The trust should ensure they are using timely data to gain assurance at board.
CQC2021-12	Trust wide	Trust	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.
CQC2021-13	Trust wide	Trust	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.
CQC2021-14	Trust wide	Trust	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.
CQC2021-15	Urgent and emergency care	Lincoln County Hospital	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.
CQC2021-16	Urgent and emergency care	Lincoln County Hospital	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).
CQC2021-17	Urgent and emergency care	Lincoln County Hospital	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.
CQC2021-18	Urgent and emergency care	Lincoln County Hospital	Should Do	The trust should ensure effective systems are in place to review the service risk register.
CQC2021-19	Children and young people	Lincoln County Hospital	Should Do	The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.
CQC2021-20	Children and young people	Lincoln County Hospital	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.
CQC2021-21	Children and young people	Lincoln County Hospital	Should Do	The trust should ensure cleaning records are completed as per trust policy.
CQC2021-22	Children and young people	Lincoln County Hospital	Should Do	The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.

CQC2021-23	Children and young people	Lincoln County Hospital	Should Do	The trust should consider the use of a communication tool to support staff working with children who have additional needs.
CQC2021-24	Children and young people	Lincoln County Hospital	Should Do	The trust should ensure that a patient's food and fluid intake is accurately recorded.
CQC2021-25	Children and young people	Lincoln County Hospital	Should Do	The trust should consider adding specific action plans to the service risk register.
CQC2021-26	Medical care (including older people's care)	Lincoln County Hospital	Should Do	The trust should ensure that safety checks of new ward environments are fully completed before moving patients.
CQC2021-27	Medical care (including older people's care)	Lincoln County Hospital	Should Do	The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.
CQC2021-28	Maternity	Lincoln County Hospital	Should Do	The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.
CQC2021-29	Maternity	Lincoln County Hospital	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.
CQC2021-30	Maternity	Lincoln County Hospital	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.
CQC2021-31	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.
CQC2021-32	Urgent and emergency care	Pilgrim Hospital	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.
CQC2021-33	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.
CQC2021-34	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.
CQC2021-35	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure deteriorating patients are identified and escalated in line with trust policy.
CQC2021-36	Urgent and emergency care	Pilgrim Hospital	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).
CQC2021-37	Urgent and emergency care	Pilgrim Hospital	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.
CQC2021-38	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure clinical pathways and policies are updated in line with national guidance.
CQC2021-39	Urgent and emergency care	Pilgrim Hospital	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.
CQC2021-40	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure effective systems are in place to review the service risk register.
CQC2021-41	Children and young people	Pilgrim Hospital	Should Do	The trust should consider all key services being available seven days a week.
CQC2021-42	Children and young people	Pilgrim Hospital	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).
CQC2021-43	Medical care (including older people's care)	Pilgrim Hospital	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.

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: 10/03/2022

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	Amber		(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	Amber		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.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Approve new policy at PEG.	Sharon Kidd (Patient Experience Manager)	10-May-22	Amber		Minutes of PEG demonstrating approval of policy.	None.		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	Amber		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 listening events with patients.	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	Amber		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	Amber		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	Amber		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	Amber		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	Amber		(1) Plan for translation of patient information resources.	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)

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: 10/03/2022

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
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	Amber		(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.		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	Green		(1) Audit findings / report; (2) Action plan in response.	(1) Monthly audit to be undertaken to test compliance.		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	Amber		(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.		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	Amber		(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.		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		(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.		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	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		(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)

					within 30 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-Mar-2022	Amber		(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)
						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		(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	Amber		(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.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						UEC	Add the SOP into the Clinical Operational Flow Policy.	Michelle Harris (Deputy Chief Operating Officer)	31-Mar-2022	Amber		(1) Revised SOP included within the Clinical Operational Flow Policy.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						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	Amber		(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-Mar-2022	Amber		(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)
						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	Amber		(1) Development of Clinical Audit Project plan.	None.		Simon Evans, Chief Operating Officer	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-Mar-2022	Amber		(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.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						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	Amber		(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		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)	30-Apr-2022	Amber		(1) Ongoing monthly assurance reporting.	(1) Ongoing monthly assurance reporting.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						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	Amber		(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-Mar-2022	Amber		(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)
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-Mar-2022	Amber		(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)
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	Amber		(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.		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	Amber		(1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements.	(1) Use of data to inform improvement action plans.		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	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	Amber		(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.		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	Amber		(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	Amber		(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	Amber		(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	Amber		(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	Amber		(1) Evidence of risk scoping and mitigation actions considered.	None.		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	Amber		TBC	TBC		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	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.		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	Amber		(1) Launch of pilot utilising the newly fashioned transfer stickers; (2) Copy of revised sticker; (3) Evidence of communications to staff regarding pilot.	None.		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	Amber		(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.		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	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) 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	Amber		(1) Approved TOR; (2) Minutes evidencing approval of TOR.	None.		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	Amber		(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.		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	Amber		(1) Addition of risk to risk register.	None.		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	Amber		(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	Amber		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.		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.		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	Green	20-Jan-2022	(1) Audit findings / report	(1) Inclusion in the CQC monthly assurance document on most relevant tab.	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	Amber		(1) Evidence of scheduled audits being undertaken; (2) Appropriate action in response to the audit findings.	(1) Ongoing assurance that audits are continuing.		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)

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: 10/03/2022

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
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	Amber		(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	Amber		(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	Amber		(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	Amber		(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	Amber		(1) Evidence of door closure device being added to the Doctors Office door.	(1) Ongoing monitoring as part of the Matron's audit process.		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	Amber		(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	30-Apr-2022	Amber		(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).		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	Amber		(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.		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 Thurwell (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	Amber		(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	Amber		(1) Evidence of plan being scoped out.	(1) Roll-out of internal 15-steps challenge methodology.		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	Amber		(1) Clarification Trust processes.	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	Amber		TBC	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	Amber		(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).		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	Amber		(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.	Divisional Nurse	04-Mar-2022	Amber		(1) Completed Safety bulletin; (2) E-mail evidence of dissemination	None.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)

						Surgery	Thermometers to be ordered for all Anaesthetic Rooms	Theatre Matrons	02-Mar-2022	Amber		(1) Written confirmation by Theatre Matrons that Thermometers are in place; (2) Temperature check sheets; (3) Practice has been commenced.	(1) Quality Accreditation Process		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Surgery	Daily Temperature Checks Sheets to be installed in all Anaesthetic rooms	Theatre Matrons	02-Mar-2022	Amber					Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Surgery	Daily Temperature Checks to be instituted by Theatre Teams	Theatre Matrons	02-Mar-2022	Amber					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	Amber		(1) Written SOP document	(1) Audit of SOP compliance at 6 month		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	Amber		(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	Amber		(1) Audit document with additional checks	(1) Ward accreditation process		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	Amber		(1) Monthly PRM Slide Deck	(1) CBU PRM Quality Process		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)
							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).	Amber		(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)	30-Apr-2022	Amber		(1) Key services availability and identification of any gaps.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						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	Amber		(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	Amber		(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)

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: 10/03/2022

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
CQC2021-09	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 Gibbibs (Deputy Divisional Nurse)	30-Apr-2022	Amber		(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.).		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	Amber		(1) Inclusion of patient information within the specialty 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)
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	Amber		(1) Environmental audits / FLO audits demonstrating that estates issues are being identified; (2) Evidence of escalation / mitigation of estates related	(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	Amber		(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	Amber		(1) Revised checklist for opening a ward; (2) Assurance evidence the checklist is in use when opening a ward; (3) Inclusion within the Trust's document control processes.	(1) Assurance evidence the checklist is in use when opening a ward.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
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.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Amber		(1) Understanding of difficulties in obtaining information from ESR.	None.		Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)

United Lincolnshire Hospitals NHS Trust

CQC Action Plan

Executive Lead: Karen Dunderdale, Director of Nursing

Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Context - Taken from the report (why was this identified as an issue)
CQC2021-01	Urgent and 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.	Systems and processes to check nationally approved child protection information sharing systems were not embedded. We were not assured there was a system in place to check an approved national child protection information sharing system for children attending the department. This meant opportunities to review any current safeguarding risks associated with the child were potentially missed. Following the inspection, the service provided assurance this process had been in place previously and would be reinstated. Systems were in place to add an alert to emergency department electronic patient record should there be a safeguarding concern. For example, to identify children and young people who attend frequently. (Page 188; Safe)
CQC2021-04	Urgent and 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.	Systems and processes to check nationally approved child protection information sharing systems were not embedded. Whilst there was a process in place to check an approved national child protection information sharing system for children attending the department, staff were not following this. This meant opportunities to review any current safeguarding risks associated with the child were potentially missed. Following the inspection, the service provided us with a plan for this to be reinstated fully by 30 November 2021. A flowchart describing the process had been shared within staff. The safeguarding team had commenced education sessions with key staff as part of team huddles and supervision sessions. (Page 29; Safe)
CQC2021-02	Urgent and 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.	The number of patients attending by emergency ambulance that waited over 60 minutes from arrival to handover at County Hospital has mostly been worse than the Midlands and England averages. Between March and September 2021 there were 1,322 patients waiting over an hour. Whilst processes were in place to improve the safe care of patients waiting on ambulances, patients had to wait until there was space in the department to be assessed and treatment commenced. (Page 206: Responsive)
CQC2021-05	Urgent and 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 minutes where the national early warning score is five or more or requiring prioritisation. Regulation 12 Safe care and treatment.	Processes were in place for medical staff to complete face to face reviews of patients waiting over 60 minutes on an ambulance, however, this was not fully implemented. The trust standard operating procedure (SOP) for management of reducing ambulance delays states patients who experience ambulance offload delays should be reviewed by a member of the ED medical team within one hour of arrival. During our inspection we did not observe this was routinely completed and ambulance staff commented this did not always take place. Following the inspection, the service sent us harm reviews of 17 patients who waited more than two hours on an ambulance. Only three of the reviews showed evidence the patients were reviewed on the ambulance by the emergency physician in charge (EPIC). In two cases, this was over an hour after arrival. Furthermore, the SOP stated patients with a NEWS score of five or above or any clinical condition which required prioritisation should be reviewed by medical staff on the ambulance within 30 minutes. During our inspection we saw a consultant review a patient on the ambulance where the NEWS score had increased and another where pain levels had worsened. However, we were not assured this process was fully implemented. For example, harm reviews showed one patient arrived at 19.53 with a National Early Warning Score (NEWS) score of five which deteriorated to a score of eight at 21.43. There was no evidence the patient had been reviewed by the consultant according to the harm review. The patient was seen by a doctor at 22.45 once offloaded from the ambulance. (Page 32-33: Safe)
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.	Medicines, including controlled drugs were not always stored securely. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. On two occasions during our inspection on the maternity ward, we were able to access medicines in unlocked drawers in an unlocked room. This room was accessible from two separate corridors meaning patients and their visitors could enter the room potentially accessing the medicines. We escalated this twice during our inspection to managers which resulted in the medicines being moved each time. Women could not be assured that their medicines were effective as staff were not ensuring medicines were being stored in line with manufacturers guidance. Temperature monitoring of medicines stored at room temperature were not being monitored despite staff telling us the rooms were consistently warm. We escalated this to managers on the labour and maternity wards. Temperature monitoring was immediately put in place on the labour ward. However, when we returned to the maternity ward on the second day of the inspection temperature monitoring was still not being completed. (Page 126-127; Safe)

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.	Not all services had enough staff to care for patients and keep them safe and not all staff were up to date with mandatory training or additional safeguarding training. (Page 3) **UEC-Pilgrim (Page 27-28; Safe):** Registered nurses were compliant with the trust target in seven out of 11 modules. For those modules where compliance levels were not achieved, the service was close to achieving the target. Medical staff received but did not always keep up to date with mandatory training. Compliance levels had improved since our last comprehensive inspection in 2019. However, medical staff were not compliant with seven out of 11 modules. For example, major incident awareness (69%), information governance (79%), infection control and prevention (79%) and fire safety (86%). Compliance to the highest level of life support training was not achieved for medical or nursing staff. Data provided to us following the inspection showed all 10 consultants and 78% of middle grade doctors working in urgent and emergency care had completed advanced life support adults (ALS) training. Furthermore, advanced trauma life support (ATLS) training had been completed by 80% of consultants and 56% of middle grade doctors. Training compliance data for basic life support (66%) was poor for registered nursing staff. Data showed 80% of consultants, 72% of middle grade doctors and three out of five locum middle grades working at the trust had completed European advanced paediatric life support (EPALS) training. Training compliance data for paediatric basic life support (75%) was below expected standards for registered nursing staff. Only 38.6% of registered nurses had completed paediatric intermediate life support (PILS) and 65% EPALS. However, a plan was in place to improve compliance. For example, it was expected 58% of nurses would have completed PILS and 71% completed EPALS by December 2021. Staff received training on sepsis recognition and treatment. Training compliance levels had improved significantly. Data provided by the service following our inspection demonstrated 91% of staff in urgent and emergency care had completed sepsis training. Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. On average 94% of registered nursing, medical and non-clinical staff had completed mental health training and 95% dementia training. Training in learning disability and autism was not provided, however, the service was in the process of developing an online training programme expected to be available to staff in December 2021. **Safeguarding Page 28:** Nursing staff received training specific for their role on how to recognise and report abuse. The 90% compliance target was met for safeguarding adults and children level two and safeguarding adults' level three. However, was not met for safeguarding children level three (87%). A plan was in place to achieve compliance. Medical staff were provided with training specific for their role on how to recognise and report abuse, however, compliance was poor. For example, data provided by the trust following our inspection showed 68% of medical staff had completed safeguarding adults and children level two, 67% had completed safeguarding adults level three and just over half (54%) had completed level three safeguarding children. However, medical staff understood how to identify a safeguarding concern and how to act on it. **Medical Care - Pilgrim (Page 69; Safe):**
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.	**UEC - Pilgrim (Page 36-38; Safe):** The service had some staffing vacancies. However, shifts were covered with bank and agency staff to ensure therewere enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The service did not have enough nursing and support staff; however, action was taken to ensure patients were safe. Planned emergency department (ED) staffing was 12 registered nurses (RN) and eight healthcare assistants (HCA) day and night. This included the nurse in charge and pre-hospital practitioner (PHP). Managers told us the current staffing template did not meet the demand of the service. For example, the blue majors' stream was particularly challenged during our inspection. One RN and one HCA was allocated to cover the cubicles and walk-ins which staff told us was challenging for them due to the variety of the role as well as number of patients they were looking after. Furthermore,the triage nurse role was challenged at time of peak demand. The number of nurses and healthcare assistants did not always match the planned numbers. On the day of our inspection the number of registered nurses met the planned level, but the service was down one healthcare assistant. The senior sister and band seven nurses were included in the numbers and working clinically to support the gaps in staffing levels to ensure all areas were covered. From June to September 2021, of the 2692 shifts unable to be filled by substantive registered nurses, 14.6% of these were unfilled. This meant 392 shifts were not covered by a nurse over this three-month period. Furthermore, over the same period 1776 shifts were unable to be filled by substantive healthcare support workers and 38% of these were unfilled. This meant 679 shifts were not covered by a healthcare assistant over this period. The service had some staffing vacancies. However, shifts were covered with bank and locum staff to ensure there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The service did not always have enough medical staff. The medical staff did not always match the planned number. There were gaps in the medical rota the service was unable to fill. For example, during September 2021 there were 28 unfilled medical shifts. On day one of our inspection there was a middle grade doctor unfilled shift and on day two a junior doctor unfilled shift. Medical staff told us they managed the service as safely as possible with the resources available. Medical leads said they reviewed staffing to ensure it was 'adequate', and as safe as possible. The service had consistently high vacancy rates for medical staff. Data provided to us following the inspection demonstrated from April to September 2021 the average vacancy rate for medical staff was 22.2%. The consultant vacancy rate remained at 16.67% throughout this period and for middle grade Doctors was particularly high with an average rate of 34%. Junior doctors showed an increasing vacancy rate with 10.4% vacancy rate in August and September 2021. **Maternity - Pilgrim (Page 63; Safe):** The service had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction. The service had enough staff to keep women and babies safe. Staffing data for September 2021 showed the service had -5% medical and -2.47% midwifery and support staff vacancies. This meant the service had no

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.	**UEC - Pilgrim (Page 46; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. However, not all staff had an appraisal within the 12 months prior to our inspection. For example, 97% medical staff had received an appraisal, however, only 46.7% of registered and non-registered nursing staff had received an appraisal. **Maternity - Pilgrim (Page 65; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. This ensured that staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. At the time of our inspection, 92% of medical staff, 72% of registered nursing staff and 81% of support staff had received an appraisal. Nursing and support staff appraisal rates were below the trust target of 90%, however plans were in place to increase appraisal rates and staff and managers had been contacted to remind them to engage in the appraisal process. **Medical Care - Pilgrim (Page 80; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. Across the medical division there was an average appraisal completion rate of 60%. The trust had a plan and targets they wanted to achieve to increase appraisal rates after they were paused due to the pandemic. A new job management software package had recently (May 2021) been introduced to support and improve the quality of appraisals, including clear objective setting, career and development conversations, wellbeing conversations, and aligning performance and behaviour to the trust values. The system was still very new to the trust and had not been fully embedded. However, we observed an action plan which contained six actions the division were working towards, documented at the August 2021 'medicine performance management framework meeting'. **CYP - Pilgrim (Page 107; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Most staff said their appraisals were really beneficial and helped them to plan their development and career pathway. All staff we spoke with told us they had received an appraisal or were due one soon. Some had been rescheduled during the Covid-19 pandemic. Data provided by the trust showed that 68% of staff had received an appraisal within the last 12 months. **Maternity - Pilgrim (Page 129; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. This ensured that staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. At the time of our inspection, 91% of medical staff, 67% of registered nursing staff and 81% of support staff had received an appraisal. Nursing and support staff appraisal rates were below the trust target of 90%, however plans were in place to increase appraisal rates and staff and managers had been contacted to remind them to engage in the appraisal process. **Medical Care - Lincoln (Page 142; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. Across the medical division there was an average appraisal completion rate of 93%. Across the medical division for non medical staff the average appraisal rate was 55%. The trust had a plan and targets they wanted to achieve to increase appraisal rates after they were paused due to the pandemic. **CYP - Lincoln (Page 169; Effective):**
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred. For the reporting period October 2020 to September 2021, compliance with the duty of candour regulation had been variable (verbal compliance 84%, written compliance 68%). The board were sighted on duty of candour performance and had taken a number of actions to address this. Further planned actions included; commissioning a piece of investigative work to review the way in which the trust record duty of candour compliance to try and understand the variability in the data, refresher training for staff covering duty of candour requirements and a review of the trust's duty of candour policy and related documentation to ensure it was fit for purpose. (Page 13) **UEC - Pilgrim (Page 41; Safe):** Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, three serious incidents we reviewed showed duty of candour was not applied in line with trust policy. **Maternity - Pilgrim (Page 64; Safe):** Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. **Medical Care - Pilgrim (Page 76; Safe):** Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. **CYP - Pilgrim (Page 103; Safe):** They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed governance meeting minutes and found that duty of candour had been used for each of the incidents discussed. **Maternity - Lincoln (Page 127; Safe):** Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. **Medical Care - Lincoln (Page 139; Safe):** Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. **CYP - Lincoln (Page 164; Safe):** Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. The duty of candour is a legal requirement; every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

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.	**UEC - Pilgrim (Page 39; Safe):** Staff did not always follow systems and processes when storing medicines, however, did when prescribing, administering, and recording medicines. Medicines were not always locked away. **Medical Care - Pilgrim (Page 75; Safe):** The service used systems and processes to safely prescribe, administer, record and store medicines. **CYP - Pilgrim (Page 101; Safe):** The service used systems and processes to safely prescribe, administer, record and store medicines. **Maternity - Lincoln (Page 126; Safe):** The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored securely or in line with manufacturers guidance **Medical Care - Lincoln (Page 138; Safe):** The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored securely. **CYP - Lincoln (Page 162-163, Safe):** The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not always follow these. **UEC - Lincoln (Page 195; Safe):** Staff did not always follow systems and processes when storing medicines, however, they did when prescribing, administering, and recording medicines. The medicine room door was regularly left open.
CQC2021-11	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they are using timely data to gain assurance at board.	**Governance Lincoln (Page 16)** Through the use of key performance indicators (KPIs) and divisional and trust wide integrated performance reports, the board had a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. Board papers we reviewed evidenced where information was used to measure for improvement, not just assurance. Through interviews with board members and our review of board papers, including agendas we were assured quality and sustainability both received sufficient coverage in relevant meetings at all levels. Information provided to the sub-committees and ultimately the board was of a good quality and enabled the NEDs to have an independent oversight and to provide constructive challenge to the executive directors. There were clear and robust service performance measures, which were reported and monitored. The trust's integrated performance report (IPR) was presented to public board monthly and provided an overview of performance over time. However, from our review of board papers we were not assured the board was using timely data to gain assurance. For example, November's IPR referenced performance data from August/September 2021. Board members told us up to date data for example, emergency department waits, was discussed through the finance, performance and estates committee meeting.
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.	Patient records were not always stored securely. (Page 3) **UEC - Pilgrim (Page 40, Safe):** Records were not stored securely. Throughout our inspection we observed patient records being left out and unattended on trolleys in walkways. For example, we saw patient record on a trolley in a corridor outside of room 15. We raised this with managers who removed the records, however we continued to see records being placed there throughout out inspection. **Medical Care - Pilgrim (Page 75, Safe):** Records were stored securely. On the wards we visited notes were stored in lockable trolleys which were locked when not in use by staff. On all the wards we visited these had been moved so they now were stored in the patient bays to ensure staff members were more visible when completing their notes. There was also space for staff to sit in the bays to maintain observation of patients when required. **CYP - Pilgrim (Page 102, Safe):** Records were easily accessed by relevant staff, legible and comprehensively completed, stored securely and locked in cabinets **Medical Care - Lincoln (Page 139, Safe):** Records were generally stored securely. On the wards we visisted notes were stored in lockable trolleys which were locked when not in use by staff. On some of the wards we visited these had been moved so they now were stored in the patient bays to ensure staff members were more visible when completing their notes. On one ward we visited there was a notes trolley that was left unlocked and was near to the entrance to the ward meaning anyone could walk in from the main hospital corridor and have access to the notes. This was raised with the ward manager who reminded staff the importance of ensuring the trolley was kept locked when not in use. **CYP - Lincoln (Page 163, Safe):** Records were stored securely when not in use. Staff kept records for patients in the hospital in lockable cabinets near to nurse stations. However, we did see two occasions where patient records were accessible to unauthorised people. See well led 'information management' for more details. Patient records were left unsecured on two occasions which could have led to a data breach. On Rainforest ward, staff had left the door to the doctors' office open allowing inspectors to enter and review a large quantity of patients' notes unchallenged. One member of staff had also not logged out of a computer which would have allowed other people to use their account and access confidential patient information. We also saw unsecured patient

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 - Pilgrim (Page 52; Responsive):** Staff did not always understand or apply the policy on meeting the information and communication needs of patients with a disability or sensory loss and did not have access to communication aids to help patients become partners in their care and treatment. Staff were not aware of communication aids that could be used for patients who had communication difficulties. Staff told us they could access sign language. **Medical Care - Pilgrim (Page 86; Responsive):** The service had information leaflets available in languages spoken by the patients and local community. **CYP - Pilgrim (Page 113; Responsive):** The service had information leaflets available in languages spoken by the children, young people, their families and local community. However, these had been removed during the Covid-19 pandemic. **Medical Care - Lincoln (Page 147; Responsive):** The service had information leaflets available in languages spoken by the patients and local community. **CYP - Lincoln (Page 177; Responsive):** The service had information leaflets available; however, these were in English only. Patients and parents/ carers told us staff provided helpful leaflets, particularly in outpatients. Data from the trust reported there are limited leaflets available in other languages. However, there were a large number in other languages for breast feeding. The trust told us they were reviewing this in line with local networks and were in the process of launching a translation tool on the neonatal website specifically. We observed that the peer review audit conducted recently by the local mental health trust also recommended information leaflets be made available in a variety of commonly used languages. **UEC - Lincoln (Page 206; Responsive):** The service did not have information leaflets available in languages spoken by the patients and local community. We did not see any information available in different languages.
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.	The design, maintenance and use of facilities, premises and equipment did not always keep people safe or follow national guidance. (Page 4 and 7) **UEC - Pilgrim (Page 30-31; Safe):** The design of the environment did not always follow national guidance. However, following our focused inspection in 2020 action was taken to improve the department. Reconfiguration works at Pilgrim hospital included a new x-ray room, an additional triage room, a modular waiting room, a fit to sit area and paediatric emergency department (ED). Patients were no longer cared for in the central area of majors. All majors' patients were streamed to a cubicle if they required a trolley. Furthermore, a fit to sit area had been created within majors and in the main waiting room. Patients attending by ambulance were held on ambulances when the department was at capacity. Whilst this was not what senior staff in the department wanted it allowed for patients to be monitored by ambulance staff whilst waiting f the department. In order to improve safety, patients were reviewed on arrival by the pre-hospital practitioner (PHP). Patients presenting with acute mental health concerns did not have access to a dedicated room which met national guidance relating to the provision of a safe environment. Staff told us a patient requiring additional supervision would be placed in an observable majors' bay. However, due to the layout of the department patients who were at risk of selfharm could have access to rooms and equipment which had the potential to cause harm. For example, the clean procedures room was easily accessible and we saw contained hazardous equipment. Toilets and bathrooms were accessible and contained ligature points. Following our inspection, the trust provided us with a plan to reinstate a mental health room (room 15) which was intended to be modified to meet appropriate standards. As an interim, the trust advised us any patient with mental health conditions requiring use of the room will receive one to one supervision. The trust confirmed they had also removed ligature risks identified in this room. **UEC - Pilgrim (Page 51 ; Safe):** The department was not designed to meet the needs of patients living with dementia. Most areas of the department were bright, busy and noisy which some groups of patients might find distressing, and there were very few side rooms where quieter care could be provided. **Medical Care - Pilgrim (Page 71; Safe):** The design of the environment did not always follow national guidance. Some of the wards we visited were old and required refurbishment. The trust had plans in place regarding refurbishments and were working through the wards.Time scales were sometimes changeable according to ward risks. However, senior ward staff and matrons were aware of changes and involved in ensuring the wards they were being decanted into were suitable for the patients within their care. For example; the cardiac monitored patients would all be moved into an area that would always be able to provide the same monitoring facilities to ensure safety of the patient. The discharge lounge was an old mental health secure unit. There was identified space in each bay for six patients. However, there were only effective curtained areas for four patients. This meant if the area did reach capacity some patients may not be afforded privacy. (Health Building Note 04-01 – Adult in-patient facilities 4.21 Privacy). **Medical Care - Lincoln (Page 135; Safe):** The design of the environment did not always follow national guidance. Some of the wards we visited were old and required refurbishment. The trust had plans in place regarding refurbishments and were working through the wards. The trust had recently carried out some refurbishment works on Coleby ward, Clayton ward, Lancaster ward and Medical Emergency Assessment Unit (MEAUB). However, staff did report that

CQC2021-15	Urgent and 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.	Mental health risk assessments were not routinely completed. However, staff told us they would be completed if a patient attended with a mental health related concern of following self-harm or attempted suicide. During our inspection, we reviewed a patient care who attended following self-harm. Despite the notes indicating the patient was at 'medium' risk, there was no mental health risk assessment in place. This was escalated and the risk assessment was subsequently completed. (Page 191) Staff did not always complete, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During our inspection we reviewed one record of a patient. However, there was no mental health risk assessment completed to ensure the patients' needs were being met and mitigations in place to reduce risk of self-harm. This was escalated and the risk assessment was implemented. Managers told us risk assessments were normally in place, however, did not audit compliance. (Page 192) Patient notes were not always comprehensive, Nursing and medical staff had access to patients' paper and electronic records and all staff could access them easily. Most sections of the casualty assessment were completed. Risk assessments were not always completed for patients with specific needs. For example, we found falls and mental health risk assessments were not consistently used for patients who required them, and transfer documentation was not regularly completed. Records were regularly updated to record two hourly care rounding. This was escalated whilst on site and the risk assessments were completed by staff. (Page 194-195) **Page 7 U&E Lincoln** 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. **Page 35 U&E Lincoln (Good)** Staff shared key information to keep patients safe when handing over their care to others. We reviewed the handovers of six patient who transferred to another ward. The handover records were fully completed with key risk information to enable the incoming ward to implement measures to manage the patient safely. **Page 192 U&E Lincoln** Staff could not always evidence that they shared key information to keep patients safe when handing over their care to others. The service had developed a handover document which was supposed to be used when patients were moving into other inpatient areas of the hospital. This was developed in line with SBAR (situation, background, assessment and recommendations). Patients' notes were also photocopied and sent over when they were transferred. In five records we reviewed of patients who had been transferred out of the emergency department, only two had complete transfer form. **Page 195 U&E Lincoln** - For example, we found falls and mental health risk assessments were not consistently used for patients who required them, and transfer documentation was not regularly completed. Records were regularly updated to record two hourly care rounding. This was escalated whilst on site and the risk assessments were completed by staff. When patients transferred to a new team, there were no delays in staff accessing their records. Paper records were transferred with patients to other departments within the hospital and electronic records were available throughout the trust. Patients who were not admitted, had their notes scanned in by administrative staff. However, patients transfer documentation was not always completed.
CQC2021-16	Urgent and 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).	The service continued not to meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children nurses on each shift. The service had one registered nurse with level four paediatric competencies on duty 24 hours with support from a healthcare support worker. Improvements had been noted since our previous inspection. Paediatric skill mix was included on the main ED roster and the service ensured there were more than one staff member with paediatric competencies available so they could offer support if demand increased. The department had been refurbished since our previous inspection with a waiting area observable at all times by staff. (Page 192-193) The service did not have a paediatric emergency medicine (PEM) consultant as recommended in the Royal College of Paediatric and Children's Health (RCPCH) guidance, 'Facing the Future: Standards for children in emergency care settings'. However, there was a lead consultant for paediatrics and medical staff working in paediatrics. The model was supported by paediatricians working in the trust and systems were in place to ensure there was a paediatrician available in the event of deterioration. The senor leadership team recognised this was an area for improvement. (Page 194)
CQC2021-36	Urgent and 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).	The service continued not to meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children nurses on each shift. The service had one registered nurse with level four paediatric competencies on duty 24 hours with support from a healthcare support worker. Improvements had been noted since our previous inspection. Paediatric skill mix was included on the main ED roster and the service ensured there were more than one staff member with paediatric competencies available so they could offer support if demand increased. (Page 36) The service did not have a paediatric emergency medicine (PEM) consultant as recommended in the Royal College of Paediatric and Children's Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings. However, there was a lead consultant for paediatrics and medical staff working in paediatrics had special interests. The model was supported by paediatricians working in the trust and systems were in place to ensure there was a paediatrician available in the event of deterioration. The senor leadership team recognised this was an area for improvement. (Page 38)
CQC2021-17	Urgent and 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.	However, we were not assured there were clear lines of governance in relation to the paediatric area within the Emergency Department. We did not see evidence of regular updates in governance meeting minutes we reviewed. (Page 58)

CQC2021-39	Urgent and 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.	However, we were not assured there were clear lines of governance in relation to the paediatric area within the Emergency Department. We did not see evidence of regular paediatric updates in governance meeting minutes we reviewed, this included at both local and divisional levels within the governance structure. (Page 212)
CQC2021-18	Urgent and 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.	Divisional risk register review and oversight processes were not always effective. It was not always clear what the risk was, when the risk was added, and it was unclear who had oversight of the risk registers. Local leaders did not have ownership of the risk register therefore there was the potential for departmental risks to be missed. Whilst most managers could describe risks, they could not always tell us what the risks were on the risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures. (Page 213)
CQC2021-40	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	Divisional risk register review and oversight processes were not always effective. It was not always clear what the risk was, when the risk was added, and it was unclear who had oversight of the risk registers. Local leaders did not have ownership of the risk register therefore there was the potential for departmental risks to be missed. Whilst most managers could describe risks, they could not always tell us what the risks were on the risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures. For example, we reviewed the Pilgrim site ED speciality governance meeting minutes for 11 August 2021. There was reference to the risk register in terms of a discussion about the best way to present to the CQC, however, there was no discussion about risks and actions. Furthermore, there was no evidence the risk register was discussed at the 15 July 2021 UEC clinical business unit governance meeting despite this being an agenda item. (Page 59)
CQC2021-19	Chidren 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.	Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. We checked medicine storage and prescriptions on both patient wards, the neonatal unit and within theatres. All medicines were stored correctly and securely. Temperature checks were undertaken as per the trust policy except for theatres where the ambient room temperature was not recorded. Paediatric services were included in an annual fridge temperature monitoring audit dated 2020/2021. This demonstrated that room temperature checks were not consistently completed including in paediatric theatre areas. (Page 163)
CQC2021-20	Chidren 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.	During the inspection, we were told by family members that interpreters had not been provided to enable parents who did not speak English to give informed consent. We reviewed two relevant patient records and found that on three occasions, there was no evidence of an interpreter being used out of a total of seven opportunities reviewed. These opportunities included medical reviews, outpatient consultations and ward admissions during which parents would be required to provide relevant patient information and give consent to various care and treatment plans. (Page 172)
CQC2021-21	Chidren and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure cleaning records are completed as per trust policy.	Cleaning records did not always demonstrate that all areas were cleaned regularly. For example, on Safari ward we found that the parents room cleaning checklist had not been completed the week of our inspection, 4 October to 7 October 2021. On the neonatal unit, we saw the cleaning log for high and low clinical areas was not completed for the 6 and 7 October 2021. (Page 156)
CQC2021-22	Chidren 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.	Staff knew about and understood the standards for mixed sex accommodation. The trust policy 'eliminating mixed sex accommodation' (updated 2021) outlined that children and young people, should ideally not share sleeping areas with patients of the opposite sex; however clinical conditions, age and other factors would take precedence over this. Staff on the wards for children and young people described working within this policy. Staff told us if a patient/ parent or carer raised this as a concern they would try to accommodate them, however this was by exception basis. Therefore, some young people may have felt uncomfortable but due to not directly raising this with staff; this was not considered. (Page 174-175)
CQC2021-23	Chidren 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.	Staff supported children and young people living with complex health care needs however did not use 'this is me' type documents. Managers and staff told us they did not use 'this is me' or similar documents to provide a quick and concise overview of individual children's needs, particularly children with additional needs which may have impaired communication. The trust had an 'all about me' booklet specific to adult patients with dementia. (Page 177)
CQC2021-24	Chidren 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.	Staff did not always fully and accurately complete children and young people's fluid and nutrition charts where needed. Managers audited nutrition and hydration. Managers monitored staff use of the Paediatric Yorkhill Malnutrition Score (PYMS) and care plans where appropriate, patients' weight being taken upon admission, children with alternate feeds having care plans, nil by mouth care plans being in place and fluid and feed charts being competed accurately. Data from the trust for Rainforest ward showed mixed results. For measures relating to PYMS; the audit score was 0% from April to July 2021 from a review of 10 patient records. This indicates staff were not using this method in this timeframe. However, 100% of records reviewed showed children had been weighed and measured on admission to a ward. In addition, where children had alternate feed plans in place; 100% had a care plan to support this. For July 2021, the audit showed 100% of fluid/ food charts were completed correctly. However, for April, May and June 2021 a score of 0% was recorded. This indicated that either there was not enough data to review, or that staff were non-compliant with this measure. (Page 166)
CQC2021-25	Chidren and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider adding specific action plans to the service risk register.	The service had a corporate risk register for the children and young people service as a whole. This included one risk specific to Pilgrim Hospital; the remainder were more generalised potential risks rather than specific to the current status of the service at Lincoln County Hospital. Mitigating actions were listed to reduce risks however these were not specifically allocated or dated therefore it was not possible to tell from the risk register if these actions were being delivered at the time of inspection. Despite this, we saw managers including the directorate leadership team, matrons and ward manager had a good understanding on active risks to the service at the time of inspection and were able to talk about how these were being specifically mitigated. (Page 182)
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.	Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys containing medicines and equipment required in an emergency were accessible on all wards we visited. They were safely secured with tamper proof seals. Most of resuscitation trolleys we looked at during our inspection were checked daily and weekly to ensure they were stocked, equipment was in working order and medicines were up to date. However, one ward which we visited, which had just been opened to receive patients, had a resuscitation trolley which had not been checked. This wasn't in line with the trust policy of checking wards before they were opened. (Page 135)
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.	As a result of the Covid-19 pandemic and the resulting ward reconfigurations, performance had declined on a number of national clinical audits including; the National Lung Cancer Audit 2020 and the Sentinel Stroke National Audit Programme 2019/21. The Healthcare Quality Improvement Partnership (HQIP) National Clinical Audit Benchmarking (NCAB) report for the data period 2018/19 was published in July 2020 and showed the trust to be performing generally 'as expected'. (Page 141)
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.	Most staff knew what incidents to report and how to report them and we saw evidence that incidents were being reported however, two of the 14 midwifery staff we spoke with told us they did not always report incidents relating to safe staffing. One staff member told us their manager had told them not to report safe staffing incidents and the other staff member had not recognised that the incident they described to us was potentially a reportable incident. The systems in place to ensure there was shared learning from incidents were not consistently followed. These systems included emailing all staff with this learning and reading out lessons learned and safety information in every handover. This safety update was referred to as a 'newsflash'. Staff did not read the newsflash out during the handovers we observed during our inspection which was not in line with the trust's agreed processes. This meant there was a risk that staff may not access learning from incidents in a timely manner if they were unable to access their emails. Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. Staff told us that managers provided debriefs and support after any serious incident. (Page 128)

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.	Specialist training for staff specific to their roles was provided. However, effective systems were not in place to ensure staff consistently completed all the required additional training for their roles. We found that an effective system was not in place to ensure midwives responsible for recovering women post anaesthesia were competent to carry out this role. At the time of our inspection, only 24 of the 42 midwives eligible for recovery training had completed this training and a list of competent midwives in recovery was not readily accessible to enable midwives in charge to allocate competent staff to the recovery role. This meant there was a risk that women would be recovered by staff who were not trained to do so. We escalated this during our inspection and the trust told us how they would address this to mitigate this risk. We found no evidence that harm had been caused as a result of this competency gap. (Page 128)
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.	The maternity dashboard audit scores from July to September 2021, had not been effective in addressing risks associated with the environment; the general environment for the maternity ward was consistently scored as 78% and RAG rated as red. This meant the equipment and facilities concerns we identified such as; unsafe door frames, broken bath panels and non-functioning blinds, whilst identified, had not been addressed in a timely manner. The lack of action from the estates team to address reported issues had also not been effectively escalated to ensure reported issues were rectified in a timely manner. This included the broken toilet seat that had been reported in May 2021 that had not been fixed at the time of our inspection. (Page 131)
CQC2021-31	Urgent and 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.	The service did not always perform well for cleanliness. Monthly audits demonstrated the service did not always meet the expected infection, prevention and control (IPC) standards. From July to August 2021 monthly IPC audit compliance averaged from 79% to 87%. An action plan was in place to improve compliance and was monitored monthly by the IPC group. Regular IPC briefings were communicated to staff to demonstrate expected standards. For example, in August 2021 a COVID-19 pandemic briefing was sent out following a rise in outbreaks with guidance for staff to protect themselves and patients. Cleaning records were generally up to date to demonstrate areas were cleaned regularly. Cleaning records over the three-month period prior to our inspection showed all areas had been cleaned as per the cleaning schedule. However, the 'decontamination of bed space' following discharge record in cubicles was not completed to demonstrate the area had been appropriately de-contaminated. Staff could not confirm a room had been decontaminated before moving a new patient in. (Page 29) Staff cleaned equipment after patient contact. We observed equipment was generally clean including blood pressure monitors, electrocardiogram machines and trolleys. A health care assistant was allocated each shift to maintain a clean and tidy environment. Equipment was not always labelled to show when it was last cleaned. 'I am clean' stickers were not always used to indicate equipment had been cleaned to the correct standard. For example, we saw a commode and ultrasound machine did not have a sticker to let staff know if it had been cleaned since last use. However, we saw urinals did have 'I am clean' stickers. Monthly matron audits from April to September 2021 demonstrated on average 86% compliance with 'I am clean' stickers on commodes. In May 2021 this was 56% and June 2021 70%. Whilst stickers were not present, we observed equipment appeared to have been cleaned. (Page 30)
CQC2021-32	Urgent and 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.	Patients presenting with acute mental health concerns did not have access to a dedicated room which met national guidance relating to the provision of a safe environment. Staff told us a patient requiring additional supervision would be placed in an observable majors' bay. However, due to the layout of the department patients who were at risk of selfharm could have access to rooms and equipment which had the potential to cause harm. For example, the clean procedures room was easily accessible and we saw contained hazardous equipment. Toilets and bathrooms were accessible and contained ligature points. Following our inspection, the trust provided us with a plan to reinstate a mental health room (room 15) which was intended to be modified to meet appropriate standards. As an interim, the trust advised us any patient with mental health conditions requiring use of the room will receive one to one supervision. The trust confirmed they had also removed ligature risks identified in this room. (Page 31) Mental health risk assessments were not routinely completed. However, staff told us they would be completed if a patient attended with a mental health related concern or following self-harm or attempted suicide. During our inspection we reviewed the care of a patient who attended following self-harm. Despite the notes indicating the patient was at 'medium' risk, there was no mental health risk assessment in place. This meant the service did not identify actions to be taken to reduce the risk of harm to the patient whilst in the department. This was escalated and the risk assessment was subsequently completed. (Page 34) Staff did not always complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During our inspection we reviewed one record where a patient was deemed to be medium risk of self-harm. However, there was no mental health risk assessment completed to ensure the patients' needs were being met and mitigations in place to reduce risk of self-harm. This was escalated and the risk assessment was implemented. Managers told us risk assessments were normally in place, however, did not audit compliance. (Page 35) We also identified the mental health risk assessment had not been updated to reflect changes with the footprint of the department and removal of the mental health room. This had a significant impact on the safe management of patients at risk of self harm. Whilst staff appeared to be aware of pathways, they could not always sign post us to where to find local guidelines. (Page 42) Processes were in place to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, we did not see evidence these processes were fully implemented. Documentation was in place which directed staff on managing patients presenting with a mental health condition. We reviewed one set of notes for a patient presenting with mental health concerns and self-harm. However, there was no mental health risk assessment in place to determine the patients background, individual needs, risks and actions to prevent the patient coming to harm. Audits were not completed to assess staff compliance with mental health risks assessments to provide assurance they were consistently implemented. (Page 43)

CQC2021-33	Urgent and 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.	However, during our inspection we found ambulance conveyed patients did not always undergo a face to face triage by the pre-hospital practitioner (PHP) at the point of arrival. The triage was taken from clinical information provided by ambulance staff who were mostly ambulance technicians as opposed to paramedics. This included an overview of the patient's complaints, condition and any clinical observations taken to enable the PHP to complete the triage tool. Ambulance crews continued to monitor patients and perform observations on the ambulance where patients could not be admitted to the department straight away. (Page 32) Processes were in place for medical staff to complete face to face reviews of patients waiting over 60 minutes on an ambulance, however, this was not fully implemented. The trust standard operating procedure (SOP) for management of reducing ambulance delays states patients who experience ambulance offload delays should be reviewed by a member of the ED medical team within one hour of arrival. During our inspection we did not observe this was routinely completed and ambulance staff commented this did not always take place. Following the inspection, the service sent us harm reviews of 17 patients who waited more than two hours on an ambulance. Only three of the reviews showed evidence the patients were reviewed on the ambulance by the emergency physician in charge (EPIC). In two cases, this was over an hour after arrival. Furthermore, the SOP stated patients with a NEWS score of five or above or any clinical condition which required prioritisation should be reviewed by medical staff on the ambulance within 30 minutes. During our inspection we saw a consultant review a patient on the ambulance where the NEWS score had increased and another where pain levels had worsened. However, we were not assured this process was fully implemented. For example, harm reviews showed one patient arrived at 19.53 with a National Early Warning Score (NEWS) score of five which deteriorated to a score of eight at 21.43. There was no evidence the patient had been reviewed by the consultant according to the harm review. The patient was seen by a doctor at 22.45 once offloaded from the ambulance. (Page 32-33) Whilst there were some concerns with patients not being physically reviewed by the PHP and medical staff whilst on ambulances, the service had improved its oversight and management of patients waiting on ambulances. Systems were in place to monitor patients. Patients were handed over in time order unless the clinical condition of the patient indicated otherwise. There was good communication between ambulance staff and PHP. We observed patients showing signs of deterioration being escalated and arrangements being made to re-prioritise for admission. For example, a patient who arrived and developed chest pain was immediately prioritised. (Page 33)
CQC2021-34	Urgent and 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.	Falls risk assessments were not completed routinely within the emergency department. However, staff told us they would be completed for patients at risk of falling. We identified five patients at risk of falling. Three had been in the department more than four hours yet did not have a falls risk assessment completed. This was escalated at the time and they were subsequently completed. Matrons monthly audits from April to September 2021 demonstrated variable compliance with falls risk assessments. In May 2021 75% falls risk assessments were completed and in June 2021 83%. Compliance had improved to 100% from July to September 2021. (Page 35 now Page 34) Patient notes were easily accessible but not always comprehensive. Nursing and medical staff had access to patients' paper and electronic records. Most sections of the casualty assessment were completed; however, the content was minimal and lacked detail of patients individualised needs. Risk assessments were not always completed for patients with specific needs. For example, we found falls and mental health risk assessments were not consistently used for patients who required them. Record were regularly updated to record two hourly care rounding, however, the content varied with lack of standardised approach to information recorded. (Page 40 now Page 39) Evidence that changes had been made as a result of feedback was variable. For example, managers told us they had introduced a ward handover document for staff to complete and document key information when handing patients over to wards. We reviewed six records of patients who had been transferred and these were completed. However, we were not assured learning from falls related incidents had been fully implemented as we observed three patients who were high risk of falling without a falls risk assessment and falls prevention practices in place. (Page 42 now Page 41)

CQC2021-35	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure deteriorating patients are identified and escalated in line with trust policy.	Furthermore, the SOP stated patients with a NEWS score of five or above or any clinical condition which required prioritisation should be reviewed by medical staff on the ambulance within 30 minutes. During our inspection we saw a consultant review a patient on the ambulance where the NEWS score had increased and another where pain levels had worsened. However, we were not assured this process was fully implemented. For example, harm reviews showed one patient arrived at 19.53 with a National Early Warning Score (NEWS) score of five which deteriorated to a score of eight at 21.43. There was no evidence the patient had been reviewed by the consultant according to the harm review. The patient was seen by a doctor at 22.45 once offloaded from the ambulance. Whilst there were some concerns with patients not being physically reviewed by the PHP and medical staff whilst on ambulances, the service had improved its oversight and management of patients waiting on ambulances. Systems were in place to monitor patients. Patients were handed over in time order unless the clinical condition of the patient indicated otherwise. There was good communication between ambulance staff and PHP. We observed patients showing signs of deterioration being escalated and arrangements being made to re-prioritise for admission. For example, a patient who arrived and developed chest pain was immediately prioritised. The PHP undertook hourly ambulance checks to review clinical observations taken by ambulance crew. This included reviewing signs of deterioration, pain assessments and comfort rounds. This was recorded in the patient casualty card. The PHP liaised with the nurse in charge (NIC) and EPIC to update on patients waiting, clinical condition and overview of NEWS. Two hourly safety huddles took place between the NIC and EPIC to review all patients in the department with input from the PHP. Harm reviews were completed where patients waited longer than two hours and rapid reviews for those waiting over four hours. Of the 17 patients waiting more than two hours on an ambulance on the days of our inspection, none had come to harm. Staff used a nationally recognised tool to identify deteriorating patients and generally escalated them appropriately. Patients were seen by a triage nurse for an initial assessment in time order, unless they presented with a red flag condition, such as suspected stroke or chest pain. A nationally recognised tool was used to triage patients which provided a risk rating of one to five. An emergency button was in the triage room used by the triage nurse if there was a clinical need for urgent prioritisation. If the patient required prioritisation but was stable a process was in place to escalate to doctors for immediate review. A consultant was located in the waiting room to ensure patients were streamed to the correct area and assisted the triage nurse in assessing patients. Clinically unwell patients were identified by a red/purple card system. We observed triage nurses escalating to the NIC and EPIC for medical review where there were concerns. The department used NEWS2 to identify acutely ill patients, which supported staff with the early recognition of deteriorating patients. NEWS we looked at during our inspection were generally completed on time and escalated and monitored in line with frequency rules. We saw where required they were escalated to the NIC and EPIC. For children and young people, the paediatric early warning score (PEWS) was used in conjunction with the paediatric observation priority score (POPS). All paediatric patient records we reviewed had observations recorded and monitored. (Page 34-35 now Page 33)
CQC2021-37	Urgent and 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.	The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses however, this was not always done in a timely manner. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, learning was not always fully implemented. When things went wrong, staff apologised and gave patients honest information and suitable support but not always in a timely manner. Managers ensured that actions from patient safety alerts were implemented and monitored. (Page 40) Staff raised concerns and reported incidents and near misses, but this was not always done within timescales outlined in trust policy. For example, we reviewed three serious incident reports and noted a delay in reporting. One was not reported for 31days following the incident, another for 18 days and another for six days. Staff told us they escalated incidents to the nurse or consultant in charge at the time. (Page 41) Incidents were not always investigated in a timely manner and there was a backlog of incidents requiring investigation. However, significant improvements had been made investigating the back log since our previous inspection in 2019 where there was a back log of over 1000 incidents. Managers told us this had reduced to approximately 140 at the time of the inspection and a plan was in place to continue to address the back log. (Page 41) However, we were not assured learning from falls related incidents had been fully implemented as we observed three patients who were high risk of falling without a falls risk assessment and falls prevention practices in place. (Page 41)
CQC2021-38	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure clinical pathways and policies are updated in line with national guidance.	Staff followed the most up to date policies to plan and deliver high quality care according to best practice and national guidance. However, policies were not always up to date. For example, the guideline for the assessment of acute chest pain was last reviewed in 2018 and was due to be reviewed in August 2021. We also identified the mental health risk assessment had not been updated to reflect changes with the footprint of the department and removal of the mental health room. This had a significant impact on the safe management of patients at risk of self harm. Whilst staff appeared to be aware of pathways, they could not always sign post us to where to find local guidelines. (Page 42)
CQC2021-41	Chidren and young people	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider all key services being available seven days a week.	Staff could call for support from doctors and other disciplines, including mental health services and some diagnostic tests, 24 hours a day, seven days a week. However, there were some tests such as ultrasound which were not always available at weekends. A business case was being formulated to move to seven-day service provision. (Page 108)
CQC2021-42	Chidren 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).	The trust did not routinely monitor or audit waiting times for children to have a medical review as per the Royal College of Paediatrics and Child Health (RCPCH). This meant the trust did not have full oversight or assurance against this measure. (Page 120)

CQC2021-43	Medical care (including older people's care)	Pilgrim Hospital	Core services inspe	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.	The trusts target for mandatory training was 90%, the average completion across all the courses for medical wards was 82%. Nursing staff received and kept up to date with their mandatory training. Face to face modules of mandatory training had been reduced during the pandemic. The division had a plan in place to increase this training as the pressure of the pandemic decreased. The trust aimed to be back to 90% by the end of November 2021. During the inspection, bank staff across the trust reported that they did not always feel supported with their mandatory training and having time to complete it. This was raised with the trust and they provided us with assurance that they were looking into mandatory training for bank staff and putting processes in place to support this. Medical staff received and kept up to date with their mandatory training. At the time of our inspection the completion rate for medical staff mandatory training across the medical wards was 85%. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included key areas relevant to emergency department staff such as: health and safety, fire safety, patient moving and handling, infection prevention and control, equality and diversity, information governance and basic life support. Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. Staff completed this training once every three years, the compliance rate for Mental Health awareness training at the time of our inspection was 90% and dementia awareness was 91%. At the time of our inspection the trust were in the process of starting training on learning disabilities and autism and hoped to have this started by December 2021. Managers monitored mandatory training and alerted staff when they needed to update their training. The trust had reports that could be collated to show compliance with mandatory training at different levels and this was monitored through the trust's governance structures. However, ward managers we spoke with would like 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. (Page 69)

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	15 March 2022
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2021/22 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **NHS and System People Plan Update** The Committee received the report noting the position as presented and the update offered in relation the priorities. The Committee would start to receive reports on assurance processes as delivery commenced. It was noted that a People Board would be in place supported by Executive Directors from each organisation that made up the Provider Collaborative. The Committee noted that involvement of both the Deputy Director of People and the Associate Director of HR/OD in supporting the system work and delivery of the People Plan. **Safer Staffing** The Committee received the regular monthly report noting that limited assurance was offered due to the continued staffing challenge. The Committee was advised that this was due to increased operational demand and the need to sustain staffing levels. There continued to be challenge due to vacancies and sickness with staffing diluted due to having a maximum number of beds open. The Committee noted that there had been reduced fill rates, particularly for Healthcare Support Workers noting that this could be correlated to the number of harms being seen in relation to falls. Whilst numbers had plateaued in March there had been some degree of harm for a small number of patients.

	There had been some increase in fill rates due to supernumerary staff moving out of this status. A number of mitigations were in place and actions taken to support the staffing position. **Establishment Review – ED** The Committee received the annual establishment review for the Emergency Departments which was based on an evidence based national model. The Committee noted the outcome of the review which would see an increase in the establishment and a change to working patterns to ensure appropriate staffing at the right times. The Committee noted that a consultation process would be undertaken as a result of the outcome of the review and whilst there was an investment required in respect of the budget line there would be an overall run rate saving. The Committee noted the positive feedback and engagement from staff as a result of the review and endorsed the paper to the Board.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Culture and Leadership Project Team Upward Report** The Committee received the upward report from the recent meeting noting that there had been a reset of the group and membership to ensure the level of those attending the meetings reflected decision making powers. The Group had considered and revised the terms of reference with the Committee offering suggestions on a number of revisions including additional clinical representation. The Committee noted the current activity underway and the intention to ensure that there was integration with other culture initiatives currently being undertaken within the Trust. **Equality, Diversity and Inclusion Group Upward Report** The Committee noted that the group had recommended in December 2021 and work was in progress regarding the Workforce Race Equality Standards delivery plan and EDI objectives. The Committee was advised that recommendations from the internal audit would also be captured within the delivery plan. It was noted that further work was required in relation to Equality Impact Assessments to empower staff to undertake these directly.

	The Committee noted that following the reports of racism against staff at the previous Committee meeting work was being carried out to review incident reports, staff survey results and anecdotal feedback in order to ensure that this was addressed appropriately. The Committee endorsed the view offered by the Chief Executive at the recent Trust Board meeting of the firm commitment to a zero-tolerance approach however recognised further work was required. The Committee would hold the Trust Executive to account to ensure delivery of this approach.
	Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Education Centre Update** The Committee were pleased to note that the Education Centre had successfully opened on time with positive feedback being received from all those attending including students.
	Assurance in respect of other areas: **QGC Referral – Savile Action Plan** The Committee received the referral from the Quality Governance Committee in respect of the Savile Action Plan noting the items being referred under the People agenda. The Committee noted the review of the gap analysis had been undertaken and the progress that had been made on previous actions identified. There were a number of actions that remained amber and were the responsibility of the Committee which remained on track however were not complete. The Committee noted that the main action related to Disclosure and Barring System (DBS) checks with an update due to be received by the Committee in April. The Committee noted the actions and were grateful to the Quality Governance Committee for oversight of the plan noting that some items remained ongoing and updates would be received on a quarterly basis. **Annual Report – Committee Effectiveness** The Committee received the final annual report which had been updated to reflect comments offered by Committee members. The Committee approved the report which would be presented to the Trust Board.

