Bundle Trust Board Meeting in Public Session 7 June 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 3 May 2022

Chair

Item 5.1 Public Board Minutes May 2022 v1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log May 2022.docx

6 Chief Executive Horizon Scan Including STP

Chief Executive

Item 6 Chief Executive's Report, 070622.docx

6.1 Integrated Improvement Plan Year 3

Director of Improvement and Integration

Item 6.1 IIP Year 3.docx

Item 6.1 ULHT IIP Year 3 Refresh - INTERNAL version_v19_Trust Board.docx

Item 6.1 Appendix 1- Comms- IIP summary.pdf

Item 6.1 Appendix 2- Comms- UHLT strategic objectives by 2025.pdf

Item 6.1 Appendix 3- Comms- what this means.pdf

7 Patient/Staff Story

Director of Nursing/ Deputy CEO
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 (plus append Continuity of Carer)

Chair of Quality Governance Committee

Item 8.1 QGC Upward report May 2022 v2.doc

Item 8.1 COVID-19 BAF including V1.8 NHS May 2022 (updated 16.05).docx

Item 8.1 QGC App A Ockenden Benchmarking and Action Plan.pdf

Item 8.1 ULHT CofC Plan.docx

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

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

Chair of People and OD Committee

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

9.2 NHS Rainbow Badge Reset

Director of People & OD

Item 9.2 Rainbow Reset Jun 2022.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 Committee

Item 10.1 FPEC Upward Report May 2022.docx

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

11.1 ASR Statement of Support - Record of virtual board discussion

Chair

Item 11.1 ASR letter of support.docx

Item 11.1 Letter to CCG Re ASR Business Case - supporting documents, 170522.pdf

12 Integrated Performance Report

Director of Finance & Digital

Item 12 IPR Trust Board - Front page.docx

Item 12 IPR Trust Board May 2022.pdf

13 Risk and Assurance

13.1 Risk Management Report

Director of Nursing/ Deputy CEO

Item 13.1 Strategic Risk Report - June 2022 v2.docx

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

13.2 Board Assurance Framework

Trust Secretary

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

Item 13.2 BAF 2022-2023 01.06.2022.xlsx

13.3 Audit Committee Upward Report

Chair of Audit Committee

Item 13.3 Audit Committee Upward Report May 2022.docx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 5 July 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 3 May 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
Ms Dani Cecchini, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Mr Simon Evans, Chief Operating Officer
Miss Gail Shadlock, Interim Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital/ Director of People and OD
Dr Colin Farquharson, Medical Director
Mrs Sarah Dunnett, Non-Executive Director
Dr Chris Gibson, Non-Executive Director

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Cathy Geddes, Improvement Director, NHSE/I
Mrs Jennie Negus, Head of Patient Experience
Mrs Libby Grooby, Divisional Head of Nursing and Midwifery
Mr Simon Hallion, Divisional Managing Director

Apologies
Dr Maria Prior, Healthwatch Representative

598/22	**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.
599/22	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Vi King** **Please can you tell me what the recruitment and retention is and staff leaving in the last months across ULHT.** The Director of People and Organisational Development responded: The current vacancy rate was 10.4% and turnover rate was 14.4%. Both figures were available within the Integrated Performance Report, page 65, and also offered the previous quarter information and year to date figures if required.
600/22	**Q2 from Jody Clark** **Firstly, I want to thank everyone working under continuous challenging circumstances, the high demand, staffing issues and the fall out from the Lincoln fire.** **My question is, with patients waiting many months for appointments, can updates be sent to those waiting more than 6 months, so they have an idea of timescales? The not knowing causes many worries, like - have they been forgotten or how long they need to manage pain and mobility problems.** The Chief Operating Officer responded: Thanks were expressed to the teams at the Trust who undertook a tremendous amount of work in recovering from the fire. Services outside of the Trust who had supported were also thanked in supporting the Trust to be able to deal with the fire in a safe and effective way. The Trust was, in the current year, engaging in recovery and reduction of waiting lists which would be a firm feature in plans and would be seen through discussions at the Trust Board in future meetings. The Trust intended to contact patients to offer updates in terms of expected waiting times as had been undertaken over the past year to 18 months. Contact would be made with all patients awaiting an operation to discuss next stages of the plan. When undertaken previously this had commenced with particular services however the Trust was looking to extend this.

	The Chief Operating Officer noted that where a patient's condition may have changed, there was an increase in pain or mobility change then those patients would be encouraged to make contact with the Trust in order that plans would be put in place to ensure patients remained safe. The Chair thanked Vi King and Jody Clark for the questions noting that they had regular correspondence with the Trust. The Chair indicated that she would be interested to receive feedback from both Vi and Jody in respect of the views of the live stream of the Trust Board meeting and requested that views on this were offered directly via e-mail.
601/22	**Item 3 Apologies for Absence** Apologies were received from Dr Maria Prior, Healthwatch Representative
602/22	**Item 4 Declarations of Interest** There were no new declarations of interest.
603/22	**Item 5.1 Minutes of the meeting held on 5 April 2022 for accuracy** The minutes of the meeting held on 5 April 2022 were agreed as a true and accurate record.
604/22	**Item 5.2 Matters arising from the previous meeting/action log** 511/22 – Anti-racism campaign – meeting scheduled to take place between Miss Shadlock and Director of People and Organisational Development, complete
605/22	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board noting the addition of the Partnership Agreement developed as a system between the NHS and University of Lincoln at item 6.1.
606/22	The Chief Executive offered the system update noting the pressures across the health and social care system in Lincolnshire and noted the strong national focus on ambulance delays. A paper had been presented to the Trust Board in April summarising ambulance handover issues noting this was as much about delays in the community as well. There was considerable pressure being applied to tackle this.
607/22	The Board noted the part that the Trust played in this along with system partners in respect of flow. There was great work ongoing in regard to this however this remained a significant issue.
608/22	The Chief Executive advised of the revised Infection, Prevention and Control (IPC) guidance which had been issued and contained a 60-page manual. Some of the key changes had allowed the Trust to remove some restrictions on visiting at the hospital sites with the Trust Board understanding how important it was for patients to receive visitors.

609/22	It was pleasing to be able to make some of these changes which would be kept under constant review to determine if it was possible to fully revert to the pre-pandemic position.
610/22	The Chief Executive referenced the consultation on the 4 NHS services, known as the Acute Services Review (ASR), for which the outcome of the public consultation would be received at the May Board meeting of the Clinical Commissioning Group, further updates were awaited.
611/22	The Board noted that the system operational plan had now been submitted to NHS England and recognised the difficulty in the ability of individual Boards to sign off the plan due to the process in place. The Trust was a key partner in the system as were the other providers in Lincolnshire and whilst the process was not designed for Board assurance and governance there had been an intention to try to achieve this. Lessons had been learnt and all Boards were aware of what was contained within the plan, which also contained some of the providers' operational plans.
612/22	The Chief Executive noted the national support provided to the Integrated Care System (ICS), the system being in the recovery support programme (RSP), with details of the support having been provided.
613/22	As the Trust was part of the system it was, by virtue of the membership of the ICS, in the RSP. Whilst the Trust had itself exited the RSP there was a tapered support package, bespoke to the organisation, in place which addressed a number of related issues to support the system package.
614/22	The Board was advised that the Health and Social Care Bill was now an act, becoming law on 28 April with changes taking place from 1 July with the Integrated Care Board (ICB) being established.
615/22	Detailed of the Integrated Care Partnership and Board appointments to the ICB were detailed within the report with the Board advised that future work was required on a further Non-Executive Director appointment. Appointments to the Medical Director position and Primary Care Partner Board members would also commence in due course.
616/22	The Chief Executive offered the Trust overview to the Board noting the year-end surplus that had been achieved noting that this had been the final year of revised financial arrangements applied to the NHS.
617/22	The Trust had again delivered the plan which was a significant achievement and demonstrated a further financial plan being achieved. Achievement of the current financial plan would be challenging with the return to a normal financial regime and the considerable pressures on services and finances within the system.
618/22	The Nuclear Medicine consultation had been extended in order to allow further face-to-face meetings to take place and to allow time for the Lincoln County Council elections to be held.

619/22 620/22	The Chief Executive advised that the full business case for the Pilgrim Emergency Department had been submitted for national approval noting the long and detailed process. It was hoped this would be received to the July national meeting for approval. The Chief Executive extend thanks to all staff in the Trust, system partners and the public for forbearance during the recovery of the fire at the Lincoln Accident and Emergency Department. The Trust Board: • **Noted the report and significant assurance provided**
621/22 622/22 623/22 624/22 625/22	**Item 6.1 University of Lincoln Partnership Agreement** The Chief Executive presented the University of Lincoln Partnership Agreement to the Board noting the significant amount of work that had been undertaken. The Trust was an NHS anchor institution and therefore had a significant impact on the social and economic development in the county. It was felt that it was an appropriate time, as the ICB came in to being, to being formalising the work of the Trust and the University and the topics to work on in collaboration to improve the health and wellbeing of the people in Lincolnshire. The document presented offered the legal position of what was being done and why with the annex offering a list of details of the topics that were anticipated to be worked on. Those topics were designed not to be exclusive and would ensure there was the ability to be fleet of foot offering a freedom add and remove from this as required. The paper was offered to the Board for information noting that this had been signed by the Vice Chancellor of the University and would be signed by the ICB Chief Executive on behalf of the NHS in Lincolnshire. The Chair was pleased to receive the partnership agreement noting the Trust would act as full and active partners. The Board would need to ensure future papers were focused not only on what was being done as an organisation but where the Trust was contributing to the wider partnership to bring better care to the population of Lincolnshire. The Trust Board: • **Received the partnership agreement**
626/22	**Item 7 Patient Story**

627/22	The Director of Nursing presented the patient story to the Board thanking Patient Panel colleagues and the Head of Patient Experience for joining the Board to present the story.
628/22	The Board watch the video presentation that detailed the work of the Patient Panel noting that this had been developed as one the objectives of year 2 of the Integrated Improvement Plan (IIP). The Patient Panel aimed to support the organisation to deliver the strategic objective in respect of improving patient experience and putting patients and safety first. The panel encouraged patients to review, comment and challenge proposals that supported the objective.
629/22	The Chair thanked the Head of Patient Experience for taking the time to put the story together noting that this was an area previously where there had been challenge for the Trust to be able to demonstrate how discussions at the Board resonated with patients and the services provided.
630/22	The Chair noted the significant number of meetings, presentations and members of staff involved especially given the pandemic and the panel only being established in 2020.
631/22	There had been a broad range of topics considered by the panel and it was possible to see a link between discussions at the Board and those held be the panel. It was reassuring to see that what was being done at Board level was receiving the right attention from staff.
632/22	The Director of Nursing noted the clear link not only to Board discussions but also with the report from the Chief Executive, noting specifically the nuclear medicine update. The Patient Panel had been involved in the development of the consultation along with NHS colleagues.
633/22	The Director of Nursing noted recent attendance at the panel to discuss the dress policy noting the panel were grounded and sensible in the advice given with the comments helping to shape further the direction of travel.
634/22	The work undertaken by the Head of Patient Experience was recognised by the Director of Nursing noting that the success of the panel had been recognised by NHS England/Improvement who wanted to work with the Trust to propagate this across the NHS.
635/22	On a twice-yearly basis a review of the panel would be undertaken to ensure an understanding and insight to gain further feedback to progress services.
636/22	Mrs Dunnett asked if there was representation from young people on the panel to support the work being undertaken and sought to understand if the panel could be expanded into the Lincolnshire system. The Head of Patient Experience noted that the Patient Panel was one element of the overarching IIP to reach out and engage and consult with patients and families. It was recognised that this was not as diverse as it could be however a patient panel

637/22	would not be suitable for all as one tool. Alongside this there were subgroups for patients with sensory loss.
638/22	Discussion had taken place with the Clinical Commissioning Group (CCG) to establish a youth forum and expert family panels which would commence the following week. Joint work was also underway with the Lincolnshire Cancer Board and Cancer Reference Groups. Further reference groups would also be established include dementia carers which would all feed up through the Patient Experience Team in order that there could be triangulation and correlation.
639/22	There remained more work to do, in particular, reaching out to hidden voices and hard to reach groups. The Board was advised however that it was not believe these groups were hard to reach bit that engagement was not being done in the right way.
640/22	Dr Gibson was pleased to note the range and diversity and asked if the use of MS Teams was supporting the panel and if this was being advertised sufficiently within the Trust.
641/22	The Head of Patient Experience noted that it was believed that the use of MS Teams was an advantage, noting that due to the size of the county attendance in person was not likely to be as good. There was a desire to try and manage face to face meetings when this was possible.
642/22	There had been advertising of the panel including information shared through the Patient Experience Newsletter and 'Fab Facts' which was circulated monthly. This was linked into quality improvement and service development with the desire to drive change and engage with the patient panel at the outset of thinking, not just once a finished product was in place.
643/22	Celebration and explanation of the panel would see greater socialisation with the Board noting that this was discussed in various governance meetings and through the Patient Experience Group.
644/22	Miss Shadlock reflected on the comment from a member of the panel about expansion and asked what plans were in place for the expansion of the panel.
645/22	The Head of Patient Experience noted that there was concern that if the panel became too large that voices would not be heard. If needed consideration would be given to the frequency of the panel. There was a large pool of panel members to draw from however there was a need to be creative in how this was done and hence the consideration of expert reference groups.
646/22	The Board noted that the panel was due for a review as it approached being in place for 2 years.
647/22	The Chief Executive noted the great work that was taking place and strongly endorsed the comments regarding hard to reach groups noting this was a reflection on the Trust and not the groups the Trust wanted to reach.

648/22	There was a need to make a different effort towards engagement and the use of patient and public involvement an engagement as early in processes as possible was strongly supported to achieve codesign and coproduce services.
649/22	The Director of Improvement and Integration reiterated the point made about coproduction noting that work had been undertaken with outpatient development as the Trust moved into year 3 of the IIP. Work would be in place to ensure voices were heard and divisions would have a plan in place at the start of the year which would support early engagement.
650/22	The Chair thanked the Head of Patient Experience for the leadership in the Trust around patient experience and engagement and for establishing the panel. The Chair thanked those who participated in the video noting appreciation for the input provided. The Board would use the knowledge and experience of the panel to be guided and influenced based on the panels' views. 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
651/22	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair advised Board members that the update from the Quality Governance Committee would be received in relation to the Maternity and Neonatal Oversight Group (MNOG) upward report and final Ockenden report prior to the remainder of the upward report being offered.
652/22	Dr Gibson noted that the Committee had spent a significant amount of time discussing the MNOG upward report and received the final Ockenden report. Tribute was paid to the Davies and Griffiths families with Dr Gibson noting that the report exposed a large number of lessons to be learnt.
653/22	The Committee noted the 15 immediate and essential actions advised in the final report noting that the full report and letter sent by NHS England/Improvement to NHS Trusts was appended to the report. Maternity and Neonatal Services had benchmarked the 15 actions with the Committee being advised that 9 could be addressed through current system and resources and 6 requiring actions to be developed.
654/22	There was a robust and rigorous collection of evidence to demonstrate these actions. There had been a specific ask in the letter regarding Continuity of Carer requiring all Trusts to review this. It was recognised by the Committee that Continuity of Carer was a desirable option however demanding in terms of the workforce. All maternity services were required to access recourse against the requirement to determine if it was possible to extend, maintain or reduce Continuity of Carer based on safer staffing numbers.

655/22	The Committee endorsed the recommendation put forward by MNOG for option 2 meaning that the Trust could not meet safe minimum staffing requirements for further roll out of Continuity of Carer but could meet the safe minimum staffing requirements for existing provision.
656/22	Dr Gibson advised the Board that this position would be reviewed regularly.
657/22	The Chair thanked the Committee for the degree of due diligence undertaken in relation to the report and for the ongoing oversight of maternity and neonatal services.
658/22	The Director of Nursing advised Board members that reports were available either through the public Board meeting papers or within the reading room. The final report of the independent review into Shrewsbury and Telford Hospital NHS Trust had been published on 30 March with appendix A setting out a further 15 immediate and essential actions, for all Trusts providing maternity services.
659/22	Appendix B offered the letter sent on 1 April by the NHS Chief Executive, Medical Director and Chief Nursing Officer to formally offer the report to all Trusts.
660/22	The report stated the need to act with an immediate call for action for all commissioners and providers to ensure lessons were rapidly learnt and services were able to drive forward improvements as quickly as possible. The Director of Nursing encouraged all members of the Board to read the full report.
661/22	The documents contained within the reading room, of the paperless Board solution, included the high-level self-assessment of the Trust position, in respect of the 15 further immediate and essential actions and comprehensive benchmarking exercise. This was underway in order to understand the position and would be presented to the Director of Nursing and MNOG in May. It was noted that further guidance would be issued regarding benchmarking.
662/22	The Director of Nursing noted in respect of action 2, Continuity of Carer, Ockenden asked all Trusts to review, and suspend if necessary, existing provision and further roll out. Unless it was possible to demonstrate staffing met the safe minimum requirements on all shifts. In light of this a risk assessment had been undertaken, in line with all options, with option 2 being chosen. This meant that the Trust could meet the safe minimum staffing requirements and existing provision but could not roll out further provision.
663/22	The Trust would continue to accept women on to the current provision however it had previously been determined that a business case process would be required in order for this to be rolled out further. As previously noted, QGC had endorsed the recommendation made by MNOG.
664/22	The Director of Nursing noted that the Trust was currently able to meet safe minimum requirements and the risk assessment to support this was available to Board members in the reading room. The position would be reviewed within 3 months in respect of Continuity of Carer.

665/22	The Director of Nursing advised the Board that all Trusts would be reviewed with a formal visit from NHS England/Improvement and the Local Maternity and Neonatal System (LMNS). The Trusts' visit would take place on 22 and 23 June to review the services against the key lines of enquiry, in line with the Ockenden report. Preparation was underway for the visit.
666/22	The Director of Nursing noted that all papers received by the Trust Board in relation to Ockenden had been offered to the LMNS meeting in April with the Trust receiving support from local LMNS services.
667/22	The Divisional Head of Nursing and Midwifery offered an emphasis on the update from the Director of Nursing in respect of the formal visit in June noting that evidence had previously been submitted and would be reviewed during the visit. Staff would also be spoken to in order to understand how well embedded the new processes were.
668/22	Benchmarking of the new actions continued, and it was noted that this was significantly more challenging than the original 7 actions. Work was taking place on those actions that could be completed immediately however a number required further national guidance in order to understand implementation in the service.
669/22	The Divisional Head of Nursing and Midwifery noted that there had always been an awareness of the need to go for a business case when increasing Continuity of Carer. This had recently been confirmed by Birth Rate Plus and the national lead for Continuity of Carer. The evidence supported that the right decisions had been taken to safely roll out the service.
670/22	The Divisional Managing Director echoed the comments made noting the level of work being undertaken by the service which needed to be recognised. Approval had been received from the Capital, Revenue and Investment Group for a business case to redevelop maternity accommodation across all sites. The team was liaising with estates in order to have a narrative and timescale in place ahead of the Ockenden visit.
671/22	Central funding had also been received for an outline business case to be completed for a maternity information system. This would be complete by June and would be key to the ability to monitor against the Ockenden requirements and demonstrate assurance to the Board.
672/22	The Non-Executive Director Maternity Safety Champion noted the seriousness with which the Trust had taken all of the reports recently in respect of maternity and neonatal services. There was a clear governance structure in place to address these at a Trust, operational and strategic level.
673/22	The pace at which the plan and progress had been brought forward and integrated into the overall service improvement plan was being view positively.
674/22	The Chief Executive noted that, through recent attendance at events, that it was clear this was not just about the review of Shrewsbury and Telford Hospital NHS Trust or maternity services but about all services. There was a need to ensure a clear

	understanding of activity in the Trust with certainty of having an understanding of what was known and if issues could arise.
675/22	The Chair reflected that this was about a holistic view of safety and quality of provision however this offered focus currently on maternity services.
676/22	Professor Baker noted that the focus on maternity services was putting significant pressure on the service and sought to understand if there was sufficient support in place.
677/22	The Divisional Head of Nursing and Midwifery acknowledged the pressure on the service and staff noting the incredible amount of support in place. Walk arounds had been conducted to gauge staff feelings on the report and drop-in sessions arranged to discuss this and ensure staff were able to express how they were feeling.
678/22	As these sessions were being well received ad useful for staff it had been agreed that these would continue on a weekly basis to discuss the progress of actions and offer a safe space for staff.
679/22	There was project management office support in place for personalised care planning as this was a particular area of challenge for the Trust, as it was for most other organisations.
680/22	The Divisional Managing Director noted that work was underway with regard to the divisional Integrated Improvement Plan for which Ockenden was expected to feature strongly. Support, if required would be discussed with the Director of Improvement and Integration, as there as currently a reliance on the maternity services team to progress actions.
681/22	Ms Cecchini asked if the Trust was making use of the patient voice in the implementation of the recommendations within the report.
682/22	The Director of Nursing advised that the Maternity Voices Partnership (MVP) Chair was a key stakeholder at the MNOG meeting. MVP were involved in a lot of the work being undertaken including the wider maternity plans and the bereavement facility. They were supporting the Trust and would continue to do so.
683/22	In terms of wider support there were a number of stakeholders who were supporting the Trust including the Clinical Commissioning Group (CCG), LMNS who had had significant investment recently for wider support to maternity services and external consultancy support.
684/22	Project management support was being considered with the integrated improvement plan and the wider improvement plan with some initial support in place to commence scoping of what wider support would be required to meet the recommendation within the Ockenden report.
685/22	The Chair summarised that the Board had received the full and final independent maternity review report undertaken by Donna Ockenden and it was recognised that

	this applied to the Trust equally, as it applied to other maternity services across the country.
686/22	As a Board there was commitment to ensuring the safety of mothers, babies and their families whilst in the care of the Trust. In the names of Kate Stanton-Davies and Pippa Griffiths the Trust needed to ensure lessons were learnt and taken in to the organisation to ensure families did not experience the tragic circumstance and loss of loved ones.
687/22	The Trust Board received appendix A and B that set out the requirements of the Board and the Chair sought to confirm that the Trust was taking forward all relevant actions with clarity provided in respect of Continuity of Carer.
688/22	The Trust Board accepted option 2 as recommended by QGC with the Trust maintaining the service but would not expand the current provision. This position would be reviewed and reported to the Trust Board in 3 months. **Action: Director of Nursing, 2 August 2022**
689/22	The Chair thanked the Director of Nursing for the leadership offered and to the Divisional Head of Nursing and Midwifery for the work undertaken since coming in to post. Thanks were extended to the Divisional Managing Director for the work being undertaken and for remaining sighted on the issues raised.
690/22	The Chair thanked Mrs Dunnett, as the Non-Executive Director Maternity Safety Champion, for the independent scrutiny being given to this on behalf of the Trust Board.
691/22	The Chair of the Quality Governance Committee, Dr Chris Gibson provided the assurances received by the Committee at the 19 April 2022 meeting noting the full agenda.
692/22	Dr Gibson noted that the Clinical Harm Oversight Group continued to meet with a focus on delays and waiting lists however the C2AI software was being found to be increasingly valued. This was being used to risk stratify patients waiting and the Committee was able to offer moderate assurance. Further work was required in respect of triangulation that would be received on a monthly basis.
693/22	A significant level of assurance was received in respect of infection, prevention and control (IPC) with the Trust recording 2 cases of methicillin-resistant Staphylococcus aureus (MRSA) and 59 cases of Clostridium difficile (C-diff) for the year ending March 2022. These figures were both less than trajectory.
694/22	The Committee noted the continued improvement in water and ventilation along with improving cleanliness and hygiene standards.
695/22	Through the Patient Safety Group, the Committee noted that mortality measures had been above expected levels however had moved back in to expected range. Signification improvement had been seen in regard to outstanding field safety notices.

696/22	The Safe to Say campaign had been launched which would support staff groups working in close partnership and for staff to raise comments. It was hoped that this would be progressed.
697/22	The Committee welcomed the establishment of the medicines management task and finish group to address medicines issues but noted the limited assurance. Concerns were raised regarding project management support which was hoped to have been resolved.
698/22	Dr Gibson noted the safeguarding report received to the Committee, following the tragic death of Arthur Labinjo-Hughes in 2020 and communication from NHS England, requiring a response from all NHS organisations.
699/22	It was noted that the key actions, in the most part, related to Multi-Agency Safeguarding Hubs (MASH) which was not in place in Lincolnshire. The Deputy Director of Safeguarding offered assurance that information sharing was conducted appropriately with positive feedback having been received from the Adult Safeguarding Board. The Committee was assured of the position.
700/22	The Committee discussed the Patient Experience Group upward report and focused on Equality, Diversity and Inclusion (EDI) assurance. It was noted that there was a substantive amount of work ongoing with the patient voice being embedded, particularly for those overlooked groups and what the specific need may be.
701/22	The Committee noted the mixed sex breaches that had occurred and noted actions in place to address areas of concern.
702/22	The Committee was pleased to receive the draft Quality Account and agreed to offer feedback on the comprehensive report outside of the meeting. It was hoped that the priorities for the coming year would be closely aligned to the Integrated Improvement Plan.
703/22	Dr Gibson noted concern in performance related to a deterioration in falls and noted that this would be an area of focus at the next Nursing, Midwifery and Allied Health Professional Advisory Forum. Concern was also noted in respect of the response time to complaints with the Committee being advised this would be a priority in the coming year to improve responses.
704/22	The Chair noted particular interest in the safeguarding report and the joint targeted area inspection noting that it was positive for the Committee to have received this and to continue to monitor any actions required. There was a need to understand that the arrangement in place was adequate and ensure discharge of responsibilities appropriately if there was not a MASH in place.
705/22	It was hoped that the project management office support in respect of medicines management could be resolved quickly and there was a need to ensure that there was a clear understanding of performance of sedation in the Trust given the updated received in respect of the Sedation Group through the Clinical Effectiveness Group upward report.

	The Trust Board: • **Received the assurance report** • **Received the Ockenden Report**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
706/22	**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 12 April 2022 meeting.
707/22	Professor Baker noted that the Freedom to Speak Up (FTSU) Guardian report had flagged issues of bullying within the Trust, which was recognised as a theme from previous meetings, the Trust was seeking to resolve these concerns.
708/22	The Committee discussed the links between bullying and the Culture and Leadership programme that was ongoing and how the processes were interrelated. There would be a focus of attention from the Committee going forward on the issue and the Committee noted the process around FTSU which appeared to be on track.
709/22	The People and Organisational Development dashboard was discussed with the Committee noting some concern that improvements were not being seen in key metrics on mandatory training appraisal turnover and sickness.
710/22	A significant discussion had been held regarding appraisals as it was recognised that the Trust was yet to achieve a culture where appraisals were seen as a helpful process. This would be an urgent area of focus and action for colleagues within the directorate and attention of future Committee meetings.
711/22	The Committee determined that, overall, the assurance ratings within the Board Assurance Framework should be altered particularly in relation to the progressive workforce and making ULHT the best place to work. It was however becoming apparent to the Committee that improvements were being made in processed and in assurance.
712/22	Professor Baker noted the intention of the Committee to undertake a more detailed review of the objectives at the next meeting to understand if it would be possible to see positive movement on the assurance ratings. If this was not possible the Committee would identify key steps to be put in place prior to improved assurance being presented.
713/22	The Chair was pleased to note the relationship in place with the FTSU Guardian noting the level of data and reporting being received by the Committee. The concern regarding appraisals was noted however the was a clear Integrated Improvement Plan, once year 3 was signed off meaning appraisals would be linked to this.

714/22	The Chair reflected that whilst there had been no movement in the assurance ratings by the Committee within the Board Assurance Framework the improvements in reporting was demonstrating positive movement.
715/22	Ms Cecchini noted the bullying elements raised in the report and sought to understand if the Trust was taking appropriate action to support the bullying and harassment agenda.
716/22	Professor Baker noted that there was consistency across areas being measured such as FTSU, Guardian of Safe Working and the staff survey. There sources were consistently flagging, and evidence was available through various networks. There was a shared view of zero tolerance and there was now a sense of feeling that staff were being listened to. This was on the agenda of the Committee and the Trust and was being addressed.
717/22	The Director of People and Organisational Development noted that this was an area of focus that had not received sufficient attention previously. The Trust Board was aware of the anti-racism campaign noting that a number of other campaigns, including bullying, needed to be worked through.
718/22	Work was required on the process and how the Trust took appropriate action earlier when an issue was raised to ensure staff were appropriately supported and actions were meaningful.
719/22	It was noted that the implementation of the Leading Together Forum would bring together 300 – 400 leaders to consider culture change and was a forum where this would move leaders to think differently. Wrapped into this was cultural intelligence training and what was needed in the Trust was a reset on processes to address bullying.
720/22	The Chair noted the description of the reset to bring all elements of the culture and leadership programme into the organisation. This would include civility and respect towards each other and how people were expected to behave towards one another.
721/22	The Chief Executive reflected that this was about setting clear expectations of behaviours with a compassionate and inclusive leadership approach being taken. Civility and kindness were not just about leaders but about all staff in the Trust and how people spoke to each other, it was noted that work was required on this.
722/22	It was clear that people were happier to come forward however there needed to be clarity over those who are bullying and those leaders who are raising issues of performance and are setting standards and raising expectations.
723/22	The Chief Executive was clear that there was no place for bullying in the Trust and actions were in place to tackle this. Part of which would be about communicating clear standards and to advise of the routes to raise concerns. These would be followed through however it was clear that people would also manage performance and hold people to account.

724/22	Miss Shadlock reflected that, through the People and Organisational Development Committee, it was clear that the directorate were addressing this and there was a level of confidence that there would be a positive change in the culture with the support of leaders. 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
725/22	**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 April 2022 meeting.
726/22	Ms Cecchini noted that the meeting had been extended by 30 minutes to enable a detailed discussion regarding the efficiency programme and plans overall, this would be discussed by the Board in the private session.
727/22	The Committee received an estates report noting that there was an improvement in assurances being received although limited assurance continued to be offered whilst improvements were embedded, particularly in regard to the structure of the directorate.
728/22	Ms Cecchini advised of the update received in respect of the Low Surface Temperature works noting that work remained ongoing to identify issues on all sites including those where the Trust was not the owner or landlord.
729/22	The Committee received the finance report and as offered by the Chief Executive, the Trust had delivered both the financial and capital plan for the year. The Committee had congratulated all staff involved in the achievement.
730/22	Discussion was held by the Committee to consider the moderate assurance level offered and for this, due to the outcome, to be moved to significant assurance.
731/22	Ms Cecchini noted that time had been taken to discuss the planning submission with the Committee assured of the robust open process ongoing within the Trust and the system to continue to develop the plan.
732/22	At the time of meeting the Committee considered a proposal for a breakeven plan to be submitted however the initial submission of the plan did not meet activity requirements and improvement following Covid-19 for both inpatients and outpatients.
733/22	A prudent view was taken in respect of the capital plan noting that an assumption was made that the Pilgrim Emergency Department Business case would not be subject to approval and, therefore, the potential increase in costs would not be funded.

734/22	The Committee considered the Cost Improvement Programme (CIP) framework and the approach taken in terms of the transactional, transformational and targeted schemes. Limited assurance was received regarding CIP and work was being undertaken to develop plans with information likely to be available in the first quarter of the year. It was noted that a reasonable level of assurance had been received on the transactional items that would support CIP delivery.
735/22	The Committee received an upward report from the Digital Hospital Group and noted the work taking place in respect of the outline business case for the Electronic Patient Record. This would be received by the Committee and onwards to the Board for approval once complete.
736/22	The Committed noted further deterioration in performance across a number of metrics including 12-hour trolley and A&E waits which were noted as an ongoing theme. It was noted however that there were some shoots of improvement, particularly around cancer outcomes. Due to the position reported the Committee received limited assurance.
737/22	The Integrated Improvement Plan was received by the Committee noting that this would be on the Board agenda with moderate assurance being received.
738/22	Ms Cecchini noted that the Committee received the Care Quality Commissions action plan noting that dedicated time would be given to this item at the following meeting due to time having been reserved for planning discussions.
739/22	The Chair noted the levels of assurance being received and acknowledged the challenge of the Committee to the Executives to consider increasing the position.
740/22	It was pleasing to hear about improvements in estates and the Chair noted the visible improvements across the Trust sites. The Chair thanked the Committee for continuing to have oversight of the Low Surface Temperature works.
741/22	The Trust Board noted the achievement of the financial and capital plan for 2021/22 and noted that it was right to take a prudent view on the 2022/23 planning submission.
742/22	The submission continued to move as this was developed however there was concern about the limited assurance offered on the CIP. There would be a need to ensure clear plans in place with updates being offered through to the Board. 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
743/22	No items

744/22	**Item 12 Integrated Performance Report** The Integrated Performance Report was received by the Board with Board members noting the updates that had been received through the reports from the Board Committees.
745/22	The Chief Operating Officer noted the focus on ambulance handovers and Urgent Care performance which had been a discussion point at the Finance, Performance and Estates Committee, as detailed in the upward report.
746/22	The number of 12-hour waits in the department had again deteriorated however, as noted through the upward report, there were some green shoots, whilst these were in the early stages it was not possible to see the outcome currently. This would feature in future upward reports and the integrated performance report.
747/22	The Chair noted the need to consider reports offered to the Board as the move towards system working developed.
748/22	Mrs Dunnett noted the slight upward trend a number of nurse sensitive indicators and sought to understand if staffing levels were correct and if there was a correlation between staffing and the increase in harm.
749/22	Mrs Dunnett also noted the increased length of stay within the report noting this was the highest it had been for 17 months and asked for an update on the current position, noting the narrative that described the system activity.
750/22	The Director of Nursing noted the clear upward trend in a number of nurse indicators, particularly regarding falls and pressure ulcers. A more specific update would be offered to the Quality Governance Committee regarding falls to look at the shift in the level of harm.
751/22	The Safer Staffing report offered to the People and Organisational Development Committee over the last few months had moved from moderate to limited assurance. There was clearly a relationship between quality indicators and staffing however this was about skill mix and not staffing numbers.
752/22	There were significant numbers of international nurses, new to healthcare staff and the use of temporary workforce to supplement the substantive position over the course of the pandemic. There had been a conscious decision to increase numbers in the establishment and all of this collectively, around skill mix, was having some impact.
753/22	Work was taking place to identify if the data was due to an increase in reporting or severity of issues around skin integrity and falls, as an increase was being seen, this work would be report to the Quality Governance Committee.
754/22	The Chief Operating Officer noted there were 3 elements to the response to the increase in length of stay. The first, having previously been discussed by the Board, about the system response and working with partners across the board, both within the NHS and local authority, to reduce delays in patients waiting to go home.

755/22	Substantial progress had been made which had seen an increase in capacity for patients to be cared for at home, however there remained a number of patients waiting for more than 24 hours for the support required to be cared for at home.
756/22	There were a number of other aspects that the Trust could deliver including Same Day Emergency Care (SDEC) which would provide care at the front of the hospitals to ensure patients, not requiring admission, could be treated. This would reduce the length of stay and work was underway progressively on this. More information would be offered to the Trust Board through the Integrated Improvement Plan report, around pathway 0 discharges. There had been limited progress on this due to the number of beds and wards open across the Trust. As these were reduced the organisation would improve these discharges.
757/22	Doing all 3 aspects should reduce the length of stay to even less than previously seen.
758/22	The Chair noted the responses offered to the questions raised recognising that further information would be offered to the relevant Committees and the Board. The Trust Board: • **Received the report noting the limited assurance**
759/22	**Item 12.1 Integrated Improvement Plan** The Director of Improvement and Integration presented the end of year report for the Integrated Improvement Plan (IIP) for year 2.
760/22	The IIP supported the 5-year strategic ambitions of the Trust and had been developed in 2019 through conversations with Executive Directors and engagement with staff across the organisation. The IIP continued to represent the Trust's journey of improving quality, experience and care.
761/22	The report offered the end of year position against the objectives and metrics, against a backdrop of a large amount of work which had been reflected in the Care Quality Commission (CQC) ratings.
762/22	The Trust had exited the System Oversight Framework level 4 which was due to the work undertaken in respect of financial planning and deliver of the financial plan with the report set against the backdrop of delivery.
763/22	The Director of Improvement and Integration reflected on the challenges over the past 12 months both operational and due to a number of incidents. The IIP demonstrated the delivery of 12 priorities and projects.
764/22	The report had been received by the Board Committees and there would be a lesson learnt review to consider how this was moved forward. A number of workshops had been held to understand how the IIP had worked for staff and how this would be improved whilst streamlining reporting.

765/22	Updates would be offered quarterly to the Trust Board accompanied by narrative from Executive Directors to ensure a wider range of assurance was captured.
766/22	The Chair expressed appreciation for the grip and control taken around the IIP noting how this had been distilled within the report into component parts and offered a comprehensive position to the Board at the end of the year.
767/22	Miss Shadlock referred to the culture elements raised during the meeting noting the engagement that was ongoing and asked how this was being received both from a leadership perspective and from others involved.
768/22	The Director of Improvement and Integration noted that there had been positive engagement on the refreshing of the IIP and co-creation was important. There was feedback to indicate that some of the project management office (PMO) processes had not worked well and this was being developed. Culturally having divisional level IIPs would support senior leadership teams with priorities described through the plan. This approach would see a balanced view at both organisational and divisional level.
769/22	The Board was advised of the limited resource in terms of support however the process meant that it was possible to review risk and ensure the emphasis was aligned appropriately. The culture was positive, and people had been open and honest.
770/22	Dr Gibson noted that the ambition set had not been achieved, which had been explained, however sought to understand if this had been considered when setting the next set of objectives.
771/22	The Director of Improvement and Integration noted that this was part of the lessons learnt, there had been 41 projects across numerous aspects. The strategic objectives would remain in place with progress being made in some areas more than others. Moving forward 3 focus areas had been identified including safety and culture of patient experience and safety, long waits and culture and leadership.
772/22	In year 3 there would be a range of projects which would drive forward the improvement journey of the Trust.
773/22	Through the MS Teams Live chat, the Improvement Director, NHSE/I noted that the report demonstrated a grip of the priorities and showed strong delivery despite the challenges of Covid-19. Congratulations were offered.
774/22	The Chair offered thanks to the Improvement Director for the support received noting that at the time the Improvement Director had joined the Trust did not have the clarity and focus now being seen. There was a clear and realistic ambition, but clarity was required about when and how this would be discharged. The divisions needed to come along on the journey and be engaged where this had not previously felt to be the case.
775/22	It was helpful to reiterate that the Trust had exited special measure as a result of the actions taken and improved CQC ratings of the Trust, particularly around well led with the IIP referenced within the report.

776/22	The IIP had been fundamental to the step change needed as a Board, this was a learning journey, and it was positive that there was reflection on comments being offered as the Trust moved into the next year.
777/22	The Chief Executive noted that, in the circumstance, this had been a good outcome for the second year, particularly given the last 2 years. The Director of Improvement and Integration was right to highlight the CQC report and exit from the recovery support programme however there remained more work to be done.
778/22	The ambition of Outstanding Care, Personally Delivered was a statement of intent to see a complete transformation of the Trust. There was a need to give hope and set out optimism and expectations for the Trust and others.
779/22	There was a large amount to do in terms of delivery that was in the direct control of the Trust and should be done but a range of issues where support was required from others. In return the Trust would offer support to the wider system challenges.
780/22	As the Trust moved in year 3 of the IIP the Chief Executive noted that the Trust had positioned itself well. There was an expectation from NHSE and the Trust Board, that the Trust continued to make progress and to build on the foundation set. There could not be complacency in the improvements made. The Trust Board: • **Received the report noting the moderate assurance** • **Received the recommendations**
	Item 13 Risk, Governance and Assurance
781/22	**Item 13.1 Risk Management Report** The Director of Nursing presented the monthly report to the Board noting that this contained 12 very high risks across number of strategic objectives namely 1a, 1c, 2a and 2b.
782/22	The very high risks were described within the body of the report with high risks included within the appendix. There had been a significant amount of work over the past few months since the reconfiguration of the risk register. This had included a review of emergency and planned care delays and reporting to each Committee those risks for which primary oversight was held, as pertained to them through the Board Assurance Framework.
783/22	The Director of Nursing advised that the Non-Invasive Ventilation (NIV) and JAG accreditation risks had reduced since the last meeting, following review through the current governance arrangements.
784/22	The most significant risks within the Trust related to the recovery of planned care pathways, level of emergency demand, availability of accurate patient information, recruitment of medical staff, staff morale, processes around echocardiograms and the ability to learn lessons from previous safety incidents.

785/22	The Board was advised that the process arrangement between clinical governance and finance teams continued to be refined in order that the risk register could be used by the Capital, Revenue and Investment Group (CRIG) in order to make decisions based on risks, specifically strategic risks.
786/22	The Chair noted that developments that continued to be seen in the reporting noting that the report was easier to read and navigate.
787/22	Ms Cecchini noted risk 4857 and the backlog of unpaid pharmacy invoices and the ability to get critical medications on site. The backlog of invoices had been discussed through the Finance, Performance and Estates Committee due to the change in the ledger however this had been cleared. Assurance was sought that this issue had been included in the resolution of the backlog.
788/22	The Director of Finance and Digital confirmed that this was included within the clearing of the invoice backlog noting that the risk was subject to a deep dive conversation at the risk confirm and challenge meetings the previous week. This would be removed from the report next month as the risk had been reviewed.
789/22	The Chair was pleased to see the dynamic nature of the report and noted the reduction of both the NIV and JAG risks in a short space of time which demonstrated the progress in reporting. This offered assurance on risks being managed in a very different way. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance** • **Note strengthened arrangement to support CRIG process**
790/22	**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 April 2022.
791/22	The report brought the year-end report in line with the report seen at item 12.1, Integrated Improvement Plan and detailed the assurances given in year as considered at the Committees.
792/22	The 2022/23 Board Assurance Framework would be received to the private Board and subsequently received through the Committee assurance process in May.
793/22	The Chair reiterated the backdrop which had been seen during the year noting that the number of green and amber assurance ratings were a testament to the hard work undertaken in the organisation. There was a full understanding of the reason for the red rated objectives which would continue to be reviewed in the coming months with an expectation that these could change.

794/22	The Trust Board agreed that the report offered a true representation of the position as seen through the Committees and noted the closure of the 2021/22 Board Assurance Framework The Trust Board: • **Received the report noting the moderate assurance** • **Closed the 2021/22 Board Assurance Framework**
795/22	**Item 13.3 Audit Committee Upward Report** The Chair of the Audit and Risk Committee, Mrs Dunnett presented the report to the Board from the meeting held on 11 April 2022.
796/22	Mrs Dunnett noted that the focus of the meeting had been on the external audit planning process for the preparation of the 2021/22 accounts. The Committee received and approved the final external audit plan and received an update on the interim audit work being undertaken by the external auditors.
797/22	The Board was advised that this was on track and the audit would be completed in accordance with the agreed timetables.
798/22	Mrs Dunnett noted the unforeseen staffing challenges within the finance team however noted that team had been able to meet the timetables.
799/22	The Board was advised that the risks faced in external audit were those consistent with many other Trusts in respect of valuations, capital expenditure and accounting for in the correct period.
800/22	A risk specific to the Trust and Lincolnshire partners was linked to the finance system. It was noted that extensive testing of the system had been completed and no issues identified in respect of year end accounts and the process concerned.
801/22	Mrs Dunnett noted that the Committee agreed all accounting policies for the 2021/22 accounts with no major differences on prior years. The Committee had also agreed the accounts could be prepared on an ongoing concern basis which was substantiated within the detailed report.
802/22	The Committee received a progress report from Internal Audit who were coming to the end of the 2021/22 year with the Board noting an additional short meeting due to take place later in May to conclude sign off of final reports and to receive the Head of Internal Audit Opinion (HIAO).
803/22	4 audits had been received for the last period, 1 of which offered partial assurance on recruitment which was being considered through the agenda of the People and Organisational Development Committee. The Audit Committee would maintain sight of the recommendations to ensure controls were in place and a focus would be given at the autumn meeting of the Audit Committee.

804/22	The Committee noted concern on the follow up of Internal Audit recommendations, both those made in reports and the implementation. The Committee was aware of the focus of the Executive Team however noted the need to ensure progress.
805/22	The quarterly counter fraud report was received with assurance offered on the work taking place throughout the year. Overall, the Trust remained on track to achieve a green rating on the Counter Fraud Functional Standard annual return. There remained some areas requiring further work however the Committee was assured that plans were in place.
806/22	The Committee received the compliance report which had been abbreviated taking into account quarter 4 as part of the year end process. The Board was asked to not the new policies in place for Standards of Business Conduct and Gifts and Hospitality. These were yet to be fully launched and a focus would be required as the Trust moved into the new financial year.
807/22	The Committee noted progress on risk management, for which the Audit Committee had an overarching view on the systems of risk management. The new Risk Management Policy was agreed and reflected the work undertaken over the past 12 months.
808//22	It was positive to see the new risk register and associated governance and policy in place that addressed the audit recommendations which had been signed off and completed. The Committee noted the upgrade to the Datix system which would further support the robustness of risk management arrangements.
809/22	The Board Assurance Framework continued to be rated as amber for objective 2c and reflected the progress of internal audit recommendations as ongoing work.
810/22	The Chair noted the report and the work being undertaken for the year end process. The challenges within the finance team were noted and the effort of the team to contribute was acknowledged.
811/22	The comments in respect of the follow up of internal audit recommendations were endorsed by the Chair with it noted that these were now starting to come through. This was positive progress however there was a need to ensure continued discharge of the actions presented.
812/22	The Chair noted the ongoing issue with policies hoping that this could be progressed in to 2022/23 with focus through restoration of business in the organisation from a governance perspective. The Trust Board: • **Received the report noting the moderate assurance**
813/22	**Item 14 Any Other Notified Items of Urgent Business** There were no items of other business.

814/22	The next scheduled meeting will be held on Tuesday 7 June 2022, arrangements to be confirmed taking account of national guidance.

Voting Members	**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**	**5 Apr 2022**	**3 May 2022**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	A	X	X	A	X	A	X	X	A	X
Geoff Hayward	A	A	X									
Gill Ponder	A											
Neill Hepburn	X	X	A									
Sarah Dunnett	X	X	X	X	X	X	X	X	X	X	A	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X				
Paul Matthew	X	X	X	X	X	X	X	X	X	A	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X
Mark Brassington	X	X	X	X								
Simon Evans					X	X	X	X	X	X	X	X
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X
David Woodward		X	A	A	X	X	X	X				
Philip Baker				X	X	X	X	X	X	X	X	X
Colin Farquharson				X	X	X	X	X	X	X	X	X
Gail Shadlock									X	X	X	X
Dani Cecchini									X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
7 December 2021	1914/21	Action Log	Establishment reviews for endoscopy and ED would be received once considered at Committee in Jan/Feb 2022 Endoscopy review to be received in July	Director of Nursing	~~01/03/2022~~ ~~05/04/2022~~ ~~07/06/2022~~ 05/07/2022	Deferred to July
5 April 2022	385/22	Public Questions	Chief Executive to share Ms McQuinn's question to the Board with the Clinical Commissioning Group for a response to be provided	Chief Executive	03/05/2022	Complete and response provided by CCG to Ms McQuinn
5 April 2022	391/22	Action Log	Action 1914/21 to be updated to reflect endoscopy establishment review to be received by the Trust Board in June 2022	Trust Secretary	03/05/2022	Complete
5 April 2022	511/22	Anti-Racism Campaign	Miss Shadlock to meet with the Director of People and OD to discuss how the campaign was messaged to the public	Director of People and OD	03/05/2022	Complete
3 May 2022	688/22	Assurance and Risk Report Quality Governance Committee	Continuity of Carer to be reviewed in respect of Ockenden Final report to consider if option 2 remains appropriate	Director of Nursing	02/08/2022	Agenda item Complete

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*7 June 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 system continue to be under significant pressure. This is similar to the NHS across the country. At the time of writing this report, significant work is underway to finalise the service resilience plans for the 4-day Jubilee period. This coincides with the school half term holiday period and an anticipated influx of visitors to the county. An update will be provided at the Board meeting on how services coped over this period.

b) NHSE have requested an updated operational plan from all systems by 20th June. This needs to include updated finance, activity and workforce figures. All systems need to plan to achieve financial break-even in 2022/23. The submitted plan for Lincolnshire contained a projected deficit of £32.9m in 2022/23. It is likely that additional central funding will be provided to cover excess inflation costs and other pressures. This should amount to approximately £17.8m. This will leave a remaining gap of £15.1m which will need to be closed by the time the updated plan is submitted. Work is underway across the system to identify the source of additional savings and to put in place the necessary assurance processes before the plan is submitted.

c) The NHS Lincolnshire CCG Board has taken the final decisions following the public consultation relating to 4 NHS Services. This was previously known as the Acute Services Review. The services in question were Orthopaedic surgery countywide, urgent and emergency care at Grantham and District Hospital, Acute Medicine at Grantham and District Hospital and Stroke services countywide. The CCG Board considered the comments made during the consultation and a decision-making business case. The CCG Board approved the changes that were the subject of the consultation. This means that work will now start on making these changes happen.

d) The latest quarterly system review meeting (QSRM) took place with NHSE on 19th May. This was a positive meeting with the summary letter from NHSE stating 'The system presented as a positive and proactive team with clearly aligned aspirations that will improve the health & wellbeing of the population of Lincolnshire. You have a clear understanding of the challenges you face and are cognisant of the potential risks of delivery. We closed recognising there are many priorities and initiatives that need to be delivered. You were encouraged to choose those that will be most impactful.'

e) Parliament has now passed the Health and Care Act 2022. This puts into law the changes around the creation of the Integrated Care Board (ICB) as a statutory body, the abolition of the CCG and the creation of the Integrated Care Partnership (ICP) as a statutory committee. These changes will come into effect on 1st July 2022. The ICB is continuing to make appointments to its Board and has recently begun the process to appoint Partner members, including those from NHS Trusts, primary care and the local authority.

f) The provider collaborative, Lincolnshire Health and Care Collaborative (LHCC), is also looking to formalise itself from 1st July. This includes securing final agreement on the Alliance Agreement between its members, and finalising the Delegation Agreement with the ICB. The focus of LHCC continues to be on implementing the System Delivery Plan, including the work

needed to help the system to exit the Recovery Support Programme, agreeing a five year strategy and putting in place a transformation hub to facilitate this work.

g) NHSE has published a report from the stocktake of primary care and integrated care systems led by Dr Claire Fuller. This report makes a series of recommendations for local and national leaders and articulates ideas about the future shape of urgent care and about the further development of neighbourhood teams. This report will inform local work around the development of these topics, which are integral to the System Delivery Plan and the work of all organisations in the ICS.