People Directorate Update – Leadership overview and priorities
The Committee received the update noting that both parts 1 and 2 were now combined and being presented.

The review of sub-groups had been completed with a draft report produced with the Committee anticipating that this would be received by the Committee in April.

The Committee noted the improvement in the metrics being presented and the baseline that was developing as a result. The information presented would develop into a dashboard offering headlines with the Committee approving the proposed metrics.

The Committee noted the updates provided in relation to themes presented reflecting that there would be benefit in holding a Board Development Session to appraise all Board members of the current and future activity of the Directorate.

Committee Performance Dashboard
The Committee received the report noting the positive direction of travel in the metrics reported.

The sickness rate was remaining steady with the Committee being advised that the Trust was on par nationally and lower than other acute Trusts in the region. The position was noted in respect of the activity undertaken to fully utilise the recruitment system to support improvement in processes and support onboarding of new starters to the Trust.

The Committee noted the benefit in providing previous data to offer trend and trajectory information however recognised that the dashboard remained in development.

PRM Upward Report
The Committee received the report noting the new format and that there were no items for escalation.

Topical, Legal and Regulatory Update
The Committee received the reporting noting that this offered a helpful update to members on current items for awareness.

Integrated Improvement Plan
The Committee received the report noting the position as reported for January 2022 and recognising that discussions would take place in respect of the 2022/23 IIP at the next Board Development Session.

Board Assurance Framework
The Committee noted the updates offered recognising that discussions held by the Committee had not impacted on the assurance ratings being provided.

	It was anticipated that the re-introduction of the sub-groups to the Committee would see greater assurances being offered to the Committee resulting in positive movement of the assurance ratings in due course.
Issues where assurance remains outstanding for escalation to the Board	No items
Items referred to other Committees for Assurance	No items referred
Committee Review of corporate risk register	The committee received the risk register noting the current risks presented noting that further review of the risks would be undertaken through the confirm and challenge sessions being held.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	No areas identified
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

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

United Lincolnshire Hospitals NHS Trust

Annual Report to the Trust Board from the People and Organisational Development Committee 2021/22

ROLE OF THE COMMITTEE

In 2021/22, in line with all other Committees of the Board, the Terms of Reference were reviewed and amended. Under the agreed terms of reference the People and Organisational Development Committee was tasked as follows:

The People and Organisational Development Committee will:

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

A modern and progressive workforce:

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

Making ULHT the best place to work

- Address the concerns around equity of treatment and opportunity within ULHT, so that the Trust is seen to be an inclusive and fair organisation

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

To Become a University Teaching Hospital

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

MEETINGS

The Committee met monthly during the year, with the exception of August and September 2021 where the Committee did not meet during the transition period of the new Non-Executive Chair and Accountable Executive Director for People and Organisational Development.

Due to the Trust continuing to respond to the Covid-19 pandemic and subsequent operational pressures the Committee, at times, to support the delivery of patient care worked to a reduced agenda and length of meeting during 2021/22.

After each meeting held an assurance report was provided to the Trust Board. An update report was provided to the Trust Board, in place of an assurance report, from the Accountable Executive Director for People and Organisational Development in respect of August and September 2021 to ensure that the Board remained sighted on the position.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2021/22 the Committee was chaired by Mr Geoff Hayward until

the end of his tenure on 22 July 2021 and was chaired by Professor Philip Baker for the remainder of 2021/22 upon commencement in post on 23 July 2021.

Details of the Committee's membership and attendance during 2021/22 is set out below:

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

Members	**22 Apr 2021**	**12 May 2021**	**16 June 2021**	**14 July 2021**	**Aug 2021**	**Sept 2021**	**13 Oct 2021**	**16 Nov 2021**	**14 Dec 2021**	**11 Jan 2022**	**15 Feb 2022**	**15 Mar 2022**
Non-Exec Director Philip Baker (Chair)					Committee meeting not held		X	X	X	X		
Non-Executive Director, Geoffrey Hayward	A	X	X	X								
Non-Executive Director (Mrs Dunnett)	X	X (Chair)	X	X			X	X	X	X		
Director of People & Organisational Development	X	X	X	X			X	X	X	X		
Medical Director	A	X	D	D			X	X	X	X		
Director of Nursing	X	A	X	D			X	X	X	X		

A denotes Apologies given
D denotes Deputy in attendance
C Director supporting response to Covid-19

REVIEW OF BUSINESS

The People and Organisational Development Committee's work programme for 2021/22 is set out as an appendix to this report.

The People and Organisational Development Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2021/22:

- Objective 2a A modern and progressive workforce working as 'One Team'
- Objective 2b Making ULHT the best place to work
- Objective 4b To become a University Hospitals Teaching Trust

During 2021/22 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. The strategic objectives at the beginning of the year were rated as follows:

Objective 2a – **AMBER**
Objective 2b – **RED**
Objective 4b – **RED**

The Committee took the decision in October 2021 to revise the assurance ratings in the Board Assurance Framework.

All ratings were moved to red with the recognition that this was not a deterioration but rather a reflection of the current position. The Committee, whilst down rating the assurances were clear on the significant progress that was being made. At the end of the year the strategic objectives were rated as follows:

Objective 2a – **RED**
Objective 2b – **RED**
Objective 4b – **RED**

OVERVIEW

The People and Organisational Development Committee has continued to, over the last twelve months, offer a level of assurance to the Board on people and organisational development. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan as defined by the terms of reference, through this annual report.

The work programme for the Committee has focused on the continued workforce challenges faced by the Trust including the impact on the workforce due to the Covid-19 pandemic. The Committee has, since recommencing meetings in October 2021, under new chairmanship and Executive Leadership, strengthened reporting to the Committee and is further developing the governance structures and subgroup reporting.

The Committee has been well attended by members throughout the year despite Covid-19 and operational pressures that have been experienced. The Chair has

been actively involved in the agenda setting alongside the Director of People and Organisational Development.

Other key areas of focus of the Committee have included:

- Freedom to Speak Up
- Guardians of Safe Working
- Safer Staffing
- International Recruitment
- Covid-19 vaccination programme
- Medical School
- University Hospital Teaching Status
- Culture and Leadership Programme

The Committee has recognised that the ability of the Trust to make progress against the “people” objective of the Integrated Improvement Plan has continued to be impacted by the Covid-19 pandemic and subsequent operational pressures that have been experienced by the Trust.

The Committee has refocused since October 2021 under the new leadership, both Non-Executive and Executive, in order to review assurances received and offered to the Board through upward reports and the Board Assurance Framework.

During the year 2021/22 the Committee continued to have focus on staff wellbeing and the health and wellbeing offer in place to support staff. The Committee were pleased to receive reports relating to the Culture and Leadership Programme that would support staff and the organisation to further develop improved leadership behaviours.

The Committee recognised however that there had been an impact on the delivery of the programme due to Covid-19 and was keen that a revision of the terms of refence of the group and objectives of the project be revisited to offer clear direction of the programme.

The appointment of a full time Freedom to Speak Up Guardian had been welcomed by the Committee and an impact was being seen as a result of the appointment. The Committee received quarterly reports noting the action plan in place with support from NHS England/Improvement.

The Committee were concerned in relation to the action plans in respect of the Workforce Race Equality Standards and Workforce Disability Equality Standards noting the requirement for improvement.

The Equality, Diversity and Inclusion Group, as a subgroup of the Committee reviewed its terms of reference and revisited the priorities in order to refocus and strengthen activities.

Risks

The BAF and Corporate risk register have been reviewed at the committee on a monthly basis identifying where updates have been required based on assurances received at the Committee.

The Committee noted the review and revision of the risk register reporting and noted the future intentions of risk reporting within the body of reports to the Committee.

Performance Review

The Committee reviews performance against the agreed Key Performance Indicators (KPIs) and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover a modern and progressive workforce and making ULHT the best place to work. The metrics presented to the report have been reviewed to ensure that the information presented offers a clear position on the performance of the Trust.

At each of the meetings held during 2021/22 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

Discussions were held in relation to safer staffing where assurance continued to be offered that there was no correlation between staffing levels and patient harm. The Committee noted that ongoing triangulation of nursing and quality metrics to ensure the quality of care being offered to patients.

The Committee were pleased with the progress of the Nursing Workforce Transformation Programme and the securing of funding from NHS England/Improvement that would continue to support a sustainable plan for the Trust.

The Committee requested, in addition to reporting of safer staffing for nursing and midwifery, that this be extended to other staff groups including Allied Health Professionals, Medical Staff and non-clinical staff. The Committee noted that this work would progress over the coming year.

In the year there had been successful recruitment of 150 Healthcare Support Workers to the System with the majority of these appointments being to the Trust.

The Committee were appraised of the position in relation to the Vaccination as a Condition of Deployment and received updates on the number of staff vaccinated. The Committee noted the action that had been put in place to fulfil the requirements however noted the change in requirements following Government announcements. The Committee and Trust continued to promote and encourage vaccination of staff against Covid-19.

The People and Organisational Development Committee is an essential element of the Trust's corporate governance structure. It works closely with the Audit Committee and the Chair of the People and Organisational Development Committee is a member of the Audit Committee, which helps provide additional assurance on the adequacy of the Trusts workforce. The Committee received all internal audits relevant to its remit for consideration of the actions and oversight of the completion of these.

United Lincolnshire Hospitals NHS Trust

United Lincolnshire Hospitals NHS Trust

People and Organisational Development Committee Forward Reporting Schedule 2021/22

				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Agenda Item	**Oversight Group****	**Executive Lead**	**Lead for Reports**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Business Items															
Committee Self Assessment		Trust Secretary	Deputy Trust Secretary										X		
Annual Report - Committee Effectiveness		Trust Secretary	Deputy Trust Secretary										X (draft)		X
Review of Committee Terms of Reference		Trust Secretary	Deputy Trust Secretary	X (Final)							x				X (Draft)
Review of Forward Reporting Schedule		Trust Secretary	Deputy Trust Secretary	X (Final)							X				X (Draft)
Reporting Group Terms of Reference and Forward Reporting Schedules		Director of People and Organisational Development	Deputy Director of Human Resources	X (Final)							X				X (Draft)
Committee (People) Performance Dashboard to inc. Executive Scorecard		Director of People and Organisational Development	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Topical, legal and regulatory update		Trust Secretary	Deputy Trust Secretary			X			X			X			X
Committee Development Session		Trust Secretary	Deputy Trust Secretary						X						
Integrated Improvement Plan		Director of Improvement and Integration	Programme Manager	X	X	X	X	X	X	X	X	X	X	X	X
Matters Referred															
Matter referred by Trust Board or other Board Sub-Committees		Trust Secretary	Deputy Trust Secretary	**To be added to the agenda as required**											
Risk and Assurance															
Board Assurance Framework		Trust Secretary	Deputy Trust Secretary	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Report		Director of People and Organisational Development	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Review of relevant external reports/inquiries including CQC (As Required)		Trust Secretary / Director of People and Organisational Development / Medical Director	Deputy Trust Secretary / Director of People and Organisational Development / Medical Director	X	X	X	X	X	X	X	X	X	X	X	X
Review of relevant internal & external audit reports		Trust Secretary	Deputy Trust Secretary	**To be added to the agenda as required**											
Strategic Objective 2 - To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT															
Objective 2a - A modern and progressive workforce															
Vacancy Rates	CPD	Director of People and Organisational Development	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Turnover Rates	CPD	Director of People and Organisational Development	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Rates of appraisal/mandatory training compliance	CPD	Director of People and Organisational Development	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Job Planning - % complete	CPD	Director of People and Organisational Development	Deputy Director of Human Resources	X	X	X	X	X	X	X	X	X	X	X	X
Learning days per staff member	CPD	Director of People and Organisational Development	Head of Organisational Development	**Data not yet available - reporting to commence 2022/23**											
Sickness/absence data	CPD	Director of People and Organisational Development	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Staff Survey feedback	WSG	Director of People and Organisational Development	Head of Organisational Development						X				X		X
NHS and System People Plan update	WSG	Director of People and Organisational Development	Director of People and Organisational Development			X			X			X			X
Safer Staffing		Director of Nursing	Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Ward Establishment Review		Director of Nursing	Director of Nursing					X						X	X
Medical Engagement Development Plan		Medical Director	Head of Organisational Development						X						
Submission to NHSE/I - Workforce Plan and numbers	WSG	Director of People and Organisational Development	Deputy Director of Human Resources								X				X
Eduction Funding		Director of People and Organisational Development	Organisational Development Lead for Education										X		
Objective 2b - Making ULHT the best place to work															
WRES Annual Report	EDIG	Director of People and Organisational Development	Equality, Diversity and Inclusion Lead					X							
WDES Annual Report	EDIG	Director of People and Organisational Development	Equality, Diversity and Inclusion Lead					X							
EDI Annual Report	EDIG	Director of People and Organisational Development	Equality, Diversity and Inclusion Lead					X							
National Staff Survey Feedback	WSG	Director of People and Organisational Development	Head of Organisational Development						X				X		X
Pulse Survey feedback	WSG	Director of People and Organisational Development	Head of Organisational Development	X			X		X						
Number of Schwartz Rounds completed		Medical Director	Medical Director												
Employee Relations Activity	CPD	Director of People and Organisational Development	Head of HR Operations			X			X			X			X
Guardians of Safe Working		Medical Director	Guardian of Safe Working		X	X Annual Report		X			X			X	
Freedom to Speak Up		Chief Executive	Freedom to Speak Up Guardian	X			X				X		X		
GMC Junior Doctor Survey Update		Medical Director	Organisational Development Lead	X			X			X			X		
Objective 4b - To become a University Hospitals Teaching Trust															
Medical School update		Medical Director	Assistant Director of Education			X			X			X			X
Numbers of clinical academic posts	UTHG	Medical Director							X						
Research, Development and Innovation**	RIGG	Medical Director	Head of Research and Innovation	X			X			X			X		
GMC Training Survey		Medical Director	Medical Director												
Medical Revalidation		Medical Director	Medical Director				X								
University Hospitals Status application**	UTHG	Director of Improvement and Integration	Director of Improvement and Integration												
Upward Highlight / Exception Reports from Groups reporting to the Committee (including any identified areas of focus for 2021/22)*:**															
Research and Innovation Governance Group	RIGG	Medical Director	Head of Research and Innovation		X		X		X		X		X		X
Culture and Leadership Project Team	CLPT	Chief Executive	Programme Lead - Culture and Leadership	X	X	X	X	X	X	X	X	X	X	X	X
University Teaching Hospital	UTHG	Director of Improvement and Integration	Clinical Strategy Manager	X			X			X	X	X	X	X	X
Equality, Diversity and Inclusion Group	EDIG	Chief Executive	Equality, Diversity and Inclusion Lead	**Meeting not being held due to Covid-19**						X			X		
Reporting from Divisions:															
PRM Upward Report		Director of Finance	Head of Information	X	X	X	X	X	X	X	X	X	X	X	X
Notes:															
In some instances reporting and assurance to P&OD will happen via the oversight group upward reports. Where appropriate, reports submitted directly to P&OD will however have been considered and be supported by the upward report from the relevant oversight sub-group; specifically key highlights and any required escalations. This will help to avoid duplication of discussion and actions															
****Where relevant the upward reports from reporting sub-groups will be aligned on the agenda to the relevant strategic objective supporting both the flow of the meeting and supporting the process of triangulation and assurance***															

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	5 April 2022
Item Number	*Item 9.2*

National NHS Staff Survey 2021 Final Results and Next Steps

Accountable Director	*Paul Matthew, Executive Director for Finance, Digital, People & OD*
Presented by	*Paul Matthew, Executive Director for Finance, Digital, People & OD*
Author(s)	*Sarah Akhtar, Associate Director for OD, Wellbeing and Inclusion*
Report previously considered at	

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

Risk Assessment	*Risk no. 4667*
Financial Impact Assessment	*Costs to be determined (recommendations if accepted will need to be costed individually)*
Quality Impact Assessment	*Not applicable*
Equality Impact Assessment	*Not applicable*
Assurance Level Assessment	*Insert assurance level* • Moderate
Recommendations/ Decision Required	Trust Board are requested to: 1. Review final National NHS Staff Survey (NNSS) 2021 results for ULHT 2. Note the headline results for ULHT 3. Give support to future direction, recommendations and proposed next steps for NNSS

Executive Summary
As detailed below

United Lincolnshire Hospitals NHS Trust

TRUST BOARD

NATIONAL NHS STAFF SURVEY (NNSS) 2021
Final Results and Analysis

March 24 2022

EXECUTIVE SUMMARY

This paper contains United Lincolnshire Hospitals Trust (ULHT) results for the 2021 NHS Staff Survey. The results are benchmarked against 'acute and acute community Trusts' (126) and are presented in the context of the best, average and worst results for this group or classification. The 'data' is 'weighted' to allow for fair comparisons between organisations and 'historical' results are also provided where possible (from 2017).

For note:

- All results are subject to a strictly enforced embargo until the official publication date of Wednesday 30 March 2022
- See also appendix one

1. How the NHS Staff Survey results are reported in 2021

For 2021 the Staff Survey questions have been aligned to the People Promise. The 'Promise' sets out, in the words of NHS staff, the areas that would most improve their working experience and consists of the following seven elements:

1. We are compassionate and inclusive
2. We are recognised and rewarded
3. We each have a voice that counts
4. We are safe and healthy
5. We are always learning
6. We work flexibly
7. We are a team

The results of this year's NHS Staff Survey are measured against the seven People Promise elements and two previously reported themes: Staff Engagement and Morale. The reporting also includes new sub-scores, which feed into the People Promise elements and themes (see appendix two).

A further and significant change to the way the NHS Staff Survey results in 2021, is staff have been asked three (see below) 'classification' questions relating to their experience during the Covid-19 pandemic.

1. *Have you worked on a Covid-19 specific ward/area at any time? Y/N*
2. *Have you been re-deployed due to Covid-19 at any time? Y/N*
3. *Have you been required to work remotely/from home during the Covid-19 pandemic? Y/N*

See appendix three.

2. Prioritising the NHS Staff Survey

The NHS Staff Survey is a mechanism for understanding and improving the lived experience of staff working in the NHS. The results give important insights about ways of working, the culture and the overall 'health' of an organisation.

Further to the NHS ambitions to create an inclusive culture and improve the experience of BAME and disabled staff working in the NHS, the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES)** were introduced as requirements for NHS organisations.

The NHS Staff Survey findings demonstrates progress against both of these standards and further evidences the primacy of the NHS Staff Survey.

3. An Overview of ULH NHS Staff Survey 2021 Results

1. ULHT organisational scores for three of the People Promise elements are also the worst for acute /acute community trusts in 2021. These are as follows:

- Promise element 1: We are compassionate and inclusive
- Promise element 3: We each have a voice that counts
- Promise element 7: We are a team

2. ULHT scores for Staff Engagement and Morale themes, are classified as the 'worst' in 2021 for acute/acute community Trusts, and both have declined (albeit very slightly) since 2020. Both Friends and Family Test Scores have declined since 2020 and both are classified as being the 'worst' for acute Trusts in 2021. The score for ULHT prioritising the 'care of patients' has also declined since last year (see appendix one).

3. ULHT participation with the 2021 NHS Staff Survey stands at 49% (3% higher than the median average for acute trusts). The survey results provide an 'indication' of how things are at ULHT and therefore need to be reviewed more deeply understand the context of this year's results and any further issues.

4. There is evidence of 'good' and 'exemplar' practice - the issue is that it exists in 'pockets' (the recent Well-Led review is evidence of this). The challenge and indeed the opportunity that exists for ULHT, is to create a culture which reinforces the positive. What this means is recognising (more) practices and behaviours which are positive as well as the behaviours which do not align to ULHT values.

5. The results of the Staff Survey (for several years) suggests ULHT values are not being lived and are perhaps not as meaningful as they once were. The absence of 'values based' processes to recruit, induct, develop and manage staff is also likely to have contributed to this. There is an opportunity therefore to 'reset' ULHT values through a process of engagement with stakeholders.

6. Whole systems approach to improving ULHT culture is key. What this means is bringing key programmes together and using the combined efforts of these projects to tackle different elements of ULHT culture. For example, a 'safe' culture depends upon inclusive and comapssionate leadeship. This will also limit duplication of effort and foster better team working.

7. Leaders influence all aspects of organisational life and have a huge role in driving cultural change (NHS Staff Survey is evidence of this). The aim therefore is to equip leaders and managers with the skills, confidence and resilience to lead and manage effectively, and not 'blame'.

8. Ambition is to achieve a positive trajectory in key areas of the 2022 NHS Staff Survey.

9. Balance between localised activity as well as corporate/big ticket action is important. What this means is true accountability and commitment from senior ULHT Divisional leadership teams to listen, understand and address concerns (through action) that are in their gift to change.

10. The issues now sighted are not new and have probably existed for a while. What the pandemic has done is highlight areas of no/limited resilience, poor staff facilities in some areas, out of date work practices and poor behaviours.

4. Further analysis – 'Worst' Promise elements for acute/community acute trusts

The following is an analysis of the questions and results that make up ULHT 'worst' Promise elements (1,3 and 7). This information provides a further insight into the behaviours and practices which have contributed to ULHT overall scores for these areas, and more importantly begin to highlight the opportunities for improvement.

Promise element 1: We are compassionate and inclusive

			2020	2021	+/-	Best	Av.	Worst
Compassionate culture	6a	I feel that my role makes a difference to patients / service users	-	85%	-	93%	88%	83%
	21a	Care of patients / service users is my organisation's top priority	66%	62%	- 4	89%	76%	59%
	21b	My organisation acts on concerns raised by patients / service users	60%	55%	- 5	86%	71%	55%
	21c	Recommend my organisation as a place to work	47%	39%	- 8	78%	58%	39%
	21d	If a friend or relative needed treatment I would be happy with the standard of care provided	50%	44%	- 6	90%	67%	44%
Compassionate leadership	9f	Immediate manager work together with me to understand problems	NEW	58%	-	75%	65%	58%
	9g	Immediate manager interested in listening when I describe challenges	NEW	61.2 %	-	76%	68%	60.9%
	9h	Immediate manager cares about my concerns	NEW	60%	-	77%	67%	60%
	9i	Immediate manager takes action to help with problems	NEW	55%	-	74%	63%	55%
Diversity and Equality	15	Acts fairly with regard to career progression / promotion, regardless of ethnicity, gender, religion, sexual orientation, disability or age	53%	51%	- 2	70%	56%	44%
	16a	Last 12months experienced discrimination from patients/relatives/members of the public	5%	7%	+2	3%	7%	15%
	16b	Last 12months experienced discrimination from manager or colleagues	9%	10%	+1	5%	9%	17%
	18	ULH respects individual difference	NEW	58%	-	83%	69%	56%
Inclusion	7h	Feel valued by team	NEW	62%	-	77%	68%	62%
	7i	Feel attachment to my team	NEW	61%	-	71%	64%	58%
	8b	People I work with are understanding and kind	NEW	63%	-	78%	69%	62%
	8c	People I work with are polite and respectful	NEW	63%	-	79%	70%	63%

Overview for People Promise Element 1 – 'we are compassionate and inclusive'

1. Five out of the six questions asked for 'compassionate culture' have declined since 2020, and three are rated as the 'worst' for the acute sector. These results suggest a low level of 'advocacy', trust and pride in working for ULH. There also appears to be a belief or perception that patient concerns are unlikely to be acted on and patient care is not a priority for ULH.

2. Two out of the four 'Inclusion' sub-scores are the worst for this group (feeling valued and respected). These scores also indicate in some areas staff are behaving poorly towards peers/colleagues and are not respectful. Only six out of ten staff participating in the survey, feel valued which is concerning and may contribute to feelings of isolation and ill-feeling.

3. Cases of discrimination appear to be increasing amongst staff participating with the Staff Survey and the Trust is perceved as not acting fairly with regards progression which is not a good sign.

4. Leadership features a great deal in this Promise and of the four questions asked, three scores rate as being the worst for acute trusts.

Recommendations (next 6-12 months):

1. Ensure leaders and managers (all staff groups and grades) are clear what ULHT expects from its leaders. There needs to be adequate support and investment in leaders and we need to ensure ULHT values are instrumental in the management, development and recruitment/promotion of leaders and managers.

2. ULHT commitment and high regard for inclusion and equality of opportunity are important priorities and should manifest in the lived experience of staff working at ULHT. Furthermore, the results appear to demonstrate that compassion, kindness and respect are lacking and raises an important question about the meaningfulness of ULHT values and staff's confidence in 'calling out' poor behaviour.

3. Strained, difficult and distant relationships between line managers and team reports as well as colleagues will make engagement and the management of performance and well-being (for all parties) almost untenable. The absence of regular 1:1, appraisal and team meetings to facilitate a regular dialogue between individuals will not help matters and needs prioritising.

ACTION 1: prioritise leadership interventions, i.e. leadership events, training in essential 'management' skills/techniques; as well as development which focuses on reflective practice and building self- awareness. A further element is to ensure leaders appreciate the role they play in creating a safe and inclusive culture.

ACTION 2: as a starting point, use staff and patient stories to hold a mirror up the organisation and engage staff in resetting ULHT organisational values (large-scale OD/staff engagement activity to target and engage between 5-10% of ULHT workforce).

ACTION 3: comprehensive overhaul and reset of appraisal for Agenda for Change staff (compliance reporting, incremental progression and responsibilities for both line manager and direct report).

Promise element 3: We each have a voice that counts

			2020	2021	+/-	Best	Av.	Worst
Autonomy and control	3a	I always know what my responsibilities are	82%	83%	+1	92%	86%	82%
	3b	I am trusted to do my job	88%	89%	+1	94%	91%	87%
	3c	Frequent opportunities to show initiative in my role	65%	66%	+1	79%	72%	65.6%
	3d	I am able to make suggestions to improve the work of my team	65%	63%	- 2	79%	70%	63%
	3e	I am involved in deciding changes that affect my team	41%	41%	-	56%	49%	41%
	3f	I am able to make improvements happen in my area of work	45%	45%	-	61%	53%	44%
	5b	I have a choice in deciding how I do my work	47%	47%	-	60%	52%	44%
Raising concerns	17a	I feel secure raising concerns about unsafe clinical practice	67%	66%	- 1	83%	74%	66%
	17b	I am confident my organisation would address my concern	47%	44%	- 3	76%	58%	44%
	21e	I feel safe speaking up about anything that concerns me in this organisation	54%	48%	- 6	75%	61%	48%
	21f	If I spoke up I am confident my organisation would address my concern	-	32%	-	67%	48%	32%

Overview for People Promise Element 3 – 'we each have a voice that counts'

1. Although not near enough to the average for acute Trusts, questions related to clarity of role, trust and intiative have improved since 2020, albeit very slightly. Important therefore to build on this through engagement and action.

2. The engagement elements of autonomy and control are lacking and perhaps relate to the absence of meaningful and regular 1:1 discussions which allow the opportunity for ideas and decsions to be discussed.

3. All questions and scores related to the raising and actioning of concerns have declined since 2020 and ULHT scores are the worst for the acute sector. The results mirror staff perception that concerns raised by patients are unlikely to be actioned or addressed by the Trust and care is viewed as a priority.

Recommendations (next 6-12 months):

ULHT commitment and high regard for patient care and safety are important priorities which need to resonate with staff. The results suggest this is not the case and we need to find out why as well as what the blocks are so that these can be addressed quickly.

ACTION 4: use the work now underway to improve ULHT 'culture' (safe culture programme, Freedom to Speak Up, leadership development), to highlight the responsibilities leaders and staff have in building a safe, respectful and inclusive culture which values the contribution of all staff.

ACTION 5: consider what opportunities might exist for engaging staff in improving patient care, ways of working, quality improvement i.e. using ULHT Integrated Improvement Plan (IIP) as a platform for engaging and empowering staff in improving patient care and services.

Promise element 7: We are a team

			2020	2021	+/-	Best	Av.	Worst
Team-working	7a	The team I work in has shared objectives	65%	67%	+2	80%	72%	67%
	7b	My team meet often to discuss their effectiveness	47%	48%	+1	64%	56%	44%
	7c	I receive the respect I deserve from colleagues	63%	62%	- 1	78%	70%	62%
	7d	Team member's understand each other's role	NEW	66.6%	-	81%	71%	66.1%
	7e	I enjoy working with colleagues in my team	NEW	78%	-	88%	81%	75%
	7f	My team has freedom in how to do its work	NEW	48%	-	68%	57%	48%
	7g	In my team disagreements are dealt with constructively	NEW	48%	-	65%	55%	48%
	8a	Teams at ULHT work well together to achieve organisations	NEW	39%	-	71%	52%	39%
Line management	9a	My immediate manager encourages me at work	61%	62%	+1	78%	69%	62%
	9b	My immediate manager gives me clear feedback on my work	51%	53%	+2	71%	61%	53%
	9c	My immediate manager asks for my opinion before making decisions	45%	48%	+3	65%	56%	48%
	9d	My immediate manager takes a positive interest in my health and wellbeing	62%	60%	- 2	75%	66%	59%

Overview for People Promise Element 7 – 'we are a team'

1. Five out of the eight questions asked for 'team working' rate as the worst for the acute sector; team cohesion, absence of team objectives, respect and autonomy being the main issues. The results suggest lack of direction, silo working and poor team relationships – and all depend greatly on leadership.

2. Three of the four questions asked for 'line management' are again the worst for the acute sector, although have increased slightly since last year. Again important for this to be developed and built on.

3. The final question relating to wellbeing indicates line managers perhaps not feeling accountable for this responsibility and/or lacking confidence in exploring this topic with line reports.

Recommendations (next 6-12 months):

Ensure leaders and managers (all staff groups and grades) are clear what ULHT expects from its leaders. There needs to be adequate support and investment in leaders and we need to ensure leaders are clear on line management responsibilities (1:1, appraisal etc).

ACTION 6: increased emphasis upon local/divisional action planning to raise profile of local leaders and ensure local level actions are addressed quickly

ACTION 7: employee assistance programme

5. Summary of key points

1. The results of the Staff Survey indicate the Trust has not prioritised the findings of the NHS Staff Survey for quite some time. The issues now sighted are not new and have probably existed for a while. What the pandemic has done is highlight areas of no/limited resilience, out of date work practices, poor systems and behaviours.

2. The NHS Staff Survey highlights the areas that make up 'organisational life' and is good/effective way to measure/monitor organisational culture.

3. The results indicates a lack of compassion and respect between colleagues, and for staff that identify as being 'different' working life will likely be difficult.

4. Ample opportunity to improve and take action on areas where there has been minimal investment and progress.

5. Going forward, developmental activities/actions should not be longer be halted because of operational pressures.

6. Aim is for a positive trajectory and some improvement in key areas in 2022 NHS Staff Survey.

7. Balance between localised activity as well as corporate/big ticket action is important. What this means is not just plans, but true accountability and commitment from senior ULHT Divisional leadership teams to listen, understand and address the concerns that are in their gift to change.

8. Responsibility to improve sits across several areas of the Trust and across all levels, including frontline colleagues.

APPENDIX ONE: NHS Staff Survey Headline Results 2021

a. Response rate:

2019	2020	2021	Median response	+/-
46%	51%	49%*	**46%**	**+3**

*4053 out of 8249 staff

b. Friends and Family Test Scores and Care as a Priority for ULHT

	2020	2021	+/-	Best	Average	Worst
Q21c. Would recommend organisation as place to work	47%	39%	**-8**	78%	58%	39%
Q21d. Friend/relative needed treatment would be happy with care provided	50%	44%	**-6**	90%	67%	44%
Q21a. Care of patients is organisation's top priority	66%	62%	**-4**	89%	75%	59%

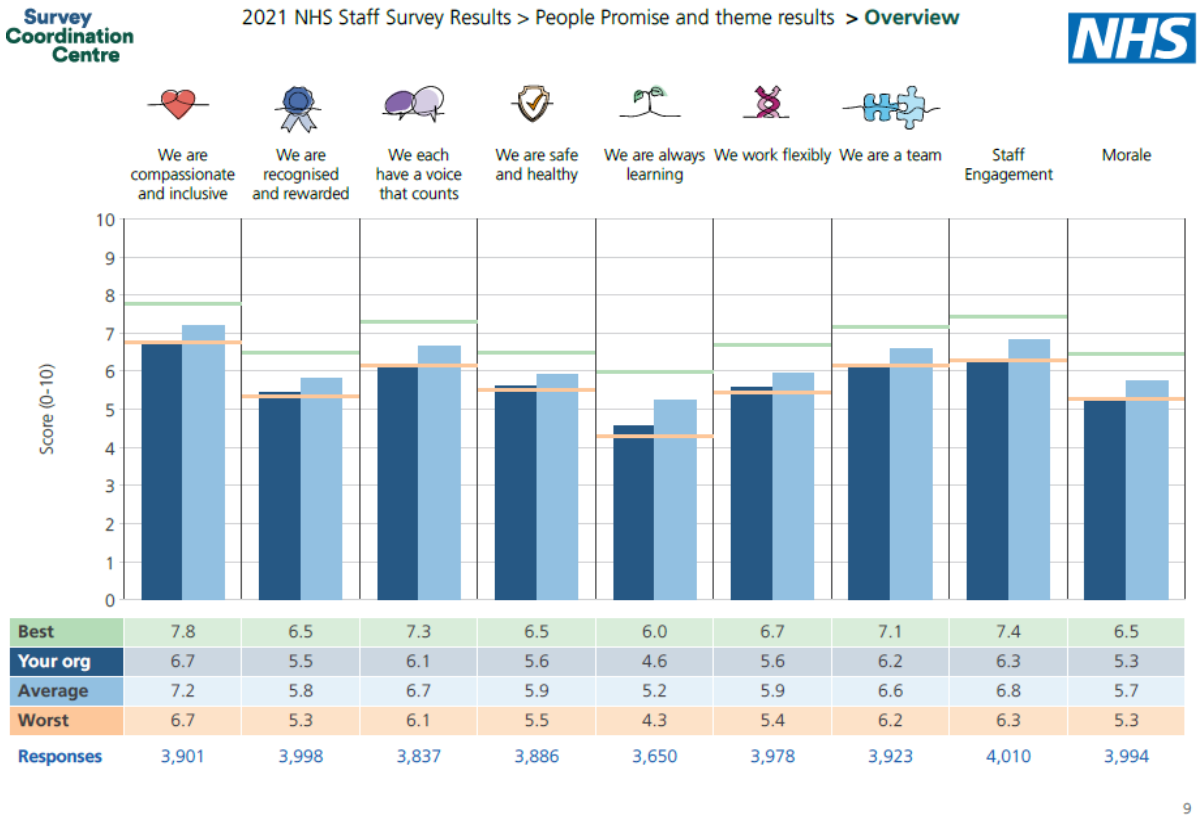
c. Staff Engagement Score (out of 10)

2020	2021	+/-	Best	Average	Worst
6.4	6.3	- 0.1	7.4	6.8	6.3

d. Morale (out of 10)

2020	2021	+/-	Best	Average	Worst
5.5	5.3	- 0.2	6.5	5.7	5.3

e. People Promise: Overview



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	6.7	5.5	6.1	5.6	4.6	5.6	6.2	6.3	5.3
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,901	3,998	3,837	3,886	3,650	3,978	3,923	4,010	3,994

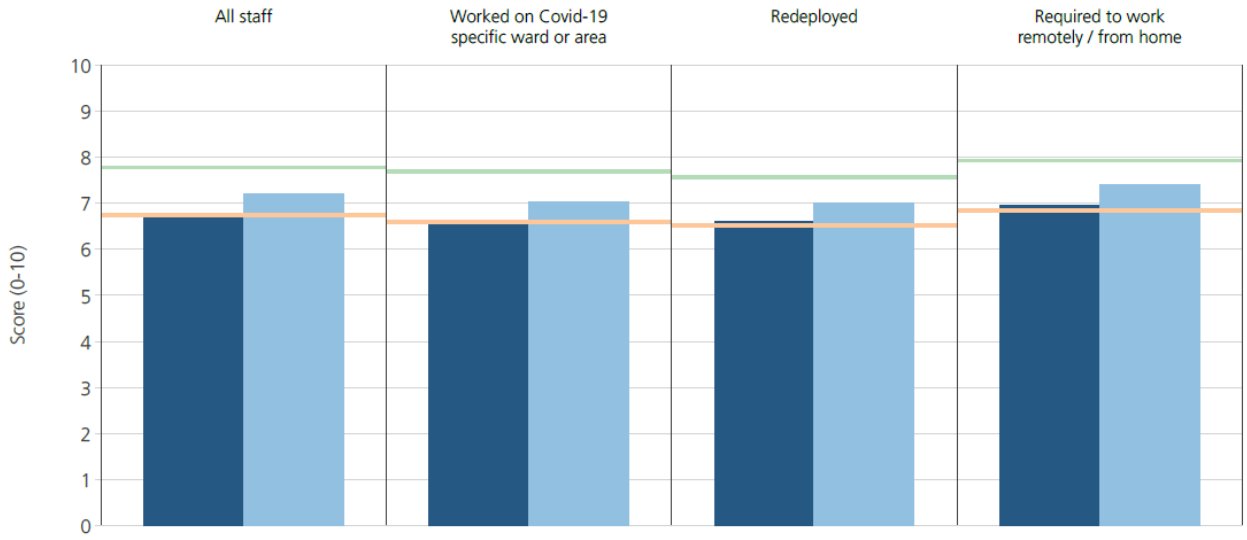
9

APPENDIX TWO: People Promise Elements and Themes

People Promise Theme	Sub-scores
1. We are **compassionate and inclusive**	Compassionate Culture Compassionate leadership Diversity and equality Inclusion
2. We are **recognised and rewarded**	
3. We each have a **voice that counts**	Autonomy Raising concerns
4. We are **safe and healthy**	Health and safety climate Burnout Negative experiences
5. We are always **learning**	Development Appraisals
6. We **work flexibly**	Support for work-life balance Flexible working
7. We are a **team**	Team-working Line management
Theme	
1. Staff Engagement	Motivation Involvement Advocacy
2. Morale	Thinking about leaving Work pressure Stressors

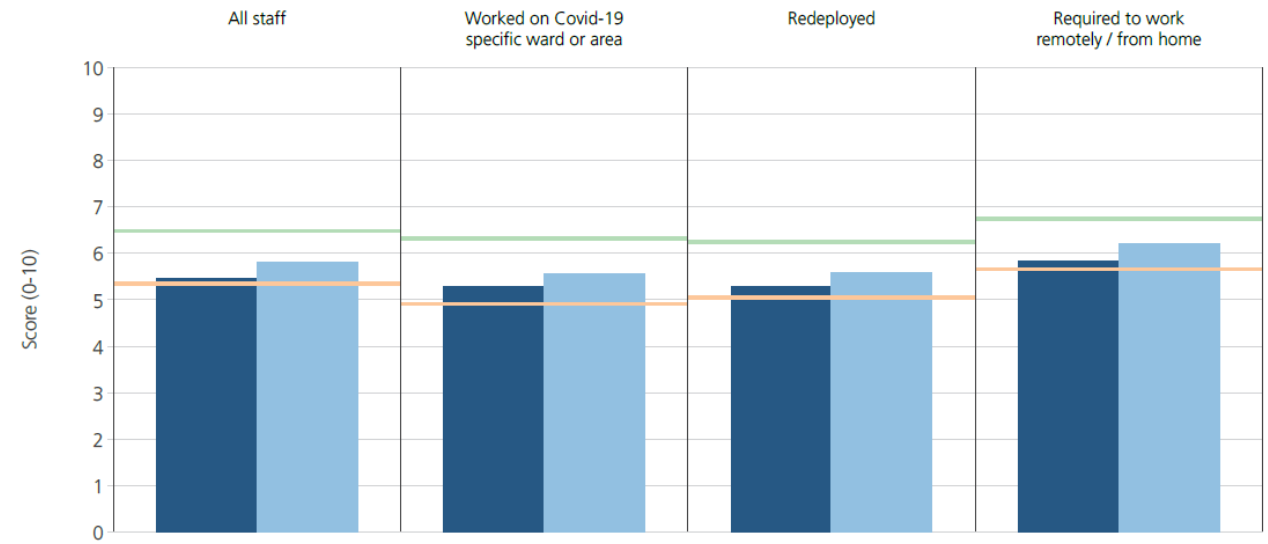
APPENDIX THREE: People Promise Theme Results / Covid-19 classification breakdowns

Promise 1: We are compassionate and inclusive



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	7.8	7.7	7.6	7.9
Your org	6.7	6.6	6.6	6.9
Average	7.2	7.0	7.0	7.4
Lowest	6.7	6.6	6.5	6.8
Responses	3,901	1,701	1,113	1,234

Promise 2: We are recognised and rewarded

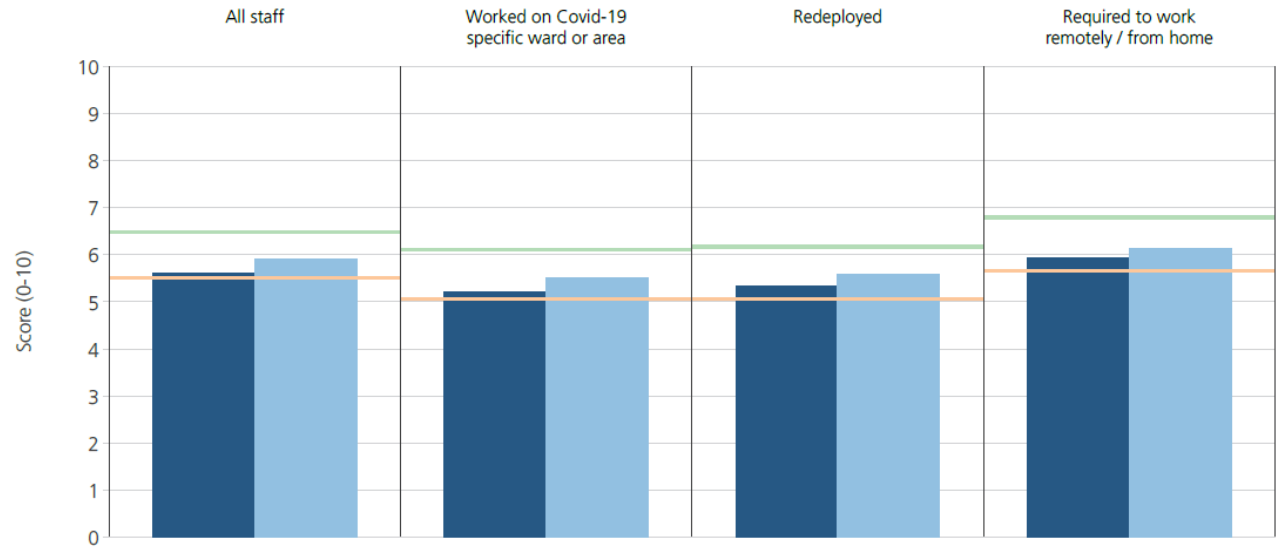


	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	6.5	6.3	6.2	6.7
Your org	5.5	5.3	5.3	5.8
Average	5.8	5.5	5.6	6.2
Lowest	5.3	4.9	5.0	5.7
Responses	3,998	1,701	1,114	1,232

Promise 3: We each have a voice that counts

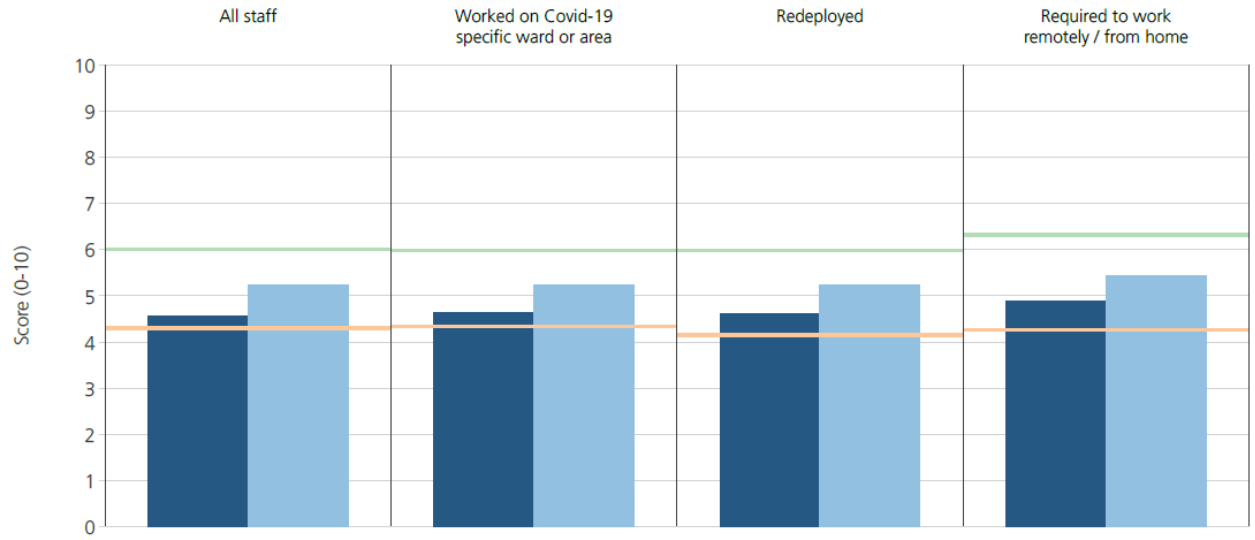
	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	7.3	7.2	7.1	7.6
Your org	6.1	6.0	6.0	6.4
Average	6.7	6.5	6.5	6.9
Lowest	6.1	6.0	6.0	6.3
Responses	3,837	1,689	1,109	1,228

Promise 4: We are safe and healthy



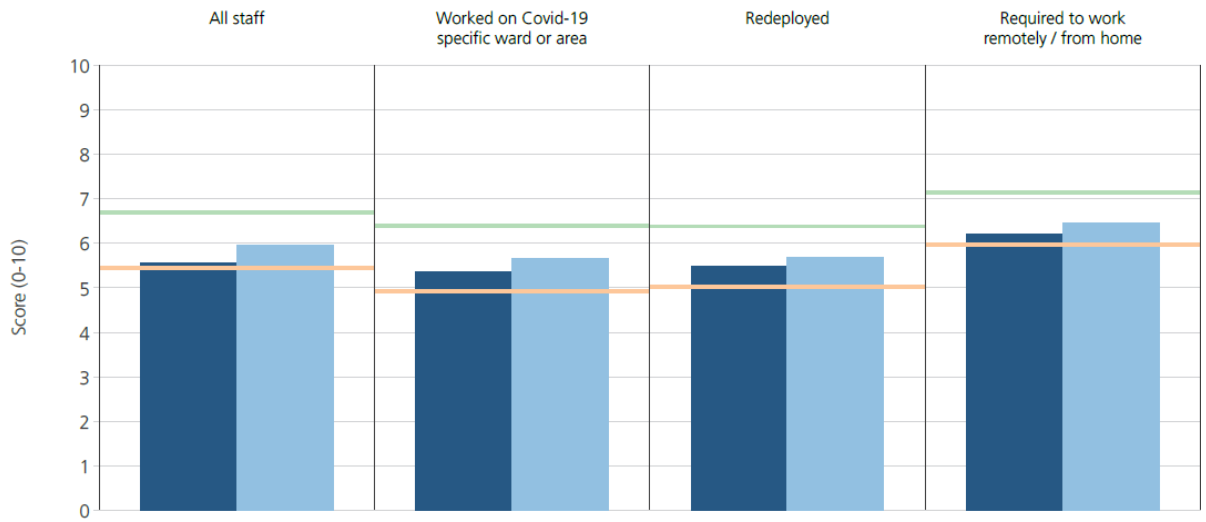
	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	6.5	6.1	6.2	6.8
Your org	5.6	5.2	5.3	5.9
Average	5.9	5.5	5.6	6.1
Lowest	5.5	5.1	5.1	5.7
Responses	3,886	1,693	1,108	1,230

Promise 5: We are always learning



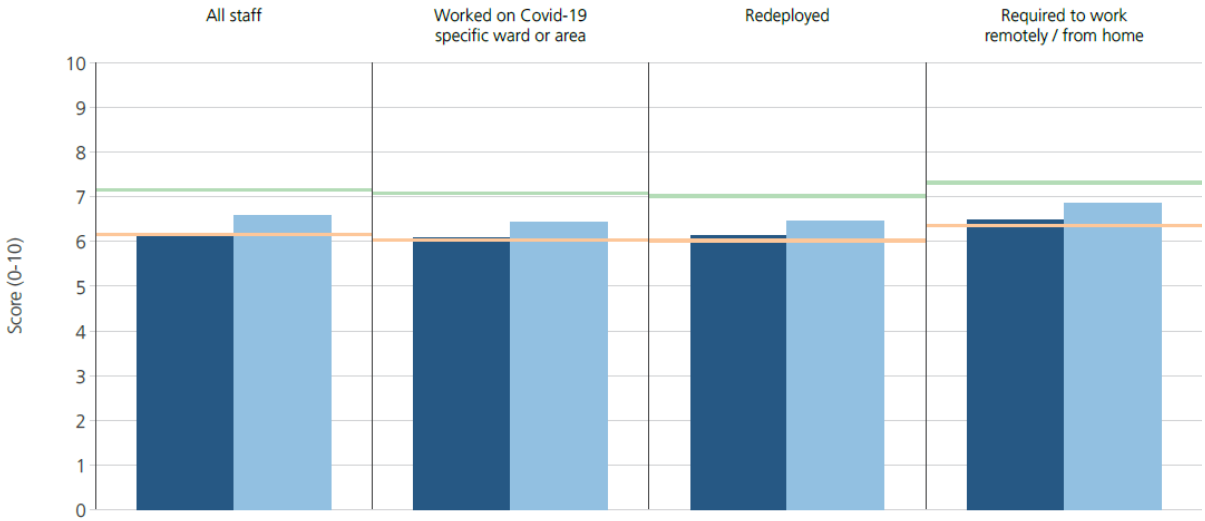
	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	6.0	6.0	6.0	6.3
Your org	4.6	4.6	4.6	4.9
Average	5.2	5.2	5.2	5.4
Lowest	4.3	4.3	4.2	4.3
Responses	3,650	1,596	1,064	1,189

Promise 6: We work flexibly



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	6.7	6.4	6.4	7.1
Your org	5.6	5.4	5.5	6.2
Average	5.9	5.6	5.7	6.5
Lowest	5.4	4.9	5.0	6.0
Responses	3,978	1,699	1,109	1,230

Promise 7: We are a team



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	7.1	7.1	7.0	7.3
Your org	6.2	6.1	6.1	6.5
Average	6.6	6.4	6.5	6.8
Lowest	6.2	6.0	6.0	6.4
Responses	3,923	1,702	1,114	1,233

Theme 1: Staff Engagement

	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	7.4	7.4	7.3	7.7
Your org	6.3	6.2	6.2	6.5
Average	6.8	6.8	6.7	7.0
Lowest	6.3	6.1	6.0	6.4
Responses	4,010	1,702	1,114	1,233

Theme 2: Morale

	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	6.5	6.4	6.3	6.7
Your org	5.3	5.0	5.0	5.5
Average	5.7	5.5	5.5	5.9
Lowest	5.3	4.9	4.9	5.3
Responses	3,994	1,702	1,115	1,233

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	5 April 2022
Item Number	*Item 9.3*
ANTI RACISM STRATEGY (Proposed)	
Accountable Director	*Paul Matthew, Executive Director for Finance, Digital, People & OD*
Presented by	*Paul Matthew, Executive Director for Finance, Digital, People & OD*
Author(s)	*Sarah Akhtar, Associate Director for OD, Wellbeing and Inclusion*
Report previously considered at	*N/A*

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

Risk Assessment	*Risk to be assessed*
Financial Impact Assessment	*To be costed (based on the acceptance of the proposals)*
Quality Impact Assessment	*To be completed ahead of implementation*
Equality Impact Assessment	*To be completed ahead of implementation*
Assurance Level Assessment	*Insert assurance level* • Moderate
Recommendations/ Decision Required	Trust Board are requested to: 1. Review and endorse the proposed Anti-Racism Strategy for ULHT / Zero Tolerance stance towards discrimination 2. Endorse further actions/next steps 3. Offer further insight and advice on how best the Trust can position itself as an anti-racist organisation

Executive Summary
As detailed below

NHS
United Lincolnshire Hospitals
NHS Trust

'United Against All Forms of Racism'

Proposed: Anti-Racism Strategy 2022/23

INTRODUCTION

- **United Lincolnshire Hospitals Trust** is committed to providing a workplace where all colleagues feel
  - a true sense of belonging
  - safe and protected from the harm caused by racism.
- Addressing all forms of racism vital to ULHT purpose to deliver outstanding care
- **ULHT is proud of the diversity of its workforce**
- Compelling evidence – NSS21, anecdotal/lived experience
- Additional to work currently underway (WRES, Dignity, Safety and Respect, inclusive and compassionate leadership; Staff Network Forums)
- Key relationship dynamics (staff/patient; peer/peer and line manager/direct report)

GOVERNANCE

We will provide absolute clarity for managing racism towards staff

Staff are protected from harm

- ✓ Support staff in the event of racial abuse
- ✓ Empowering staff to act effectively and confidently
- ✓ Ensure policies and procedures clarify and reinforce ULHT commitment to address all forms of racism
- ✓ Robust oversight and assurance of how incidents are reported, managed and monitored

ACTIONS:

- ✓ Engagement and dialogue with professional bodies to protect registered staff/all staff from complaints and legal challenge when managing racism towards staff
- ✓ Incident ‘flowchart’ to guide the management and escalation of incidents (including how staff are supported)
- ✓ Review policies and guidance to ensure messaging and language is appropriately robust and meaningful
- ✓ Review HR policies and guidance to ensure and enable racist incidents to be managed/addressed effectively
- ✓ Monthly/quarterly reporting of racial incidents/abuse to Executive Team

ULHT ‘CULTURE’

We will build a culture of dignity, safety and respect

Staff are treated with dignity and respect

- ✓ Ensure staff are appropriately supported and feel safe when raising concerns
- ✓ Listen and acknowledge the ‘lived’ experience of staff that have suffered discrimination and prejudice
- ✓ Empower staff to recognise and ‘call out’ inappropriate behaviour and language
- ✓ Empower and work in partnership with leaders, Staffside, Freedom to Speak Up (F2SU) and Staff Networks to inform future actions and role model/live ULHT values

ACTIONS:

- ✓ Large scale, staff engagement activity to reset ULHT values and behaviours
- ✓ Secure leadership and management commitment to compassionate and inclusive leadership
- ✓ Engage Staff Networks and Staffside in future actions
- ✓ Identify and remove barriers staff may feel when raising concerns and speaking up
- ✓ Ensure HR policies and guidance enable incidents to be addressed effectively
- ✓ Celebrate diversity of ULHT workforce, i.e. EDI Calendar, History month, acknowledge ULHT global workforce and community
- ✓ Apply ULHT values to determine recruitment and promotion decisions

COMMUNICATION

We will be bold in our communication to staff, patients and partners

Messaging is clear, visible and robust

- ✓ Communication will support understanding and awareness
- ✓ Strong, appropriate and clear language will reinforce ULHT position as an ‘anti-racist’ organisation and employer
- ✓ Expectation of behaviour towards staff is clear
- ✓ A broad range of channels will share information and news about the Trust’s inclusive culture

ACTIONS:

- ✓ ‘Respect’ statement to be prominently displayed at all sites and included in all patient letters/information leaflets
- ✓ Deliver a ULHT anti-racism campaign (see appendix one)
- ✓ Share the story to explain why ULHT are positioned as an ‘anti-racist’ employer (and what this means for our patients, existing/prospective staff)
- ✓ Share lived experience videos and stories to raise awareness and understanding
- ✓ EDI web-pages (intranet/internet)

TRAINING AND EDUCATION

We will train staff and leaders in EDI

Development fosters empathy and awareness

- ✓ Wider and broader application of CQ (Cultural Intelligence) training
- ✓ Unconscious bias training for all staff groups as a minimum
- ✓ EDI/inclusion integral to new leadership and management development offer
- ✓ Accessibility to training
- ✓ Staff and patient lived experience used to define discriminatory behaviours and demonstrate ‘harm’

ACTIONS:

- ✓ EDI added as an annual requirement to mandatory training
- ✓ Development of workshop/briefing (e-learning/face to face) for calling out racism, homophobia, misogyny or religious hate
- ✓ Unconscious bias and micro-aggression to be included in future development
- ✓ Managing discriminatory behaviours content for all leaders
- ✓ Review induction/support programmes for trainee and international doctors/nurses
- ✓ Review induction/support programmes for Apprenticeships, New to Care

MANAGING COMPLAINTS

We will support staff in the event of a complaint

Staff feel assured they have ULHT support

- ✓ Zero tolerance towards ‘discriminatory’ banter and behaviour
- ✓ Abuse is not tolerated as ‘part of the job’
- ✓ Complaints managed sensitively and with compassion
- ✓ Support offered recognises and understands the severity and impact of abuse
- ✓ ULHT position as an anti racist organisation is explained firmly and with confidence

ACTIONS:

- ✓ Review and update the patient complaints policy, to ensure Trust response to racism, homophobia, misogyny or religious hate and is supportive of staff
- ✓ Review relevant policies and support available to staff ‘under investigation’ (ensuring equity)
- ✓ Review patient complaints procedure
- ✓ Consider if ‘Datix’ is the best method for capturing and reporting racial abuse (and what happens to this information)
- ✓ Clarity and ease of access to complaints procedure
- ✓ Mindful of discriminatory behaviours upon physical and psychological well-being

RACISM
DOES NOT BELONG HERE

NHS
United Lincolnshire Hospitals
NHS Trust

Racism hurts
✓ We will stand by all of our colleagues

Racism is a crime
✓ We will involve the police

Racism will not be tolerated
✓ We will protect our staff

UNITED AGAINST ALL FORMS OF DISCRIMINATION

RACISM
DOES NOT BELONG HERE

NHS
United Lincolnshire Hospitals
NHS Trust

Racism hurts
✓ We will stand by all of our colleagues

Racism is a crime
✓ We will involve the police

Racism will not be tolerated
✓ We will protect our staff

UNITED AGAINST ALL FORMS OF DISCRIMINATION

RACISM
DOES NOT BELONG HERE

NHS
United Lincolnshire Hospitals
NHS Trust

Racism hurts
✓ We will stand by all of our colleagues

Racism is a crime
✓ We will involve the police

Racism will not be tolerated
✓ We will protect our staff

UNITED AGAINST ALL FORMS OF DISCRIMINATION

RACISM
DOES NOT BELONG HERE

NHS
United Lincolnshire Hospitals
NHS Trust

Racism hurts
✓ We will stand by all of our colleagues

Racism is a crime
✓ We will involve the police

Racism will not be tolerated
✓ We will protect our staff

UNITED AGAINST ALL FORMS OF DISCRIMINATION

NEXT STEPS

- Anti Racism strategy launch date – 6 April 2022
- ULHT positioned as an Anti-Racist organisation
- Zero tolerance policy towards racist/discriminatory behaviour, language and ‘banter’
- Working group and formal programme of work to embed anti-racism strategy
- ‘Socialisation’ of strategy (Staffside, Staff Networks, employees)
- Alignment with cultural change, leadership and wellbeing
- Stance on anti-racism – same for all protected characteristics (*United Against all Forms of Discrimination*)

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 April 2022*
Item Number	*Item 9.4*
Establishment Review – Emergency Departments	
Accountable Director	*Dr Karen Dunderdale*
Presented by	*Dr Karen Dunderdale*
Author(s)	*Dr Karen Dunderdale*
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	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*Insert risk register reference*
Financial Impact Assessment	overall increase in wte of 34.62 (Lincoln) and 16.67wte (Pilgrim) and a funding increase of £1,421k and £266k full year effect
Quality Impact Assessment	*Completed ahead of implementation*
Equality Impact Assessment	*Completed ahead of implementation*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• The Committee are asked to approve the establishment review and subsequent investment to enable planned recruitment to the posts to commence and therefore break the cycle of agency usage

Executive Summary

Establishments have been reviewed using the Department activity and application of the urgent and emergency care establishment tool, incorporating a change of shift pattern to match departmental activity and an emergency care Nursing Ratio model to provide added objectivity.