Trust Overview

a) At Month 1, the Trust reported a deficit of £636k against a planned deficit of £432k. This is £204k adverse to plan. This is against a current financial plan for 2022/23 of a year-end deficit of £5.811m. This is part of the system planned deficit of £32.9m. As mentioned above however, the system is working on a new plan for 2022/23, which must include financial break-even at year-end. This means that the Trust plan will change as well.

b) The Trust has opened Lincolnshire's first Community Diagnostic Centre. This will be known as the Gonerby Road Community Diagnostic Centre and is based in Grantham. This is part of the first wave of 40 CDCs to be opened across England. The system is engaging with the public about a potential location for a second CDC.

c) The Trust has also opened a new pharmaceutical aseptic unit that will make chemotherapy, intravenous nutrition and other injectable medicines. The unit is at the Lincoln Science and Innovation Park and is a further development in the relationship between the Trust, Lincolnshire Co-Op and the University of Lincoln.

d) The Trust is one of the main presenters at a national conference on 7th June about the Recovery Support Programme. The Trust exited the Recovery Support Programme earlier in the year and has been asked to share its experiences about how this was achieved, the learning from the work, what went well, what could have been done differently, as well as sharing general reflections on the Recovery Support Programme. This will be a joint presentation with John Turner the CEO Designate of the ICB.

e) The Trust has put in place an Employee Assistance Package (EAP) through an organisation called Health Assured. The EAP offers expert advice and guidance 24/7 on a range of topics including counselling, legal information, bereavement support, medical information, online CBT. The service also offers some support to immediate family members of Trust staff. In addition to the EAP, staff also have access to 'My Healthy Advantage', which is a new health and wellbeing app.

f) A 'Big Thank You' variety show was held at the New Theatre Royal in Lincoln on Sunday 29th May in honour of all of the work the NHS did during the pandemic. All proceeds from the evening are going to the United Lincolnshire Hospitals Charity.

g) Events are taking place across the Trust to mark the Jubilee. This includes garden parties on the Lincoln, Boston and Grantham sites on each of the 30th May, 31st May and 1st June. To ensure that nobody misses out on the celebrations, treats are being provided for staff working at Louth and across community hospital sites, as well as for staff who work nights.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board (Public)*
Date of Meeting	*7th June 2022*
Item Number	*Item number allocated by admin*

Integrated Improvement Plan Year 3 (2022-23)

Accountable Director	*Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration*
Presented by	*Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration*
Author(s)	*Georgina Grace, Head of Strategy & Planning; Lindsey Marshall, Strategy Support, Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration* *Comms- Stephen Knight Senior Communications Officer, Sharon Bradwell, Senior Communications Officer*
Report previously considered at	*n/a*

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

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

Recommendations/ Decision Required	**Review and approve the final Year 3 Integrated Improvement Plan (IIP) for 2022/23** • Attached is the final refreshed version of the Integrated Improvement Plan Year 3 (2022/23) which sets out our focus for the year, with clear alignment of our priorities to our 2020-2025 strategic direction. It sets out how we intend to deliver our strategy. • Key stakeholders for each Strategic Objective have contributed to the IIP narrative to ensure alignment to local and national priorities, taking into account population health and the health inequality agenda. • Patient Panel have reviewed the Integrated Improvement Plan on 17th May 2022 and we will continue to engage and iterate as we further develop our plans to deliver our strategy.

	• Following approval of the year 3 IIP, we will move into the communication phase with onward delivery against our agreed priorities for 2022/23. • A shorter and more succinct version of the document has been created for sharing on the Trust Website, taking the key points from the full document (Appendix 1). • Within the appendices of this paper, are the graphics which support the Integrated Improvement Plan which will form the way we will actively communicate the IIP within the organisation, ensuring that the ambitions are clearly identifiable and demonstrates what this means our patients, people, services and partners. Appendix 1: Summary IIP version Appendix 2: Comms-ULHT Strategy "By 2025" with 2022/23 Focus Area Appendix 3: Comms- what this means?

NHS
United Lincolnshire Hospitals
NHS Trust

United Lincolnshire Hospitals NHS Trust (ULHT) Strategy

Year 3 of our Integration Improvement Plan

(2022-2023)

OUTSTANDING CARE
personally DELIVERED

Draft -V19

AUDIENCE FOR THIS DOCUMENT

- Trust Board
- Executive Leadership Team (ELT)
- Trust Leadership Team (TLT)
- Divisional Teams
- Corporate Teams

Contents

1 Introduction

Following the pandemic, the NHS, including the Lincolnshire health and care system, is facing its most testing time. As we emerge from the peak of the COVID-19 pandemic, we have reviewed our strategy in the light of our learning and the significant recovery and operational challenges that lay ahead.

The CQC published their latest inspection report on ULHT in February 2022, highlighting the significant and widespread improvements in the safety and quality of the services in our Trust. The ratings for both the Effective and Well Led domains improved from 'Requires Improvement' to 'Good'. The rating for the Caring domain remained as 'Good'. The ratings for Safety and Responsive remained as 'Requires Improvement'.

However, we still have a long way to go if we are to build an organisation that achieves our aspirations. We remain rated overall as 'Requires Improvement'. For staff satisfaction we are in the bottom 25% of all NHS Trusts. National workforce shortages in many professions and specialties, stretches an already fatigued workforce, difficulties in recruitment and retention and high agency staff (and spend), all resulting in below standard staff survey results. Consequently, these resource limitations negatively impact our ability to respond to the challenges to operate in an efficient and more sustainable way.

Our focus this year will be on our efficiency and productivity and our subsequent Cost Improvement Programmes. Following significant progress and improvements within the Trust in recent years, the Trust has now moved out of segment 4 and into segment 3 of the NHS System Oversight Framework (SOF). This means the Trust has exited the Recovery Support Programme (formerly 'Special Measures'). This is a significant achievement for us.

Effective financial management flows from relentlessly focusing on service quality. We are committed to using public money responsibly and investing in innovation to improve patient, carer, family and staff experience. We want to optimise quality and efficiency across the entire pathway whilst improving our productivity. Increasing productivity means working more effectively not necessarily harder, reducing waste not sacrificing quality.

We want to redouble our efforts to reduce discrimination, violence, bullying and harassment and continue to embed equality and diversity in all that we do. The connection between a highly-engaged workforce and improved patient outcomes is well documented and it's no surprise that a more satisfied workforce leads to better patient experience. Our culture isn't static and is nurtured by our values and behaviours, the role-modelling by our leaders and through the many activities that together create an engaged workforce and organisation.

We also recognise that, alongside the impact on patients, the pandemic has had a significant impact on the wellbeing and resilience of our people, whose continued dedication and efforts are key to us delivering safe, high quality services. This is why we want to continue to invest in our staff's health and wellbeing and ensuring our people feel supported and valued.

We continue to operate under significant operational pressures. Key areas of focus continue to be around reducing ambulance handover delays at hospitals and in the community and on the timely and safe discharges of patients who no longer require hospital care. As the current pressures ease and our hospitals de-escalate, we are focusing heavily on recovery of our clinical services in order of clinical priority. As we recover our services, backlogs in care need to be tackled, the number of people awaiting treatment will continue to rise unless we take action. Delays in care will also mean a deterioration in condition that will mean that more people will require hospital treatment than would otherwise have been the case. We know that it will take time - and a series of targeted actions to build capacity and redesign patient pathways to ensure our patients are seen as soon as possible in the most approipaite setting.

As the second largest county in the UK, Lincolnshire faces many challenges due to our rurality and proximity of our sites . We need to better understand the unique factors impacting health outcomes in rural, remote and coastal communities- the health inequalities challenge facing our communities differs from the challenge faced by more urban populations. Increasing our focus on prevention and public health – we have an important role to play in supporting the wider health and wellbeing of the populations we serve and to keep people well in the community. Our efforts to implement seamless and best value, quality care for our people of Lincolnshire has been supported by changes in national policy. 2022 will see the introduction of Integrated Care Board (ICB), and Lincolnsire Health and Care Provider Collaborative (LHCC). These policies formalise how and where partnership working can support us in the delivery of our strategic objectives.

Our Integrated Improvement Plan (IIP)- the overarching Trust Strategy, was approved by the Trust Board in 2020 to cover the five-year period 2020-2025. Our IIP identifies the key priorities for the Trust, ensuring we are focused on the right things for both our patients and our staff and empowering them to make changes.

We need to make progress against all our strategic objectives to keep moving towards our true north vision of ‘achieving outstanding care personally delivered’, but this year our focus is on 3 things that we will deliver through our Outstanding Care Together Programme:

1) Continue improvements in patient safety and experience
2) Reduce long waiting times for treatment
3) Make our people feel valued and supported by improving our culture and leadership

To support this, our leaders and managers will need to act and behave differently moving to an approach that includes more coaching and support. We want to continue building and embedding quality improvement in our day to day and providing the required training, incorporating the work of our Quality, Service Improvement and Redesign (QSIR) faculty and supporting our staff to use and implement QSIR tools and techniques.

To make positive change a reality, every single one of us needs to be a part of the change. Nothing will be different unless we all commit to designing, implementing our plans that we have agreed to deliver through our IIP. This is all part of our day job and core to us restoring pride in our organisation.

This strategy refersh brings together work undertaken by our organisational Leadership Teams and Trust Board to reset a more cohesive direction for our organisation, rooted in our values and behaviours. We believe that how we go about achieving our vision is as important as what we do to achieve our vision; cultural change is a fundamental building block for this.

We have linked our broad strategic objectives to key deliverables and specific priorties with our plan for 22/23. We are renewing our commitment to this framework as described below.

We can all help to grow our Trust

By 2025 we want to achieve 'Outstanding Care Personally Delivered' by improving the quality of care and experience for our patients and the wellbeing of our staff

by living our values

Patient centred

Respect

Excellence

Safety

Compassion

and by delivering our strategic objectives

For our patients
High quality, safe and responsive services, shaped by best practice and our communities

For our people
Our people to lead, work differently and feel valued, motivated and proud

For our services
Sustainable services making best use of resources, technology and estate

For our partners
Improve the health of our populations by implementing integrated models of care

and our key focus areas in 2022/23 are:

Continue improvements in patient safety and experience

Reduce long waiting times for treatment

Make our people feel valued and supported by improving our culture and leadership

2 Our Organisation and Lincolnshire ICS

United Lincolnshire Hospitals Trust (ULHT) serves one of the largest geographical areas in England with a population of around 755,833 (Office of National Statistics 2018). We provide a comprehensive range of hospital based medical, surgical, paediatric, obstetric and gynaecological services to more than 750,000 people across the county of Lincolnshire. We operate across 4 hospital sites and deliver services in a range of other settings, employing around 7,800 staff.

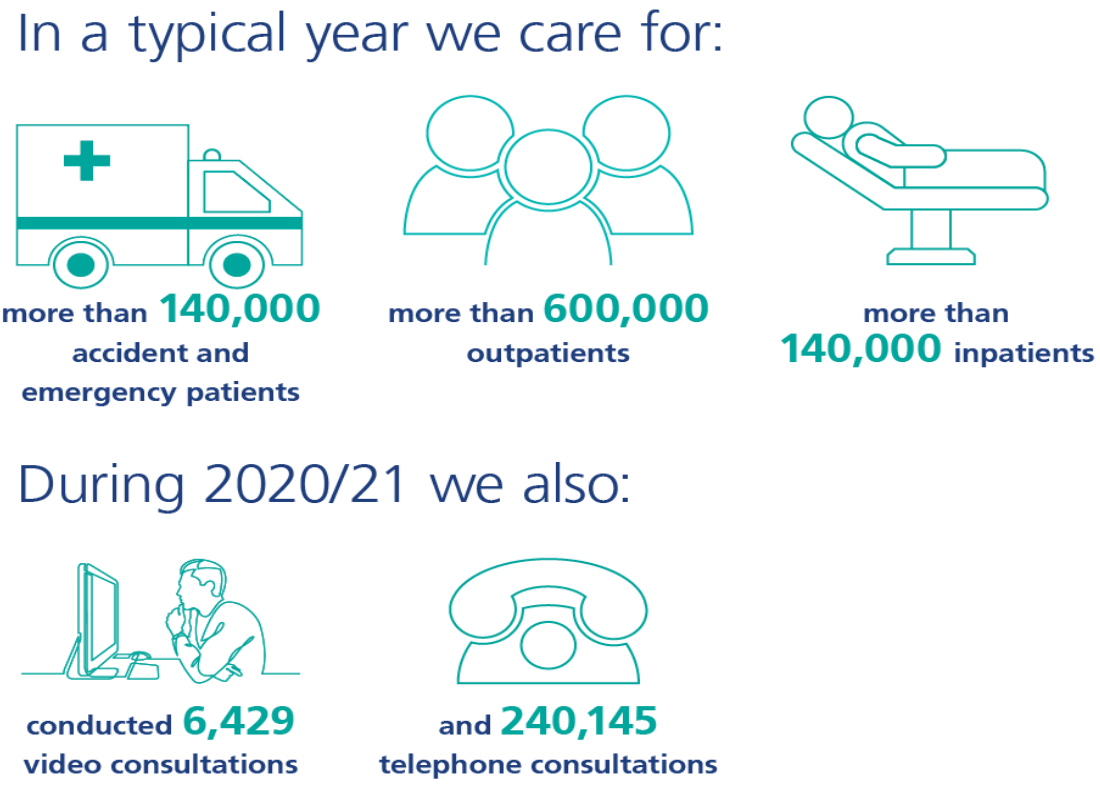
Lincolnshire is the second largest county in the UK. It is characterised by a dispersed population in towns, in the city of Lincoln and largely rural communities. We have an annual income of circa £643m (20/21).

We provide services from three acute hospitals in Lincolnshire with a bed stock, excluding obstetrics, of 889 beds:

- Lincoln County Hospital has 516
- Pilgrim Hospital Boston has 341
- Grantham & District Hospital has 32

The bed numbers for Lincoln and Pilgrim also include a number of escalation beds. The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by NHS property Services. These include:

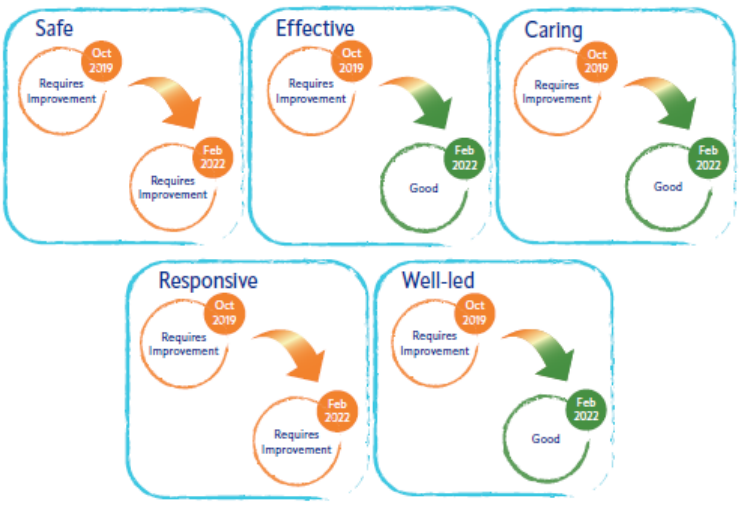
- County Hospital Louth
- John Coupland Hospital, Gainsborough
- Johnson Community Hospital
  Spalding Skegness and District General Hospital



Our focus this year will be on our efficiency and productivity and our subsequent Cost Improvement Programmes. Following significant progress and improvements within the Trust in recent years, the Trust has now moved out of segment 4 and into segment 3 of the NHS System Oversight Framework (SOF). This means the Trust has exited the Recovery Support Programme (formerly 'Special Measures'). The SOF requires Trusts and Integrated Care Systems (ICSs) to be evaluated and placed into one of four segments. Those organisations placed in segments 3 and 4 receive mandated support from NHS England and NHS Improvement through the nationally co-ordinated Recovery Support Programme. Whilst the progress and improvements made have been recognised at a Trust level, there remains a need to further improve services as we move into a more mature ICS, and develop other collaborative working relationships with partner organisations in Lincolnshire. The Lincolnshire ICS has been placed into segment 4 meaning it receives mandated support and is part of the RSP.

The CQC published their latest inspection report on ULHT in February 2022, highlighting the significant and widespread improvements in the safety and quality of the services in the Trust. This followed their inspection in October and November 2021. The ratings for both the Effective and Well Led domains improved from 'Requires Improvement' to 'Good'. The rating for the Caring domain remained as 'Good'. The ratings for Safety and Responsive remained as 'Requires Improvement'. The overall rating remained as 'Requires Improvement'. This overall rating could not change this time because not all sites and all services were inspected.

The CQC commented that this was particularly impressive against the COVID backdrop. Positive comments were also made about the Trust having a strong cohesive team with collective leadership at Board level. Whilst widespread improvements have been made there was an acknowledgement that the Trust needs to improve access and flow in the A&E department at Lincoln County Hospital and also improve waiting times and the arrangements to admit, treat and discharge patients.



We are building strong collaborative relationships with the University of Lincoln. The Trust welcomed the first cohort of students from Lincoln Medical School in February 2022. The Trust will be providing secondary care clinical placements to students and it is hoped that the new Medical School, which offers first class training will encourage graduates to complete their junior doctor training locally and apply for jobs in the region.

2.1 Our services

Our services are delivered by our four core clinical Divisions: Medicine, Surgery, Family Heath, and Clinical Support, with support from our Corporate Division. Each Division will have an Integrated Improvement Plan for 2022/23 which focuses on their key priorities for the year aligned to the organisaitonal strategy and enabling plans.

2.1.1 *Medicine Division*

The Medicine Division delivers emergency and secondary care to our local population of Lincolnshire. Services include Accident & Emergency, Acute Medicine, Stroke, Cardiology, Diabetes, Endocrinology, Renal, Dermatology, Rheumatology, Neurology, Respiratory, Health Care of the Older Person and Gastroenterology.

The Medicine Division has been part of the 'Lincolnshire Stroke Transformation: 100 Day Challenge' and were awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021. Stroke services were identified as a system priority during 2019/20. Using rapid improvement methodology significant work took place to implement a 'one team' approach to establishing an integrated, seamless pathway and a community based stroke rehabilitation service that is able to support stroke survivors. This allows for a smoother and more rapid transition from hospital, and provides improvements such as a reduction in the length of stay in hospital, and launching a patient handbook that travels with the patient from acute to community and beyond.

In December 2021, we commenced provision of an anti-viral treatment for COVID-19 at Lincoln County Hospital. This outpatient service, benefits patients with underlying health conditions who may otherwise be at inceased risk of admission to hospital. The service was able to successfully help more than 130 patients within the first month

2.1.2 *.Surgery Division*

The Surgery Division provides a large proportion of the Trust's elective activity and consists of clinical specialties covering Head and Neck, General Surgery, Vascular, Urology, Trauma & Orthopaedics, Ophthalmology, Orthoptics, Theatres and Critical Care.

Nationally, the Division of Surgery have been recognised for achievements relating to the Orthopaedic Getting it Right First Time (GIRFT) programme as part of the work to separate elective (cold) and trauma (hot) on to two separate sites, to help to tackle patient delays for routine orthopaedic surgery by reducing last minute cancellations due to beds being required for emergency patients. The team are also supporting other Trusts within the region to reduce their backlogs and reduce waiting times following the impact of the pandemic, this ongoing work will support delivery of the National recovery priority and elimination of 104week waits.

The Surgery Division has recently procured a state-of-the-art robotic surgery system which supports less invasive surgery techniques, faster recovery and reduced waiting times.

2.1.3 *Family Health Division*

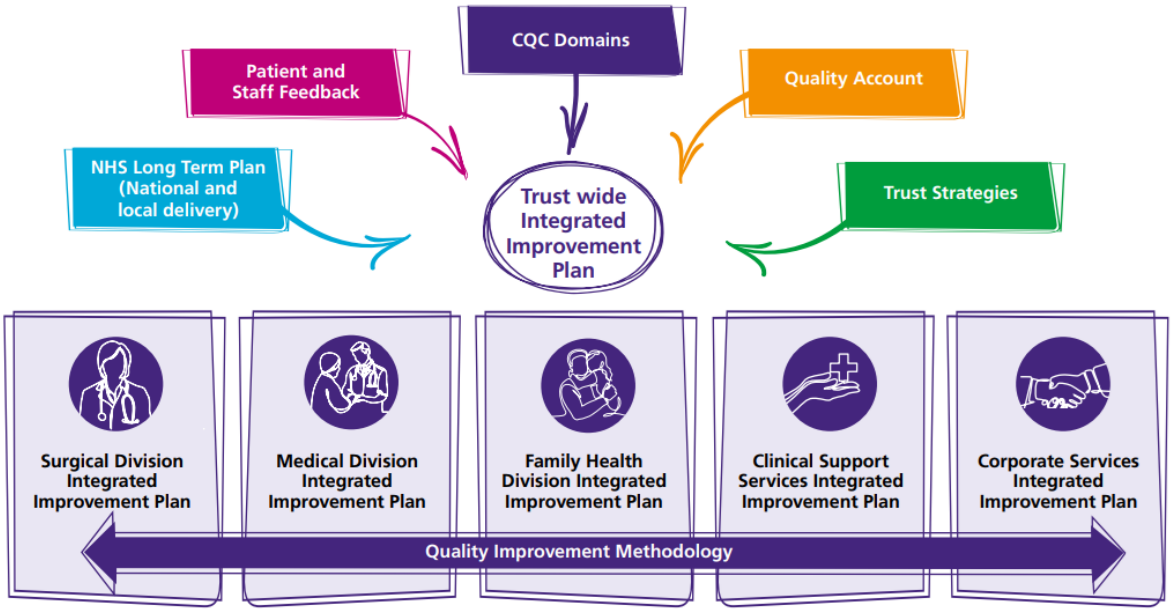
The Family Health Division, delivers secondary care to our local population of Lincolnshire. The Division delivers services in Breast, Obstetrics, Gynaecology, Pediatrics and Neonatology.

The Family Health Division have worked with Primary Care and Clinical Commissioning colleagues to model and deliver a new Breast Pain Clinic which is able to deliver the best care for patients across Lincolnshire who are suffering from breast pain alone. This collaboration means that patients can be seen quickly for their symptoms, and as well as improved outcomes, the changes will help reduce two week wait cancer referrals by 15-20% relieving significant pressure on our cancer services.

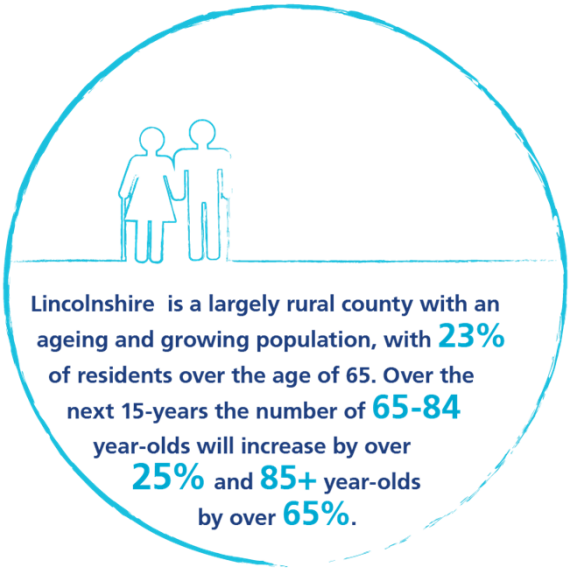
2.1.4 *Clinical Support Division*

The Clinical Support Division supports the Trust to deliver a range of supporting services such as: Radiology, Radiotherapy, Medical Physics, Pathology, Audiology, Rehabilitation Medicine, Occupational Therapy, Speech and Language Therapy, Dietetics, Physiotherapy, Pharmacy, Outpatients and Cancer Services.

In April 2022, the Clinical Support Division commenced services at our new Community Diagnostic Centre (CDC) in Grantham. The new centre is the first CDC in Lincolnshire, and one of the very first stand alone centres to have opened nationally. The CDC will help to support diagnostic capacity within Lincolnshire which will reduce wait times and support care closer to home for patients who require tests such as x-ray, non-obstetrics ultrasound and echocardiogram.



2.2 Lincolnshire Population Health and Inequalities

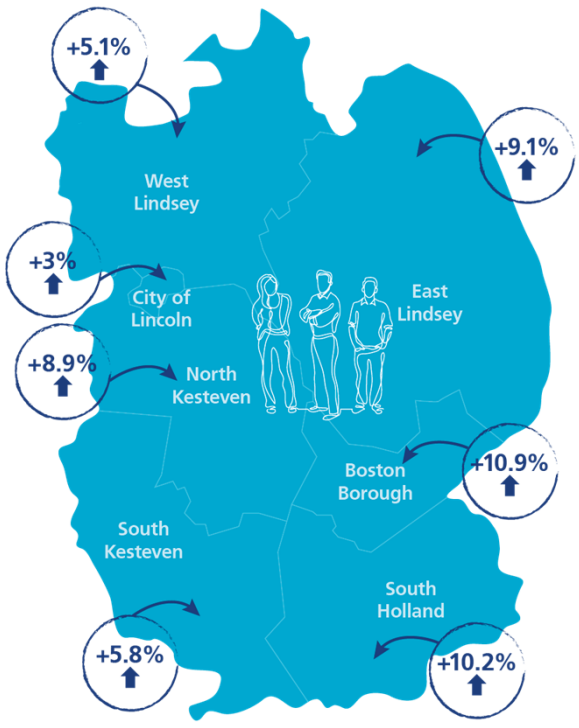


We also know that key lifestyle factors impacting on life expectancy are improving in the more affluent areas of Lincolnshire, compared to the more deprived areas of Lincoln and Boston. North East Lincolnshire is within the top 20 local authority districts with the highest proportion of neighbourhoods in the most deprived 10% of neighbourhoods nationally. People living in the more deprived areas of Lincolnshire (e.g. Lincoln and East Lindsey) have less healthy lifestyle choices (smoking, alcohol and less physically active) and higher levels of disability, with poorer health and wellbeing outcomes.

The main causes of death of our population in Lincolnshire are cancers, heart disease, strokes and long-term conditions. Mortality rates from cardiovascular diseases and cancer have improved, but remain higher than the England average. Emergency admissions for hip fractures are significantly above the national average for many districts and owing to the rural nature of the county, the rate of those killed or seriously injured on the counties road is almost 60% above the national average.

The birth rate in our catchment population has decreased slightly over the last three years, and this trend is anticipated to continue. However, the above average teenage conception rate, high percentage of smoking during pregnancy and low percentage of breastfeeding initiation, increases the proportion of high risk and complex pregnancies that require specialist consultant-led care and foetal medicine. A focus on children is also required as the prevalence of obesity in children aged 10-11 is increasing within the county.

Lincolnshire population growth by 2031



Our ageing and growing population with multiple co-morbidities and long-term conditions has implications for future planning and delivery of services in order to meet their health and wellbeing needs. Hospitals are not always the best places to care for this group of patients. The introduction of the Lincolnshire Integrated Care System (ICS) has implications for our clinical services through ambitions to reduce demand on our hospitals by redesigning primary and community services, delivering more care closer to home, improved self-care, and through a focus on healthy living and the prevention agenda.

2.3 Lincolnshire ICS

Integrated care systems (ICSs) are partnerships of health and care organisations, local government and the voluntary sector. They exist to improve population health, tackle health inequalities, enhance productivity and help the NHS support broader social and economic development. The government is now aiming to strengthen the approach to Integrated Care Systems by removing barriers and creating the conditions for local partnerships to thrive. Legislation is currently passing through parliament with a key feature being the introduction of a new NHS Statutory body which will come into place in July 2022. A key feature of the legislation will be for the Integrated Care Board (ICB) to work with an Integrated Care Partnership (ICP) committee which will be formed jointly with Local Authority Partners. Together the ICP and ICB will become the ICS.

The new ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with a common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to deliver the best health outcomes for the populations we serve. They will ensure that dynamic joint working arrangements, as demonstrated through the response to COVID-19, become the norm. They will establish shared strategic priorities within the NHS and provide seamless connections to wider partnership arrangements at a system level to tackle population health challenges and enhance services at the interface of health and social care.

Sir Andrew Cash has been appointed as the Interim Chair of the Lincolnshire Integrated Care Board. Subject to legislation, the ICB will be fully established on 1st July 2022 to oversee the commissioning, performance, financial management and transformation of the local NHS. It will subsume the responsibilities of the NHS Lincolnshire CCG, which will cease to exist on 30th June. The ICB is currently appointing its Board members. The provider collaborative in Lincolnshire, Lincolnshire Health and Care Collaborative (LHCC), is continuing to develop its plans and working arrangements. This includes formalising the Alliance Agreement between its members and agreeing the governance and decision making arrangements.

The All-Party Parliamentary Group for Rural Health and Care and the National Centre for Rural Health and Care have published a national Inquiry into rural health and care. The National Centre is based in Lincolnshire. The Inquiry calls for an overarching place-based rural strategy to address rural health inequalities. This inquiry will inform the work of the Lincolnshire ICS.

For an NHS ICS to become truly agile, connected and integrated we need new system wide capabilities which align and enable the commissioners and providers to work effectively together to focus on improving the health of the population, reducing the inequalities, improving outcomes, improving staff engagement and achieving long term financial sustainability. Year 3 of the Trust's Integrated Improvement Plan will align with the system's strategic delivery plan, operational plan and the national planning guidelines.

3 Our Vision, Mission and Our Objectives

We have a vision and five key values which demonstrate what we stand for, how we want to be known and how we behave. Our Integrated Improvement Plan (IIP) sets out our vision for the future and how we will get there. Our vision is to provide 'outstanding care, personally delivered'.

Our Integrated Improvement Plan will be at the centre of all we do, supported by our Trust values:

Patient Centred:	Putting patients at the heart of our care
Safety:	Ensuring patients and staff are free from harm
Excellence:	Supporting innovation, improvement and learning
Compassion:	Caring for patients and loved ones
Respect:	Treating our patients and each other positively

Based on feedback we receive from our patients, staff and our partners we know we need to make more progress and improve rapidly in a number of areas. Our patients and their families have told us they want to be more involved in decisions about their care and how local services are developed.

In keeping with our Trust values, our staff want to be able to come to work to deliver excellent patient care and feel respected and valued. Through working with partners we know we can do more to improve the safety of care we deliver to our patients with improved staffing numbers and a clean and safe environment.

- **Patients:** By 2025, we will deliver high quality, safe and responsive patient services, shaped by best practice and our wider communities.
- **People:** By 2025, we will enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT.
- **Services:** By 2025, our services will be sustainable and make best use of resources, while being supported by technology and delivered from an improved estate.
- **Partners:** By 2025, we will work collaboratively with our partners to improve the health and wellbeing of our populations and implement new integrated models of care.

Underpinning the ambition in each of the strategic objectives, we have identified key priorities, which will help monitor our progress. Each year detailed actions will be created for the current year priorities, which will form the basis of the Trust's Annual Plan. This will ensure specific plans are in place for each area and service, enabling appropriate resources to be directed in order to ensure achievement of the vision and our Strategic Objectives.

Each objective will also be supported by enabling strategies. The strategy, in-year priorities and enabling strategies will be reviewed and refreshed annually to ensure they remain up-to-date in response to changes in our operating environment, new policy implications and local population needs which are set out in the long-term health and social care plan.

We recognise that to achieve our vision for the future, we need to look ahead and be prepared to make bold and ambitious plans for the coming years. We cannot deliver this strategy in isolation and will work in partnership with others to ensure its effective implementation. This means addressing immediate challenges at the same time as putting in motion longer-term transformational system-wide change that will build the health and care we require for our patients in the future.

3.1 Our Patients

To deliver high quality, safe and responsive patient services, shaped by best practice and our wider communities

Across Lincolnshire, we face a rising demand for health and care services associated with an ageing population and an increasing number of people with multiple co-morbidities and long-term conditions.

We want to ensure that every interaction our staff have with our patients, has a positive impact on our patients' health and well-being and that every ULHT contact, adds value to each patient's experience of the NHS.

Where ill-health does occur, we want to ensure our patients receive high quality, safe and responsive care to achieve the best possible clinical outcomes. Improving quality is a process of continuously evaluating and improving what we do to make services, care and treatments better for all our patients. To deliver this, it is key that all staff are empowered to lead and make improvements in their everyday work and that all performance and outcomes are measured and monitored in a systematic manner.

Patient and user experience is integral to us, all staff working within the Trust have a duty to ensure that those who use our services receive an experience that meets or exceeds their physical and emotional needs and expectations. We know that patient experience is critical to both individual patients and their families, and goes well beyond the health outcomes of their care.

Therefore, we will enhance patient experience by listening to our patients when they share their experience, when they feedback their views and by engaging with them in the co-creation of new developments in our services to ensure their voice is heard and their input is valued.

To support this, the Equality, Diversity and Inclusion and Patient Experience teams are working to firmly embed the voice of the patient throughout the organisation, to address the needs and wants of patients. We are also revising our approach for engaging with our hard to reach, and seldom heard groups, with the establishment of a Health Inequalities Cell.

To support the delivery of high quality and safe care across the organisation, we have selected five areas for targeted efforts; maternity services, medication management, diabetes management (DKA), infection prevention and control (IPC) and Urgent and Emergency care. We will triangulate data from a number of sources, including CQC inspections, internal audits and incidents, to identify improvements.

We are committed to improving discharge and flow across our hospitals, working with system colleagues to enhance patient experience, with specific focus on improved discharge processes. This collaboration will support identification of additional opportunities, aligned to national and local guidnace. This includes delivering services as locally as possible, to support accessibility by providing the right care in the right place, moving from treatment to prevention and self-care and giving patients choice and control over their care through a person centred approach.

When we fall short of the standards we and our patients expect, we will be open, transparent and learn from events and identify where and how we can improve. The management of Diabetic Ketoacidosis (DKA) has been selected as a key improvement area to enhance patient safety by learning from reported incidents and through thorough investigation, identification of themes and improvement opportunities. This will enable the provision of increased support and improved management, of patients admitted to acute care with symptoms of DKA.

Improving the safety of Medicines Management is key to the delivery of harm-free care across the organisation and is aligned to opportunities contained in the 'Developing a Safety Culture' programme. By raising the profile of medication safety, engaging with our clinical teams more effectively and identifying opportunities for improved medication safety we will enhance our ability to provide harm-free care. This will be supported by our ePMA (electronic prescribing and medicine administration) system which is due to launch later in the year.

Year 3 of our Integrated Improvement Plan priorities are described below.

2022/23 Priorities	**By 2025**	**Our Outcomes**
1.1 Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients.	• Improve patient experience • Improve clinical outcomes • Deliver high quality care which is safe, responsive and able to meet the needs of the population	• Improved discharge processes • Patients do not come to harm in our care
1.2 Enhance clinical effectiveness by ensuring that care delivered to patients is based on evidence based, best practice leading to improved clinical outcomes.		

1.3 Enhance patient safety by learning from incidents, specifically:- • Maternity Services (Personalised Care) • Medication Management • Diabetes Management (DKA) • Infection Prevention and Control • Urgent and emergency care		• Patients receive high quality, safe care

3.2 Our People

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

Like the wider NHS, ULHT faces a number of pressing workforce challenges and this is compounded rural and remote communities we serve and we have difficulty attracting doctors, nurses and other allied health professionals.

High workload (and its impact on work-life balance) and financial pressures have led to a decline in our staff engagement in recent years. Without an engaged team, we will struggle to achieve our ambitions. We are in the bottom quartile of Trusts for agency staff spend and at the end of 2021/22 our staff turnover was 13.96%. Our organisational scores for three of the People Promise elements (described below) are also the worst for acute /acute community trusts in 2021.

- 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*

Our scores for Staff Engagement and Morale themes, are also classified as the 'worst' in 2021 for acute/acute community Trusts, and both have declined (albeit very slightly) since 2020. A further point for note is the scores for both themes have remained more or less static since 2017. 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 to better understand the context of this year's results and any further issues.

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.

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.

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, Safe Culture and EDI overlap with leadership, and all contribute to safe patient care. This will also limit duplication of effort and foster better team working.

We want to redouble our efforts to reduce discrimination, violence, bullying and harassment and continue to embed equality and diversity in all that we do. The connection between a highly-engaged workforce and improved patient outcomes is well documented and it's no surprise that a more satisfied workforce leads to better patient experience. Our culture isn't static and is nurtured by our values and behaviours, the role-modelling by our leaders and through the many activities that together create an engaged workforce and organisation.

Relying only on recruiting more staff will not meet our needs and is not sustainable. We need to create excellent employee experiences and fundamentally change 'how we do things around here', challenging the existing concepts of 'work'. We must build a modern culture where staff feel supported, valued and respected – and want to stay and develop in our organisation. Offering better support to our staff, adopting flexible and smarter ways of working, optimising technology, planning and delivery of capability and capacity, workforce redesign, and working across organisational boundaries are the critical changes that will move us on from traditional approaches to workforce.

Year 3 of our Integrated Improvement Plan priorities are described below.

2022/23 Priorities	**By 2025**	**Our Outcomes**
2.1 Be great place to Work • Quarterly Survey to be 'relaunched' as the main moral barometer, with reviewed comms and process to be completed every Quarter • Tailored question element to be adapted each quarter • Includes Quality, Safe, Recommend care to Friends and family, Place to work metrics • Linked to annual staff survey • Turnover and vacancy rates • 'Just and Learning Culture' embedded for both staff and patients	• A modern and progressive workforce • Making ULHT the best place to work • Well Led services	• An improved benchmark position for vacancy and turnover rates when compared to Peer and National medians • Improved position against all domains of the Staff Survey • Rated CQC Outstanding for Well Led
2.2 Be great place to receive care • WRES/WDES agreed objectives scorecard to be included in Directorate oversight/PRM meetings		
2.3 Quality and Safety is the Organisation's Top Priority and we will be in Top 25% of NHS Acute Organisations for indicators for: • Quality • Safety • Recommend as a place to work • Recommend as a place of care for Friend and Family		

3.3 Our Services

To ensure that services are sustainable, make best use of resources and are supported by technology and delivered from an improved estate

In light of the Covid-19 pandemic, we continue to operate under significant operational pressures. Key areas of focus continue to be around reducing ambulance handover delays at hospitals and in the community and on the timely and safe discharges of patients who no longer require hospital care. As the current pressures ease and our hospitals de-escalate, we are focusing heavily on recovery of our clinical services in order of clinical priority. We want to transform the way we provide elective care; whilst reducing long waits and reducing the risk of harm to our patients. There remain underlying constraints relating to the 'living with COVID' era that make our operating environment complex, together with uncertainty around future demand (COVID demand, referral demand for elective and cancer care and non-elective presentations). The extent to which we may experience surges in demand for patients that have chosen not to access services during the pandemic is not yet known.

Effective financial management flows from relentlessly focusing on service quality. We are committed to using public money responsibly and investing in innovation to improve patient, carer, family and staff experience. We want to optimise quality and efficiency across the entire pathway whilst improving our productivity. Increasing productivity means working more effectively not necessarily harder, reducing waste not sacrificing quality. Throughout 2022/23 there is an ambition to deliver a £25m (3.6%) cost improvement programme (CIP), this is inclusive of providing sufficient headroom to invest in improving services. It is proposed that the Trust establish a 3 year CIP Framework with indicative targets for years 2 and 3. The over-arching CIP framework for 2022/23 will be the same as that established and agreed for 2020/21 but not embedded due to the impact of COVID, incorporating the T's; Transformation, Targeted and Transactional. But with greater oversight and improved reporting and support. The Focus in year 3 will be Cash Releasing Efficiency Savings (CIP). CIP to be focused on 'cost out' unless growth is aligned to Trust plans, agreed with our commissioning partners and supportive of our restoration plans.

CIP will be embedded in the Trust to support delivery of the Integrated Improvement Plan. All parts of the Trust should contribute to CIP and all Directorates and Divisions will receive a minimum CIP target, based on the prior year outturn. Additional CIP stretch targets will be allocated based on the opportunity to improve financial performance. CIP schemes should be aligned to improvement projects and not be seen as an extra burden. Additional investment into the Trust will be constrained by CIP delivery. Furthermore, where the achievement of the minimum CIP target has not been identified, investment reserves will be held to offset shortfall. Gainshare agreements within and outside of the Trust will be utilised to reward identification and delivery of CIP that sit outside of Direct budgets.

Managing our estate effectively will support the delivery of high-quality care at minimum cost, both financially and environmentally. We also recognise that modern fit-for-purpose premises can have a significant positive impact on patient recovery and staff wellbeing. Our aging buildings, particularly at Lincoln and Boston, require significant modernisation to meet required standards, resulting in a a total backlog cost of £68.2m (net build cost). ULHT has a significant level of backlog maintenance with average backlog cost of £433.2/m² (2020/21). The removal of existing Backlog Maintenance (BLM) will result in one-off backlog avoidance savings of c.£37m of the existing £75m shown on Estates return information collection. Based on 6-facet

surveys, the total outturn cost of delivering the £75m BLM is estimated at £275m – of this, the backlog avoidance for this scheme will eradicate £125m in backlog outturn costs.

The Trust estate is a significant component of the Trust's overall cost profile, and with this in mind, the way in which we deliver our services needs to be efficient, and the environment the best possible for staff, patients and their families or carers. We intend to utilise Modern Methods of Construction and other sustainable approaches (e.g. efficiency gains due to reduced travel by staff, patients and visitors) to help ensure progression towards Net Zero Carbon targets.

Rurality of Lincolnshire makes it a challenge for patients to access healthcare services, including a fragmented healthcare delivery system, stretched and diminishing rural health workforce. We want to empower patients with the information and tools to engage in their health care and will explore ways to support enhanced access through the use of health information technology. Digital technology has the potential to transform how we provide services to our patients. We need a fast, reliable, and secure system to support our staff to deliver integrated services of an outstanding quality, with a dynamic foundation that is scalable and future-ready.

During the pandemic, the embraced the opportunity to drive forward digital capabilities for patients and staff. This has included access to virtual clinics using video consultations to support patients to access care from home without the need to attend an acute hospital. With care closer to home being a Lincolnshire ICS priority, further expansion of our digital footprint will be a continued aspiration for the Trust. This includes the development of an Electronic Patient Record (EPR) and expansion of our digital infrastructure to support future implementation of our digital agenda.

One of the biggest challenges for ULHT and the Lincolnshire System has historically been the ability to access external funding due to the way in which digital investment has been prioritised for Trusts/Systems. With changes to the prioritoisation criteria, ULHT are now in a position to actively bid for digital funding and support through the levelling up agenda. This will allow us to progress our ambition to maximise our analytical capabilties to identify trends and understand population health data, and support our approach to reducing the health inequalities within Lincolnshire.

To improve patient experience, we have plans to upgrade our patient entertainment system and continue the use of digital technology to help them keep in touch with their loved ones whilst in hospital.

Year 3 of our Integrated Improvement Plan priorities are described below.

2022/23 Priorities	**By 2025**	**Our Outcomes**
3.1 Improve access for patients by reducing unwarranted variation in service delivery through transformation: • Urgent Care • Planned care • Cancer Care	• Efficient use of our resources • A modern, clean and fit for purpose environment • Enhanced data and digital capability • Improving cancer services access	• Deliver a balanced finance plan with a framework in place to identify targeted improvement schemes • Capital funding secured to deliver Trust strategies, including the Trust Green Plan • Staff will have access to real-time data via electronic systems
3.2 Implement Year 1 of our Estates Strategy		
3.3 Implementing the 22/23 actions of becoming a paper lite digital hospital		

3.4 Collaboratively work to develop an evidence based approach to more efficient services	• Reduce waits for patients who require planned care and diagnostics to constitutional standards	• Patients will be able to access services in timeframes that are safe and responsive

3.4 Our Partners

To work collaboratively with our partners to improve the health and wellbeing of our populations and implement new integrated models

We need to better understand the unique factors impacting health outcomes in rural, remote and coastal communities- the health inequalities challenge facing our communities differs from the challenge faced by more urban populations. Rural areas are also more likely to contain hidden areas of significant deprivation, masked by the way statistics are recorded. Moreover, coastal and rural economies are highly seasonal in nature. Tourism, the hospitality industry, agricultural production, and our fishing industry all influence the ebb and flow of rural and coastal populations.

Increasing our focus on prevention and public health – we have an important role to play in supporting the wider health and wellbeing of the populations we serve and to keep people well in the community. Within Lincolnshire, there is a clear requirement for focussed attention along the East coast, with this area flagging in all domains of deprivation, although there are also pockets within each of the cities across the county. We will therefore work more closely with our ICS partners to identify opportunities to help prevent ill health, building on the understanding of the distinctive health and care needs of rural areas. The Core20PLUS programme has enabled identification of four population groups within Lincolnshire, experiencing poorer-than-average health access, experience and/or outcomes; these are farming and rural, military families, Eastern European communities and temporary residents / travellers. The Quality and Outcomes framework (2020-21) has permitted identification of specific areas for assessment/improvements, which support the clinical focus areas within the Core20 Plus 5 programme, particularly cardiovascular disease, mental health and respiratory. Additionally, the prevalence of chronic kidney disease, diabetes mellitus and obesity are all above national average.

Although unemployment rates in Lincolnshire remain below national average (2.7 vs 2.8), improvements in this area, particularly around education, skills and training would secure a more stable future position, currently Lincolnshire registers 25.5 against a 21.7 average on the education, skills and training deprivation score. Often poverty and unemployment rates are higher in rural areas than in urban and suburban areas. Employers, educational institutions, and community members can work together to increase job skills for residents, and set children on a path towards academic and financial success. Within Lincolnshire, we have a large rural (farming) community which increases employment ratios in these areas, despite them being more sparcely populated. Although employment deprivation is clear on the East coast, the majority of other rural areas don't reflect the same level of employment deprivation as may be seen in other areas nationally.

A strong local economy will support employment opportunities and healthy lifestyle choices for individuals and families, and is also linked to lower rates of poverty and unemployment. We will build on our role as an 'Anchor' organisation working with our local communities and partners to deliver even greater local benefits (e.g. through procurement, supply chains, partnership working, community outreach). We will strengthen our relationship with the University of Lincoln to enhance local employment opportunities through the development of joint strategy with a focus on rural healthcare and medical and nursing education.

We will adopt a more system-focused approach to the design and delivery of services, designed around rural communities and their unique needs and circumstances, ensuring that decisions about any provision of services work within the system as a whole, and that services are delivered in the context of the right patient pathway, location or provider. For example, it might make sense for some of our services to be delivered outside of our hospitals and within the community, in partnership with GP surgeries or by another NHS provider within the region. Our ability to implement new integrated models of care to improve Lincolnshire's health and wellbeing, meet our constitutional standards, and become financially sustainable is crucially dependant on our services working more closely with our ICS partners. This will be a key focus of our clinical strategy, to be developed in 2022/23. We want to be an effective system partner, recognising that the outcomes and impact we can achieve together for our population as a system are greater than any individual organisation can deliver alone.

As part of our 2020-2025 Integrated Improvement Plan, we have an ambition to become a University Teaching Hospital Trust. With this in mind, we are actively working with the University of Lincoln to drive forward plans to attain approved status by 2025. Close links are being forged between the Trust, Lincoln Medical School and our respective Research & Innovation Teams. This ambition will realise a significant progression in the levels of research undertaken within Lincolnshire focusing on rural healthcare, and will provide a collaborative platform to improve clinical outcomes and health inequalities within Lincolnshire.

Year 3 of our Integrated Improvement Plan priorities are described below.

2022/23 Priorities	**By 2025**	**Our Outcomes**
4.1 Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	• Becoming a University Teaching Hospital Trust • Establish collaborative models of care with our partners • Successful delivery of the Acute Services Review and Recovery Support plans	• Leading partner for the ICS and having a positive impact on our population health outcomes and local economy • Grow a culture of R&I • Embed a deeper understanding of our role to reduce health inequalities
4.2 Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative		
4.3 Develop a ULHT clinical service strategy with a focus on fragile services in order to provide sustainable and safe services for the future		

4 Delivering our Strategy

This strategy, and the divisional plans which underpin it, mark an important step forward for our Trust. It identifies the key priorities for the Trust in 22/23, ensuring we are focused on the right things for both our patients and our staff. There is a strong focus on 'getting the basics right' first, whilst also planning for longer-term changes to our services.

We have identified 18 metrics as part of executive score card. We have adopted the following approach to monitor delivery of our 22/23 IIP:

- a deep dive on relevant objectives and actions at relevant Board Committees as described in table below.
- whilst ensuring, at the end of each quarter, we will have a detailed report on the IIP to individual committees and Trust Board, which will focus on the narrative aspects and will describe these within the context of the metrics, highlighting progress and focussing on key actions/mitigations for off track actions.

Objective	Committee
Patients- To deliver high quality, safe and responsive patient services, shaped by best practice and our wider communities	Quality Governance Committee (QGC)
People- To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT	People & Organisational Development (POD)
Services- To ensure that services are sustainable, make best use of resources and are supported by technology and delivered from an improved estate	Finance, Performance & Estates Committee (FPEC)
Partners- To work collaboratively with our partners to improve the health and wellbeing of our populations and implement new integrated models of care	Trust Board People & Organisational Development (POD) Finance, Performance & Estates Commitee (FPEC)

Furthermore, we will monitor delivery of our key focus areas for 22/23 through our outstanding care together programme as described below. Each of these programmes are also contained within our 22/23 IIP.

4.1 Enabling strategies

There are a wide range of key enabling strategies for each strategic objective that will support the delivery of the Trust strategy. All of the enabling strategies are either in development, or being reviewed and published to reflect the vision outlined here and ensure they will help us deliver our objectives. Enabling strategies to support us to achieve our objectives include but are not limited to:

- Quality and Safety Strategy
- Estates Strategy
- Digital Strategy
- People Plan
- Research and Innovation Strategy

4.2 Divisional Integrated Improvement Plan

Having clearly defined Divisional Integrated Improvement Plans is central to delivering the strategic objectives and priorities as set out in the Trust Integrated Improvement Plan.

Each Division will analyse their services and to produce a SWOT (Strengths, Weaknesses, Opportunities and Threats) and to be able to consider key areas of developments and identify areas improvement which will form part of their Divisional Integrated Improvement Plan.

An example of what the Divisional Integrated Improvement Plans will include and what this looks like is shown below.

[Insert Division Here] Integrated Improvement Plan Summary [Insert Year Here]

Patients (max 3 bullet points each box)	People (max 3 bullet points each box)	Services (max 3 bullet points each box)	Partners (max 3 bullet points each box)
1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.

1. Activity and performance [3-5 bullet points]	2. Capacity [3-5 bullet points]

3. Risks and issues [3-5 bullet points]	4. Quality Improvements [3-5 bullet points]

Speciality high risks [>16 score]

ID	Description	Risk score	Mitigating actions

Quality improvements

QI schemes	22/23	23/24	23/24	Enablers

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List of Abbreviations

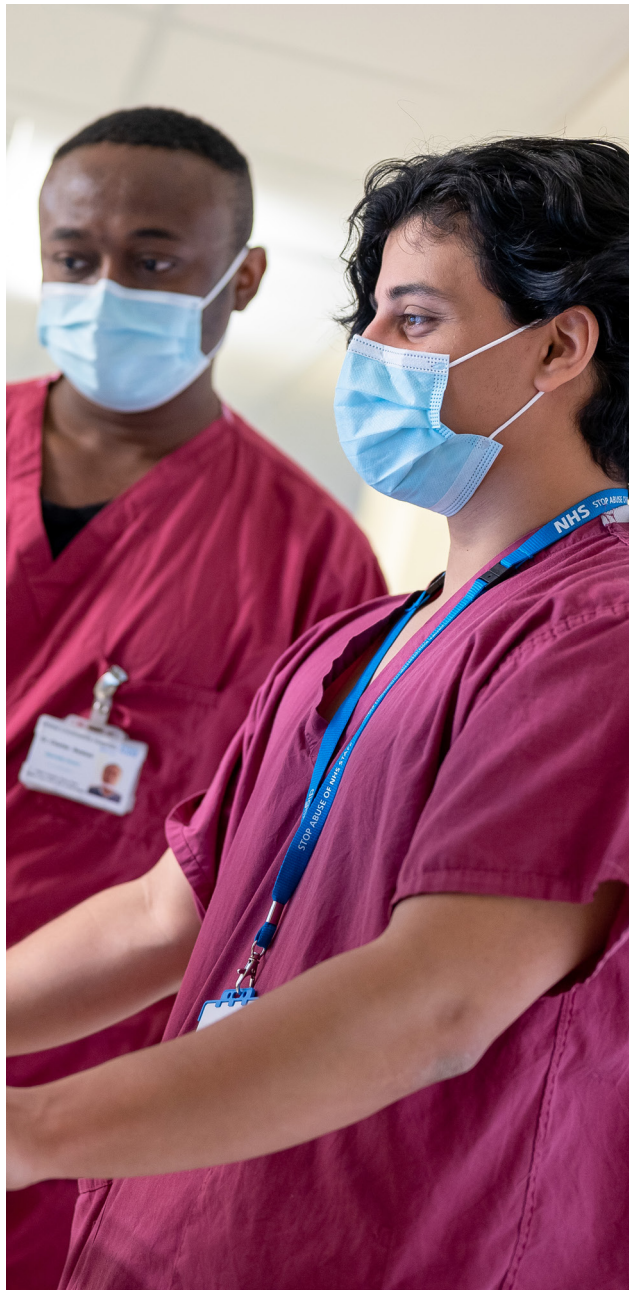
A&E	Accident & Emergency
CCG	Clinical Commissioning Group
CDC	Community Diagnostic Centre
CIP	Cost Improvement Programme
CQC	Care Quality Commission
DTOC	Delayed Transfer of Care
ED	Emergency Department
EDI	Equality, Diveresion and Inclusion
EPR	Electronic Patient Record
EU	European Union
GIRFT	Getting It Right First Time
ICB	Integrated Care Board
ICS	Integrated Care System
ICP	Integrated Care Partnership
IIP	Integrated Improvement Plan
LCHS	Lincolnshire Community Health Services
LHCC	Lincolnshire Health and Care Provider Collaborative
LPFT	Lincolnshire Partnership Foundation Trust
JAG	Joint Advisory Group on Gastrointestinal Endoscopy
PCR	Polymerase Chain Reaction
PESTLE	Political, Economical, Social, Technological, Legal and Environmental
QSIR	Quality, Service Improvement and Redesign
RSP	Recovery Support Programme
RTT	Referral to Treatment
SOF	System Oversight Framework
STP	System Transformation Plan
SWOT	Strengths, Weaknesses, Opportunities, Threats
ULHT	United Lincolnshire Hospitals Trust
UoL	University of Lincoln

NHS
United Lincolnshire Hospitals
NHS Trust

ULHT Integrated Improvement Plan

Our Strategy for 2022/23

Contents



1. INTRODUCTION

In 2020, we launched our five-year Integrated Improvement Plan- our strategic plan to help us move forward as a Trust and ensure we were focusing on the right things for our patients and our staff.

Our plan recognised the considerable time and effort already taken to address some immediate improvements and urgent quality and safety issues, while supporting our ambitions to move to a more comprehensive and planned approach for the future.

As we move into the third year of our plan, we find ourselves operating in a changed environment and in need to refresh our priorities to achieve our vision of Outstanding Care Personally Delivered.

While some of our challenges remain unchanged, including supporting an ageing population in rural and geographically disparate communities, we face significant operational pressures due to increased demand on our services and ongoing recovery from the impact of the COVID-19 pandemic. The organisation also continues to be impacted by workforce challenges, where national staffing shortages contribute to difficulties in recruitment and retention and high agency spend.

The introduction of Lincolnshire Integrated Care System (ICS) in July 2022 will have implications for all of our services and provide opportunities to remodel some services, supporting the delivery of care closer to home, improved self-care and the prevention agenda.

Amidst challenge, there has also been notable improvement. Although our Care Quality Commission (CQC) rating remained at 'Requires Improvement' following the latest inspection in October 2021, CQC inspectors highlighted widespread improvements in many areas, which was even more impressive in light of the COVID backdrop.

2. WHO WE ARE

United Lincolnshire Hospitals NHS Trust (ULHT) provides a comprehensive range of hospital based medical, surgical, paediatric, obstetric and gynaecological services to more than 800,000 people across Lincolnshire. We operate across four hospital sites and deliver services in a range of other settings, employing around 7,800 staff.

We have an annual income £643m (2020/21). At the end of the financial year 2021/22, the Trust reported a year-end surplus of £1,840k and fully delivered the capital programme of £45.7m. This is a huge achievement by everyone in the Trust.

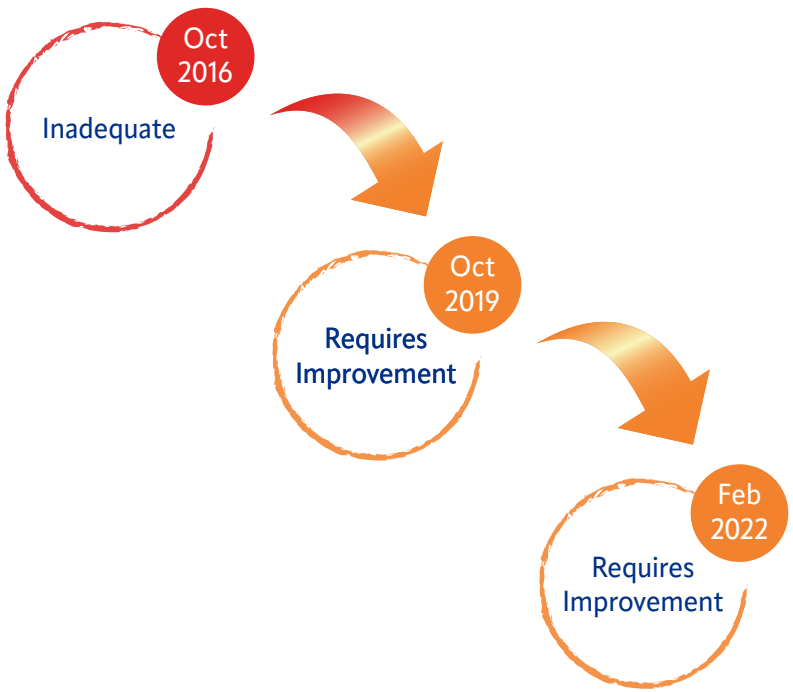
Following significant progress and improvements in recent years, it was confirmed in March 2022 that the Trust was to be moved out of segment 4 and into segment 3 of the NHS System Oversight Framework (SOF).

This meant the Trust exited the Recovery Support Programme (formerly 'Special Measures'). The SOF requires Trusts and Integrated Care Systems (ICSs) to be evaluated and placed into one of four segments. Those organisations placed in segments 3 and 4 receive mandated support from NHS England and NHS Improvement through the nationally co-ordinated Recovery Support Programme.

Whilst the progress and improvements made have been recognised at a Trust level, there remains a need to further improve services as we move into a functioning ICS, and develop other collaborative working relationships with partner organisations in Lincolnshire.

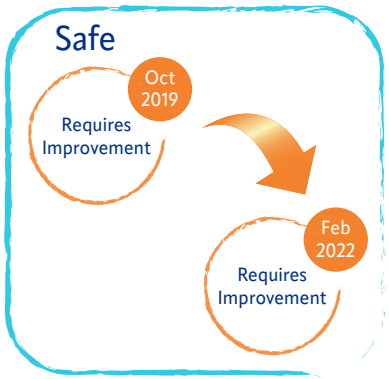
The Lincolnshire ICS has been placed into segment 4 meaning it receives mandated support and is part of the RSP.

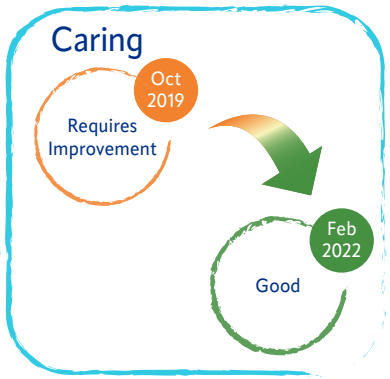
Overall CQC rating

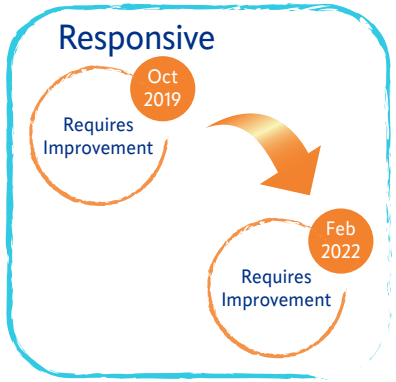


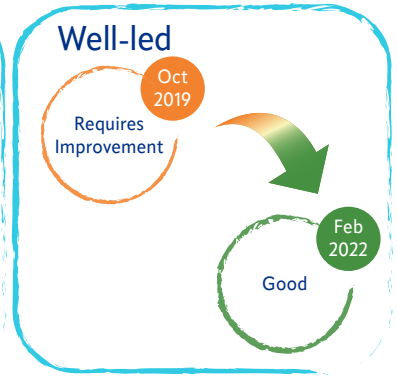
CQC inspectors also recognised improvements at our Trust during visits in October and November 2021. The CQC highlighted the significant and widespread improvements in the safety and quality of the services in the Trust in the report published in February 2022. The CQC commented that this was particularly impressive against the COVID backdrop. Positive comments were also made about the Trust having a strong cohesive team with collective leadership at Board level. Whilst widespread improvements have been made there was an acknowledgement that the Trust needs to improve access and flow in the A&E department at Lincoln County Hospital and also improve waiting times and the arrangements to admit, treat and discharge patients.

The Trust's overall CQC rating of 'Requires Improvement' remained the same due to not all sites and all services being inspected.









3. OUR VISION

We have a vision and five key values which demonstrate what we stand for, how we want to be known and how we behave. Our Integrated Improvement Plan sets out our vision for the future and how we will get there.

We can all help to grow our Trust

By 2025 we want to achieve 'Outstanding Care Personally Delivered' by improving the quality of care and experience for our patients and the wellbeing of our staff

by living our values

- Patient centred
- Respect
- Excellence
- Safety
- Compassion

and by delivering our strategic objectives

For our patients
High quality, safe and responsive services, shaped by best practice and our wider communities

For our people
Our people to lead, work differently and feel valued, motivated and proud

For our services
Sustainable services making best use of resources, technology and estate

For our partners
Improve the health of our populations by implementing integrated models of care

4. THREE KEY FOCUS AREAS

Underpinning the ambition in each of the strategic objectives, we have identified priorities, which will help to monitor our progress. Each year detailed actions will be created for the current year priorities, which will form the basis of the Trust's Annual Plan.

Our three key focus areas for 2022/23 are to:

1. Continue improvements in patient safety and experience
2. Reduce long waiting times for treatment
3. Make our people feel valued and supported by improving our culture and leadership

Each of our core clinical divisions, Medicine, Surgery, Family Health and Clinical Support, will also have a divisional Integrated Improvement Plan which focuses on their area's key priorities for the year aligned to the organisational strategy and plans.

Continue improvements in patient safety and experience

Reduce long waiting times for treatment

Make our people feel valued and supported by improving our culture and leadership

5. PRIORITIES FOR OUR PATIENTS

By 2025, we will deliver high quality, safe and responsive patient services, shaped by best practice and our wider communities.

We will:

- improve patient experience
- improve clinical outcomes
- deliver high quality care which is safe, responsive and able to meet the needs of the population.

What this will look like:

- We will have improved discharge processes
- Patients will not come to harm in our care
- Patients will receive high quality, safe care

In 2022/23, we will:

- enhance patient experience by learning from patient feedback and demonstrating our values when delivering care, specifically focusing on when patients are discharged
- ensure that care delivered to patients is based on evidence and best practice, leading to improved clinical outcomes
- improve patient safety by learning from incidents, focusing on personalised care in maternity services, medication management, diabetes management (DKA), infection prevention and control and urgent and emergency care

6. PRIORITIES FOR OUR PEOPLE

By 2025, we will enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT.

We will:

- have a modern and progressive workforce
- make ULHT the best place to work
- have well led services

What this will look like:

- We will have an improved benchmark position for vacancy and turnover rates when compared to peer and national medians
- We will have an improved position in all domains of the national NHS Staff Survey
- We will be rated Outstanding for Well Led by the Care Quality Commission

In 2022/23, we will:

- make UHLT a great place to work
  - listening to our staff and improving engagement, measured through a quarterly survey and linked to other recognised initiatives including the national staff survey and safety and quality measures.
  - improving turnover and vacancy rates
  - embedding a 'Just and Learning Culture' for both staff and patients
- make UHLT a great place to receive care by establishing race and disability standards (WRES/WDES) objective scorecards in Directorate oversight/PRM meetings
- make quality and safety the organisation's top priority and be recognised in the top 25% of NHS acute organisations for indicators relating to quality, safety, as a recommended place to work and as a recommended place for friends and family to receive care

7. PRIORITIES FOR OUR SERVICES

By 2025, our services will be sustainable and make best use of resources, while being supported by technology and delivered from an improved estate.

We will:

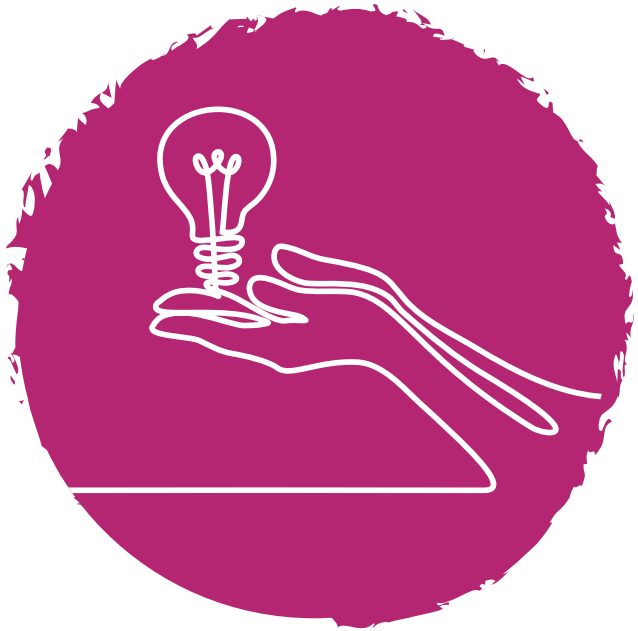
- make efficient use of our resources
- have a modern, clean and fit for purpose environment
- have enhanced data and digital capability
- improve access to cancer services
- reduce waiting times for patients who need planned care and diagnostics to constitutional standards

What this looks like:

- deliver a balanced finance plan with a framework in place to identify targeted improvement schemes
- secure capital funding to deliver Trust strategies, including the Trust Green Plan
- our staff will have access to real-time data via electronic systems
- our patients will be able to access services in timeframes that are safe and responsive

In 2022/23, we will:

- improve access for patients by reducing unwarranted variation in the services they receive, focusing on urgent care, planned care and cancer care
- implement Year 1 of our Estates Strategy
- continue to work towards becoming a paper lite digital hospital
- work collaboratively with others to develop an evidence-based approach to making our services more efficient and productive



8. PRIORITIES FOR OUR PARTNERS

By 2025, we will work collaboratively with our partners to improve the health and wellbeing of our populations and implement new integrated models of care.

By 2025, we will:

- Become a University Teaching Hospital Trust
- Have established collaborative models of care with our partners
- Have successfully delivered the Acute Services Review and our recovery support plans

What this looks like:

- We will be a leading partner for the ICS and be making a positive impact on our population health outcomes and the local economy
- We will be growing a culture of research and innovation
- We will have embed a deeper understanding of our role to reduce health inequalities

In 2022/23, we will:

- develop a strong professional relationship with the University of Lincoln and the Medical School, jointly creating a strategy to focus on developing rural healthcare, education and other healthcare roles
- lead the Lincolnshire ICS and Provider Collaborative as an 'anchor institution' and play an increasing leadership role within the East Midlands Acute Services Collaborative
- develop a ULHT clinical service strategy with a focus on fragile services to provide sustainable and safe services for the future

9. DELIVERING OUR STRATEGY

This strategy, and the divisional plans which underpin it, mark an important step forward for our Trust. It identifies the key priorities for the Trust in 2022/23, ensuring we are focused on the right things for both our patients and our staff. There is a strong focus on 'getting the basics right' first, whilst also planning for longer-term changes to our services.

To monitor our progress, we have identified 18 metrics as part of an executive score card. The Trust will undertake a deep dive on relevant objectives and actions at relevant Board Committees, whilst ensuring, at the end of each quarter, we will have a detailed report on the Integrated Improvement Plan to individual committees and Trust Board to provide further assurance.

Furthermore, we will monitor delivery of our key focus areas for 2022/23 through our Outstanding Care Together programme. This includes dedicated work programmes for quality and safety, maternity, recovery and improvement, as well as our Leading Together Forum and culture programme.

United Lincolnshire Hospitals NHS Trust
Lincoln County Hospital
Greetwell Road
Lincoln
Lincolnshire
LN2 5QY

www.ulh.nhs.uk

We can all help to grow our Trust

By 2025 we want to achieve 'Outstanding Care Personally Delivered' by improving the quality of care and experience for our patients and the wellbeing of our staff

by living our values

Patient centred

Respect

Excellence

Safety

Compassion

and by delivering our strategic objectives

For our patients
High quality, safe and responsive services, shaped by best practice and our wider communities

For our people
Our people to lead, work differently and feel valued, motivated and proud

For our services
Sustainable services making best use of resources, technology and estate

For our partners
Improve the health of our populations by implementing integrated models of care

Our key focus areas in 2022/23 are:

Continue improvements in patient safety and experience

Reduce long waiting times for treatment

Make our people feel valued and supported by improving our culture and leadership

Priorities for our patients

By 2025, we will deliver high quality, safe and responsive patient services, shaped by best practice and our wider communities.

In 2022/23, we will:

- enhance patient experience by learning from patient feedback and demonstrating our values when delivering care, specifically focusing on when patients are discharged
- ensure that care delivered to patients is based on evidence and best practice, leading to improved clinical outcomes
- improve patient safety by learning from incidents, focusing on personalised care in maternity services, medication management, diabetes management (DKA), infection prevention and control and urgent and emergency care

Priorities for our people

By 2025, we will enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT.

In 2022/23, we will:

- make UHLT a great place to work
  - listening to our staff and improving engagement, measured through a quarterly survey and linked to other recognised initiatives including the national staff survey and safety and quality measures.
  - improving turnover and vacancy rates
  - embedding a 'Just and Learning Culture' for both staff and patients
- make UHLT a great place to receive care by establishing race and disability standards (WRES/WDES) objective scorecards in Directorate oversight/PRM meetings
- make quality and safety the organisation's top priority and be recognised in the top 25% of NHS acute organisations for indicators relating to quality, safety, as a recommended place to work and as a recommended place for friends and family to receive care

Priorities for our partners

By 2025, we will work collaboratively with our partners to improve the health and wellbeing of our populations and implement new integrated models of care.

In 2022/23, we will:

- develop a strong professional relationship with the University of Lincoln and the Medical School, jointly creating a strategy to focus on developing rural healthcare, education and other healthcare roles
- lead the Lincolnshire ICS and Provider Collaborative as an 'anchor institution' and play an increasing leadership role within the East Midlands Acute Services Collaborative
- develop a ULHT clinical service strategy with a focus on fragile services to provide sustainable and safe services for the future

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OUR STRATEGY

Year 3 of our Integrated Improvement Plan

United Lincolnshire Hospitals
NHS Trust

What this means for our patients

Our Integrated Improvement Plan is our Trust's strategy for the future. It explains how we will achieve 'Outstanding Care Personally Delivered' by improving the quality of care and experience for our patients and the wellbeing of our staff.

Our key focus areas in 2022/23 are to:

Continue improvements in patient safety and experience

We will treat you with kindness and compassion

We will keep you safe in our care

We will be honest with you if we make mistakes

Reduce long waiting times for treatment

We will see you quicker if you come to us in an emergency

We will explore how we can deliver planned surgeries differently

We will use technology to support you to access services easier

Make our people feel valued and supported by improving our culture and leadership

We will listen to you

We will care for you

We will support you and keep you healthy, independent and at home

OUTSTANDING CARE
personally DELIVERED

OUR STRATEGY

Year 3 of our Integrated Improvement Plan

NHS
United Lincolnshire Hospitals
NHS Trust

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Our key focus areas in 2022/23 are:

Continue improvements in patient safety and experience

You will be treated with kindness and respect

You will have the right people on your team to provide outstanding care

You will help to improve safety by learning from mistakes

Reduce long waiting times for treatment

You will have access to the latest technology to deliver care

You will be given the right tools to make our records digital

You will have a say in how services develop

Make our people feel valued and supported by improving our culture and leadership

You will feel safe to raise concerns

You will not be bullied, harassed or discriminated against

You will be supported in your wellbeing and professional development

OUTSTANDING CARE
personally DELIVERED

OUR STRATEGY

Year 3 of our Integrated Improvement Plan

NHS
United Lincolnshire Hospitals
NHS Trust

What this means for our services

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Our key focus areas in 2022/23 are:

Continue improvements in patient safety and experience

We will meet our statutory health and safety duties

We will invest in services responsibly

We will upgrade our buildings to become modern and suitable places of care

Reduce long waiting times for treatment

We will develop fast, reliable and secure digital systems

We will make sure patients get the same high standard of service no matter where they live

We will support our services to continue to recover from the impact of the COVID-19 pandemic

Make our people feel valued and supported by improving our culture and leadership

We will enable our people to provide the outstanding care they aspire to

We will give our people access to the digital tools they need

We will involve our people as we develop sustainable services

OUTSTANDING CARE
personally DELIVERED

OUR STRATEGY

Year 3 of our Integrated Improvement Plan

United Lincolnshire Hospitals
NHS Trust

What this means for our partners

Our Integrated Improvement Plan is our Trust's strategy for the future. It explains how we will achieve 'Outstanding Care Personally Delivered' by improving the quality of care and experience for our patients and the wellbeing of our staff.

Our key focus areas in 2022/23 are to:

Continue improvements in patient safety and experience

We will better understand our communities

We will be proactive to prevent ill health

We will reduce healthcare inequalities

Reduce long waiting times for treatment

We will design services together

We will deliver services in the right place

We will make decisions as an integrated healthcare system

Make our people feel valued and supported by improving our culture and leadership

We will develop healthcare education

We will drive plans to becomea University Teaching Hospital

We will enhance local employment opportunities

OUTSTANDING CARE
personally DELIVERED

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	24 May 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 Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
	Assurance in respect of SO 1a Issue: Deliver harm free care **Clinical Harm Oversight Group Upward Report** The Committee received the upward report. The Committee noted that as part of the plan to review groups of patients which could be excluded from the harm review process those patients who were subject to a Medical Examiner review were agreed for exclusion. Further exclusions would be considered by the Group in June. The Committee sought assurance that the ME review would cover those areas required for the harm review and this assurance was provided by the Medical Director. It was noted that the increasing volume of reviews required different solutions and these were being considered. The Group made no specific escalations to the Committee. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the upward report with a high level of assurance noting that there had been 2 cases of MRSA in the year April 2021 to March 2022, and 59 cases of C. difficile against a trajectory of 70. During April 2022 there had been no cases of MRSA and 4 cases of C. difficile. The Trust remained on trajectory. The Committee noted the lower overall incidence of covid 19 infections resulting in fewer nosocomial cases and outbreaks, and reduced staff absences. The Committee were advised of the NHS England/Improvement IPC visit which had taken place. Verbal feedback had indicated a move to a Green

	rating for the Trust. Formal feedback was awaited. The Trust had seen significant improvement in non-inpatient areas. A full revisit was planned in September. The Committee received the IPC Covid 19 BAF and noted that this had an improved level of compliance. The Committee agreed that this should be highlighted to the Board with the full BAF available to Board members for information. **Maternity and Neonatal Oversight Group Upward Report inc. Ockenden Report** The Committee received the upward report appended with the output of a benchmarking exercise against the recommendations from the second Ockenden Report. The Committee were advised that there were some areas where the Trust was not compliant which was consistent with the regional and national picture, and that further guidance was awaited in some areas. The Committee were advised that the application for the Trust to exit the Maternity Safety Support Programme was being prepared. The Non Executive Maternity Safety Champion updated the Committee acknowledging some of the specific estates challenges faced by the Trust The Committee received appended to the upward report the submission to achieve Midwifery Continuity of Carer as the default model of care. This came with a required staffing uplift and was supported by the Committee in accordance with national guidance. The submission would be appended to the upward report form the Committee to Trust Board, noting that national submission was required by 15 June 2022. **Nursing Midwifery and AHP Advisory Forum Upward Report** The Committee noted that this Group had not met in May. **Medicines Management Task and Finish Group** The Committee noted that this Group had not met in May. The Committee asked for assurance that momentum had not been lost with the actions required in respect of Medicines Management. The Medical Director confirmed that a new Project Lead had been appointed. **Patient Safety Group Upward Report** The Committee received the upward report. The Group also presented the Theatre Safety Group exception report to provide an understanding of the focus of the Group and the lessons learnt. The Committee agreed that this supported the assurances provided and agreed to review quarterly. **Serious Incident Summary Report** The Committee received the report noting the number of SIs and overdue actions in month.

	The Director of Nursing advised the Committee that the Trust had reported one Never Event in April and a further Never Event in May. Any themes identified were reported in the CLIPs report. **High Profile Cases** The Committee received the report noting the content. The Committee noted that an external review had been commissioned focussed on decontamination. **Safeguarding Report** The Deputy Director of Safeguarding joined the meeting to present the update. The Committee were updated on the remaining Child Protection Information Sharing System actions which were red rated and the mitigations in place. The Committee were advised that the Local Safeguarding Children's Board had been asked to comment on safeguarding processes through their input to the safeguarding Annual Report. **Mortality Report** The Committee received the Mortality Report and noted the improvement and good benchmarking outcomes, and agreed to receive the report quarterly at its meetings going forward.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Duty of Candour update** The Committee noted the figures in the report and were provided with a verbal update on the latest data which showed improved positions for both verbal and written duty of candour. Work continued to support the divisions to improve the position further. It was agreed that the procedure was not yet embedded and the focus would remain until the numbers reduced to a manageable level. **Patient Experience Group Upward Report** The Committee received the report from the Group, noting that appointment processes and letter to patients had been highlighted and would feature in the outpatient transformation work. **Complaints Report** The Committee received the quarterly complaints report. It was noted that numbers were increasing but themes from complaints remained consistent. **Mixed Sex Accommodation Assurance Report** The Committee received the Mixed Sex Accommodation Assurance Report. It was noted that covid pathways had adversely impacted on how mixed sex breaches were managed. The pathway for UEC was highlighted

	as an area where the pandemic had normalised alternative practices and these needed to be reversed. The Committee noted that the Patient Experience Group would be monitoring on a monthly basis.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report, Confidential Enquiries and Clinical Audit Outliers** The Committee received the upward report which detailed the results of clinical records and consent audits which had taken place. The Committee noted that an internal audit review of the clinical audit programme and process had resulted in significant assurance. The Committee were pleased to see the improved assurances being presented from the Group and the considerable work which had gone in to strengthening its functioning. **NICE Guidance Baseline Assessment Q4** The Committee were advised of the position in assessing 253 relevant NICE guidelines and the Trust compliance with embedding actions. 129 assessments were fully completed with actions completed. The other actions were either in train or the assessment was ongoing. This was an improved position to report.
	Assurance in respect of other areas: **Savile Action Plan Quarterly Update** The Committee received the quarterly update against actions from the Savile Report which had been revisited by the Committee. The continued achievement of the actions was noted and there were no red ratings. The Committee noted that the action plan was also considered at the People and OD Committee because of the actions relating to DBS checks for staff. **Human Tissue Authority Inspection** The Medical Director advised that verbal feedback had been given to the Trust following the visits. This would be followed with a formal report which would be shared with Trust Board in early June. The Committee noted that no individual major issues had been identified but that a number of minor issues had been highlighted by the review. Actions would be considered and a plan put in place promptly and a task and finish group had been established to give oversight. **Performance Management Update** The Committee noted the ongoing changes to the PRM process and

	framework linked to the IIP. **Actions arising from CQC Inspection** The Committee received the monthly update in respect of actions arising from the CQC inspection noting that in addition to this an overall report would be received by the Committee on a quarterly basis. The Committee noted the monthly assurance meetings with the divisions, led by the Director of Nursing and Medical Director, to hold to account and support areas to deliver necessary actions. **Report on Clinical Governance Review** The Committee noted the closure of the 61 recommendations from the review. 18 new recommendations would become business as usual for the Committee.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee noted the risk register and the addition of a risk in relation to Falls from the confirm and challenge process.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. The Committee agreed that Objective 1c Improve Clinical Outcomes should improve to Green rating.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	J	J	A	S	O	N	D	J	F	M	A	M
Elizabeth Libiszewski Non-Executive Director	X	X	X	X	A	X	X					
Chris Gibson Non-Executive Director	X	X	X	A	X	X	X	X	X	X	X	X
Alison Dickinson Non-Executive Director								X				
Sarah Dunnett Non-Executive Director (Maternity Safety Champion)	X	X	X	A	X	X	A		X	X	X	X
Neill Hepburn Medical Director	X	X										

Karen Dunderdale Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Simon Evans Chief Operating Officer	D	D	D	D	D	X	D	D	X	D	X	D
Colin Farquharson Medical Director			X	X	X	A	X	X	X	X	X	X

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

Infection Prevention and Control COVID-19 Board Assurance Framework: C1501 Version 1.8

May 2022 Progress Update

Overview:

- National COVID-19 Infection Prevention and Control Board Assurance Framework (BAF) documents produced on 4 May 2020 (V1.6) and 24 December 2021 describe the key lines of enquiry, local systems and processes to be in place as well as national and the local supporting guidance Lincolnshire ICS Infection prevention and control principles adapted from Midlands – next steps principles and options for infection prevention and control and related activities in healthcare setting to accommodate living with COVID-19 (Draft: Version 6: 22 April 2022)
- Local risk assessments are based on the measures as prioritised in the hierarchy of controls
- The tool has been developed to provide Trust-wide assurance and document compliance with UKSHA and other COVID-19 related infection prevention and control (IPC) guidance as well as identifying the risks to maintaining quality standards
- The ULHT BAF is presented to the Quality Governance Committee as a sub-group of the Trust Board
- Quarterly monitoring is via the Infection Prevention and Control Group (IPCG).

Executive Summary:

- ULHT has a wide range of systems, policies and procedures in place to prevent and reduce the COVID-19 risks posed to patients, visitors and staff
- Where there are gaps in assurance data, plans to address them are described within the BAF
- Nosocomial transmission and outbreaks have occurred at the Lincoln and Boston sites. Where these occur they are reviewed and the management is overseen by the Outbreak Cell. The challenges of poor environmental infrastructure are a concern
- COVID audits undertaken on every ward and completion of the Ward Assurance Log, provide assurance with basic IPC, personal protective equipment (PPE) and social distancing practice. In the event of an outbreak in an area the audit frequency is increased. Audit data and the ward assurance logs are reviewed with confirm and challenge taking place
- Continual access to nationally recommended PPE
- Maintenance of very good standards of PPE, social distancing and hygiene
- Significant risks related to high bed occupancy, building design, poor ventilation and limited single isolation rooms
- Continuous review of practice and learning from transmission events to enable improvement
- High compliance with staff COVID vaccination programme.

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users					
	Key Lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
1(a)	A respiratory season/winter plan is in place: • that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services • to enable appropriate segregation of cases depending on the pathogen • plan for and manage increasing case numbers where they occur • a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan	**Assured ↔**	Systems and processes in place to achieve a comprehensive plan for the respiratory season/winter. Includes designated wards and POCT. Cases as per pathogen are segregated or cohorted. Robust plans to manage an increase in cases are risk assessed to balance capacity and IPC. Very good multidisciplinary working with forums to provide discussion and forward thinking plans of action	Insufficient isolation rooms to meet capacity requirements across all sites	Risk assessed use of single room accommodation and implementation of cohorting in bays with doors as escalation dictates
1(b)	Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone	**Assured ↔**	In place across the sites and evidenced by audit data. Maximum occupancy signage in situ	Some staff rooms and office accommodation support limited occupancy	Staggered break times and the use of other adjacent accommodation as well as working from home arrangements instigated as applicable

1(c)	Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: • based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area • applied in order and include elimination; substitution, engineering, administration and PPE/RPE • communicated to staff	**Assured ↑**	Good assessment of risk processes and work progressing to base on the measures prioritised in the hierarchy of controls	Work to continue to align to the hierarchy of controls process	Current assessments of risk in the context of managing seasonal respiratory infectious agents provide a good level of assurance with monitoring by the IPC Group (IPCG)
1(d)	Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems	**Assured ↔**	Good governance and risk based processes evidenced by documentation are in place to achieve safe systems of working	No gaps in assurance identified	No mitigating actions identified
1(e)	If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems	**Assured ↔**	High level of compliance with national guidance that evidenced via a range of documentation and audit processes Isolation of contacts reduced from 14 to 10-14 days and was the subject of a risk assessment, approval by Gold and monitoring via the IPCG Communicated to the relevant external partners	No gaps in assurance identified	Monitoring has not identified increased risk and national guidance in January 2022 decreased the requirement of contacts to isolate from 14 to 10 days **May 22:** Progression of Lincolnshire ICS IPC principles (April 22)
1(f)	Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and	**Assured ↔**	To promote a workable and streamlined approach, risk-	No gaps in assurance identified	No mitigating actions identified

	experience to be able to recognise the hazards associated with respiratory infectious agents		based hazards are assessed via an audit approach. This provides a good range of Divisional progress and exception data		
1(g)	If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered	**Assured ↔**	The extended use of RPE introduced by an assessment of risk approach to areas such as COVID and respiratory wards as well as accident and emergency and assessment units	No gaps in assurance identified	No mitigating actions identified
1(h)	Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services	**Assured ↔**	Dedicated COVID wards at Lincoln and Boston sites. Project Salus supports the risk based care of patients within the most appropriate speciality setting to mitigate the need for transfer between care areas	No gaps in assurance identified	No mitigating actions identified
1(i)	The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sit rep. in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	**Assured ↔**	Daily sit rep provides a good level of IPC related detail with oversight by the Executive Team who reiterate and support via weekly pan-organisation communications	No gaps in assurance identified	No mitigating actions identified
1 (j)	There are check and challenge opportunities by the executive / senior leadership teams of IPC practice in both clinical and non- clinical areas	**Assured ↔**	Undertaken by audit, walkabouts with assurance and monitoring by the monthly IPCG and upward reporting to the Quality Governance Committee (QGC). Good Divisional	No gaps in assurance identified	No mitigating actions identified

			accountability and engagement		
1(k)	Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors)	**Assured ↔**	Robust audit processes in place to gain assurance of the required standards. Progress and exception reporting to the IPC with upward reporting to the QGC	No gaps in assurance identified	No mitigating actions identified
1(l)	The application of IPC practices within this guidance is monitored, e.g.: • hand hygiene • PPE donning and doffing training • cleaning and decontamination	**Assured ↔**	Robust audit processes are in place to gain assurance of the required standards. Progress and exception reporting to the IPC with upward reporting to the QGC	No gaps in assurance identified	No mitigating actions identified
1(m)	The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust Board	**Assured ↔**	Documented evidence of review and BAF development with assurance and monitoring by the IPCG. Upward progress and exception reporting to the QGC and Trust Board as appropriate	No gaps in assurance identified	No mitigating actions identified
1(n)	The Trust Board has oversight of ongoing outbreaks and action plans	**Assured ↔**	Upward report to the QCG and oversight communicated by Director of Nursing/Deputy Chief Executive/Director IPC	No gaps in assurance identified	No mitigating actions identified
1(o)	The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required	**Assured ↔**	Work led by Health and Safety Team has been completed and signed off	No gaps in assurance identified	No mitigating actions identified

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections					
	Key lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
2(a)	The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level	**Assured ↔**	Work led by a Task and Finish Group. Progress made in all areas and directed by the implementation plan. Monthly progress to the IPCG with upward reporting to the QGC	No gaps in assurance identified	No mitigating actions identified
2(b)	The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	**Assured ↔**	Estates and Facilities with support from IPC Team have oversight of changes of area/room function. This would also be identified during the audit process	No gaps in assurance identified	No mitigating actions identified
2(c)	Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment	**Assured ↔**	Cleaning standards and frequencies reviewed and displayed. Presented to and approved by the IPCG. Consistently applied via audit processes and escalation of issues to achieve prompt rectification. Monthly progress and exception to the IPCG	No gaps in assurance identified	No mitigating actions identified

2(d)	Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas	**Assured ↔**	Achieved and monitored by the IPC Cell in relation to outbreaks of COVID	No gaps in assurance identified	No mitigating actions identified
2(e)	Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance	**Assured ↔**	Trust policy and is consistently applied. Evidenced by audit	No gaps in assurance identified	No mitigating actions identified
2(f)	If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses	**Assured ↔**	Hydrogen peroxide total room decontamination is deployed as required and has been approved by the IPC Team	No gaps in assurance identified	No mitigating actions identified
2(g)	Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products	**Assured ↔**	Trust policy and is consistently applied via a SOP and training (Cleaning for Confidence)	No gaps in assurance identified	No mitigating actions identified
2(h)	A minimum of twice daily cleaning of: • patient isolation rooms • cohort areas • donning & doffing areas • 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails • Where there may be higher environmental contamination rates, including • Toilets/commodes particularly if patients have diarrhoea	**Assured ↔**	Trust policy and is consistently applied via a SOP and training. Good level of attention to detail evidenced by auditing and reporting processes	No gaps in assurance identified	No mitigating actions identified
2(i)	A terminal/deep clean of inpatient rooms is carried out: o following resolutions of symptoms and removal of precautions:	**Assured ↔**	Trust policy and is consistently applied via a SOP and training. Good level of attention to	No gaps in assurance identified	No mitigating actions identified

	when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)		detail evidenced by auditing and reporting processes. Deployment of hydrogen peroxide decontamination as appropriate		
2(j)	Reusable non-invasive care equipment is decontaminated: o between each use: • after blood and/or body fluid contamination • at regular predefined intervals as part of an equipment cleaning protocol • before inspection, servicing, or repair equipment	**Assured ↔**	Decontamination processes in place and monitored via audit. A-Z guidance document for the cleaning of clinical equipment by clinical staff. Clean between and "Ring the Bell for Clinell" initiative continues. Overall, good level of compliance, however clinical cleaning does on occasion score lower than cleaning team elements. Work progressing to address with upward reporting to the IPCG	No gaps in assurance identified Clinical cleaning requirements are challenged during an outbreak of COVID	No mitigating actions identified Redeployed staff support
2(k)	Compliance with regular cleaning regimes monitored including that of reusable patient care equipment.	**Assured ↔**	Evidenced by audit and aligned to the National Standards of Healthcare Cleanliness 2021. See above	No gaps in assurance identified	No mitigating actions identified
2(l)	As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance:	**Partial ↔**	Work progressing via the Ventilation Group with upward progress and exception reporting to the IPCG and the QGC	Gaps in assurance identified by the Ventilation Group. Good level of personnel with the required expertise	Prioritisation plan in place with assurance and monitoring by the IPCG and upward reporting to the QGC

	In patient Care Health Building Note 04-01: Adult in-patient facilities				
2(m)	The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer	**Assured ↔**	The required personnel undertake the work with specialist advice. Evidenced by assessment documentation	No gaps in assurance identified	No mitigating actions identified
2(n)	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	**Partial ↔**	Work progressing via the Ventilation Group with upward progress and exception reporting	Ventilation Group has identified gaps in assurance. Good level of personnel with the required expertise	Good level of personnel with the required expertise
2(o)	Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	**Assured ↔**	Undertaken throughout the organisation, minimum of 10 minutes every hour	No gaps in assurance identified	No mitigating actions identified
2(p)	Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group	**Partial ↔**	Some CO2 monitoring is in place with data evidencing < 800ppm	Alternative technologies to be explored via the Ventilation Group	Continuation and development of CO2 monitoring using a risk-based approach, e.g. increased deployment for outbreaks of COVID **May 22:** portable air filtration technology is being explored
2(q)	When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place	**Assured ↔**	Achieved and cleaning schedules are in place and consistently applied	No gaps in assurance identified	No mitigating actions identified

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
	Key Lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
3(a)	Arrangements around antimicrobial stewardship are maintained	**Assured ↔**	Antimicrobial Pharmacists accessibility that is well utilised for antibiotic advice and infection management (for all staff including junior doctors). Out of hours and weekend advice provided by on-call microbiologist following resuming post COVID 5-day working. Increased frequency of antimicrobial requests enhanced by MS Teams as a preferred method Range of key messages communication in place with very good uptake (PGME and pharmacy reminders, newsletters, tweets). Trust wide antibiotic guidelines aligned to NICE guidance. Microguide metrics report indicates continued success with positive end user feedback Successful virtual antimicrobial ward rounds pilot with gradual rollout to other areas.	No gaps in assurance identified	No mitigating actions identified

			Antimicrobial audit programme on track and quality improvement projects are underway Education slots delivered to staff, liaison with educational leads. Multidisciplinary group contributes to the awareness of antimicrobial stewardship		
3(b)	Previous antimicrobial history is considered	**Assured ↔**	Part of tailored patient advice and antimicrobial ward rounds. Guidelines and teaching sessions advise consideration of antimicrobial history. Ward pharmacist review routinely addresses this. Pharmacy Team reconciliation process on patient admission includes specific note of recent antibiotics from GP to enable consideration in current management plan Prescription chart specific antimicrobial pages enable easier view of antimicrobial journey during patient stay	No gaps in assurance identified	No mitigating actions identified
3(c)	The use of antimicrobials is managed and monitored: • to reduce inappropriate prescribing	**Assured ↔**	Ward pharmacists review all antibiotic prescriptions in accordance with guidelines. Tight control of ward antibiotic stock with annual	No gaps in assurance identified	No mitigating actions identified

	• to ensure patients with infections are treated promptly with correct antibiotic		review. Assurance remains concerning the challenge of ward specialism and function changes High-risk sepsis antimicrobials available on all wards, rapid access process in place to ensure supply balanced with a level of restriction to avoid inappropriate use. Annual audit indicates well utilised. Prompt treatment supported by range of resources, e.g. mandated posters Ward rounds audits/QIPs enable prescribers to make appropriate and educated decisions. Sharing of principles with peers. *C. difficile* ward-rounds replaced with IPC/microbiologist advisory calls. Ward Pharmacist medication review and discussion with lead Consultant as required Monthly antimicrobial consumption surveillance reviewed at the Antimicrobial Stewardship Strategy Group (ASSG). Quarterly East Midlands benchmarking		

3(d)	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	**Assured ↔**	Dedicated time for *C. difficile* root-cause analysis (RCA) and period of increased incidence (PII) audit investigations to ensure antimicrobial prescribing input as well as a prompt response. Virtual communications with clinical teams embedded Functioning ASSG with a diverse membership (PGME, electronic prescribing, and Clinical Governance). Reports up to Trust board via Medicines Quality Group. IPCG and DTC sighted on ASSG activity and progress. ICS AMR lead is consultant Antimicrobial Pharmacist. As per NHSEI direction, regular system-wide collaboration and discussions take place and feed in to STP meetings	No gaps in assurance identified	No mitigating actions identified
3(e)	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens	**Assured ↔**	OPAT service benefits include avoidance of HCAIs. Antimicrobial prescribing key performance indicators (KPIs) include stop/review date to deter resistance emerging from unnecessary prolonged	No gaps in assurance identified	No mitigating actions identified

			duration. Teaching, guidelines and tailored advice aimed at reducing spectrum of activity at earliest opportunity. IV to oral switch and other positively received educational sessions via "bite size" video clips Guidelines and tailored advice give careful consideration to antibiotic choices to reduce risk of unintended consequences from other pathogens as well as the antimicrobial drugs		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion					
	Key lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
4(a)	Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	**Assured ↔**	Visiting continues to be undertaken or restricted in line with national guidance and local COVID prevalence. Comprehensive risk-based visiting guidance document implemented at all sites. Every effort made to ensure a compassionate, caring and	No gaps in assurance identified	No mitigating actions identified **May 22:** Controlled visiting has been reintroduced

			rational approach. Very good patient experience lead oversight		
4(b)	National guidance on visiting patients in care settings is implemented	**Assured ↔**	National guidance on visiting is implemented (as a minimum) in conjunction with local requirements, e.g. prevalence	No gaps in assurance identified	No mitigating actions identified
4(c)	Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment	**Assured ↔**	Restricted visiting is implemented as appropriate and also defined by the Project Salus risk categories, e.g. increase to high risk during an outbreak of COVID	No gaps in assurance identified	No mitigating actions identified **May 22:** restricted visiting remains in place during an outbreak of COVID-19
4(d)	There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing	**Assured ↔**	A range of information is clearly displayed across the organisation that is refreshed/updated as required. Project Salus narrative at ward entrances offers an understandable and consistent approach	No gaps in assurance identified	No mitigating actions identified
4(e)	If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM	**Assured ↔**	The risk category of a clinical area will be denoted by written and pictorial information. The wearing of PPE will be advised and supervised by clinical staff	No gaps in assurance identified	No mitigating actions identified
4(f)	Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible	**Assured ↔**	This would be taken on an individual case basis with guidance and support from the IPC Team	No gaps in assurance identified	No mitigating actions identified

4(g)	Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian	**Assured ↔**	This would be taken on an individual case basis with guidance and support from the IPC Team	No gaps in assurance identified	No mitigating actions identified
4(h)	Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted	**Assured ↔**	Elements of the toolkit used to address the barriers to IPC compliance. Initiatives can be evidenced visually across the organisation as well as from regular communications to reiterate and refresh key messages	No gaps in assurance identified	No mitigating actions identified

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people					
	Key lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
5(a)	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival	**Assured ↔**	Signage is displayed at all sites	No gaps in assurance identified	No mitigating actions identified
5(b)	Infection status of the patient is communicated to the receiving organisation, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred	**Assured ↔**	Infection status is communicated and evidenced via patient documentation	No gaps in assurance identified	No mitigating actions identified
5(c)	Staff are aware of agreed template for screening questions to ask	**Assured ↔**	The required screening questions remain in place with documentation to evidence	No gaps in assurance identified	No mitigating actions identified

5(d)	Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment	**Assured ↔**	Pre-admission screening is undertaken and procedure in place if this cannot be undertaken. Evidenced via patient documentation	No gaps in assurance identified	No mitigating actions identified **May 22:** updated screening guidance has been implemented in line with national and Lincolnshire guidance
5(e)	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance	**Assured ↔**	Appropriate triaging is in place and is developed and revised due to capacity requirements and COVID prevalence	ED waiting rooms are at capacity	Increase in lateral flow testing. Evidenced via a SOP
5(f)	Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	**Assured ↔**	Staff are trained and competent	No gaps in assurance identified	No mitigating actions identified
5(g)	There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved	**Assured ↑**	Routine patient testing in line with national and local guidance is advocated	Patient reviews indicate some tests are missed	Testing regimes reiterated and Web V component to be implemented to electronically indicate when a test is due **May 22:** updated screening guidance has been implemented in line with national and Lincolnshire guidance
5(h)	Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated	**Assured ↔**	All patients issued with type 11R surgical facemasks. Exemption processes and associated documentation are in place and evidenced via audit	No gaps in assurance identified	No mitigating actions identified