A review of this years' (2021/22) service costs shows a forecast overspend of £1,103k (£781k Lincoln and £321k Pilgrim)

This reports an overall budget increase at Lincoln and Pilgrim of 34.62wte & 1.67wte respectively with an increase of £1,421k & £266k full year effect. Please note of the £1,421k at Lincoln £767k (21.04wte) relates to the segregation requirements as a consequence of Covid management.

The current run rate as at January 2022 for nursing in these areas only is £919k above plan and worked wte is 19.68wte more than contracted establishment. On a straight line basis this would mean a £1,103k over plan position by the end of the financial year.

Current forecast actual is £12m with a costed substantive model of £10m, this creates a potential for actual cost reduction with the two Emergency departments if recruited substantively

Nurse Establishment Review:

Emergency Departments Lincoln and Boston

1: Nursing Review Process:

The Nurse Establishment Review set out in November 2021 to take undertake a comprehensive review of nursing establishments in our ED departments based which was designed to comprehensively redesign the establishments to activity to ensure the optimum balance of care quality and efficient use of resources.

This paper sets out the review for the Emergency Departments.

2. Emergency Department – Review:

This review covers all distinct areas and nursing elements within the Emergency Departments including 24 hour adult and paediatric service provision.

Establishments have been reviewed using the Department activity and application of the urgent and emergency care establishment tool, incorporating a change of shift pattern to match departmental activity and an emergency care Nursing Ratio model to provide added objectivity. The model has taken into account patient acuity and complexity of care in order to ensure the nursing levels are optimised for workloads in each discreet area of the Department. Shift patterns with appropriate staff numbers have been collated using an establishment-setting tool, which is configured to create both an establishment and budget for any given shift pattern. A range of establishment options were developed and discussed as part of the review process. The model uses the following assumptions:

- Shift patterns as identified, according to Departmental activity and skill mix need.
- Proactive introduction of Nursing Associates across the departments in all areas
- Leave cover arrangements based upon standard leave entitlements (33 days + 8 B/H)
- Training cover set to 8 days per WTE per year
- Sickness absence cover set at 3.65% sickness rate (bank cover)

The calculated establishment includes all nursing, but excludes support functions and administration. It does include supernumerary nurse management tied directly to the Department establishment. In addition, the review assumed a default position of a Departmental manager (band 8a) per week day supernumerary and a clinical educator supernumerary 5 days to the patient centred establishment. There is also an allowance for each Band 7 to have one office day per week over and above the 24/7 department cover.
A review of this years' (2021/22) service costs shows a forecast overspend of £1,103k (£781k Lincoln and £321k Pilgrim) with non-recurrent COVID costs of circa £767k.

Each area of the EDs were reviewed with regard to the nursing workforce plan to incorporate Trainee & Nursing Associates and extended clinical placements for student nurses. This will be

added to the separate workforce plan following the recent in-patient wards establishment reviews.

Each area had an assessment of their skill mix and adjustments for consistency of the numbers of band 6 nurses has been included in the review outcome.

Consistency of supernumerary time for each band 7 applied as a proportion in line with in patient wards has been included in the review outcome (equates to 1 day per week for each band 7).

4. Outcome of the Review:

Appendix 1 identifies the outcome for each area of the departments based on activity modelling based on the current establishment and the proposed establishment.

Detailed analysis around the current staffing model and further changes to the proposed model are also identified within the analysis.

Roster plan appendices, with the detailed calculations for the Department, including the activity levels underlying the establishment calculations, is available separately.

Table 1 below provides high level information regarding the WTE, cost and variance

This reports an overall budget increase at Lincoln and Pilgrim of 34.62wte & 1.67wte respectively with an increase of £1,421k & £266k full year effect. Please note of the £1,421k at Lincoln £767k (21.04wte) relates to the segregation requirements as a consequence of Covid management.

The current run rate as at January 2022 for nursing in these areas only is £919k above plan and worked wte is 19.68wte more than contracted establishment. On a straight line basis this would mean a £1,103k over plan position by the end of the financial year.

Current forecast actual is £12m with a costed substantive model of £10m, this creates a potential for actual cost reduction with the two Emergency departments if recruited substantively. During the initial year the service would still rely on some agency and bank cover whilst recruiting and training potential Band 4 NAs; needing cover at registered level.

The reported increase in establishment is a combination of running higher than their funded establishment due to activity, demand and safety and non-recurrent costs for COVID activity.

Table 1 – Summary of budgetary Changes

	Proposed Establishment		Recurrent Budget		Impact of New Rotas		Skill Mix (Budget)		Skill Mix (Proposed)		Budget		Proposed	
	WTE	BUDGET	Bud WTE	BUDGET	WTE	COST	RN	CSW	RN	CSW	Registered	Un-Registerd	Registered	Un-Registerd
Lincoln Emergency Department	121.57	5,148,300	86.95	3,727,500	34.62	1,420,800	65.11	21.84	86.55	35.02	3,061,700	665,800	4,080,600	1,067,700
Pilgrim Emergency Department	109.9	4,534,500	108.23	4,268,900	1.67	265,600	64.95	43.28	74.00	35.90	2,929,900	1,339,000	3,442,400	1,092,100
Total	**231.47**	**9,682,800**	**195.18**	**7,996,400**	**36.29**	**1,686,400**	**130.06**	**65.12**	**160.55**	**70.92**	**5,991,600**	**2,004,800**	**7,523,000**	**2,159,800**

8. Workforce Changes:

The establishment requirement set by this review process will be compared to the current staffing in post with the following actions to take place to re-align/recruit staffing where there are gaps following the skill mix review.

Recruitment actions will include:

- Implement recruitment in accordance with the Trust Recruitment Strategy
- Cohort recruitment and establishment of talent pools
- Support our HCSW's to nurse training and backfill with an apprentice provision
- Continue to recruit to Nursing Associate role and to the trainee NA role
- Support placement of Return to Practice Nursing provision
- Continue to actively recruit through local and national recruitment drives
- Develop a Nursing Workforce strategy in line with new roles

9. Implementation Plan:

The implementation plan will include the following elements:

Action 1: management of change paper and consultation exercise with affected nursing staff to run for 3 months as per Trust Policy with following notice period of 1 month prior to agreed changes of shift times.
Date: June 2022

Action 2: Implement proposed roster plan changes within e-rostering system
Date: July 2022

10. Next steps:

- Management of change process to be undertaken with affected nursing staff in the Department.
- Implementation of the establishments as per the implementation plan following agreement in the consultation process.

- Feed the output of the establishment review into the nursing workforce transformation programme to ensure agency controls are in place.
- Clear competency framework for the Nursing Associate role in the Department.
- Plan for the introduction of Nursing Associates into the establishments going forward

11. Recommendations

In order to break the cycle of agency usage the board are asked to approve the establishment review and subsequent investment to enable planned recruitment to the posts to commence and therefore break the cycle of agency usage

Dr Karen Dunderdale, Director of Nursing
Simon Evans, Chief Operating Officer
Paul Matthew, Director of Finance & Digital
March 2022

Appendix 1 – Detail by Grade

Lincoln Site

Current Establishment (Recurrent)				Proposed Establishment					Change				Covid		Net Change	
Banding	WTE	Cost Per WTE	Annual Cost	Banding	WTE	Basic + oncost	Cost Per (enh) WTE	Annual Cost	Banding	WTE	Cost Per WTE	Annual Cost	WTE	£	WTE	£
Band 8a	1.00	73,600	73,600	Band 8a	1.00		73,600	73,600	Band 8a	0.00		0	0.00	0	0.00	0
Band 7	5.26	62,928	331,000	Band 7	6.48	53,800	62,928	407,800	Band 7	1.22		76,800	0.00	0	1.22	76,800
Band 6	16.78	53,474	897,300	Band 6	29.94	49,071	53,474	1,601,000	Band 6	13.16		703,700	0.00	0	13.16	703,700
Band 5	37.15	42,390	1,574,800	Band 5	31.53	40,077	42,390	1,336,400	Band 5	(5.62)		(238,400)	10.52	445,946	(16.14)	(684,346)
Band 4 NA	4.92	37,602	185,000	Band 4 NA	17.60		37,602	661,800	Band 4	12.68		476,800	0.00		12.68	476,800
Total Registered	**65.11**	**269,994**	**3,061,700**	**Total Registered**	**86.55**			**4,080,600**	**Total Registered**	**21.44**		**1,018,900**	**10.52**	**445,946**	**10.92**	**572,954**
Band 4	-		0	Band 4	-		0	0	Band 4	0.00		0			0.00	0
Band 3				Band 3	-		0	0	Band 3	0.00		0			0.00	0
Band 2	21.84	30,485	665,800	Band 2	35.02	30,693	30,485	1,067,700	Band 2	13.18		401,900	10.52	320,706	2.66	81,194
Band 1	-	0	0	Band 1	-		0	0	Band 1	0.00		0			0.00	0
Band 1 - Nrs Lnr Cadet	-	0	0	Band 1 - Nrs Lnr Cadet			0		Band 1 - Nrs Lnr Cad	0.00		0			0.00	0
Total Unregistered	**21.84**	**30,485**	**665,800**	**Total Unregistered**	**35.02**			**1,067,700**	**Total Unregistered**	**13.18**		**401,900**	**10.52**	**320,706**	**2.66**	**81,194**
Total Establishment	**86.95**	**300,479**	**3,727,500**	**Total Establishment**	**121.57**		**-**	**5,148,300**	**Total Establishment**	**34.62**		**1,420,800**	**21.04**	**766,652**	**13.58**	**654,148**
Registered Bank	-		0	Registered Bank	-	40,077	42,390	0	Registered Bank	0.00		0				
Unregistered Bank	-		0	Unregistered Bank	-	30,693	30,485	0	Unregistered Bank	0.00		0				
Total Bank	**-**	**-**	**-**	**Total Bank**	**-**			**-**	**Total Bank**	**0.00**		**0**				
Total	**86.95**	**300,479**	**3,727,500**	**Total**	**121.57**		**-**	**5,148,300**	**Total**	**34.62**	**-**	**1,420,800**	**21.04**	**766,652**	**13.58**	**654,148**

Boston Site

Banding	WTE	Cost Per WTE	Annual Cost
Band 8a	1.00	57,400	57,400
Band 7	5.26	63,327	333,100
Band 6	11.12	51,133	568,600
Band 5	45.57	41,628	1,897,000
Band 4 NA	2.00	36,900	73,800
Total Registered	**64.95**	**250,388**	**2,929,900**
Band 4	-	0	0
Band 3			
Band 2	43.28	30,421	1,316,600
Band 1	-	0	0
Band 1 - Nrs Lnr Cadet	-	0	0
Total Unregistered	**43.28**	**30,421**	**1,316,600**
Total Establishment	**108.23**	**280,809**	**4,246,500**
Registered Bank	-		0
Unregistered Bank	-		22,400
Total Bank	**-**	**-**	**22,400**
Total	**108.23**	**280,809**	**4,268,900**

Banding	WTE	Basic + oncost	Cost Per (enh) WTE	Annual Cost
Band 8a	1.00		57,400	57,400
Band 7	6.27	53,800	63,327	397,100
Band 6	24.72	49,071	51,133	1,264,000
Band 5	36.75	40,077	41,628	1,529,800
Band 4 NA	5.26		36,900	194,100
Total Registered	**74.00**			**3,442,400**
Band 4	-	38,551	0	0
Band 3			0	0
Band 2	35.90	30,693	30,421	1,092,100
Band 1	-		0	0
Band 1 - Nrs Lnr Cadet			0	
Total Unregistered	**35.90**			**1,092,100**
Total Establishment	**109.90**		**-**	**4,534,500**
Registered Bank	-	40,077	41,628	0
Unregistered Bank	-	30,693	30,421	
Total Bank	**-**			**-**
Total	**109.90**		**-**	**4,534,500**

Banding	WTE	Cost Per WTE	Annual Cost
Band 8a	0.00		0
Band 7	1.01		64,000
Band 6	13.60		695,400
Band 5	(8.82)		(367,200)
Band 4	3.26		120,300
Total Registered	**9.05**		**512,500**
Band 4	0.00		0
Band 3	0.00		0
Band 2	(7.38)		(224,500)
Band 1	0.00		0
Band 1 - Nrs Lnr Cadet	0.00		0
Total Unregistered	**(7.38)**		**(224,500)**
Total Establishment	**1.67**		**288,000**
Registered Bank	0.00		0
Unregistered Bank	0.00		(22,400)
Total Bank	**0.00**		**(22,400)**
Total	**1.67**	**-**	**265,600**

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	24 March 2022
Chairperson:	Dani Cecchini, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Report** The Committee received the report noting the continued improvement in the assurances being offered to the Committee. The Committee were pleased to note the recent visit undertaken by Lincolnshire Fire and Rescue to Pilgrim Hospital. It was anticipated that the outcome of the visit would result in enforcement actions being lifted however confirmation was awaited. Concern was noted regarding the increase in reactive response times however the Committee noted that this was due to the shift in focus to Planned Preventative Maintenance noting this was part of the adjustment period. The Trust had however engaged an external provider to support the reduction in the backlog of reactive tasks. The Committee noted this whilst limited assurance was offered there continued to be an improving position reported to the Committee on a monthly basis. **Emergency Planning Update to include Cyber Security** The Committee received the report and were pleased to note that following an assessment of the Emergency Preparedness Resilience and Response Core Standards the Trust remained substantially complaint with a number of key achievements reported. Activity was underway to further strengthen business continuity plans across the organisation with a task and finish group established to support divisions in updating plans.

	The Committee noted the intention to hold the debrief following the declaration of the major incident in January in early April with all key stakeholders present. The Committee received and noted the update provided in relation to Cyber Security which offered moderate assurance.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc CRIG upward report, Contract Report and Efficiency Report** The Committee received the reports noting the financial position with the Trust delivering the planned and required position at year end. The Committee noted that it had been a challenging period as the financial plan had been determined prior to the Covid-19 Omicron variant which had impacted on the position. The Committed noted that there had been an increase in pay and a decrease in the non-pay position. There had been a number of avenues of other income during the half which had been combined to manage the position. **Capital Report** The Committee received the report noting that programme of capital had reached £45m for the year with schemes crystallising in the remaining weeks of the financial year. Year to date the Trust had spent circa £24m on capital programmes with a remaining spend of £21m in the final month of the year. The Committee noted assurance of the deliverability assessment with circa £15-16m locked in and a further £5-6m likely to deliver. There continued to be a forecast of delivery within the limit value however the Committee noted the volume of work required to achieve this. The Committee were pleased to note the moderate assurance offered through the report noting the positive position that had been achieved, in part due to the over-commitment made earlier in the year. **Budget Setting Process** The Committee received the report that offered assurance on the process in place, engagement with divisions and expectations of the interactive process. Due to Covid-19 there had been an impact on engagement with the divisions in respect of the budget setting process which was now being reset. Work would align with the divisions and performance teams to ensure that there was clarity of demand and capacity within the financial

	envelope for delivery. There was an ambition to embed this from M1 however the Committee were aware of the need for this to be aligned to the financial plan. **Financial Plan Submission** The Committee received the financial plan submission noting that this was a combination of both the System and Trust plan. The Committee noted that the Trust intended to submit a breakeven plan however recognised that discussions would be required to determine the appropriate level of Cost Improvement Programmes. The move out of Covid-19 offered an opportunity to review the cost base and to progress with cost improvements as was in place prior to the pandemic. The Committee noted concern regarding the plan as presented noting that further discussions would be required across the system to align the plan prior to submission. The Committee would receive the final plan at the April meeting and would hold focused discussion on the Cost Improvement Programme due to the limited assurance. **FSM Exit Criteria** The Committee received the report that provided an update on the Trusts position with regard to Financial Special Measures and the exit criteria. The Committee was pleased to note the progress being demonstrated on the criteria set noting that this would support future discussions with NHS England/Improvement. **Establishment Review – ED** The Committee received the establishment review in respect of the Emergency Departments noting that this had been completed utilising an evidence-based review. The Committee noted that review had identified a need to review shift patterns to support staff with activity levels and a consultation would be undertaken to reflect the changes required. The Committee noted the increase in substantive establishment required with an investment of £1.6m however reflecting that, once fully established, a cost reduction of £2m would be realised for the department against the current run rate and spend. A transitional period would be experienced and a trajectory developed to reflect the appointment of staff. The Committee endorsed the paper onward for approval by the Board.

	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting that the Trust had received the Information Commissioners Office report following the audit conducted in December 2021. The Trust had received a rating of reasonable assurance, this being the second highest ratings. It was noted that there were no immediate actions required however a plan was being developed following the outcome of the audit. The Committee noted the low levels of performance in respect of Subject Access Requests and Freedom of Information Requests noting that there had been an impact during Covid-19 and response times needed to improve. The Committee noted the limited level of assurance offered however was reassured that a plan was in place and delivery underway.
	Assurance in respect of SO 4a Establish new evidence based models of care No items received
	Assurance in respect of other areas: **Annual Report – Committee Effectiveness** The Committee approved the report subject to some further additions to reflect discussions held in relation to planning and cyber security. **Topical, Legal and Regulatory Update** The Committee received the update noting the information that was offered and sought to understand if this would include regulatory and statutory updates in respect of Estates. The Committee noted that these updates would feature through the Health and Safety Group upward reports to the Committee as required. **Committee Performance Dashboard** The Committee received the report noting the performance that was reported and the impact that was being seen due to increasing numbers of Covid-19 positive patients within the Trust. It was noted that some improvements that were being seen were not in line with trajectory noting that there would be a point at which activity stabilised. **PRM Upward Report** The Committee received the report noting that this offered a summary of the February activity from the performance review meetings which offered limited assurance. The Committee recognised that the report did

	not offer assurance however noted the intention to refresh both the meetings and reporting for 2022/23. The Committee requested an understanding of the performance management framework noting that this would be reported to the Committee in May as the refresh of the arrangements in place were reported. **Integrated Improvement Plan** The Committee received the February update noting that planning was underway for Year 3 of the IIP. Sessions were being held with the division as part of the planning process. Discussion was held regarding the link to the Cost Improvement Programmes noting that a proposal would be presented back to the Committee in due course. **Operational Performance against National Standards:** **Urgent Care** The Committee noted that the Trust continued to be below the optimal standard on the 4-hour transit target however noted that if new constitutional standards were agreed there would be a move to an aggregated, more holistic target. The Committee noted the move to dynamic risk assessments in respect of the declaration of critical incidents noting that there were now conducted to consider assessment of access to critical pathways. The Trust continued to see an increase in 12-hour trolley waits with the Committee noting the improvement work underway to improve the offer in the urgent care pathways. Support was in place from an Urgent Care Lead to focus on pathways, flow and discharge. The Committee noted the move to a joint offer of domiciliary care from both health and social care noting that this was coming online incrementally with benefits starting to be seen. The Committee were advised on the intention to revise the report format in order to offer further assurance and clear demonstration of improvements in future reports. **Cancer Performance inc Breast Service update** The Committee received the report noting that the Trust had achieved 2 of the 10 national standards during the reporting period however noted that there were green shoots of recovery. The Committee were pleased to note the positive recruitment within cancer services noting that overseas recruitment was also underway. An update was offered in respect of Breast Services within improvements noted against trajectory for the 28-day standard.

	Actions were in place to ensure utilisation of DNA (Did not attend) appointments in order to continue to progress with improvements. The Committee noted the activity in P categorisations and the continued use of the Artificial Intelligence system to support clinicians. The Committee noted the positive improvements being seen however noted that these were limited due to the volume of the backlog.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risks presented noting that further work was required to review and develop risks.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	A	M	J	J	A	S	O	N	D	J	F	M
Gill Ponder, Non-Exec Director	X											
David Woodward, Non-Exec Director		O	X	X	X	X	X	X	X			
Dani Cecchini, Non-Exec Director										X	X	X
Geoff Hayward, Non-Exec Director	A	X	X	A								
Chris Gibson, Non-Exec Director	X	X	X	X	X	A	X	X	X	X	X	
Gail Shadlock, Non-Exec Director											X	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	X	X	X	D
Director of Improvement & Integration	X	X	X	X	A					X	X	X

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

United Lincolnshire Hospitals NHS Trust

Annual Report to the Trust Board from the Finance, Performance and Estates Committee 2021/22

ROLE OF THE COMMITTEE

In 2021/22, in line with all other Committees of the Board, the Terms of Reference were reviewed and amended. Under the agreed terms of reference the Finance, Performance and Estates Committee was tasked as follows:

The Finance, Performance and Estates Committee will:

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

A modern, clean and fit for purpose environment:

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

Efficient use of resources:

- Delivering cost improvement programme
- Delivering financial plan

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

Enhanced data and digital capability:

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

Establish new, evidence-based models of care:

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

MEETINGS

The Committee met monthly during the year and after each meeting provided an assurance report to the Trust Board.

Due to the Trust continuing to respond to the Covid-19 pandemic and subsequent operational pressures the Committee, at times, to support the delivery of patient care worked to a reduced agenda and length of meeting during 2021/22.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2021/22 the Committee was chaired by Mrs Gill Ponder until the end of her tenure in May 2021.

The Committee was subsequently chaired by Mr David Woodward, Interim Non-Executive Director from June 2021 to December 2021 when Mrs Cecchini was appointed a Chair of the Committee commencing in post 1 January 2022.

Details of the Committee's membership and attendance during 2021/22 is set out below:

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

Members	**22 April 2021**	**20 May 2021**	**24 Jun 2021**	**22 July 2021**	**26 Aug 2021**	**23 Sep 2021**	**21 Oct 2021**	**25 Nov 2021**	**23 Dec 2021**	**20 Jan 2022**	**21 Feb 2022**	**24 Mar 2022**
Non-Executive Director (Mrs Cecchini, Chair)									Observing	X	X	X
Interim Non-Executive Director (Mr Woodward, Chair)		Observing	X	X	X	X	X	X	X			
Non-Executive Director (Mrs Ponder, Chair)	X											
Non-Executive Director (Mr Hayward)	A	X	X									
Non-Executive Director (Dr Gibson)	X	X	X	X	X	A	X	X	X	X	X	
Director of Finance and Digital	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	X	X	X	X	X	X	X	X	X	D
Director of Improvement and Integration	X	X	X	X	A	Interim Deputy in attendance	A From interim Dir	Interim Deputy in attendance	Interim Deputy in attendance	X	X	X

A denotes Apologies given
D denotes Deputy in attendance
C Director supporting response to Covid-19

REVIEW OF BUSINESS

The Finance, Performance and Estates Committee work programme for 2021/22 is set out as an appendix to this report.

The Finance, Performance and Estates Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2021/22:

- Objective 3a A modern, clean and fit for purpose environment
- Objective 3b Efficient use of our resources
- Objective 3c Enhanced data and digital capability
- Objective 4a Establish new evidence based models of care

During 2021/22 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF.

The strategic objectives at the beginning of the year were rated as follows:

Objective 3a – **RED**
Objective 3b – **GREEN**
Objective 3c – **AMBER**
Objective 4a – **AMBER**

At the end of the year the strategic objectives were rated as follows:

Objective 3a – **AMBER**
Objective 3b – **AMBER**
Objective 3c – **AMBER**
Objective 4a – **AMBER**

OVERVIEW

The Finance, Performance and Estates Committee has continued to, over the last twelve months, improve the assurance it can give to the Board on finance, operational performance, estates and digital services. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan, as defined by the terms of reference through this annual report.

The Committee has been well attended by members and the Chair has been actively involved in the agenda setting alongside the Director of Finance and Digital.

Other key areas of focus of the Committee have included:

- Estates
- Health and Safety
- Emergency planning
- Digital services
- Constitutional standards
- Restore and Recovery

There has been a continued focus for the Committee on work within the Estates Directorate and continued improvements in reporting ensuring that assurance could be provided to the Trust Board.

The Committee noted there had been a positive impact as a result of the appointment of Authorising Engineers. The Estates Directorate continued to see improvements in respect of Health and Safety with the achievement of a three (out of 5) star rating from the British Safety Council in respect of the Occupational Health and Safety Audit.

The Committee were pleased to see significant progress in the year of the lifting of fire safety notices from Lincolnshire Fire and Rescue. This had resulted in the Trust having all enforcement notices lifted across all sites.

The Committee noted the actions in place to introduce an Artificial Intelligence to support clinical prioritisation of patients on the waiting list. The artificial intelligence solution would support the classification of patients into the correct grading and support clinical decision making.

The Committee continued to monitor the delivery of the Integrated Improvement Plan noting that the delivery of projects had been adversely affected by the Covid-19 pandemic.

Continued improvements in financial reporting had resulted in increased assurance being received in respect of Capital Reporting and confidence to deliver the largest capital programme to date for the Trust.

Throughout the year the Committee has periodically received updates in respect of cyber security that have offered assurance on the levels of cyber security being achieved by the Trust.

The Committee towards the end of the financial year had given focus to the planning ahead to ensure the planning activity was in place for 2022/23.

Risks

The BAF and Corporate risk register have been reviewed at the committee on a monthly basis identifying where updates have been required based on assurances received at the Committee.

During 2021/22 the Director of Nursing undertook a review and reconfiguration of the Risk Register resulting in the Committee receiving a revised report. The reconfiguration and revision of the risk register has allowed the Committee to be more clearly sighted on risk within the organisation and receive assurance on the mitigations in place.

Performance Review

The Committee reviews performance against the agreed Key Performance Indicators (KPIs) and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover operational performance and efficient use of resources.

The Committee have actively engaged in the development of the performance dashboard, ensuring that the KPIs requiring monitoring by the Committee were reported. At each of the meetings held during 2021/22 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

Discussions around the performance report were focused on the impact of Covid-19 and the deterioration seen in performance. Whilst there had been in-year recovery seen in relation to a number of areas of performance this had not been maintained due to subsequent waves of Covid-19. It should be noted that whilst National Indicators were not being met by the Trust, there had been good performance against the restoration profile.

The Committee were pleased to note the financial position, noting the delivery of a £1.8m surplus in the first half of the year and delivery of a breakeven position each month to the end of half 2 and the financial year. The Trust had managed the year through block payments and Covid-19 top ups alongside the Covid-19 vaccination programme for which funding had been received.

During 2020/21 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals were made during the year offering opportunities for the Committee to seek further assurances.

The Finance, Performance and Estates Committee is an essential element of the Trust's corporate governance structure. It works closely with the Audit Committee and the Chair of the Finance, Performance and Estates Committee is also a member of the Audit Committee, which helps provide additional assurance on the adequacy of the Trusts financial controls and systems. The Committee received all internal audits relevant to its remit for consideration of the actions and oversight of the completion of these.

United Lincolnshire Hospitals NHS Trust

United Lincolnshire Hospitals NHS Trust

Finance, Performance and Estates Committee Forward Reporting Schedule 2021/22

				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Agenda Item	**Oversight Group****	**Executive Lead**	**Lead for Reports**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Business Items															
Committee Self Assessment		Trust Secretary	Deputy Trust Secretary										X		
Annual Report - Committee Effectiveness		Trust Secretary	Deputy Trust Secretary										X (Draft)	X (Draft)	X
Committee Terms of Reference		Trust Secretary	Deputy Trust Secretary	X (Final)											X (Draft)
Forward Reporting Schedule		Trust Secretary	Deputy Trust Secretary	X (Final)											X (Draft)
Reporting Group Terms of Reference and Forward Reporting Schedules		Director of Finance and Digital / Chief Operating Officer		X (Final)											X (Draft)
Committee (Finance and Performance) Performance Dashboard Executive Scorecard		Director of Finance and Digital / Chief Operating Officer		X	X	X	X	X	X	X	X	X	X	X	X
Topical, legal and regulatory update		Trust Secretary	Deputy Trust Secretary			X			X			X			X
Committee Development Session		Trust Secretary	Deputy Trust Secretary						X		X				
Operational Performance against National Standards to inc. Cancer, Urgent and Planned care		Chief Operating Officer		X	X	X	X	X	X	X	X	X	X	X	X
Integrated Improvement Plan		Director of Improvement and Integration	Assistant Director of Improvement	X	X	X	X	X	X	X	X	X	X	X	X
Matters Referred															
Matter referred by Trust Board or other Board Sub-Committees		Trust Secretary	Deputy Trust Secretary	**To be added to the agenda as required**											
Risk and Assurance															
Board Assurance Framework		Trust Secretary	Deputy Trust Secretary	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Report		Director of Finance and Digital / Chief Operating Officer		X	X	X	X	X	X	X	X	X	X	X	X
Review of relevant external reports/inquiries including CQC (As Required)		Director of Finance and Digital / Chief Operating Officer	Deputy Trust Secretary	X	X	X	X	X	X	X	X	X	X	X	X
Review of relevant internal & external audit reports		Trust Secretary	Deputy Trust Secretary	**To be added to the agenda as required**											
Strategic Objective 3 - To ensure that services are sustainable, supported by technology and delivered from an improved estate															
Objective 3a - A modern, clean and fit for purpose environment															
PLACE Assessments**	EG	Chief Operating Officer	Director of Estates		X		X		X		X		X		X
Staff and user surveys**	EG	Chief Operating Officer	Director of Estates		X		X		X		X		X		X
MiC4C cleaning inspections**	EG	Chief Operating Officer	Director of Estates		X		X		X		X		X		X
Response times to urgent estates requests**	EG	Chief Operating Officer	Director of Estates		X		X		X		X		X		X
Estates-led condition inspections of the environment**	EG	Chief Operating Officer	Director of Estates		X		X		X		X		X		X
Response times for reactive estates repair requests**	EG	Chief Operating Officer	Director of Estates		X		X		X		X		X		X
Progress towards removal of enforcement notices**	EG	Chief Operating Officer	Director of Estates		X		X		X		X		X		X
Quality and VFM housekeeping**	EG	Chief Operating Officer	Director of Estates		X		X		X		X		X		X
Objective 3b - Efficient use of our resources															
Delivery of cost improvement programme**	PRM	Director of Finance and Digital	Deputy Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Achievement of financial pan - ULHT and system**	PRM	Director of Finance and Digital	Deputy Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Achievement of Model Hospital opportunities**	PRM	Director of Finance and Digital	Deputy Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Improve service line profitability**	PRM	Director of Finance and Digital	Deputy Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Contract Award Reports		Director of Finance and Digital	Director of Finance and Digital	**To be added to the agenda as required**											
Capital update - monthly high level, quarterly in-depth		Director of Finance and Digital	Deputy Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Objective 3c - Enhanced data and digital capability															
Number of staff using Care Portal**	DHG	Director of Finance and Digital	Associate Director of Digital Services	X		X		X		X		X		X	
Delivery of 2021/22 e-HR plan**	DHG	Director of Finance and Digital	Associate Director of Digital Services	X		X		X		X		X		X	
Number of RPA agents implemented **	DHG	Director of Finance and Digital	Associate Director of Digital Services	X		X		X		X		X		X	
Ensuring every IPR metric has an associated data quality kite mark**	DHG	Director of Finance and Digital	Associate Director of Digital Services	X		X		X		X		X		X	
Delivering improved information and reports**	DHG	Director of Finance and Digital	Associate Director of Digital Services	X		X		X		X		X		X	
Implementing a refreshed IPR**	DHG	Director of Finance and Digital	Associate Director of Digital Services	X		X		X		X		X		X	
Strategic Objective 4 - To implement new integrated models of care with our partners to improve Lincolnshire's health and wellbeing															
Objective 4a - Establish new, evidence-based models of care															
Upward Highlight / Exception Reports from Groups reporting to the Committee (including any identified areas of focus for 2021/22)*:**															
Information Governance Group (IGG)		Director of Finance and Digital	Associate Director of Digital Services		X		X		X		X	X	X		X
Digital Hospital Group (DHG)		Director of Finance and Digital	Associate Director of Digital Services	X		X		X		X		X		X	
Emergency Planning Group (EPG)		Chief Operating Officer	Head of Emergency Planning		X			X			X			X	
Estates Group (EG)		Chief Operating Officer	Director of Estates and Facilities		X		X		X		X		X		X
Health and Safety Committee (HSC)		Chief Operating Officer	Director of Estates and Facilities	Meetings due to commence end July 2021				X			X			X	
Capital, Revenue and Investment Group (CRIG)		Director of Finance and Digital	Head of Planning, Capital and Costing/Assistant Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Reporting from Divisions:															
PRM Upward Report		Director of Finance	Head of Information	X	X	X	X	X	X	X	X	X	X	X	X
Notes:															

In some instances reporting and assurance to FPEC will happen via the oversight group upward reports. Where appropriate, reports submitted directly to FPEC will however have been considered and be supported by the upward report from the relevant oversight sub-group; specifically key highlights and any required escalations. This will help to avoid duplication of discussion and actions

****Where relevant the upward reports from reporting sub-groups will be aligned on the agenda to the relevant strategic objective supporting both the flow of the meeting and supporting the process of triangulation and assurance***

Deferred items subsequently received by the Committee have been denoted with a X

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	5th April 2022
Item Number	*Item 12*
Integrated Performance Report for February 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 have been 3 falls in February resulting in moderate harm. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. February has seen a reduction in the number of repeat falls incidents and a small decrease in the number of these which were unwitnessed in comparison to January.

Pressure Ulcers

The number of category 2 PU is at 39, category 3 PU is at 3, category 4 PU is at 1 and unstageables at 6 for February 2022. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. Work is being undertaken to replace existing bed frames with 400 profiling beds, this will assist repositioning of patients who are vulnerable to skin damage and support safer manual handing for staff.

Medications

For the month of February, the number or incidents reported in relation to omitted or delayed medications equated to 39% an increase from the previous month. 23% of medication incidents identified that harm had been caused and is noted to be above the national average and an increase from the previous month equating to 143 reported incidents. 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.

HSMR

The Trust HSMR is currently at 103.12 for February with an overall HSMR seeing a reduction. Dr Foster will attend the mortality meeting to explain the reasons for the difference in the HSMR data.

SHMI

The Trust SHMI is 111.20, an increase from the last reporting period. The Trust has moved to a 'Higher than expected SHMI' despite all 3 sites being within expected level. 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.

National Clinical Audits

The Trust has received an outlier notification for participation in the National Bowel Cancer Audit Project. This outlier notification may remain for a number of years due to it being a five year rolling audit. Case note reviews are underway and will be presented to the Clinical Effectiveness Group in March.

eDD

The Trust achieved 88.9% with sending eDDs within 24 hours for February 2022 against a target of 95% with 93% being sent anytime within the month.

Sepsis compliance – based on January data

Screening / IVAB / inpatient child - Screening compliance for paediatrics in ED was 86% and inpatients at 84.61%, with the administration of IVAB for inpatient paediatrics at 83.3% in January 2021, an improving picture from the previous month. Screening compliance for adult inpatients has increased slightly this month to 89.8%, whilst screening for adults within ED has decreased slightly to 89.1%. Clinical Harm reviews continue as indicated and actions to recover can be seen further within this report.

Duty of Candour (DoC) – January Data

Verbal compliance for January has seen a significant increase at 85% against a 100% target and 38% for written. DoC training has been sourced from an external provider and was delivered throughout November 2021 with a further.

Operational Performance

The Covid 4th wave has seen an increase demand in terms of hospitalisation with numbers of inpatients now reducing. At the time of writing this executive summary (12th March 2022), the Trust has 44 positive inpatients. There are no patients requiring Intensive Care interventions. The Peak of wave 4 saw 90 patients being treated as inpatients and the highest number in February was 57. The impact of the 4th wave on staff absences remains high due to the increased prevalence of positive cases within our population. Lincolnshire has had at times the highest sickness rate in the Midlands. The current sickness absence attributed to Covid as of 11th March is 66 out of 666.

This report covers February's performance, and it should be noted that as the demands of Wave 4 decreases, the Trust has moved from the *Manage* phase into the *Recovery* and *Restoration* of services phase. This signifies to teams across the organisation transition to 2022/23 and the recovery of waiting times and return towards pre-Covid access.

On 14th February 2022 at 22.20hrs, the Trust escalated to an Internal Critical Incident where it remained until 08.15hrs on 18th February at which time the Trust de-escalated to OPEL 4.
The Trust engaged in a system supported intensive discharge event on 16th February which contributed to the Trust's ability to de-escalate.

A & E and Ambulance Performance

Whilst the summary below pertains to February'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 Urgent Care FPEC paper.

4-hour performance for February deteriorated against January's performance of 63.49% being reported at 61.18%. The Trust's performance has been below the agreed trajectory consistently for 16 months.

There were 637 12-hr trolley wait, reported via the agreed process. This represents an increase of 27.01% from January. Sub-optimal discharges to meet emergency demand remains the root cause but has been compounded with increased staff absence through sickness and agency booking cancellations. (Implications of this risk are captured in the Trust Risk Register)

Performance against the 15 min triage target in February demonstrated a deterioration of 4.64%. 81.98% in February verses 86.62% in January.

Overall Ambulance conveyances for February were 3,764 a reduction of 478 conveyances. This represents an 11.27% decrease against January. There were 781 >59minute handover delays recorded in February, an increase of 125 from January, representing a 16.01% increase. 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. February saw an increase of >120mins handover delays compared with January 391 in February compared with 296 in January, representing a 24.30% deterioration. >4hrs handover delays also increased, particularly at LCH. A total of 89 in February compared to 35 in January. This represents a 60.68% increase in the most extreme delays experienced by ambulance teams.

Length of Stay

Non-Elective Length of Stay remains of concern and is the major contributor to overcrowding in EDs and the subsequent impact on ambulance handovers. At 5.1 days average Length of Stay it is now the highest point for more than 16 months. The average bed occupancy for February 2022, was 90.90% vs 90.87% in January 2021. 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 (Home 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 has increased slightly in January to 2.97 days (January reported 2.72 days). This is mainly due to a higher level of complex patients accessing surgical pathways that require post-operative care period in intensive care or level 1 beds and is expected to fluctuate as more services are restored and recovered.

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.

January demonstrated a further decrease in performance of 1.45% to 53.52%. The Trust reported 2758 incomplete 52-week breaches for January end of month compared to 2185 in December. 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 January, the Trust reported 28 patients waiting longer than 104weeks. As of 8th March, the Trust still has 28 patients waiting longer than 104 weeks. A large proportion of these waits have been identified as a patient choice issue.

Waiting Lists

Overall waiting list size has increased in January to 61,224 compared to 59,747 in December, an increase of 1,477. 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. February demonstrated a slight increase (449 verses 424 in January). As of 8th March, ASI numbers have increased to 555 and is now above the agreed trajectory. The trajectory is 550.

As at week ending 6th March 2022, the Trust reported 21,812 over 26 week waits, 10,336 over 40 week waits, 3,696 over 52 weeks and 122 over 78 weeks. The longest waiting patients continue to be tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

DM01

DM01 for February reported a 64.91% compliance against the national target of 99%. A negative variation of 34.09% against the national target but a 6.03% improvement on the January outturn. The main area of concern remains Echocardiography.

Cancelled Ops

This indicator has not been met since July 2021. The compliance target for this indicator s 0.8%. February demonstrated a 1.90% compliance. A negative variance of 1.10% against the agreed target but an improvement of 0.31% on January.

The target for not treated within 28 days of cancellation is zero. February experienced 25 breaches against this standard verses 31 in January. An improvement of 19.36%

A review of the effectiveness of the 6:4:2 theatre scheduling meetings continues, however with variations in 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. Nationally none were met.

Trust compliance against the 62day classic treatment standard is 40.20% (against 85% target.) February compared to January demonstrates a decline in performance of 1.87%.

37.70% of the 14-day standard performance was 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.

62 Day pathway backlogs are not reducing in line with the trajectory but has shown improvement – 411 as of 10th March 2022 verses 487 as of 9th February 2022.

Workforce

Mandatory Training – Mandatory training rates have remained constant over the past 3 months. Staffing challenges and the lack of protected time while on shifts is being cited as one of the main reasons for staff not completing their core learning.

Sickness Absence – The sickness rate has continued to reduce and is at its lowest for the last 3 months, however this figure is expected to have a continual rise, which is then expected to spike again with the rise in COVID cases nationally following the government restrictions being lifted.

There continues to be a review of the Trusts recording and monitoring within the Absence Management System 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.

Additional on-site Physiological support is in the final stages of being arranged with a Business Case being prepared for approval of the additional funding required.

The requirement for the mandatory Covid vaccination has now been withdrawn however the Trust will continue to promote for the protection of colleagues and patients that we recommend that staff undertake having the COVID vaccinations when offered.

Staff Appraisals – The OD team has now completed a deep dive into the drop in appraisal completion rates. This report has been presented to the senior leaders in HR/OD for discussion and next steps. The WorkPAL contract is also under discussion with the vendor. Ongoing operational pressures and staffing challenges in the Trust has impacted the appraisal completion rate over the past 6 months.

Staff Turnover – Turnover has remained at over 13.5% for the past 3 months. This increasing trend is similar in other acute Trusts as well. Operational pressures, staffing challenges and Covid has meant that an increasing proportion of staff are looking for other avenues outside the Trust. The OD team also now offer face to face / Teams exit interviews and this will give us deeper insight into why people are leaving (in additional to the results on ESR / EF3 form).

Finance

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

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

The Lincolnshire system has submitted a break-even position for H2 including delivery of £20m of efficiency savings. As part of the system plan, the Trust plans a break-even position in H2 including delivery of £6.0m of efficiency savings. The Trust delivered a breakeven position in month 11, and the Trust has YTD delivered a surplus of £1,923k (£123k favourable to plan).

The capital programme for 2021/22 currently stands at c£45.6m for the full year; actual capital expenditure of £23.9m has been incurred YTD with £21.7m needing to be incurred in March 2022.

The month end cash balance is £68.6m which is an increase of £14.6m against cash at 31 March 2021.

Paul Matthew
Director of Finance & Digital and (interim) People
March 2022

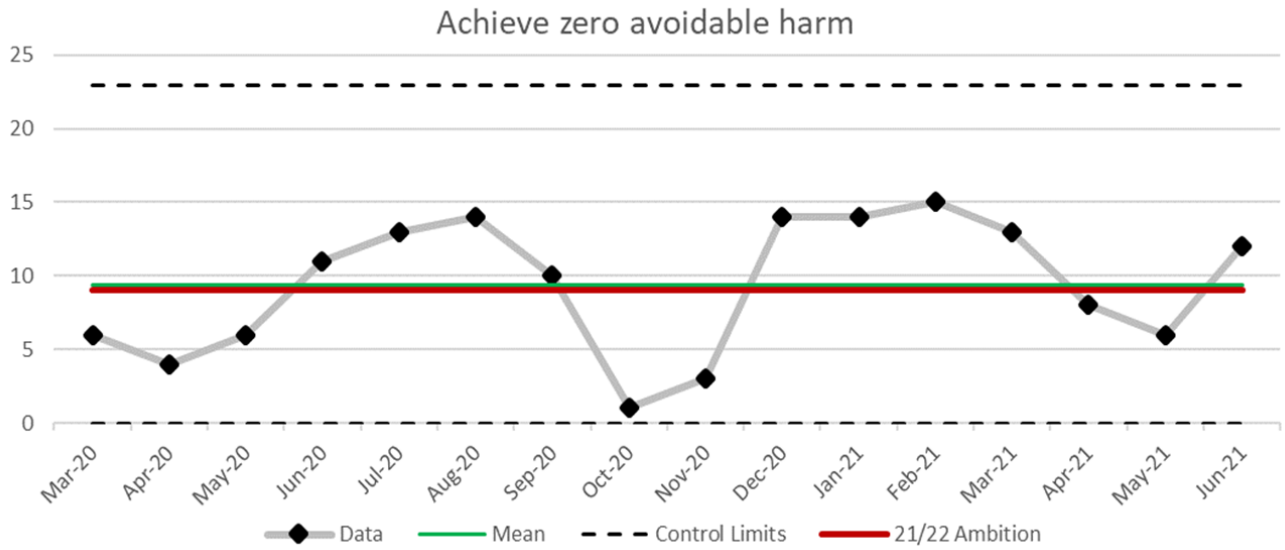
Statistical Process Control Charts

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

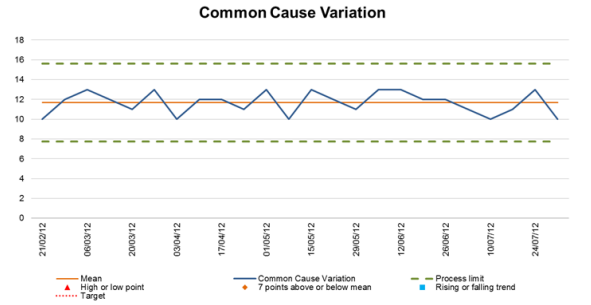
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

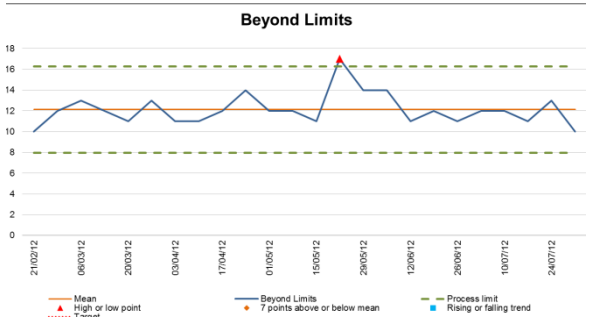
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



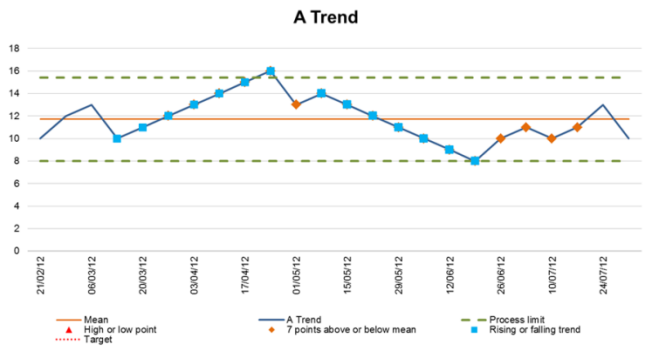
Extreme Values

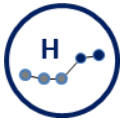
There is no Icon for this scenario.



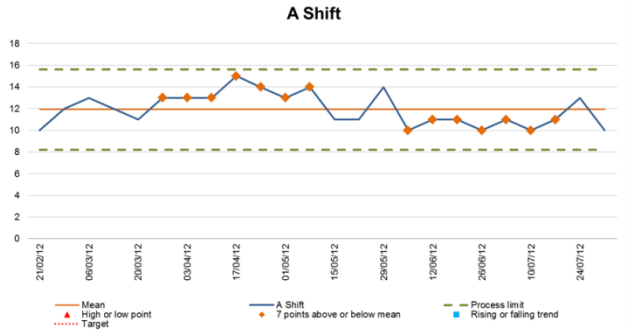
Statistical Process Control Charts

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

EXECUTIVE SCORECARD

									2021/2022				
Strategic Goal	Domain	Measure ID	Measure	Measure Definition	Baseline	21/22 Ambition	£'000	Dec	Jan	Feb	Latest month pass/fail to ambition	Trend variation
Strategic Metrics	Patients	1	Top 25% for acute Trusts for 'Overall' Inpatient experience	Monthly Inpatient Friends and Family Test results, which are a proxy for annual inpatient experience survey.	4th Quartile	3rd Quartile		(4th Quartile) (90.43%) (96th of 118)	(tbc) (89.85%) (tbc)	(tbc) (85.87%) (tbc)		
	Patients	2	Achieve zero avoidable harm	Serious incidents (including Never Events) of harm - Moderate, severe and death.	15	9		2	5	3		
	Patients	3	Top 25% for SHMI	Summary Hospital-level Mortality Indicator	4th Quartile	4th Quartile		4th Quartile (110.20) (105th of 122)	4th Quartile (110.73) (106th of 122)	4th Quartile (111.20) (108th of 122)		
	People	4	Top 25% for acute Trusts across all 10 themes in the staff survey	In year monitoring via staff survey on staff morale and leadership.		+10% improvement						
	Partners	26	Deliver 62 day combined cancer standard (77%)	Patients that start a first treatment for cancer within two months (62 days) of an urgent GP referral, including NHS cancer screening services.	69.20%	77%		54.30%	39.10%			
	Partners	27	Total wait in Emergency Department over 12 hours (<1% of patients)	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	3.60%	<1%		14.30%	17.43%	21.43%		
	Partners	28	Urgent Treatment (P2) treatment turnaround time is less than 4 weeks	Waiting time from receiving patient referral until treatment is given.	6.7	<4 weeks		6.3	7.5	9.1		
	Partners	29	Deliver Outpatient activity through non-face to face	Increase volume of Outpatients activity for pre-booked telephone and web-based sessions, between consultant and patient	45.28%	>25%		32.85%	33.41%	32.54%		
	Services	9	Deliver a breakeven revenue position	Financial status - Revenue monthly variance to plan		Breakeven	£'000	£0.00	£123.00	£0.00		
	Services	10	Deliver £200m capital plan	Financial status - Capital monthly actual shown cumulatively	£15m	£39m	£'000	£12,887.30	£18,341.70	£23,869.70		
Local Projects	Patients	11	No. of medication errors causing harm is <10%	Medication incidents reported as causing harm (low /moderate /severe / death), as a percentage of total medication incidents.	20%	13%		23.20%	18.80%	23.08%		
	Patients	12	Reduce no. of patient fall incidents. (Last 3 month Average)	Number of Falls reported (including no harm)	200	159 (-20.5%)		172.3	180.0	170.7		
	People	13	% of staff saying proud to work for ULHT	Staff survey on morale and leadership		+10% improvement						
	Partners	14	First non elective admission by 10am	Daily situation reporting before 10am, on unplanned admissions of patients for specific General and Acute wards.	48%	60%		62.18%	57.14%	56.43%		
	Services	15	Reduce agency spend by 25%	Reduction in hospital recruiting to posts as temporary cover (non permanent salaried positions). Agency - cumulative actuals	£44m	£33m (-25%)	£'000	£34,171	£38,060	£41,861		
Watch Metrics	Patients	16	Reduce complaints around discharge by 50%	Where patient has been discharged from hospital but is unsatisfied in the way the discharge was handled	n/a							
	Patients	17	Reduce complaints about the experience in A&E by 50%	Patient experience complaints about treatment of A&E	n/a							
	Patients	18	Time to screening and treatment for sepsis (1 hour)	Number of sepsis incidents reported - % of 8 metrics passing to 90%	37.5% (3/8)	62.5% (5/8)		37.5% (3/8)	37.5% (3/8)			
	Patients	19	Reduce incidence of pressure ulcers	Number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable	58 pcm	45 pcm		51	47	49		
	People	20	% of staff that feel trusted and valued	Staff survey on morale and leadership								
	People	21	No. of managers trained in coaching skills	Staff survey on morale and leadership								
	Partners	22	Increase the proportion of patients seen by a decision maker within one hour	Patient arrival to the time seeing a A&E doctor, within 1 hour.	50%			46.33%	50.47%	45.19%		
	Partners	23	Reduction in the new to follow up ratio	Reduction in the number of follow up outpatient activities undertaken.	1:2.28			1:1.51	1:1.48	1:1.41		
	Partners	24	First OPA within 4 weeks	Number of outpatients seen within 4 weeks of their referral to hospital. Includes external referrals only (from GP, Dentist, Optician) for all urgency types (2WW, Urgent, Routine) to consultant led services (non-telephone).	51%			38.60%	34.28%	43.52%		
	Services	25	Improve CIP performance to a minimum of 4% by 2021/22	Improving the financial performance through proactive monitoring of Cost Improvement Plan (CIP) - monthly variance to CIP plan (H1 £6.412m)	£11.1m	£15.4m	£'000	£468.00	£0.00	£39.00		

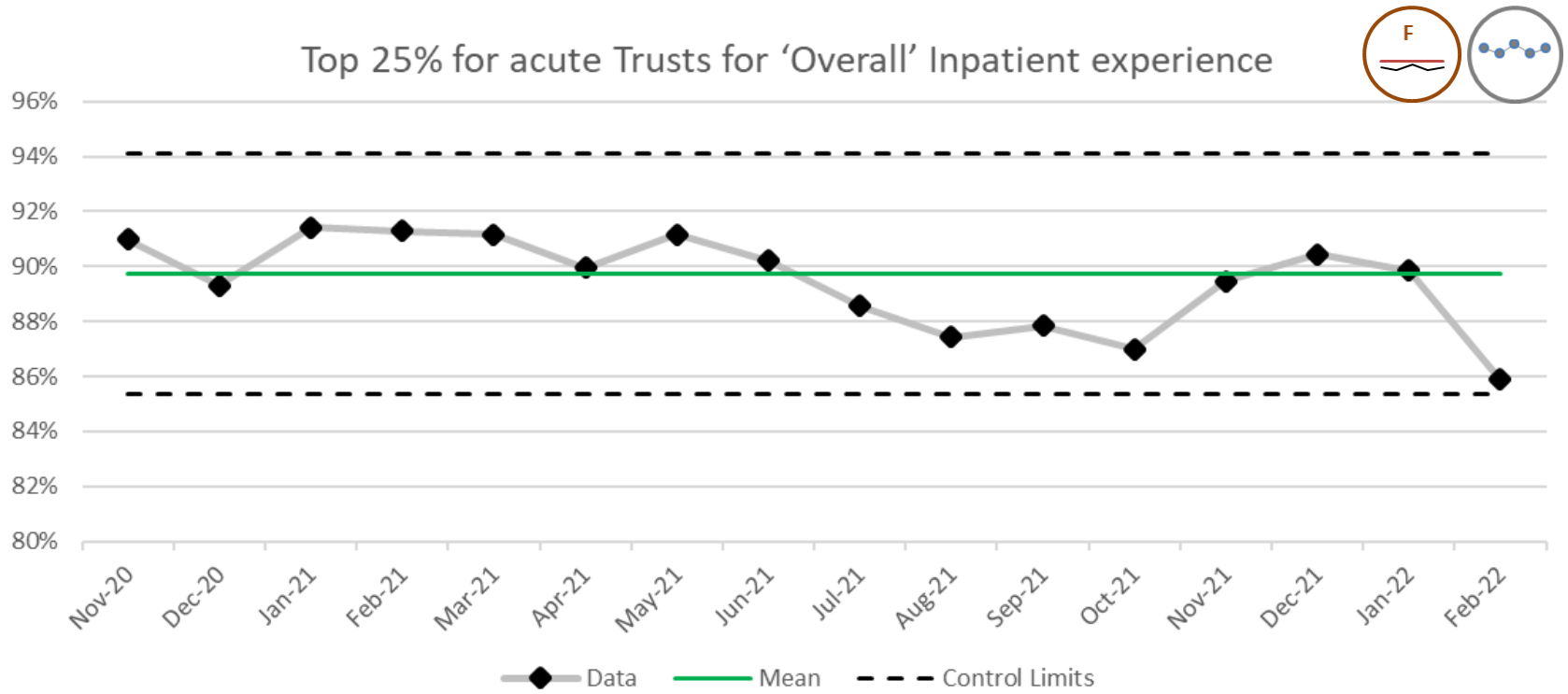
Quality | Operational Performance | Workforce | Finance

(Grey means data unavailable, red is missing)

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
85.87% ranking tbc
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
3rd Quartile
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:
Top 25% for acute Trusts for 'Overall' Inpatient experience

What the chart tells us:
We are currently at 85.87% for February 2022.

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

- Waiting times
- Communication
- Staff

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

Actions:

- Waiting times – this largely relates to ED reflecting the current and protracted challenges with capacity. Patient Experience team currently scoping a deep dive into patient experiences within EDs.
- Communication – Phone a Relative campaign in development.

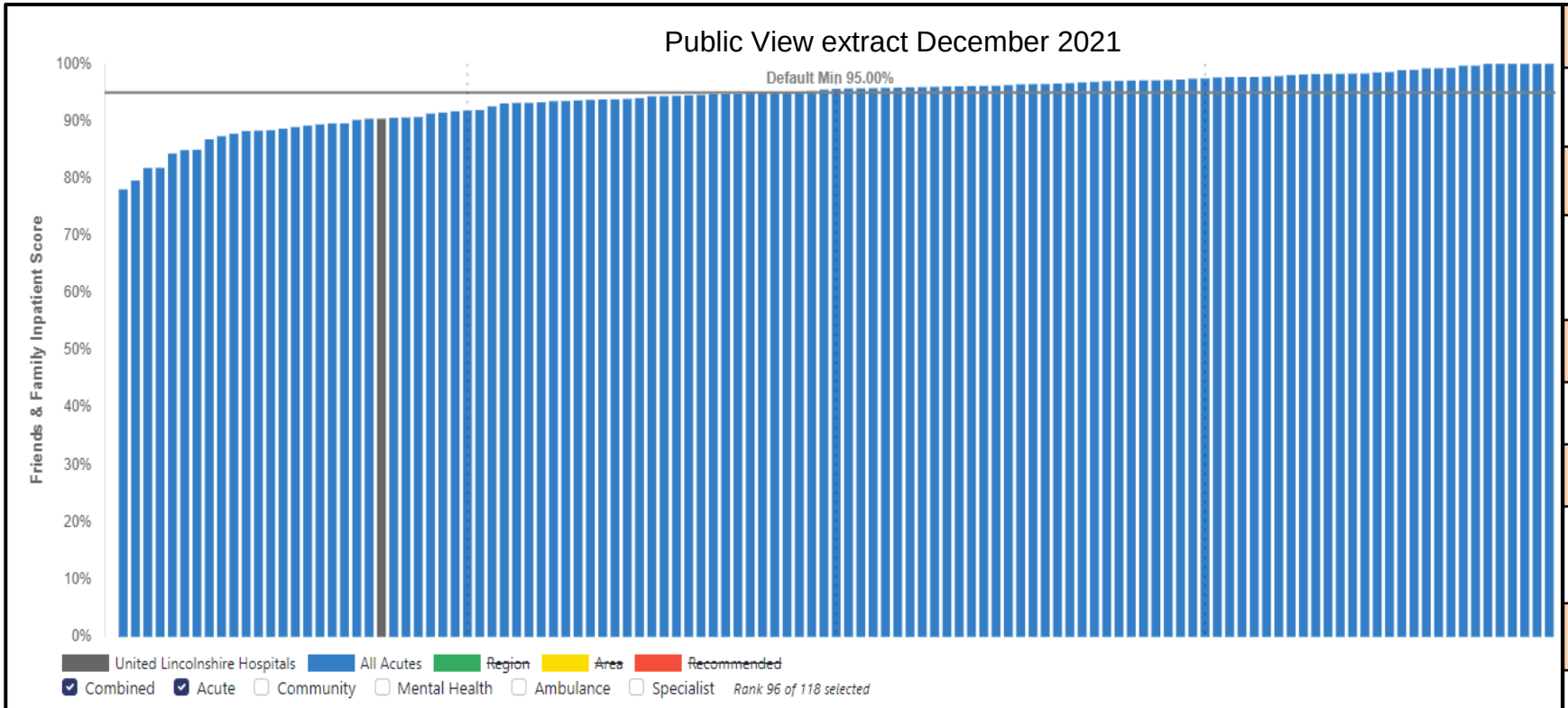
Mitigations:

- Patient Experience training approved and to be launched in March.
- Overarching combined national survey action plan in development.
- Divisional assurance reporting strengthened.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-21
4th Quartile (90.43%) (96th out of 118)
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
3rd Quartile
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:
Top 25% for acute Trusts for 'Overall' Inpatient experience

What the chart tells us:
The latest reported month in Public view December 2021 shows we are 96th out of 118 Trusts, in the 4th quartile, against a 21/22 ambition to be in the 3rd quartile.
Rankings are Acute Trusts excluding specialised.

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

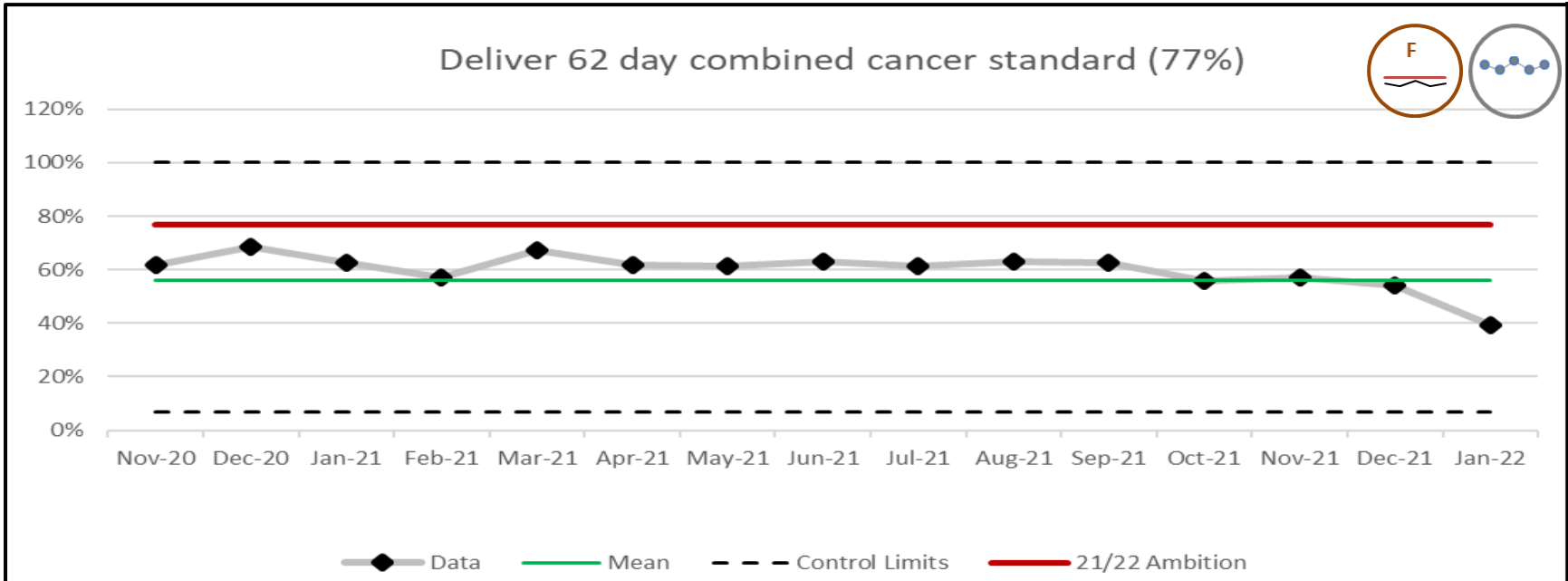
Actions:
- Drive the thematic actions as detailed above.
- New Patient Experience Manager commenced 07.03.22 and across the 2 post-holders will reach in and support services.

Mitigations:
- 'Patient Experience pop-ins' commencing April with patient experience team visiting all wards and departments to undertake audit and identify development needs.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-21
39.10%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
77%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 39.10% against a 77% target.

Issues:

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

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

Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, and 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 for 2021-22. Two substantive Medical Oncologist posts are out to advert. A third is with Royal College awaiting approval of job plan. Two of these posts are currently being covered by Locums. A fourth substantive consultant post is taking a 6 month break and is out to advert. There is a significant lack of consultants nationally and very few available from agency.

Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI, Head & Neck, Skin and Lung CBU's to support clinical engagement.

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

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

The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists commenced on 14/02/2022. Robotic training for the Colorectal consultants is underway and lists are in the process of being identified.

Mitigations:

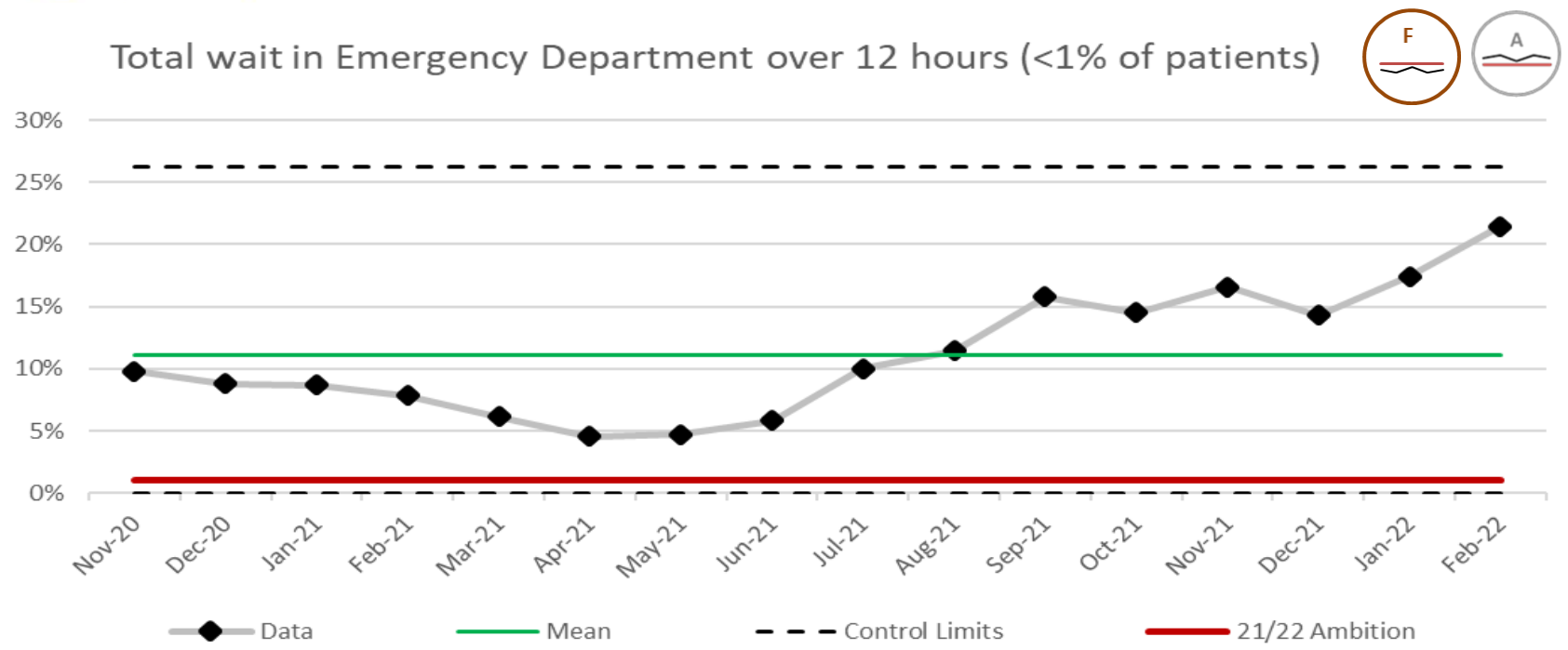
Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at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

The number of Head and Neck diagnostic investigations performed at first appointments are set to increase from April 2022 due to the purchase of scopes for all outpatient clinics

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
21.43%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
21/22 Ambition
<1%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

February experienced an increase in the numbers of patients with an aggregated time of arrival greater than 12 hours. 1750 in February compared to 1453 in January

The target for this metric has not been met.

Issues:

The main factor continues to be because of exit block due to inadequate discharges to meet the demand. A slight deterioration in the discharge profile was seen in February

Escalation of SDEC areas (although less frequent) impacting on flow.

Increased number of patients experiencing an elongated LOS due to requiring non acute admission but requiring access to an alternative health care setting such as domiciliary care, transitional care, community hospital and Adult Social Care. The establishment of a joint health and social care off for domiciliary care is now in place.

Delays in time to first assessment contribute to the clear formulation of a treatment plan, especially out of hours.

Limited ability to enact ExIT protocol due to restricted access to inpatient bed through IPC reasons.

Actions:

These actions are repetitive but remain relevant.

Reduce the burden on the Emergency Department through maximising discharges in the morning to create flow and reduce exit block.

Use of alternative pathways such as the UTC, CAS, SDEC, FAU and SAU.

Direct access via EMAS to Community and transitional care facilities established and now in place to SDEC, FAU and SAU.

The use of the Trust agreed ExIT procedure as part of the Full Capacity Protocol which allow each ward (agreed list) to support the care of an extra patient, above their current bed base.

Mitigations:

EMAS have enacted a targeted admission avoidance process.

The Discharge Lounge at LCH and PHB continue to operate a 24/7 service provision to release the burden placed on the Emergency Department at in terms of patients awaiting AIR/CIR and transport home. Although increased overnight closures of the DL have been experienced in February

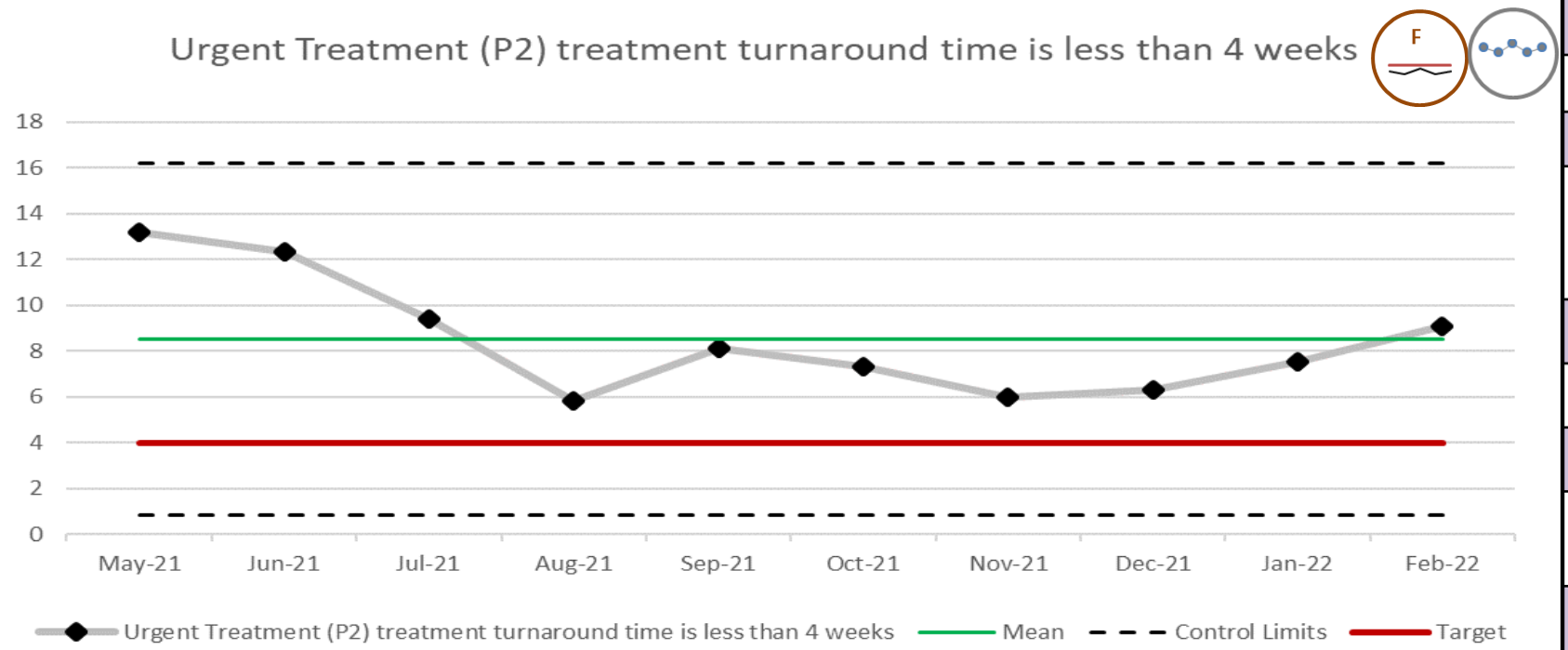
Increased CAS and 111 support especially out of hours have been further enhanced.

Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation. Although the ability to board patients is becoming more problematic, this is being formally review via the Quality Cell.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
9.1
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
< 4 weeks
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

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

What the chart tells us:
General reduction in turnaround times since May 2021, although target of 4 weeks has not been met and is currently at 9.1 weeks which is deterioration of 1.56 weeks since January.

Issues:
The admitted position remains challenging. Wave 3/4, winter pressures and capacity challenges are impacting on service delivery, which will in turn, detrimentally effect P2 turnaround times. The largest specialty challenge remains Colorectal Surgery.

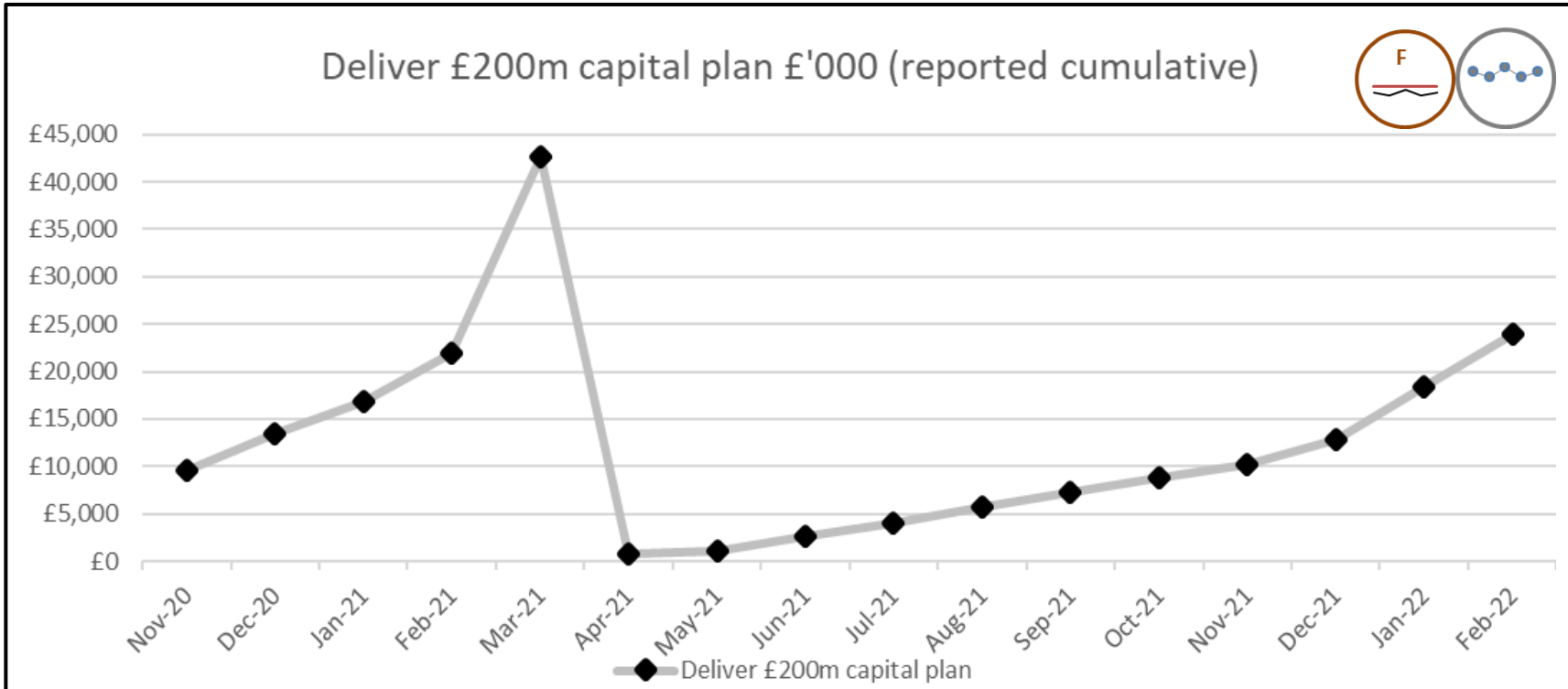
Actions:
Admitted patients are individually graded and allocated a priority code. The longest waiting patients, irrespective of their P code status are treated alongside urgent and P2 patients. Working to use and implement C2AI to ensure appropriate prioritisation of patients. The clinical prioritisation cell, reporting to the Planning Steering Group, is focusing closely on Cancer patients and overdue P2 patients and that Lincoln and Boston adult elective activity is currently focused on these cohorts.
There are now 'ring fenced' beds on Day Case ward at PHB, 'ring fenced' beds on SAL and 'ring fenced' level 1 beds on Hatton Ward at LCH.

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
£23,869.70k
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£39 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

Background:
The Trust had a revised capital programme to deliver of £45.6m, as at the end of February.

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

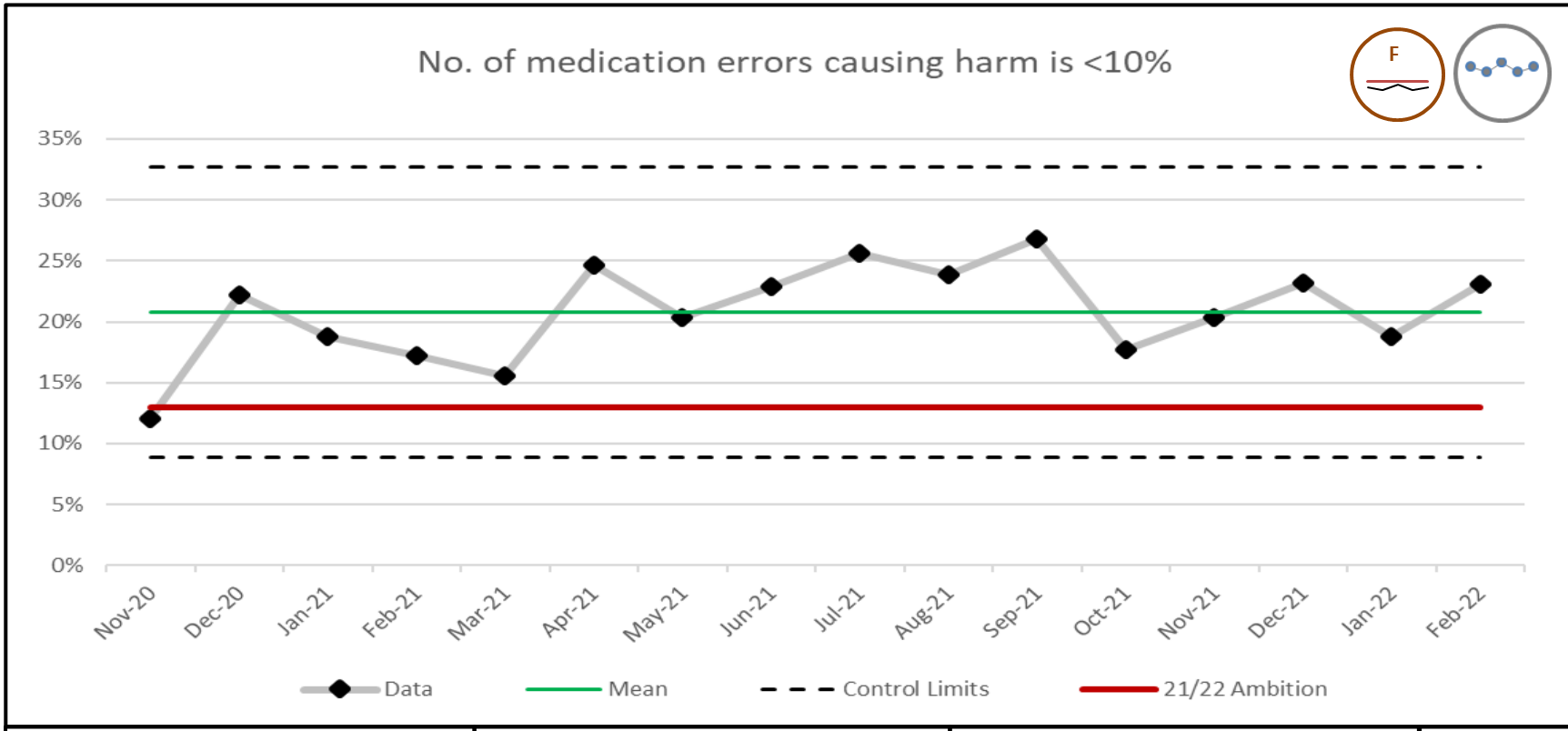
Issues:
The Trust has a large capital programme to deliver in 2021/22, and delivery of the programme is at greater risk if the actual expenditure profile is heavily weighted in the final two quarters.
As at the end of February, YTD expenditure of £23.9m has been incurred. Therefore expenditure of £21.7m in needed in March to deliver the revised programme in full.

Actions:
To ensure that the capital programme will be delivered in full, the programme is being managed via Capital Delivery Group (CDG). Forecasting meetings are continually held with scheme leads highlighting areas of slippage, risk and mitigations. Details shared and schemes will be managed through CDG. Updated forecasts to be constantly under review.

Mitigations:
Where slippage exists, delegated authority has been provided by Trust Board to DoF and COO. Following this agreement, local decision has been reached to re-allocate based on the 'transition' year agreement at Financial Leadership Group (FLG) for 2021/22. Where this isn't possible, agree the next scheme within the 'System' based on the current known priorities.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
23.08%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
13%
Achievement
Metric is consistently failing to ambition
Executive Lead
Medical Director

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

What the chart tells us:
In the month of February 2022 the number of incidents reported was 143. This equates to 5.16 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 23.08% which is above the national average of 10.8.

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

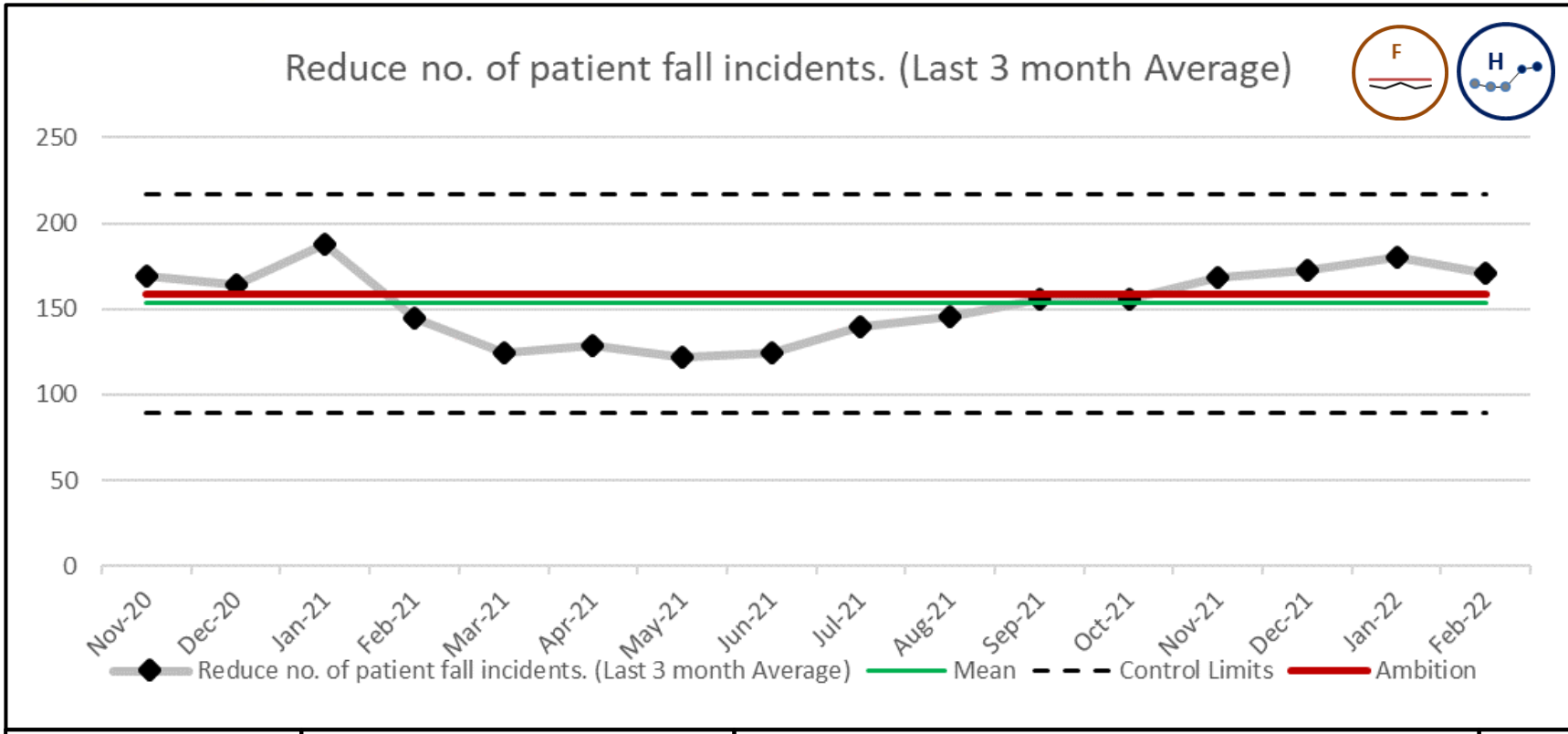
Actions:
A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management and reduce the number and potential severity of medicines incidents.

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
171
Variance Type
Metric is currently experiencing Special Cause Variation – High trend
21/22 Ambition
159
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:

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

What the chart tells us:

The actual number of inpatient falls for February has decreased by 36 from January. This has contributed to a decrease in the 3 monthly average although has not achieved ambition.

Issues:

Overall, this month, inpatient falls saw a decrease of 36 (January 187, February 151)

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

- Patient / family involvement with falls prevention
- Preventing repeat falls
- Assessment and consistent application of enhanced care processes
- Unwitnessed falls

Actions:

Review of the Enhanced Care process is underway in collaboration with the Safeguarding team to update the policy and simplify the assessment and process criteria for staff.
An initial falls prevention training schedule has been developed and will commence rollout in April 2022. Delivery will begin in areas demonstrating increased falls incidents.
Bespoke falls prevention training for the Emergency Department has been delivered throughout February to increase staff awareness of the risks of falls in their patient groups, and support early identification and intervention for patients vulnerable to falling.
Quality Matron team continue to monitor daily for patients who have had repeat falls and liaise with ward areas to ensure the risk is identified and appropriate interventions are instigated.

Mitigations:

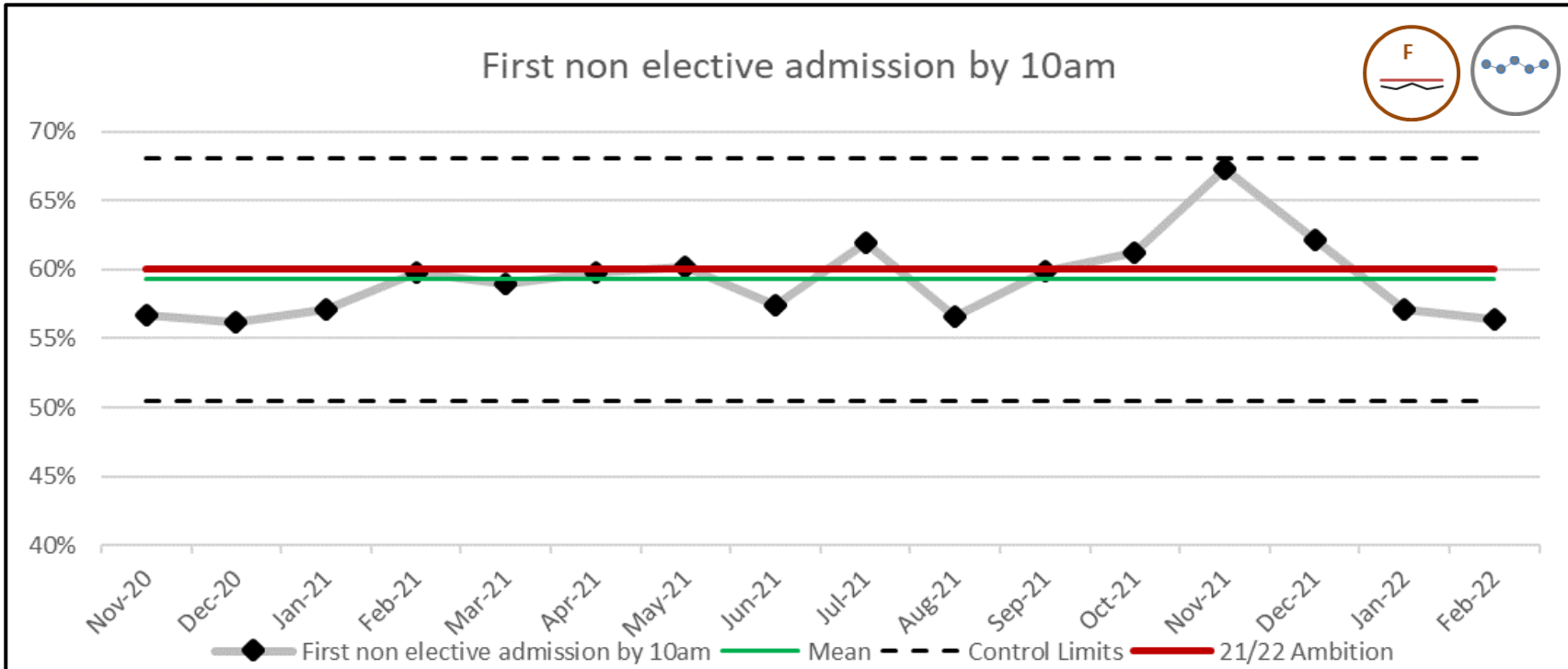
Falls prevention care is reviewed in the weekly ward/dept leaders assurance and monthly matrons audits.

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
56.43%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
< 4 weeks
Achievement
Metric is failing to ambition
Executive Lead
Chief Operating Officer

Background:

The Trust target against this standard is 60% of total non-elective admission being admitted before 10am.

What the chart tells us:

This metric achieved against the target from October 2021 to December 2021.
February experienced a decrease in the number of non-elective admission before 10am.
The compliance stated for January has been subject to additional scrutiny against the target of 60%.
The compliance against this metric is 56.43%. This equates to 662 patients admitted before 10am.

Issues:

The main factor causing this deterioration is attributed to poor flow the previous day thus leading to increased bed waits in the emergency departments in the morning.
Zero compliance against the standard of 10 discharges by 10am, sub optimal use of the discharge lounge before 10am and against the national standard of 35% of all discharges before midday.
The above is probably a more informative indicator.

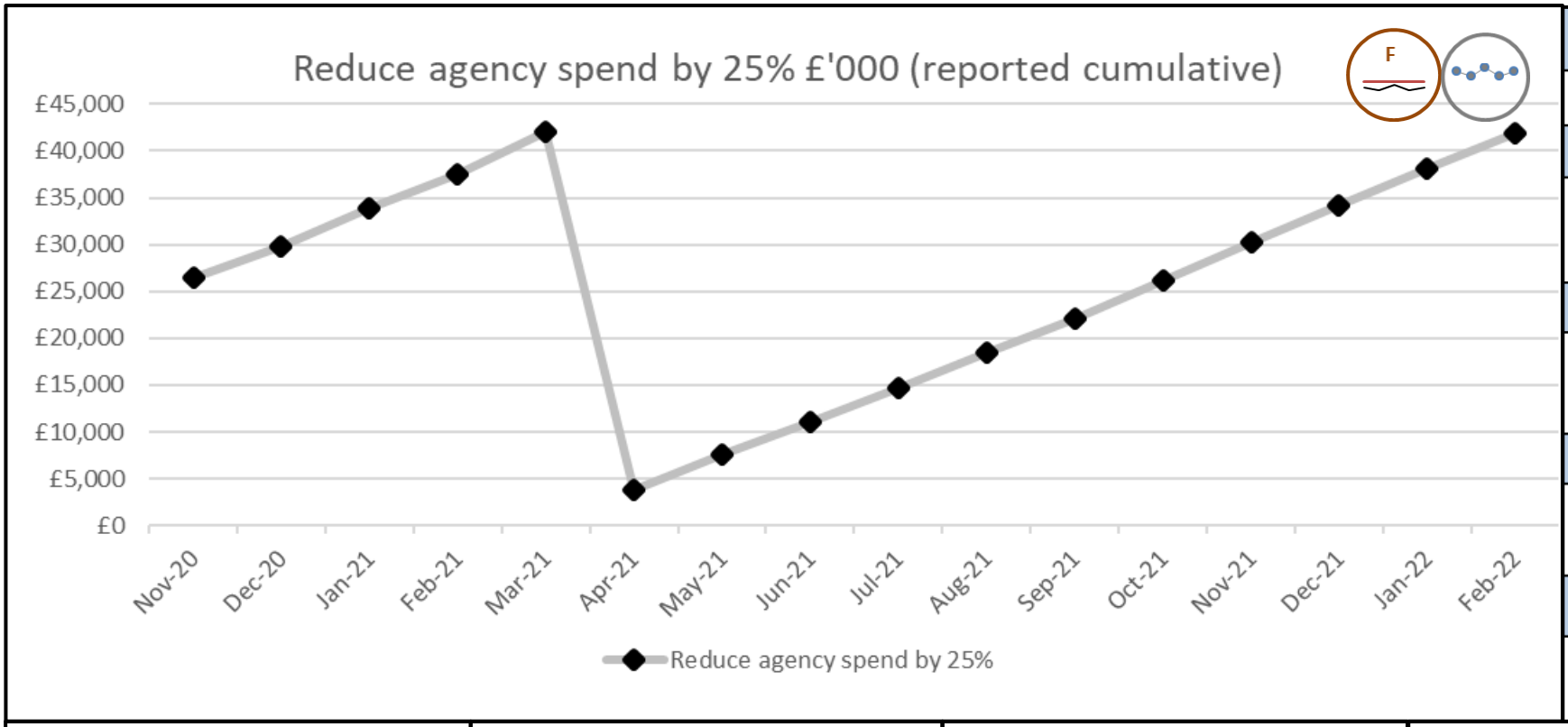
Actions:

Effective utilisation of the Reason to Reside intelligence to optimise discharges.
Identification of '10 by 10' patients the previous day, ensuring all discharge arrangement are complete and communicated clearly.
Extended opening hours of the discharge lounge incorporating a pull model/in reach to the wards.
Forward look over 72 hours against discharge planning and readiness to leave.
Pull model by system partners to allow exit of all patients on pathway 1, 2 and 3 with a greater then 24hrs LOS post becoming medically optimised.

Mitigations:

3 x daily updates on flow and discharge using local intelligence and reason to reside information to effect more timely morning discharges.
Early use of the discharge lounge for confirmed medically optimised discharges on pathway 1, 2 and 3.
Appropriate use of the full capacity protocol to release assessment unit capacity.

Quality | Operational Performance | Workforce | Finance



Feb-22
£41,861k
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£33 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

Background:
Aim to reduce agency spend by 25% or £11.0m from £44.1m in 2019/20 to £33.0m in 2021/22; the Trust has an Agency Ceiling of £21m.

What the chart tells us:
Agency spend of £41.9m YTD in 2021/22 has exceeded the annual target spend of £33.0m and with one month left spend in 2021/22 will in likelihood exceeds 2019/20 levels by £1.6m.

Issues:
The Trust has traditionally spent most on Medical and Dental Agency than on any other staff category. However, a continued focus upon a Plan for Every Post has meant that Medical and Dental YTD spend is £0.2m favourable to the IIP plan.

Increased Agency spend on Registered Nursing, Midwifery & Health Visitors has meant that YTD spend is £7.9m adverse to the IIP.

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

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

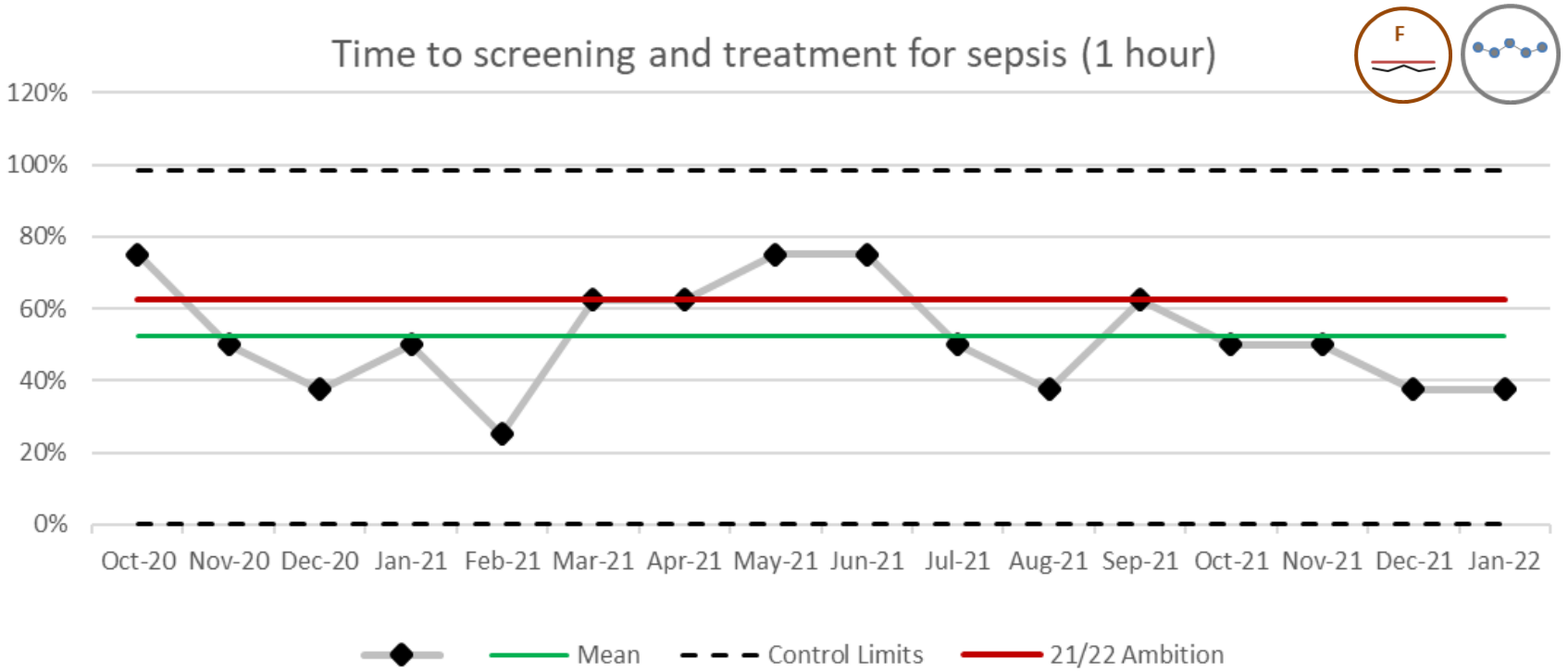
Mitigations:
There remains a continued focus upon Plan for Every post across all staffing categories.

The Trust also continues to review opportunities in the following areas: convert Agency staff to NHS locums; reduce our usage of higher tier agencies; reduce our reliance on Agency staff by increasing the Staff Bank.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
37.5% (3/8)
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
62.5% (5/8)
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

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

What the chart tells us:
3 out of the 8 sepsis metrics passed to target (37.5% pass rate) against an ambition of 5 out of 8 (62.5% pass rate).

Issues:
The reporting month has shown an increase in metrics failing the ambition with adult metrics showing a dip in compliance compared to previous months. The paediatric figures, whilst still below 90% for compliance, are showing steady and tangible improvement. Within Adult metrics there is a slight site based theme.

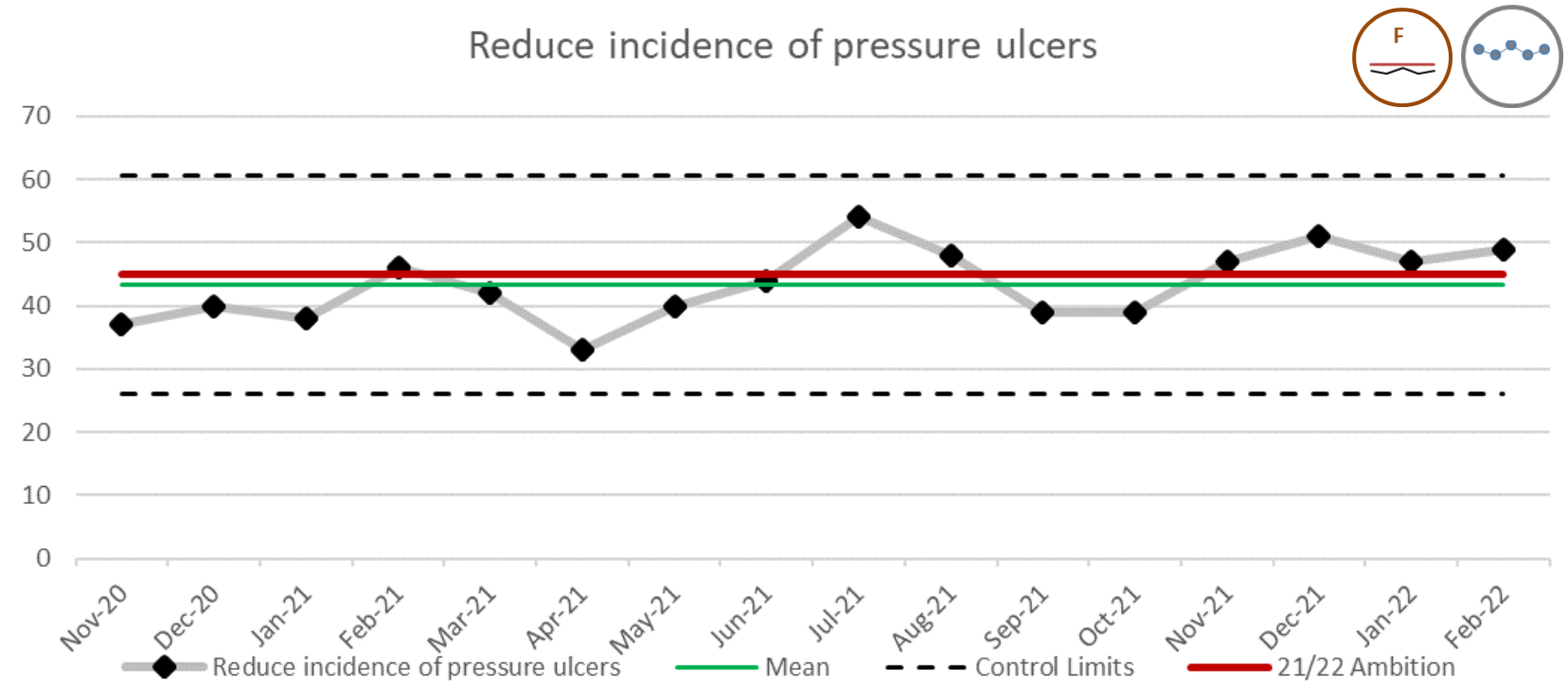
Actions:
Appointment of a sepsis practitioner at Lincoln will augment the team and help support further teaching in areas that have shown a dip in compliance.
Work continues on an enhanced e-learning module to improve the relevance to our practice.

Mitigations:
Data is being pulled frequently and Harm reviews are being completed for all patients with delayed Screens or bundles.
Following completion of an induction period a second sepsis practitioner will be able to support ward areas. AIMS training is now available which includes sepsis and management of shock.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
49
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
45
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:

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

What the chart tells us:

The total number of reported hospital acquired pressure ulcers for Categories 2, 3, 4 and Unstageables is 49, an increase of 2 from January.

Issues:

There has been one category 4 pressure ulcer reported in February. This will be investigated in accordance with the serious incident framework.
This is the second category 4 reported since May 2021.

Three Category 3 pressure ulcers were reported, this remains the same as January. These will be investigated and RCA meetings will be undertaken with the clinical teams.

There has been an increase in moisture associated skin damage incidents which have not always been appropriately managed leading to a subsequent deterioration and resulting pressure ulcer.

Actions:

A RCA meeting chaired by the Deputy Director of Nursing will be undertaken to review the category 4 pressure ulcer with the teams involved across the patient's pathway of care in order to identify learning and actions to improve.

In line with the National Awareness Day for Moisture Associated Skin Damage (MASD) on the 17th March the Tissue Viability team will be promoting preventative treatment and providing education for staff.

Work is being undertaken to replace existing bed frames with 400 profiling beds, this will assist repositioning of patients who are vulnerable to skin damage and support safer manual handing for staff.