5(i)	Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result	**Assured ↔**	A patient with respiratory symptoms would be segregated/isolated	No gaps in assurance identified	No mitigating actions identified
5(j)	Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing	**Assured ↔**	These patients would be allocated single room accommodation pending testing result	No gaps in assurance identified	No mitigating actions identified
5(k)	Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered	**Assured ↔**	Designated wards with single room accommodation and prioritisation of single rooms outside of these areas	No gaps in assurance identified	No mitigating actions identified
5(l)	Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes	**Assured ↔**	Instigated across the organisation via a risk-based process with guidance and support from the IPC Team as required	No gaps in assurance identified	No mitigating actions identified
5(m)	Face masks/coverings are worn by staff and patients in all health and care facilities	**Assured ↔**	Good compliance and evidenced via audit processes. Patient exemption assessment and documentation	No gaps in assurance identified	No mitigating actions identified
5(n)	Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance	**Assured ↔**	2m physical distancing continues to be adopted to mitigate risk associated with infrastructure concerns. Single room accommodation used where available. Evidenced via audit data	No gaps in assurance identified	No mitigating actions identified

5(o)	Patients, visitors, and staff can maintain 1 metre or greater social and physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	**Assured ↔**	Physical distancing continues to be in place with overall very good compliance. Evidenced via audit. Visiting restricted or on an appointment basis to achieve the above	No gaps in assurance identified	No mitigating actions identified **May 22:** updated physical distancing guidance is being implemented via a risk-based approach in line with national and Lincolnshire guidance
5(p)	Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	**Assured ↔**	A patient developing symptoms of COVID would be isolated and in patients are tested as per national guidance	No gaps in assurance identified	No mitigating actions identified **May 22:** updated contacts guidance has been implemented in line with national and Lincolnshire guidance
5(q)	Isolation, testing and instigation of contact tracing is achieved for all patients with new onset symptoms, until proven negative	**Assured ↔**	Patients with symptoms would be isolated and tested until proven negative. Very good processes for the identification and monitoring of contacts in line with revised national and local guidance	No gaps in assurance identified	No mitigating actions identified
5(r)	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	**Assured ↔**	Patients are informed via letter not to attend if symptomatic. If they attend with symptoms they would be segregated from others and assessed re the risk of COVID vs clinical need	No gaps in assurance identified	No mitigating actions identified

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection					
	Key lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
6(a)	Appropriate infection prevention education is provided for staff, patients, and visitors	**Assured ↔**	A range of education materials are available that are subject to review and update. Communicated via Intranet, Internet and social media as well as in paper/poster format	No gaps in assurance identified	No mitigating actions identified
6(b)	Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely	**Assured ↔**	Training has been provided throughout the pandemic and has been supplemented by IPC bulletins and other Trust-wide communications	No gaps in assurance identified	No mitigating actions identified
6(c)	All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it	**Assured ↔**	Training has been provided throughout the pandemic and has been supplemented by IPC bulletins and other Trust-wide communications	Requirement to provide enhanced PPE, e.g. FFP3 mask in line with national guidance	Trust-wide communication and fit testing undertaken
6(d)	Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	**Assured ↔**	Compliance with national guidance achieved and evidenced via audit. Prompt rectification of an issue of concern	No gaps in assurance identified	No mitigating actions identified
6(e)	Gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's	**Assured ↔**	SICP's in place across the organisation. Evidenced via audit and Divisional monthly progress	No gaps in assurance identified	No mitigating actions identified

			and exception reporting to the IPCG		
8(f)	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	**Assured ↔**	Appropriately placed paper hand towel dispensers containing a good quality paper towel are in situ across the organisation	No gaps in assurance identified	No mitigating actions identified
6(g)	Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the work place	**Assured ↔**	Good overall levels of compliance. Maximum occupancy signs in situ and some working from home continues to be in place	No gaps in assurance identified	No mitigating actions identified **May 22:** updated physical distancing guidance for office areas is being implemented in line with national and Lincolnshire guidance
6(h)	Staff understand the requirements for uniform laundering where this is not provided for on site	**Assured ↔**	Contained in uniform policy and reiterated by IPC bulletins. Good availability of scrubs at all sites for higher risk COVID environments	No gaps in assurance identified	No mitigating actions identified
6(i)	All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance	**Assured ↔**	Assessment of Risk for Staff who are COVID Positive or a Contact with employee and manager sign off. Data collated by Occupational Health	No gaps in assurance identified	No mitigating actions identified **May 22:** implemented in line with revised national guidance and the discontinuation of Pillar 2 PCR testing from 01/04/22
6(j)	To monitor compliance and reporting for asymptomatic staff testing	**Assured ↔**	Staff undertake at least twice weekly lateral flow testing with Divisional compliance monitoring	No gaps in assurance identified	No mitigating actions identified
6(k)	There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	**Assured ↔**	Programme of surveillance is in place and can be evidenced by data and reports. Assurance and monitoring by the IPCG with upward reporting to the QGC	No gaps in assurance identified	No mitigating actions identified

6(l)	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	**Assured ↔**	Integrated case investigation working with Governance Team. Outbreaks investigation and management via the IPC Cell. Evidenced by reports. Assurance and monitoring by the IPCG with upward reporting to the QGC	No gaps in assurance identified	No mitigating actions identified

7. Provide or secure adequate isolation facilities					
	Key lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
7(a)	That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs	**Assured ↔**	Clear guidance for patient mask wearing and a documented exemption assessment. Evidenced via audit processes. Further Divisional assurance provided, e.g. during an outbreak of COVID	No gaps in assurance identified	No mitigating actions identified
7(b)	Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients	**Assured ↔**	A good range of segregation arrangements continue to be in place, evidenced via audit. Supported by Project Salus	No gaps in assurance identified	No mitigating actions identified **May 22:** updated physical distancing guidance is being implemented via a risk-based approach in line with national and Lincolnshire guidance
7(c)	Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk	**Assured ↔**	The patient's care provided via the Project Salus high-risk pathway. This organisation-wide approach mitigates the risk of the patient not receiving the	No gaps in assurance identified	No mitigating actions identified

	of spread of the virus to other patients/individuals		required level of care due to a transmissible infection		
7(d)	Patients are appropriately placed i.e. infectious patients in isolation or cohorts	**Assured ↔**	Isolation and cohorting arrangements in place and IPC Team support the Operations Team to achieve appropriate patient placement. Very good use of COVID wards to prevent and reduce transmission	No gaps in assurance identified	No mitigating actions identified
7(e)	Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	**Assured ↔**	Ward moves or reconfigurations would instigate an assessment of physical distancing and bed spacing. Staffing Hub has oversight and management of staff to patient ratios. Divisions manage equipment needs to ensure the required amount and good state of repair	No gaps in assurance identified	No mitigating actions identified
7(f)	Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	**Assured ↔**	SIPC's are implemented for all patients and evidenced via audit	No gaps in assurance identified	No mitigating actions identified **May 22:** in line with national and Lincolnshire guidance
7(g)	The principles of SICPs and TBPs continued to be applied when caring for the deceased	**Assured ↔**	SIPC's would continue for a deceased patient as per Trust policy	No gaps in assurance identified	No mitigating actions identified **May 22:** in line with national and Lincolnshire guidance

8. Secure adequate access to laboratory support as appropriate					
	Key lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
8(a)	Testing is undertaken by competent and trained individuals	**Assured ↔**	Relevant staff are trained and deemed competent in testing procedures before undertaking this work. Path Links laboratories have UKAS accreditation. HCPC registered BMS staff are undertaking and overseeing the testing. Full validation and verification has been undertaken. V&V documents, SOPs, training records and manufacturers' information documents are in place	No gaps in assurance identified	No mitigating actions identified
8(b)	Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance	**Assured ↔**	National guidance is followed and there is good compliance with testing for respiratory viruses	No gaps in assurance identified	No mitigating actions identified
8(c)	Staff testing protocols are in place	**Assured ↔**	Occupational Health protocols are in place as well as an Assessment of Risk for Staff who are COVID Positive or a Contact process and documentation	No gaps in assurance identified	No mitigating actions identified **May 22:** implemented in line with revised national guidance and the discontinuation of Pillar 2 PCR testing from 01/04/22. Pillar 1 staff testing if indicated for an outbreak of COVID-19

8(d)	There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time results are available	**Assured ↔**	Monitoring with prompt rectification of any issues of concern	No gaps in assurance identified	No mitigating actions identified
8(e)	There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	**Assured ↔**	Identified cases are tested and reported in line with testing protocols, evidenced via laboratory data	No gaps in assurance identified	No mitigating actions identified
8(f)	Screening for other potential infections takes place	**Assured ↔**	Pre COVID screening remains in place, evidenced via laboratory data	No gaps in assurance identified	No mitigating actions identified
8(g)	All emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission	**Assured ↑**	Emergency patient testing has been revised in line with revised national and local guidance	Assurance has increased due to a streamlined process that has had a positive impact on COVId-19 related patient flow	**May 22:** updated screening guidance has been implemented in line with national and Lincolnshire guidance (09/04/22)
8(h)	That those inpatients who go on to develop symptoms of respiratory infection / COVID-19 after admission are retested at the point symptoms arise	**Assured ↔**	Overall good compliance with this action with advice and guidance from the IPC Team. Evidence would be obtained from a patient's records	No gaps in assurance identified	No mitigating actions identified **May 22:** Updated list of COVID-19 symptoms disseminated in line with national guidance (09/04/22)
8(i)	That all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission and again between 5-7 days post admission	**Assured ↑**	Emergency admissions testing in line with national and local guidance is advocated Patient testing has been revised in line with revised national and local guidance. No longer a requirement to retest unless onset of COVID-19 symptoms (unless vulnerable patient group)	No gaps in assurance identified	**May 22:** updated screening guidance has been implemented in line with national and Lincolnshire guidance. Identification of vulnerable patient groups and updated list of COVID-19 symptoms disseminated (09/04/22)

8(j)	That sites with a high nosocomial rate should consider testing COVID-19 negative patients daily	**Assured ↔**	This is undertaken on an assessment of risk basis	No gaps in assurance identified	No mitigating actions identified
8(k)	That those being discharged to care homes are tested for COVID-19, 48 hours prior to discharge (unless tested positive within previous 90 days) and the result is communicated to receiving organisation prior to discharge	**Assured ↔**	Good compliance and can be evidenced from a patient's records	No gaps in assurance identified	No mitigating actions identified **May 22:** revised guidance to be issued upon receipt of final version of Lincolnshire ICS IPC principles (April 22)
8(l)	Those patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	**Assured ↔**	Trust follows national guidance and initiates good communication with care homes	Some care homes are reluctant to accept a patient back in line with national guidance	Work progressing to look at ways of resolving the issue of concern and escalation to the relevant CCG for their input, management and support **May 22:** revised guidance to be issued upon receipt of final version of Lincolnshire ICS IPC principles (April 22)
8(m)	There is an assessment of the need for a negative PCR and 3-days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of a case suspected / confirmed case of COVID -19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance link	**Assured ↔**	Local assessment of risk utilising the hierarch of control has been updated and is being implemented in line with national and local guidance	No gaps in assurance identified	No mitigating actions identified **May 22:** updated screening and self-isolation guidance is being rolled out as per national and local guidance

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection					
	Key lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
9(a)	The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors)	**Assured ↔**	Evidenced by a comprehensive programme of audit with resources in place. Good Divisional accountability and engagement. Monitoring by the IPCG with upward reporting to the QGC	No gaps in assurance identified	No mitigating actions identified
9(b)	Staff are supported in adhering to all IPC policies, including those for other alert organisms	**Assured ↔**	Trust provides daily updates (SBAR) and the Executive Team host Facebook Live events to provide advice and information to staff. IPC Team continue to support wards and departments to ensure infections are effectively managed. Guidance at a glance implemented. Revised and developed IPC policies compiled and published on Intranet	No gaps in assurance identified	No mitigating actions identified **May 22:** compliance with National IPC manual for England (14/04/22)
9(c)	Safe spaces for staff break areas/changing facilities are provided	**Partial ↔**	Some accommodation availability and size constraints	Adequately sized break rooms are not available across all areas, exacerbated by the maximum occupancy requirements. There is	Divisions are sighted of these concerns and continue to progress actions to mitigate risk. This could be staggering breaks and/or the utilising of other temporary areas

				also limited access to changing facilities in some areas	
9(d)	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak	**Assured ↔**	Outbreak of Infection policy is in place. Oversight by IPC Cell. Investigation and management evidenced by outbreak, timelines, meeting agendas and minutes and summary reports. Monitoring by the IPCG with upward reporting to the QGC	No gaps in assurance identified	No mitigating actions identified
9(e)	Any changes to the UKSHA national guidance on PPE are quickly identified and effectively communicated to staff	**Assured ↔**	Trust has subscribed to the automated UKSHA update system and once notifications are received they are reviewed and escalated to the DIPC and COVID Command. Necessary actions or adjustments are disseminated as soon as practicably possible via the daily SBAR communication to all staff	No gaps in assurance identified	No mitigating actions identified
9(f)	All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	**Assured ↔**	Waste is handled, stored and managed in line with national guidance. This can be evidenced by audit data	No gaps in assurance identified	No mitigating actions identified **May 22:** compliance with National IPC manual for England (14/04/22)
9(g)	PPE stock is appropriately stored and accessible to staff who require it	**Assured ↔**	PPE is stored centrally and controlled by the Trust Procurement Teams. There is a PPE 'hotline' so staff can access PPE stocks at short notice. A daily PPE stock report is produced which includes a tracker for each line item stating	No gaps in assurance identified	No mitigating actions identified

			the number of days stock available		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
	Key lines of Enquiry	**Current Assurance**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Systems and processes are in place to ensure that:				
10(a)	Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	**Assured ↔**	Occupational Health service at all sites with support from IPCT as appropriate. Local policy in place	No gaps in assurance identified	No mitigating actions identified
10(b)	Bank, agency, and locum staff follow the same deployment advice as permanent staff.	**Assured ↔**	The same policy and processes are followed	No gaps in assurance identified	No mitigating actions identified
10(c)	Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	**Assured ↔**	National guidance and directives promptly interpreted into local processes and communicated. Outlined in the Assessment of Risk for Staff who are COVID Positive or a Contact. Adherence to IPC precautions is via an employee and manager sign off	No gaps in assurance identified	No mitigating actions identified **May 22:** implemented in line with revised national guidance and the discontinuation of Pillar 2 PCR testing from 01/04/22. Pillar 1 staff testing if indicated for an outbreak of COVID-19
10(d)	Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE	**Assured ↔**	Overall good level of assurance and can be evidenced via audit processes	Divisions are progressing refresher donning and doffing training and documentation	Monitoring via the IPCG
10(e)	A fit testing programme is in place for those who may need to wear respiratory protection	**Assured ↔**	Fit testing programme led by Health and Safety Team	No gaps in assurance identified	No mitigating actions identified

			supported by Divisional fit testers		
10(f)	Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and absence • facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce • lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 • encourage staff vaccine uptake	**Assured ↔**	Requirements to follow regarding a breach of IPC procedures affecting a member of staff led by Occupational Health with support and guidance from the IPC Team. There is good oversight of the COVID and influenza vaccination programmes as well as encouraging uptake	No gaps in assurance identified	No mitigating actions identified
10(g)	Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance	**Assured ↔**	National guidance and directives promptly interpreted into local processes and communicated. For COVID this is outlined in the Assessment of Risk for Staff who are COVID Positive or a Contact. Adherence to IPC precautions is via an employee and manager sign off	No gaps in assurance identified	No mitigating actions identified
10(h)	A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at risk of complications from respiratory infections such as influenza and severe illness from COVID-19:	**Assured ↔**	Robust risk assessment processes in place. All staff have completed a COVID risk assessment including calculation of COVID age. One to one staff assessment and	No gaps in assurance identified	No mitigating actions identified

	• a discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups • that advice is available to all health and social care staff, including specific advice to those at risk from complications • bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff • a risk assessment is required for health and social care staff at high risk of complications, including pregnant staff		discussion progressed as appropriate. Information located on the Intranet for managers, Human Resources and Occupational Health support and guidance. Wellbeing service available to all staff, including access to counselling. Staff vaccination continues to be implemented in line with JCVI guidance. Deployment advice is for all who work at the Trust		
10(i)	Vaccination and testing policies are in place as advised by occupational health/public health	**Assured ↔**	Required policies are in place with a good level of data to evidence	No gaps in assurance identified	No mitigating actions identified
10(j)	Staff required to wear FFP3 reusable respirators undergo training that is compliant with UKSHA national guidance and a record of this training is maintained	**Assured ↔**	Training is in line with national guidance and can be evidenced by records	No gaps in assurance identified	No mitigating actions identified
10(k)	Staff who carry out fit testing are trained and competent to do so	**Assured ↔**	These members of staff receive the required training and competency assessment	No gaps in assurance identified	No mitigating actions identified
10(l)	All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used	**Assured ↔**	These actions are in place and communicated out	No gaps in assurance identified	No mitigating actions identified
10(m)	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	**Assured ↔**	Led by Health and Safety Team, has been risk assessed with approval and sign off of local	No gaps in assurance identified	No mitigating actions identified

			arrangements to provide a safe and achievable process		
10(n)	A record of the fit testing and result is given to and kept by the trainee and centrally within the organisation	**Assured ↔**	Evidenced via records and summary analysis reports	No gaps in assurance identified	No mitigating actions identified
10(0)	Those who fail the fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods	**Assured ↔**	Evidenced by documented records	No gaps in assurance identified	No mitigating actions identified
10(p)	That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	**Assured ↔**	Availability of suitable alternative equipment, used in accordance with HSE and manufacturers' instructions. Evidenced by documented records	No gaps in assurance identified	No mitigating actions identified
10(q)	Members of staff who fail to be adequately fit tested, a discussion should be had, regarding redeployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	**Assured ↔**	Process in place led by Occupational Health and Human Resources with guidance and support from the IPC Team. Staff member could wear a hood	No gaps in assurance identified	Availability of hoods at all sites
10(r)	A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment recording including Occupational Health	**Assured ↔**	Discussions are documented and communicated to the member of staff as well as being held centrally	No gaps in assurance identified	No mitigating actions identified
10(s)	Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	**Assured ↔**	Evidenced by Board and sub-committee papers and records	No gaps in assurance identified	No mitigating actions identified

10(t)	Consistency in staff allocation should be maintained, reducing movement of staff and crossover of care pathways between planned/ elective care pathways and urgent / emergency care pathways as per national guidance	**Assured ↔**	Led by the organisation-wide Staffing Hub. IPC requirements are integrated. Evidenced by Staff Hub daily reports	No gaps in assurance identified	No mitigating actions identified
10(u)	Health and care settings are COVID-19 secure workplaces as far as practical, that is that any workplace risks(s) are mitigated maximally for everyone	**Assured ↔**	COVID secure health and care settings achieved, supported by the ongoing implementation of the risk-based Project Salus to Current national directives are followed with prompt interpretation to a local level	No gaps in assurance identified	No mitigating actions identified **May 22:** updated physical distancing guidance for office areas is being implemented in line with national and Lincolnshire guidance
10(v)	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	**Assured ↔**	Daily reporting and monitoring of staff absence. Human Resources procedure and process documents in place. Assessment of Risk for Staff who are COVID Positive or a Contact provides the required isolating and testing requirements in line with the current national guidance	No gaps in assurance identified	No mitigating actions identified
10(w)	Staff that test positive have adequate information and support to aid their recovery and return to work.	**Assured ↔**	Assessment of Risk for Staff who are COVID Positive or a Contact provides adequate information in line with the current national guidance. The process includes employee and manager engagement and elements relating to wellbeing	No gaps in assurance identified	No mitigating actions identified

Infection Prevention and Control (NV: DDIPC): May 2022 (revised 16.05.22)

1: WORKFORCE PLANNING AND SUSTAINABILITY		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action – financing a safe maternity workforce The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.					
	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements				HoM LMNS	
	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.				HoM	
	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.					
	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.			Preceptorship programme in place	Preceptorship Team	
	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.			Preceptorship programme in place	Preceptorship Team	
Essential action – training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.				Education team?	
	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.				Education team?	
	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.			Avanced maternity care training available	Education team?	
	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.			Gap analysis required	HoM/DHoM	
	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.					

2: SAFE STAFFING		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.			Review escalation policy	HoM?	
	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	?			Suganthi Joachim Chris Chantry Manju Sant Simon Hallion	
	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.			Job Description?	Inpatient Matrons	
	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.			MCOC Action Plan	Deputy HoM Community Matron, CoC Lead	
	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.			MCOC Action Plan	Deputy HoM Community Matron, CoC Lead	
	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.				Suganthi Joachim Chris Chantry Manju Sant Simon Hallion	
	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.				Education Team	
	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.				Consultant Midwife?	
	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.				Community Matron Inpatient Matrons ANC Matron	
	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.			See also outstanding actions from Kirkup	Suganthi Joachim Chris Chantry Manju Sant Simon Hallion	

3: ESCALATION AND ACCOUNTABILITY		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.				Guideline team Inpatient Matrons Lead Consultant	
	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	??			Suganthi Joachim Chris Chantry Manju Sant Simon Hallion	
	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.				Suganthi Joachim Chris Chantry Manju Sant Simon Hallion	
	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.		Guideline in place			
	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.				Guideline team Inpatient Matrons Lead Consultant	

4: CLINICAL GOVERNANCE - LEADERSHIP		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.		MNOG		HoM Deputy HoM Maternty Safety Champions	
	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.		Review assessment completion		Safety Lead Midwife	
	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.		Bridy Clark, Helen Shelton and Kathryn Helley in post	Need confirmation of Patient Safety Specilaist JD and ?completion of Patient Safety Specialist	Safety Lead Midwife	
	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	?			Suganthi Joachim Chris Chantry Manju Sant Simon Hallion	
	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.				Consultant Midwife?	
	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.				Clinical Lead Audit & Guideline Midwife	
	All maternity services must ensure they have midwifery and obstetric co-leads for audits.				Clinical Lead Audit & Guideline Midwife	

5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATION AND COMPLAINTS		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.				Michael Foreman Paula Izod Matrons	
	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.				Risk Lead Education Team Clinical Lead	
	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.					
	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.					
	All trusts must ensure that complaints which meet SI threshold must be investigated as such.					
	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.					
	Complaints themes and trends must be monitored by the maternity governance team.					

6: LEARNING FROM MATERNAL DEATHS		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings..	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death					
	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.					
	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.					

7: MULTIDISCIPLINARY TRAINING		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.				Education Team Clinical Lead	
	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.				Education Team	
	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.				Education Team LMNS	
	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		Prompt BLS		Education Team	
	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.		PMA Work Afterthoughts		PMAs	
	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.		PROMPT FM Leads Appointed	Evidence of Obstetric FM Lead Rotas required	Education Team / FM Leads	
	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.		Not currently compliant with <90% of staff having completed PROMPT, EFM and NLS		Education Team	

8: COMPLEX ANTENATAL CARE		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.					
	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.		Advert currently out for multiples lead			
	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		ULHT guidelines do not reflect NICE guidelines. Neither guideline curently being followed in terms of timing of birth			
	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.					
	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).					

9: PRETERM BIRTH		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.					
	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		Guideline currently under review			
	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.		PMRT has identifed lack of MDT with NNU			
	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		Place of birth audit in place			

10: LABOUR AND BIRTH		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.					
	Midwifery-led units must complete yearly operational risk assessments.					
	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.					
	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.					
	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.					
	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.					

11: OBSTETRIC ANAESTHESIA		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.					
	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.					
	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC.					
	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance. Obstetric anaesthesia staffing guidance to include: *- The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.* *- The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.* *- The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.* *- Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.*					

12: POSTNATAL CARE		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times.	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.				Inpatient Matrons	
	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.				Inpatient Matrons	
	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.				Inpatient Matrons	
	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.				Inpatient Matrons	

13: BEREAVEMENT CARE		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services**.**	11 Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.			5 day service at present	Bereavement Midwife	
	12 All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.				Clinical Leads	
	13 All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.				Bereavement Midwife	
	14 Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.				Bereavement Midwife	

14: NEONATAL CARE		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.				LMNS ODN HoM NNU Matron	
	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.				NNU Matron	
	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.				Inpatient Matrons NNU Matrons	
	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.				ODN	
	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.				ODN	
	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.				NNU Matron NNU Clinical Leads	
	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.				NNU Education	
	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.				NNU Matron NNU Clinical Leads	

15: SUPPORTING FAMILIES		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.					
	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.					
	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.			PNMHT in place Maternal mental health role also in development	PMHT Mental Health Midwife	

APPENDIX D

Purpose of Report: For Board adoption and subsequent monitoring of a plan to achieve Midwifery Continuity of Carer as the default model of care.

Maternity Board Paper			
Agenda item:		**Enclosure Number:**	
Date:	01/05/2022		
Title:	**Plan to Board for Default Midwifery Continuity of Carer (CofC)**		
Author /Sponsoring Director/Presenter	Emma Upjohn, Deputy Head of Midwifery Libby Grooby, Head of Midwifery		

Purpose of Report		Tick all that apply ✓	
To provide assurance	√	For discussion and debate	√
For information only		For approval	√
To highlight an emerging risk or issue		For monitoring	√

Summary of Report:

This paper outlines:

- Background
- Current position including
  - Activity
  - Imports and exports
  - Current staffing
- Staffing deployment plan with time scales and recruitment plan ensuring building blocks are in place
- Framework of activities that will ensure readiness to implement and sustain CofC
- Time frame and monitoring process.

Recommendation:

- Accept the contents of this report
- Support maternity service in delivery of national transformed model of care.
- National guidance requires quarterly monitoring of this plan – agree for return of plan to board on a quarterly basis and LMNS.

Background:

Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long

Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks (see appendix/ A for assurance framework) are in place this should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first**.**

What does it mean to offer Midwifery Continuity of Carer as the 'default model of care'?

In line with *Better Births* and the *NHS Long Term Plan*, all women should be offered the opportunity to receive the benefits of Continuity of Carer across antenatal, intrapartum, and postnatal care. However, not all women will be in a position to receive continuity of carer, through choosing to receive some of their care at another maternity service. In a small number of cases, women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.

Providing Continuity of Carer by default therefore means:

1. Offering all women Midwifery Continuity of Carer as early as possible antenatal; and
2. Putting in place clinical capacity to provide Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care at the provider.

NHS England require Maternity services and LMNS to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all women.

Current position:

ULHT books approx. 6298 women per year and births approx. 4526. This cohort, who access antenatal, intrapartum and postnatal care with ULHT, would be eligible for Continuity of Carer. ULHT has 2 maternity units – situated 40 miles apart taking approximately one hour by car due to rurality, which brings added complexities. April 2020 – March 2021 data as based on recent Birth rate plus report;

- Lincoln books 3901 and births 2813
- Boston books 2397 and births 1713
- Provides AN and PN care to 1202 who birth outside of Trust (cross border births imports)
- Provides Intrapartum care to 105 who chose to birth at hospital only (exports)
- Attrition (miscarriage or move away) 670

ULHT provides antenatal and postnatal care for women who choose to birth cross borders at; Peterborough, Kings Lynn, Nottingham QMC/City, Grimsby and Scunthorpe. This is thought to be mainly due to accessibility and potentially the facilities offered at cross border hospitals i.e. Midwifery Led Birthing Units and newly refurbished Labour wards. If ULHT provides Continuity of Carer to these groups of women it is anticipated it may encourage women to return to ULHT

and birth at Lincoln or Boston. However, due to geographical location there is also the potential it won't.

Cross border activity can have significant impact on community resources in two ways. Some women receive antenatal and postnatal care from their "home" maternity service but give birth in another. These count as 'additional' workload over and above the number of annual births recorded by a unit and are described as "imported cross border" cases. Some units provide intrapartum and some degree of immediate postnatal to women from another maternity service, but who "export" their community care. Adjustments to midwifery establishments have been made to accommodate the community flows.

Cross border births will affect the total number of women who can receive CofC, therefore the plan will need to include how Trusts regionally are going to work together to be able to provide CofC for default.

Around 105 women come to ULHT for birth. This is partly due to the tourism on the East Coast with women going into labour whilst on holiday and women who live on the Newark border choosing to birth at Lincoln.

Continuity of Carer – March 2022 position

ULHT currently has 3 Continuity of Carer teams who are providing full continuity of care, including intrapartum care. The teams are geographic, community based and are in known areas of social deprivation. They are based on the team midwifery model; a named midwife works with wider team to deliver a total care of package (antenatal, intrapartum, postnatal) to women in the teams caseload. These teams work within a more structured format of shift patterns, with on call days and on call nights and operate flexibly within the existing working arrangements to deliver safe care to women in their team.

The team comprises of 6-8 midwives or on average 6.6 wte. As part of the existing preceptorship programme Newly Qualified Midwives (NQM) are rotated out to the teams for 1 year. Each team takes 1 or 2 NQM. NHS England have now recommended at each CofC team have 7 wte. This requirement will be explored in the plan.

The teams are created with existing community midwives and inpatient midwives who expressed an interest in working in a Continuity of Carer model. The inpatient midwives have moved from the acute service and joined the Continuity team. The staffing templates on both labour wards have remained the same. This has meant an over spend of establishment budgets on backfill for those labour ward shifts. The Trusts financial team have supported this overspend to ensure safety on both labour wards is maintained. This required overspend is evidenced in Appendix B which demonstrates the required staffing for CofC. However, this overspend cannot be maintained long term and case of need/business case would need to be submitted to CRIG, and the system finance board (FLG), for investment to support further CofC delivery.

The current 3 teams provide care to between approximately 240 – 290 women with a mix of midwife- and consultant-led care. This is approximately 5% of total bookings in each team.

1. Gainsborough team have been providing care across the antenatal, intrapartum and postnatal pathways since August 2019
2. Sleaford team who commenced intrapartum care from September 2020
3. The Wolds team who commenced providing intrapartum care from March 2022

These teams have been impacted by staffing sickness and operational challenges the COVID-19 pandemic has brought. Sleaford have carried a 1.6wte vacancy for 6 months which has impacted on the amount of intrapartum care they are able to deliver and affected team morale.

During the first wave of the pandemic, Gainsborough had members of the team needing to shield, and again this impacted on the amount of intrapartum care they were able to provide. The COVID 19 pandemic has brought significant staffing challenges within the units which have affected the Continuity teams. The midwives have supported the acute units on escalation. This escalation support was not planned at the outset of CofC – in fact the aim was to protect the Continuity teas from this to enable them to support true continuity and facilitate a successful launch. However, operational pressures have led to the Continuity teams needing to support the acute units to maintain safety for all women.

In addition to the 3 existing teams there is another team almost established, who will begin providing intrapartum care in May 2022. That team is based in Skegness.

When the 4 teams are established ULHT will be providing CofC to about 20% of total eligible women.

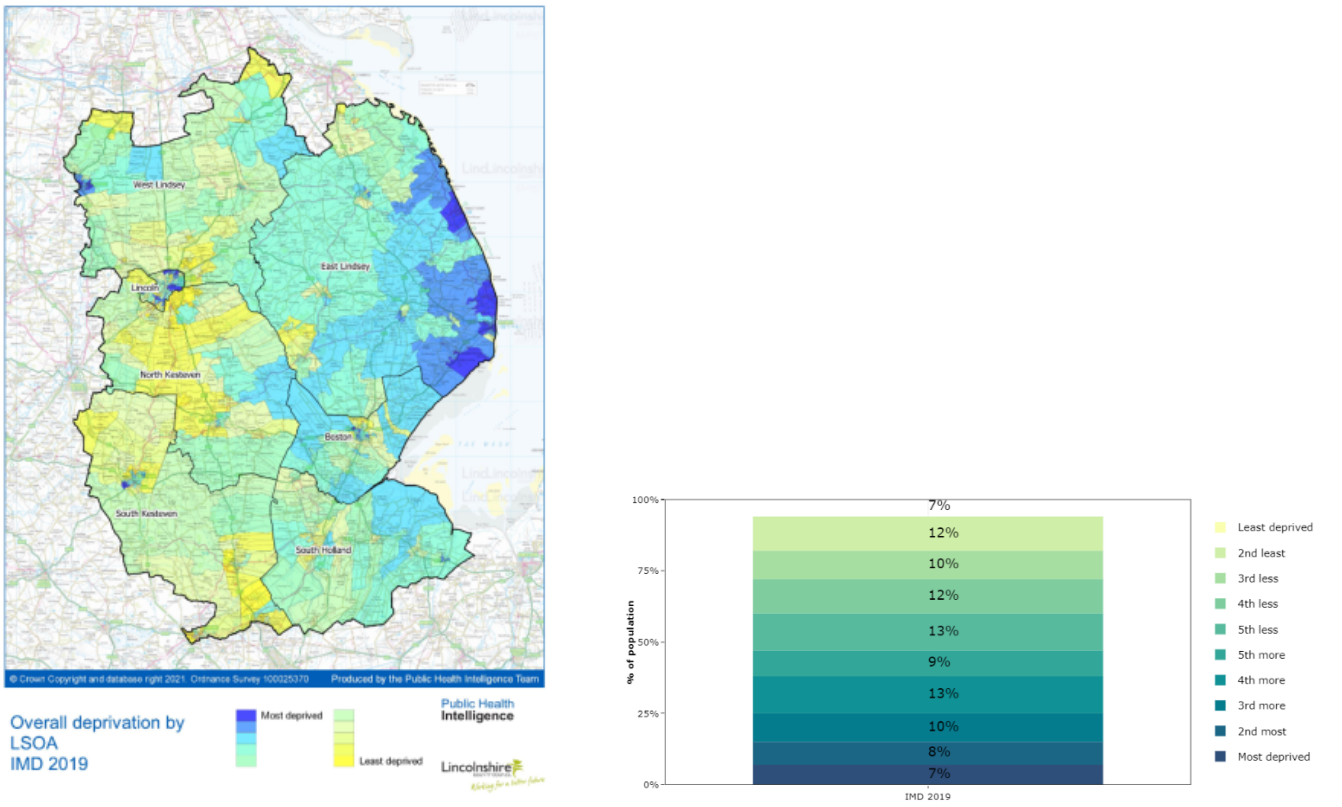

Figure 1: Overall population deprivation by LSOA IMD 2019.

We do have significant number of women that live in a postcode from the bottom decile of deprivation. Skegness is in the top 10% most deprived areas in the country. The teams were based on this information: Gainsborough, Skegness. The Wolds and Sleaford also do have some areas of the lowest social deprivation, but also provide care to women with partners at the RAF bases.

In addition to the Continuity of Carer teams, ULHT has a home birth rate of approximately 3-5% which is almost double the national average. Home births are facilitated by the Community midwifery team.

3% of ULHT bookings are women who are identified as Black and Asian Ethnic Minority Groups. The majority of these women live in Lincoln and this warrants a targeted approach of a separate team. The other population of BAME women would be cared for by their nearest geographic CofC team. Moving forward the CofC plan will link into the Equity and Equality Strategy.

The Plan: BUILDING BLOCKS

It is essential that the building blocks are in place prior to and during the rollout of CofC. They are set out as a readiness to implement and sustain CofC. This provides an opportunity to RAG status all the building blocks that need to be in place to achieve and monitor sustained transformation. These building blocks are the key elements in the plan to roll out CofC from the

current position to default for most women. ULHT aims to provide CofC to 4526 eligible women out of total 6298 bookings. About 1200 women, or 12% of total bookings receive care from other maternity services and are unlikely to change their position due to geography.

Safe staffing: BUILDING BLOCK 1

Birth Rate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units for a significant number of years. ULHT undertook a BR+ review in March 2021.

The recent report shows an increase in dependency of the women who access the services on both sites. Taking the increase in dependency into account the report recommends safe staffing ratios for the maternity service are-

LCH 1:23
PHB 1:23

The variance in the BR+ report was 3.51 wte and the Trust has actively recruited to these hours. The report also identified the need for the Trust to review the specialist midwife role and their clinical inclusion in the ratios. BR+ expects around 8-10% of the midwifery establishment to not be included in the clinical numbers; this includes management roles and a proportion of specialist midwife roles. This ensures dedicated time for safe management and leadership of the service. Further work has been done on this following receipt of the report and it can be seen that currently ULHT have 6% of the workforce in specialist/management roles and that the majority are not funded and taken from clinical establishment.

BR+ plus, however, has used this calculation for many years and has not been altered to account for the increased national expectation or the huge safety agenda in maternity services.

ULHT undertook a review in March 2021.The review found the required staffing was as below:

	Hospital	*Community*	*Total wte*
Lincoln	*87.41 wte*	*38.44*	*125.85*
Pilgrim	*51.29 wte*	*23.31*	*74.60*
Additional Specialist and management wte			*22.05*

	Birth Rate Plus wte	*Current Funded wte*	*Variance*
All clinical, Specialists & Management wte.	*222.50 wte*	*218.99 wte*	*-3.51 wte*

Following a detailed review of the increased need of specialist midwives to support the safety agenda it is felt that on top of the 3.51 WTE recommended in birth rate plus an additional 7.79

WTE is required to enable assurance on delivery. Some of this has been enabled by the successful Ockenden bid, but further investment was needed. This was highlighted in a case of need presented to CRIG.

The uplift was agreed and now the specialist midwifery numbers are in line with the BR+ recommendations of 8-10% of the workforce.

In addition to this the Trust Nursing establishment reviews that are undertaken 6 monthly identified the need to increase staffing on Nettleham Ward at Lincoln and Labour ward at Pilgrim. Some of this uplift has already been achieved from the Ockenden bid, but further funding was required. A paper was submitted to board and recruitment has commenced.

Recruitment can be challenging, often relying on recruiting qualifying students rather than attracting midwives from other units. This is in part because of Lincolnshire's rural location and midwives who work in cross border hospitals not wanting to travel long distances to Lincoln or Boston sites. Lincoln university have been training midwives for the last 2 years with the first cohort of students anticipated to qualify in Sept 2022. This is welcomed and can be used as a realistic time frame for when ULHT may be able to fully recruit to its current establishment vacancy.

Gainsborough Continuity of Carer team are piloting with Lincoln University a new method of training Student Midwives. Midwifery students will be with the team throughout the 3 year midwifery training, gaining antenatal, intrapartum and postnatal experience in the Continuity of Carer model. For Continuity of Carer to be accepted by midwives the workforce need to be trained in these teams for it to become the default model for providing maternity care.

The CofC working group will commence again in May 2022. The group was established initially with the aim to assist with achieving the national ambition. However during the Covid 19 pandemic the group had been stood down.

Job adverts and Job descriptions for all Community Midwives now include working in a Continuity of Carer model. The next step would be to amend Inpatient and ANC Job Descriptions. It is anticipated the CofC working group will need support from ULHT Human Resources and ULHT Organisational team to help: engage with staff, discuss and agree uplift or on call payments, amend job descriptions, support recruitment and change process.

ULHT has a number of midwives who are over retirement age, or are able to retire in the next 5 years. Whilst we are unable to say which of these midwives will choose to retire the numbers eligible are significant and pose a risk to the organisation of increased vacancy.

We currently have 33 midwives (13%) who are working in ULHT that are over 55 and are able to retire. We also have a further 43 (17%) midwives who are between the ages of 50-55 years. This means that over the next 5-10 years we could potentially lose 76 (30%) experienced midwives. Anecdotally it is these midwives who are not supportive of the Continuity of Carer methodology and would not be prepared to work in this way.

To offer and deliver CofC to 4526 births. 18 CofC teams would be required:

1) PHB births would require 7 Teams
2) LCH births would require 11 Teams.
3) The plan below includes the existing 4 teams
4) Planned outline for another 14 teams.

It also includes 2 teams required to provide care for women who birth outside of ULHT at a cross border hospital.

Planning spreadsheet – BUILDING BLOCK 2 – See below

Blue – 20% CofC on track
Pink – action required; business case, CRIG approval and recruitment
Yellow – 35% CofC
Amber – 35% - 50 % CofC
Green – 75-100 % CofC

Trajectory to achieve ambition	Name of Team	Model of Care	Area of Need	Start Date	Action req.	Caseload per year 1:35	% CofC and wte uplift required (BR+ data)
Already LaunchedL Wave 1 20% CoC							
Already Launched: **20% CofC**	Gainsborough	Geographic Low/High Risk	Social Deprivation	August 2019	Established to 6.2 wte **Requires uplift of 0.8 wte**	250	
	Sleaford	Geographic Low/High Risk	Military wives	Sept 2020	Established to 7.2 Waiting for start dates; 1 new starter 1 Preceptor	250	
	Skegness	Geographic Low/High Risk	Social Deprivation	Jan 2021	**Recruit 3 wte**	250	
April 22-June 22	Wolds	Geographic Low/High Risk	Military wives,	Feb 2021	Fully Established	250	
July 22-Sept 22							**20% CofC Uplift of 5.05 wte required. Business pan to CRIG.** Recruit into uplift if approved.
Wave 2 35% CoC							
Oct 22 – Dec 22	Boston Team 1	Geographic Low/High Risk	English as Second Language		High Priority Team	250	
	Lincoln Team 1	Geographic Low/High Risk	BAME/Social Deprivation		High Priority Team	250	
	Lincoln Team 2	Geographic Low/High Risk	Social Deprivation			250	

Jan 23 – March 23							**35%** CofC Uplift of 3.64 wte required. **Business plan to CRIG to request 3.64 wte** Recruit into uplift if approved.
April 23–June 23	Grantham Team 1	Geographic Low/High Risk				250	
	Grantham Cross Border team	Geographic Low/High Risk				500	
	Boston Team 2	Geographic Low/High Risk	Social Deprivation			250	
Wave 3 50% CoC							
July 23- Sep 23	Lincoln Team 3	Geographic Low/High Risk	Mixed caseloads			250	
							50% CofC uplift of 3.88 wte required **Business plan to CRIG to request 3.88**
Jan 24-March 24	Spalding 1	Geographic Low/High Risk	ESL			250	
	Spalding 2	Geographic Low/High Risk	Cross Border Team			500	
	Lincoln Team 4	Geographic Low/High Risk	Social Deprivation			250	
	Lincoln Team 5	Geographic Low/High Risk	Social Deprivation			250	
							Business plan to CRIG to request uplift 5.81 wte to achieve 75%

							Recruit into uplift if approved.
Wave 4: 75 – 100% CoC							
Wave 4 – to achieve 75 % April 24 – June 24							
July 24 – Sept 24	Boston 3	Geographic Low/High Risk	Mixed caseloads			250	
	Lincoln Team 6	Geographic Low/High Risk	Mixed caseloads			250	
To achieve 100% Oct 24-Dec 24	Lincoln Team 7	Geographic Low/High Risk	Mixed caseloads			250	
							Business plan to CRIG to request uplift 6.07 wte to achieve 100% Recruit into uplift if approved.
Jan 25-March 25	Grantham 1	Geographic Low/High Risk	Mixed caseloads			250	
	Grantham 2	Geographic Low/High Risk	Social Deprivation			250	

The next 4 CofC teams to be established will be focused and based on priority of needs. This is entirely dependent on business case agreement for uplift of staff and success of subsequent recruitment.

- There will be 2 teams in Lincoln; 1 providing care to women who have English as a second language and the other to support women of BAME ethnicity based on social deprivation indices.
- There will be 1 team in Boston; providing care to women who have English as a second language and 1 team in Grantham.
- They will be mixed risk teams and geographically based. The midwife will be the lead and follow the woman and as necessary/appropriate seek specialist input.
- Lincolnshire is the third largest county and the teams have to be geographically based rather than on specialist need i.e. Teenage pregnancy team.
- We aim to manage the flow well by keeping the system as simple as possible – each midwife picking up 3-4 women per month and birthing 3 women per month, in this way we know that every woman will have a midwife at any given time.
- We have used a combination of the NHSE/I toolkit and the recent BR+ review to plan the phased role out – Appendix B. This will demonstrate time frames for roll out and recruitment plan – (how many midwives and when). The toolkit account for staffing ratios, demonstrating planned safe staffing at any given time during this process, providing assurance that appropriate staffing ratios have been considered in this plan. The next steps are outlined in waves of recruitment and financial uplift.

NEXT STEPS ACTION PLAN

April – June 2022

- Before we can commence further phased roll out of CfoC it is essential the established teams are stable and are in a position to be positive about the further roll out of teams. This is essential for staff engagement and further commitment. We need to recruit 3 wte midwives to Skegness team and 0.8 wte to Gainsborough team. Sleaford have recently recruited and are awaiting start date.
- Submit CofC Business Case to CRIG for uplift of 5.05 wte to achieve 20%

July 2022 – Sept 2022.

- If CRIG business case supported and approved. Review current overspend areas.
- Recruit into vacancy

Communication and engagement plan – BUILDING BLOCK 3

1. We acknowledge for Continuity of Carer to be successful we need to communicate and engage with staff. At the launch of our 2 teams we initially held Continuity of Carer open events where staff could come and talk to the senior team about CofC. What we plan to do is;

    - Encourage staff to participate in the NHS England CofC Webinar
    - Offer insight days to the current CofC teams
    - Offer secondments into the CofC teams "try before you buy" approach
    - The Continuity of Carer teams will start doing "day in the life of" journals to share with staff
    - Fully utilise CofC social media presence to promote and encourage positivity surrounding work life balance and job satisfaction of model
    - Continue with Preceptorship rotation to teams
    - Continue to work closely with the Universities to assist Students to be trained in this methodology.
    - Discuss CofC ambition and plan on yearly Midwives Mandatory training
    - Reinstate Continuity of Carer monthly working group – key senior midwifery team members, including RCM, HR representatives
    - Commence Continuity of Carer team meetings for the existing teams to support, discuss and solve concerns as they arise.
    - Commence CofC questionnaire for staff to look at barriers for implementation
    - Commence survey monkey asking for staff views on preferred models of work i.e. shift based, on call based.
    - Seek HR guidance and support around process of staff consultation. However, acknowledging for our trust this needs to be the last option in view of amount of midwives who are approaching retirement age and may leave.
    - Review and Amend Job Descriptions.
    - **Timescales for the above by Sept 2022**

Skill mix planning – BUILDING BLOCK 4

- Skill mix planning is essential. The teams will be based of 6-8 midwives and NQM will rotate out to the teams as part of their preceptorship. It is essential that no more than 2 NQM (Band 5) are placed in each team.
- The current Continuity of Carer training needs analysis will be reviewed to ensure there is support for those staff working in the core existing community and inpatient teams.
- NQM Band 5 to be supported by a buddy during their preceptorship rotation
- Appropriate and planned use of MSW particularly in teams working in areas of greatest need.
- Ensure preparedness of band 7 labour ward coordinators to support programme of change.

    - **Timescales for the above by Sept 2022**

Training – BUILDING BLOCK 5

This is a key building block.

1) Midwives who are joining the new Continuity teams are to be supported by the Practice Development Midwives (PDM). They will have individual TNA depending on their needs and will have the time to ensure they have the set of competencies required for the change in working pattern.
2) Midwives from the Community will have supernumerary time (time dependant on their needs) on the labour wards, supported by the Core Inpatient staff and Labour Ward Coordinator.
3) Midwives from the inpatient services will have supernumerary time in the Community (time dependant on their needs)
4) Professional Midwifery Advocates will be available to support midwives
5) Identify buddies from existing teams to support individuals in new teams.

- **No timescales – continuous involvement**

Linked Obstetrician – BUILDING BLOCK 6

1) Each Continuity of Carer team will need to have a linked Obstetrician. The teams are geographic based. The peripheral teams will have a named Obstetrician who is linked to that team i.e. Gainsborough = Miss Harper & Skegness = Miss Rao.
2) This is more complicated for Sleaford and Wold's team. Both teams have women choosing to birth at either Lincoln or Boston. All women have named Obstetricians however Sleaford women may have a few linked obstetricians, rather than 1. A clear process needs to be established and agreed for how the CofC midwives know which Obstetrician the woman is linked to and how to contact them.
3) A further plan will be required on how the teams covering Boston and Lincoln will be managed. Women currently are linked to Obstetricians depending on what day of the week they attend for dating scan, or clinical need i.e. Diabetic
4) The SOP for linked Obstetrician will need to be written. This SOP will be based on national guidance.
5) The process of linked Obstetrician will then need to be clearly set out in the SOP

- **Timescales for the above Sept 2022 Quarter 2**

Standard operating Policy (SOP) – BUILDING BLOCK 7

The current ULHT SOP for Continuity of Carer provides assurance around roles and responsibilities. However, this will need updating and monitoring as the plan develops and is implemented.

- **Will need review Sept 2022 Quarter 2**

Midwifery Pay – BUILDING BLOCK 8

RCM requests that no midwife should be financially disadvantaged for working in this way. Current teams are based on Agenda for Change and are paid an on call payment for night on calls and then unsocial hours, depending on how many night hours worked. They are also paid for weekend enhancements. This will need to be reviewed with Human Resources (HR). HR representation to be requested at the CofC working group.

- **Timescales June 2022 Quarter 2**

Estate and equipment – BUILDING BLOCK 9

1) The teams are geographically based and are linked to GP practices. Gainsborough, Sleaford and Skegness midwives are based in the local children centre and run the clinics from there too. However, The Wolds team, and any subsequent teams will require bases. This will need a system approach to venues. More GP's surgeries are asking midwives to move from their premises and Antenatal care is then being provided in any accommodating Children Centres.
2) The Board, LMNS and ICS will need to work in collaboration to source appropriate venues across the county.
3) There will be additional financial costs with buying laptops, IPhone, scales, sonic aids and additional clinical equipment. Each midwife that moves from the inpatient service to join a team will require equipment. The plan will need to include predicted costs.

- **Further equipment ordered after receiving £10k funding via LMNS for CofC equipment.**

Review Process BUILDING BLOCK 10

1. The plan will be co designed and reviewed with the LMNS and MVP
2. The plan will be linked to CNST standards and reported into the monthly Maternity and Neonatal Oversight Group and LMNS Transformation Group bi-monthly meeting
3. The plan will be reviewed quarterly at ULHT Maternity & Neonatal Oversight group (MNOG) and upwardly to QGC for assurance and escalation.