Mitigations:

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

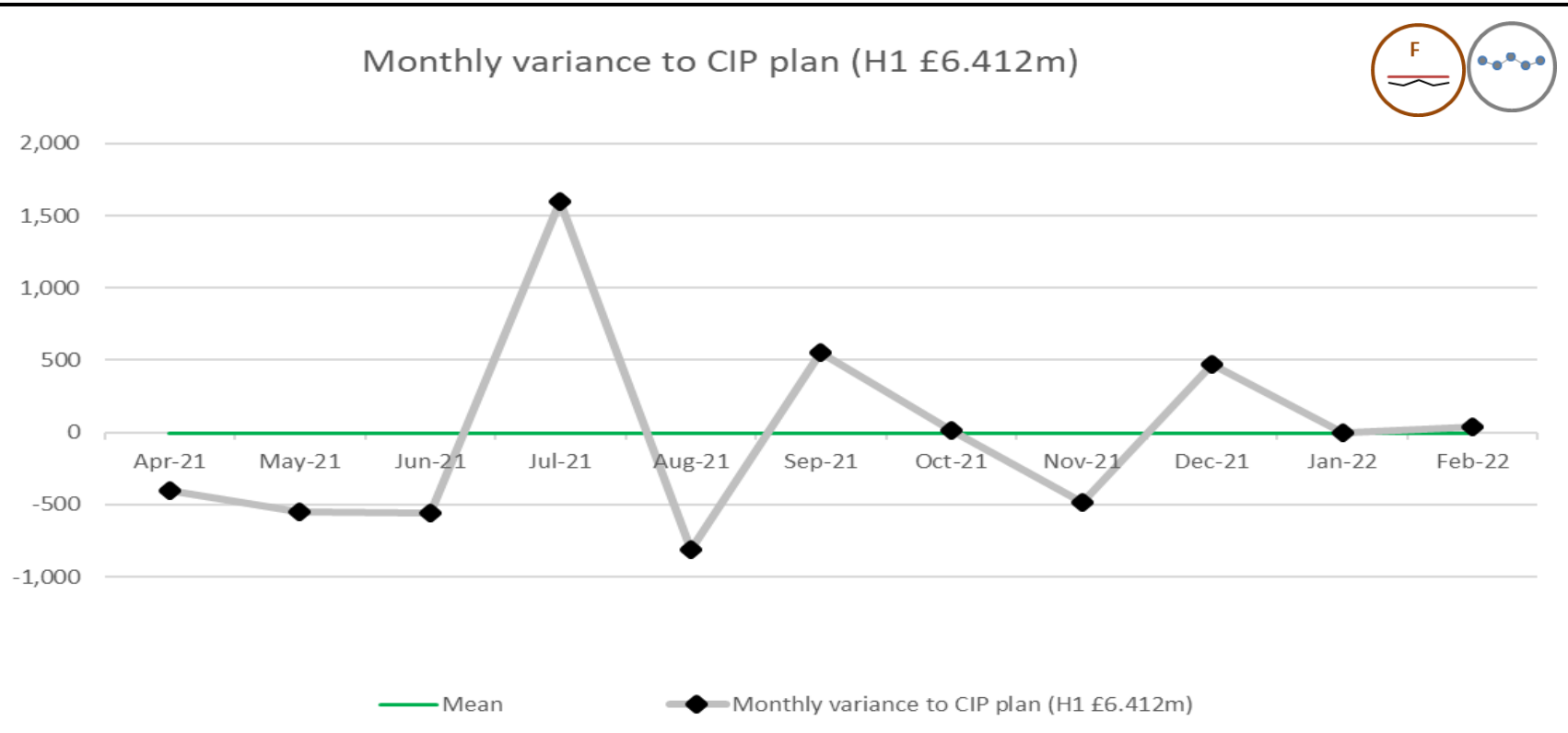
Skin integrity care is reviewed in the weekly ward/dept leaders assurance and monthly matrons audits.

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22

Variance to plan £39k

Variance Type

Metric is currently experiencing Common Cause Variation

21/22 Ambition

£15.4 Million for the year

Achievement

Metric is failing to ambition

Executive Lead

Director of Finance

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

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

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

Delivery in H2, whilst in line with plan, remains overly reliant upon non recurrent savings.

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

Recruitment to the vacant efficiency manager posts is ongoing.

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Dec-21	Jan-22	Feb-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	6	7	3	51	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	1	0	0	2	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.00	0.07	0.01	0.04		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.23	0.01	0.10		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1				5		
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.23	0.07	0.11	0.09	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	3	3	13	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	1	1	3	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	8	8	6	61	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	95.58%	94.80%	95.03%	95.75%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	2	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.59	4.67	5.16	5.30	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	23.2%	18.8%	23.0%	22.45%	F	A

OUTSTANDING CARE personally DELIVERED

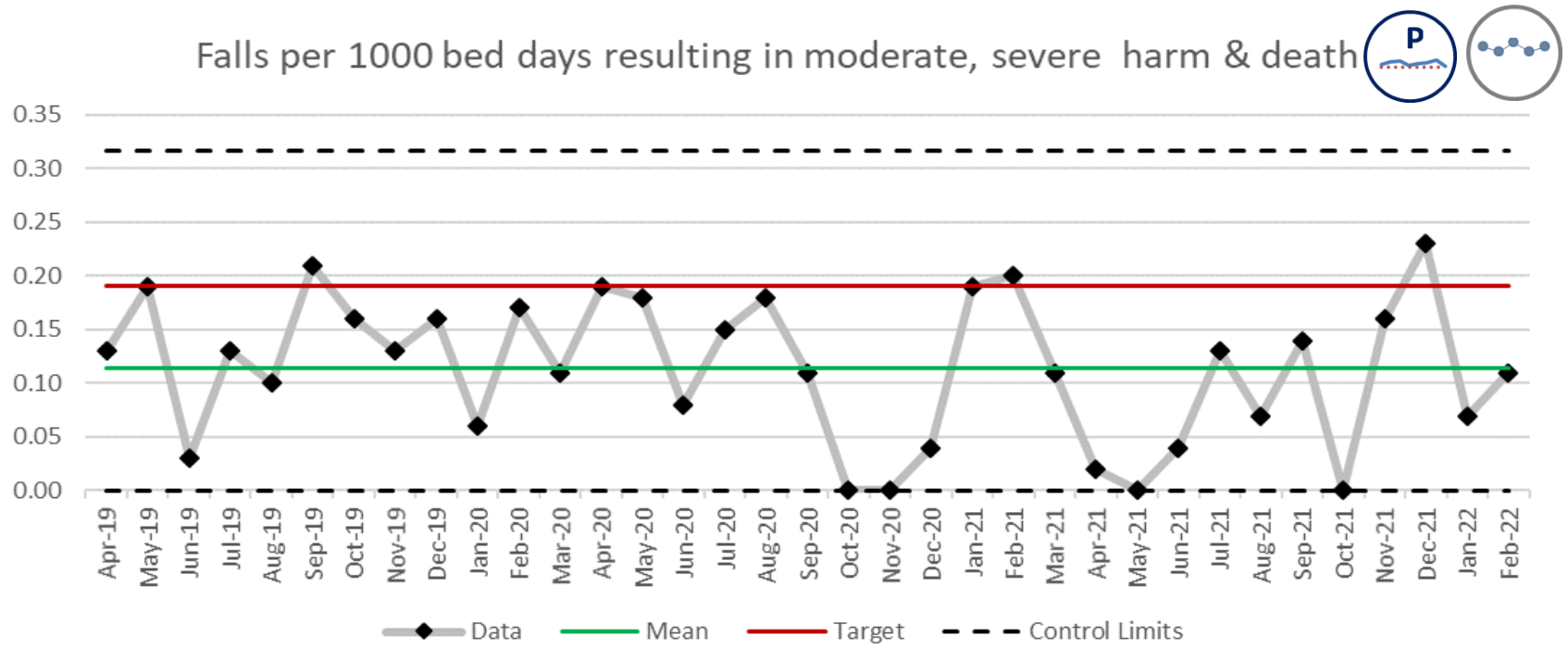
NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Dec-21	Jan-22	Feb-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	73.40%	P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	107.28	107.40	103.12	108.22	F	A
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	110.20	110.73	111.20	111.46	F	A
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	98.00%	98.00%	100.00%	96.68%	P	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	88.20%	89.50%	88.90%	89.51%	F	B
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	86.6%	89.8%		89.75%	F	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	83.0%	84.6%		85.50%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	96.4%	96.5%		93.89%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	88.9%	83.3%		84.78%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	92.8%	89.1%		91.96%	F	A
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	76.6%	86.0%		82.84%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	95.8%	95.8%		95.00%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	71.4%	100.0%		69.90%	P	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	3.24	3.00	3.42	3.12	P	B
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	70.00%	85.00%		63.70%	F	B
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	33.00%	38.00%		37.00%	F	B

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
3
Variance Type
Metric is currently experiencing Common Cause Variation
Target
1.6
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:

Patient falls resulting in moderate harm.

What the chart tells us:

There have been 3 falls resulting in moderate harm in February. This is an increase from 0 in January.

These will be validated through the incident review process and the appropriate level of investigation instigated.

There have been 0 fall incidents reported with the severity recorded as severe harm or death in February, which is a reduction from 2 in January.

We are currently at 20 moderate harm falls incidents for Q1/Q2/Q3/Q4 against a target of ≤19 per annum, and 8 severe harm falls incidents for Q1/Q2/Q3/Q4 against a target of ≤ 17 per annum.

Issues:

Assessment and consistent application of enhanced care processes remains a priority area to improve. This has continued to be impacted by continued operational and staffing pressures during February.

February has seen a reduction in the number of repeat falls incidents and a small decrease in the number of these which were unwitnessed in comparison to January.

Actions:

Review of the Enhanced Care process is underway in collaboration with the Safeguarding team to update the policy and simplify the assessment and process criteria for staff.

An initial falls prevention training schedule has been developed and will commence rollout in April 2022. Delivery will begin in areas demonstrating increased falls incidents.

Bespoke falls prevention training for the Emergency Department has been delivered throughout February to increase staff awareness of the risks of falls in their patient groups, and support early identification and intervention for patients vulnerable to falling.

Quality Matron team continue to monitor daily for patients who have had repeat falls and liaise with ward areas to ensure the risk is identified and appropriate interventions are instigated.

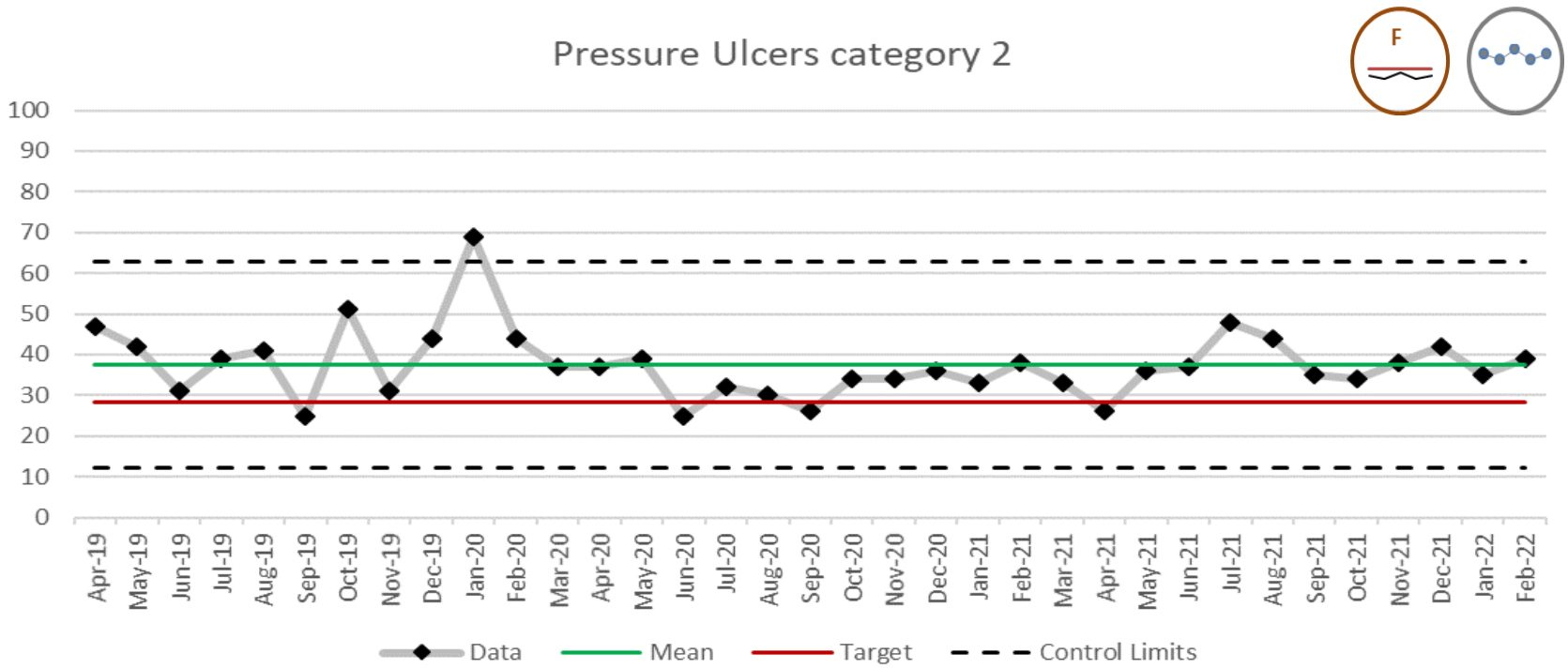
Mitigations:

Falls Prevention Steering Group are sighted on areas with increased incidences where deep dives need to be undertaken, and informed of the outcome to facilitate enhanced support offers where necessary.

Quality Matron team provide support to areas with increased incidences.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
39
Variance Type
Metric is currently experiencing Common Cause Variation
Target
28.3
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:

Pressure Ulcers Category 2.

What the chart tells us:

We are currently at 39 against a target of 28 per month. An increase of 4 from the month of January.

Issues:

For the second month higher numbers of Category 2 damage has been reported at LCH in comparison to PHB.

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

1. Delayed and incomplete skin assessments within the Emergency Department (ED), resulting in skin damage being identified by the admitting wards.
2. Documented that some patients are declining initial skin assessment and later damage has been identified. Not consistently evident that reasons for checks and risks of skin damage are being explained.
3. Due to operational pressures occasions when patients have spent a prolonged time in ED or waiting to be transferred from ambulance trolley.

Actions:

A skin integrity education proposal has been agreed at Skin Integrity Group (SIG) and will be presented to the Nursing, Midwifery, AHP Advisory Forum (NMAAF) in March.

A skin integrity Ambassador proposal has also been agreed at SIG and will be presented to NMAAF in March. This will provide additional specialised training for nominated staff members from each ward/dept. These will both provide a structured framework to develop knowledge and competency of staff groups based on the requirements of their role.

The Tissue Viability team continue to provide additional daily focus to ED's.

Urgent Care and Quality teams will be meeting again to review progress against initial improvement actions identified and to establish any additional actions and support required to reduce pressure ulcer incidents.

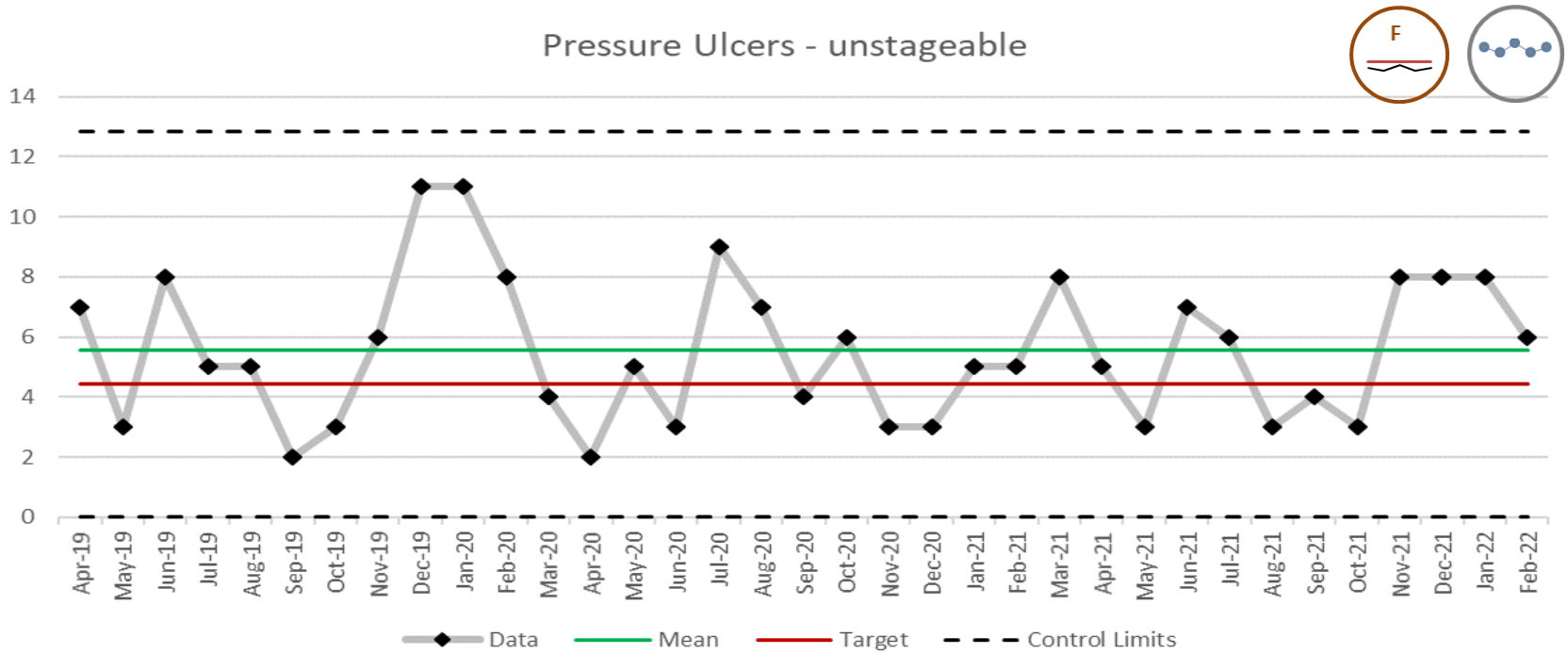
Mitigations:

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
6
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.4
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:

Pressure Ulcers Unstageables.

What the chart tells us:

We are currently at 6 against a target of 4 per month which is a reduction of 2 from January.

Issues: Continued

Theme identified relating to wound dressings present when a patient is admitted are not always being removed and reviewed in a timely way and therefore existing skin damage may be being missed. When this is later identified it is attributed as hospital acquired. This will be an area of focus to improve.

3 of the incidents were evolvement from Deep Tissue Injury damage.

One incident was device related.

Actions: Continued

Unstageable pressure ulcers will be investigated and reviewed through the pressure ulcer incident process. Themes identified will provide further areas of focus to improve.

During April there will be an education focus led by the Tissue Viability (TV) team promoting the importance of dressing removal and assessment on admission.

A review of dressing stocks in all emergency admission areas to take place which will include:

1. Ensuring appropriate dressing stocks are readily available.
2. TV team to provide visual aids on recommended dressing selection.
3. Promoting the correct usage of wound assessment charts to ensure accurate and timely assessments are undertaken and clear documentation of dressing plan to support ongoing care.

.

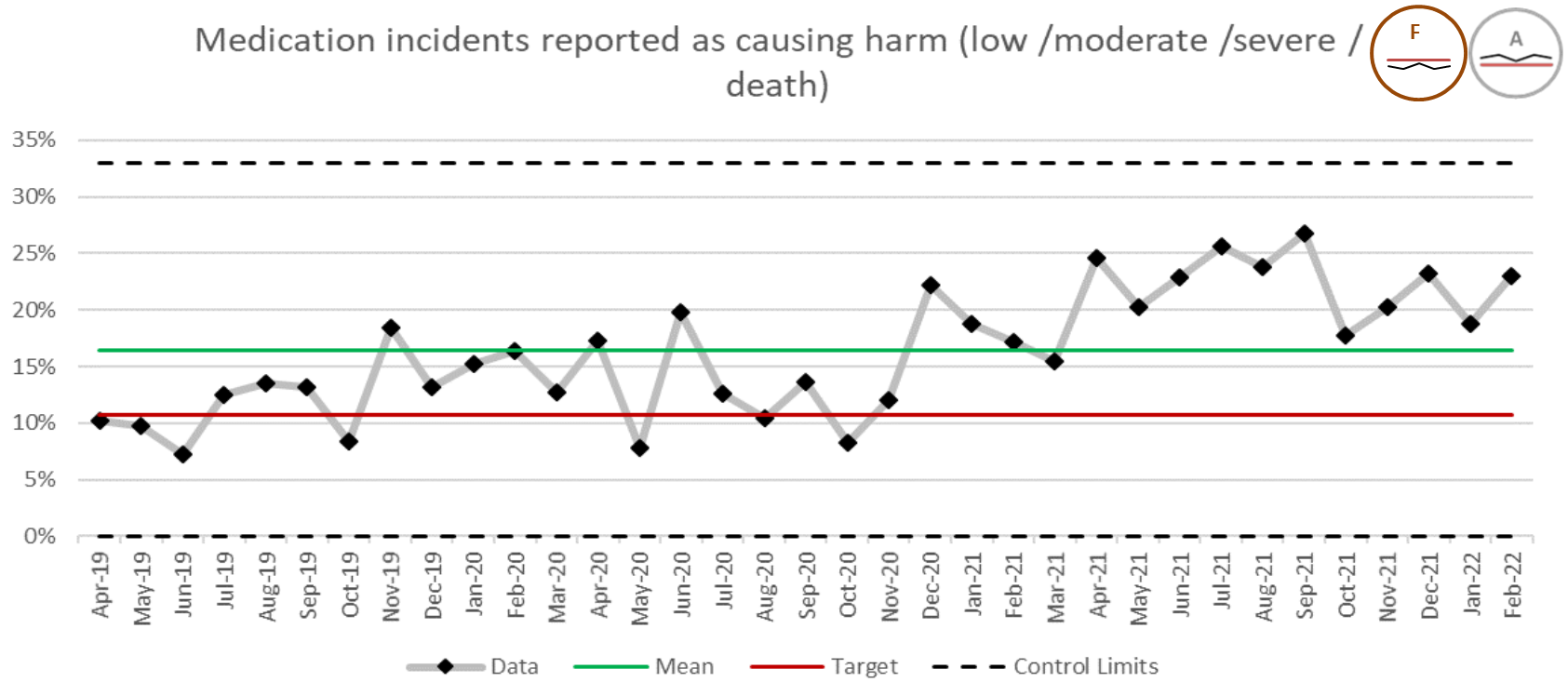
Mitigations:

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
23%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
10.7%
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of February 2022 the number of incidents reported was 143. This equates to 5.16 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 23.08% which is above the national average of 10.8.

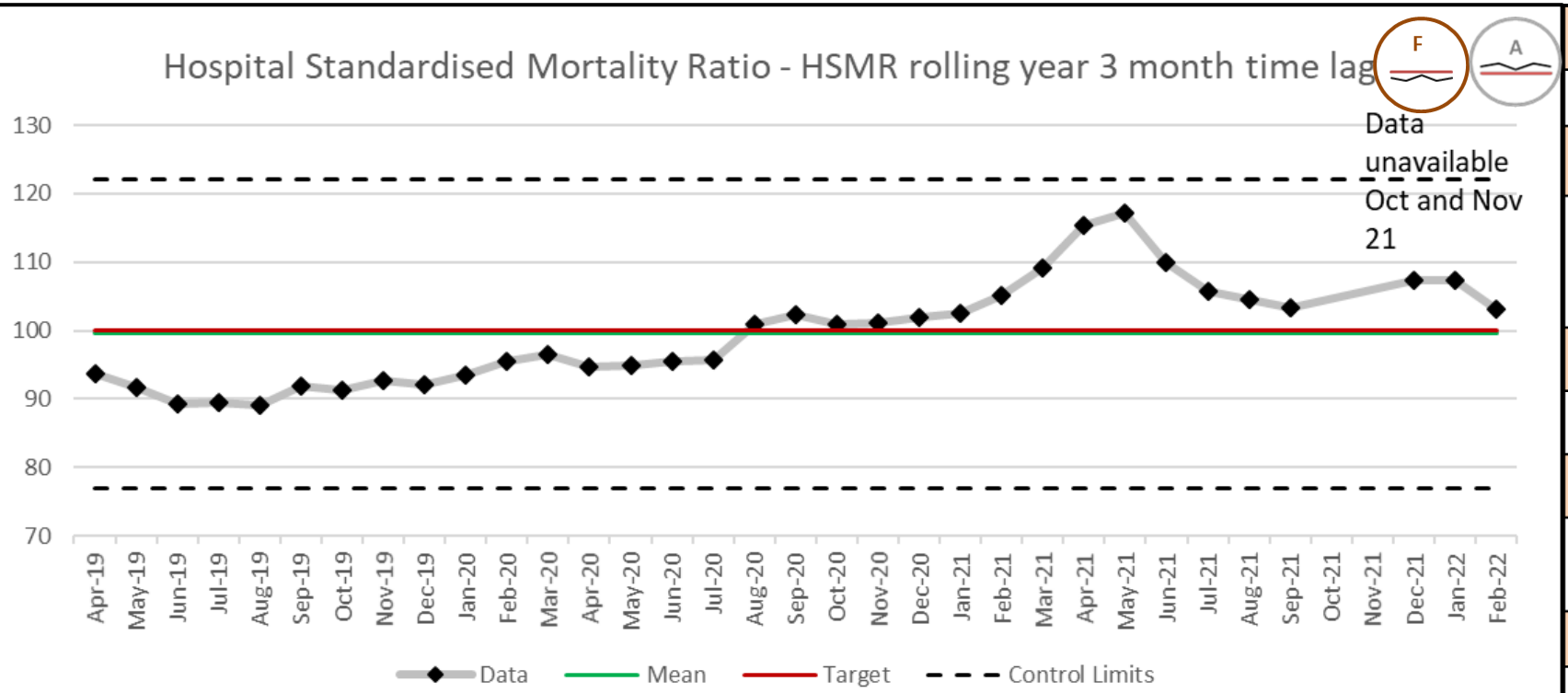
Issues:
Medication incidents causing harm is above the national average. The majority of incidents are at the point of administration of medication and the main error is omitting medicines.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
103.12
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

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

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

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

Actions:
Mortality report presented at MorALS

All alerts are investigated

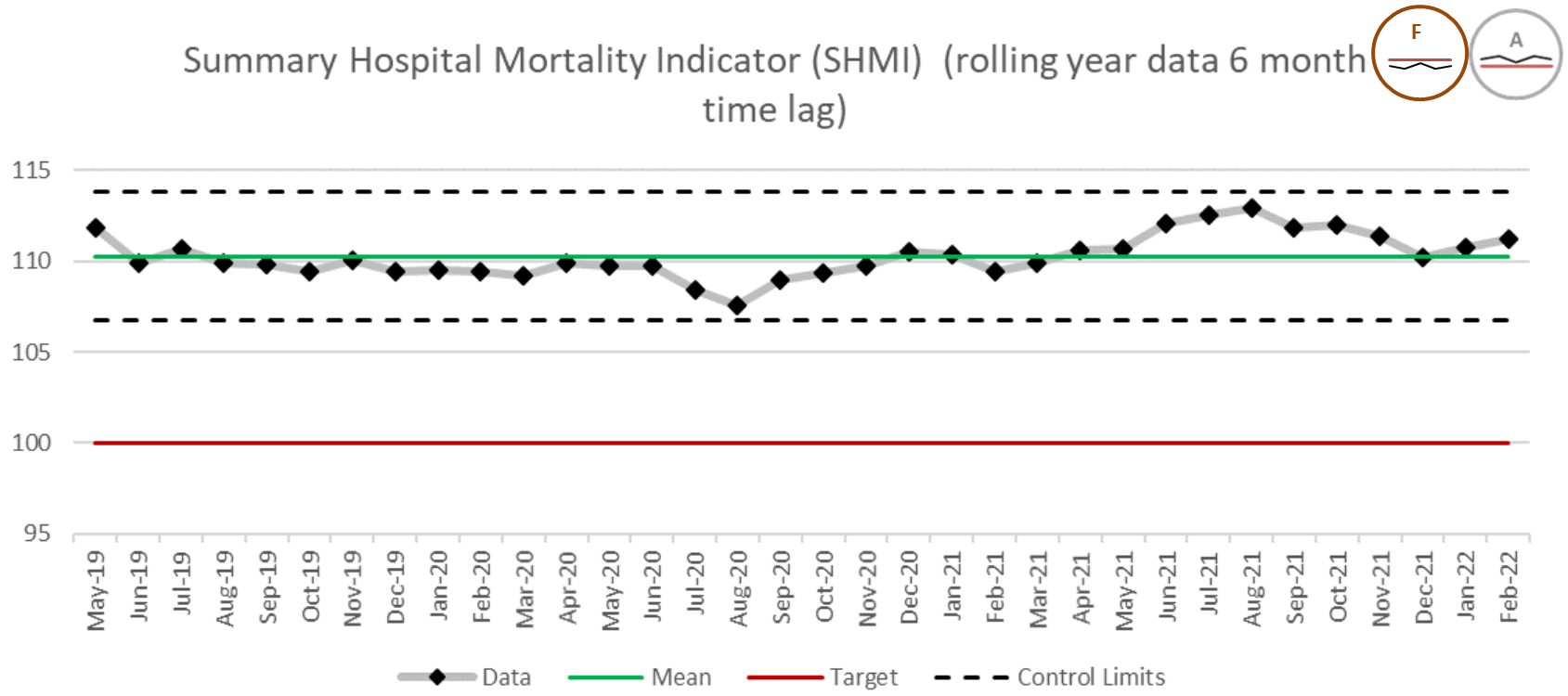
There are monthly Divisional reports produced for the Triumvirate to present at MorALS.

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

Dr Foster will attend the mortality meeting to explain the reasons for the difference in the HSMR data.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
111.20
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
ULHT SHMI is 111.20; an increase from the last reporting period. The Trust has moved to a 'Higher than expected SHMI' despite all 3 sites being within expected level.

Issues:
The COVID-19 pandemic has impacted on the Trusts SHMI. The data period is reflective from Oct 20 – Sept 2021.

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

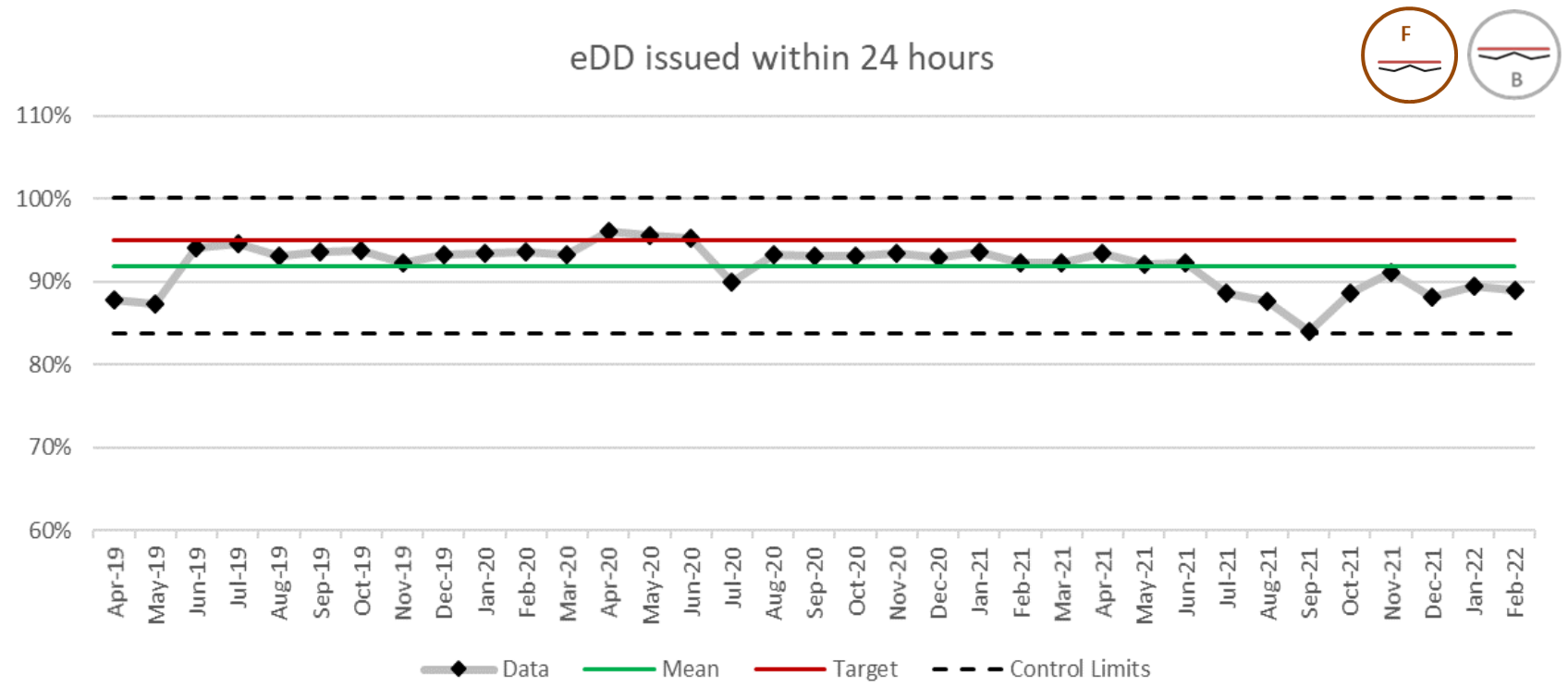
The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
88.90%
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 February the Trust achieved 89.9% for this standard. The Trust however achieved 93% for eDDs sent anytime within the month of February.

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

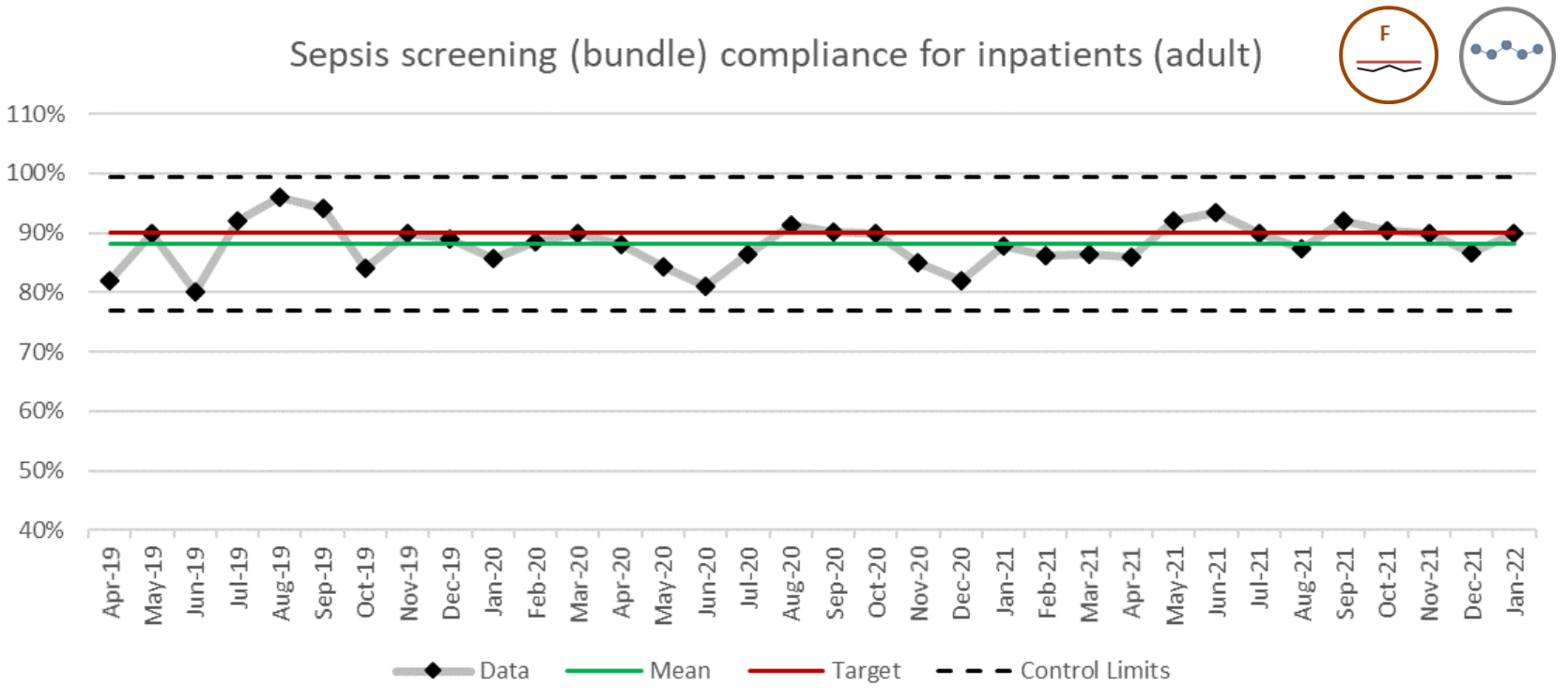
This is because of a number of factors, including considerable operational pressures on both bed capacity and staffing within the Trust.

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 to how eDDs will be managed going forward within the Trust in collaboration with system partners, in combination through the eDD task and finish group.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
89.8%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

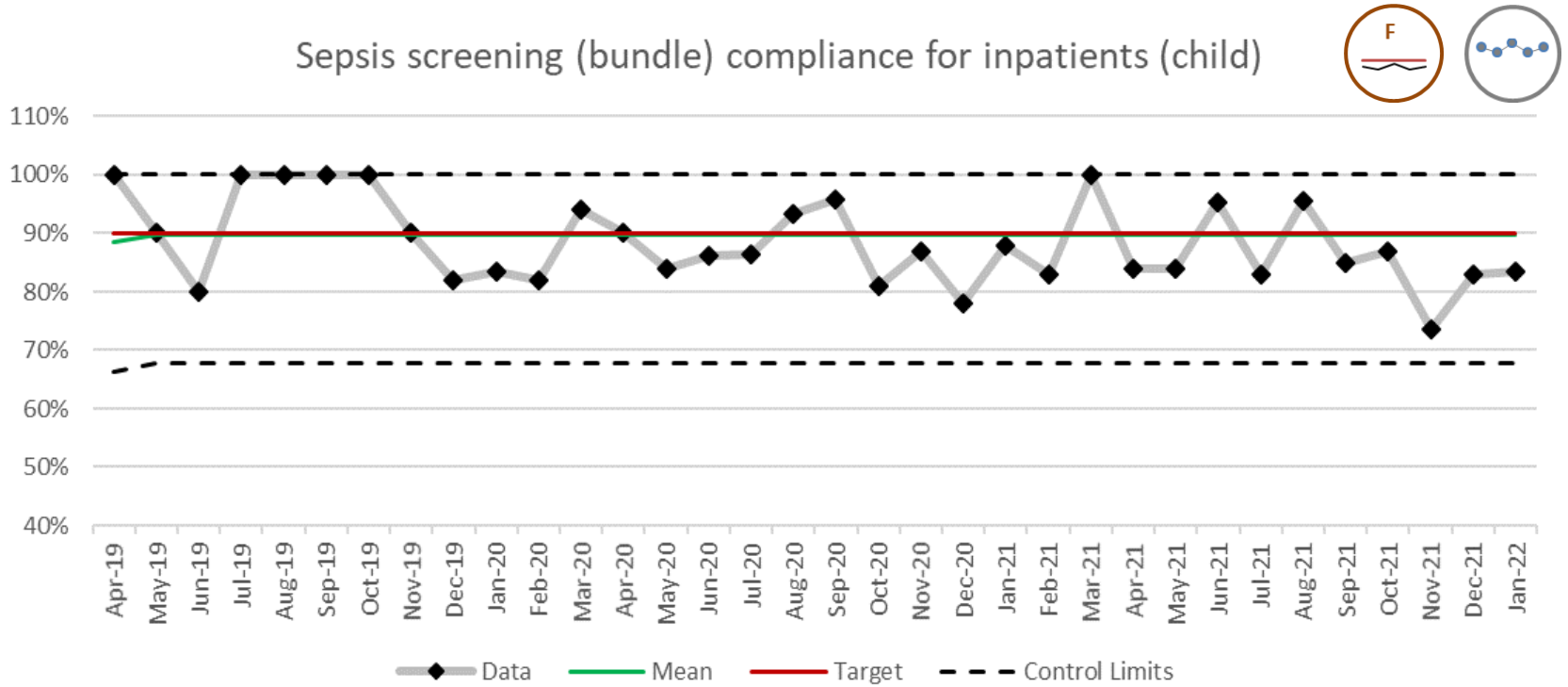
Background:
Sepsis screening (bundle) compliance in inpatients (adult).

What the chart tells us:
The current compliance is at 89.8% against a target of 90%.

Issues:
There has been a slight increase in compliance but this is still below the 90% standard. The main areas of concern are medical specialty wards at Lincoln with a slight bias towards Bank and Agency nurses. This will require further investigation to confirm these as themes.

Actions:
During this period the service was running with only one Practitioner but induction has now commenced for an additional practitioner and additional training is now planned for specific wards in conjunction with the CCOT team.

Mitigations:
Training continues for the international nurse cohorts and the preceptorship courses and this will help support the junior members of the team. There are now additional resources available on line including a more comprehensive sepsis workbook and a video detailing correct completion of a sepsis bundle on web v. A video has been prepared of a sepsis scenario to be released shortly.



Jan-22
84.61%
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

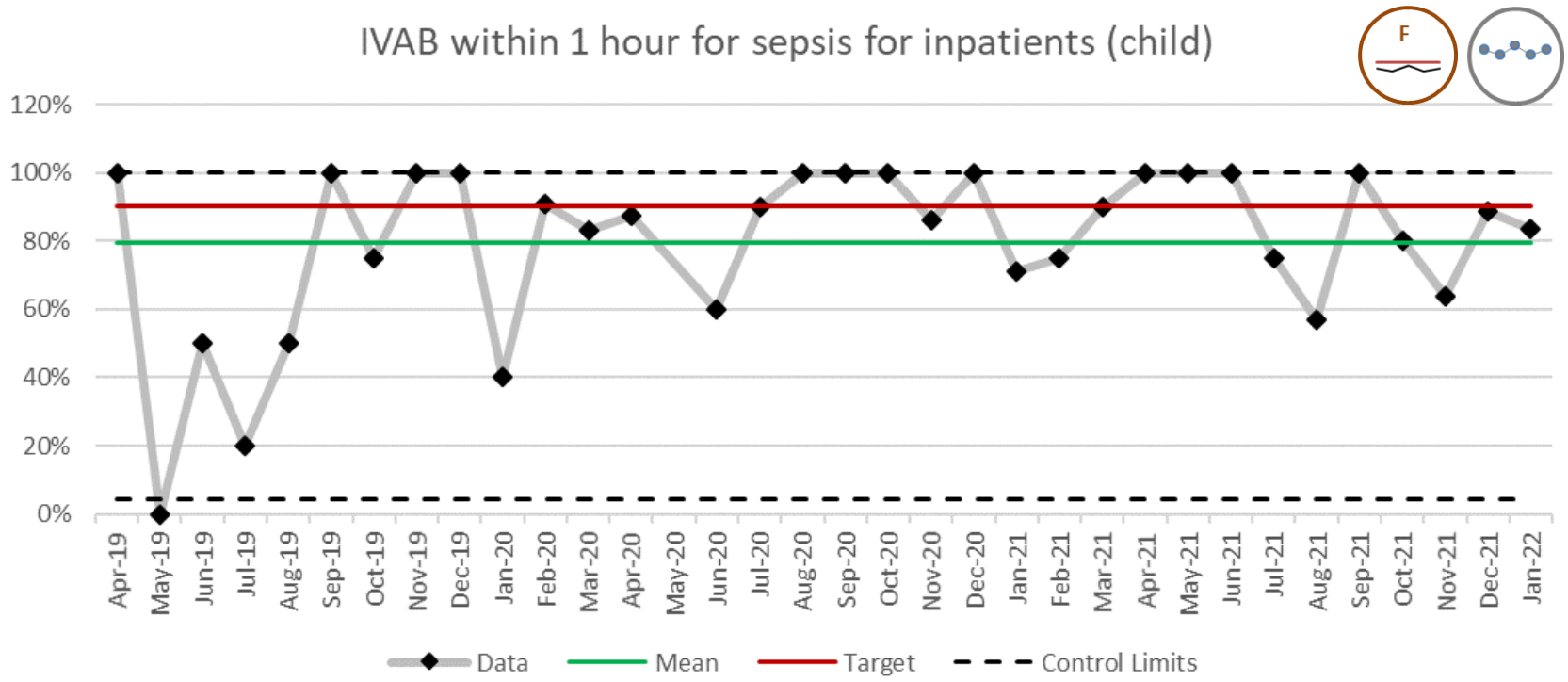
Background:
Sepsis screening (bundle) compliance in inpatients (child).

What the chart tells us:
The current compliance is at 84.61% against a target of 90%.
Screening was completed on 44 of 52 children.

Issues:
The wards have had an increased number of patients and acuity during January along with staffing issues.
The majority of missed/delayed screens are non- infection. There was no harm found on any of the harm reviews done on these patients.
All current face to face training has been cancelled due to hospital site pressures.

Actions:
The CYP Practitioner is visiting the ward regularly to offer support with Sepsis Screening.
Short sessions of face to face training are happening with staff that have been highlighted as missing a screen.
More simulation training regarding sepsis is planned as soon as this can go ahead.
Training has also been offered to new cohort of Drs when they start.

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



Jan-22
83.3%
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 83.3% against a target of 90%.
There were 5 out of 6 patients that received antibiotics within the one hour time frame.

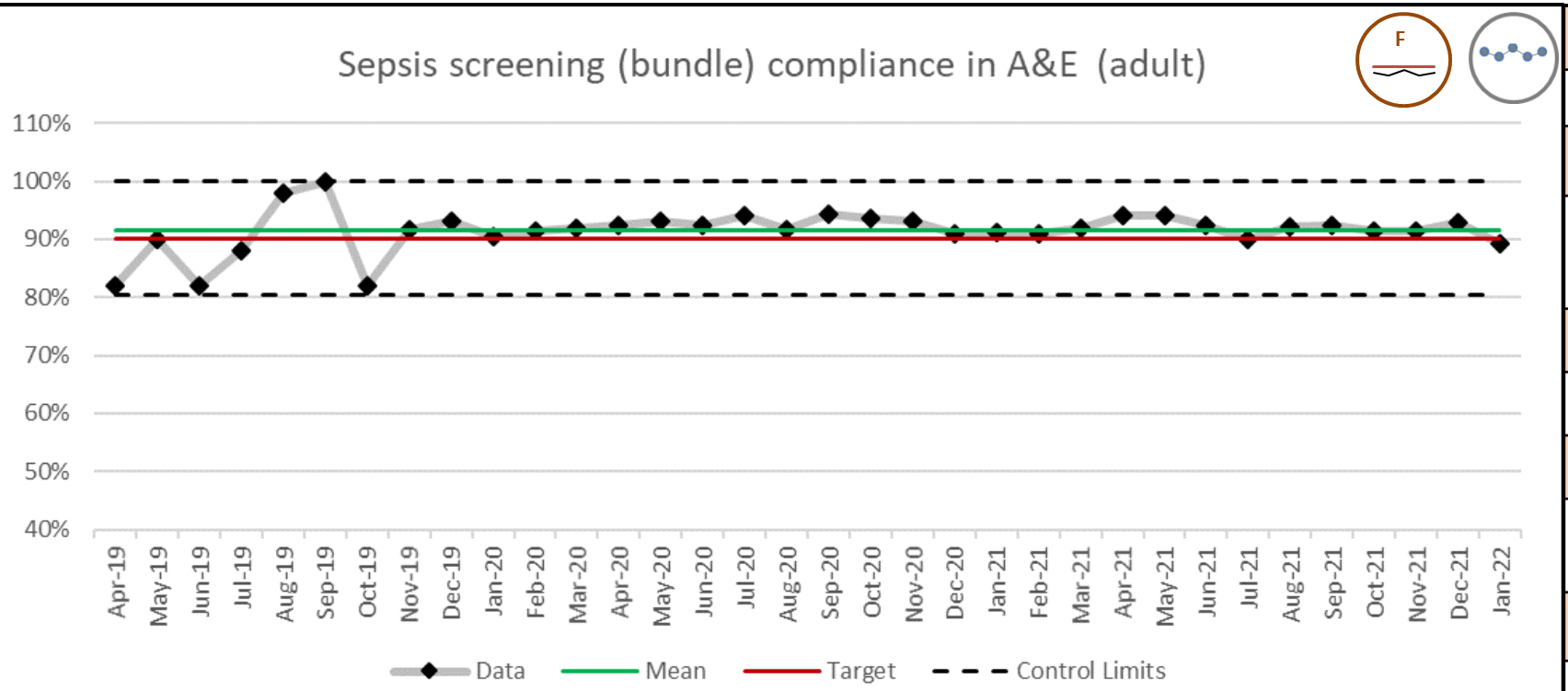
Issues:
There was one patient that had delayed antibiotics but the cause was not found to be sepsis and there was no harm found from the delay. This was due to a delay in being able to get IV access.

Actions:
A harm review was completed for this patient which concluded that no harm was caused from the delay. An IR1 has also been completed so that it can be investigated and learning points can be actioned from this. No Harm found from delay. Discussions are being held regarding further staff having cannulation training, there are some Nursing staff keen to do this.

Mitigations:
Ongoing meetings taking place between CYP Practitioner, Ward Sister and Clinical Educators to highlight issues early and formulate action plans.
CYP Practitioner is also meeting with Ward Drs to discuss any issues around sepsis.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
89.1%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The current compliance is 89.1% against a target of 90%.

Issues:
The compliance for screening within A&E has fallen below the 90% standard for the first time in 2 years.
The reporting period experienced a larger volume of patients presenting to the emergency pathways and this has put an additional strain on the ED staff.

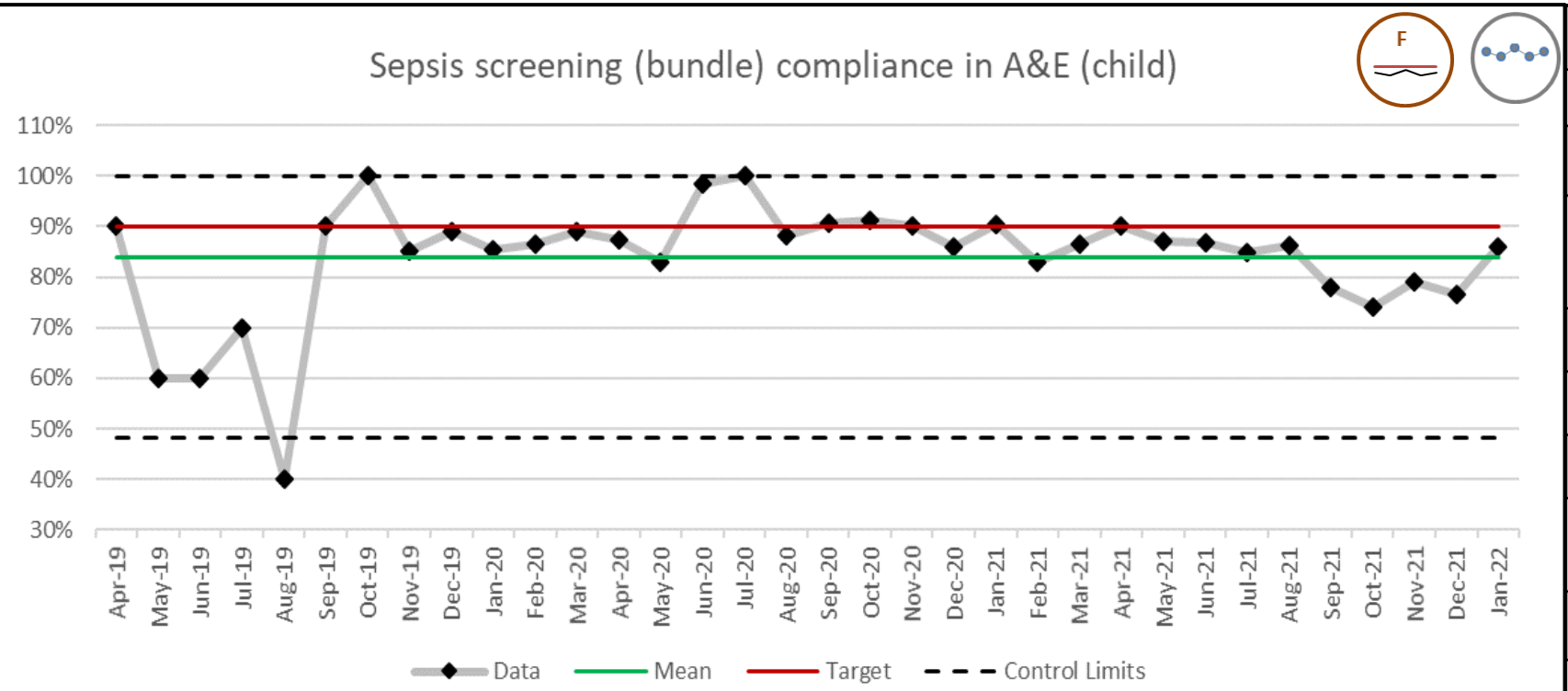
Actions:
An audit is currently underway to understand the disparity between sites. The aim is to adopt those actions that have had the most impact and ensure that this is mirrored across all sites.
A second sepsis practitioner has now been appointed for LCH and this will allow for more engagement and training.
Focus groups will continue bi-weekly for the next 2 months.

Mitigations:
Simulation training has been paused due to site pressures and redeployment outside of the department but this should be re-started in March.
Future appointments into clinical educator roles should strengthen the support to staff working within ED.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
86.0%
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 83.06% which is below the 90% target. 154 of 179 patients received screening for sepsis within the hour.

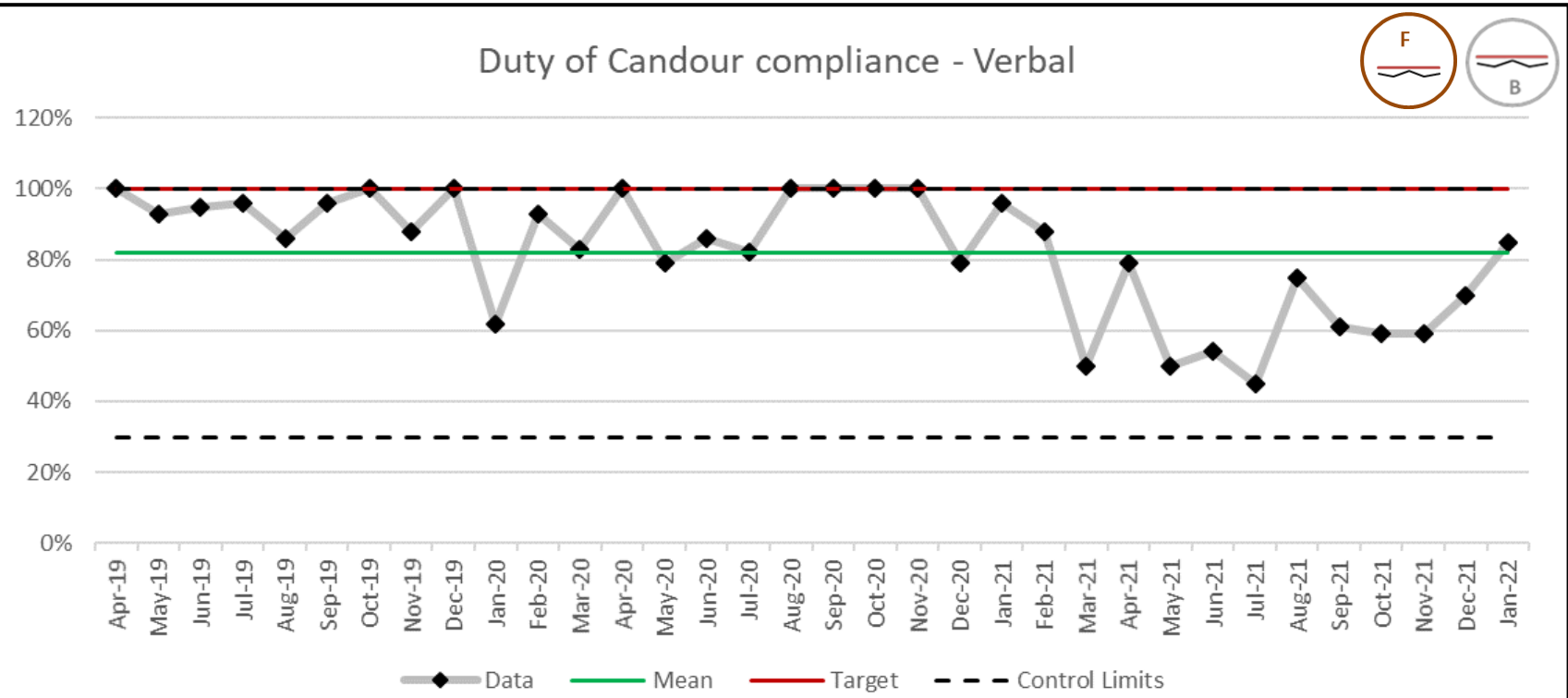
Issues:
ED has recently seen a large turnover of staff. ED is also seeing a large increase in the number of patients being seen within the department as well as a higher acuity of patients. Staff have reported that they are struggling with the Paediatric workload as a single Paeds Nurse in the ED department. Face to face training is cancelled at present.

Actions:
Sepsis Practitioners are currently doing regular walk rounds in the department and offering any assistance if needed. Harm reviews are carried out for all delayed / missed screens. Sepsis Practitioner will attend morning huddles and ED meetings for support and training. There appears to be a greater issue with delayed screens at Lincoln and Grantham so the focus will be on those two sites. A member of medical team has been identified as a link at Lincoln.

Mitigations:
There are ongoing fortnightly Sepsis meetings for ED at present, Issues are discussed at these and action plans are put in place quickly to try and assist the department compliance. Previous action plans are also reviewed at these meetings. Issues are discussed at Governance.
Paediatric Drs and Nurses from the Ward are supporting the ED when possible.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
85%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
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:
Since April 2019 the Trust has met the verbal Duty of Candour requirement just over 80% of the time.

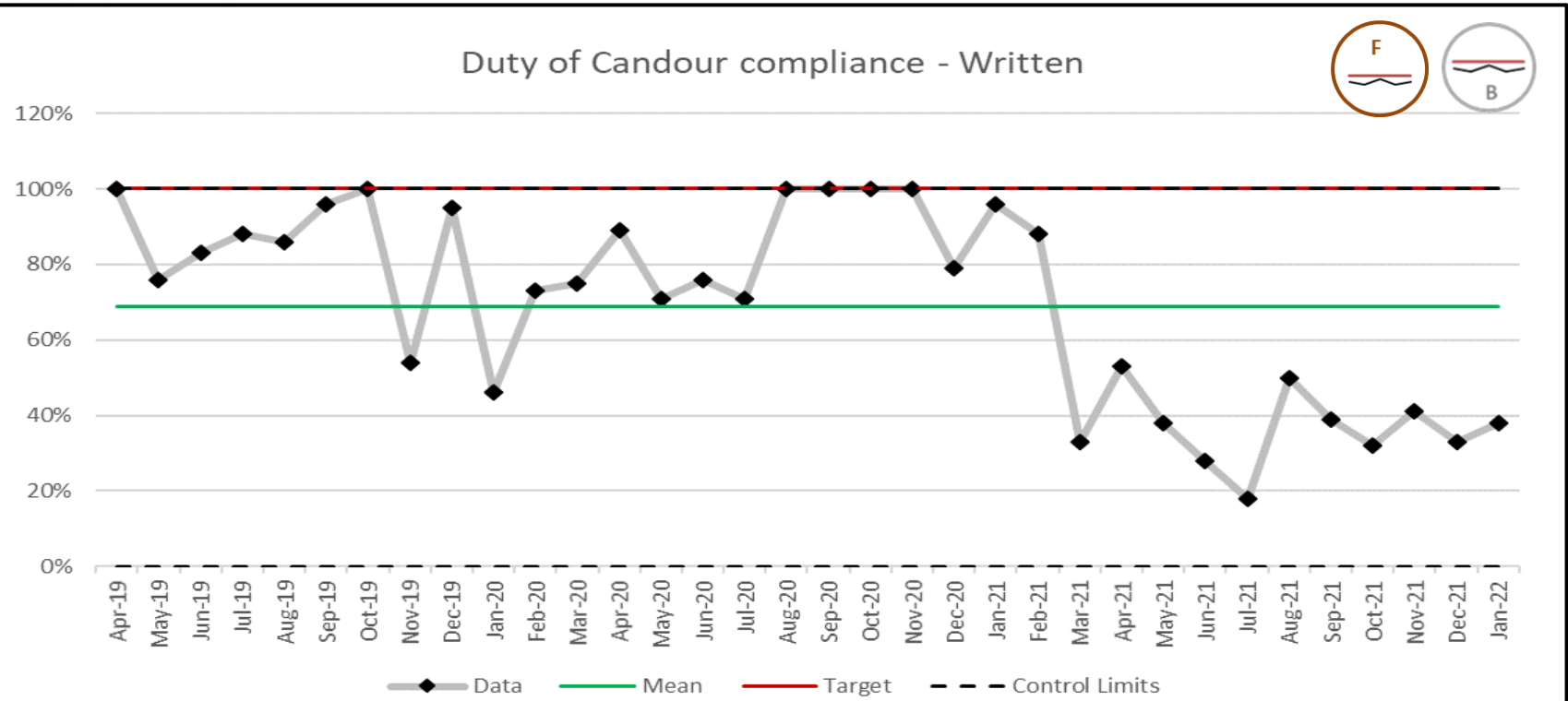
Issues:
Duty of Candour is frequently completed in person but not recorded on Datix. There are also issues with incidents that are reported retrospectively, where responsibility for Duty of Candour is not always clear at time of reporting.

Actions:
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 now sent to Divisional Triumvirate.

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%.



Jan-22
38%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
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:
Since April 2019 the Trust has met the written Duty of Candour requirement just under 70% of the time.

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:
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 now sent to Divisional Triumvirate.

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	Dec-21	Jan-22	Feb-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%	0.07%	0.13%	0.26%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	64.67%	63.49%	61.18%	66.24%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	330	465	637	1955	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	86.15%	86.62%	81.98%	86.00%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	2185	2758		15,234	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	54.97%	53.52%		56.96%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	59,747	61,224		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	42.97%	40.20%		56.28%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	57.26%	47.60%		71.41%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	0.74%	2.60%		9.02%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	89.94%	84.40%		90.75%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	99.27%	96.00%		99.14%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	61.76%	63.30%		71.76%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	95.61%	95.10%		96.52%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	53.85%	38.30%		67.66%	90.00%			

OUTSTANDING CARE personally DELIVERED

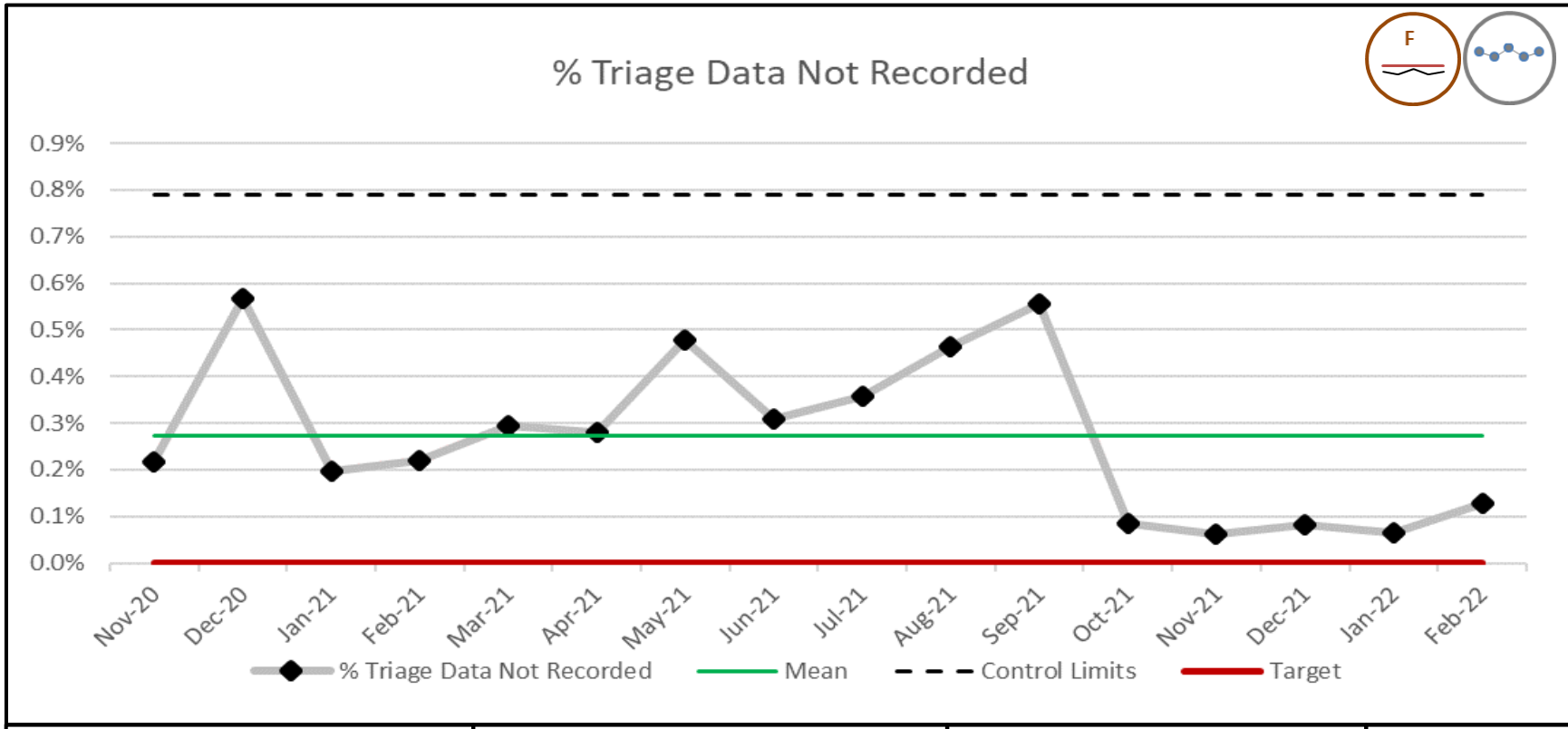
NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Dec-21	Jan-22	Feb-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%	80.72%	67.30%		74.38%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	60.54%	58.88%	64.91%	65.96%	99.00%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.82%	2.21%	1.90%	2.07%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	21	31	25	202	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	84.00%	92.59%	92.31%	90.10%	90%	P		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	70.67%	74.07%	47.69%	72.85%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,167	4,242	3,764	4,342	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	654	656	781	597	0	F	A	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	161	168	151	1,036	110	F	H	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.59	2.72	2.97	2.72	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.81	5.01	5.10	4.65	4.5	F	A	
	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	19,326	20,006	21,117	17,127	4,524	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	41.8%	42.9%	44.0%	42.98%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	36.3%	38.8%	38.2%	39.72%	45.00%	F		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
0.13%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%.
February reported 0.13% data not recorded verses 0.07% in December
February demonstrated a 0.06% negative variation compared with January.
This metric is below target.

Issues:

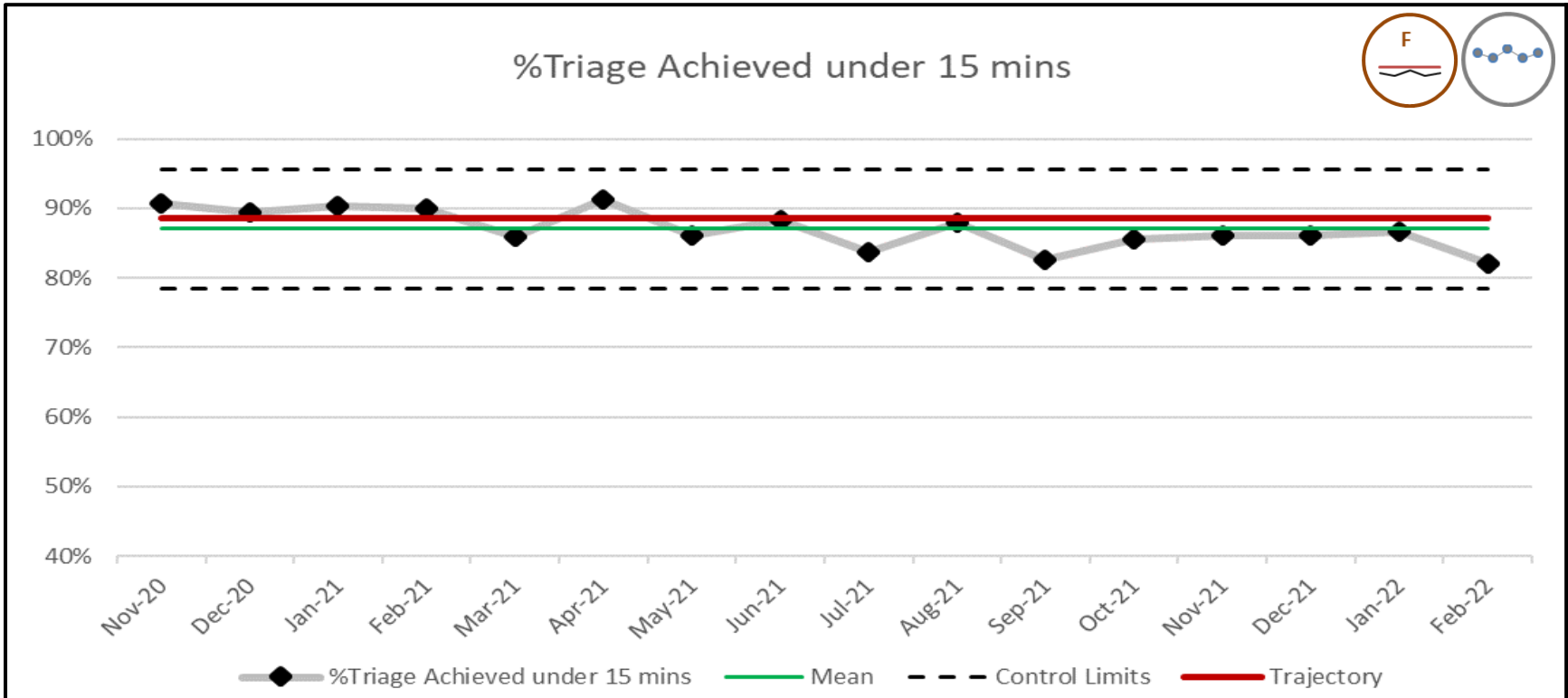
- Timely inputting of data.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been less problematic at all three sites.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP) but a slight improvement in rostering has been seen.
- 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 Emergency Care 'Team's chat'.
- Increased nursing workforce following a targeted recruitment campaign has been successful and supernumerary period, has, in the main come to an end.
- Twice daily staffing reviews to ensure appropriate allocation of the ED workforce to meet this indicator.
- The Urgent and Emergency Care Clinical Business Unit continue to undertake daily interventions regarding compliance (recording and undertaking).



Feb-22
81.98%
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%.
February outturn was 81.98% which is 6.52%% below the agreed target.
February demonstrated a deterioration in performance of 4.64% compared with February.
This target has not been met.

Issues:

- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 but is improving.
- Dual department roles. For example, the second triage nurse is also the allocated paediatric trained nurse, whilst reduced is still on occasion, problematic.
- Inability to maintain agreed staffing template, particularly registrants, due high to sickness and agency cancellations at short notice.
- The ability to effectively maintain two triage streams continues to be mainly out of hours but improvement is noted.

Actions:

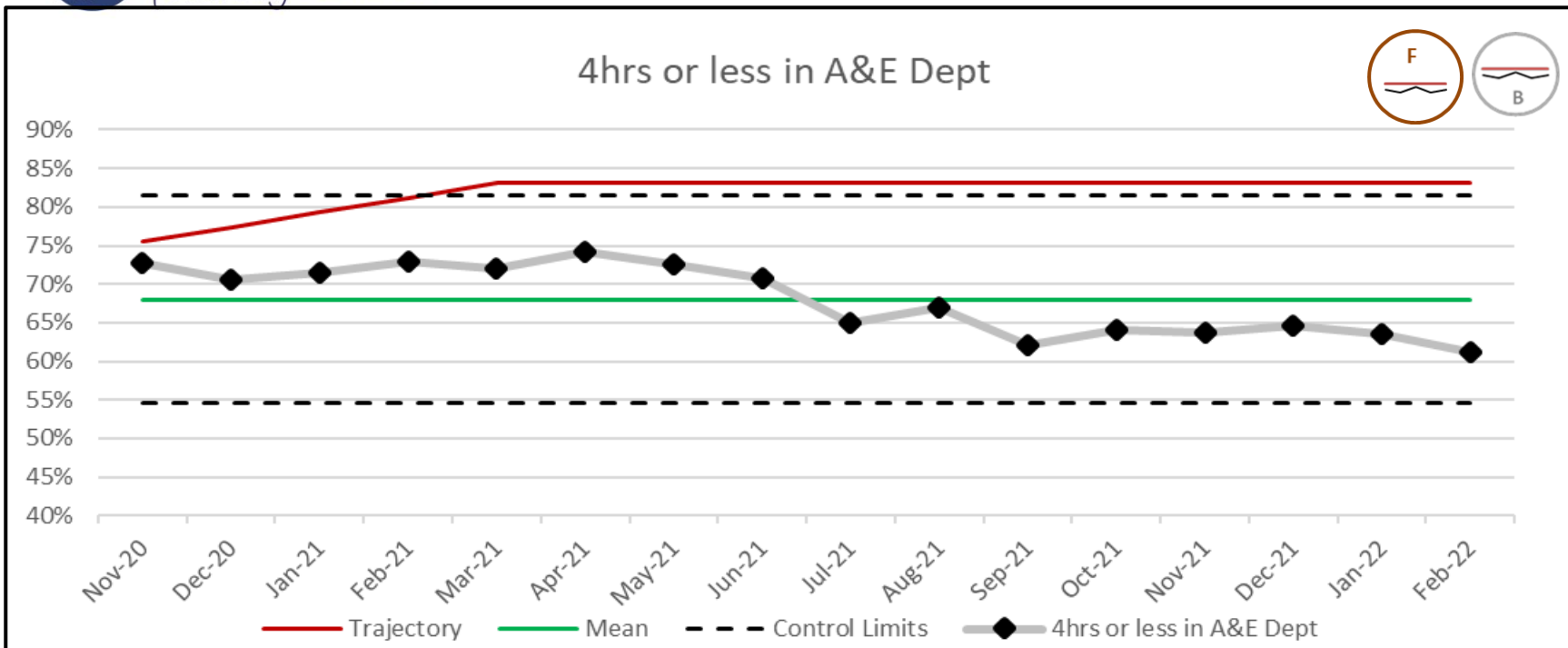
The actions are repetitive but remain relevant.
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings.

Mitigations:

The Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
The confirmation of 2 triage streams is ascertained at the 4 x daily Capacity meetings.
Early escalation and rectification are also managed through the Emergency Department Teams Chat and Staffing Cell.
A twice daily staffing meeting staffing meeting in in operations 7 days a week and a daily staffing forecast is also in place.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
61.18%
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 February was 61.18% which is 21.94% below the agreed target.
February out turned at 61.18% compared to 63.49% in January. A 2.31% negative variance compared to January.

Issues:

The Emergency Departments saw a 3.51% decrease in attendances in February (562 patients) compared to January. 15,478 combined attendances (ED and UTC) in February compared to 16,040 combined attendances in January.
A comparison to February 2020 denotes a slight increase of 1.48% (15,249 combined attendances). Against a comparison to February 2021 denotes a 19.77% increase (12,418 combined attendances).
Of the 15,478 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 10,215 and type 3 accounted for 5,263. This is a decrease on type 1 and type 3 attendances is across all 3 acute sites.
Inadequate daily discharges to meet the admission demand remains an issue leading to extended ED LOS.
Ongoing medical and nursing gaps that were not Emergency Department specific.
Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps.

Actions:

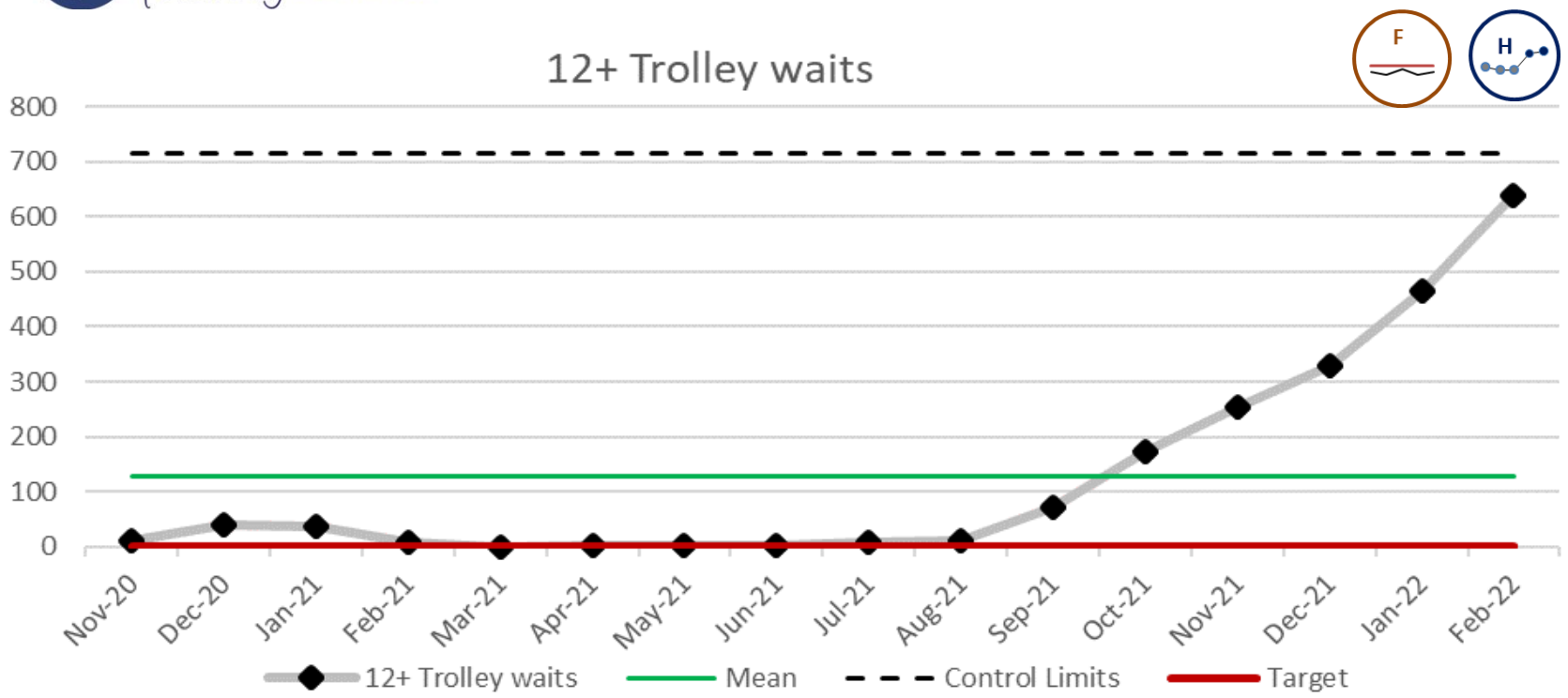
The actions are repetitive but still relevant
Reducing the burden placed upon the Emergency Departments further will be though the continued development of Same Day Emergency Care (SDEC) Services.
Direct EMAS conveyance to SDEC services has commenced but CAD not yet updated with destination.
Maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients.
A twice daily report is sent to all Divisions.
Twice daily System calls are in place to maximise pathway 1, 2, and 3 patients. This is led by the Lead Nurse for Discharge in partnership with System Partners. All delays >24hrs post optimisation are escalated for resolution.

Mitigations:

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
637
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:

February experienced 637 12-hr trolley wait breaches, which is the highest ever recorded for ULHT. This is the unvalidated position. This represents an increase of 27.01% since January. This equates to 4.11% of all type 1 attendances for February.

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.
February 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.
February saw a decrease in the number of new positive covid cases (179 in February vs 269 in January).
To prevent nosocomial transmission, the use of boarding areas as per the Full Capacity Protocol areas has been problematic.

Actions:

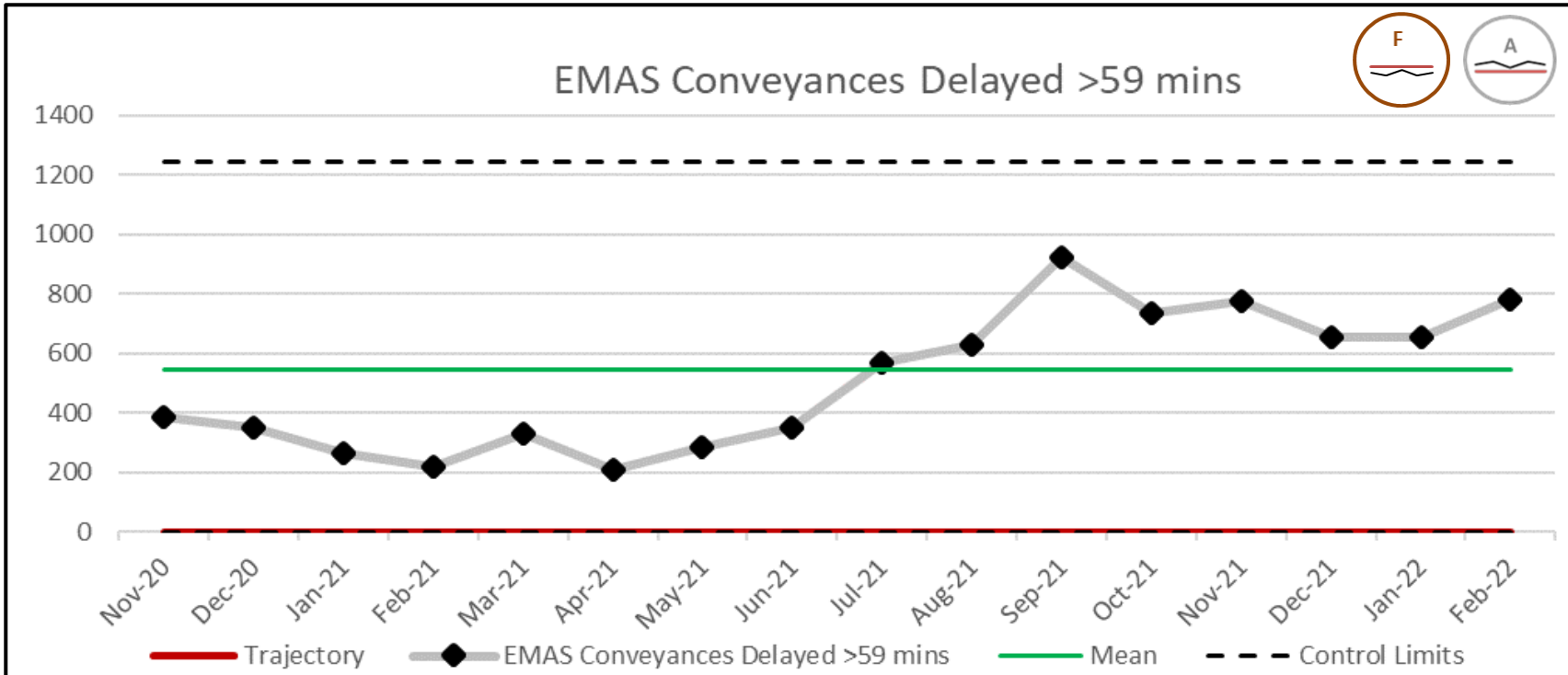
The Trust continues to work closely with national regulators in reviewing and reporting these breaches.
Due to the number of 12hrs trolley waits breaches currently, harm reviews are completed by the UEC team, DATIX are completed and escalations to the CCG and NHSE/I are in place.
A daily review of all 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 has demonstrated a positive impact but due to staffing gaps, there is an increased request to close this facility. Permission to close these areas now sits solely with the Chief Operating Officer and Director of Nursing or delegated officer
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
781
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

February demonstrated an increase in greater than 59 minutes' handover delays. 781 in February compared to 656 in January. This represents a 16.01% increase.

What the chart does not tell us is the increase of >2hrs in February 2022 (391 in February vs 296 in January) and the increase in >4hr delays (89 in February compared to 35 in January).

Issues:

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

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

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

A more detailed account of >59-minute handover delays are featured in the UEC FPEC report.

Actions:

All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager and 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.

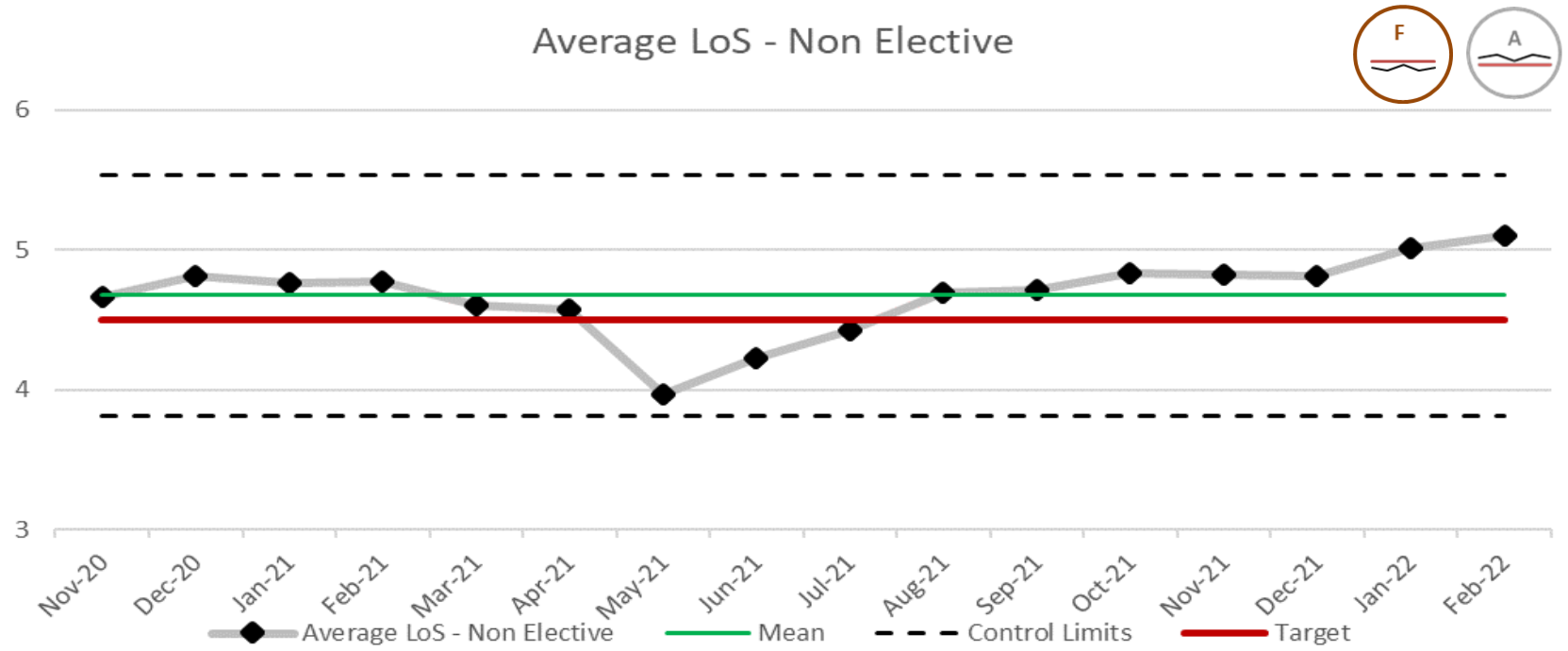
The rapid handover protocol has now been revisited and agreed. Designated escalation areas are being identified/confirmed to assist in reducing delays in handover.

February saw 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.



Feb-22
5.10
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for non-Elective inpatients.

What the chart tells us:

The agreed target is 4.5 days verses the actual of 5.10days in February vs 5.01 days in January.
This is an increase of 0.09 days
compared with January.
This is a 0.6 variance against the agreed target.

Issues:

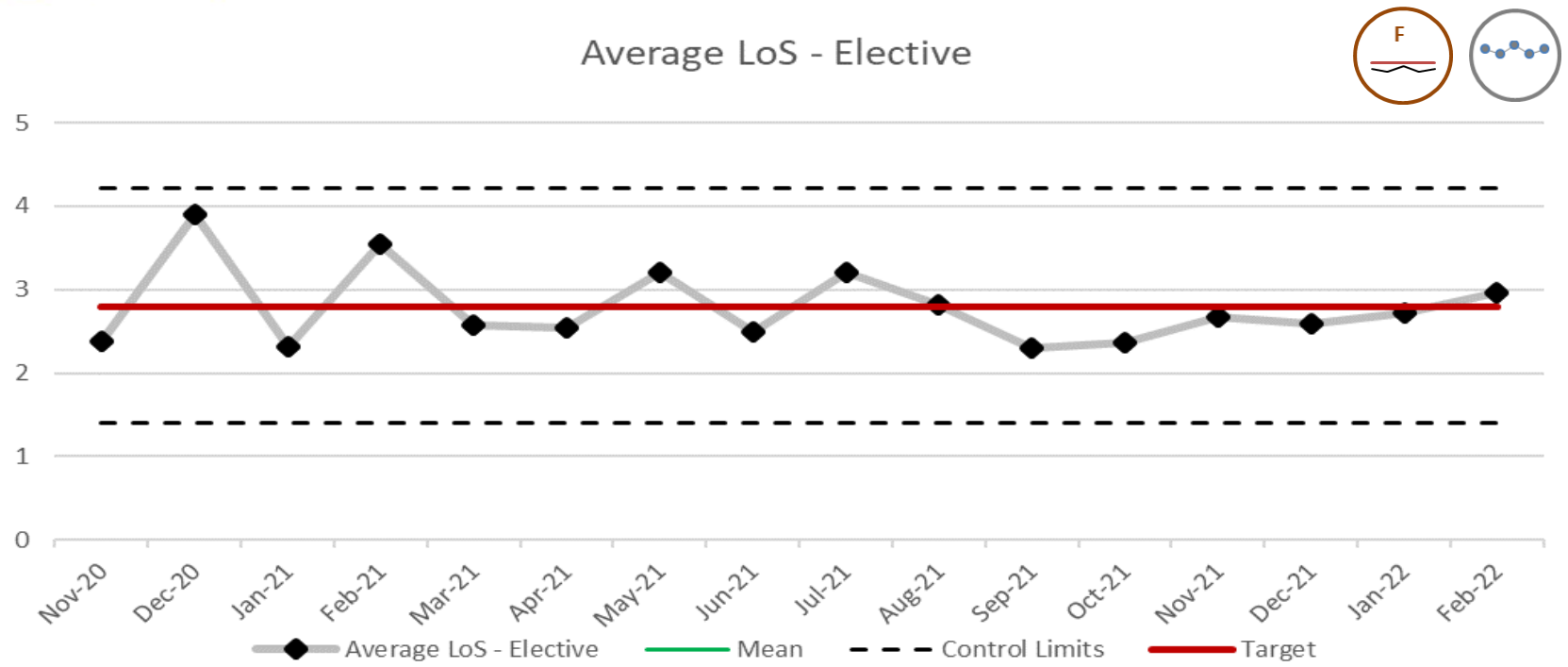
Numbers of stranded and super stranded pts continues to increase.
Increasing length of stay of all pathways 1-3. The most significant increase in volume of bed days is Pathway 1 Domiciliary care but since the advent of the joint D2A process, benefits are being realised but there remains insufficient 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 is underway. The frequency is being finalised.



Feb-22
5.10
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
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 2.72 days in January to 2.97 days in February. This is an increase of 0.25 days and represents an increase of 8.42%.
The trajectory for Elective LOS is 2.8 days.

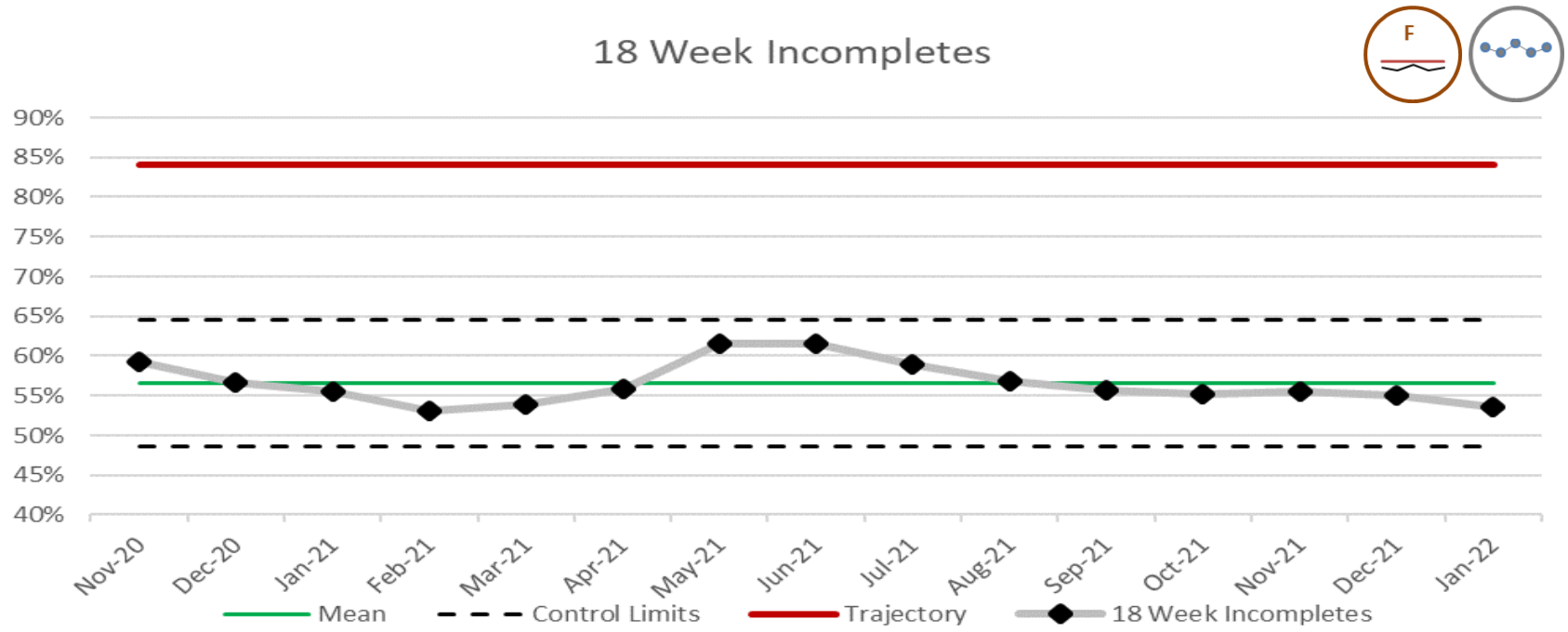
Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
53.52%
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. January saw RTT performance of 53.52% against a 92% target, which is 1.45% down on December.

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:

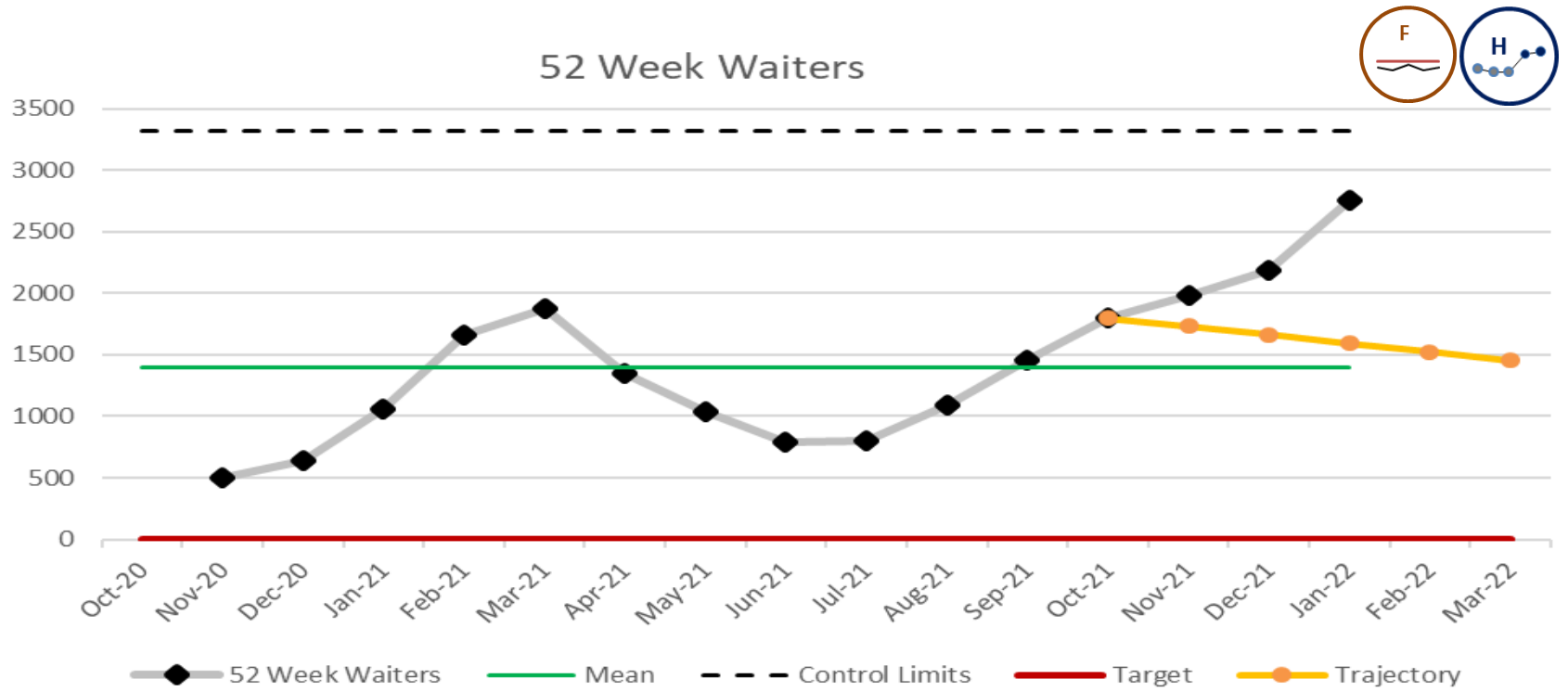
- ENT – 4731 (increased by 258)
- Dermatology – 2925 (increased by 127)
- Gastroenterology – 2840 (Increased by 246)
- Gynaecology – 2609 (Increased by 136)
- Ophthalmology - 2092 (increased by 82).

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.

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
2758
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 2758 incomplete 52-week breaches for January. An increase of 573 from December. The number of 52-week breaches has increased considerably since August.

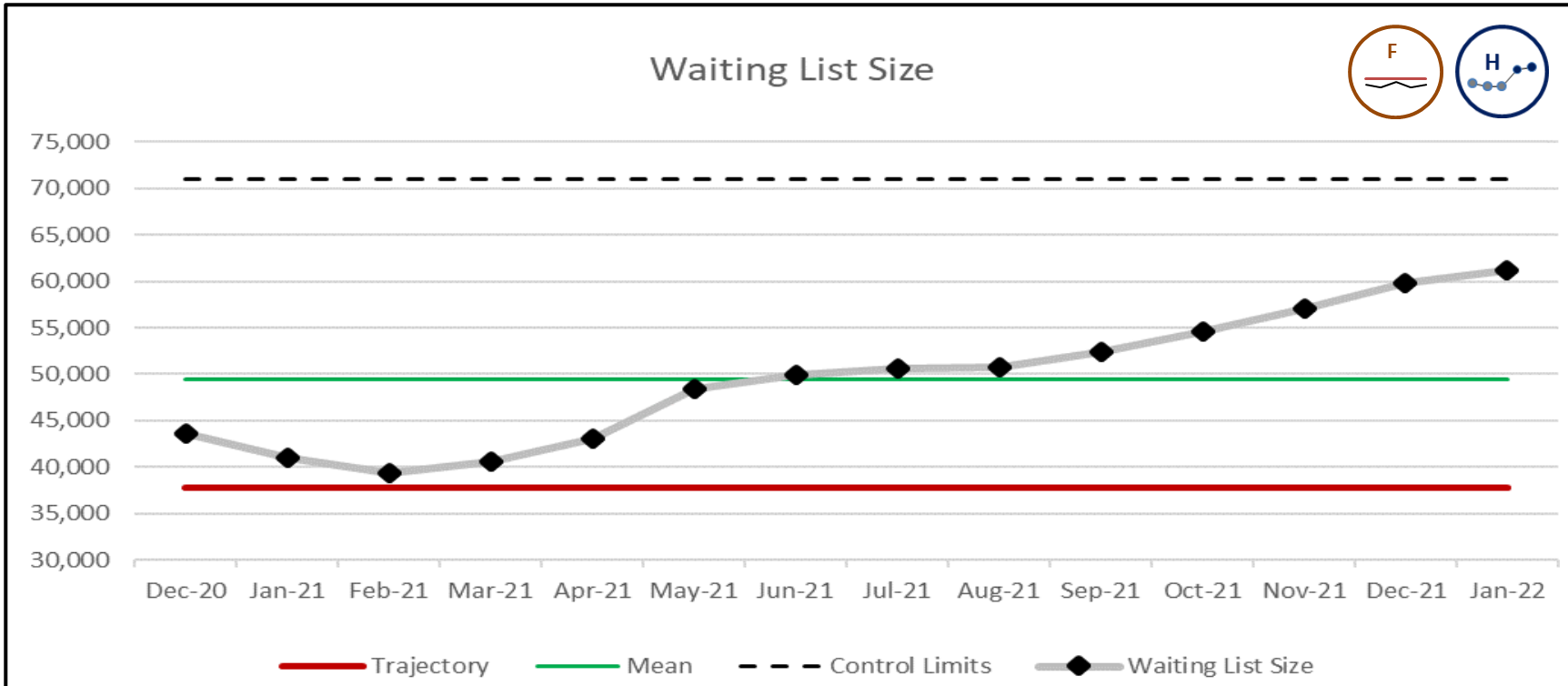
Issues:
Both the admitted and non-admitted position remains very challenging. Current capacity challenges and staffing issues are all impacting on service delivery, which is, in turn, detrimentally affecting the 52-week position.

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 an RCA and harm review completed. The harm review process is discussed at the Clinical Harms Oversight Group with a view to streamline how the Trust administers this.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
61,224
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

The number of patients currently on a waiting list.

What the chart tells us:

Overall waiting list size has increased from December, with January showing an increase of 1477 to 61,224.

The incomplete position for January 2022 has increased by approximately 23,198 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 December are:

- Gastroenterology + 235
- ENT + 227
- Gynaecology + 162
- Ophthalmology + 143
- Dermatology + 139

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

- Breast Surgery – 85
- Clinical Oncology - 39
- Paed Trauma & Orthopaedics - 39
- Urology - 22
- Geriatric Medicine - 17

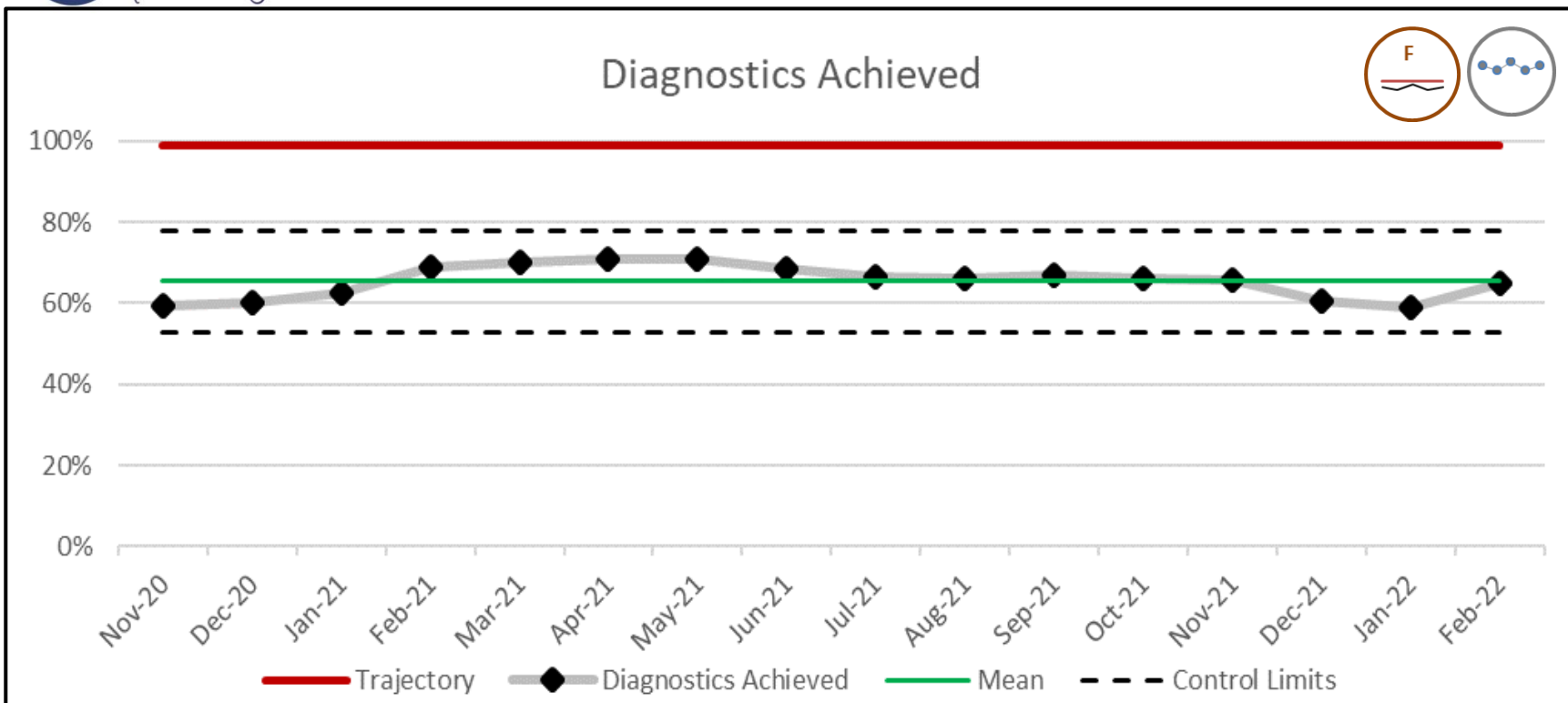
The Trust reported 8392 over 40 week waits; an increase of 1242 on December. Patient numbers waiting over 26 weeks increased by 1583.

Actions/Mitigations:

The longest waiting patients at 78w+ are monitored and discussed at a weekly PTL meeting and with system partners at a weekly ICS meeting. Issues preventing the booking and treating of patients are also discussed to look at finding solutions and subsequently enable service delivery. Transferring of appropriate admitted patients to ISP's continues. Non admitted patients in two of the most pressured specialities are now also being transferred out.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
64.91%
Variance Type
Metric is currently experiencing Common Cause Variation
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 64.91% for February 2022 against the 99.00% target.

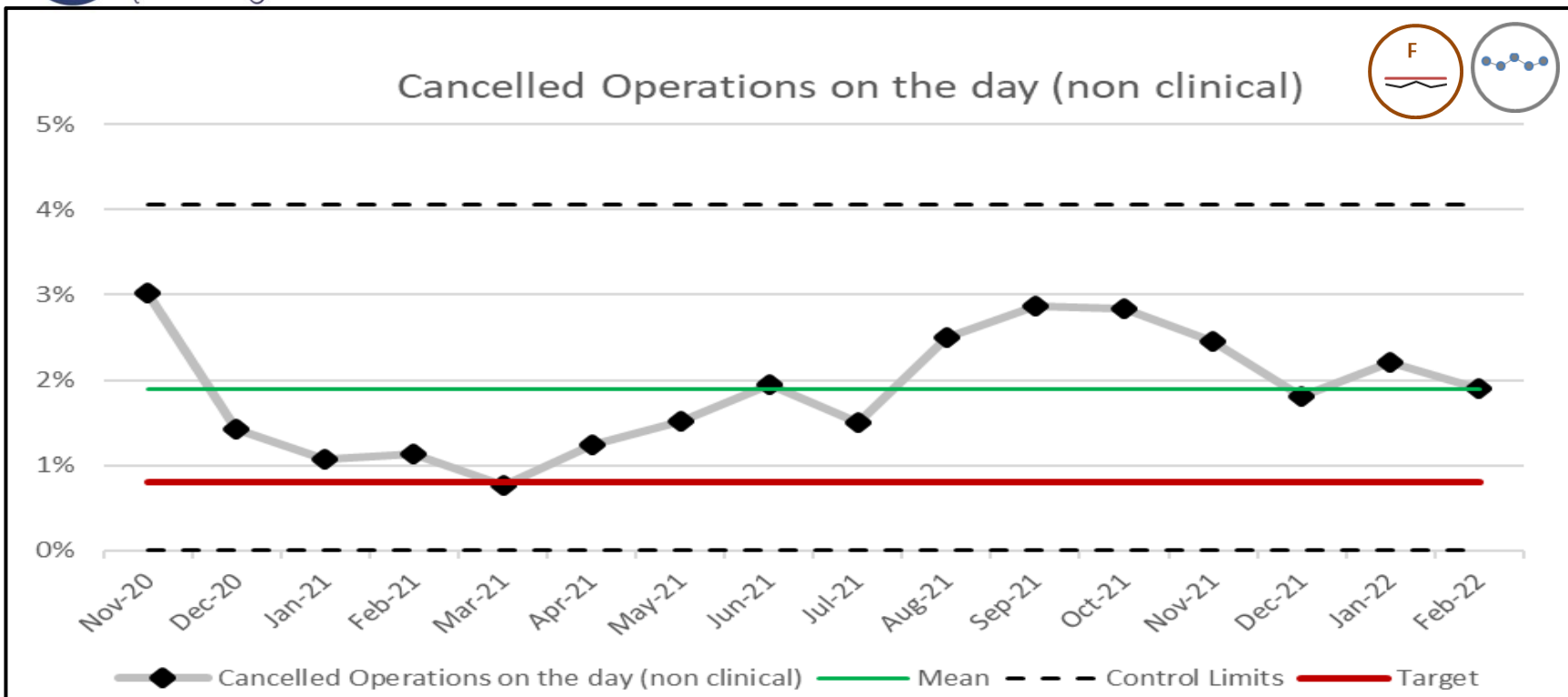
Issues:
All areas have lost capacity due to social distancing, demand is still higher than capacity for some procedures so causing increased backlogs for some specialities and increasing the number of breaches declared each month for those specialities. Increase demand in Ultrasound due to Mediscan being stopped by the CQC this has caused an additional 2000 scans a month from AQP, Cardiac Echoes have a considerable backlog due to lack of capacity.

Actions:
Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes, additional US list are happening but not enough to deal with the additional 2000 scans Ultrasound are doing additional lists at the weekend. A case of need is being completed by radiology asking for resource to deal with the additional AQP work.

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 assign to that patient. This will make sure all patients are seen in clinical urgency. Additional list for ultrasound and echo.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
1.90%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
This shows the number of patients cancelled on the day due to non-clinical reasons.

What the chart tells us:
February shows a reduction in patients who have had their operation cancelled on the day of surgery and therefore remains above the agreed trajectory of 0.8%.