- **Timescales June 2022.**

Appendix A

BUILDING BLOCKS Readiness to implement and sustain CofC assessment framework:

Item	Detail/Notes	RAG for progress
	The plan needs to be written first and presented to the board and LMNS The remainder of the work should roll out in accordance to population need. Work that is already in place should not need to cease unless there is an urgent reason to do so.	
Planning spreadsheet	Demonstrates safety from a staffing perspective: • How many women can receive CofC -reviewing in area and out of area, cross boundary movement • Where women are cared for at any given time, now and in CofC models • Midwifery deployment plan for CofC including timescales and recruitment plan for a phased scale up to default position.	
Safe Staffing	• How many midwives required • How many in post • Recruitment plan to optimal midwifery staffing with time frames	
Communication and engagement	• Provides evidence of staff engagement and log responses/counter responses • Gives opportunity to share vision • Whether or not a consultation is required	
Skill mix	• Review of skill mix, including number of band 5 midwives placed in CofC team. B5 midwives those working in the core ensuring appropriate support throughout. Band 5 (usually 1 per team) report being very well supported whilst undertaking preceptor programme. • Appropriate and planned use of MSW particularly in teams working in areas of greatest need. This is dependent on staffing and acuity. • Work with B7 labour ward co-ordinators in readiness for role out of CoC programme	
Training	Each midwife has a personal Training Needs Analysis	
Team building	Time allocated for team building and softer midwifery development as midwives move to a new	

	way of working. Consider organisational development support	
Linked Obstetrician	Review of obstetric involvement and linked obstetricians identified. Referral to obstetrician process to be clearly set out in the SOP as well as other clinical guidance.	
Standard Operating Policy (SOP)	Update SOP to outline roles and responsibilities to delivery CoC programme. Ensure Robust governance in regards to embedding the process of SOP.	
Pay	Pay to be reviewed in line with RCM request that no midwife should be financially disadvantaged for working in this way.	
Estate and equipment	Infrastructure planning for clinical venues and equipment.	
Evaluation	Local, regional, and national in line with the NHE England framework.	
Review Process	Initial plan to be review by Trust Board followed by quarterly review. LMNS, regional and national review dates to be confirmed.	

Appendix B – Staffing deployment plan to deliver CofC with dates and recruitment plan.

LINCOLN – including Grantham, Gainsborough and Sleaford community teams.

It is likely that some women will require additional support from core labour ward staff and have postnatal ward stay which need to be factored into the core staffing for both units. Core staffing has to ensure adequate staffing for non-birthing activity for women not on CofC model.

The table below shows clinically staffing of midwives and postnatal MSWs for core hospital services and community and continuity teams.

	Baseline Staffing	20% Delivery of CoC	35% Delivery of CoC	51% Delivery of CoC	75% Delivery of CoC	100% Delivery of CoC
Bardney	35.16	30.78	26.80	22.55	16.18	9.54
Nettleham	36.08	35.15	33.87	32.50	30.45	28.31
ANC	16.14	16.14	16.14	16.14	16.14	16.14
Core Community	38.46	31.19	26.87	22.25	15.32	8.11
Continuity Teams	0.00	15.63	27.35	39.85	58.60	78.14
Total Clinical wte PN Band 3's to MW Band 7s	125.87	128.89	131.02	133.29	136.69	140.24
Clinical Variance		3.02	5.15	7.42	10.83	14.37

BOSTON – including Skegness, Spalding and Boston community teams.

It is likely that some women will require additional support from core labour ward staff and have postnatal ward stay which need to be factored into the core staffing for both units. Core staffing has to ensure adequate staffing for non-birthing activity for women not on CofC model.

The table below shows clinical staffing of midwives and postnatal MSWs for core hospital services and community and continuity teams.

	Baseline Staffing	20% Delivery of CofC	35% Delivery of CofC	51% Delivery of CofC	75% Delivery of CofC	100% Delivery of CofC
Labour Ward	22.22	19.22	16.88	14.39	10.66	6.77
Maternity Ward	19.86	19.01	18.31	17.56	16.44	15.27
ANC/AAU	9.23	9.23	9.23	9.23	9.23	9.23
Core Community	23.29	19.65	16.65	14.29	10.15	5.83
Continuity Teams	0.00	9.52	17.06	24.27	35.69	47.58
Total Clinical wte PN Band 3s to MW Band 7s	74.60	76.62	78.14	79.95	82.16	84.68
Clinical Variance		2.03	3.54	5.15	7.57	10.08

Appendix C

NHS England Delivering Midwifery Continuity of Carer at full scale; Guidance on planning, implementation and monitoring 2021/22.

The maternity team have met with Trixie McAree National Midwifery Lead for Continuity of Carer to work through the NHS England planning tool using March 2021 BR+ maternity workforce data (p21). The outcome of the tool compares with the BR+ prediction for CofC. ULHT do need more midwives, to deliver default CofC.

Copy of United Lincoln April 22 (002

Appendix D

Uplift= 22.5	Birth rate plus Lincoln	Actual		C of C	All women		deliveries:				BOSTON Birth rate plus			C of C	All women		deliveries:			
Percentage and local calc	Midwife to woman ratio:1:	funded:125.85	attrition rate:	10%							Midwife to woman ratio:1:	funded:	attrition rate:	7%						
168/37.8+22.5%=5.48	total b3-b8=139.65 managers/specialists=14 clinical midwives= 113.27 PN MSW=12.58	actual staffing 125.85	deployment (=BR+	C of C pathway	All care given:2813 AN/PN only:688 attrition 400 total=3901	% of women delivered	in area:2813 OOA:72		time scale	recruitment plan	total b3-b8 =83.1 managers/spec=6.5 clinical midwives= 70.9 PN MSW=3.7	actual staffing	deployment (=BR+)	C of C pathway	All care given:1713 AN/PN only: 514 attrition =170	% of women delivered	in area: 1713 OOA:33		time scale	recruitment plan
care location	Total b5-8 midwives:127.27	125.85	per shift 6.4 per IP		3901	0.00%	2885				Total b5-8 midwives:79.39	79.39	per shift 4 for ip care		2397	0.00%	1746			1
C of C team									current										current	
DS	35.18	38.36	7 (6.4)					1 to 82			22.18	22.18	4					1 to 78.7		
AN/PN ward 8.02MW AN &28.06=36.08-8.22 MSW=27.86 MW	27.86	24.82	4.5 (5)		8.22 MSW						16.18	16.18	2.9	3.7 MSW						
ANC	9.31	9									5.63	5.6								
AAC /triage	6.83	5.48									3.59	3.5								
community 38.44-4.36 MSW	34.08	34.19	ratio of 1to114 BR+		4.36 MSW						23.31	23.31	102.8 BR+							
specialists																				
managers 7	14	14									8.5	8.5								
managers 8a & up																				
TOTAL	127.26	125.85								125.85	79.39	79.27								80.27
Wave 1	CURRENT		8.4 per IP shift	6.97%		8.49%				2.5	skeg	1 team	4.6 for ip care	11.68%		14.43%				3
C of C team		6.8		272		245						7		280		252				
DS		35.18	6.4				2640.2	1 to 82				20	3.6				1494	1 to 74.7		
AN/PN ward 8.02MW AN &28.06=36.08-8.22 MSW=27.86 MW		22.5	4.1									16.18	2.9							
ANC		9										5.6								
AAC /triage		5.48										3.5								
community 38.44-4.36 MSW		31.8	1 to 114		3629							20	102		2117					
specialists																				
managers 7		14										8.5								
managers 8a & up																				
TOTAL		124.76								127.26		80.78								83.78
Wave 2		2 teams enlarged	8 per shift	14%		17.47%				5		3 teams	6 for ip care	35%		43.30%				7
C of C team		14		560		504						21		840		756				
DS		33	6				2381	1 to 72				16.44	3							
AN/PN ward 8.02MW AN &28.06=36.08-8.22 MSW=27.86 MW		22.5	4.1									16.18	2.9				990			
ANC		9										3								
AAC /triage		5.48										3.5								
community 38.44-4.36 MSW		29.3	1 to 114		3341							15	102		1557					
specialists																				
managers 7		14										8.5								
managers 8a & up																				
Total		127.29								#REF!		83.62								90.62
Wave 3		4 teams	8.7 IP available	28.71%		34.94%						6 teams	8.5 for ip care	1.96%		96.91%				0
C of C team		28		1120		1008						47		1974		1692				
DS		26	4.7				1877	1 to 72			scrub nurses?	13.7	2.5				54			
AN/PN ward 8.02MW AN &28.06=36.08-8.22 MSW=27.86 MW		22.5	4.1									10.96	2		increase MSW provision?					
ANC		8										3								
AAC /triage		5.48										3.5								
community 38.44-4.36 MSW		24	1 to 114		2781							4			423					
specialists																				
managers 7		14										8.5								
managers 8a & up																				
Total		127.98								#REF!		90.66								#REF!

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	10 May 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 2022/23 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Safer Staffing** The Committee noted the limited assurance being offered through the report as a result of the prolonged challenges of unprecedented demand and sustained staff challenges. The Committee was advised of the decrease in pressure ulcer incidents along with the severity of harm noting there had been no grade 4 pressure ulcers reported during April. Concern was noted in respect to the increase in patient falls, not only the number of incidents but also the severity of harm. Action was being taken on a daily basis to address staffing gaps with mitigations in place.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Guardians of Safe Working Report – inc Racism update** The Committee received the quarterly report from the Guardian of Safe Working noting a number of issues that had been raised by junior doctors. The Committee was pleased to note that there had been positive feedback in respect of the anti-racism campaign and noted that a formal discussion was due to take place at the Junior Doctor Forum. The Committee noted the issues raised in respect of wellbeing and the junior doctors mess, clinical and education support to locally employed doctors and concerns regarding exception reporting by junior doctors.

	The Committee was pleased to note the responses offered during the meeting by the Executive Directors which demonstrated clear actions to be taken to address the concerns raised. **Equality, Diversity and Inclusion Group upward report** The Committee received the upward report from the group noting the need to ratify the EDI objectives by the end of June with a draft proposed to be presented to the Committee in June. Work was underway to ensure a clear understanding from the group on the assurances required with the Committee noting concern on the slow progress shown. **Employee Exclusions** The Committee were assured on the actions being taken to bring to a conclusion the two outstanding employee exclusions. Monitoring was now underway through monthly case reviews.
	Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** No items received.
	Assurance in respect of other areas: **Draft Terms of Reference and Work Programmes 2022/23** The Committee received the draft terms of reference and work programme that had been updated in line with year 3 of the Integrated Improvement Plan. The Committee would receive a final version for sign off at the June Committee prior to approval by the Trust Board. **People and OD Directorate priorities overview update** The Committee received the update noting the formal launch of the People and OD directorate consultation. It was noted that alongside the consultation discussions would take place with divisional colleagues to ensure the proposals met the needs of the divisions. The Committee fully supported the restructuring of the directorate to ensure that this was fit for purpose. The Committee noted the launch of the anti-racism campaign and the current work to draft the equality, diversity and inclusion (EDI) objectives which formed part of the public sector duty. This would set the strategic direction of EDI for the coming 2-3 years. The Committee noted the work underway in relation to an appropriate appraisal solution to support staff who did not routinely have access to complete these digitally.

Reporting Group Governance Review
The Committee received the governance review that had been undertaken to identify areas of improvement to support the Committee and Board to receive assurance.

The Committee noted and endorsed the recommendations, which in the most part, related to the strengthening of the reporting groups to the Committee.

Work would be undertaken to conduct a full review and refresh of the reporting group terms of reference which would be presented back to the Committee in June.

Committee Performance Dashboard
The Committee expressed continued concern on the lack of movement in the metrics reported. It was recognised that once the Workforce Strategy Group was re-established appropriate narrative would be provided on the actions being taken to deliver the metrics.

Particular concern was noted in respect of appraisal rates and the continued position.

PRM Upward Report
The Committee took the report as read noting that the report did not offer assurance however was reassured of the developments underway to revise the executive scorecard and agree measurables to underpin the metrics.

Once tolerances had been agreed and KPIs, in addition to improvement KPIs the move would be made to update the PRMs and ensure focused attention on the areas required.

Integrated Improvement Plan
The Committee received the report noting the position as reported for the year end 2021/22 which had been discussed through other forums.

Board Assurance Framework
The Committee received the 2022/23 Board Assurance Framework noting the updates that had been put forward.

Discussion took place regarding the assurance ratings and the associated action required in order for these to be moved from red to amber. The Committee recognised the importance of the revision of the reporting groups to enable controls to be in place prior to the assurance ratings being revised.

Recruitment Internal Audit
The Committee received the recruitment internal audit repot noting that this offered partial assurance. Work had commenced to address the

	recommendations as detailed in the report following the appointment of the Head of Recruitment. The Committee were disappointed to note the outcome of the report, and the lack of progress from previous audits, and expressed a robust view of the action required to see improvement. **CQC Actions Update** The Committee received the report which offered a progress update in respect of those actions, relevant to the Committees oversight, required by the CQC following the unannounced inspection in 2021. The Committee noted 7 of the 9 actions rated as red being advised that these were specific to mandatory training. The Committee was assured that assurance meetings would be held with the divisions on a monthly basis to support the drive forward of actions. The Committee was pleased to note that the report triangulated with data received during the course of the meeting and actions were in place.
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 a deep dive was due to take place and would see a full review and refresh of the risks presented to the Committee.
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	J	J	A	S	O	N	D	J	F	M	A	M
Geoff Hayward	X	X	Meeting not held									
Philip Baker (Chair)					X	X	X	X	X	X	X	X
Sarah Dunnett	X	X			X	X	X	X				
Gail Shadlock									X	X	X	A
Karen Dunderdale	X	D			X	X	X	X	X	X	D	X
Paul Matthew					X	X	X	X	X	X	X	X
Martin Rayson	X	X										
Simon Evans	A	D			A	A	A	A	X	A	A	A
Colin Farquharson					X	X	X	X	X	X	A	X

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	ULHT Trust Board
Date of Meeting	7 June 2022
Item Number	

Equality Diversity and Inclusion (EDI) NHS 'Rainbow' Badge Re-endorsement

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	
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	Not applicable
Financial Impact Assessment	Not applicable
Quality Impact Assessment	Not applicable
Equality Impact Assessment	Not applicable
Assurance Level Assessment	Significant
Recommendations/ Decision Required	Trust Board are requested to: 1. Review the attached report 2. Re-endorse ULHT commitment to the NHS Rainbow Badge initiative and the pledge (Appendix 1) 3. Support ULHT ambitions to create an inclusive culture 4. Agree proposed next steps
Executive Summary	
As detailed below	

NHS
United Lincolnshire Hospitals
NHS Trust

ULHT TRUST BOARD
7 June 2022

EQUALITY, DIVERSITY AND INCLUSION (EDI)

NHS 'Rainbow' Badge

1. Purpose of this report

The aim of the report is to assure Trust Board that action is currently underway to create and foster an inclusive culture.

What this means in practical terms is:

a. staff feeling 'safe' in bringing their 'whole self' to work,
b. ULHT taking steps to create a sense of belonging and
c. harness the value of diversity in order to deliver better patient care.

This report sets out a proposal to reaffirm ULHT commitment to the **NHS Rainbow Badge** and is one of several actions currently underway to foster inclusion and respect at the Trust.

2. About the initiative

The NHS Rainbow Badges initiative started in 2019 at Evelina Children's Hospital in London and has quickly gained pace throughout the NHS. ULHT are proud to be joining the movement and making a public commitment to support both patients and staff that identify as LGBT+.

Increased awareness of the issues surrounding LGBT+ people when accessing healthcare on the part of NHS staff can make significant differences to LGBT+ peoples' experiences, and, in turn on their physical and mental health.

83 Acute Trusts (incl. ULHT) in the UK have already signed up to the scheme with over 150,000 NHS staff proudly wearing the NHS Rainbow badges. The Trust has over 400 staff have already signed up and display the badges

3. Why wearing the Badge is important to the care of patients and staff

LGBT+ patients continue to face inequalities in their experience of NHS healthcare. Despite improving social attitudes in general towards LGBT+ people in the UK, negative attitudes (homophobia, biphobia, transphobia) continue to be widely prevalent.

Mental health issues such as depression and anxiety are much higher in people who identify as LGBT+. Many people still feel afraid to disclose their sexuality or gender identity, and to 'come out'. Being unable to do this often increases their risk of physical and mental health problems.

Similarly, NHS staff can also face these challenges with many reporting that they aren't comfortable disclosing their sexual orientation at work. This can lead to stress and anxiety and impact on an individuals' ability to deliver their job.

Staff choosing to wear this Badge, send an important and powerful message to both patients and staff that 'you can talk to me and I will listen'. Staff that wear the badges are not expected to have the answers to all issues and concerns, but what they can do is 'signpost' staff to support available, i.e. Employee Assistance Programme (EAP), ULHT Pride Plus Staff Network and other useful sources such as the Albert Kennedy Trust and Stonewall.

The visibility of the badge also symbolises ULHT commitment to creating a respectful and safe place to receive care and work, and reinforces the following – all of which are essential to promoting inclusion:

- Use of inclusive language in all discussions;
- Affirm the identity that a person chooses to use
- Assurance of confidentiality

4. ULHT commitment to inclusion

The decision to reaffirm ULHT commitment to the **NHS Rainbow Badge** initiative is centred upon the premise that inclusion results in better health care. The proposal is to remind staff and patients of what the Rainbow badge symbolises and is an obvious visual cue to support patients in feeling comfortable disclosing their sexual orientation and in seeking advice and support. The badge is also a gentle reminder about the importance of delivering care with compassion, understanding and respect.

Inclusion also improves staff wellbeing and increases the Trust's ability to attract as well as retain talent. The Rainbow badge is a way of educating and raising awareness of the importance of LGBT+ experiences and to ensure staff feel safe at work and free from all forms of discrimination.

5. PROPOSED NEXT STEPS

1. Relaunch and reaffirm ULHT commitment to the **NHS Rainbow Badge** initiative

2. Liaise with ULHT corporate communications team to develop a powerful and persuasive campaign about the importance of inclusion to the delivery of patient care and in making ULHT a good place to work

3. Apply the narrative for the **NHS Rainbow Badge** to raise awareness and understanding about the lived experiences of LGBT+ staff and patients

4. Use the **NHS Rainbow Badge** to highlight the responsibility each staff member has in promoting inclusion and fostering dignity and respect for both patients and staff.

Appendix 1

ULHT's pledge to the NHS Rainbow Badge initiative

The NHS Rainbow Badge initiative is a positive, yet discreet, way for staff within the Trust to demonstrate that they are aware of the challenges that LGBT+ people may face when accessing healthcare and show their commitment to be welcoming and supportive of the LGBT+ community.

At ULHT we support this initiative wholeheartedly and confirm that staff wearing a badge:

- Have identified themselves as someone who an LGBT+ person can feel comfortable talking to about issues relating to sexuality or gender identity
- Understand the responsibility of wearing the Rainbow Badge and supporting LGBT+ people
- Are there to listen without judgement and signpost to further support, if needed
- Demonstrate commitment to the Trust's core values and Inclusion Strategy, to foster an inclusive environment for all patients and staff, regardless of sexual orientation or gender identity

We will promote ULHT as an inclusive workplace where staff can be themselves. We will champion LGBT+ equality within the Trust by ensuring the needs of LGBT+ patients, service users and staff are met.

Signed by:

Chair
Chief Executive
Exec lead for PRIDE+ (Director of Finance & Digital)

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	30 May 2022
Chairperson:	Dani Cecchini, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Report** The Committee received the report noting the limited assurance that was offered and the need to escalate to the Board the limitation of the infrastructure across the Trust which was being further highlighted through the work of Authorising Engineers. The Committee noted the intention for a future report to be presented in respect of capital prioritisation for infrastructure recognising the risk this posed to the Trust. Conversations were held regularly with NHS England regarding the position. The Committee noted the continued progress to open areas of the hospital following the fire at Lincoln County and was advised that changes would not be seen until the end of June. **Low Surface Temperature Report** The Committee noted that work continued at Louth Hospital in respect of low surface temperature works with this nearing completion. Rented accommodation continued to be reviewed with quantity surveyors supporting and assessing the required works. For those buildings not owned by the Trust clarity would be required on the conversations to be held with landlords regarding the works to be completed. The Committee received significant assurance that immediate actions had been resolved with work continuing in respect of third-party accommodation.

	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency and Capital** The Committee noted the month 1 position and was advised that there had been no formal external reporting requirements for the month with the exception of the pay position. The Trust had reported £204k adverse to plan, against the plan submitted in April. A further plan would be submitted on 20 June with an expectation that month 1 and 2 would be locked in. The Committee noted the need to readdress the balance of delivery elective and non-elective activity and the requirement to address the Cost Improvement Programme (CIP) position. The Committee requested sight of the CIP plans in order to receive assurance on delivery. The Committee received limited assurance noting that the financial recovery plan was not yet clear however the Improvement Steering Group would meet for the first time on 10 June and from these, further assurance should be received. The Committee received the contracting update noting that worked continued with the Clinical Commissioning Group to sign the contract by the end of June. There would be a system deficit which would need to be bridged in order to deliver a more balanced position. **Planning Update to inc. Revenue, Capital, Contract, Efficiency and contracts and values** The Committee received the update noting the submission of the third iteration due to be made on 20 June. This would be received retrospectively by the Committee in June and onward to the Trust Board. The Committee noted the position and the system risks identified within the paper that would impact the plan including failure to achieve 104% activity and claw back, CIP delivery, control of additional investments, process and governance, Covid-19 cost reduction and excess inflation. The Committee received moderate assurance noting the risks presented and the possible rise of excess inflation.
	Assurance in respect of SO 3c Enhanced data and digital capability **Cyber Security Update** The Committee received an update in respect of Cyber Security noting the position offered and continued work being undertaken by the Trust. **Information Governance Group Upward Report** The Committee received the upward report noting the continued limited assurance being offered by the group specifically due to the ongoing concerns regarding freedom of information and subject access requests.

	The Committee was pleased to note the introduction of the assurance dashboard that would be offered alongside future upward reports to the Committee in order to demonstrate performance. The Committee noted the activity being undertaken to strengthen the information governance resources within the Trust and to deliver the required improvements. **Data Security Protection Toolkit Submission** The Committee noted the update offered in respect of the DSPT submission noting the introduction of a task and finish group to support confirm and challenge of the evidence used for the submission. A full review against the elements had been undertaken with a clear view of the risks to achieving full compliance by the submission date in June. **Internal Audit – Data Security Protection Toolkit** The Committee received the internal audit noting the position reported and the work underway to address the actions. **Internal Audit Recommendations** The Committee received the outstanding internal audit recommendations for information and noted that a number of actions, based on recent discussions held by the Committee, could be closed. A more focused review would be undertaken by the Committee at the next update.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting that the Trust had entered a long term relationship with ECIST which would see a focus on improvement in urgent care pathways. IMPOWER would remain working with the Trust until the end of June and would offer clear objectives for recovery and trajectories. The Committee noted the national zero tolerance approach to ambulance handover delays over 60 minutes with the Trust required to ensure this was achieved by the end of September 2022. Following the planned care away day it was noted that there were improvements being seen with High volume low complexity work continuing and a positive position being seen as momentum was gained and theatre capacity utilised. The Committee noted concern with the possible introduction of guidance to lateral flow all patients attending outpatient diagnostic appointments which would severely impact on capacity. Achievement of 0 patients waiting over 52 weeks continued with the trajectory suggesting this would be achieved, as planned, by March 2023.

	Diagnostics continued to recover following the fire at Lincoln County and the Committee noted the position of breast services where performance continued to be reduced. The Committee was pleased to note the colorectal 14-day improvement from 2.3% in January to meeting the standard in March and April at 94%.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 4a Establish new evidence based models of care No items received
	Assurance in respect of other areas: **Draft Terms of Reference and Work Programme 2022/23** The Committee received the revised terms of reference and work programme noting the proposed changes. The Committee agreed further work would be undertaken to ensure these were accurate prior to sign off and onward approval by the Trust Board. **Board Assurance Framework 2022/23** The Committee received the 2022/23 version of the Board Assurance Framework noting the changes that had been made as a result of the year 3 IIP refresh and noted the need to undertake a wider review to ensure accuracy of the content. The Committee noted that at the planned development session consideration would be given to the controls and assurances presented. **CQC Action Plan** The Committee received the relevant aspects of the CQC action plan noting the current position and raising concern regarding the number of actions rated as red. The Committee requested that a detailed paper be presented to the Committee in June detailing the timelines for delivery and constraints and challenges of those actions rated as red. This would offer further assurance on the actions being undertaken and provider realistic recommendations of completion dates. The Committee noted the moderate assurance being offered and reflected that this could reduce should progress not be made in respect of actions.

	Committee Performance Dashboard The Committee received the report noting the limited assurance that was offered. Concern was noted due to the continued deterioration being seen across a number of metrics. The Committee was advised of the development of trajectories and tolerances that would flow through in to reporting in June and ensure accountability and links to improvement work. **PRM Upward Report** The Committee received the report for information noting that once scorecards had been finalised future reporting would offer assurance to Committees. Future reporting to the PRMs would see multiple scorecards used including the executive scorecard, divisional scorecards for improvement projects and an additional scorecard containing other metrics and associated tolerances. This would provide improved reporting and accountability through the meetings and would underpin both the IIP and Integrated Performance Report. **Integrated Improvement Plan** The Committee noted the report and the process undertaken in order to update the IIP for year 3 which had specified a series of outcomes by 2025. The Committee noted concern that the Trust continued in the planning phase and hoped that there would be a move forward in reporting from June that would demonstrate delivery. The Committee noted the moderate assurance offered and was pleased with the development of reporting. **Improvement Steering Group** The Committee received an update in respect of the establishment of the Improvement Steering Group noting that the first meeting was due to take place on 10 June. The Group would work closely with the finance and performance teams and would align with post Covid-19 recovery and meet on a monthly basis. The Committee noted the interim support in place for planned and unplanned care to support delivery and updates from the group would be offered on a monthly basis to the Committee. Updates would also be offered to the Trust Leadership Team with the Committee suggesting this needed to take place on a more frequent basis than the proposed quarterly updates.

	The Committee reflected on the membership of the group within the terms of reference presented and it was agreed that these would be updated to ensure clarity on attendees and accountability. The Committee noted the Finance People and Activity Meeting terms of reference noting that these meetings would run alongside the PRMs and would offer triangulation. Moderate assurance was received by the Committee with an expectation that this would increase governance was strengthened into the divisions.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the very high risks as presented. A deep dive of the finance risks would be undertaken through the confirm and challenge session during June and would result in the risks being revised and updated.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

X in attendance

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7 June 2022*
Item Number	*Item 11.1*
Letter of Support - ASR	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

Recommendations/ Decision Required	• *Board to note and ratify the letter of support which was submitted following virtual agreement by Trust board members, outside of their scheduled meetings*

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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John Turner, CEO
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17 May 2022

Dear Gerry and John

Re: Supporting Documents for consideration of Acute Service Review Decision Making Business Case

The appendices to this letter contain a number of supporting documents in respect of the Acute Services Review Decision Making Business Case which the CCG Board is due to consider at the end of this month:

Appendix 1 – Orthopaedic Statement of Support

Appendix 2 – Stroke Services Statement of Support

Appendix 3 – Acute Medical Services Statement of Support

Appendix 4 – Urgent and Emergency Care Statement of Support

Appendix 5 – Benefits Plan Orthopaedic

Appendix 6 – Benefits Plan Stroke Services

Appendix 7 – Benefits Plan Acute Medical Services

Appendix 8 – Benefits Plan Urgent and Emergency Care

Appendix 9 - Outline Implementation Timeline Orthopaedic

Appendix 10 - Outline Implementation Timeline Stroke

Appendix 11 - Outline Implementation Timeline Medical Services

Appendix 12 - Outline Implementation Timeline Urgent and Emergency Care

These documents were reviewed:

- By the ULHT Executive Leadership Team on 12th May; and
- By the ULHT Trust Board (virtually) on 13th May 2022.

Based on those discussions, the Trust is able to provide these documents to the CCG Board. ULHT recognises that the documents are advisory only in nature and makes no presumption that it will be the provider of any of the services referenced within them in future.

Please do not hesitate to contact us if you have any queries.

Yours sincerely

Elaine Baylis
Chair

Andrew Morgan
Chief Executive

Cc. Maz Fosh, Chief Executive, LCHS

Appendix 1
Statement of Support:

Clinical lead(s): Mr Kulandaive Sakthivel
Operational leads(s): Mark Lacey, Sarah Southall, Angela Shimada

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to develop a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospital, along with a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality Orthopaedic services are delivered in Lincolnshire in a sustainable way for the future:

- At the end of February 2020 the evaluation of the orthopaedics pilot showed very positive results. The experience of the pilot has reaffirmed the preferred option for the future provision of orthopaedic services identified through the ASR options appraisal (to consolidated elective orthopaedic services at Grantham Hospital) and allowed it to be refined.

- Achieve a balance between access and ensuring the long term sustainability of services.

- This reconfiguration of services is highly likely to repatriate services back into our County which in turn helps both the patients and the healthcare staff.

- As an example we highlight one of the metrics for quality of care - Reduction in the average length of stay for elective orthopaedics at Grantham Hospital from 2.7 days to 1.7 days, demonstrating strong operational performance. A reduction in the Trust-wide orthopaedic elective length of stay has been achieved from 2.9 days to 2.3 days.

- For further details on the improvement of quality of care please refer to the PCBC.

Access to care

- Patients are more likely to receive timely assessment, treatment and diagnosis when they arrive at hospital.

- Improve support to patients with regards to travel in the broadest sense across Lincolnshire

- Reduced cancellations for elective patients, as following this reconfiguration as hot and cold activity are split

- For further details on the improvement of quality of care please refer to PCBC

Deliverability – achievable workforce requirement

The proposed future model of a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery supports a more sustainable and resilient workforce:

- A reduction in a heavy reliance on locum and agency staff.
- Increases the chances of recruiting to substantive roles.
- The pilot workforce model has successfully removed all agency doctor usage within orthopaedics ULHT wide. Before the pilot, agency doctors were used to cover one consultant post, a number of junior doctor posts and a number of middle grade posts.
- Helps staff maintain their skills working in a specialist elective centre with negligible patient cancellations.
- For further details on the improvement of quality of care please refer to the PCBC.

Conclusion

The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix 2
Statement of Support:

Clinical lead(s): Dr Abdul Elmarimi

Operational leads(s): Carl Ratcliff, Sarah Southall, Angela Shimada

Statement of support

The United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services Trusts support the change proposal to develop a sustainable stroke service in Lincolnshire for hyper acute and acute stroke services at Lincoln county hospital. This will be supported by a community stroke rehabilitation service across the county. This will support earlier discharge for patients to have their rehabilitation and care closer to home.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality hyper-acute and acute stroke services are delivered in Lincolnshire in a sustainable way for the long term, by:

- Ensuring hospital stroke services are based on national clinical evidence
- The benefit of faster access to diagnosis and treatment once at the acute site offsets the longer travel times for some patients. The evidence of the temporary consolidation of hyper acute stroke services demonstrated that on average patient's diagnosis and treatment times were improved and all patients who were eligible for thrombolysis received this within the four hour window from onset of symptoms.
- Our hospital stroke services receive over 600 (over 1000 across the county) stroke patients a year so that our doctors and nurses here in Lincolnshire maintain and develop their specialist skills and expertise
- Improving the ability of hospital stroke services to attract and retain talented and substantive staff by building a strong, high quality and successful service, reducing our reliance on agency locum staffing
- Stroke patients spend the minimum time necessary in a hospital bed, by ensuring community services have the right skills and capacity to support stroke patients at home, or as close to home as possible

Access to care

- The benefit of faster access to diagnosis and treatment once at the acute site offsets the longer travel times for some patients. The evidence of the temporary consolidation of hyper acute stroke services demonstrated that on average patient's diagnosis and treatment times were improved and all patients who were eligible for thrombolysis received this within the four hour window from onset of symptoms.
- Patients are more likely to see the right specialist, first time and receive the best possible care upon arrival to the single site due to better staffing levels

Deliverability – achievable workforce requirement

- It is not possible to provide a robust stroke service across two acute hospitals. It is difficult to recruit stroke consultants nationally. With over 50% of posts remaining unfilled. The current model where the on call cover is spilt by three consultants on each site makes recruitment very difficult and results in a service that is vulnerable in the event of sickness or absence. This has resulted in many of the posts covered by agency staff. Currently, there is only one substantive accredited consultant in stroke medicine in ULHT.

- The proposed future model of acute stroke services supports a more sustainable and resilient workforce, particularly in the medical consultant and nursing groups, by:

- Increases the chances of recruiting to substantive roles (and the retention) if the service is based at Lincoln Hospital alongside other specialist services

- Avoids having to spread 6.0 consultants across two sites which are covered mainly by locum consultants at present.

- A reduction in a heavy reliance on locum and agency staff

- Supports a concentration (through service consolidation and the provision of fewer beds) of nursing staff at the Lincoln site, where there are currently fewer vacancies than at the Pilgrim site

- Supports the services ambition to provide posts with an academic element which again would make these posts more attractive and potentially sub-specialist interests

- There are gaps in the workforce at all levels. A consolidated model facilitates increase specialisation and by concentrating, the workforce on one site allows a rota with greater coverage over the working day/week.

- Supports skill mix and facilitates Advanced Nurse, therapist and consultant Practitioners who can provide a site presence to reduce the demands on the medical workforce and support patients by facilitating faster access to diagnostics and workup so that the consultant can commence treatment faster.

The table below sets out the current hospital based stroke service workforce model (funded establishment) together with the workforce model under the proposed preferred option.
The current workforce and future requirements for acute stroke services are outlined in the tables below:

Staff Group	**Current configuration**		**Preferred Option**	
	Lincoln Hospital	**Pilgrim Hospital**	**Lincoln Hospital**	**Pilgrim Hospital**
Medical				.
Consultants	3.0	3.0	6.0	-
Associate Spec.	1.0	1.0	2.0	-
F2 (Trust)	-	1.0	1.0	-
F2 (Deanery)	1.0	-	1.0	
F1 (Trust)	-	1.0	1.0	
F1 (Deanery)	1.0	1.0	2.0	
GPVTS (Deanery)	1.0	-	1.0	
Core Trainee (Deanery)	-	1.0	1.0	
Administration	2.0	2.66	4.66	

ACP Nurse ACPs			5.8	
Nursing Registered Nursing Associate Non Registered Ward Clerk	26.90 2.00 15.32 1.0	23.24 4.0 11.26 2.0	51.08 - 21.04 1.4	- -
AHP Physio/OT/SALT	39.36 (Across the trust)		33.67	

NOTE: TABLE IS TAKEN FROM PCBC. CURRENT CONFIGURATION THEREFORE REFERS TO 19/20 BASELINE

As there will no longer be a stroke service at Pilgrim Hospital, staff will be offered the opportunity to transfer to Lincoln Hospital, or to be re-deployed within another department at the Pilgrim Hospital.

The enhanced community stroke rehabilitation service will link closely with the Neighbourhood Teams, who will provide the requisite nursing, social care support and on-going 'self-care' options and support for stroke survivors.

At present between four and six stroke survivors per week are discharged into a community bed, which is expected to continue. However, the overriding principle for this work is 'home first' and as the enhanced community stroke service embeds and integrates into Neighbourhood working the ability to support complex survivors at home is expected to increase.

Conclusion

The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix 3
Statement of Support:

Clinical lead(s): Kate Scheele

Operational leads(s): Carl Ratcliff, Sarah Southall, Angela Shimada

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to provide an innovative integrated model of integrated community/acute beds at Grantham Hospital to work closely with the neighbourhood team.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality services are delivered in Lincolnshire in a sustainable way for the long term, by:

- Providing an excellent balance between access and sustainable long term outcomes
- Achieving a balance between access and ensuring the long term sustainability of services
- Grantham Hospital will become a hub for supporting community teams and community services across the county (including existing inpatient community hospital beds), reducing acute medicine admissions not just at Grantham Hospital but potentially across the county.
- The Same Day Emergency Care (SDEC) unit will offer an expansion of the current Ambulatory Assessment Unit (AAU), which is to be re-named in line with the national shift to 'Same Day Emergency Care'. The unit would receive referrals directly from the UTC, EMAS and primary / community care teams. The SDEC unit will be led by an Acute Physician team.
- Complex Frailty Service will offer specialist care and support for elderly and frail patients, including those with complex needs. The team will offer a day assessment and care service, supporting frail/complex patients who require diagnostics, multi-disciplinary assessment, medical review, therapy and social service assessments.
- The proposal would enable Grantham Hospital to offer services which may not be offered elsewhere and build a centre of excellence for integrated multi-disciplinary care, particularly for frail patients

Access to care

- It is estimated that no more patients than currently do now will be travelling over 60 minutes for non-elective care, the travel time threshold set by the local health system for activity of this type
- Patients are more likely to receive timely assessment, treatment and diagnosis when they arrive at hospital
- Patients are more likely to see the right specialist, first time, 24/7 and receive the best possible care.
- more patients going to the right place for care first time and minimising subsequent transfers

Acute medicine is currently provided from three wards on the Grantham hospital site that have a combined capacity of 79 beds:

- Emergency Assessment Unit - 28 beds (19/20 non-elective av. length of stay = 2.8)
- Ward 1 - 28 beds (19/20 non-elective av. length of stay = 7.1)
- Ward 6 - 23 beds (19/20 non-elective av. length of stay = 5.6

Based on the current activity levels and the current average lengths of stay across the wards the required bed capacity for acute medicine at Grantham hospital is estimated to be 73 beds, based on a 92% occupancy

Figure 154 – Estimated future acute medicine bed requirement analysis

Grantham acute medicine bed requirement under preferred option	Non-Elective		Elective		Day Case		Total	
	19/20	23/24	19/20	23/24	19/20	23/24	19/20	23/24
ONS based population projection								
Admissions	3,858	3,963	61	62	2,954	3,034	**6,873**	**7,059**
Acute medicine beds	63	65	1	1	9	9	**73**	**75**
High Acuity Beds	42	43						
Lower Acuity Beds	21	22						
Basecase: ONS growth & 25% with NEWS ≥5 transferred to specialist site (equals 10% reduction)								
Admissions	3,858	3,566	61	62	2,954	3,034	**6,873**	**6,662**
Acute medicine beds	63	59	1	1	9	9	**73**	**69**
High Acuity Beds	42	40						
Lower Acuity Beds	21	19						
Sensitivity 1: Basecase PLUS 10% admission avoidance / early discharge								
Admissions	3,858	3,170	61	62	2,954	3,034	**6,873**	**6,266**
Acute medicine beds	63	52	1	1	9	9	**73**	**62**
High Acuity Beds	42	35						
Low Acuity Beds	21	17						
Sensitivity 2: ONS growth & 50% with NEWS ≥5 transferred to specialist site (equals 20% reduction)								
Admissions	3,858	3,170	61	62	2,954	3,034	**6,873**	**6,266**
Acute medicine beds	63	52	1	1	9	9	**73**	**62**
High Acuity Beds	42	35						
Lower Acuity Beds	21	17						

Deliverability – achievable workforce requirement

The proposed future model of services supports a more sustainable and resilient workforce by:

- Introducing exposure to community-based services for the medical teams, particularly trainee roles, developing new specialists for the future with a more detailed understanding of the capabilities of community teams and the growing capacity for higher acuity care in the community.
- Supports a concentration (through service consolidation and the provision of fewer beds) of nursing staff at the Lincoln site, where there are currently fewer vacancies than at the Pilgrim site
- ULHT and the community provider would work together closely to establish the employment arrangements for the consultants and middle grades
- Recruitment and retention of medical staff has been a long-standing concern for ULHT, although Grantham Hospital has not had as many issues as Lincoln and Pilgrim Hospitals. At Grantham Hospital the majority of consultant posts are held by permanent Trust employees offering a consistency of service and training provision. Though there has been an increase in agency cover for some specialties more recently.

Staff Group	Current configuration (wte)	Preferred Option (wte)*
Medical		
General / Acute Medicine		
• Consultants	3.0	3.0
• Middle/Trust Grade	2.0	2.0
• Foundation/Trainee	6.0	6.0
Respiratory		
• Consultants	2.0	2.0
• Middle/Trust Grade	1.0	1.0
• Foundation/Trainee	3.0	3.0
Health Care for Elderly		
• Consultants	2.0	2.0
• Middle/Trust Grade	2.0	2.0
• Foundation/Trainee	2.0	2.0
		PLUS
Gastroenterology	Majority of care provided in OP setting	• 1.0 additional consultant (to give a total of 8**)
• Consultants	3.0	• 3.0 additional middle grades, likely in respiratory medicine and medicine of elderly (to give a total of 8)
• Middle/Trust Grade	2.0	
• Foundation/Trainee	2.0	
Cardiology		• Gastro and Cardiology Foundation/Trainee to be replaced including by GP VTS, IMP and ACPs
• Consultants	2.0	
• Middle/Trust Grade	1.0	
• Foundation/Trainee	4.0	
Admin	14.0	14.0
Nursing (SDEC / Frailty Service / Ward)		
• Registered	49.0	49.0
• Nursing Associate	7.5	7.5
• Non Registered	37.5	37.5
• Ward Clark	5.5	5.5

**Planning assumptions: All subject to review and change once service is fully operational – optimal nursing skill-mix will be refined over time once service is fully operational to ensure alignment with patient need*

*** In line with the innovative acute/community model consideration will be given to one of the consultants being a non-medical consultant.*

The expectation for the new model is that existing provision will be extended, offering a number of benefits:

- Roles integrated into community provision, supporting working across both a community base and hospital units / wards.
- Reducing medical workload and reliance. Supporting any gaps in junior medical staffing / medical trainees within the new model.
- Increased consistency in service provision.
- Specialist knowledge across a range of disciplines, offering high level intervention in non-medical areas, for example frailty specialist therapy assessment and care planning.

<u>Conclusion</u>

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to provide an innovative integrated model of integrated community/acute beds at Grantham Hospital as part of the neighbourhood team

Appendix 4
Statement of Support:

Clinical lead(s): Dr Flynn

Operational leads(s): Carl Ratcliff, Cheryl Thomson, Sarah Southall, Angela Shimada

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to re-designate the Grantham A&E service as an Urgent Treatment Centre (UTC) and maintain 24/7 A&E services provided from Lincoln Hospital and Pilgrim Hospital.

The benefits we believe these changes will result in are set out below.

Quality of care
24/7 walk in urgent care would return to Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term.

- Reduce the number of intra hospital transfers to another site, so demonstrating that the patient was getting to the definitive treatment site, first time.
- Support a more consistent achievement of clinical standards, i.e. the NHS constitutional four-hour standard, time to triage at the Lincoln Hospital and Pilgrim Hospital sites and time to treatment across all three ULHT hospital sites.
- Ensuring Grantham Hospital receives an appropriate mix of patient acuity in line with its capabilities.
- Aligns with NHS England and Improvements vision for urgent and emergency care patients.
- Encourages integrated service delivery between primary care, community care and acute care providers.
- Given the medical workforce challenges and heavy reliance on locum doctors who are likely to represent a less stable workforce, will minimise additional pressures across the A&E system in Lincolnshire and patient risk.
- Minimise the pressure on ULHT's nursing staff, where there are already significant vacancies, and therefore impact on the quality and safety of care provided.

Access to care
The UTC would provide greater accessibility due to increased opening hours compared to the current A&E arrangements (currently closed between 6.30pm and 8.00am).

- Under the proposed model of a 24/7 UTC at Grantham Hospital (and integrated community/acute medicine beds described later) the exclusion criterion for the Grantham Hospital site would be refined, meaning a relatively small number of patients currently attending the A&E, would not in the future. This would mean more patients going to the right place for care first time and minimising subsequent patient transfers.
- Patients are more likely to see the right specialist, first time, 24/7 and receive the best possible care

	24/7 A&E (as was)	24/7 UTC
Opening hours	• 24hrs a day 7 days a week Av. 80 attendances per day (24hrs) • Av. 11 attendances between 23.00-07.00	• 24hrs a day 7 days a week
Acuity	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals. • Refinement of exclusion criteria to allow a larger proportion of frail and elderly patients from the geographic locality to receive inpatient care at Grantham and a small volume of higher acuity cases currently managed at Grantham to receive specialised treatment elsewhere
Workforce	• Consultants: 80hrs/week plus on-call evenings & weekends • Middle Grades: 24/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours	• Consultants: 40hrs/week no on-call evenings & weekends • Middle Grades: 16/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours Planning assumptions: All subject to review and change once service is fully operational
Diagnostic	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7

- In addition, through workshops with stakeholders proposals have been developed to improve support to patients with regards to travel in the broadest sense across Lincolnshire (i.e. not just relating to proposed service changes under the acute services review). These include:
  - Ensuring a seamless process for advice, eligibility assessment and booking
  - Improved coordinated way of ensuring the appropriate transport is arranged for discharges from hospital:
  - The default should be Non-Emergency Patient Transport Services (NEPTS) unless there is a 'medical need'
  - Better planning and coordination with the family/patient early in a patients stay as an integral part of discharge planning
  - Coordination of NEPTS with potential other options through a single system approach to discharge planning

- Booking of clinics:
  - More proactive choices regarding clinic bookings should include a discussion on 'how are you intending to travel'
  - Real time information to support administrators in understanding public transport should be easily accessible on their IT systems so that is the patient is travelling by bus and the first bus doesn't arrive until 10:00 the patient is offered an appointment after this time
- Integration of CallConnect and NEPTS journey planning to reduce duplication
- Integration of systems to allow funded, non-funded and concessionary fares/bus passes to use multiple types of transport.
- Access to treatment would further improve for children because the UTC team would broaden to include community and primary care staff (eg. GPs) who are more experienced and familiar with treating children than a traditional, non-paediatric A&E team.
- The vast majority of patients (estimated to be around 97%) seen at the Grantham and District Hospital A&E department would continue to be seen and treated at the 24/7 Urgent Treatment Centre (UTC).
- For a small number of patients (estimated to be around 3%, which is equivalent to 2 patients a day on average) currently attending the Grantham and District Hospital A&E who wouldn't be able to have their care needs met by the UTC, care would be received at an alternative site with the right facilities and expertise to ensure better clinical care outcomes.

Deliverability – achievable workforce requirement

The proposed model supports a more sustainable and resilient workforce by:

- The Consultant workforce will be ULHT employed and will undertake sessions at Grantham UTC on a rotational basis. This will support the likelihood of recruiting to substantive ED Consultant posts by linking the service to the remaining Type 1 EDs.
- Initially a total of ten sessions of Emergency Medicine Consultant cover will be provided (equivalent to 40 hours a week). This will be reviewed at three, six and 12 months.
- The proposed model being led by a community provider should also minimise the pressure on ULHT's nursing staff, where there are already significant vacancies.
- By implementing the proposed model of an Urgent Treatment Centre at Grantham Hospital it is believed the optimum balance of patient volumes, acuity, outcomes and resource will be achieved. Medical middle grades will support the UTC between 08.00 and midnight when activity is known to be at its highest and will not need to staff an on-call rota at night. When the A&E operated as a 24/7 service on average 11 patients a day attended between 23.00 and 07.00.

Estimated future Grantham UTC attendance analysis

Attendees at the proposed Grantham Urgent Treatment Centre				
15/16		**19/20**	**23/24 Scenario 1**	**23/24 Scenario 2**
Grantham 24/7 A&E attendances Assuming 24/7 operation in 19/20	29,297	33,900	-	-
Grantham OOH service	15,675	7,600	7,800	11,600
Grantham 24/7 UTC attendances	-	-	34,900	39,000
Total	44,972	41,500	42,700	50,600
Adjusted for displaced patients	-	-	42,000	49,900
Sensitivity analysis – reduction in 10% of attendances through ICC				
Grantham 24/7 UTC attendances	-	-	37,800	44,910

The table below sets out the proposed workforce (funded establishment) of the Grantham Hospital A&E when it operated 24/7 together with the Out of Hours workforce, what the workforce currently is (19/20 baseline 'pre-covid') and the workforce for the proposed 24/7 Urgent Treatment Centre developed for planning purposes.

Grantham UTC model workforce compared to A&E & Out of Hours model (funded establishment)

	A&E 24/7 & Out of Hours (WTE) 2015/16	**A&E (08.00-18.30) & Out of Hours (WTE) 2019/20**	**UTC 24/7 (WTE)*** **
Medical • Consultants • Middle/Trust Grade • Foundation/Trainee • Admin • GPs	 2.0* 6.0** 7.0 0.6 10 sessions/week	 2.0 5.0 6.0 0.6 10 sessions/week	 1.2 5.0 6.0**** 0.6 10 sessions/week + OOH
ACP • Nurse ACPs	 4.5	 4.0	 4.0
Nursing • Registered • Nursing Associate • Non Registered • Receptionist	 24.5 2.5 10.0 4.0	 19.0 1.0 7.5 2.5	 25.5 1.0 14.0 2.5
Out of Hours • GP • Registered • Non Registered/ Clerk	 2.0 6.5 7.0	 2.0 6.5 6.5	 Out of Hours will be integrated with UTC

** Consultants provided on-call cover overnight and at weekends*
*** Middle grades covered the whole out of hour's rota between them – 'rule of thumb' guidance suggests should be 12.0*
**** Planning assumptions: All subject to review and change once service is fully operational*
***** Junior training posts will be retained, proposed model will offer a valuable and interesting environment. Ongoing engagement of HEE to ensure they remain supportive and posts will need to be considered in the context of the overall requirement/ need for these posts across the whole of ULHT*

The service change proposal improves the services ability to attract and retain talented and substantive staff through building a strong and successful service that offers opportunities to work in a centre of excellence.
Recruitment and retention of urgent and emergency staff has been a long-standing concern for Lincolnshire, although Grantham Hospital has not had as many issues as Lincoln and Pilgrim Hospitals.
The proposed model of an Urgent Treatment Centre at Grantham Hospital is seen to provide and achieve the optimum balance of patient volumes, acuity, outcomes and resource. Medical middle grades would support the UTC between 08.00 and midnight when activity is known to be at its highest and will not need to staff an on-call rota at night.