Issues:
The top 3 reasons for same day non-clinical cancellations for February have been identified as

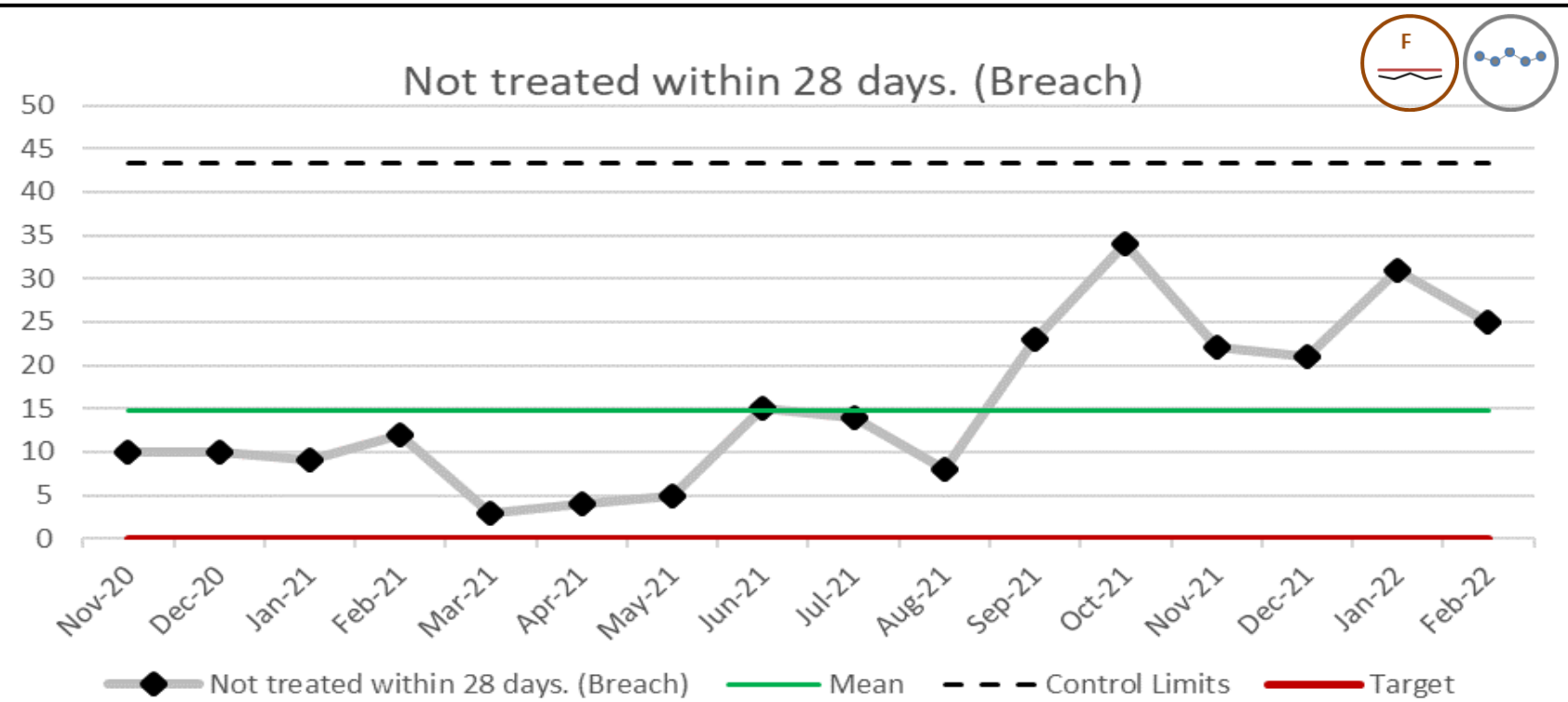
- Admission moved back;
- No surgeon;
- Admission brought forward.

Actions:
Twice weekly meetings in place to ensure focused actions for our long waiter patients to ensure surgery offered before end March 2022.

List availability shared with surgeons to provide increased capacity for patient activity. This is provided at week 4 of 642 to all specialities.

Mitigations:
Staffing gap reviews continue daily with redeployment to alternative sites as required and able.

Increased outsourcing activity is taking place as well as increased focus on our long waiting patients.



Feb-22
25
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

The number of breaches for February is 25, which is a decrease from 31 last month.
The agree target of zero has not been achieved.

Issues:

Limited pre assessment availability, with the addition of PCR testing/isolation means that it is difficult to fill slots at short notice therefore lists can be underutilised.

Limited availability of surgeons and theatre staffing, due to both planned and unplanned absences impacts on availability of lists.

Actions:

Waiting list and CBU continue to work proactively together to reschedule patients who have experienced any on the day non-clinical cancellations.

CBUs to ensure all underutilised and available lists are shared with clinicians to provide increased capacity in the short term.

Work with pre assessment to ensure appropriate time to plan the patient's pathway in line with their surgery.

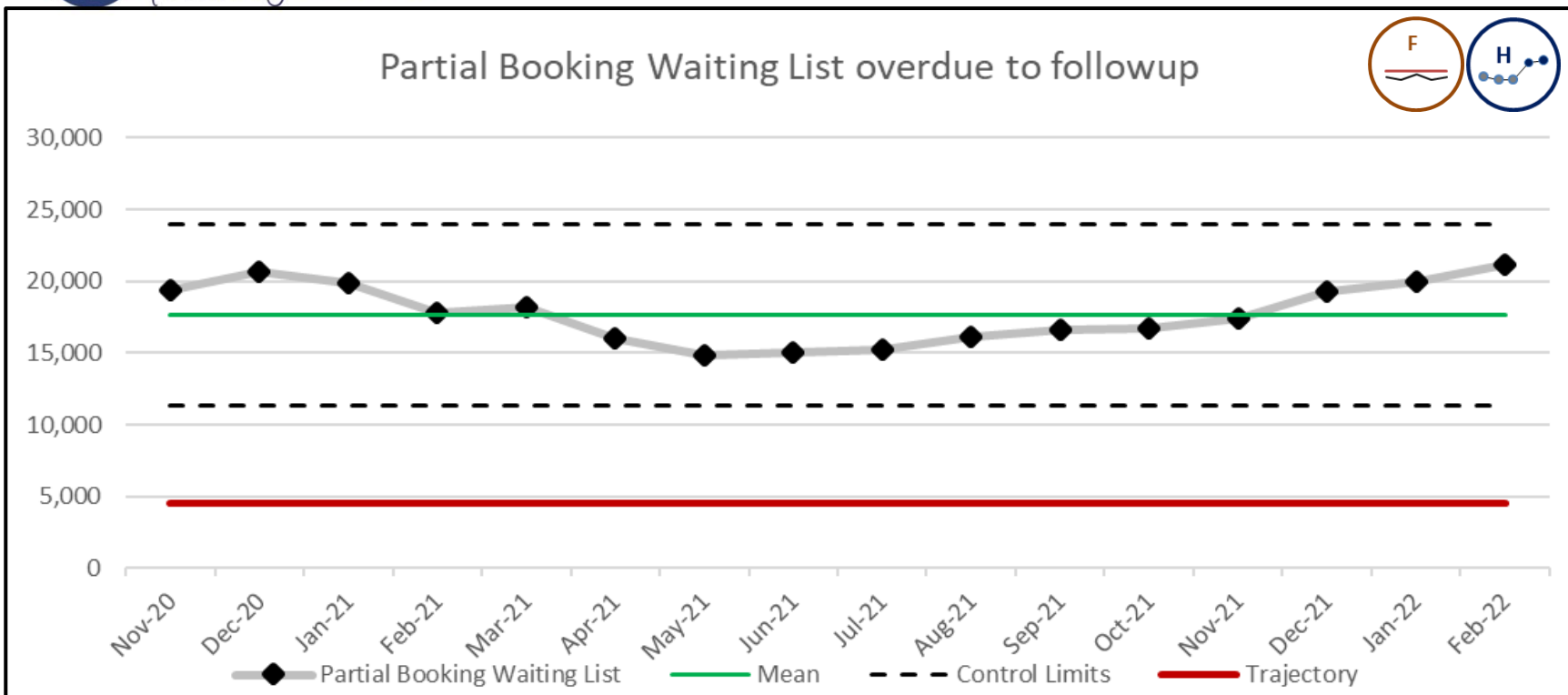
Mitigations:

Working closely with CBUs to increase utilisation of lists and identify underutilisation at an earlier point to ensure sufficient capacity to plan patients

Increase to establishment of waiting lists clerks to ensure capacity to book patients in a timely way. Interviews have been held and we are awaiting start dates of the successful candidates.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
21,117
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 20,006 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.

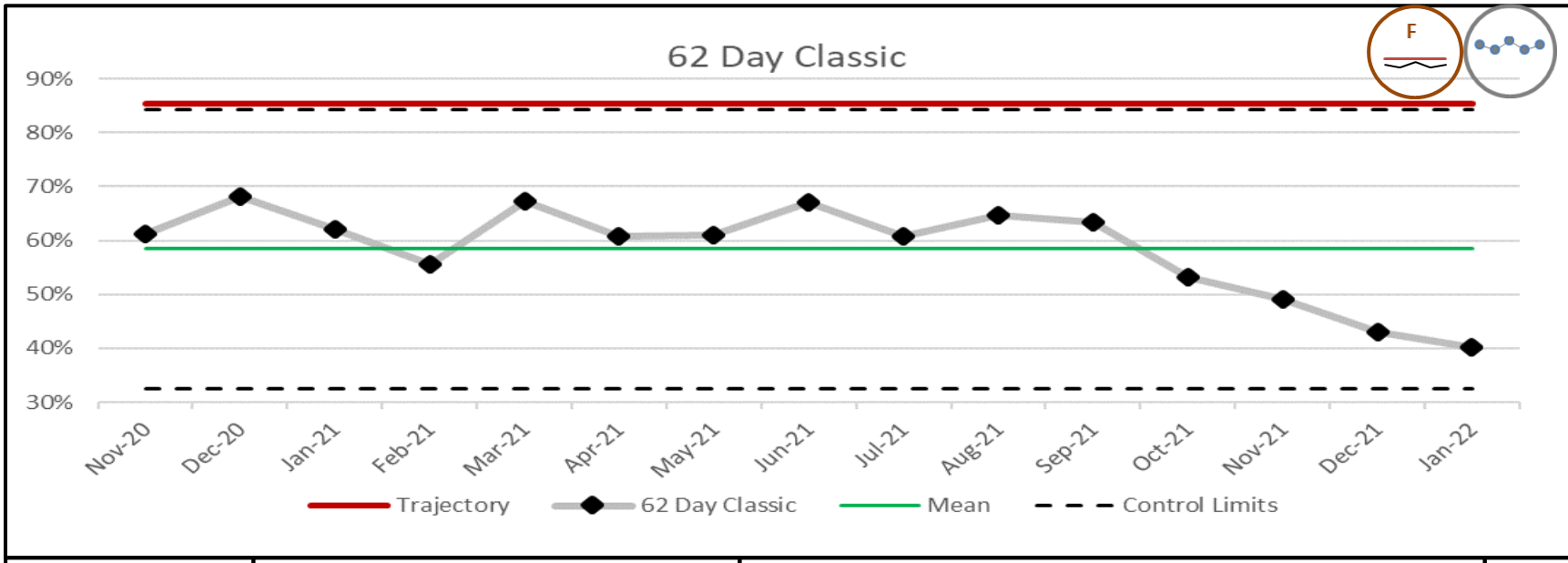
Issues:
The organisation is continually pressured in a number of areas especially in urgent / emergency care that has taken priority over outpatients. The fluctuating impact of covid also has an impact on conflicting priorities, increasing demand on resources, sickness levels, staffing issues, space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

Actions:
Specialities are continuing to plan demand and capacity for the next financial year to improve their PBWL position and reduce patient waits.
Further work with validation, clinical triage, technological solutions and PIFU.
Clinical Harm Oversight Group are reviewing the categories of patients that require a harm review on PBWL. PBWL meeting in place to challenge capacity shortfalls.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
40.20%
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 40.20% against an 85.4% target.

Issues:

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

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

Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements.

Patients not willing to travel to where our service and / or capacity is. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, and 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 for 2021-22. Two substantive Medical Oncologist posts are out to advert. A third is with Royal College awaiting approval of job plan. Two of these posts are currently being covered by Locums. A fourth substantive consultant post is taking a 6 month break and is out to advert. There is a significant lack of consultants nationally and very few available from agency.

Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI, Head & Neck, Skin and Lung CBU's to support clinical engagement.

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

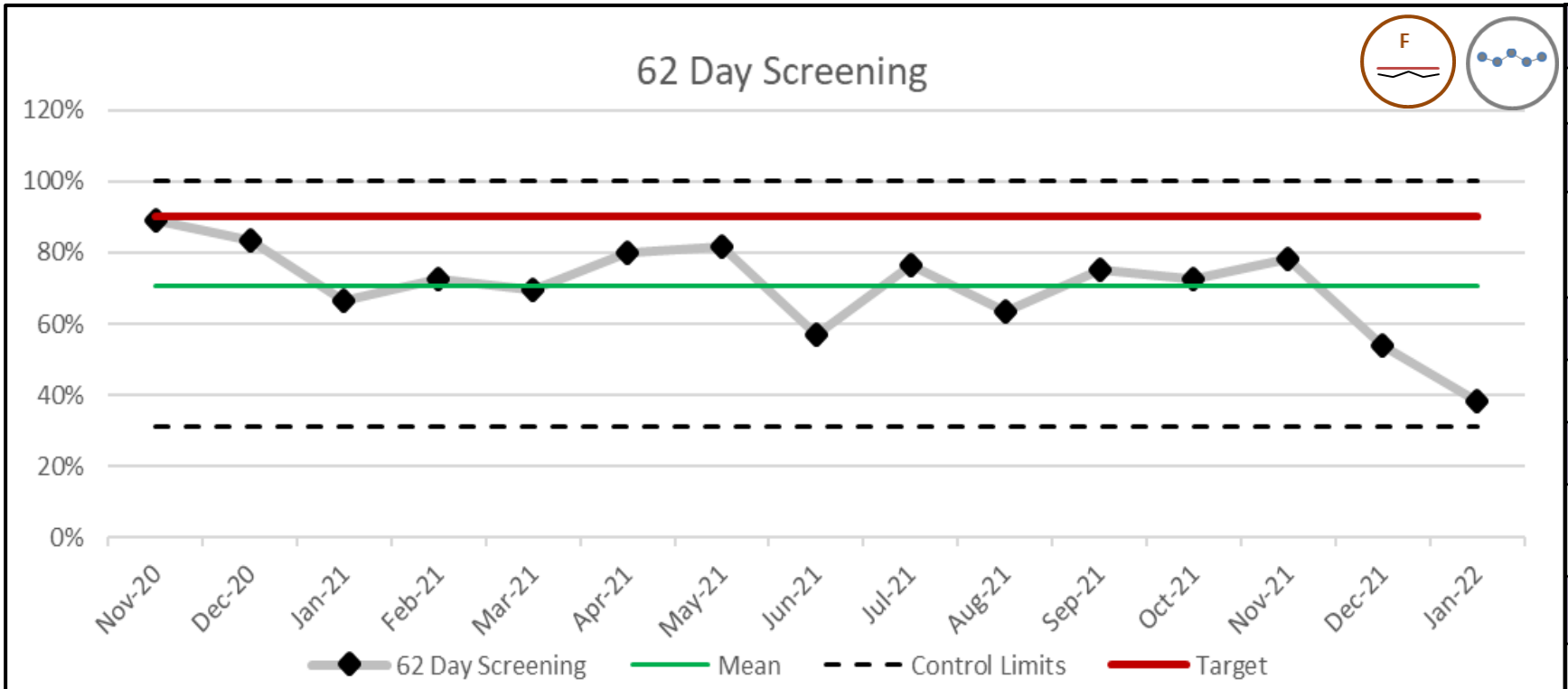
A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists commenced on 14/02/2022. Robotic training for the Colorectal consultants is underway and lists are in the process of being identified.

Mitigations:

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

The number of Head and Neck diagnostic investigations performed at first appointments are set to increase from April 2022 due to the purchase of scopes for all outpatient clinics.



Jan-22
38.30%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

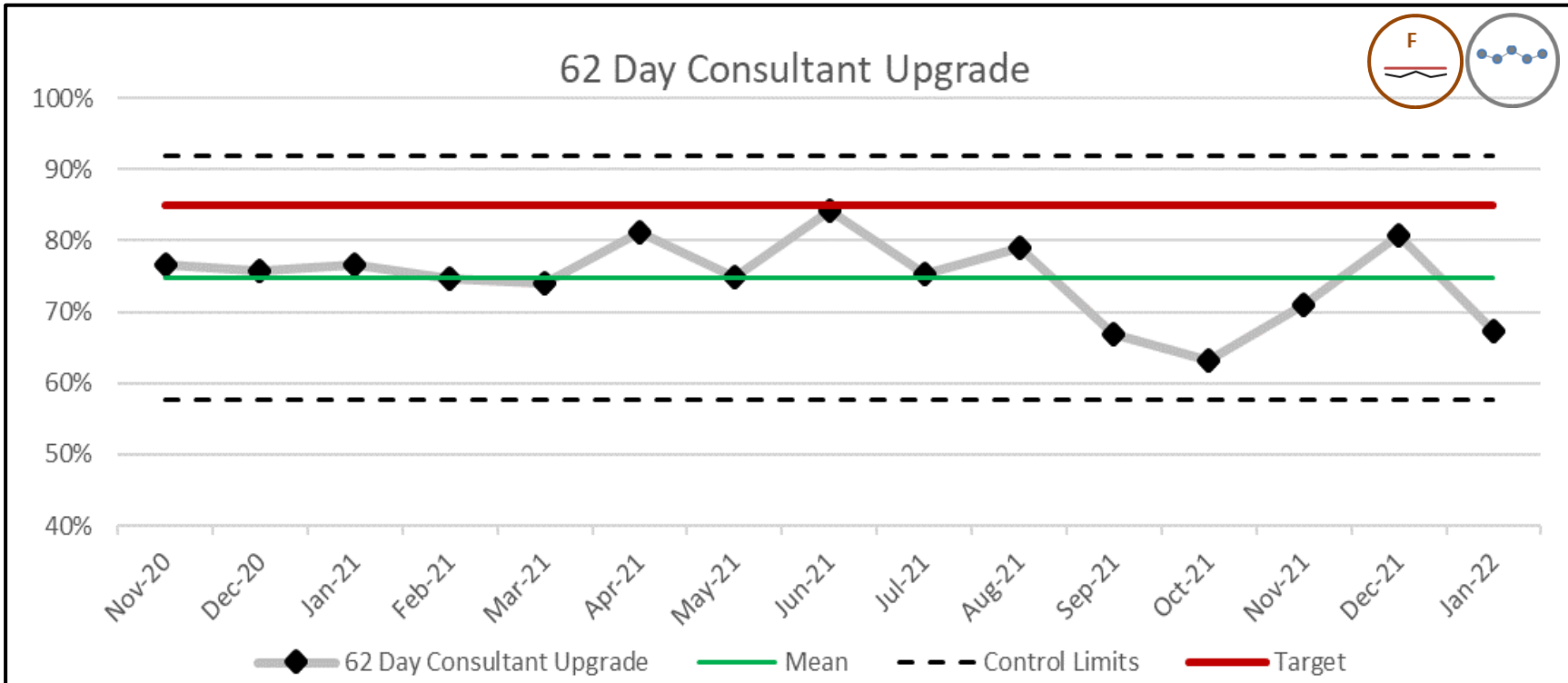
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 38.30% 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.



Jan-22
67.30%
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 67.30% against an 85% target.

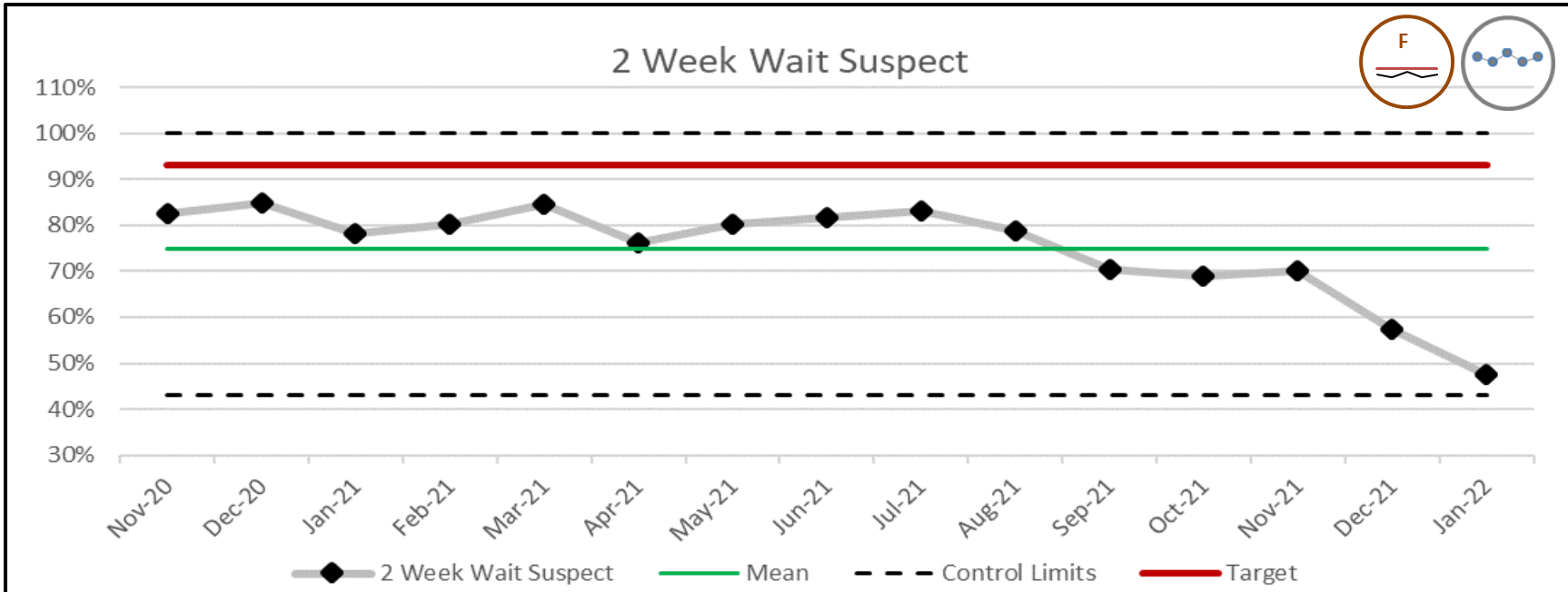
Issues:
See issues on previous page – 62 day classic.

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



Jan-22
47.60%
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 seen by a specialist within two weeks of 2ww referral for suspected cancer.

What the chart tells us:

We are currently at 47.60% 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 2.6%: - 37.7% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Colorectal (2.3%), Lung (41.4%), Urology (47.2%), Gynaecology (47.3%), Brain 76.9%, Sarcoma (80%) Upper GI (81.8%), Skin (83.4), Haematology (87.5%). Head & Neck only just missed achieving the standard at 92.6%.

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

Actions:

The Trust is actively seeking to implement RDC pathways for brain, haematuria and Upper GI by the end of March 2022. The direct access testicular pathway is set to be implemented by the end of April 2022. 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.

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.

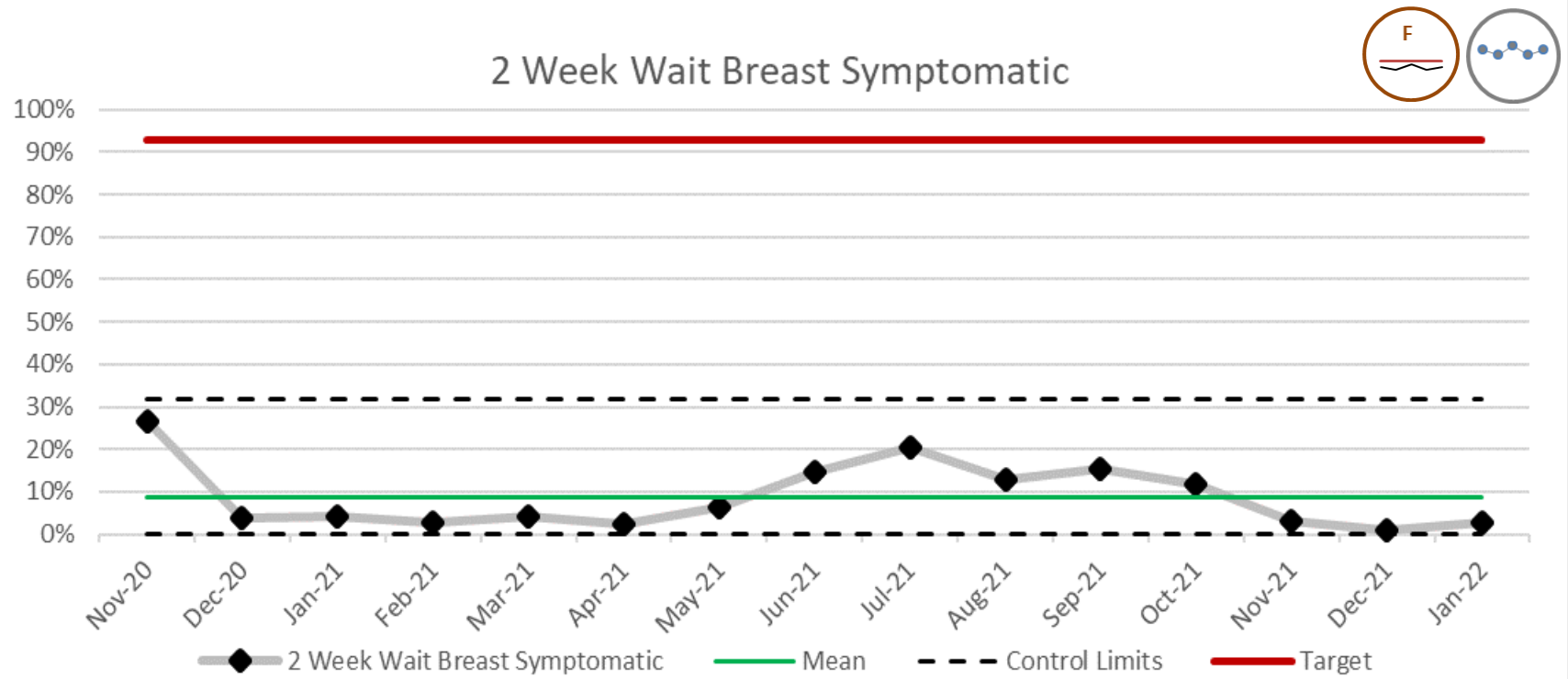
Overseas recruitment is underway for gastroenterology consultants. 2 posts are in place to commence mid-2022 – dates are yet to be confirmed.

Mitigations:

Further respiratory consultant posts will secure lung clinic capacity and support the pilot to appoint lung patients within 48 hours – 2 Lung Specialty Doctors have commenced in post in Boston. A consultant post has also needed to go back out to tier 2 agencies due to continuous delays. Extra consultant cover for weekends and remote CT Triage have been booked for weekends to release consultants to carry out weekend clinics moving forward.

Within Colorectal, SDF funding has been sought to recruit 1 x Band 7 to support NURTEL clinics. Current Band 7 CNS are undertaking additional NURTEL clinics (30 slots per week – rising to 50 per week on completion of recruitment)

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. ACP training commenced in January, so additional FOC / TPLA clinics will be provided from mid-March.



Jan-22
2.60%
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 2.60% against a 93% target.

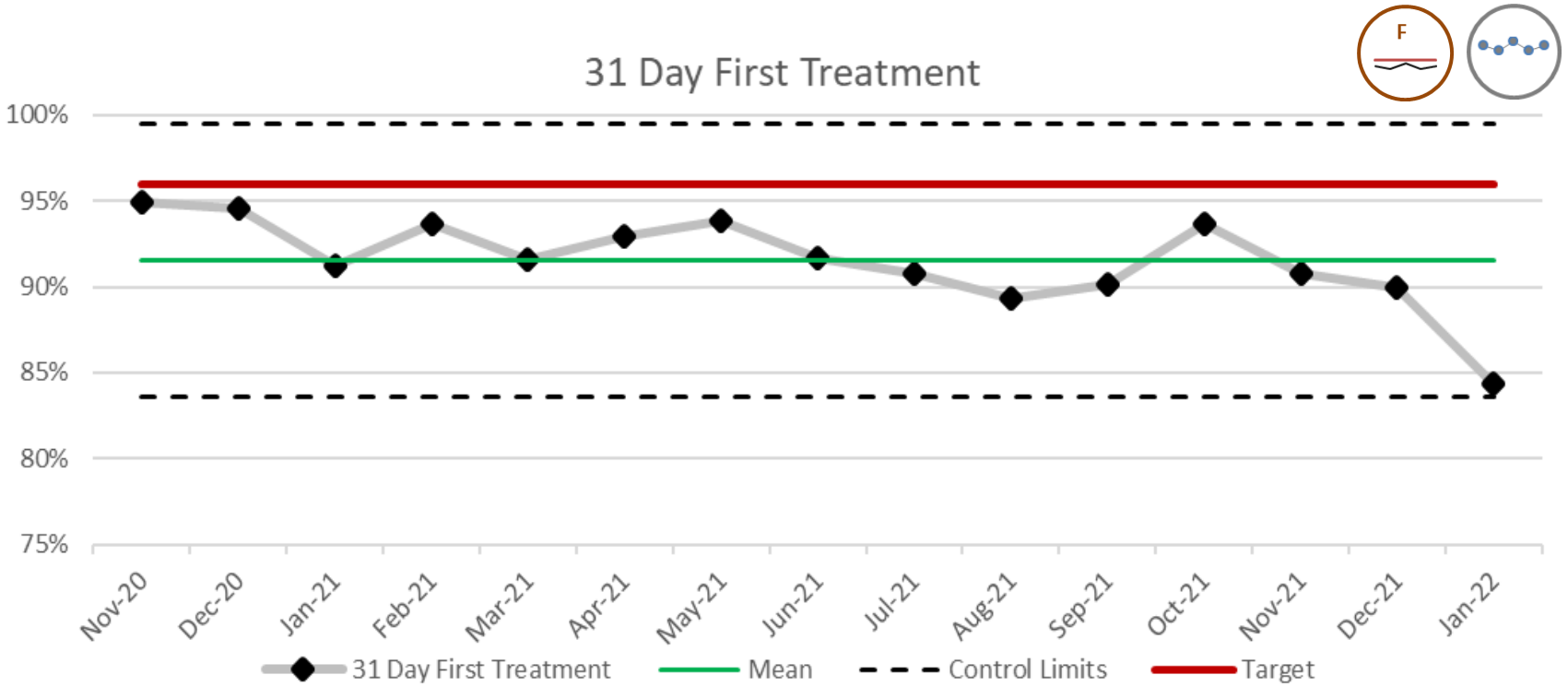
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.

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

Mitigations:
Breast clinic capacity has now been restored to pre-COVID levels and additional clinics to clear the backlog are being sought and will continue to be until the backlog is cleared. A mastalgia pathway is being worked up with primary care and system partners which has the potential to reduce inbound referrals by circa 15%.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-22
84.40%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

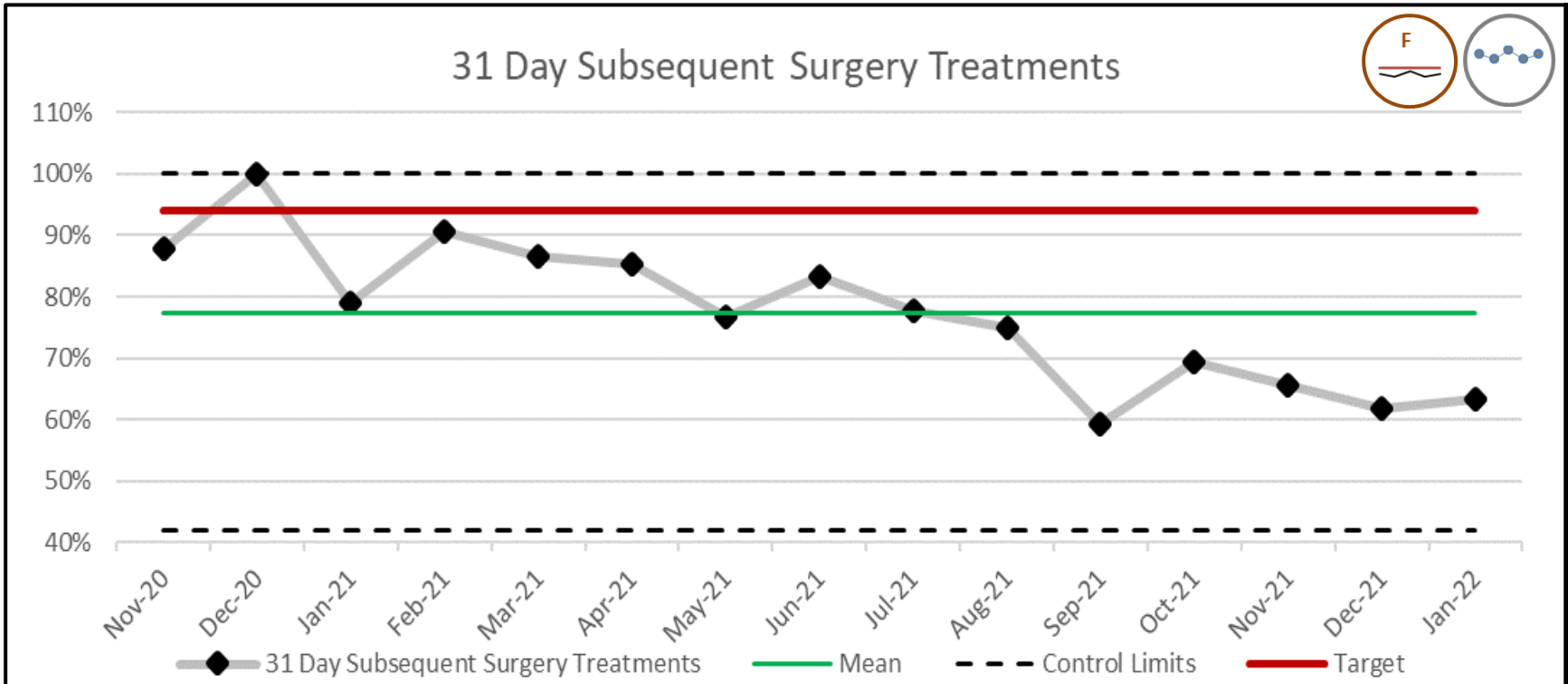
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 84.40% against a 96% target.

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

Actions:
Two substantive Medical Oncologist posts are out to advert. A third is with Royal College awaiting approval of job plan. Two of these posts are currently being covered by Locums. A fourth substantive consultant post is taking a 6 month break and is out to advert. There is a significant lack of consultants nationally and very few available from agency.
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:
A review of colorectal theatre list scheduling in order to better align with clinician availability continues, and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work.
The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists commenced on 14/02/2022. Robotic training for the Colorectal consultants is underway and lists are in the process of being identified.



Jan-22
63.3%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

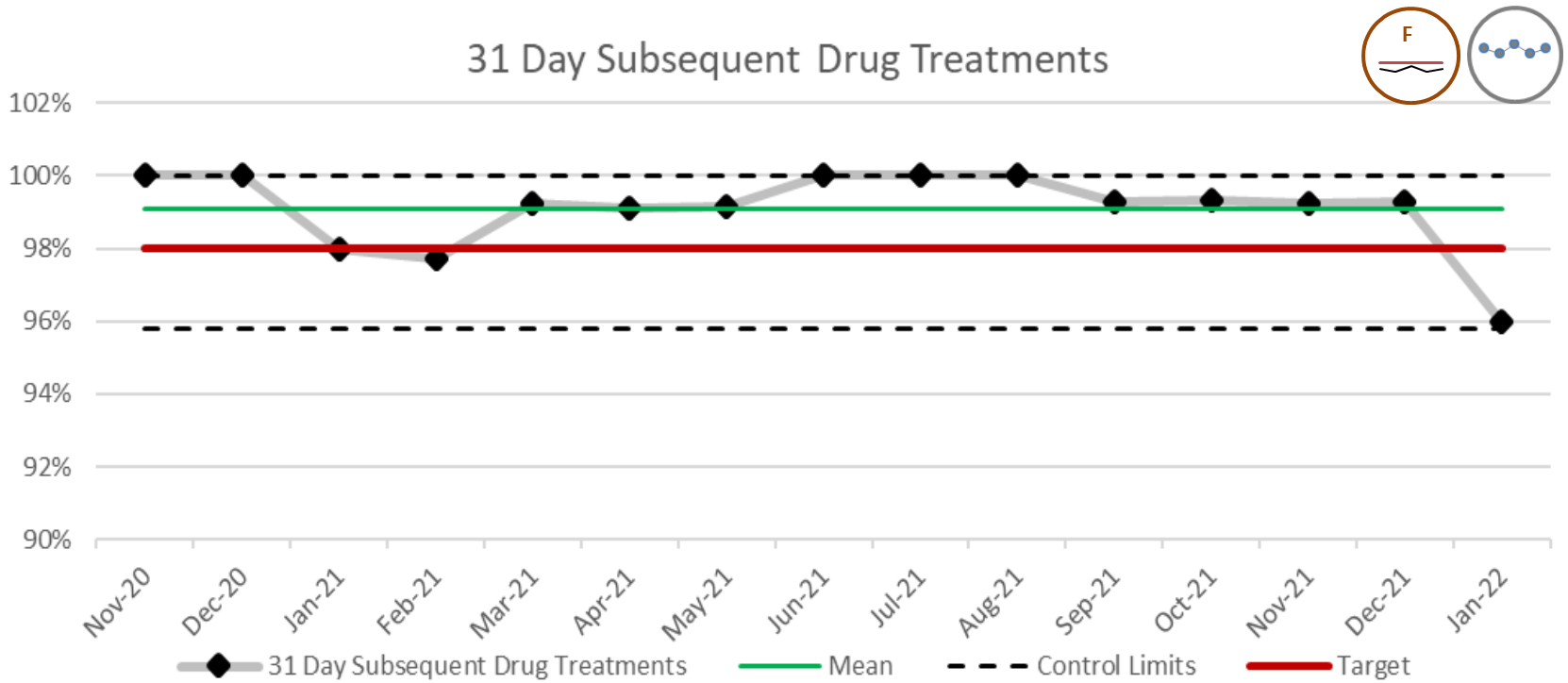
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was surgery.

What the chart tells us:
We are currently at 63.3% against a 94% target.

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

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

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



Jan-22
96%
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 drugs.

What the chart tells us:
We are currently at 96% against a 98% target.

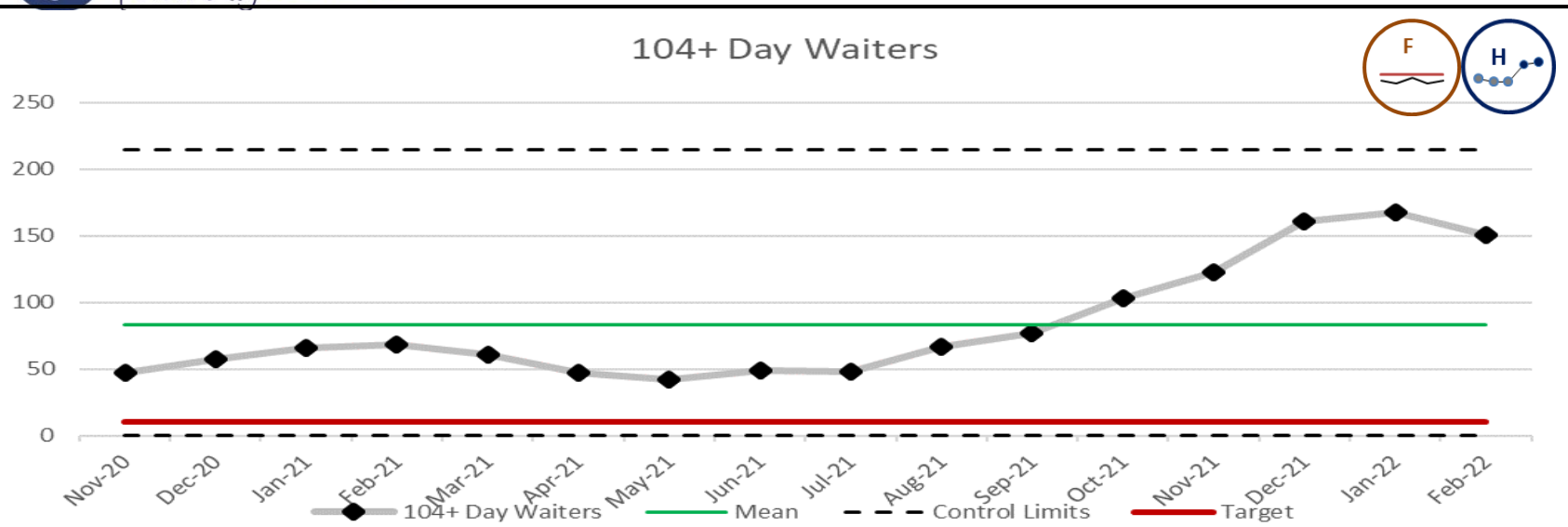
Issues:
See issues on previous page - 31 day first treatment.

Actions:
Two substantive Medical Oncologist posts are out to advert. A third is with Royal College awaiting approval of job plan. Two of these posts are currently being covered by Locums. A fourth substantive consultant post is taking a 6 month break and is out to advert. There is a significant lack of consultants nationally and very few available from agency.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
151
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Number of cancer patients waiting over 104 days.

What the chart tells us:

As of 10th March the 104 Day backlog was at 151 patients. The agreed target is <10.

The current position by tumour site is as follows: - 99 Colorectal, 26 Urology, 10 Lung, 4 each Gynaecology and Upper GI, 2 each Head & Neck, Haematology and Breast, 1 each CUP and Sarcoma.

Issues:

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

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 'effectiveness' period) – this is starting to improve.

Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is available. Reduced theatre capacity across the Trust, all Specialties vying for additional sessions. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Upper GI, Lung and Gynaecology. Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients. Approximately 13% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologist posts are out to advert. A third is with Royal College awaiting approval of job plan. Two of these posts are currently being covered by Locums. A fourth substantive consultant post is taking a 6 month break and is out to advert. There is a significant lack of consultants nationally and very few available from agency.

Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI, Head & Neck, Skin and Lung CBU's to support clinical engagement.

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

For Colorectal, a Deep Dive and pathway analysis is underway, supported by CCG colleagues.

Mitigations:

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

The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists commenced on 14/02/2022. Robotic training for the Colorectal consultants is underway and lists are in the process of being identified.

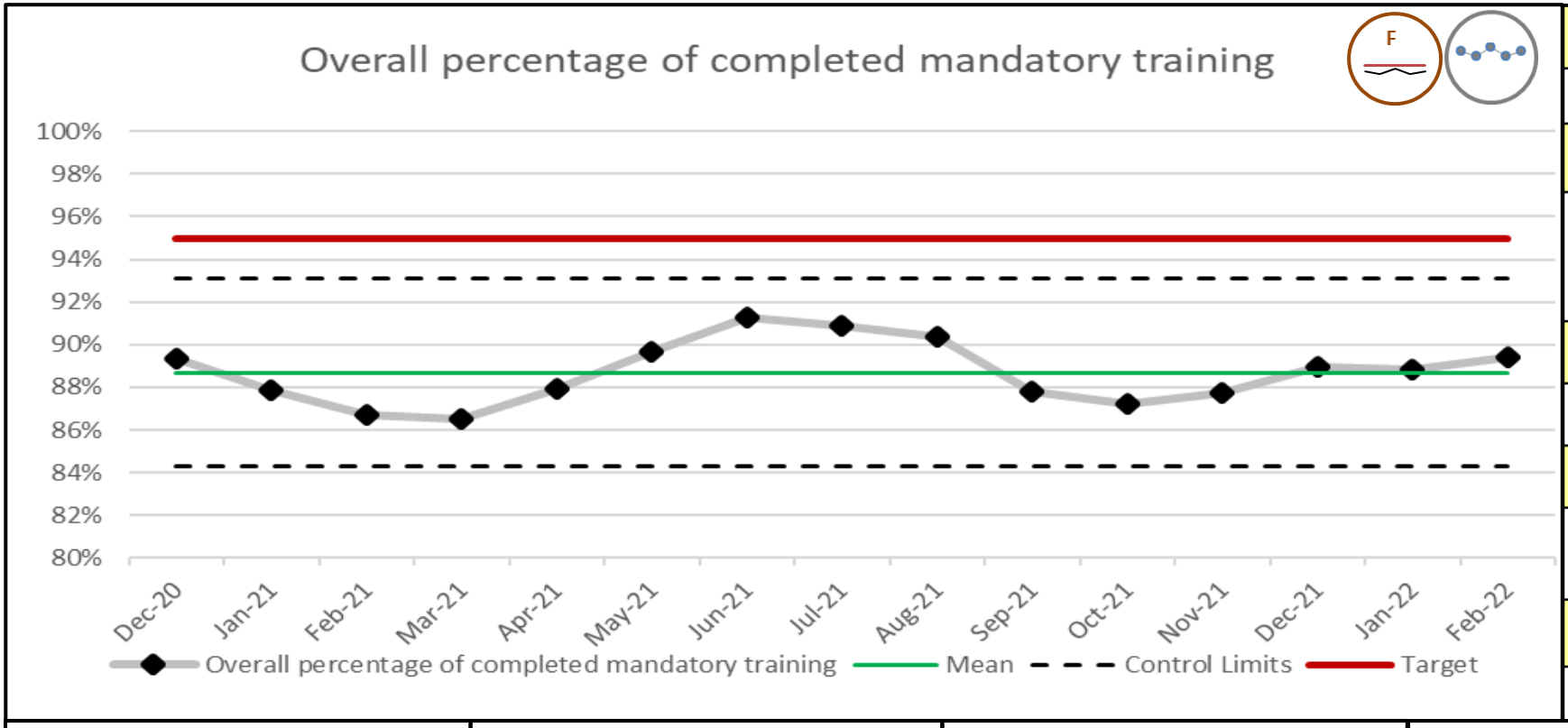
A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Dec-21	Jan-22	Feb-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%	88.94%	88.82%	89.41%	89.10%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	11.18%	10.64%	10.24%	10.78%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.20%	5.09%	5.07%	5.11%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	13.99%	13.99%	13.96%	12.78%		F	H	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	52.40%	53.03%	53.63%	61.27%		F	B	



Fab-22
89.41%
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.

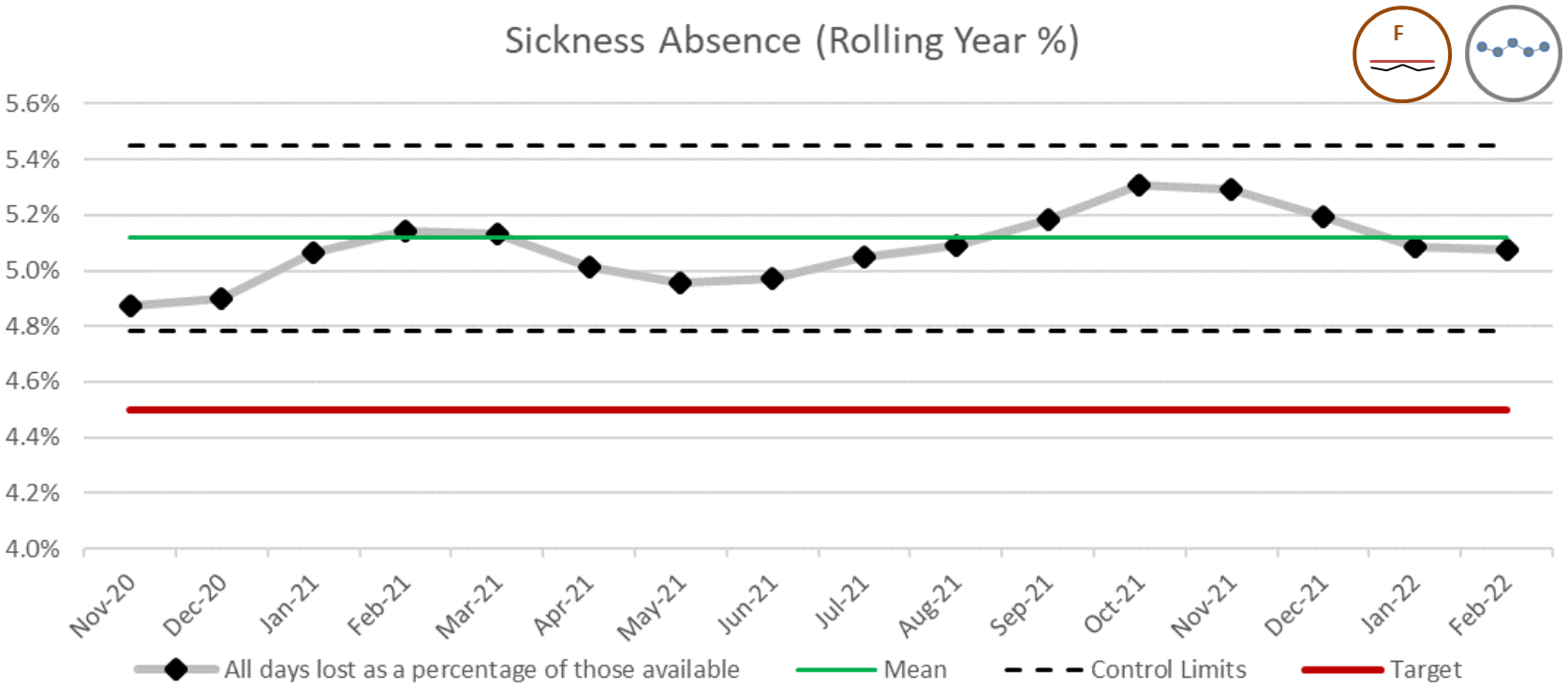
Issues:
- Protected time for learning continues to be a challenge for staff – especially front line staff.
- Social media posts make mention of lack of time to access core learning while on shift and difficulties to access from home.
- Medicine has the lowest compliance at 85.5%.

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

Mitigations:
Messages from The Director of Finance and Digital (Wednesday blog) has helped in reinforcing protected time off for completion of core learning. These messages will need to be repeated over the next month.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
5.07%
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 reduced again in month and is at its lowest of the last 3 months, however the percentage is still high and above the target of 4.5%.

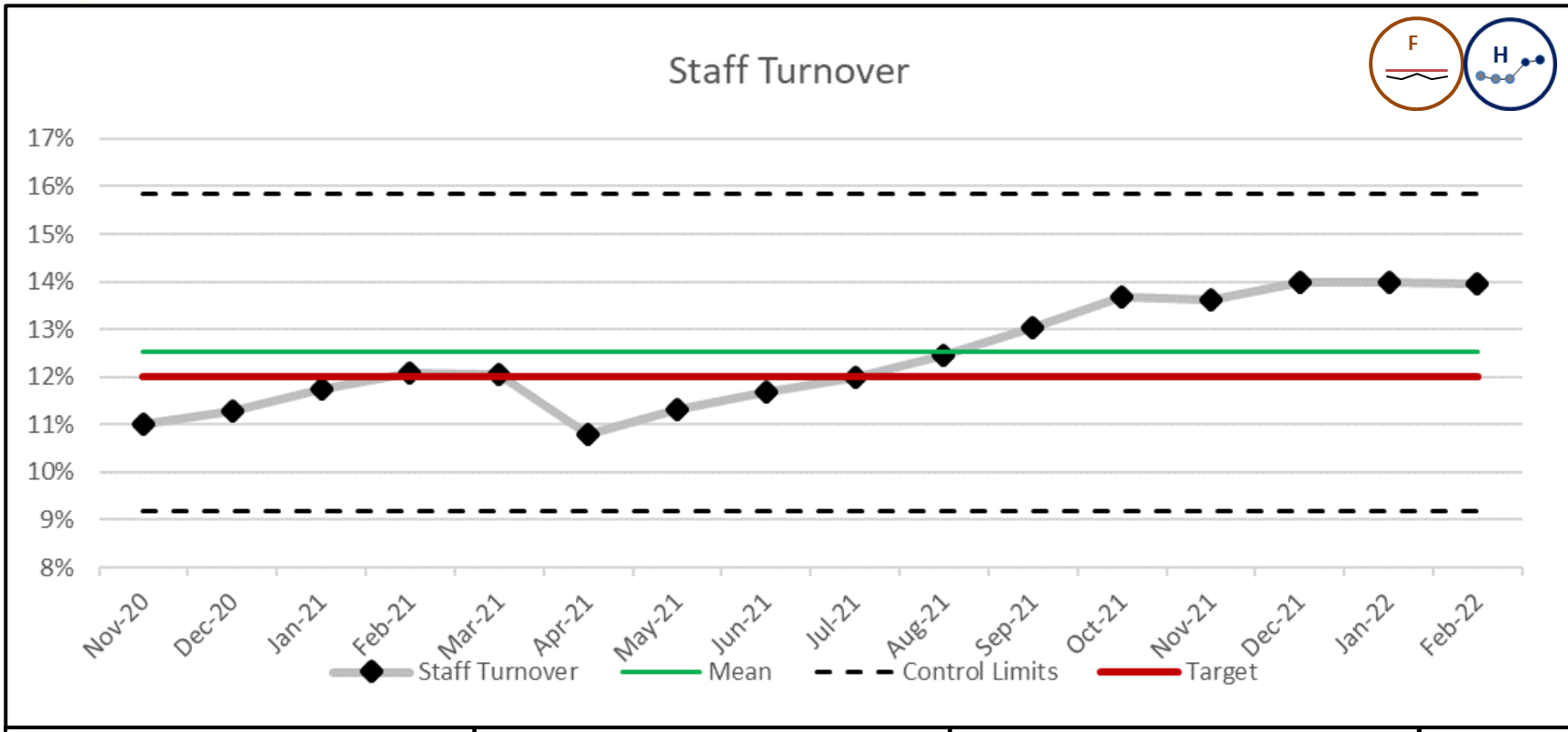
Issues:
- The Absent figures remain at its lowest over the last 12 months
- The COVID absences have not started to increase in line with the national picture of positive Covid infections
- A high proportion of absence remain 'unknown' due to AMS not being updated by managers,
- There is an prediction that absences will significantly increase with a rise in Covid absences.

Actions:
- The implementation of the revised isolation periods means people do not have to isolate, however this is expected to see an increase in infections, the Trust will continue to monitor the impact on workforce absences being reported
- There continues to be an implementation of the wellbeing offer to staff to ensure there is support to the increase in staff suffering with mental health and wellbeing
- the review of the usage and recoding of the Absence management System is continuing to look at issues and hot spots, this is paramount with the expected increase in employee absences.

Mitigations:
See Actions.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-22
13.96%
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:
As expected, turnover rates continue to steadily creep up. Other partners in the system and Trusts regionally are also seeing similar increases in turnover.

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

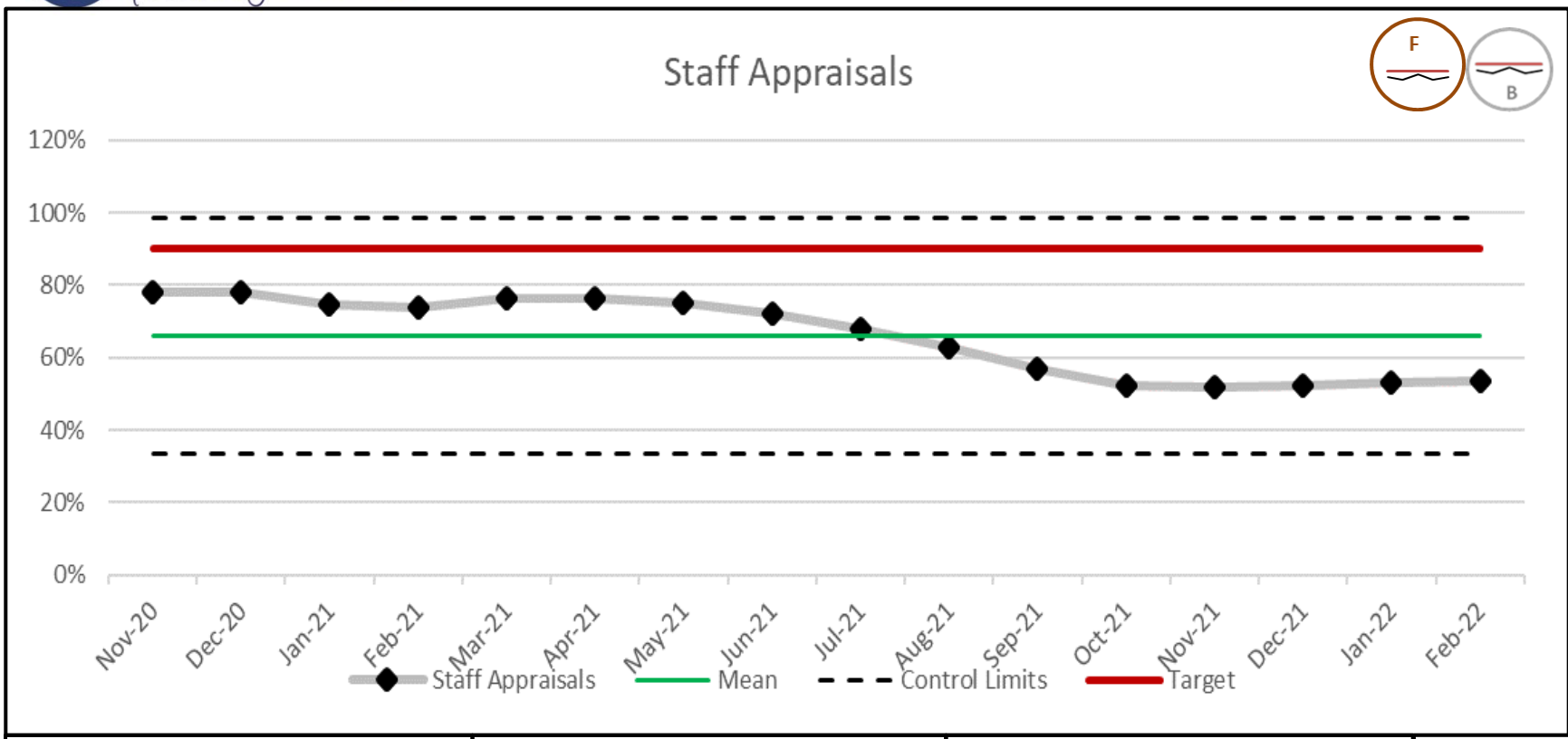
- Lack of flexible working opportunities continues to be one of the main reasons for people leaving.
- Lack of development opportunities is another key reason.

The reasons are exactly the same as last month.

Actions:

- A Culture and leadership Task & Finish group has been put in place and this programme is now being reinvigorated.
- The ban on non-essential training is being lifted in the new financial year and staff will be encouraged to attend.

Mitigations:
See actions



Feb-22
53.63%
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 53.63%.

What the chart tells us:
Operational pressures and staffing challenges continue to impact appraisal completion rates. The completion rate has ever so slightly increased over the past month.

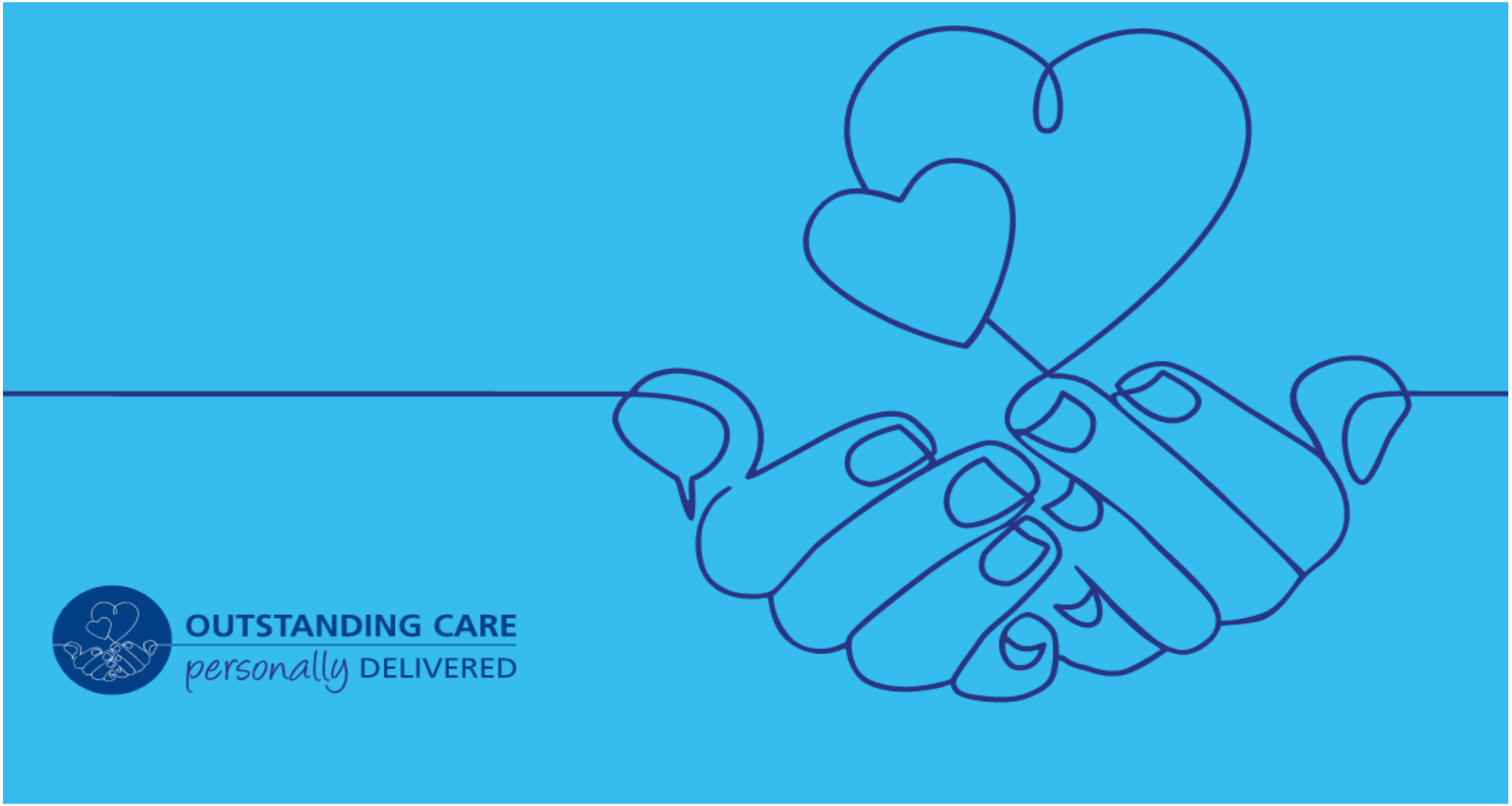
Issues:
- Operational pressures are causing an impact on completion.
- Message understood by staff is that non-essential meetings are being stood down including appraisal discussions.

Actions:
- Appraisal completion deep-dive has been completed and a report shared with senior leaders in HR/OD for next steps
- Appraisal completion to be focussed through the divisions regardless of operational pressures – strong message to go out from Director of People and OD to the divisions.

Mitigations:
- Report and recommended actions to be shared with TLT/ELT in the coming month.

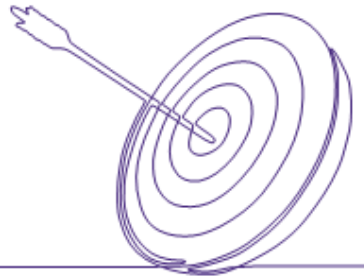
Financial Position Month 11 (2021/22)
Finance Report
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust



Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)

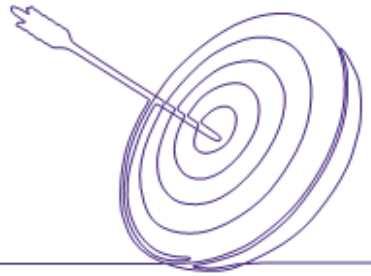


NHS
United Lincolnshire Hospitals
NHS Trust

		Current Month			Year To Date		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
	Operating income from patient care activities	53,005	53,169	164	566,665	568,973	2,308
	Other operating income	2,738	4,024	1,286	29,460	32,223	2,763
	Employee expenses	(35,972)	(37,060)	(1,088)	(389,002)	(399,019)	(10,017)
	Operating expenses excluding employee expenses	(19,209)	(19,784)	(575)	(198,715)	(194,498)	4,217
	Net Finance Costs	(618)	(403)	215	(6,924)	(6,248)	676
	Other gains/(losses) including disposal of assets	0	0	0	0	(215)	(215)
	Surplus/(Deficit) For The Period/Year	**(56)**	**(55)**	**1**	**1,484**	**1,215**	**(269)**
	Add back all I&E impairments/(reversals)	0	0	0	0	94	94
	Remove capital donations/grants I&E impact	56	55	(1)	316	614	298
1	**Adjusted financial performance surplus/(deficit)**	**(0)**	**0**	**0**	**1,800**	**1,923**	**123**
	Less gains on disposal of assets	0	0	0	0	(123)	(123)
2	**Adjusted surplus/(deficit) for the purposes of system achievement**	**(0)**	**0**	**0**	**1,800**	**1,800**	**0**

- The Lincolnshire system delivered a £2.0m surplus in H1 inclusive of a £1.8m surplus delivered by the Trust. The Lincolnshire system has submitted a break-even position for H2 inclusive of a break-even position for the Trust in H2.
- The above table shows that (as per 1) in Month 11 the Trust delivered a breakeven position in line with plan), and that the Trust has YTD delivered a surplus of £1,923k (£123k favourable to plan).
- For the purpose of measuring system financial performance, gains from disposal of assets are removed, and the above table shows (as per 2) that YTD the Trust is on plan with a surplus of £1.8m.

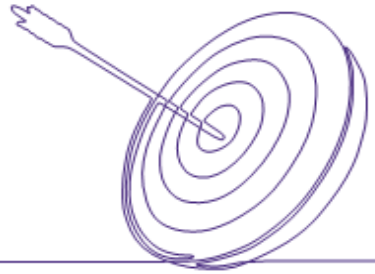
Finance Spotlight Report (Key areas of focus - Income)



NHS
United Lincolnshire Hospitals
NHS Trust

- The overall YTD Income position at Month 11 is £5.1m favourable to plan:
  - **£4.5m favourable movement re Pay award** – This movement reflects the fact that the Trust's H1 income position includes unplanned income of £4.5m for the cost of the pay award; funding for the cost of the pay award in H2 is included within the Trust's H2 income plan.
  - **£2.0m favourable movement re other Patient Care Income** – The overall movement is driven by passthrough.
  - **£4.2m adverse movement re ERF/ERF stretch** – This movement reflects the fact that achievement of ERF was £4.2m lower than planned in H1; the financial plan for H1 assumed ERF income of £7.6m, but the Trust only achieved £3.4m of ERF income; ERF stretch of £1.56m has been achieved in the current month in line with plan.
  - **£2.8m favourable movement re Other Operating Income** – driven by additional top up funding (in relation to Covid) which is offset by additional expenditure, and over performance on variable income streams such as non patient care recharges, car parking income and catering income for which there is some offset in expenditure.
- Shadow monitoring of activity on a Tariff basis determined that actual activity of £33.9m was delivered in the current month.

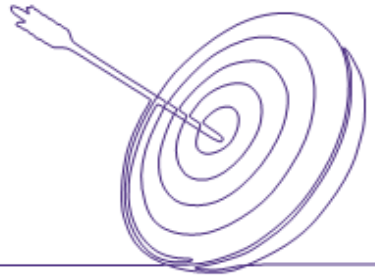
Finance Spotlight Report (Key areas of focus - Pay)



NHS
United Lincolnshire Hospitals
NHS Trust

- **The overall YTD Pay position is £10.0m adverse to plan**:
  - **£4.5m adverse movement re pay award** – This movement reflects the fact that the Trust's H1 Pay position includes unplanned expenditure of £4.5m for the cost of the pay award; funding for the cost of the pay award in H2 is included within the Trust's H2 expenditure plan.
  - **£3.4m adverse movement re Pay CIP delivery** – Savings delivery in H1 was £1.8m lower than planned, including non recurrent Pay savings of £0.6m; Savings delivery to date in H2 is £1.6m lower than planned, including non recurrent Pay savings of £0.2m.
  - **£1.1m adverse movement re Restore and Covid** – The additional costs of Covid in H1 (including the cost of bank incentive rates) were £2.0m higher than planned, but this pressure was mitigated in part by £0.9m lower than planned costs in relation to Restore; it has not been possible to provide an update re Covid and Restore costs in H2 for the Month 11 report.
  - **£1.0m adverse movement overall re other items** – A number of other adverse movements (e.g. expenditure related to top-up funding) have been partly mitigated by other upsides in the position.
- **Pay expenditure of £37.1m in February is £0.3m lower than £37.3m in January**; Substantive Pay was £0.1m higher, Agency Pay was £0.1m lower and Bank Pay was £0.3m lower; some reduction in Bank and Agency Pay would be expected given there are fewer days in February than in January.

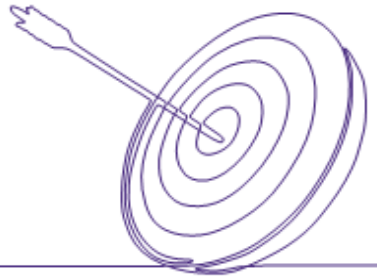
Finance Spotlight Report (Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

- The overall YTD Non Pay position is £4.2m favourable to plan, which is a worsening of £0.6m compared to the reported YTD Non Pay position at Month 10; Non Pay expenditure of £19.8m in February is £2.3m higher than expenditure of £17.5m in January.
- In H1, the Trust planned CIP savings of £6.4m and delivered £6.2m in relation to 2021/22 savings schemes including £5.2m of non recurrent savings. The Trust's original plan required a further £9m of savings in H2, but the H2 plan submitted is based upon delivery of £6m in H2. Against the H2 CIP plan, the Trust has delivered savings of £4.9m (broadly in line with plan); see separate CIP report for details.
- Capital funding levels for 2021/22 agreed through Trust Board & FPEC, showed a plan of c£47.5m at M10. A final decision has been made to not draw-down TIF for C2-AI (c£1.2m reduction), offset by new Diagnostic funding (c£0.5m) for MRI Software and Trans-nasal scopes. Further to this, due to notification of further slippage in scheme delivery a decision has been made to reduce the ULHT cash support by £1.3m so that the revised scheme forecast is aligned. These decisions have decreased the 'live' capital envelope to c£45.6m as at the end of M11.
- Capital spend incurred at M11 equated to c£23.9m, with in month-spend amounting to £5.5m (highest monthly spend this financial year). There is therefore a requirement to spend c£21.7m in M12 to achieve full maximisation of the capital allocation. Please see separate capital report for details.
- The month end cash balance is £68.6m which is an increase of £14.6m against cash at 31 March 2021.

Finance Spotlight Report (Key areas of focus - Other)



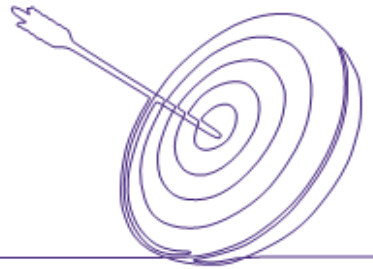
United Lincolnshire Hospitals NHS Trust

- The Trust forecasts to deliver its element of the System's financial plan i.e. a surplus of £1.8m. For the purpose of measuring system financial performance, gains from the disposal of assets are removed, and the Trust has YTD made £123k from the disposal of assets. The Trust therefore forecasts to deliver an adjusted surplus of £1.923m, so that once gains from the disposal of assets are removed it will meet its system target to deliver a £1.8m surplus. However, the mounting operational changes required to support the Trust addressing the COVID and wider NEL pressures create a financial risk. In the H2 financial plan submission supporting paper, an indicative risk of 'winter' of £3m was identified, and further forecast analysis is contained in this report.

- BPPC performance is 90% / 85% by value / volume of invoices paid for the period April 21 – February 22 (appendix 5d). (In month performance 82%/ 70% by value / volume). During December in particular, but also January, the processing and payment of invoices has been impacted by the migration to the new finance system. In an average month, the Trust would expect to pay circa 9,000 invoices / £24m spend; in December 2,700 invoices at a cost of £3m were processed. This has since recovered so that in January (8300 / £23m) and February (9100 / £24m) invoices were paid.

  A backlog remains however and can be seen in the increased level of trade creditors and reduced performance against the BPPC target. The BPPC performance will slowly recover as the backlog is cleared, likely to be in the early part of 2022/23.

Finance Dashboard



NHS
United Lincolnshire Hospitals
NHS Trust

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

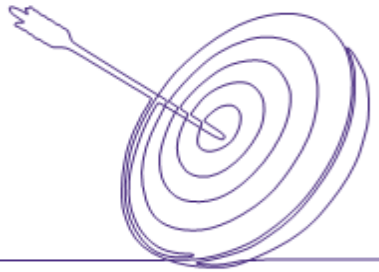
Clinical Services
People
Clinical Support Services
Corporate Services, Procurement, Estates and Facilities
Finance

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

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

Finance and use of resources rating	Full Year	Full Year	Full Year	Actual	Forecast
	31/03/2019	31/03/2020	31/03/2021	FEB 2021	31/03/2022
Capital service cover metric	(10.40)	(1.73)	0.06	1.73	1.75
Capital service cover rating	4	4	4	3	3
Liquidity metric	(98.73)	(128.28)	3.71	5.02	3.75
Liquidity rating	4	4	1	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.32%	0.32%
I&E margin rating	4	4	2	2	2
Agency metric	77.00%	110.00%	113.00%	118.00%	118.00%
Agency rating	4	4	4	4	4
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.02%	0.04%
I&E margin: distance from financial plan - rating	4	1	n/a	1	1

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

	31 March 2021	28 February 2022		31 March 2022
		Plan	Actual	Forecast
	£000	£000	£000	£000
Intangible assets	4,600	2,934	3,031	2,888
Property, plant and equipment	247,119	264,746	258,124	278,389
Receivables	2,790	2,781	2,676	2,706
Total non-current assets	**254,509**	**270,461**	**263,832**	**283,983**
Inventories	6,510	6,728	6,585	6,600
Receivables	25,935	34,806	26,066	27,000
Cash and cash equivalents	54,042	16,951	68,648	71,598
Total current assets	**86,487**	**58,485**	**101,300**	**105,198**
Trade and other payables	(69,643)	(54,177)	(78,282)	(81,683)
Borrowings	(402)	(1,108)	(555)	(1,110)
Provisions	(2,056)	(2,178)	(2,171)	(6,000)
Other liabilities	(1,587)	(2,943)	(5,004)	(3,503)
Total current liabilities	**(73,688)**	**(60,406)**	**(86,012)**	**(92,296)**
Total assets less current liabilities	**267,308**	**268,539**	**279,119**	**296,885**
Borrowings	(3,624)	(4,437)	(3,471)	(2,916)
Provisions	(4,069)	(4,032)	(4,047)	(4,047)
Other liabilities	(12,075)	(11,613)	(11,614)	(11,572)
Total non-current liabilities	**(19,768)**	**(20,082)**	**(19,132)**	**(18,535)**
Total assets employed	**247,540**	**248,457**	**259,987**	**278,350**
Financed by				
Public dividend capital	677,570	677,570	688,802	707,173
Revaluation reserve	27,522	26,884	26,882	26,824
Other reserves	190	190	190	190
Income and expenditure reserve	(457,742)	(456,187)	(455,887)	(455,837)
Total taxpayers' equity	**247,540**	**248,457**	**259,987**	**278,350**

Note 1: Payables, Receivables and Cash have each been impacted in the last three months 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 not expected to return to 'normal' business levels until early in the new financial year..

Note 2: Trade and other receivables continue to be supressed below pre-pandemic levels with the continuation of block contract payments for the remainder of 2021/22. The increased receivables balance in January / February is due to 'catch-up' following delays in raising invoices during the ledger implementation period. See Appendix 5a-b

Note 3: Trade Payables and other payables are circa £17-20m higher than would be normally be expected. Whilst trade creditors are expected to reduce during March, the level of capital creditors is likely to rise significantly as the capital programme is completed.
The payables balance of £78m is broadly split between: Staff related creditors £18m, Trade Payables / accruals £34m, Capital creditors £8m, Tax / Superannuation £15m and PDC dividend £3m.
BPPC and aged creditor performance have been impacted by the system implementation and are reported at Appendix 5c-d.

Note 4: Capital PDC of £11m was drawn in February, with a further £18m receivable in March.

Cashflow reconciliation– April 2021– February 2022

United Lincolnshire Hospitals NHS Trust

	Full Year 2020/21	28 February 2022		31 March 2022
		Plan	Actual	Forecast
	£000	£000	£000	£000
Operating surplus / (deficit)	8,778	7,921	7,679	8,236
Depreciation and amortisation	13,674	14,308	13,994	15,612
Impairments and reversals	3,121	-	94	93
Income recognised in respect of capital donations	(3,923)	(550)	-	(50)
Amortisation of PFI deferred credit	(503)	(462)	(461)	(503)
(Increase) / decrease in receivables and other assets	16,119	(8,862)	(17)	(981)
(Increase) / decrease in inventories	527	(218)	(75)	(90)
Increase/(decrease) in trade and other payables	16,987	(11,343)	10,524	2,684
Increase/(decrease) in other liabilities	(2,085)	1,356	3,417	1,916
Increase / (decrease) in provisions	1,556	114	122	3,951
Net cash flows from / (used in) operating activities	**54,251**	**2,265**	**35,276**	**30,868**
Interest received	12	-	14	23
Purchase of intangible assets	(1,245)	-	(106)	(106)
Purchase of property, plant and equipment	(39,483)	(37,040)	(28,821)	(36,814)
Proceeds from sales of property, plant and equipment	625	-	128	128
Net cash flows from / (used in) investing activities	(40,091)	(37,040)	(28,785)	(36,769)
Public dividend capital received	409,664	-	11,232	29,601
Loans from Department of Health and Social Care - repaid	(377,859)	-	-	-
Other loans received	2,544	1,520	-	-
Interest paid	(2,522)	-	(1)	(1)
PDC dividend (paid)/refunded	(5,662)	(3,836)	(3,117)	(6,143)
Net cash flows from / (used in) financing activities	26,165	(2,316)	8,114	23,457
Increase / (decrease) in cash and cash equivalents	**40,325**	**(37,091)**	**14,605**	**17,556**
Cash and cash equivalents at 1 April - brought forward	13,717	54,042	54,042	54,042
Cash and cash equivalents at period end	**54,042**	**16,951**	**68,647**	**71,598**

Note 1: Cash held at 28 February was £68.6m against a plan of £17.0m.

Note 2: Principle reasons for the cash variance to plan of £51.7m are:

- a shortfall of £8.2m against planned capital payments, linked to delays in the capital programme.
- The continued block contract regime suppressing receivables.
- Increases through December / January in trade payables and accruals linked to the implementation of the new finance system and delayed supplier payments.

Note 3: Underlying cash balances remain significantly increased on 2019/20 levels primarily due to:

- the continued block payment regime
- Receipt in March 21 of £7.1m to cover future outgoings associated with accrued annual leave.
- Delays in the capital programme.

Note 4: Cash balances are expected to remain at similar levels for the reminder of 21/22 with the drawdown of a further £18m PDC scheduled in March.

Meeting	*Trust Board*
Date of Meeting	*Tuesday 5 April 2022*
Item Number	*Item 13.1*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing / Deputy CEO*
Presented by	*Dr Karen Dunderdale, Director of Nursing / Deputy CEO*
Author(s)	*Paul White, Head of Risk and Governance*
Report previously considered at	*N/A*

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

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

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

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks to strategic objectives currently being managed within the Trust (those with a rating of Very high, 20-25).
- There are 14 active risks that are rated Very high (20-25) and 13 rated High (15-16); 80% of the risk register (197 risks) has a current rating of Moderate (8-12).
- The Risk Register Confirm & Challenge Group in March discussed planned care recovery and ambulance handover risks, agreeing that these should all be rated as Very high risk (20) at present
- The Group agreed that the NIV risk had reduced and would be reassessed by the clinical team, with a recommendation that the score change from 20 to 16
- There is also a new Very high (20) risk in relation to the potential impact of the new eFinancials system on the medicines supply chain
- A process is being developed integrate the use of the risk register with decisions of the Capital and Revenue Investment Group (CRIG)
- The Risk Management Policy and associated procedures have now been finalised and will be presented to the Audit & Risk Committee in April

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 in sections 2.2-2.6 below. Moderate and Low risks (12 and below) are managed at divisional level.

1.2 At the Risk Register Confirm & Challenge Group (RRC&CG) meeting on 23 March 2022 there was discussion regarding the risks associated with planned care recovery and delayed ambulance handovers to Emergency Departments. The Group agreed that at present all of these areas represented significant risk to the Trust and accordingly they have been rated as Very high risk (20) and are included in this report. In addition, risks relating to delayed admissions and overcrowding within Emergency Departments are

still being assessed within Medicine Division and will be presented to the RRC&CG in April.

1.3 It was also raised that risks of this nature have both a reputation and a quality of care impact. It was agreed that the Finance, Performance & Estates Committee would be the lead for assurance against performance risks, with the Quality Governance Committee also receiving regular updates on progress with these risks so as to maintain oversight from a quality perspective. The same principles have also been applied to patient information and medicine supply risks.

1.4 The RRC&CG agreed that the NIV patient safety risk had reduced as a result of progress with the Respiratory Improvement Plan. The Divisional Managing Director agreed to review the risk with the clinical team, with a recommendation that the rating should change from Very high (20) to High (16).

1.5 The Group has also requested that Digital Services re-assess the risk of a critical ICT infrastructure failure to ensure that it is clearly understood as a separate but related risk to the financial challenges of funding all required software and hardware upgrades.

1.6 Following on from previous discussions at the RRC&CG, a process is being developed between Clinical Governance and Finance to integrate the use of the risk register within the Capital and Revenue Investment Group (CRIG) decision making arrangements.

2. Trust Risk Profile

2.1 There 246 active risks currently recorded on the Trust risk register. There are 14 risks with a current rating of Very high (20-25). **Chart 1** shows the number of active risks by current risk rating:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
0 (0%)	**22** (9%)	**197** (80%)	**13** (5%)	**14** (6%)

Strategic objective 1a: Deliver harm free care

2.2 Significant active risks to this objective:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4622	If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients.	Very high risk (20)	- Safety Culture Project, part of Integrated Improvement Plan (IIP) - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previously called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ	08/11/2021
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	03/02/2022
4646	If the Trust is not consistently compliant with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	Very high risk (20)	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	14/12/2021

Strategic objective 1c: Improve clinical outcomes

2.3 Significant active risks to this objective:

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

Strategic objective 2a: A modern and progressive workforce

2.4 Significant active risks to this objective:

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

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

2.5 Significant active risks to this objective:

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

Strategic objective 3c: Enhanced data and digital capability

2.6 Significant active risks to this objective:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	26/01/2022
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.	26/01/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4857	Following upgrade to new eFinancials system there is a backlog of unpaid pharmacy invoices, there have been issues with BACS payments made to suppliers (including urgent CHAPS payments) due to incorrect or missing payment remittances resulting in them being unable to correctly allocate payments, also payments have been made to incorrect suppliers. If this situation continues then there will be an impact on our ability to source critical medications, for example chemotherapy products from Quantum, and this will directly and negatively impact on patient care.	Very high risk (20)	Escalation to Finance; identification of 'priority' suppliers where we absolutely must not be put on stop (eg. Wholesalers, pharmaceutical manufacturers supporting the chemotherapy service, etc); Finance team need to be able to provide a system that is able to process the backlog of invoices quickly and ensure that moving forwards invoices continue to be processed and paid correctly.	22/03/2022

Strategic objective 4a: Establish new evidence based models of care

2.7 Significant active risks to this objective:

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	23/03/2022
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	23/03/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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	23/03/2022
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

3. Conclusions & recommendations

3.1 The risk register is now becoming more reflective of the significant risks faced by the Trust to highlight as services continue to recover from the impact of the Covid-19 pandemic. Some of these are traditional risks within healthcare and have established plans to address them:

- Recruitment and retention of medical and nursing staff.
- Workload management and staff morale.
- The accuracy and availability of clinical and patient information.
- Delays to planned care, including elective surgery; outpatient appointment; and cancer care.
- Ambulance handover delays at A&E.

3.2 There are also some specific clinical risks that have been highlighted by divisions as the new risk registers are reviewed and updated:

- The care of patients requiring Non-Invasive Ventilation (NIV) – this risk is to be re-assessed within Medicine Division to take account of progress with the Respiratory improvement plan; the recommendation is that it is reduced from Very high (20) to High (16)

- Delays in processing echocardiograms.
- Renewal of the Trust's JAG accreditation for Endoscopy at Lincoln County Hospital.

3.3 A process is being developed between Clinical Governance and Finance to integrate the use of the risk register within the Capital and Revenue Investment Group (CRIG) decision making arrangements.

3.4 The Trust Board is invited to review the report and to advise of any further action required at this time to improve the management of strategic risks or to strengthen the Trust's risk management framework.

Appendix A: Details of all active Very high and High risks (15-25)

Strategic Objective	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
1a. Deliver Harm Free Care	4622	Patient safety (physical or psychological harm)	Karen Dunderdale	Kathryn Helley	Patient Safety Group	09/04/2018	20	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	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 experence or a poor clinical outcome 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"	08/11/2021	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	Low risk	31/01/2019	31/03/2023	31/03/2022
1a. Deliver Harm Free Care	4646	Physical or psychological harm	Karen Dunderdale	Donna Gibbins	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	Extremely likely	High	Very high risk	20	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	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	30/04/2022
1a. Deliver Harm Free Care	4789	Physical or psychological harm	Tracey Wall	Clare Spendlove	Clinical Effectiveness 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 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	03/02/2022	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	Meridian on week 4 of 10 week support. Number of measures being developed to improve pathways/flow Inboxes streamlined across sites weekly meetings in place to review and track progress	Low risk	31/03/2022	31/03/2023	30/06/2022
1a. Deliver Harm Free Care	4624	Physical or psychological harm	AD4 (Deleted User)	Sarah Addlesee	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: - Frailty lead nurse / 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 - Audits of compliance with Trust policy / evaluation of training / training compliance rates	09/02/2022	Quite likely	High	High risk	16	• 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	Weekly Falls Investigation Panel embedded / Falls Prevention Steering Group meets monthly / Falls improvement work ongoing across the Trust and focused pieces of work identified through the steering group / training package approved at NMAAF in Jan 22.	Low risk	31/12/2021	31/03/2023	30/06/2022

Appendix A: Details of all active Very high and High risks (15-25)

Strategic Objective	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
1a. Deliver Harm Free Care	4625	Patient safety (physical or psychological harm)	Karen Dunderdale	Natalie Vaughan	Infection Prevention and Control Group	05/06/2018	16	Risk assessments	Corporate	Nursing Directorate	Infection Prevention and Control		If the Trust's infection prevention and control measures are not effective and an outbreak of serious infectious disease occurs it could result in serious harm affecting a large number of patients, staff and visitors across multiple hospital locations.	National Policy: - DH Hygiene Code 2008 (2015) - NHS National Standards of Healthcare Cleanliness (2021) ULHT Policy: - Infection Prevention and Control Management and Operational Policy (approved August 2021, due for review August 2024) # Mandatory infection control training as part of Core Learning - Management of Infection Outbreak or Incident Policy (approved July 2020, due for review July 2023) - Infection Prevention Surveillance Policy (approved April 2021, due for review April 2023) ULHT Governance: - Infection Control Committee & sub-group governance structure (Decontamination Group; Water Safety Group) - Executive lead - Director of Infection Prevention & Control (DIPC) - Director of Nursing: # Deputy Director of Infection Prevention & Control (DDIPC) # Infection Prevention & Control Team (IPCT) # Infection Prevention Link Practitioners (IPLPs)	- Volume and severity of infection outbreaks - Reported patient safety incidents of hospital acquired infection (frequency, severity & location) - Infection control compliance monitoring / auditing	14/02/2022	Quite likely	High	High risk	16	- Estates team reviewing plans to make negative pressure rooms HTM compliant. - Identify and implement (with Pathlinks) an upgrade or replacement for the Cognos system.	Thematic review in progress to identify learning from Covid-19 pandemic.	Low risk	31/12/2021	31/03/2023	31/12/2021
1a. Deliver Harm Free Care	4868	Physical or psychological harm	Colin Farquharson	Francisca Martinez	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.	22/03/2022	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.	Low risk	30/09/2022	30/09/2022	29/04/2022
1c. Improve clinical outcomes	4825	Regulatory compliance	Simon Evans	Ian Fulloway	Clinical Effectiveness Group	16/01/2022	25	Risk assessments	Clinical Support Services	Diagnostics CBU	Endoscopy	Lincoln County Hospital	JAG Accreditation deferred for Lincoln due to poor state of current Lincoln Endoscopy accommodation	JAG accreditation process Endoscopy operational policies & procedures	Self assessment against JAG accreditation criteria	08/12/2021	Quite likely	Extreme	Very high risk	20	Case of need for immediate remedial works required, plan to take to September CRIG Estates strategy and plans for replacement of current accommodation within the next 2 years	Factual accuracy report received 27/10/21 and service response provided 28/11/21. Awaiting final report and letter.	Low risk	31/07/2021	31/03/2022	31/03/2022
1c. Improve clinical outcomes	4824	Physical or psychological harm	Anita Cooper	Nigel Allen	Clinical Effectiveness Group	16/01/2022	15	Risk assessments	Clinical Support Services	Diagnostics CBU	Radiology	Lincoln County Hospital	The interventional suite at Lincoln County (Philips Allura fd20)is 11 years old. Royal College of Radiologist guidelines suggest replacement. Philips Medical Systems has told the Trust that it will no longer be supported from 31 December 2021. This will mean a much reduced Interventional service at Lincoln	Business case procedures / CRIG	Monitoring age / condition / performance of IR suite	08/12/2021	Extremely likely	Medium	High risk	15	Business case being written to be submitted early August 2021. Comprehensive service contract including flat plate detector and x-ray tube is in place.	Case of Need completed and submitted to Diagnostics Clinical Lead	Low risk	31/01/2020	31/12/2022	31/03/2022

Appendix A: Details of all active Very high and High risks (15-25)

Strategic Objective	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
2a. A modern and progressive workforce	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
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
2a. A modern and progressive workforce	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
2a. A modern and progressive workforce	4741	Service disruption	Colin Farquharson	Aurora A Sanz Torres	Workforce Strategy 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
2a. A modern and progressive workforce	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

Appendix A: Details of all active Very high and High risks (15-25)

Strategic Objective	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
2b. Making ULHT the best place to work	4667	Service disruption	Paul Matthew	Claire Low	Workforce Strategy Group	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
3a. A modern, clean and fit for purpose environment	4654	Physical or psychological harm	Simon Evans	Keiron Davey	Fire Safety Group	06/01/2022	25	Risk assessments	Corporate	Estates and Facilities	Fire and Security		If flammable and / or explosive substances or large quantities of combustible products are stored inappropriately (i.e. Not in accordance with DSEAR or risk assessments), then it could lead to a major fire resulting in multiple casualties and extensive property damage	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) - Dangerous Substances & Explosive Atmospheres Regulations (2002) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors - Medical Gas Pipeline Systems and Medical Gas Cylinder Management Policy (July 2019) - Control of Substances Hazardous to Health (CoSHH) Policy & Procedures (August 2021) 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 / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit	Fire safety compliance audits, currently indicate: - Acetylene storage adjacent to Pathology at Lincoln County (3rd party use, Path Links / NLAG). - Large quantities of hand gel containing 70-80% ethanol, stored in quantities of 1,000l+ on all 3 sites. - Large quantities of combustibles stored on all 3 sites (waste / cardboard). - High levels of oxygen storage in clinical environments, due to higher oxygen use on wards using CPAP devices. Fire safety incidents involving flammable / combustible materials.	02/02/2022	Reasonably likely	Extreme	High risk	15	Cease storage of acetylene cylinders. Education & informing of local managers on safe storage and control measures for flammable and combustible materials (where storage is required). Ceased decanting of ethanol products in restricted spaces (e.g. small cupboards).	Acetylene cylinders issue - Estates have ceased all internal use of acetylene; area adjacent to Path Links - regional service provision being withdrawn by NLAG to allow removal of cylinder. CoSHH signage installed in all affected areas as indicated by risk assessments.	Low risk	31/03/2022	31/03/2023	30/06/2022
3a. A modern, clean and fit for purpose environment	4858	Service disruption	Michael Parkhill	Stuart Whitehead	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 Pilgrim Hospital 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

Appendix A: Details of all active Very high and High risks (15-25)

Strategic Objective	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
3a. A modern, clean and fit for purpose environment	4648	Physical or psychological harm	Simon Evans	Keiron Davey	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 / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire	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.	02/02/2022	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 risk priority. - 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.	Low risk	31/03/2022	31/12/2022	30/06/2022
3b. Efficient use of our resources	4664	Finances	Paul Matthew	Jonathan Young		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
3c. Enhanced data and digital capability	4731	Physical or psychological harm	Simon Evans	Lee Parkin	Clinical Effectiveness 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 lead to delayed diagnosis and treatment, reducing the likelihood of a positive clinical outcome and possibly causing serious harm	- 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.	26/01/2022	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 Medical Records Group.	Low risk	30/06/2018	31/03/2023	30/06/2022
3c. Enhanced data and digital capability	4828	Physical or psychological harm	Colin Farquharson	Colin Costello	Digital Hospital 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.	22/03/2022	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.	Low risk	31/03/2022	30/09/2022	30/06/2022

Appendix A: Details of all active Very high and High risks (15-25)

Strategic Objective	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
3c. Enhanced data and digital capability	4857	Service disruption	Colin Farquharson	Lisa Hansford	Medicines Quality Group	10/02/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	Following upgrade to new eFinancials system there is a backlog of unpaid pharmacy invoices, there have been issues with BACS payments made to suppliers (including urgent CHAPS payments) due to incorrect or missing payment remittances resulting in them being unable to correctly allocate payments, also payments have been made to incorrect suppliers. Some of the work required to correct these errors is being passed to the pharmacy team to resolve which is an additional workload pressure for a small team already working at/over capacity. Delays in payments to pharmaceutical suppliers will put us at risk of accounts being stopped, resulting in a risk of us not being able to source vital medication for patient care. A number of suppliers have already escalated our accounts. If this situation continues then there will be an impact on our ability to source critical medications, for example chemotherapy products from Quantum, and this will directly and negatively impact on patient care.	The finance team are able to process CHAPS payments when required, but this still requires invoices to have been correctly processed. Pharmacy receive e-mails from the credit control teams at suppliers chasing payment.	Monitoring backlog of unpaid pharmacy invoices.	22/03/2022	Extremely likely	High	Very high risk	20	Escalation to Finance; identification of 'priority' suppliers where we absolutely must not be put on stop (eg. Wholesalers, pharmaceutical manufacturers supporting the chemotherapy service, etc); Finance team need to be able to provide a system that is able to process the backlog of invoices quickly and ensure that moving forwards invoices continue to be processed and paid correctly.	Escalated to Finance. Risk reviewed by Chief Pharmacist, confirmed that Medical Director is fully sighted on the risk.	Low risk	10/02/2022	30/09/2022	30/04/2022
3c. Enhanced data and digital capability	4661	Reputation	Jayne Warner	Jayne Warner	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	Low risk	31/03/2022	31/01/2023	30/06/2022
3c. Enhanced data and digital capability	4659	Reputation	Paul Matthew	Jayne Warner	Information Governance Group	10/01/2022	15	Aggregation of Incident/Claims & Complaints/PALS	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If there is under-reporting of information governance incidents, or a lack of learning from incident investigations, then it is difficult for the Trust to make an accurate assessment of the extent of risk exposure and put in place effective mitigation, resulting in an increased likelihood of similar incidents occurring in the future	National policy: - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy (updated January 2022) & supporting appendices - Incident Management Policy and Procedures (approved September 2021, due for review September 2024) 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	Frequency, type and severity of IG incidents Internal audit of IG incident reporting processes	23/03/2022	Extremely likely	Medium	High risk	15	To identify a means of evaluating the IG incident reporting culture, including the possibility of conducting a regular staff survey to measure understanding of and confidence in the reporting and investigation process & enhancements to the incident report form & trackers on Datix.	Datix incident form requires review to inform configuration for upgrade to Datix Cloud IQ in 2022. Discussed at Risk Register Confirm & Challenge Group 23 March 2022. Agreed to review & potentially reduce current risk rating.	Low risk	31/03/2022	31/12/2022	30/06/2022

Appendix A: Details of all active Very high and High risks (15-25)

Strategic Objective	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
4a. Establish new evidence based models of care	4877	Reputation	Simon Evans	Angus Maitland		28/03/2022	20	Risk assessments	Corporate	Operations			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	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
4a. Establish new evidence based models of care	4878	Reputation	Simon Evans	Angus Maitland		28/03/2022	20	Risk assessments	Corporate	Operations			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	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
4a. Establish new evidence based models of care	4879	Reputation	Simon Evans	Angus Maitland		28/03/2022	20	Risk assessments	Corporate	Operations			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	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
4a. Establish new evidence based models of care	4803	Reputation	Simon Evans	Maxine Skinner		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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 April 2022*
Item Number	*Item*
Board Assurance Framework (BAF) 2021/22	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

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

Executive Summary

The relevant objectives of the 2021/22 BAF were presented to all Committees during March and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives and have been confirmed by the Committees. Objective 1a has been considered by the Quality Governance Committee and the rating moved from Amber to Green in month.

The following assurance ratings have been identified:

Objective		Rating at start of 2021/22	Previous month (February)	Assurance Rating (March)
1a	Deliver harm free care	Red	Amber	Green
1b	Improve patient experience	Red	Amber	Amber
1c	Improve clinical outcomes	Red	Amber	Amber
2a	A modern and progressive workforce	Amber	Red	Red
2b	Making ULHT the best place to work	Red	Red	Red
2c	Well led services	Amber	Amber	Amber
3a	A modern, clean and fit for purpose environment	Red	Amber	Amber
3b	Efficient use of resources	Green	Amber	Amber
3c	Enhanced data and digital capability	Amber	Amber	Amber
4a	Establish new evidence based models of care	Red	Amber	Amber
4b	To become a University Hospitals Teaching Trust	Red	Red	Red

Work is now underway with the Director of Improvement and Integration to devise the 2022/23 Board Assurance Framework. Once planning is complete and the Integrated Improvement Plan in place a draft 2022/23 Board Assurance Framework will be presented to the Trust Board.

Until the planning process for 2022/23 is complete the 2021/22 Board Assurance Framework will continue to be utilised.

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

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

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Group, lead & plan in place to support the delivery of an improved patient safety culture (PSG)	Operational pressures have meant that meetings have not taken place. Human Factors training has now restarted and is being facilitated face to face. Definition of Safety Culture Ambition. Focus groups now complete - next steps developmental focus groups to understand where the Trust wants to be.	External Safety Culture company engaged to deliver focus groups at all levels through the organisation and support development of safety culture ambition to go to the Executive team in February. Online Human Factors training commenced December 2021 and monitored through ESR. Project lead continues to review project and complete highlight reports as appropriate	Safety Culture Surveys Action plans from focus groups and Pascal survey findings. Monthly update reports to the Patient Safety Group and upwardly reported to QGC Theatre Safety Group reporting progress against a Quality Improvement plan to PSG. "It's Safe to Say" Campaign launch launched 14 March 2022.	Surgery currently reporting into the Theatre Safety group on progress against Safety Culture. The other Divisions will need to start to report into PSG and PRM to provide assurance and accountability.	Where possible, safety conversations have been taking place with staff. "Safe to Say" Campaign focus groups have been continuing with formal underway 14 March 2022.		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	Operational pressures have meant that QGC meeting has been reduced.	All papers have been considered and discussed by exception. Assurances provided to QGC include feedback from gold and relevant cells as outlined below.	Upward reports from QGC sub-groups 6 month review of sub-group function				
						Effective sub-group structure and reporting to QGC in place (CG)	Due to operational pressures, not all sub-groups have met and others have had a reduced agenda.	All papers have either been discussed by exception or a chair/vice chair upward report completed following review of the papers. 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.	Sub-Group upward reports to QGC				

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC policies have been reviewed, written and ratified by the IPCG. IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on 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.		

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
						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.		
1a	Deliver Harm Free Care	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG (PSG)	Gaps in the number of structured judgement reviews undertaken - 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.	Quality Governance Committee	**Green**
						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. 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.	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports	PSG currently do not receive assurance reports from the Divisions as their governance process reports to their PRM	Divisions present focussed pieces of work to PSG on an ad hoc basis as requested by the group. There is strong Divisional representation at PSG each month. Workplan for PSG for the next financial year will incorporate a Divisional report.		

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
			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			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.		
						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		
						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					

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. (Ensuring early detection and treatment of deteriorating patients) (PSG)	Number of incidents occurring regarding lack of recognition of the deteriorating patient Maturity of some of the sub-groups of DPG not yet realised Observation policy has now been reviewed and is out for approval.	Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA Observation policy ready to go to next NMAAF 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		
						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.	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 (CG)	Training provision for Divisional Clinical Governance Leads No formal job description of roles and responsibilities for Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads Draft role description for a Clinical Governance Lead developed for consultation.	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				

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
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 colleagues exploring development of a Health Inequalities cell to combine efforts in reaching out. Date not yet secured. ULHT Experts by Experience project progressing with Mastalgia Expert reference group established, Cancer Board recruiting in the New Year and discussions to continue with Gastroenterology & CYP (Expert Families)		

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
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Inconsistency in applying end of life visiting exceptions.	Swan resource boxes distributed to all areas Wedding boxes created for a number of key wards and within Chaplaincy services. Exceptions guidance re-issued. Monitor through complaints & PALs.	Report to PEG through complaints & PALs reports; upward reports from Visiting Review working group.	Visiting experience section within complaints & PALs reports.	Complaints/PALs reports to include visiting concerns; divisional assurance reports to include visiting related issues. Visiting review indicates inconsistency in EoL visiting; criteria and process being strengthened. Request to ME's to ask relatives about visiting experience at EoL.		

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
						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.		
1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Clinical 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.	Pandemic and operational pressures has meant that meetings have been sporadic. When meetings occur attendance has generally improved. Control gap to remain in place until regular CEG meetings are back in operation.	If papers are still received and meeting stood down, chair and Vice Chair will review papers and produce Chairs report for QGC. Where papers have not been received, Chair and Vice Chair will review work programme and identify priority papers to be produced, standing all others down. 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	Effective upward reporting to QGC	Upward reporting may not be comprehensive due to reduction in meetings.	Chair and Vice Chair will ensure oversight of priority areas through the review of agenda items and required papers.	Quality Governance Committee	**Amber**
						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.		
						National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG)	Due to operational pressures, clinicians have been unable to collect all data for national audits.	In agreement with the Medical Director, it was agreed that audit team support would be directed at national audits for the foreseeable future, leading to reduced support to local audit.	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		

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
						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.					
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.		
						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.		

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
2a	A modern and progressive workforce	Director of People and Organisational Development	Vacancy rates rises Turnover increases Sickness absence rises Under-investment in education & learning Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce	4362	CQC Safe CQC Responsive CQC Effective	Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up Performance Dashboard developed offering accurate and timely information to all appropriate managers and staff		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.	People and Organisational Development Committee	**Red**
						Focus on retention of staff - creating positive working environments System retention role secured (8a) appointment pending	IIP projects on hold	IIP Projects Appraisal - deep dive planned Dec21 Mandatory training - currently in scope Talent management - held National Talent Management Framework launched, Lincs system identified as pilot site for launch	Regional Midlands Talent Board Model Employer ambition appraisal/mandatory training compliance	Appraisal and training compliance levels not at expected level Appraisal Improvement Plan (Mar'22) to address low compliance / improve quality of conversations and process			
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff					
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	The reports are run daily and any abnormalities are considered in the context of the national and regional position. The pandemic and the critical incidents the Trust is in has impacted on usual trends. AMS data is reviewed regularly and reported into Divisions on accuracy. Data currently for absence is inline with national reporting. AMS Project is being relaunched with a training roll-out plan and SHRBP support.		
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation	IIP projects in early stage of delivery	IIP projects - education and learning Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year End March - mandatory training improvement plan System LEAD (Learning, Education and Development) Board to provide system oversight (proposed)				

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
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	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	People and Organisational Development Committee	Red
						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	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey	Culture and Leadership Programme Group upward report	Delivery of agreed output	Improved function of group and reporting to be in place for November report		
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT)		L&M programme reset from April - piloting new programme (subject to approval)	Pulse surveys - " Have your say" Number of staff attending leadership courses		Proposal to be shared with ELT (Dec'21): gradual introduction of L&M activities NB. L&M apprenticeship on going		
						Perception of fairness and equity in the way staff are treated	EDI Group (report to PODC) live from Dec 2021	IIP Project - Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation EDI Group membership reset - to ensure representation and coverage	Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NNSS	WRES/ WDES/MRES	Currently developing WRES and WDES action plans and internal audit to deliver the first actions for the 31.12.21 WRES/WDES and Internal Audit actions being monitored through Committee		
						Staff networks	Some staff networks stronger than others	Continued work to embed the networks and provide them with effective support	Protect our staff from bullying, violence and harassment - measure through National Staff Survey		Governance for EDI Recruitment process for SN Chair/VC - Feb'22		

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
						Demonstrate that we care and are concerned about staff health and wellbeing			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		
						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)		
2c	Well led services	Chief Executive	Current risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes 4 sessions during Oct / Nov 21 Risk Register Confirm and Challenge Group ToRs Upgrade to datix system Full Risk Register review	Updated Policy and Strategy document for approval at December 21 Risk Register Confirm and Challenge meeting - Meeting Cancelled Covid pressures	Consider at January meeting	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**
						Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6			

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
						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.		
						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.		

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
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	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)	Finance, Performance and Estates Committee	**Amber**
						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				
						Delivering £12.4m CIP programme in 21/22	Operational ownership and delivery of efficiency schemes	Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21. Request to all Divisions to provide detailed CIP recovery plans.	Delivery of revised CIP Achievement of both ULHT and STP financial Plan	Ability of clinical and operational colleagues to engage due to service pressures.	Gaps are being reviewed monthly with Divisions through FRMs		
						Delivering financial plan aligned to the Trust and Lincolnshire System financial plan / forecast for 2021/22	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire System collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for 21/22	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		

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
			Efficiency schemes do not cover extent of savings required			Reduce agency spend by 25% from the 19/20 baseline as per IIP priority	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team	Delivery of the IIP 25% agency reduction target.	Granular detailed plan for every post plans.	Through the Medical and Nursing Workforce Transformation Groups and through FRMs upward into FPEC		

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
3b	Efficient use of our resources	Director of Finance and Digital	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 and operational pressures in H2) National requirements and Trust response to Restoration and Recovery and third COVID wave.	4382 4383 4384	CQC Well Led CQC Use of Resources	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 21/22 IIP	Finance, Performance and Estates Committee	**Amber**
						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 H1 and H2 21/22 and 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 21/22.	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		
						Detailed workforce and activity modelling aligned to resource requirements to support Trust and System Restoration.	Impact of Wave 3 and 4 and increasing acuity of NEL patients creating bed and staffing resource pressures to deliver restoration plan.	Trust Restoration plan and through Restoration and Recovery daily Trust meetings. Lincolnshire System activity plan Lincolnshire System collective management of restoration of planned care activity	Reporting against the Trust and System Restoration plan and national Trajectories.				
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182	CQC Responsive	Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal	Schemes paused to enable tactical response to Covid-19. Progress now being made again. .	Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces. EMAS, GPs, mental health, community, social care and care homes data now also available within the Care Portal.	Finance, Performance and Estates Committee	**Amber**
						Commence implementation of the electronic health record	Roll-out IT equipment to enable agile user base Redeployment of staff as a result of Trust response to Covid-19.	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of 20/21 e HR plan		EPR OBC to be approved by NHSE/I OBC 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 being completed in July 2021 for June 2021 reporting.	Steady implementation of PowerBI through specific bespoke dashboards and requests.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
			Critical Infrastructure failure	4481		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.		
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System -Region	Impact of specialty changes	New performance framework will address and the upward report regarding IIP	Finance, Performance and Estates Committee	**Amber**
						Improvement programmes for cancer, outpatients and urgent care in progress	Recovery post COVID and risk of further waves Urgent Care Transformation team not yet established	Outpatient Improvement Group Cancer Improvement Board Urgent and Emergency Care Board.	Improvement against strategic metrics % of patients in Emergency Department >12 hrs (Total Time) Delivery against 62 day combined standard Urgent Treatment (P2) turnaround time Deliver outpatient activity non face to face		Reporting via FPEC		
						Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans.	Engagement exercise required to seek further views regarding the proposed revised model	CYP Group re-established	Board report July 2021				
						Urology Transformational change programme - complete			Board report July 2021				
						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				

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						Support Creation of ICS - Lincolnshire designation July 2022	Delay to review and adoption of legislation	Weekly ICS meetings Provider Collaborative Steering Group	SLB reports and upward reports by CEO / Chair				
						Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team	Awaiting outcome of themes from consultation	Attendance at Consultation Steering Group once in place	SLB reports and upward reports by CEO / Chair				
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress	Disruption due to COVID has resulted in a less mature approach to strategy deployment, broad understanding across the organisation, progress on building capacity and capability.	ELT/TLT oversight Board / system reporting	Weekly ELT updates Monthly TLT updates Quarterly board reports Quarterly board development sessions				
4b	To become a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	University Hospital Teaching Trust Status Developing a business case to support the case for change	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			People and Organisational Development Committee	**Red**
						Increasing the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increased clinical academics and RCF funding 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		
						Improve the training environment for students	Ensuring that, due to the revised UHA guidance we are able to offer the facilities required for a functioning clinical academic department	The gaps are being managed through the revision of the library and training facilities. This will meet the criteria within the UHA guidance	GMC training survey Stock check against checklist Internal Audit - Education Funding				
						Developing an MOU with the University of Lincoln	This is now a requirement of the UHA guidance. Historically this has not been required.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy. MOU will be developed once the Joint Strategy has been signed off.	RD&I Strategy and implementation plan agreed by Trust Board	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		
						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		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating

The BAF management process

The Trust Board has assigned each strategic objective of the 2021/22 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