<u>Conclusion</u>
The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix 5
Benefits Plan**:Orthopaedics**

Clinical lead(s): Mr Kulandaivel Sakthivel Consultant Orthopaedic Surgeon
Operational leads(s): Mr Mark Lacey Divisional Managing Director - Surgery

ASR Proposal - Benefits Management Framework (Orthopaedics)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the ASR can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	Orthopaedics	This proposed change should improve patient safety. Patients will have improved access to elective and non-elective care, improving health outcomes.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
	Orthopaedics	It is highly likely that the new model of care will be able to meet the needs of a significant majority of patients locally, through an integrated model of provision.	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly
	Orthopaedics	Reduced chance of post-op infection, extended use of	Length of Stay and current recorded	Provider	PAS Data / Provider Datix /	Monthly

		enhanced recovery.	incidents and patient quality indicators		Complaints System	
	Orthopaedics	Reduced cancellations for elective patients, as following this reconfiguration as hot and cold activity are split.	Monitor current recorded cancellations	Provider	PAS Data	Monthly
	Orthopaedics	Reduced waiting times for surgery.	Monitor performance of the reduction	Provider	PAS Data	Monthly
	Orthopaedics	Improve opportunities for staff to be developed in post. Staff will retain their base site and travelling between sites for the elective surgery which is part of Trust-wide working.	Current WTE and Vacancy Gap	Provider	Workforce Data / ESR	Monthly
	Orthopaedics	The new model should make remaining in post more attractive, with more opportunities for development in the care of orthopaedic work.	Current WTE and Vacancy Gap	Provider	Workforce Data / ESR	Monthly

Appendix 6
ASR Proposal - Benefits Management Framework (Stroke Services)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the project can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	Stroke Services	Community slow stream rehab service would be in place which will support a reduction in LOS in the acute sector by increasing the availability of acute beds for patients with complex needs.	Length of Stay	Provider	PAS Data	Monthly
	Stroke Services	This proposed changes should improve patient safety.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
	Stroke Services	By creating a specialist centre of excellence for Stroke Services that safely meets patient's clinical needs and maintains access locally	National Standards	Provider	PAS Data	Monthly
	Stroke Services	This program should improve overall performance against constitutional standards.	National Standards	Provider	PAS Data	Monthly

	Stroke Services	By creating a specialist centre for Stroke Services, this should attract candidates from further afield	Vacancy rate	Provider	Workforce Data / ESR	Monthly
	Stroke Services	Impact could be both positive and negative. Staff who do not wish to transfer from Pilgrim site could increase turnover rate or absenteeism. Positive impact could be a more robust workforce at Lincoln improving retention rates and reducing sickness.	Turnover Rates Sickness Rates	Provider	Workforce Data / ESR	Monthly
	Stroke Services	Could be both positive and negative impact. Pilgrim Staff will potentially respond negatively and Lincoln Staff will potentially respond positively	Staff Survey	Provider	Workforce Data / ESR	Monthly

Appendix 7
ASR Proposal - Benefits Management Framework (Acute Med)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the project can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	Acute Med	This proposed changes should improve patient safety.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
	Acute Med	The development of an integrated community/acute provision that safely meets patient's clinical needs and maintains access locally should address the workforce challenges.	Current WTE and Vacancy Gap	Provider	Workforce Data / ESR	Monthly
	Acute Med	It is highly likely that the new model of care will be able to meet the needs of a significant majority of patients locally, through an integrated community/acute model of provision. It will build on the locality model of integrated neighbourhood working.	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly

	Acute Med	An integrated community/acute provision will allow for a service that safely meets patients' clinical needs and maintains access locally. The service will be aligned with the local Integrated Care Team that will support the management of the local bed base and be used to support people closer to home.	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly
	Acute Med	The proposals may provide opportunity currently experienced by ULHT with significant workforce challenges in acute medicine. This will help to address the recruitment challenges faced by ULHT in this area.	Current WTE and Vacancy Gap	Provider	Workforce Data / ESR	Monthly
	Acute Med	Greater integration with the Integrated Neighbourhood Team should support earlier discharge from the integrated community/acute beds	Length of Stay	Provider	PAS Data	Monthly
	Acute Med	This program should improve overall performance against constitutional standards.	National Standards	Provider	PAS Data	Monthly
	Acute Med	Positive Impact - Following the implementation of multiple initiatives related to patient flow and care closer to home there has been significant change supporting acute and community care.	Monitor Performance of the impact from Care Closer to Home Initiatives and Patient flow Discharge Models.	Commissioner	PAS Data	Monthly

Appendix 8
ASR Proposal - Benefits Management Framework (UEC)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the project can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	UEC	This service change may improve patient safety as it will ensure those patients with the highest acuity go to the right hospital first time.	Reduction in Incidents / Complaints	Provider	Provider Datix / Complaints System	Monthly
	UEC	Positive impact related to greater accessibility (opening hours) and a direct link with Primary Care and Community services	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly
	UEC	Positive impact on time spent by patients within the department due to the UTC model of assessment and management versus the A&E model of care	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly
	UEC	Improve overall recruitment and retention due UTC changes that should make roles more attractive to some staff groups	WTE and Vacancy Fill	Provider	ESR	Monthly

Appendix 9

<u>Outline Implementation Plan</u>: Orthopaedics

Clinical lead(s): Mr Kulandaivel Sakthivel Consultant Orthopaedic Surgeon
Operational leads(s): Mr Mark Lacey Divisional Managing Director - Surgery

Formal governance arrangements are required to steer and govern the process of service change and deliver the changes to Orthopaedics.
It is proposed that a dedicated implementation group will be established to ensure that the proposed changes to orthopaedics that is currently being piloted can be delivered as a permanent change to the service. This will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues and manage risks.
- Involve members of the ICS such as Acute/Community Trusts, local GP's and the ICS function.
- Appoint an SRO.
- Agree and monitor performance metrics to track and manage progress against key metrics.
- Align any other key programmes in place as required such as other ASR projects.

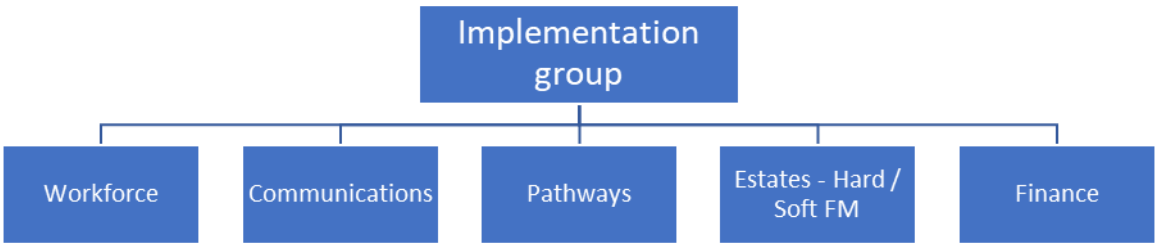
A number of workstreams will be established to lead on both the planning and development required to support changes to the services, as well as the transactional process of change. The governance arrangements will report into respective organisations structures.
A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting are maintained.

The proposed changes to the service have been in place, as part of a national pilot, since August 2018.

Therefore if the proposed change was approved provisions would need to be made for this pilot to become a permanent change. Key aspects of this would be the need to review internal governance around the programme and any necessary HR facets, such as staff consultation.

The proposed change shouldn't see a protracted timeframe, given the current circumstances.

Governance Structure:



Clinical Work streams

There are a number of clinical work streams based on the ASR and the programme will be in place to avoid silo working. Each work stream will be responsible for planning the service change and report back to the lead implementation group and they will focus on:

- Agree pathways for patients.
- Ensure function of other aspects of ASR fit into the model, other system Health/Social care provision.
- How service changes will be made/when will services start.

Non clinical Work streams

There will be a number of non-clinical to support clinical work streams in delivery of the proposed model including:

- Workforce – recruitment and training.
- Estates.
- Equipment.
- Communications and stakeholder management.
- Finance.

Appendix 10

Outline Implementation Plan: Stroke

Clinical lead(s): Dr Abdul Elmarimi Consultant Stroke Medicine
Operational leads(s): Carl Ratcliff Managing Director Medicine

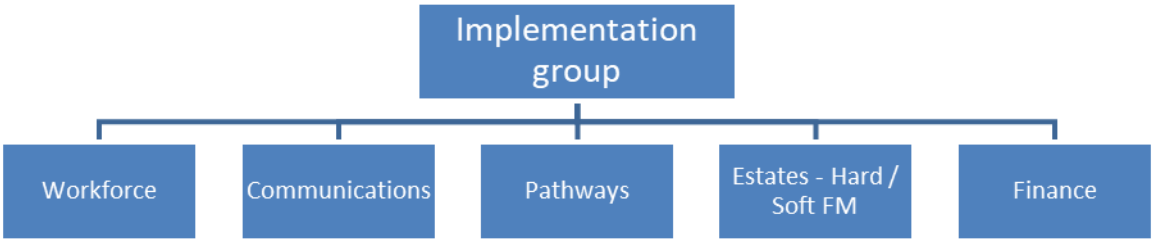
Formal governance arrangements are required to steer and govern the process of service change and deliver the changes in the stroke pathway. It is proposed that a dedicated implementation group will be established to ensure the project is delivered and embedded. This will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues an manage risks
- Involve members of the ICS such as Acute/ Community Trusts, local GP's and ICS function.
- Appoint a SRO for the project
- Agree and monitor performance metrics to track and manage progress against key metrics
- Align any other key programmes in place as required such as other ASR projects.

A number of work streams will be established to lead on both the planning and development required to support changes to the services, as well as the transactional process of change. The governance arrangements will report into respective organisations structures.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting are maintained.

Governance Structure:



Prior to the implementation of the proposed single site model, there would need to be a business case development process which we envisage to take circa.18 months to increase the footprint of the current Lincoln stroke unit.

	Month											
Stroke	1	2	3	4	5	6	7	8	9	10	11	12
Review of start point/end model with current mitigation of service*												
Review of Implementation												
Business case development/Approval for capital/ revenue												
Impact Assessments												
Establishment / function of Operational & Governance Structures / Working Groups												
Recruitment of staff including LCHS therapy staff**												
Commencement of Build (if required)	18 months to completion once approved											
Implementation												
Staff Consultation												
Evaluation												

* Consultation has been on the service that existed before any current service mitigations were made. There will be an evaluation on the changes required to move to the new model, taking into account these required mitigations that are only in place as a temporary measure to keep the service safe.
** LCHS have already started recruitment outside of the ASR, on the need as a result of the ASR work. This has been driven by COVID and general recruitment challenges per say.
However this recruitment does not reach the levels required for the complete Stroke ASR work.

Clinical Work streams

There are a number of clinical work streams based on the ASR and the programme will be in place to avoid silo working. Each work stream will be responsible for planning the service change and report back to the lead implementation group and they will focus on:

- Agree pathways for patients.
- Ensure function of other aspects of ASR fit into the medical bed model, along with SDEC and frailty units and other system health / social care provision.
- How service changes will be made, for example will there be double running / when will services start.
- Management structures, workforce issues, governance including policies and protocols.
- Management of the deteriorating patient.

Non clinical Work streams

There will be a number of non-clinical to support clinical work streams in delivery of the proposed model including:

- Workforce – recruitment and training
- Estates (including Business case
- Equipment
- Communications and stakeholder management
- Finance

Appendix 11

Outline Implementation Timescales: Acute Med

Clinical lead(s): Kate Scheele Consultant Respiratory - Medicine
Operational leads(s): Carl Ratcliff Managing Director - Medicine

Implementation

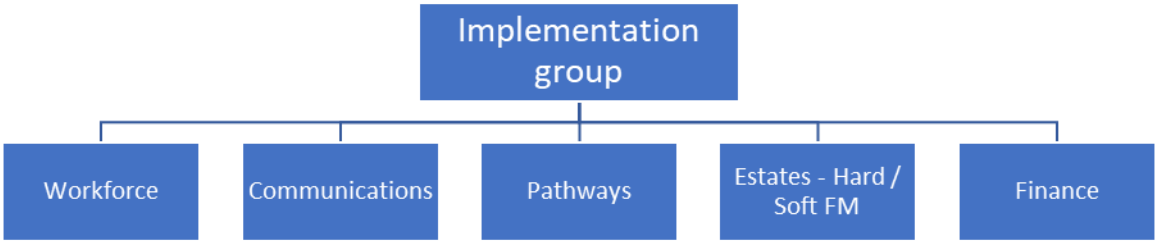
Formal governance arrangements are required to steer and govern the process of service change and deliver the changes in the medical beds. It is proposed that a dedicated implementation group will be established to ensure the project is delivered and embedded. This will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues and manage risks.
- Involve members of the ICS such as Acute/Community Trusts, local GP's and ICS function.
- Appoint a SRO for the project.
- Agree and monitor performance metrics to track and manage progress against key metrics.
- Align any other key programmes in place as required such as other ASR projects.

A number of work streams will be established to lead on both the planning and development required to support changes to the services, as well as the transactional process of change. The governance arrangements will report into respective organisations structures.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting are maintained.

Governance Structure:



	Month													
Acute Medicine	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Evaluation of Procurement for new provider														
Organisational Review														
Provider Collaborative Agreed														
Establishment of Operational & Governance Structures / Working Groups														
Staff Consultation														
Implementation														
Evaluation														

Clinical Work streams

There are a number of clinical work streams based on the ASR and the programme will be in place to avoid silo working. Each work stream will be responsible for planning the service change and report back to the lead implementation group and they will focus on:

- Agree pathways for patients.
- Ensure function of other aspects of ASR fit into the medical bed model, along with SDEC and frailty units and other system health / social care provision.
- How service changes will be made, for example will there be double running / when will services start.
- Management structures, workforce issues, governance including policies and protocols.
- Management of the deteriorating patient.

Non clinical Work streams

There will be a number of non-clinical to support clinical work streams in delivery of the proposed model including:

- Workforce – recruitment and training.
- Estates.
- Equipment.
- Communications and stakeholder management.
- Finance.

Appendix 12

<u>Outline Implementation Plans</u>: UEC

Clinical lead(s): Dr Flynn Consultant A&E

Operational leads(s): Carl Ratcliff Managing Director Medicine
Cheryl Thomson General Manager Urgent & Emergency Care

Formal governance arrangements are required to steer and govern the process of service change and deliver the changes in the Emergency care pathway. It is proposed that a dedicated implementation group will be established to ensure the project is delivered and embedded. This will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues and manage risks.
- Involve members of the ICS such as Acute/Community Trusts, local GP's and ICS function.
- Appoint a SRO for the project.
- Agree and monitor performance metrics to track and manage progress against key metrics.
- Align any other key programmes in place as required such as other ASR projects.

A number of work streams will be established to lead on both the planning and development required to support changes to the services, as well as the transactional process of change. The governance arrangements will report into respective organisations structures.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting are maintained.

Governance Structure:

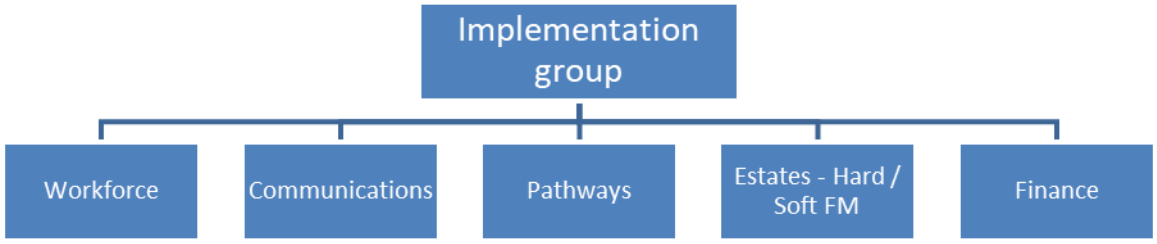


Figure 1: UEC Implementation Proposed Timeline

	Month																	
UEC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Evaluation of Procurement for new provider																		
Organisational Review																		
Provider Collaborative Agreed																		
Establishment of Operational & Governance Structures / Working Groups																		
Staff Consultation																		
Implementation																		
Evaluation																		

Clinical Work streams

There are a number of clinical work streams based on the ASR and the programme will be in place to avoid silo working. Each work stream will be responsible for planning the service change and report back to the lead implementation group and they will focus on:

- Agree pathways for patients.
- Ensure function of other aspects of ASR fit into the medical bed model, along with SDEC and frailty units and other system health / social care provision.
- How service changes will be made, for example will there be double running / when will services start.
- Management structures, workforce issues, governance including policies and protocols.
- Management of the deteriorating patient.

Non clinical Work streams

There will be a number of non-clinical to support clinical work streams in delivery of the proposed model including:

- Workforce – recruitment and training.
- Estates.
- Equipment.
- Communications and stakeholder management.
- Finance.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	7th June 2022
Item Number	
Integrated Performance Report for April 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 7 falls in April resulting in moderate harm and 1 fall where the patient died. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. Assessment and consistent application of enhanced care processes remains a priority area to improve. A review of the Enhanced Care policy has been undertaken. Currently going through consultation and approval processes.

Pressure Ulcers

The number of category 2 PU is 38 for April 2022 a decrease of 6 from the previous month. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. Both LCH & PHB ED's are trialing the use of a small number of beds in the department instead of trollies. This will provide a more appropriate surface for patients at risk, with additional room to reposition patients, minimizing the risk of skin integrity damage.

Never Event

There has been 1 Never Event declared within April that is currently under investigation. This has been reported as a low harm incident relating to an anaesthetic block performed on the incorrect side. Immediate actions have already been implemented by the Surgical Division.

Medications

For the month of April, the number or incidents reported in relation to omitted or delayed medications equated to 31% a decrease from the previous month. 20.9% of medication incidents identified that harm had been caused and is noted to be above the national average and a decrease from the previous month equating to 172 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.

Medicines reconciliation on all three sites is consistently below target. The Pharmacy department do not currently have funding to provide a 7 day service. An internal audit into Medicines Management was undertaken in February 2022.

SHMI

The Trust SHMI is 109.48, a slight decrease from the last reporting period. The Trust has moved from a 'Higher than expected SHMI to 'as expected'. The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.

eDD

The Trust achieved 88.6% with sending eDDs within 24 hours for April 2022 against a target of 95% with 92.1% being sent anytime within the month. A proposal has been developed and agreed to how eDDs will be managed going forward within the Trust. This will be in collaboration with our system partners.

Sepsis compliance – based on March data

Screening / IVAB / inpatient child - Screening compliance for inpatient paediatrics was 81.8%, screening compliance for paediatrics in ED was 83.5%, with the administration of IVAB for inpatient paediatrics 75% for March 2022. Screening compliance for adult inpatients remains the same (88.6%). Clinical Harm reviews continue as indicated and actions to recover can be seen further within this report.

Duty of Candour (DoC) – March Data

Verbal compliance for March was 89% against a 100% target and 71% for written against a target of 100%. This is a significant improvement from the previous months. Of note, due to the ongoing work by the Clinical Governance team and Divisional teams there has also been an improvement for February and March 2022as can be seen within the data sets below. It is predicted that these figures will continue to improve month on month.

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 (14th May 2022), the Trust has 35 positive inpatients. There are 0 patients requiring Intensive Care interventions. 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.

This report covers April's performance, and it should be noted the demands of Wave 4 has decreased, the Trust is now moving at pace 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.

The Trust declared 1 Critical Incident in April. The declaration was made at 17.43hrs 13th April and was stood down at 18.00hrs on 15th April 2022.

A & E and Ambulance Performance

Whilst the summary below pertains to April's data and performance, the proposed new Urgent Care Constitutional Standards continue to be adopted and run-in shadow form. Performance against these will be described in the supplementary combined operational performance FPEC paper.

4-hour performance improved slightly against March's performance of 61.18% being reported at 63.08% in April. The Trust's performance has been below the agreed trajectory consistently for 17 months.

There were 745 12-hr trolley waits, reported via the agreed process. This represents a decrease of 10.68% from March. 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 April demonstrated an improvement of 2.16%. 83.34 in April verses 81.18% in March.

Overall Ambulance conveyances for April were 3799, a decrease of 73 conveyances. This represents a 1.89% decrease against March. There were 819 >59minute handover delays recorded in March, an increase of 3 from March, representing a 0.37% 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. April saw a very slight increase in >120mins handover delays compared with March, 461 in April compared with 459 in March, representing a 0.44% deterioration. >4hrs handover delays decreased, particularly at PHB. A total of 118 in April compared to 148 in March. This represents a 20.28% decrease. Category 1 conveyance have increased.

Length of Stay

Non-Elective Length of Stay in beginning to reduce but remains major contributor to overcrowding in EDs and the subsequent impact on ambulance handovers. At 5.02 days average Length of Stay, there has been a 0.15-day reduction in April. The average bed occupancy for April 2022, was 92% vs 91.37% in March. 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 is now with the agreed parameters.

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.

March demonstrated a further decrease in performance of 1.03% to 51.22%. The Trust reported 4,177 incomplete 52-week breaches for March end of month compared to 3,318 in February. The Trust remains in a strong position when compared to other regional providers.
The Cancer/Elective Cell continue to meet weekly, with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation cell to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and

clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 52+ and 78+ week patients on the 18-week monitoring lists.

At the end of March, the Trust reported 23 patients waiting longer than 104weeks. A large proportion of these waits have been identified as a patient choice issue.

Waiting Lists

Overall waiting list size has increased in March to 66,539 compared to February to 63,680, an increase of 2,859. 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. April demonstrated an increase (596 verses 462 in March). As of 12th May, ASI numbers have increased to 834 and is above the agreed trajectory. The trajectory is 550.

DM01

DM01 for April reported a 56.03% compliance against the national target of 99%. A negative variation of 42.97% against the national target and a 6.23% deterioration on the March outturn. Whilst the main area of concern remains Echocardiography, DM01 was significantly impacted by the fire at LCH.

Cancelled Ops

This indicator has not been met since July 2021. The compliance target for this indicator s 0.8%. April demonstrated a 2.09% compliance. A negative variance of 1.29% against the agreed target but an improvement of 0.34% on March.

The target for not treated within 28 days of cancellation is zero. April experienced 33 breaches against this standard verses 22 in March. A deterioration of 33.34%

A review of the effectiveness of the 6:4:2 theatre scheduling meetings continues and ICU capacity as a response to internal and external pressures is improving so it is likely that performance will continue to improve.

Cancer

Of the ten cancer standards, ULHT achieved two March. Nationally only one was met.

Trust compliance against the 62day classic treatment standard is 54.17% (against 85.4% target.) This demonstrates a deterioration in performance of 1.7% since the last reporting period.

35.2% 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 were reducing in line with the trajectory, maintaining a level below trajectory until Easter where the impact of multiple Bank Holidays, with associated annual leave has shown a significant deterioration. As of 11th May 2022 there are 526 verses 421 as of 14th April 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 increased by 0.10% in April, however we are now seeing a decrease in Covid absences.

Work is continuing to support the 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. This continues to have a positive impact in reducing the 'blank' reasons.

Additional on-site Physiological support is now available to all staff and has been launched in the Trust.

Staff Appraisals – The OD team completed a deep dive into appraisal completion rates which was presented to the senior leaders in HR/OD for discussion and next steps. The WorkPAL contract is under discussion with the vendor. Ongoing service pressures and staffing challenges in the Trust have impacted appraisal completion rate over the past 6 months. Return to normality rates will be slow due to backlog.

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 offers face to face / Teams exit interviews to gather deeper insights on the reasons for leaving (in addition to ESR / EF3 form results).

Finance

The Trust submitted a financial plan for 2022/23 of a £5.8m deficit; the plan is inclusive of a £25m cost improvement programme.

A further financial plan submission is required in June to take account of expected additional national funding for 'excess' inflation and pressures - the additional funding comes with the expectation that systems and organisations within them will further improve their plan positions.

The Trust delivered a £0.6m deficit in April (£0.2m adverse to a planned deficit of £0.4m); cost improvement delivery, though, has not been reported for month 1.

Capital funding levels for 2022/23, agreed through Trust Board & FPEC, show a plan of c£41.0m; capital expenditure incurred in month 1 equated to c£0.2m.

The April 2022 cash balance is £77.6m, which is a decrease of £10.7m against the March year-end cash balance of £88.3m.

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

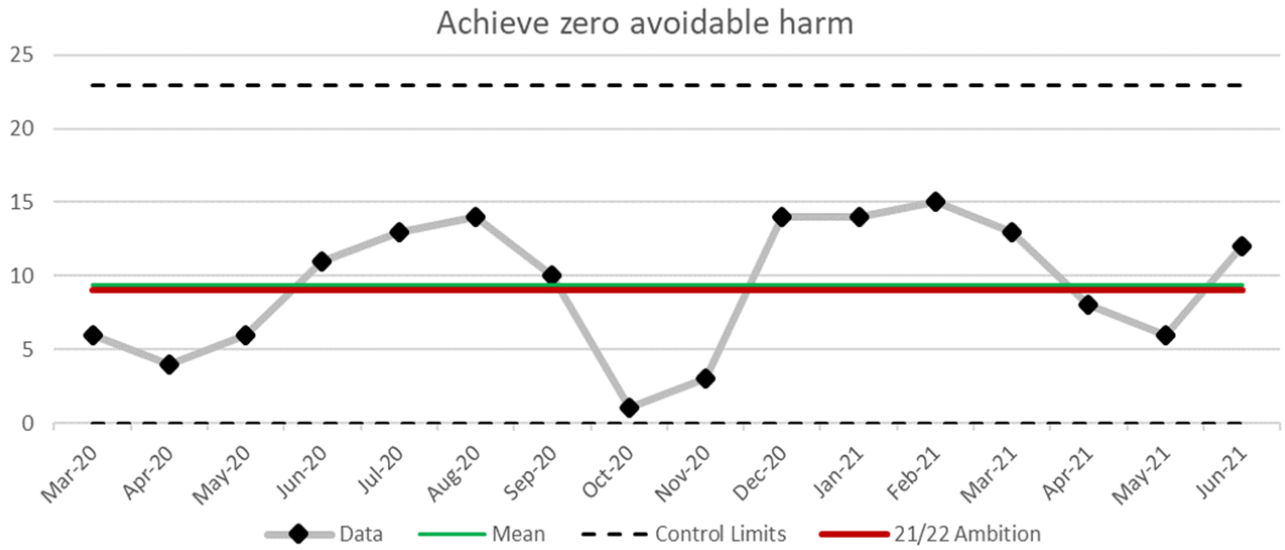
Statistical Process Control Charts

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

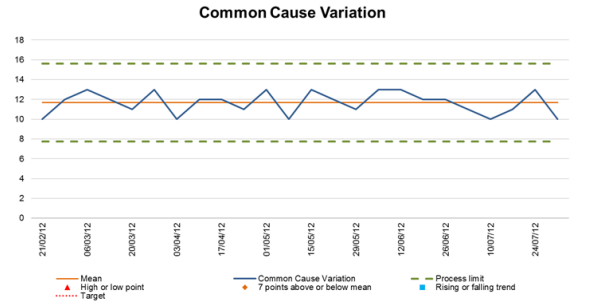
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

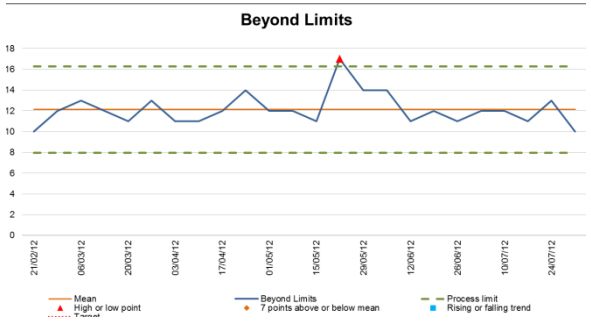
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



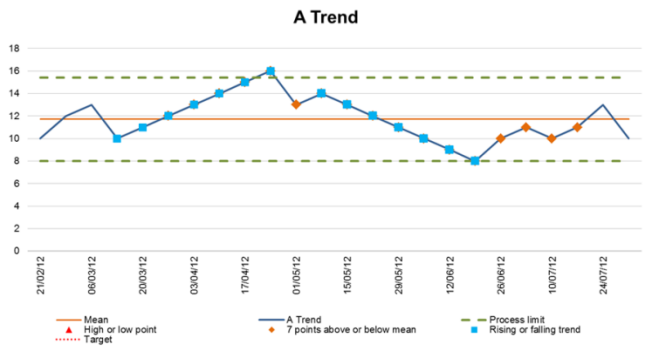
Extreme Values

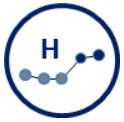
There is no Icon for this scenario.



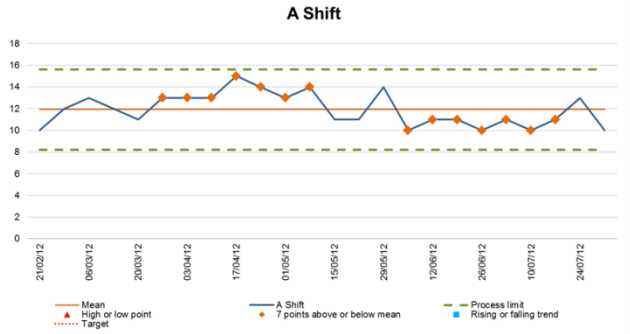
Statistical Process Control Charts

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		2022/2023		
Strategic Goal	Domain	Measure ID	Measure	Measure Definition	Baseline	21/22 Ambition	£'000	Feb	Mar	Apr	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) (85.87%) (112th of 120)	(TBC) (87.85%) (TBC)	(TBC) (87.89%) (TBC)		
	Patients	2	Achieve zero avoidable harm	Serious incidents (including Never Events) of harm - Moderate, severe and death.	15	9		4	7	13		
	Patients	3	Top 25% for SHMI	Summary Hospital-level Mortality Indicator	4th Quartile	4th Quartile		4th Quartile (111.20) (108th of 122)	4th Quartile (111.23) (108th of 122)	4th Quartile (109.48) (107th 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%		54.90%	51.70%			
	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%		21.43%	19.69%	20.28%		
	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		9.1	8.2	4.7		
	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%		32.54%	32.53%	32.39%		
	Services	9	Deliver a breakeven revenue position	Financial status - Revenue monthly variance to plan		Breakeven	£'000	£0.00	£59.00			
	Services	10	Deliver £200m capital plan	Financial status - Capital monthly actual shown cumulatively	£15m	£39m	£'000	£23,869.70	£45,716.67			
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%		23.08%	27.80%	20.90%		
	Patients	12	Reduce no. of patient fall incidents. (Last 3 month Average)	Number of Falls reported (including no harm)	200	159 (-20.5%)		170.7	183.0	184.0		
	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%		56.43%	54.57%	54.83%		
	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	£41,861	£46,064			
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)	50% (4/8)			
	Patients	19	Reduce incidence of pressure ulcers	Number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable	58 pcm	45 pcm		49	48	41		
	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%			45.19%	46.86%	50.65%		
	Partners	23	Reduction in the new to follow up ratio	Reduction in the number of follow up outpatient activities undertaken.	1:2.28			1:1.45	1:1.42	1:1.46		
	Partners	24	First OPA within 4 weeks	Number of outpatients seen within 4 weeks of their referral to hospital. Includes external referrals only (from GP, Dentist, Optician) for all urgency types (2WW, Urgent, Routine) to consultant led services (non-telephone).	51%			43.52%	49.30%	49.45%		
	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	£39.00	£134.00			

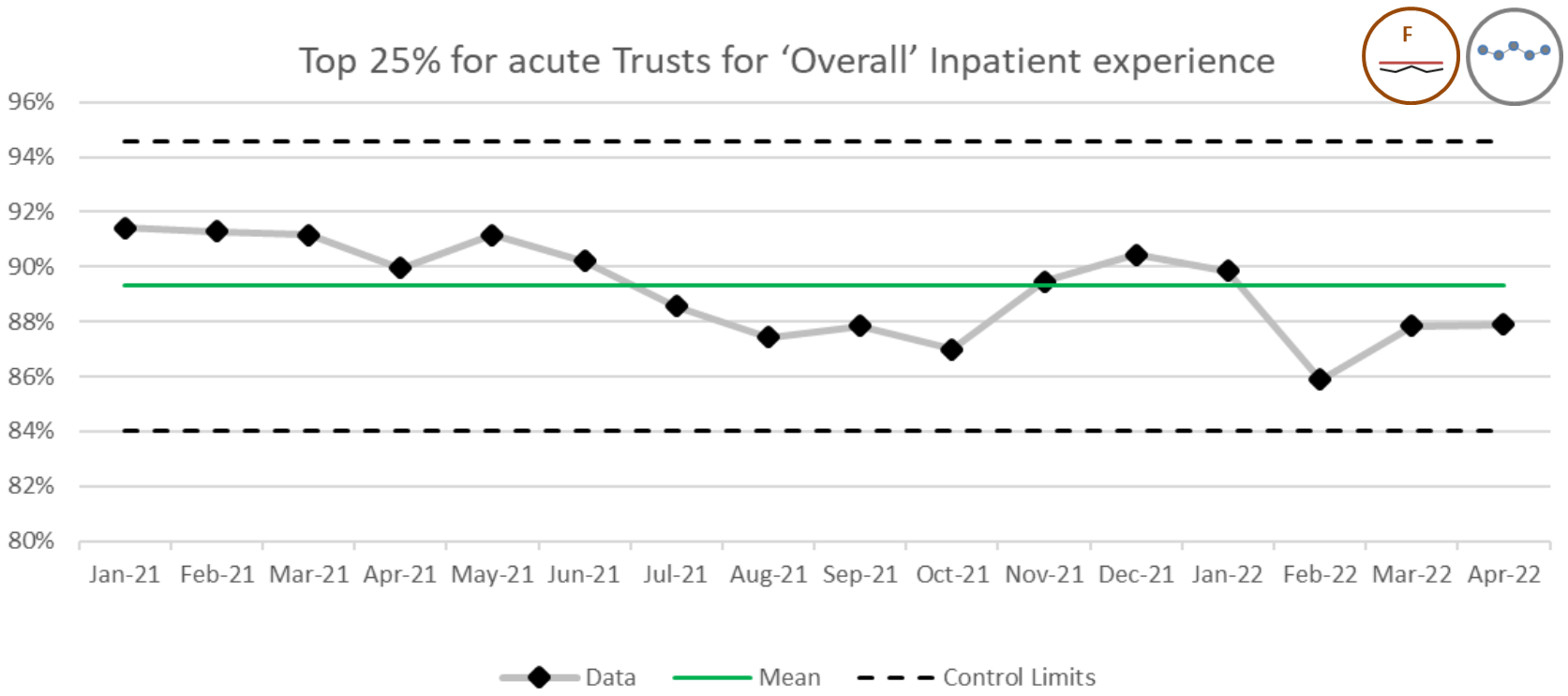
Quality | Operational Performance | Workforce | Finance

(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



Apr-22
87.89% 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 87.89% for April 2022.

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

- Waiting times
- Communication
- Appointments

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:

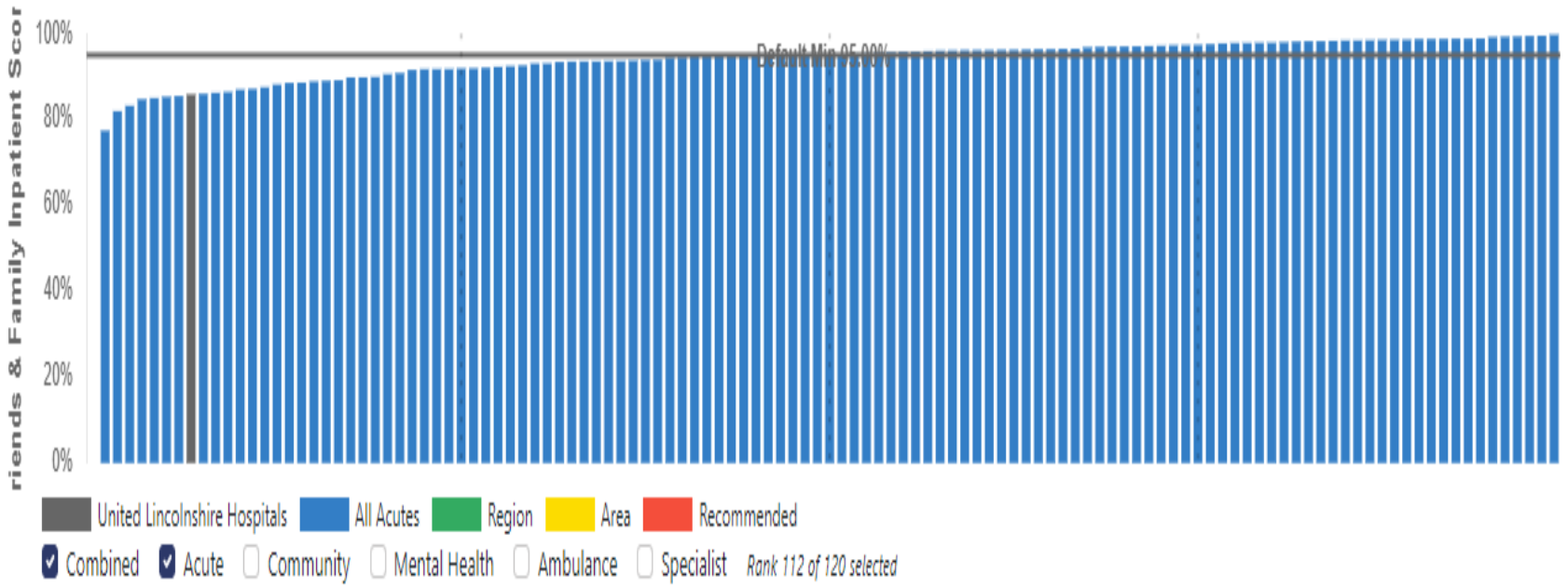
- Patient Experience training launched in March and to date over 100 staff attended or booked. Running weekly March – June and then monthly from July onwards.
- Overarching combined national survey action plan in development.
- Divisional assurance reporting strengthened.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Public View extract February 2022



Feb-22
4th Quartile (85.87%) (112th out of 120)
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 February 2022 shows we are 112th out of 120 Trusts, in the 4th quartile, against a 21/22 ambition to be in the 3rd quartile.
Rankings are Acute Trusts excluding specialised.

Issues:
FFT themes can be triangulated across all data sources; waiting times, communication and appointments.

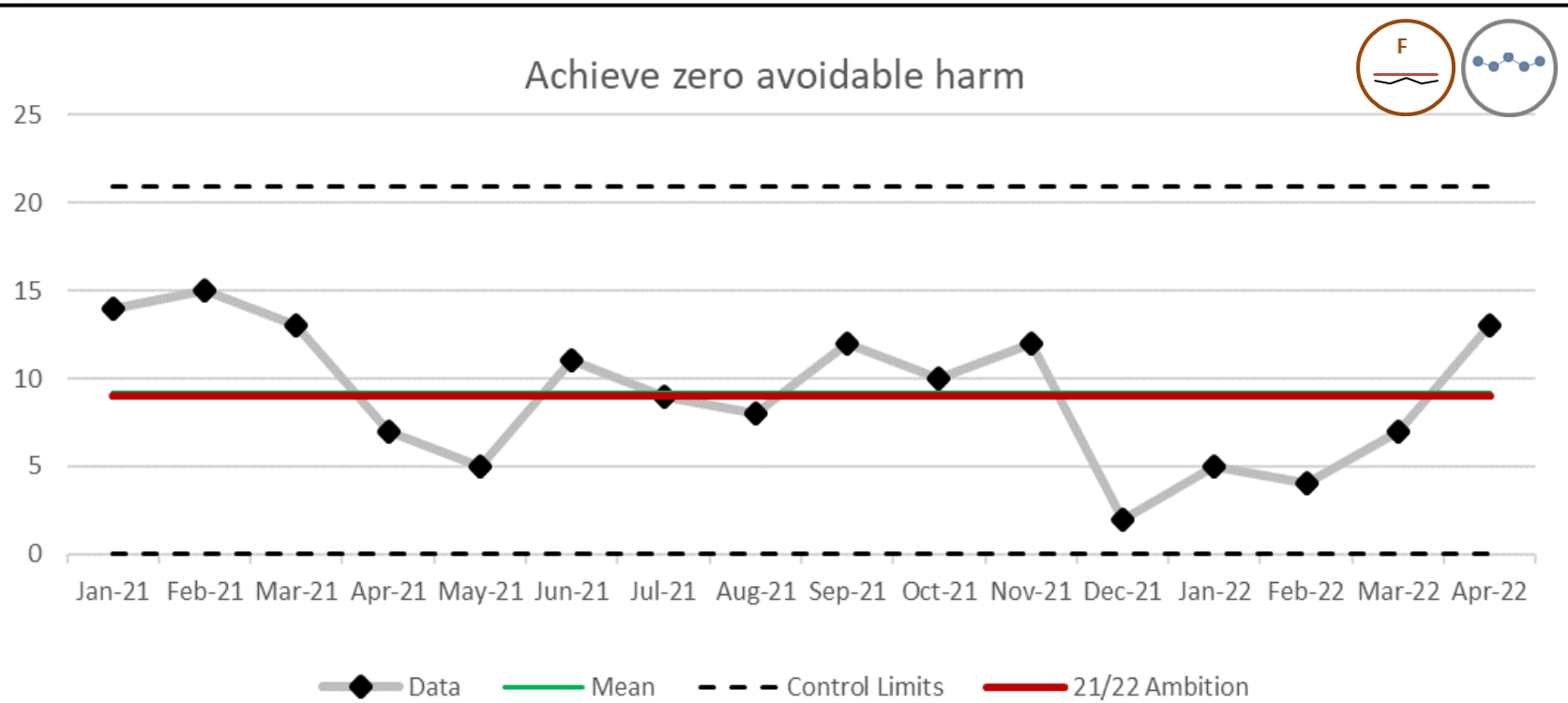
Actions:
- Drive the thematic actions as detailed above.
- New Patient Experience Manager commenced and reaching in to ward / department level experience champions.

Mitigations:
- 'Patient Experience pop-ins' planned June - August 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



Apr-22
13
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
9
Achievement
Metric is failing to ambition
Executive Lead
Director of Nursing

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

What the chart tells us:

There have been 13 reported serious incidents and 1 Never Event for the month of April.

Issues:
A review of the incidents has again identified this month the ongoing theme relating to recognition and delays with treatment and / or diagnosis.

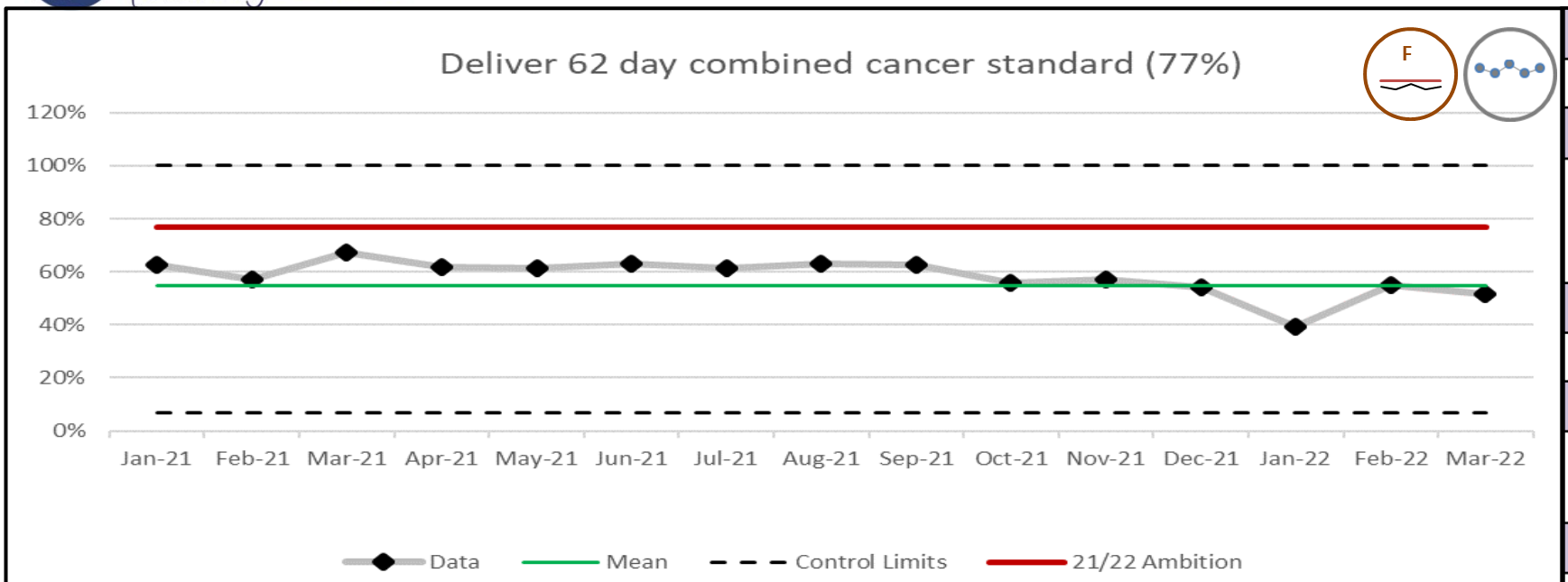
Actions:
The Clinical Governance team are in the process of undertaking a deep dive into the declared incidents from January – April 2022 and this will be presented at the Patient Safety Group in June.

Mitigations:
The Serious Incident Panel has oversight of all declared Serious Incidents and actively identifies common themes that require more in depth reviews.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-21
51.7%
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 51.7% against a 77% target.

Issues:

The impact of critical and major incidents on Trust activity and patient pathways.
Pressure on diagnostic services following the fire in Radiology at LCH.
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 'effectiveness' period). 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. One Locum Medical Oncologist Locum has started in post in May. Other posts are still going through recruitment processes. There is a significant lack of consultants nationally and very few available from agency.
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 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.
Capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to anaesthetic assessment capacity.

Mitigations:

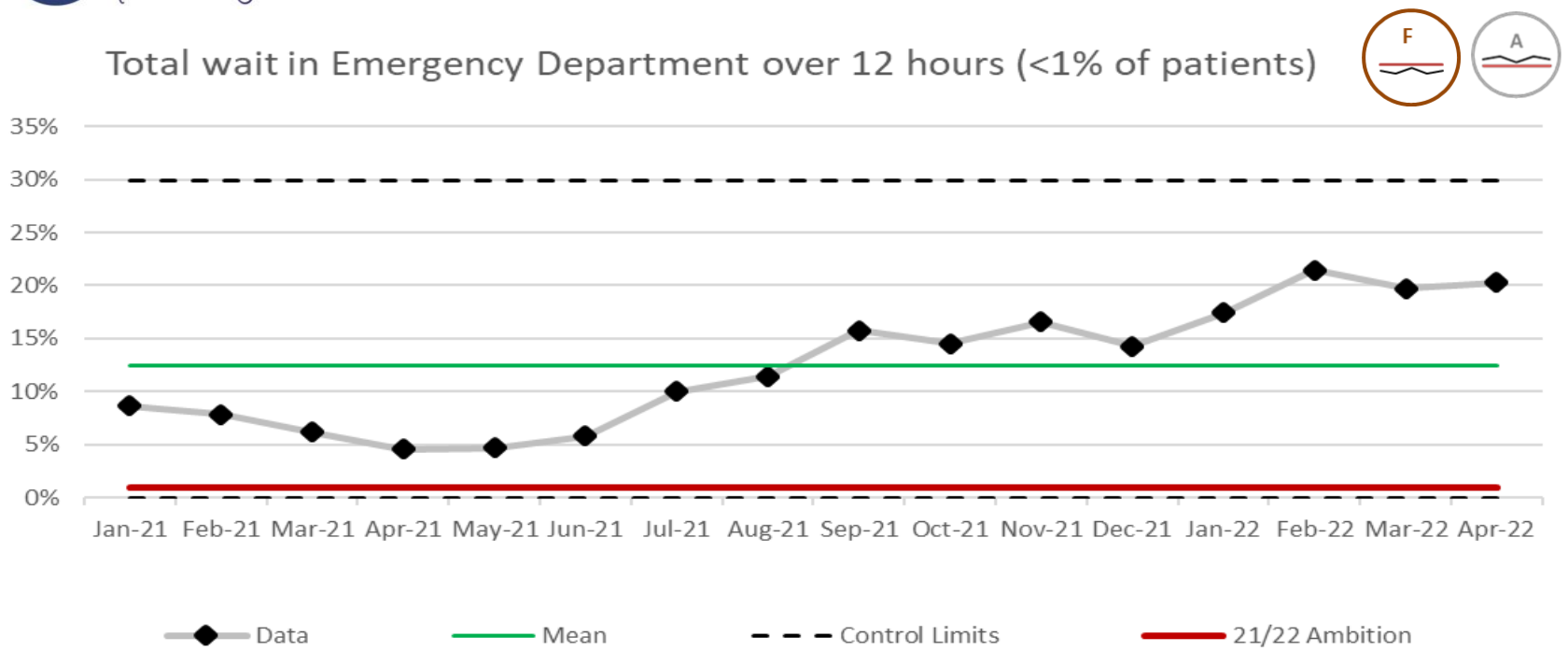
Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at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

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



Apr-22
20.28%
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:

March experienced a further increase in the numbers of patients with an aggregated time of arrival greater than 12 hours. 1761 in April (20.28%) compared to 1805 in March (19.69%). 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 increase in the discharge profile was seen in March

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 March.

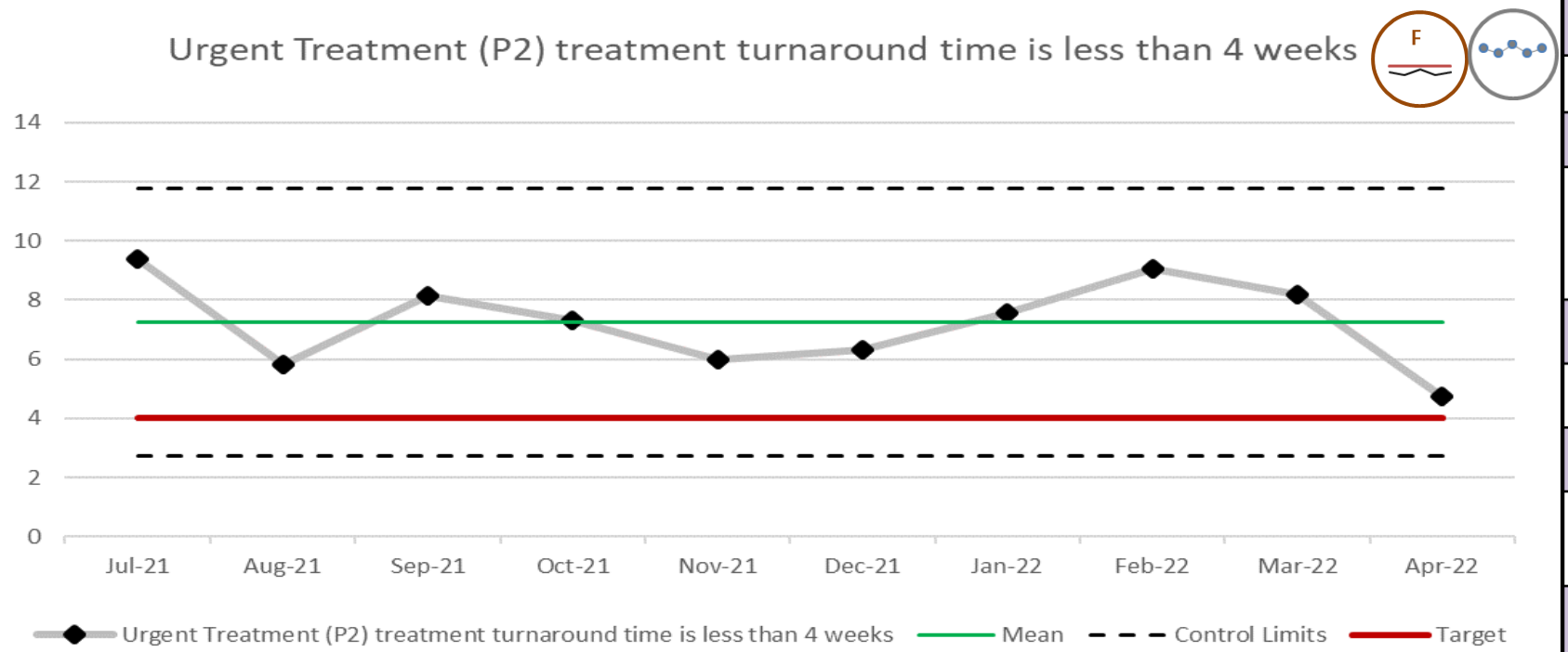
Increased CAS and 111 support especially out of hours have been further enhanced.

Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation, although the ability to board patients is becoming more problematic.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-22
4.7
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 4.7 weeks which is an improvement 3.5 weeks since March

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

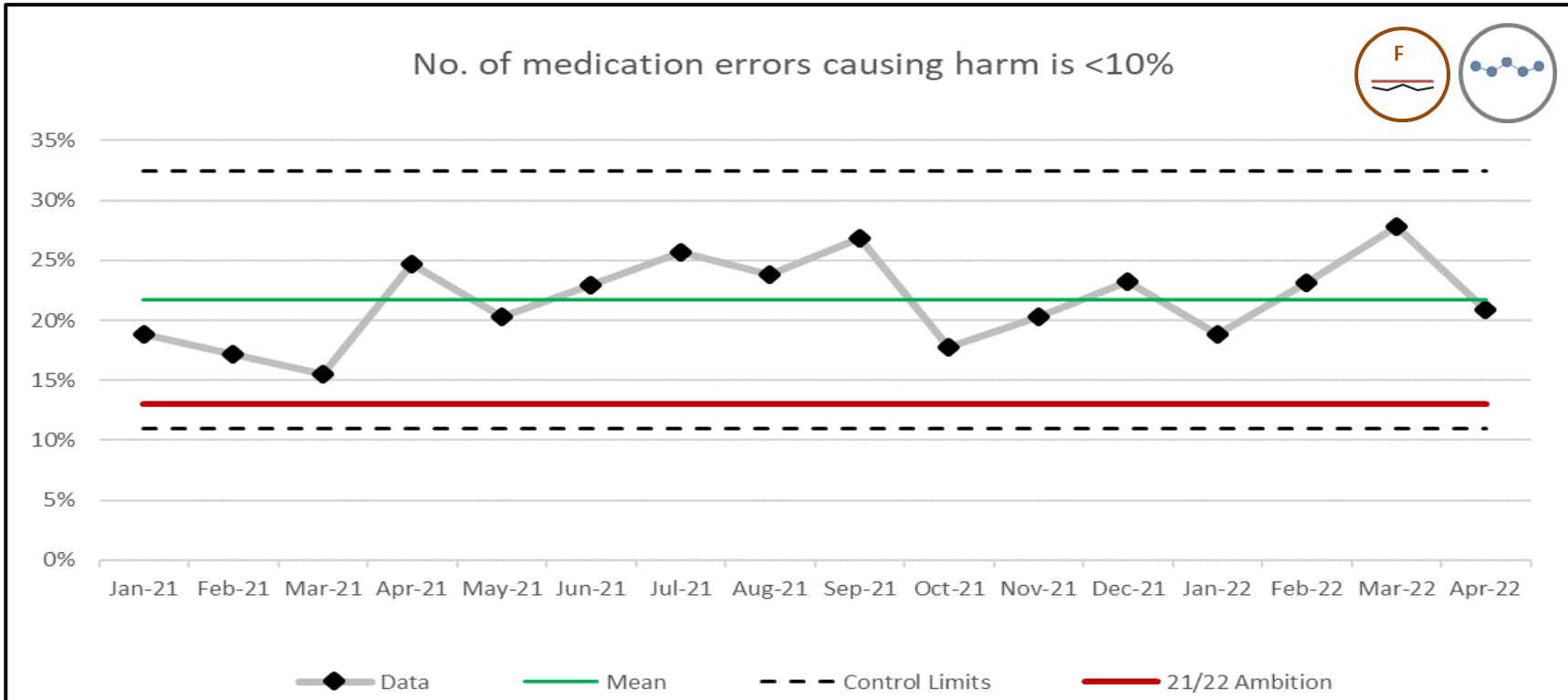
Actions:
Admitted patients are individually graded and allocated a priority code. The longest waiting patients, irrespective of their P code status are treated alongside urgent and P2 patients. Working to use and implement C2AI to ensure appropriate prioritisation of patients. The clinical prioritisation 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



Apr-22
20.9%
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 April the number of incidents reported was 172. This equates to 5.73 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 20.9 % 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.

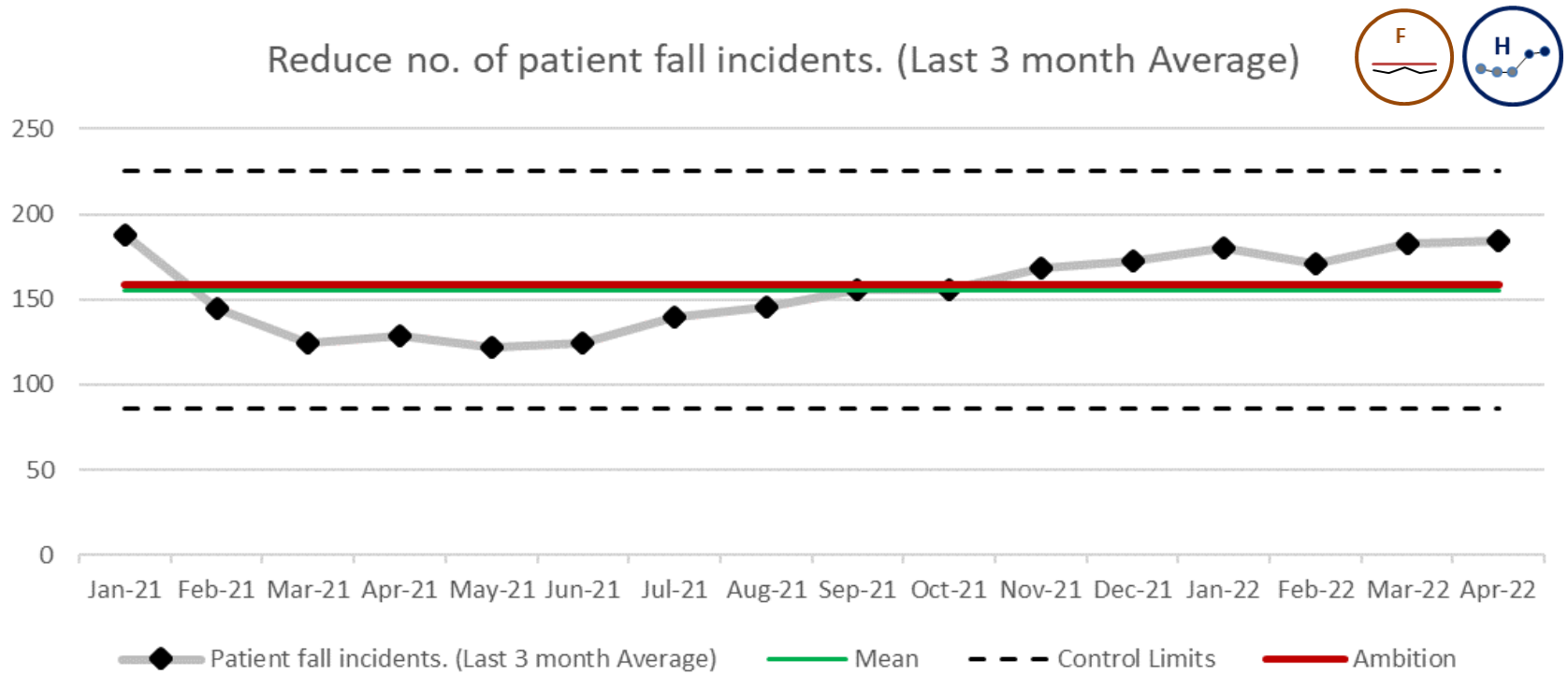
Actions:
A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management and reduce the number and potential severity of medicines incidents.

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



Apr-22
184
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)

What the chart tells us:
The actual number of inpatient falls for April has decreased by 23 from March. However, as the overall number remains elevated this has contributed to a minimal increase in the 3 monthly average.

Ambition has not been achieved.

Issues:
Overall, this month, inpatient falls saw a decrease of 23 (March 213, April 190)

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

- Care of patients who experience repeat falls.
- Inconsistent application of Bay nursing (Carewatch).
- Assessment and consistent application of enhanced care processes.

Actions:
Falls prevention and Flojac training schedule commenced in April 2022 delivered by the Quality Matron and Health & Safety teams. Wards identified as having higher falls occurrences are being prioritised. This will support staff to be more cognisant of the potential risks of falls in their area and to implement individualised care planning.

A falls prevention e-learning package is being finalised for publishing. In addition national ElfH falls prevention training has been updated and will be made available via ESR by the end of May.

An outline business case for a Falls Prevention team is to be presented to CRIG in May 2022.
An organisational falls prevention quality improvement project has been commissioned. The project plan will be shared at the May Falls Prevention Steering Group (FPSG) which will provide oversight and monitoring of the programme of work.

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

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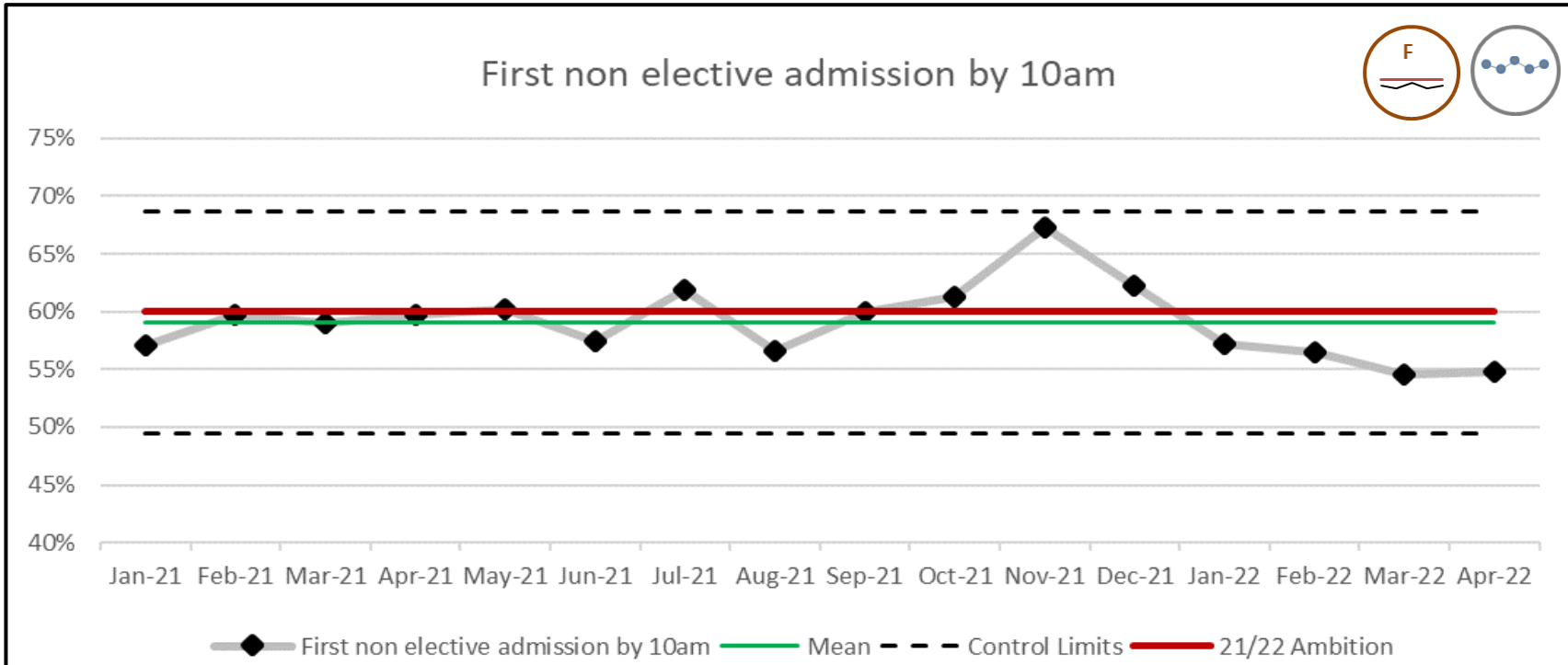
NHS United Lincolnshire Hospitals NHS Trust



Apr-22
54.83%
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:

April experienced a slight improvement in the number of non-elective admission before 10am.
The compliance against this metric is 54.83% (54.57% in March).
This equates to 692 patients admitted before 10am.
This metric has not been met.

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.

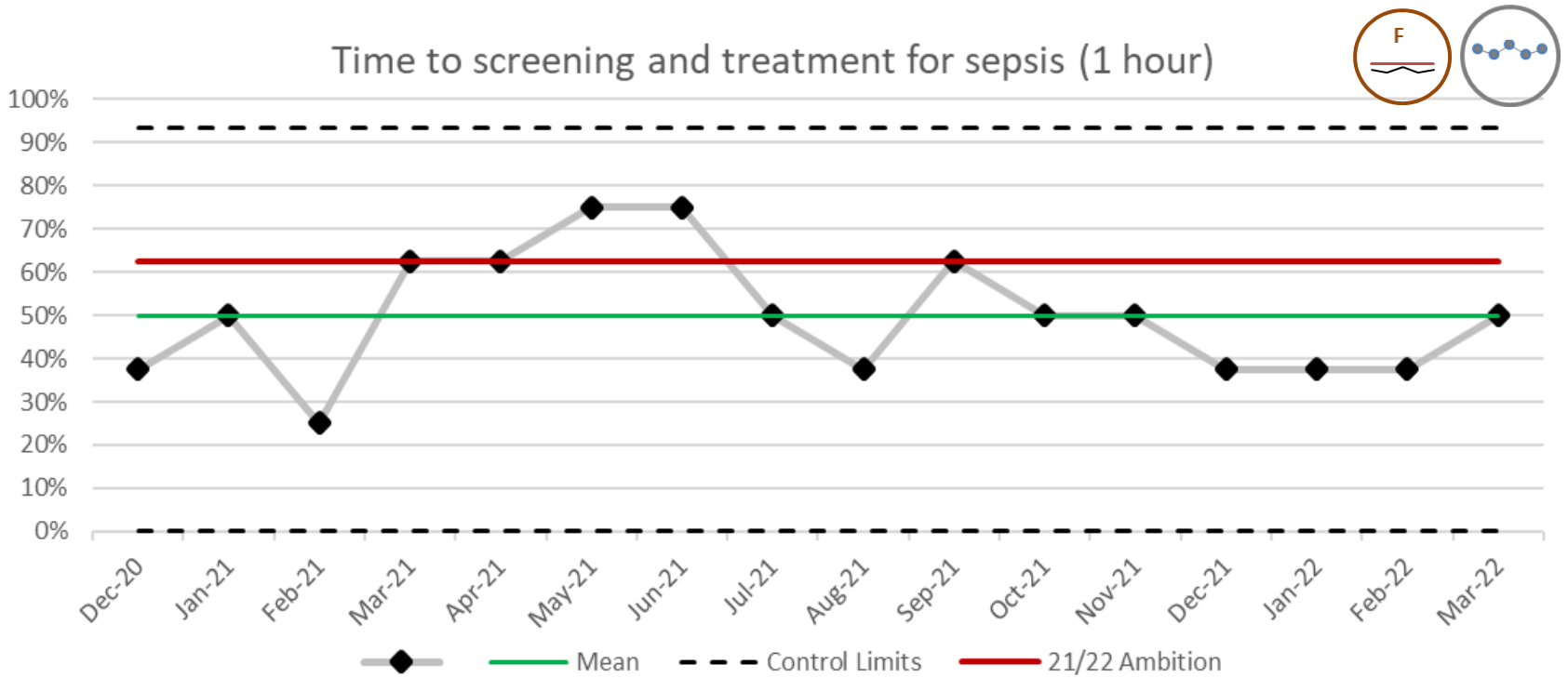
Mitigations:

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



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

Background:
Number of sepsis incidents reported
% of 8 metrics passing to 90% target. (THIS SEEMS TO BE MISSING SOME DATA)

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

Issues:
The reporting month has again seen a dip in compliance for adult inpatients. The paediatric figures are still below 90% for compliance, although the relatively low numbers do mean that the percentages are more sensitive to very slight differences. Within all metrics that are failing, there is a definite site based theme as Pilgrim Hospital are achieving strong results.

Actions:
The appointment of a sepsis practitioner at Lincoln has helped support further teaching in areas that have shown a dip in compliance and it is hoped that this will show improvements in the coming months Work continues on an enhanced e-learning module to improve the relevance to our practice. This is being hampered by vacancies within the e-learning team. This has been escalated via the DPG meeting.

Mitigations:
Data is being monitored frequently and Harm reviews are being completed for all patients with delayed Screens or bundles.
AIMS training is now available which includes sepsis and management of shock. For both Paediatric and adult patients there has been increased medical engagement and this is leading to adoption of different ways of working and will hopefully lead to an increase in compliance.

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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	Feb-22	Mar-22	Apr-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	3	5	4	4	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.00	-		
	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	0.02	0.01	0.01		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1						
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.11	0.20	0.27	0.27	F	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	3	2	1	1	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	0	0	0	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	6	2	2	2	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	95.03%	95.54%	95.35%	95.35%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	1	1	F	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.16	5.5	5.73	5.73	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	23.0%	27.8%	20.9%	20.90%	F	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Feb-22	Mar-22	Apr-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	None due	None due	None due		P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	103.12	98.10	94.19	94.19	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	111.20	111.23	109.48	109.48	F	
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	100.00%	100.00%	P	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	88.90%	88.20%	88.60%	88.60%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	88.6%	88.6%		89.55%	F	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	92.3%	81.8%		85.76%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	94.3%	93.6%		93.90%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	80.0%	75.0%		83.57%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	88.4%	90.0%		91.50%	P	A
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	82.0%	83.5%		82.83%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.5%	93.8%		94.86%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	60.0%	100.0%		71.59%	P	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	3.42	3.03	3.43	3.43	P	
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	93.00%	89.00%		65.50%	F	B
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	82.00%	71.00%		38.75%	F	B

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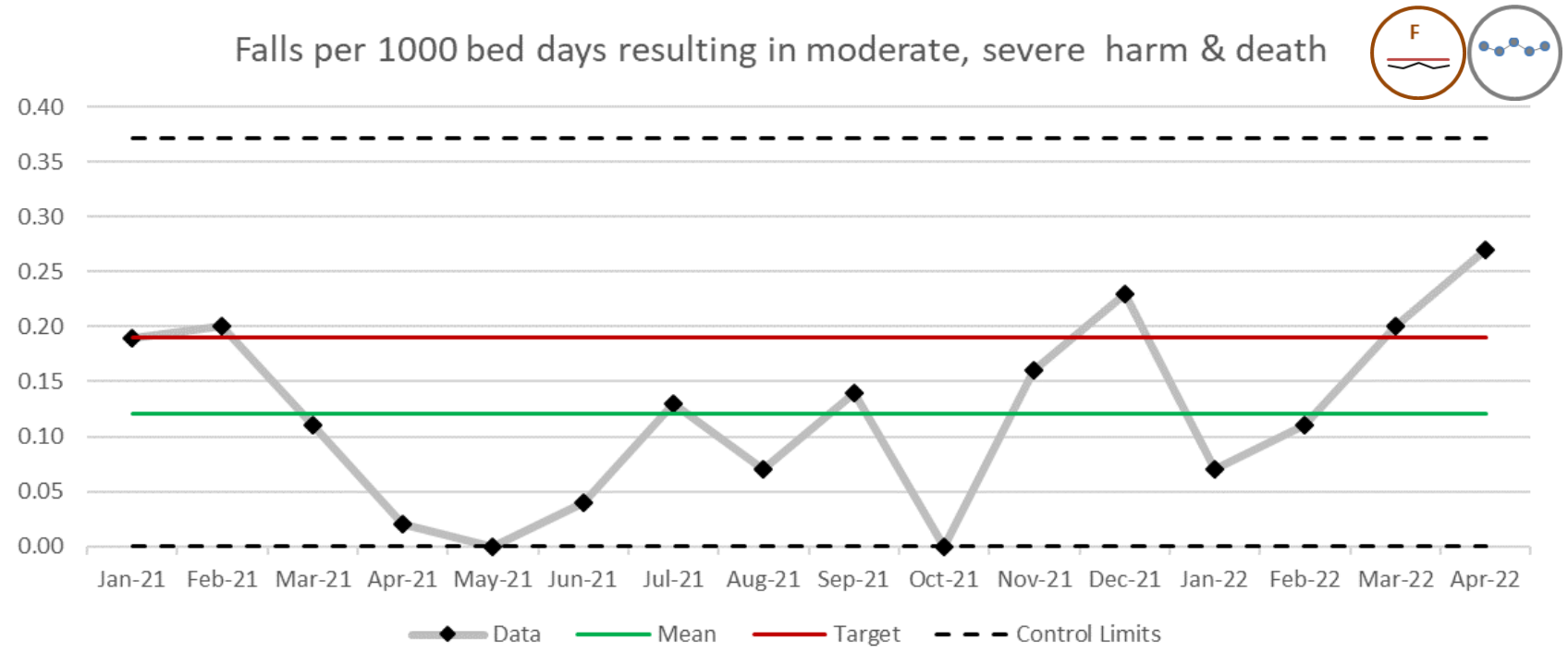
NHS United Lincolnshire Hospitals NHS Trust



Apr-22
0.27
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.19
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:

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

What the chart tells us:

There have been 7 falls resulting in moderate harm in April.
This is an increase on the 3 reported in March.

There has been 0 falls incidents reported as resulting in severe harm.

There has been 1 falls incident reported with the severity recorded as death. This is the same as March.

These will be validated through the incident review process and the appropriate level of investigation instigated. The severity of some incidents may change following the validation process.

We are currently at 7 moderate harm falls incidents for Q1 against a target of ≤19 per annum, and 0 severe harm falls incidents for Q1 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 the continued operational and staffing pressures during April.

The prolonged length of stay in the Emergency Department for some patients awaiting admission may impact on existing frailty and increase the vulnerability to having a fall.

Actions:

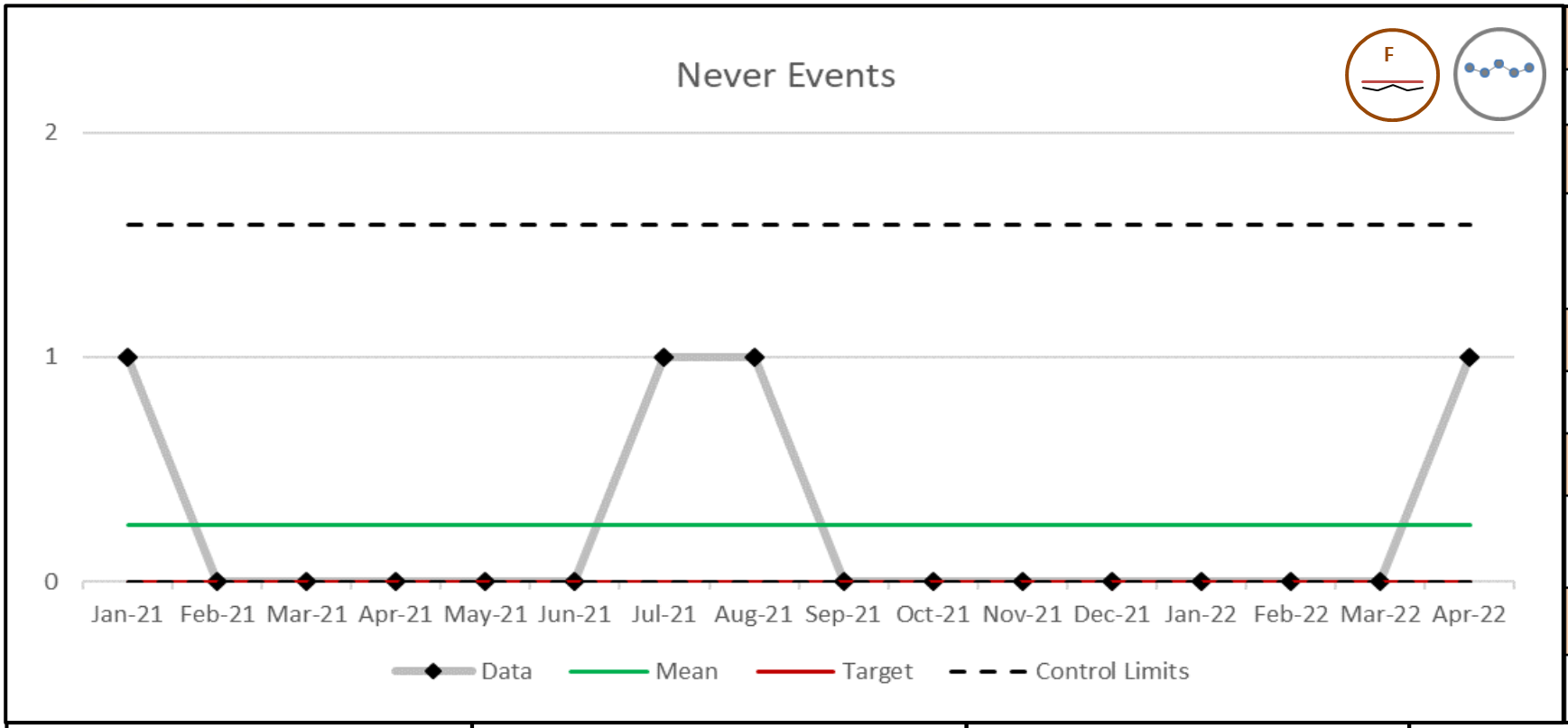
Exploring the option to create an alert on the Web V system to highlight when repeat falls patients present to hospital and notify when transferred to a ward area. This would enable staff to have early indication if a person is vulnerable to falling so to plan preventative care.

A review of the Enhanced Care policy has been undertaken. Currently going through consultation and approval processes.

Planning is underway to re-establish a falls prevention link professional role and network in June 2022.

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.



Apr-22
1
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

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

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

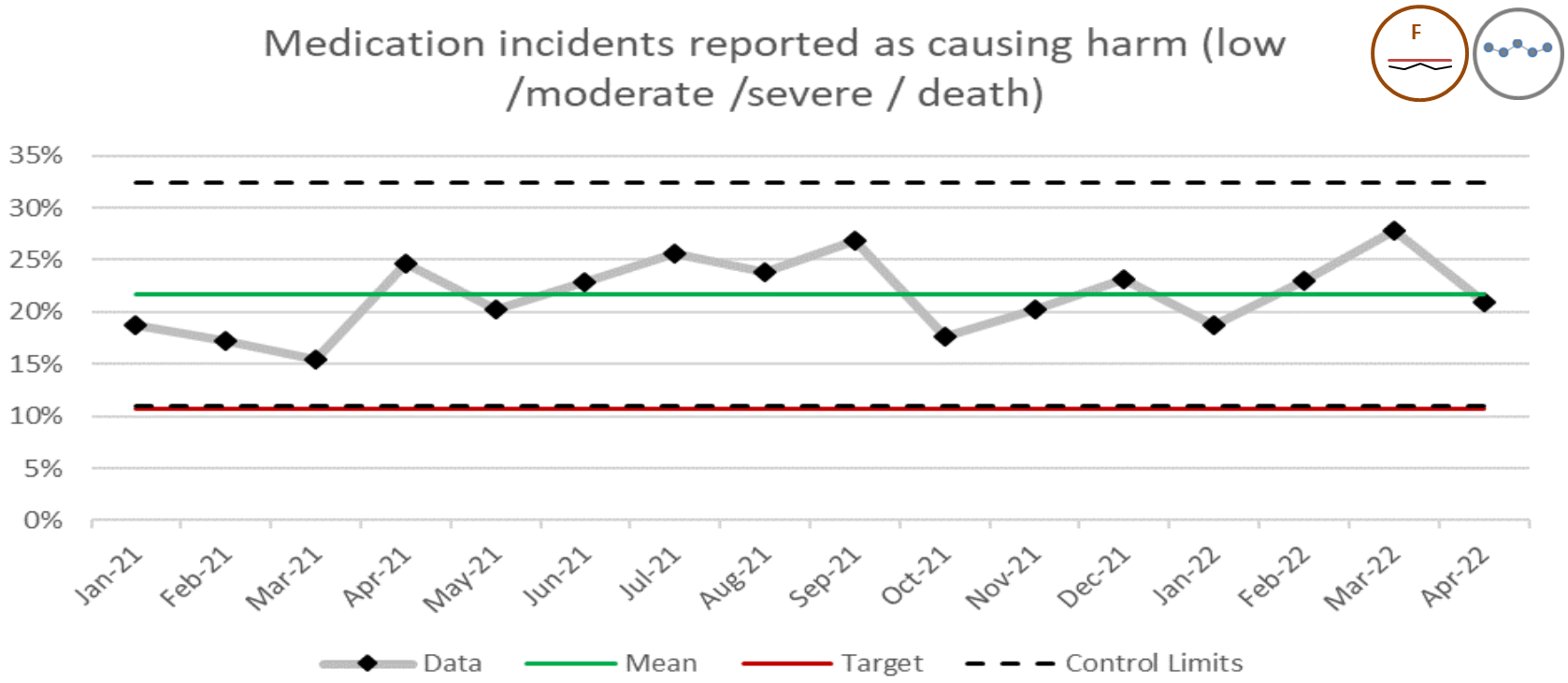
Issues:
The incident relates to an anaesthetic block performed on the incorrect side prior to a Total Knee Replacement.

Actions:
Serious Incident procedure initiated leading to local investigation and rapid review – declared to commissioners as SI within approved timeframe
Immediate actions have already been recognised and implemented by the Surgical Division.

Mitigations:
Investigation team identified and Governance support assigned.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-22
20.9%
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 April the number of incidents reported was 172. This equates to 5.73 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 20.9 % 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.

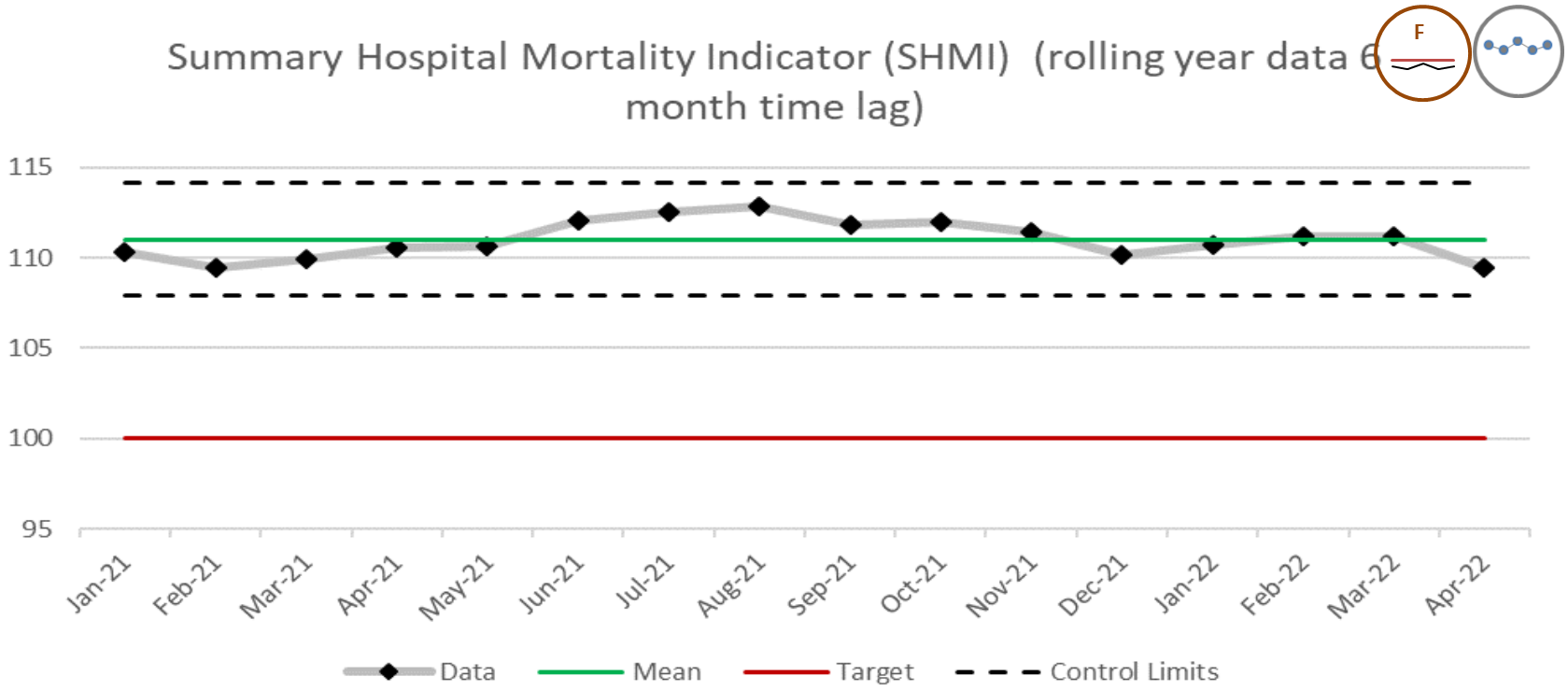
Actions:
A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management and reduce the number and potential severity of medicines incidents.

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



Apr-22
109.48
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 109.48; a decrease of 1.75 from the last reporting period. The Trust has moved from 'Higher than expected SHMI' to 'as expected'.

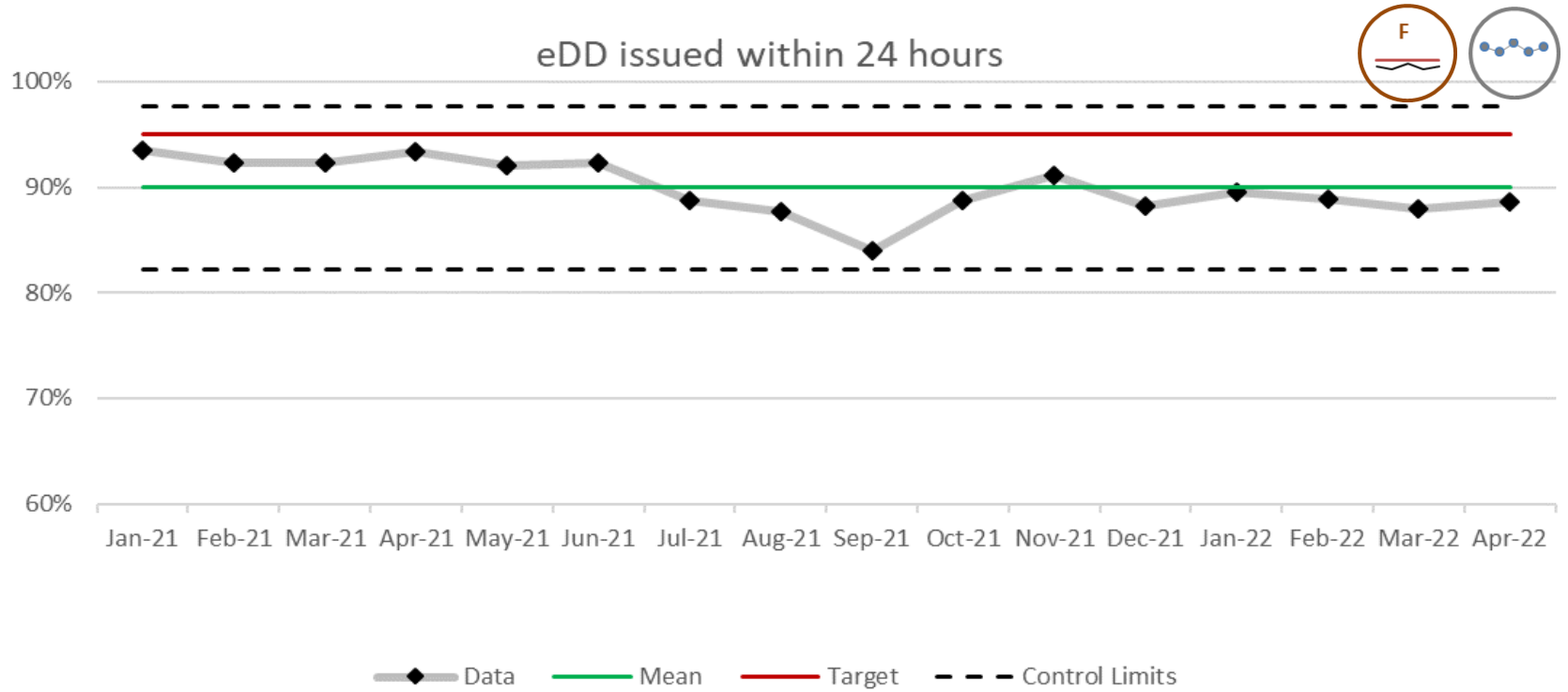
Issues:
The COVID-19 pandemic has impacted on the Trusts SHMI. The data period is reflective from Dec 20 – Nov 21.

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

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

Mitigations:
The MEs will commence reviewing all deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified.

Learning is shared at the Lincolnshire Mortality Collaborative Group which is attended by all system partners.
HSMR is 94.19 and within expected levels.



Apr-22
88.60%
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 March the Trust achieved 88.6% for this standard. The Trust however achieved 92.1% for eDDs sent anytime within the month of April.

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

The highest proportion of eDDs not sent within April were from Lincoln Discharge Lounge and Family Health.

Actions:
A dashboard has therefore been developed to highlight compliance at both ward and consultant level, which can then help to highlight areas of suboptimal compliance to help focus targeted work to address this.

Mitigations:
A proposal has been developed and agreed to how eDDs will be managed going forward within the Trust.
Each Division will review their performance at their Performance Review Meetings.

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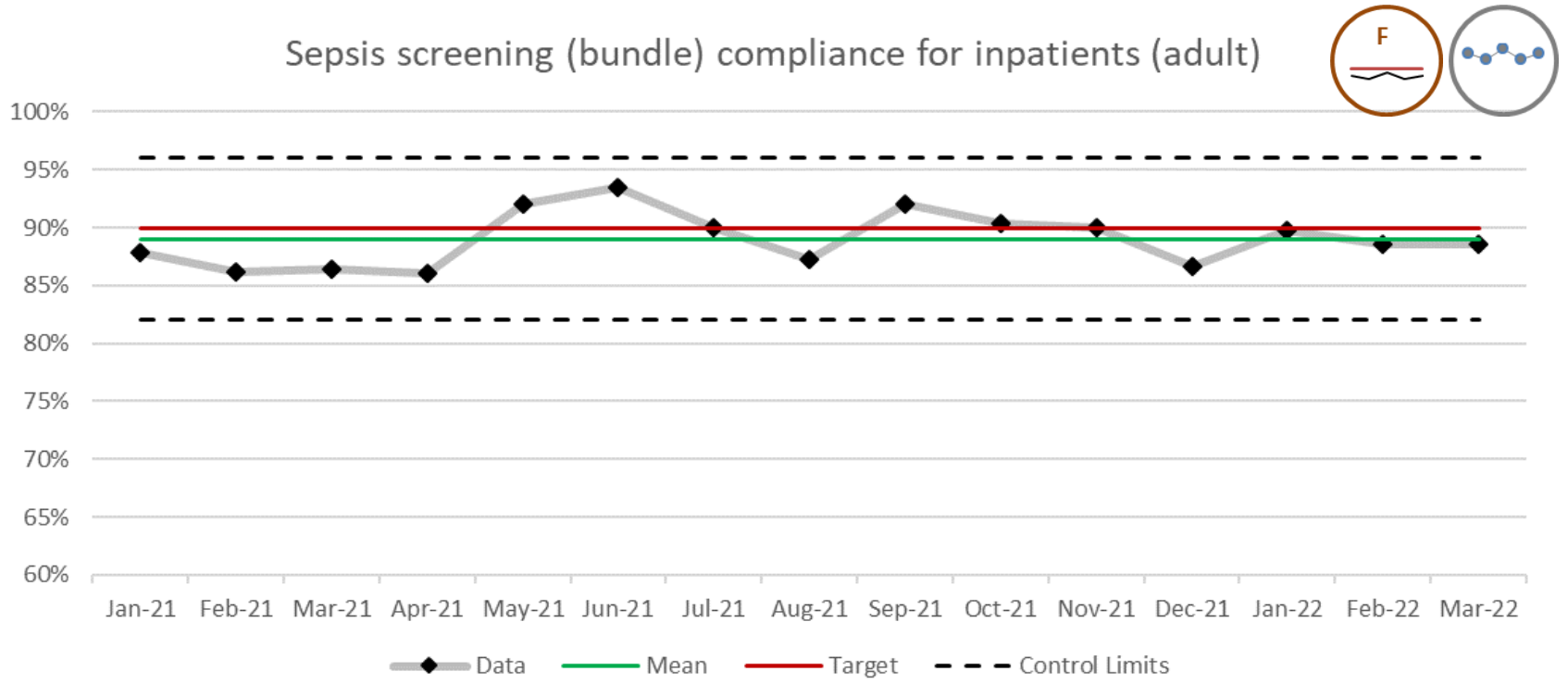
NHS United Lincolnshire Hospitals NHS Trust



Mar-22
88.6%
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

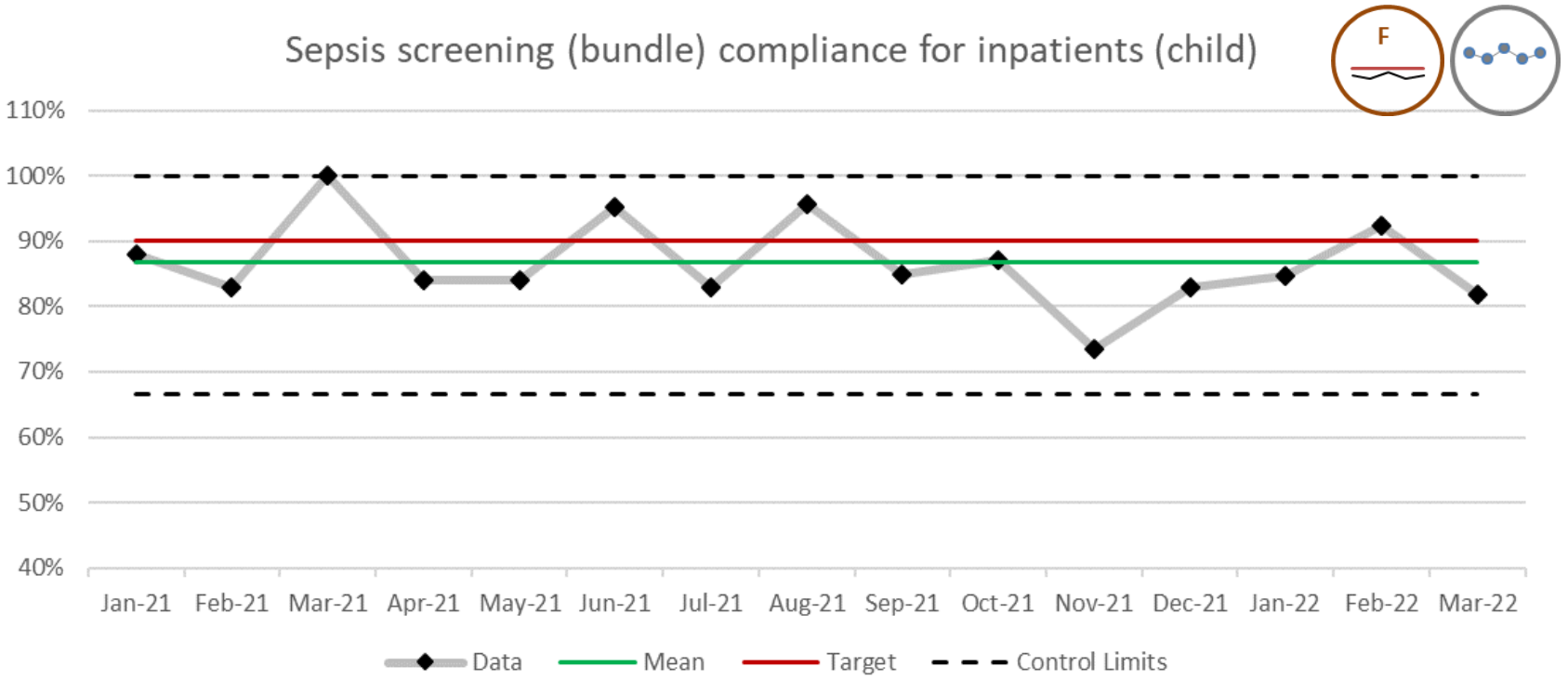
Background:
Sepsis screening (bundle) compliance in inpatients (adult).

What the chart tells us:
The current compliance is at 88.6% against a target of 90%.

Issues:
Inpatient compliance is 88.6 % for the second month and hence below the 90% standard. In part this can be explained by the capacity and staffing issues across the Trust but there are specific ward areas that require increased support and a slight bias towards Bank and Agency nurses.

Actions:
Additional training has now commenced for specific wards in conjunction with the CCOT team to look at escalation and the deteriorating patient. AIMs courses are now running apace and this has filled a gap between the basic resuscitation courses and the more advanced courses. There will need to be further focused work as the rollout of the AIMs will take several months.

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. The e-learning for sepsis is due to be upgraded once there are appointments to the e-learning team.



Mar-22
81.8%
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 (child).

What the chart tells us:
The current compliance is at 81.80% against a target of 90%. This is for 36 out of 44 patients.

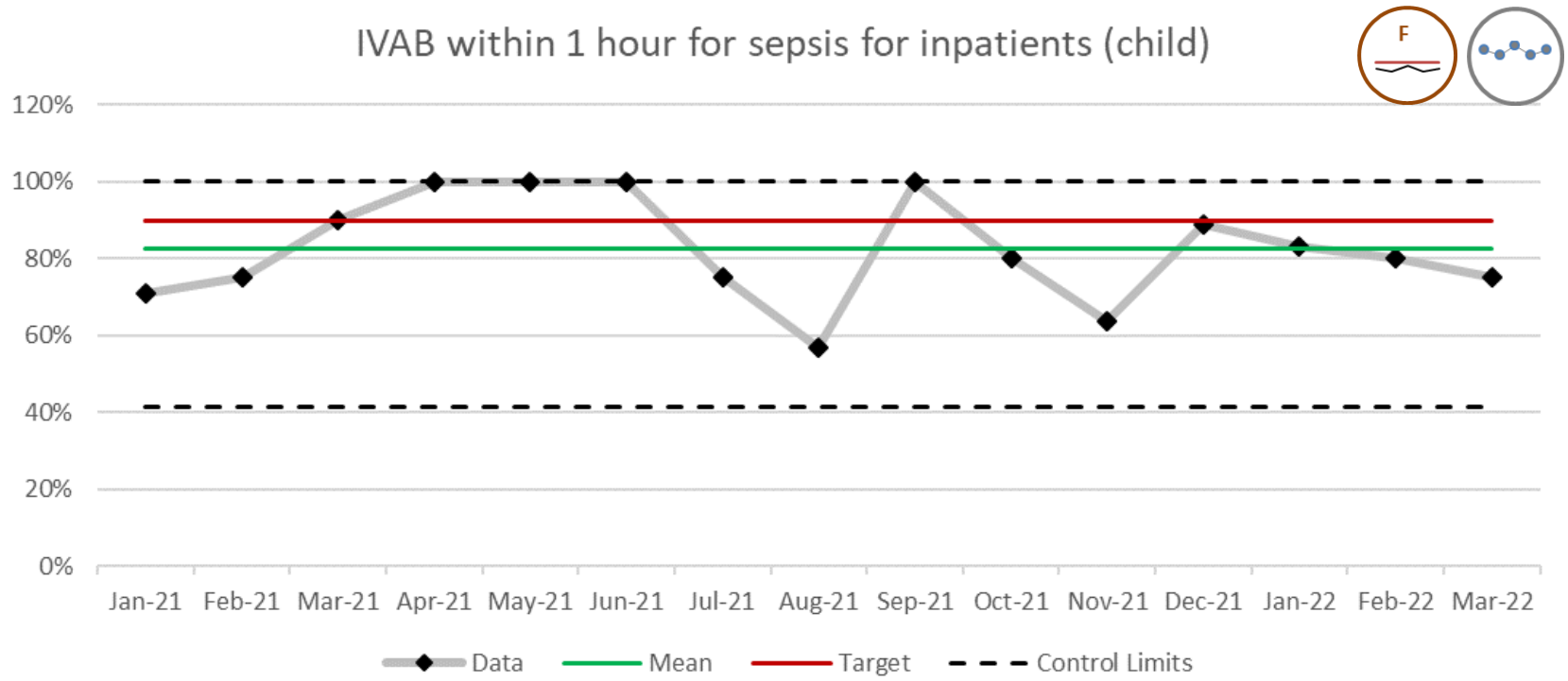
Issues:
There were 8 patients found to have not had a sepsis screen within the required hour. Two of the mentioned patients also had delayed treatment – No harm found. One patient was in a different area and not on the ward. All other patients has a viral or injury cause for elevated PEWS – not Sepsis.

Actions:
Educator at Lincoln is currently doing harm reviews for missed screens the aim is that the link nurse at Pilgrim will take on this role too.
There is teaching planned with the medical teams on both sites with medical teams starting 23rd May 2022
Sepsis training Sim also planned for 18th May 2022

Mitigations:
The Educator on wards as Lincoln is doing harm reviews and is able to address issues with staff as she finds them.
Ongoing meeting between Ward sisters, Clinical educators and Sepsis practitioner at both sites in order to highlight any issues or training needs.
Sepsis practitioner visiting wards regularly in order to offer support.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-22
75.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The current compliance is at 75.0% against a target of 90%.
There were 4 out of 6patients that received antibiotics within the one hour time frame.

Issues:
There were two patients that had delayed antibiotics. The harm reviews showed that there was no harm to patients from the delay. One delay was due to difficulties getting IV access for the patient. Antibiotics were given as soon as IV access obtained. The second patient the Doctors were unsure of cause and waited for blood results prior to starting treatment.

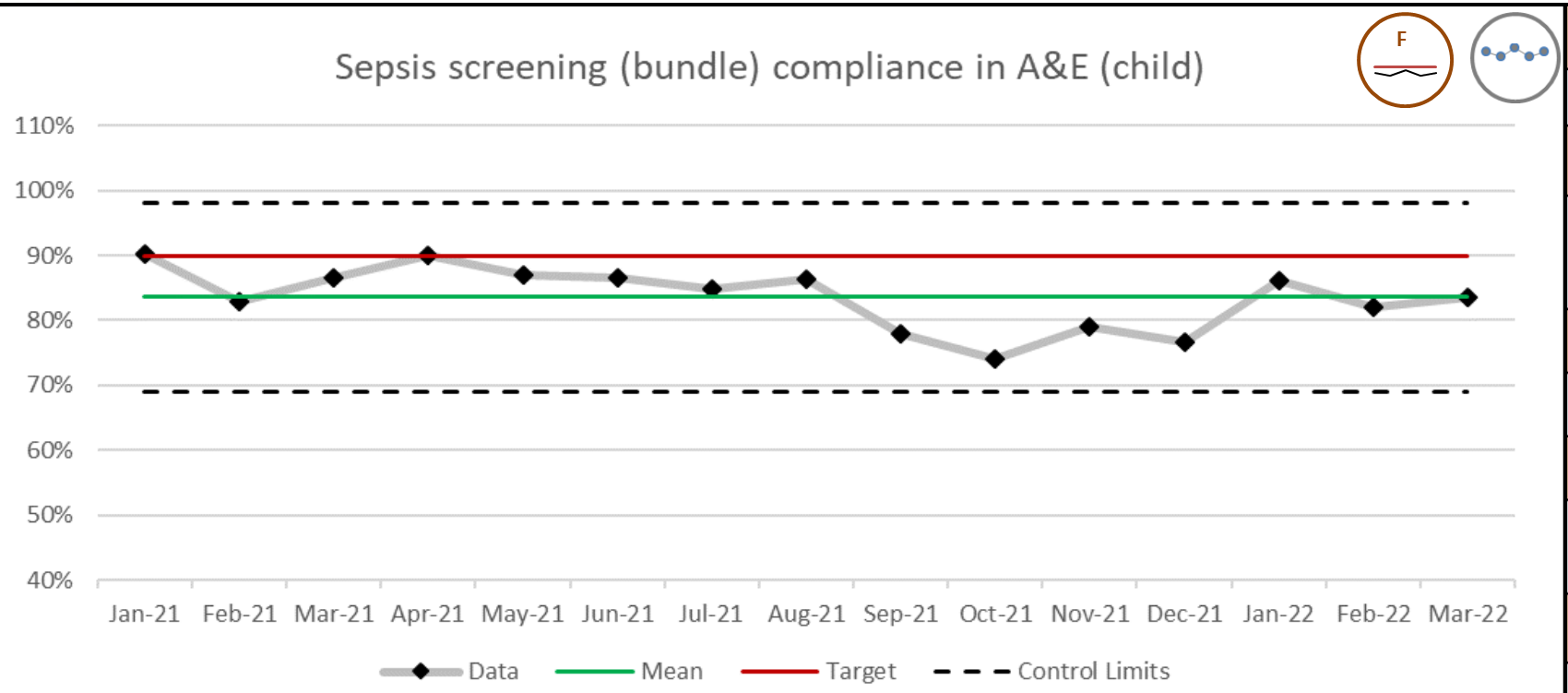
Actions:
A harm review was completed for this patient which concluded that no harm was caused from the delay.
Discussions are being held regarding further staff having cannulation training.
Simulation training has been planned to commence from April. This will include Sepsis and MDT working. The Sepsis practitioner is also doing training for Paediatric Doctors.

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. Any issues are being highlighted to both clinical lead and ward manager.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-22
83.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance in ED is 83.50% which is below the 90% target. 183 of 219 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.

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. ED meetings for support and training. A member of medical team has been identified as a link at Lincoln. Engagement from ED staff feels more positive. Sepsis sims training has taken place in ED this month with some learning points.

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.

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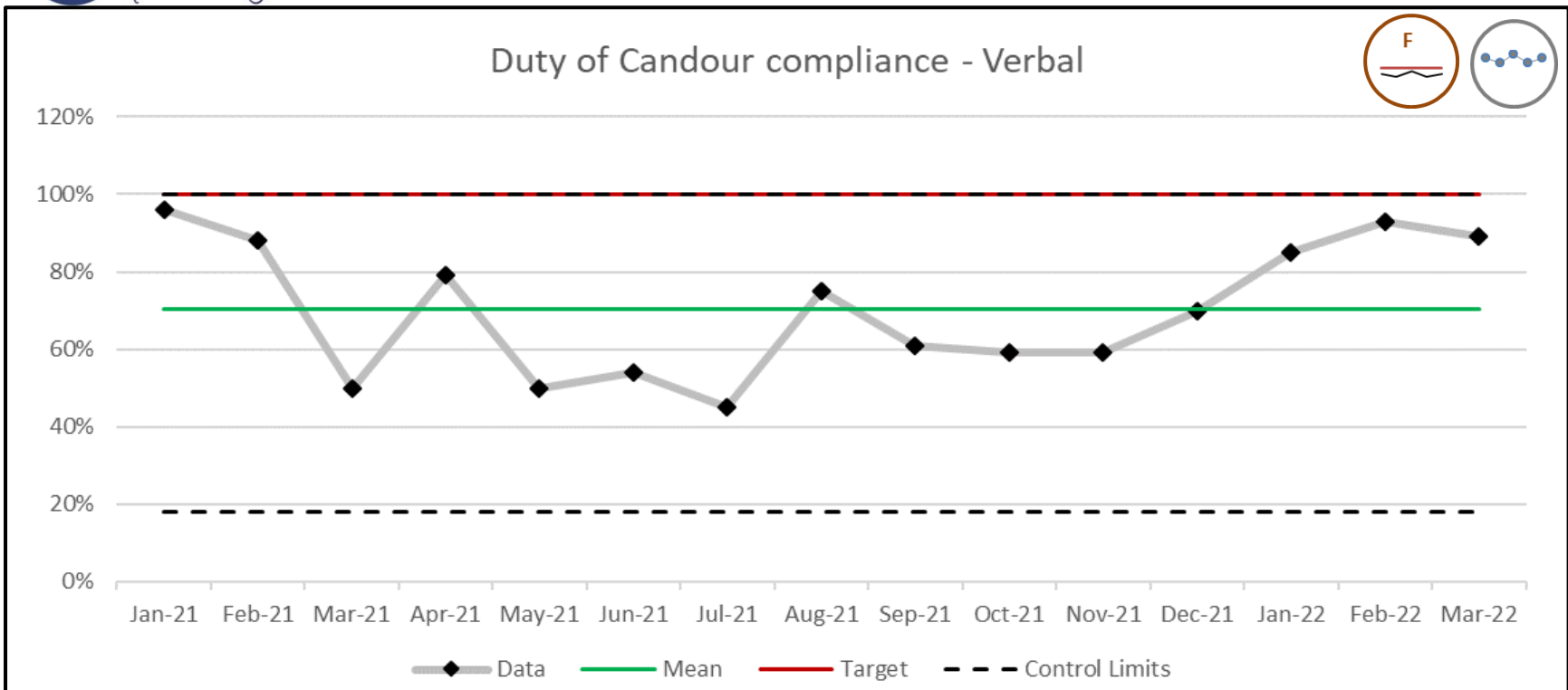
NHS United Lincolnshire Hospitals NHS Trust



Apr-22
89%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Compliance with the NHS requirement for verbal Duty of Candour, which applies to all patient safety incidents where harm is moderate or above.

What the chart tells us:
There is a gradual improving position. The ongoing work by the Clinical Governance team and the Divisional teams has resulted in an improved compliance for the previous months. This data will be kept under review each month.

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 and CBU's.

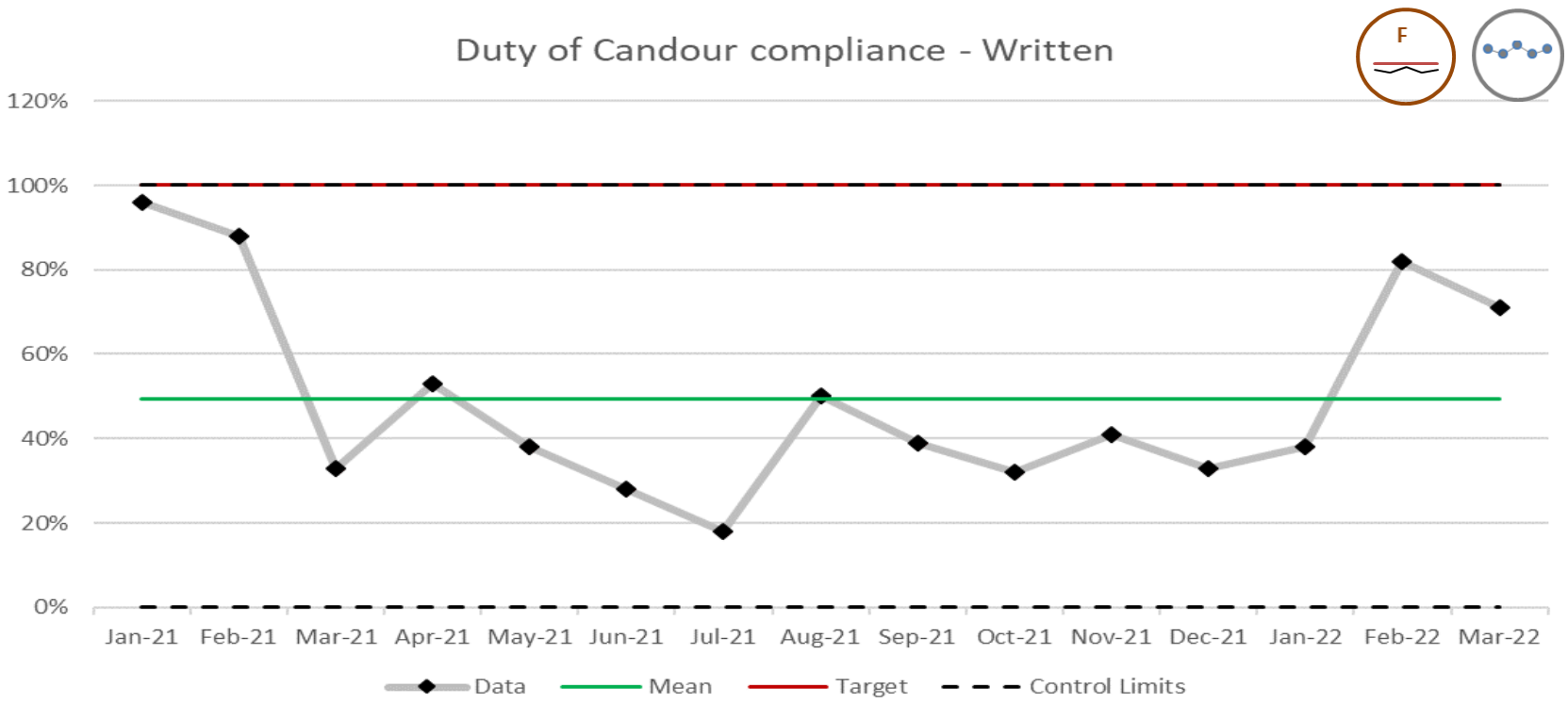
Mitigations:
Series of briefings on Duty of Candour delivered by external provider in October / November 2021 and again in April 2022.

Completion rate for Duty of Candour Core Learning is consistently above 95%.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-22
71%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Compliance with the NHS requirement for written Duty of Candour, which applies to all patient safety incidents where harm is moderate or above.

What the chart tells us:
There is a gradual improving position. The ongoing work by the Clinical Governance team and the Divisional teams has resulted in an improved compliance for the previous months. This data will be kept under review each month.

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 and CBU's.

Mitigations:
Series of briefings on Duty of Candour delivered by external provider in October / November 2021.

Completion rate for Duty of Candour Core Learning is consistently above 95%.

Datix prompts have been added, reminding users to attach copies of Duty of Candour letters.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Feb-22	Mar-22	Apr-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.13%	0.08%	0.09%	0.09%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	61.18%	61.71%	63.08%	63.08%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	637	834	745	745	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	81.98%	81.18%	83.34%	83.34%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	3318	4177		22,729	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	52.24%	51.22%		56.09%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	63,680	66,539		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	56.85%	54.17%		56.15%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	58.92%	73.90%		70.58%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	8.29%	9.30%		8.98%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	89.07%	89.29%		90.49%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	98.54%	98.11%		99.00%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	60.98%	77.78%		71.36%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	98.82%	98.25%		96.86%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	52.63%	28.57%		63.15%	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	Feb-22	Mar-22	Apr-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%	64.38%	68.82%		73.08%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	64.91%	62.26%	56.03%	56.03%	99.00%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.90%	2.43%	2.09%	2.09%	0.80%	F	A	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	25	22	33	33	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	92.31%	83.13%	71.95%	71.95%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	47.69%	63.86%	45.12%	45.12%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,764	3,872	3,799	3,799	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	781	816	819	819	0	F	A	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	151	111	132	132	10	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.97	3.55	2.70	2.70	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	5.10	5.17	5.02	5.02	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	21,117	22,327	23,562	23,562	4,524	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	44.0%	39.1%	43.9%	42.62%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	37.1%	40.4%	38.4%	39.64%	45.00%	F		

OUTSTANDING CARE personally DELIVERED

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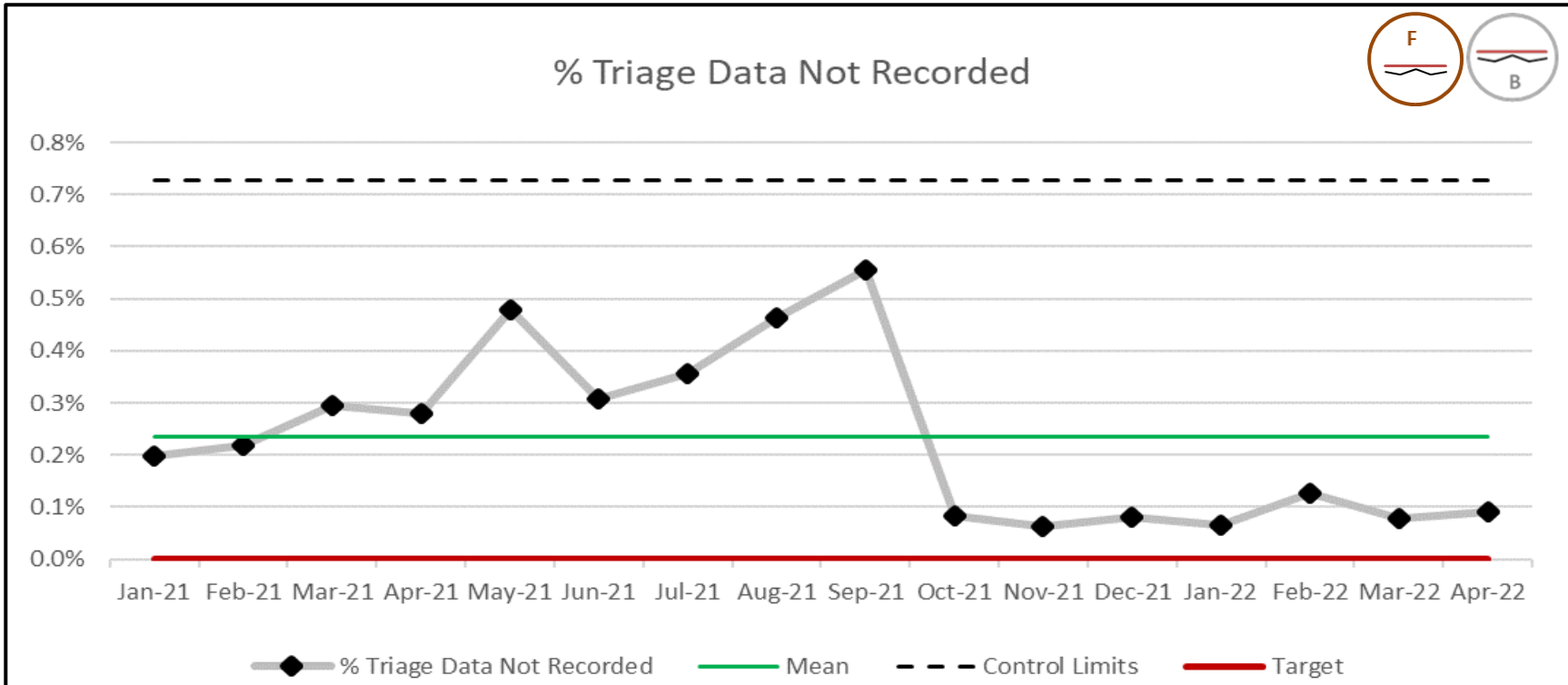


Apr-22
0.09%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%.
April reported 0.09% data not recorded verses 0.08% in March
March demonstrated a 0.01% negative variation compared with March.
This metric is below target.

Issues:

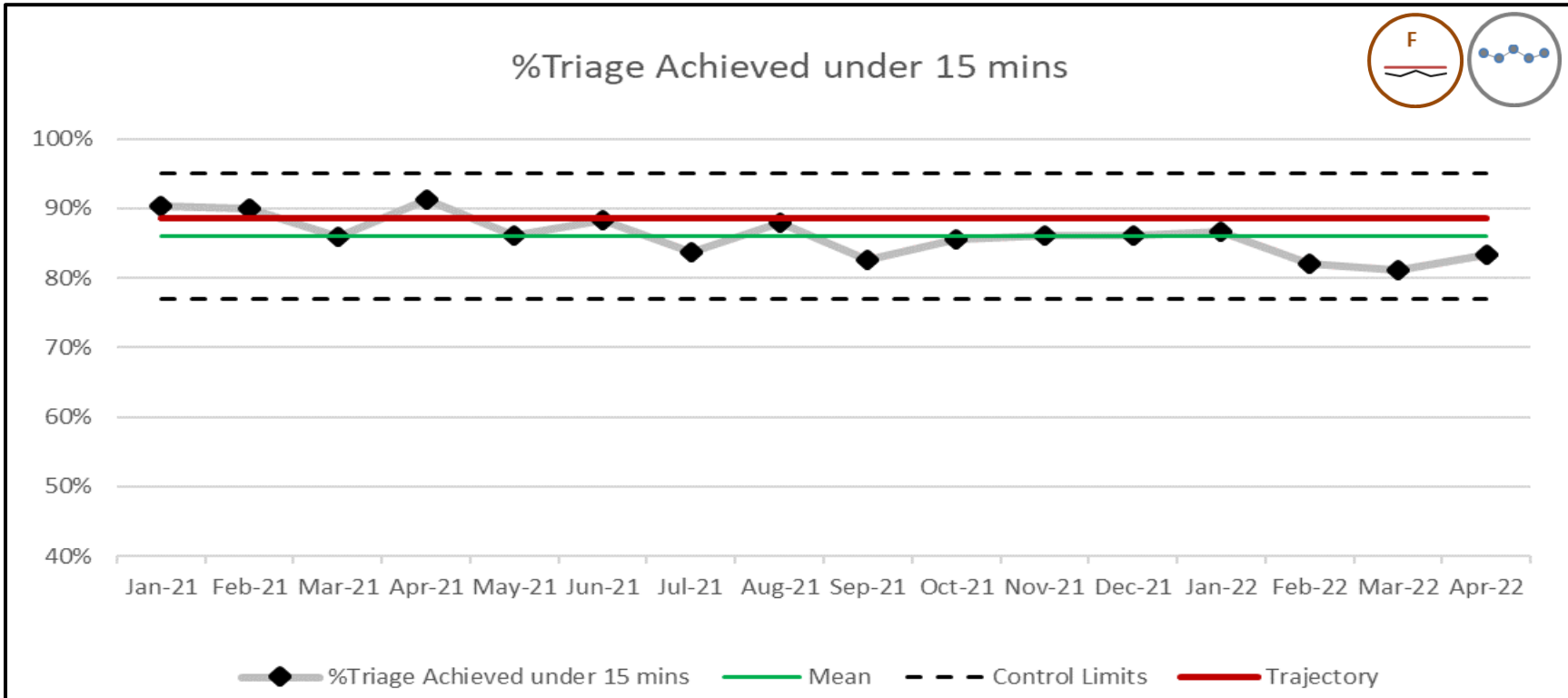
- Timely inputting of data.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been less problematic at all three sites.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP) but a slight improvement in rostering has been seen.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

Actions:

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

Mitigations:

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



Apr-22
83.34%
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%.
April outturn was 83.34% compared to 81.18% in March.
This demonstrated an improvement in performance of 2.16% compared with March.
This target has not been met.

Issues:

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

Actions:

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

Mitigations:

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

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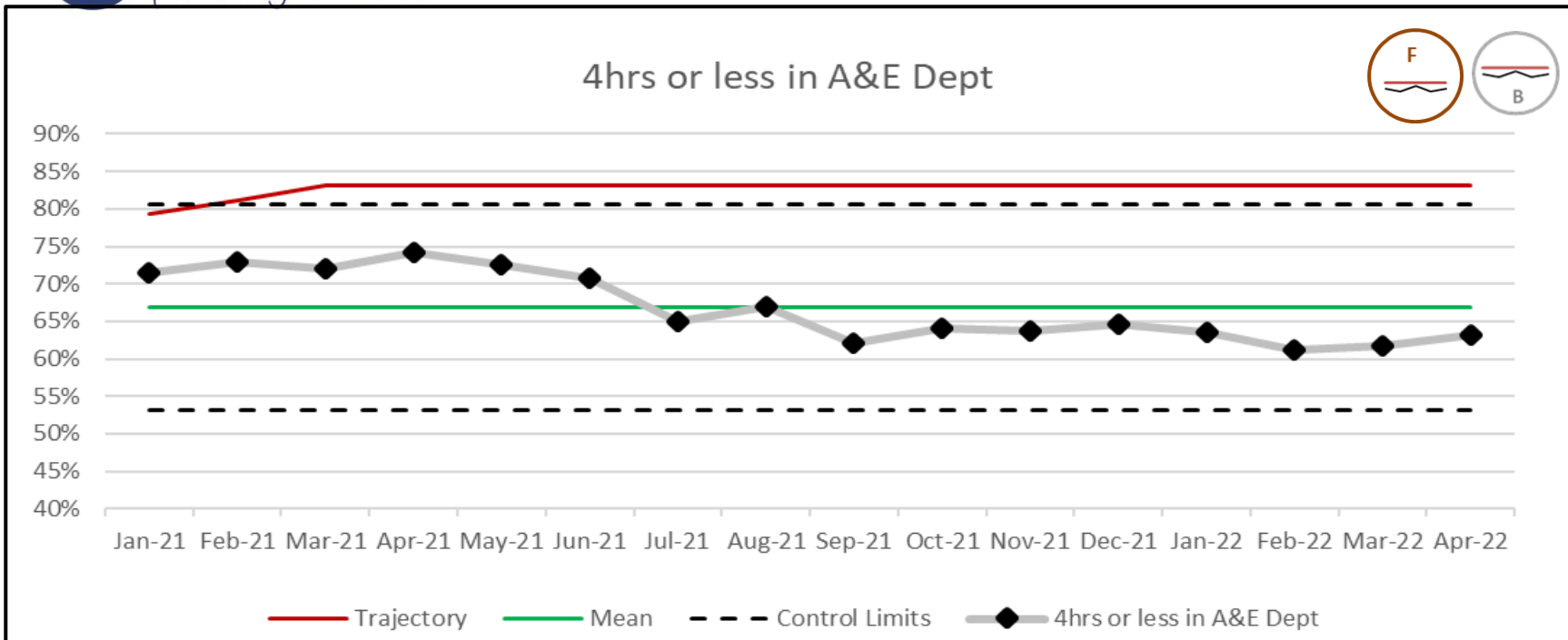

Apr-22
63.08%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 April was 63.08% compared to 61.71% which is an improvement of 1.37% but is 20.04% below the agreed target.

Issues:

The Emergency Departments saw a 3.84% decrease in attendances in April (665 patients) compared to March.
16,693 combined attendances (ED and UTC) in April compared to 17,358 combined attendances in March.
Of the 16,693 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 11,164 and type 3 accounted for 5,729. 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 and CAD now updated with destination.
Maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients.
A twice daily report is sent to all Divisions.
Twice daily System calls are in place to maximise pathway 1, 2, and 3 patients. This is led by the Lead Nurse for Discharge in partnership with System Partners. All delays >24hrs post optimisation are escalated for resolution.

Mitigations:

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

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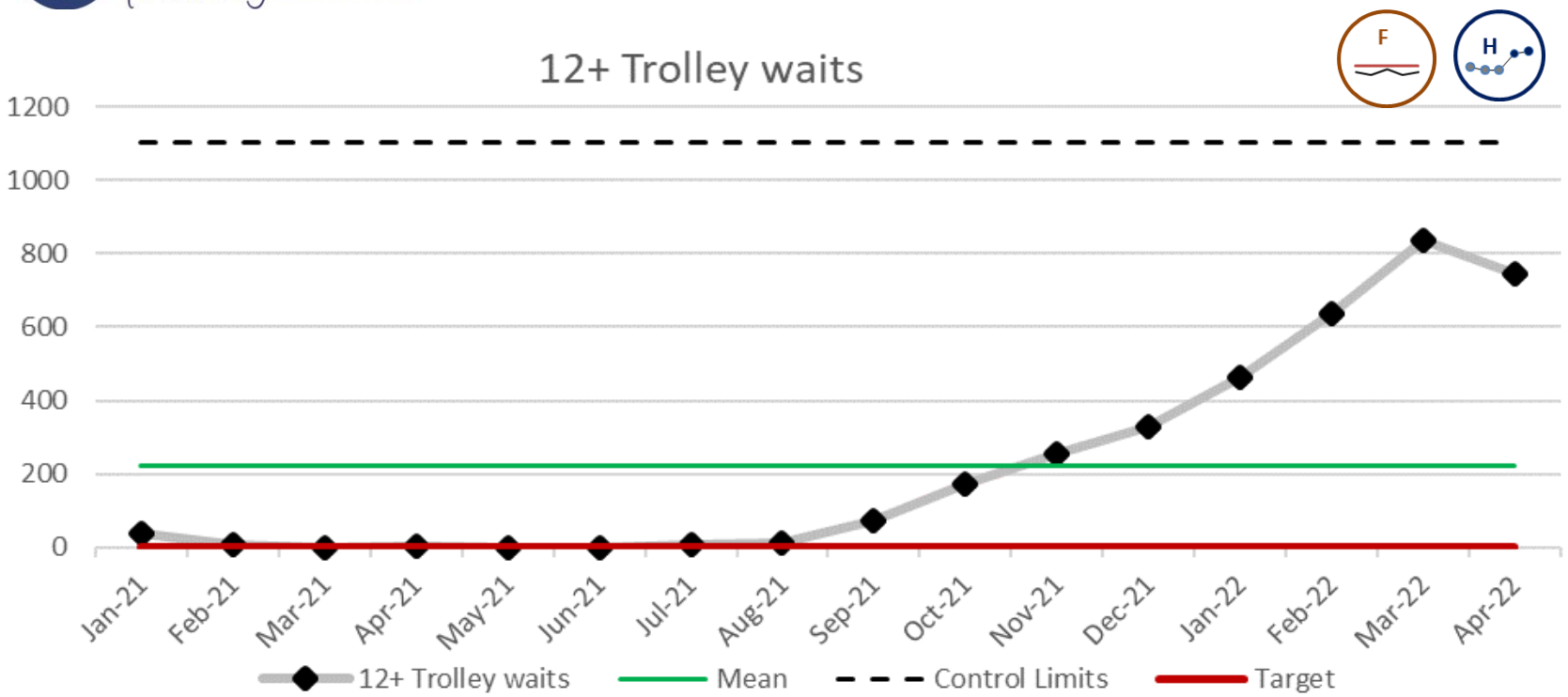

Apr-22
745
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

April experienced 745 12-hr trolley wait breaches. This is the unvalidated position. This a reduction of 89 12-hr trolley wait breaches compared to March. This represents a decrease of 10.68%. This equates to 6.67% of all type 1 attendances for April.

Issues:

Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or failure to transfer. The actual number of 12hr trolleys wait breaches, whilst anticipated against flow predictions, exceeded actual expectations.
March has experienced an increase in incidental positive covid cases and nosocomial transmission, which as restricted the use of several inpatients' beds, impacting further on flow.
March saw a significant increase in the number of new positive covid cases akin to wave 1 and 2 peaks.
To prevent nosocomial transmission, the use of boarding areas as per the Full Capacity Protocol areas has been problematic.

Actions:

The Trust continues to work closely with national regulators in reviewing and reporting these breaches.
Due to the number of 12hrs trolley waits breaches currently, harm reviews are completed by the UEC team, DATIX are completed and escalations to the CCG and NHSE/I are in place.
A daily review of all potential 12hr trolley waits is in place and escalated to all key strategic tactical and operational leads and divisional triumvirates.
System Partners and Regulators remain actively engaged and offer practical support in situational escalations.
A substantial programme of work out of hospital is in place with system partners to reduce delayed discharges which are upwards of 15% of all beds at times.
Internal actions on admission avoidance are focussed on Same Day emergency Care and recent developments have shown a 100% increase in some areas.

Mitigations:

All potential DTA risks are escalated at 8hrs to the Daytime Tactical Lead, out of hours Tactical Lead On Call Manager and CCG Tactical Lead – in and out of hours. Rectification plans are agreed with all CBU teams in hours.
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support. This demonstrates a positive impact but due to staffing gaps, there is an increased request to close this facility. Permission to close these areas now sits solely with the Chief Operating Officer and Director of Nursing or delegated officer
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.

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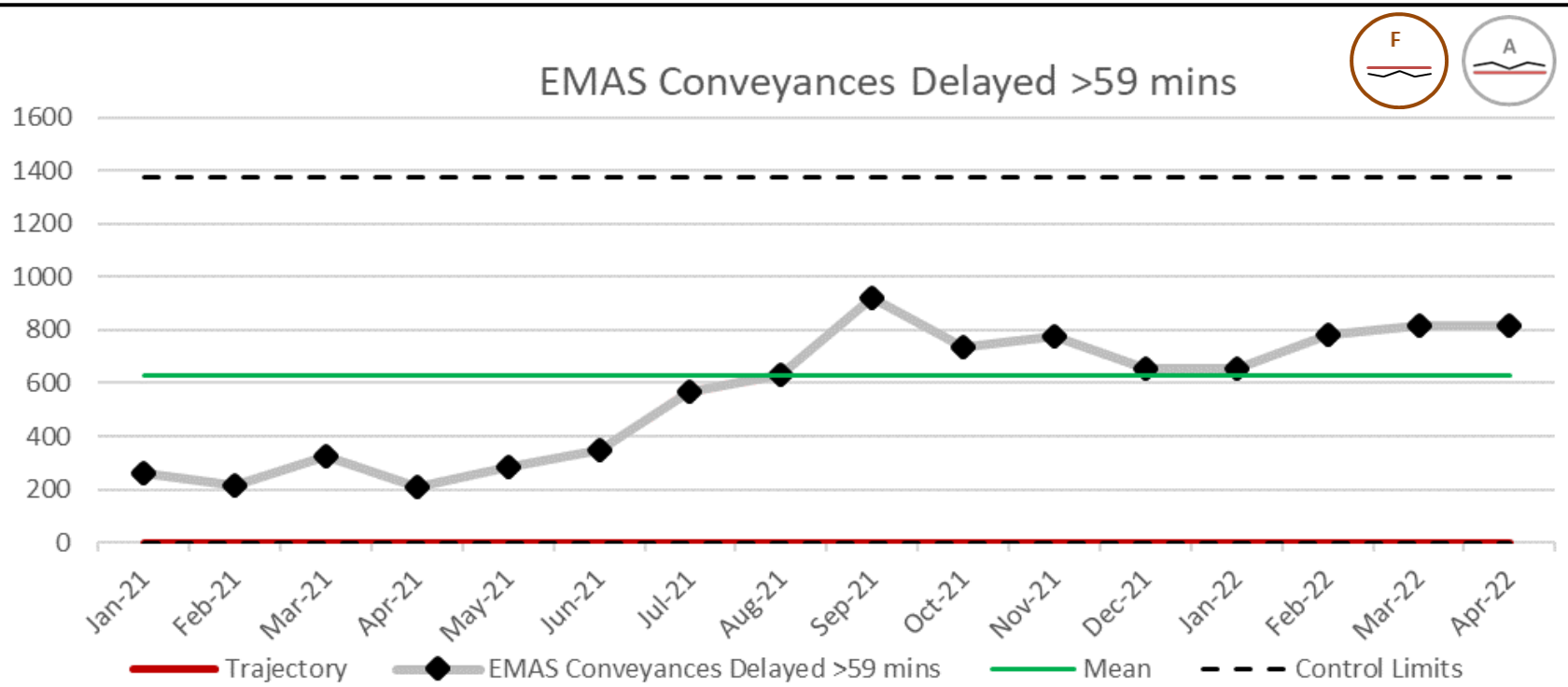


Apr-22
819
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

April demonstrated a slight increase in greater than 59 minutes' handover delays 819 in April compared to 816 in March. This represents a 0.37% increase.
What the chart does not tell us is the increase of >2hrs in April 2022 (461 in April vs 459 in March) and the decrease in >4hr delays (118 in April compared to 148 in March).

Issues:

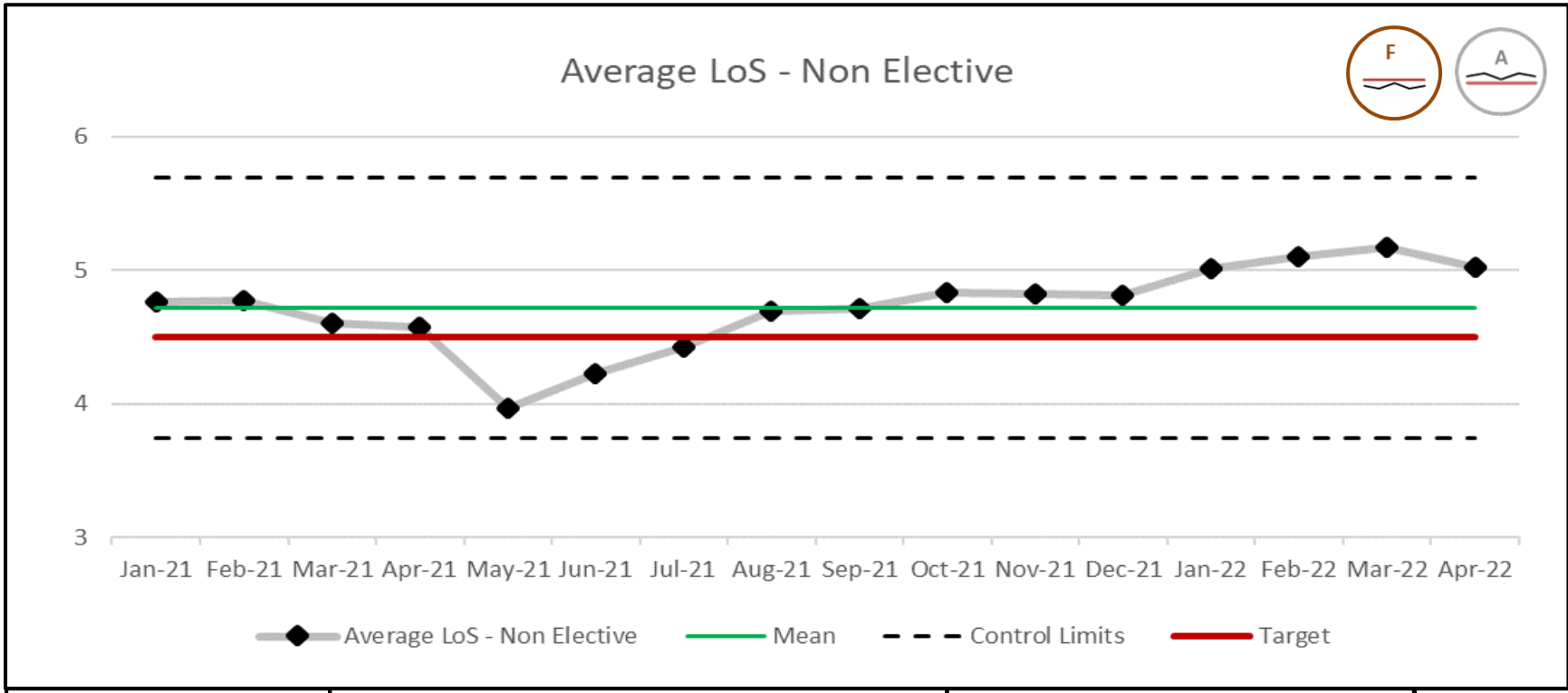
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number of category 1 and 2 patients being conveyed.
Inadequate flow and sub-optimal discharges continue to result in the emergency departments being unable to de-escalate due to an increased number of patients waiting for admission.

Actions:

All ambulances approaching 30 minutes without a plan to off load 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.
March saw an increase in formal requests from EMAS to enact the rapid handover protocol.

Mitigations:

Early intelligence of increasing EMAS demand has allowed for planning and preparedness to receive and escalate.
Contact points throughout the day and night with the Clinical Site Manager and Tactical Lead (in and out of hours) to appreciate EMAS on scene (active calls) and calls waiting by district and potential conveyance by site.



Apr-22
5.02
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 5.02 days in April vs 5.17 in March.
This is a decrease of 0.15 days
compared with March
This is a 0.52 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 has been agreed as an 8 week rolling programme

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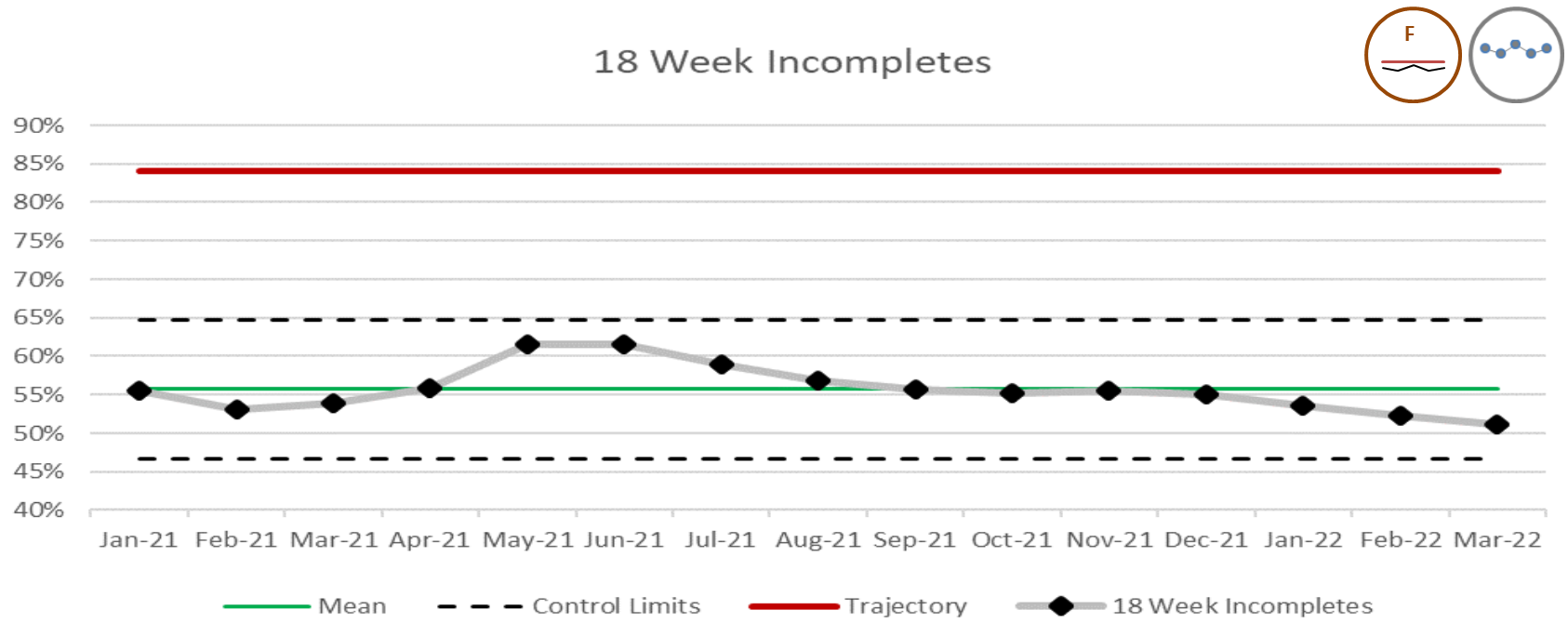

Mar-22
51.22%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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. March saw RTT performance of 51.22 % against a 92% target, which is 1.03% down on February.

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 – 5256 (increased by 292)
- Gastroenterology – 3412 (increased by 314)
- Dermatology – 3224 (Increased by 148)
- Gynaecology – 2854 (Increased by 100)
- Ophthalmology - 2375 (increased by 132).

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. A review of the Trust's IPC measures are currently taking place. Guidelines have recently been updated with regard to PCR testing and isolation for admitted patients with low risk, vaccinated day cases no longer requiring these measures. This should have a positive impact on utilisation of capacity.

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

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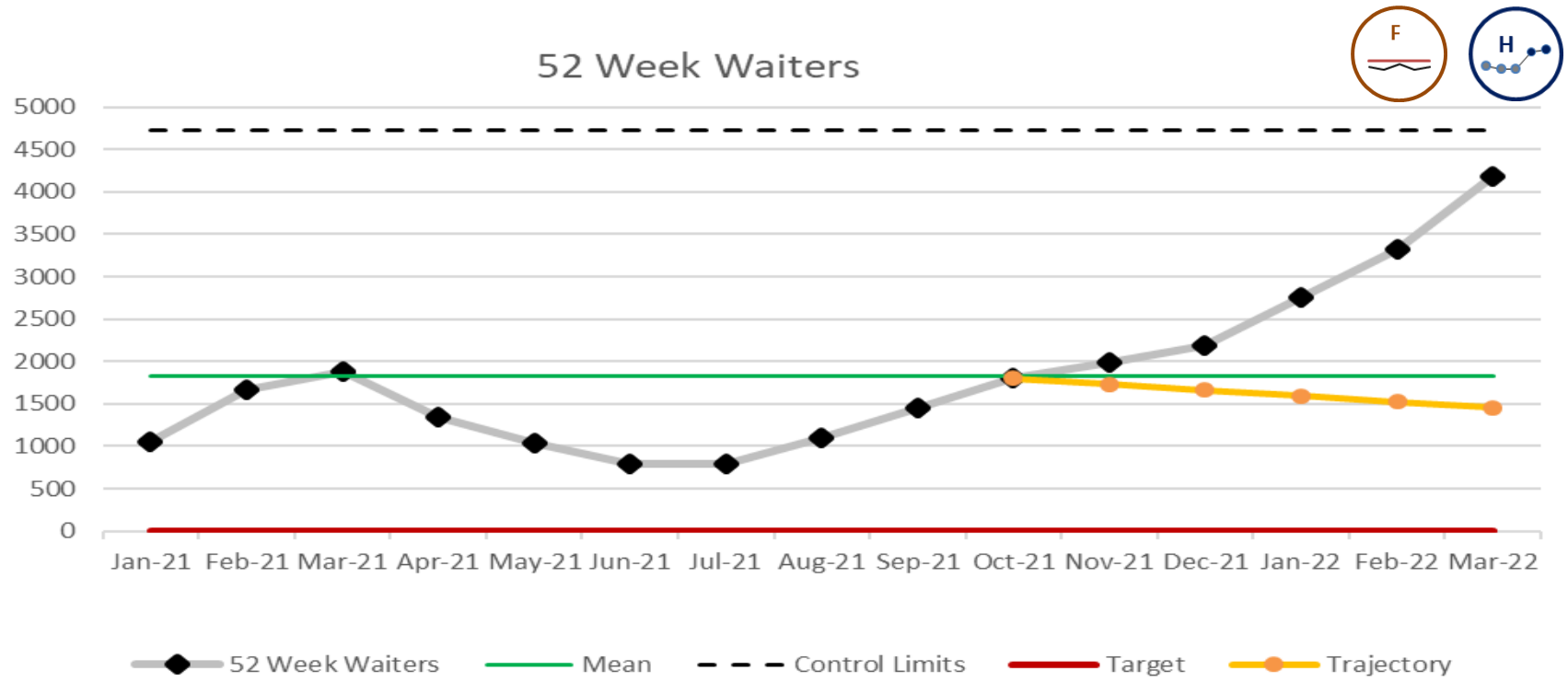

Mar-22
4177
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 4177 incomplete 52-week breaches for March. An increase of 859 from February. 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 a harm review completed. The harm review process is discussed at the Clinical Harms Oversight Group with a new piece of software being developed in-house to better enable monitoring and recording.

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

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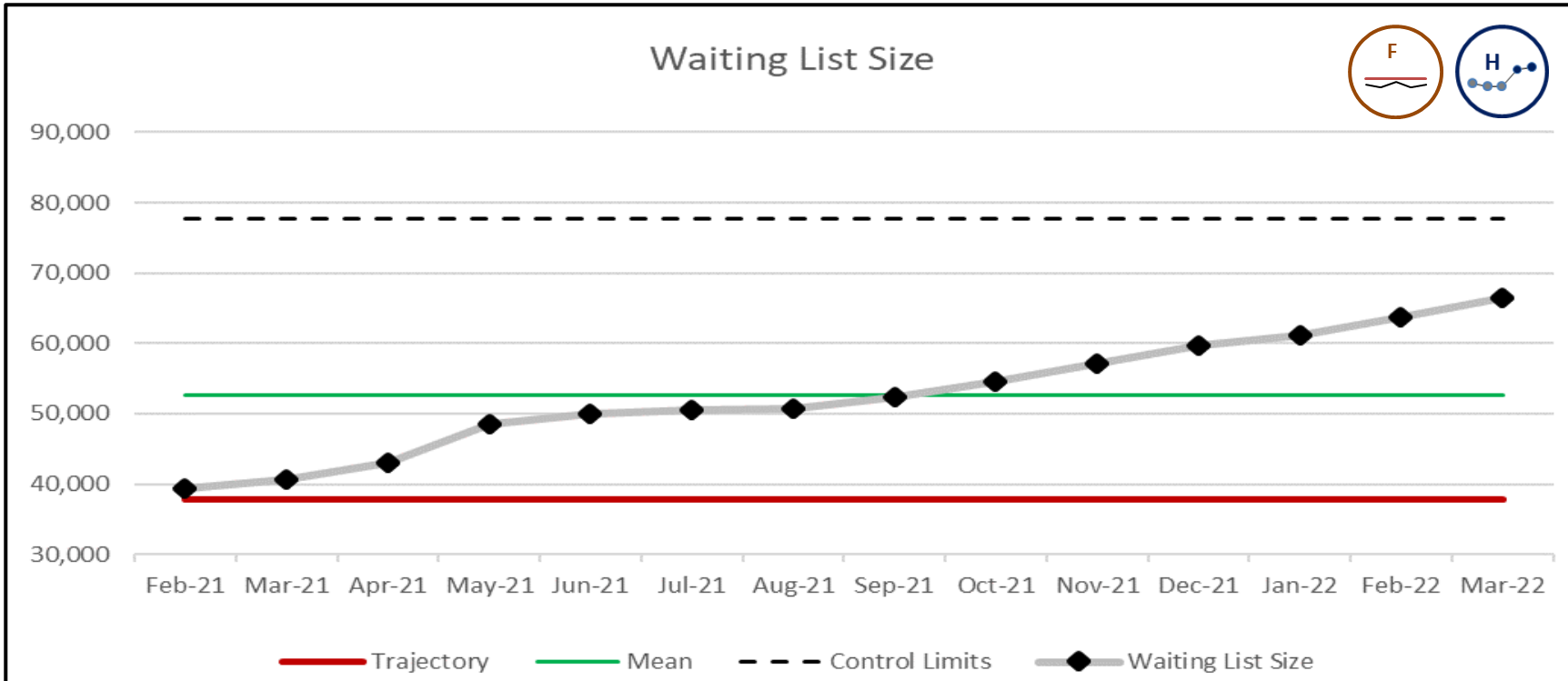

Mar-22
66,539
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has increased from February, with March showing an increase of 2859 to 66,539.
The incomplete position for March 2022 has increased by approximately 28,513 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 February are:

- ENT + 395
- Dermatology + 329
- Trauma & Orthopaedics + 275
- Gastroenterology + 267
- Colorectal Surgery + 199

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

- Clinical Oncology – 29
- Medical Oncology - 14
- Diabetic Medicine - 13
- General Surgery - 3
- Paediatrics - 3

The Trust reported 10,765 over 40 week waits; an increase of 1234 on February. Patient numbers waiting over 26 weeks increased by 1356.

Actions/Mitigations:
The longest waiting patients at 78w+ are monitored and discussed at a weekly PTL meeting and also with system partners at a weekly ICS meeting.
Transferring of appropriate admitted patients to ISP's continues. Non admitted patients in two of the most pressured specialities continue to be transferred out. Medical specialities are also looking at a possible external clinical validation company for their non-admitted patients.

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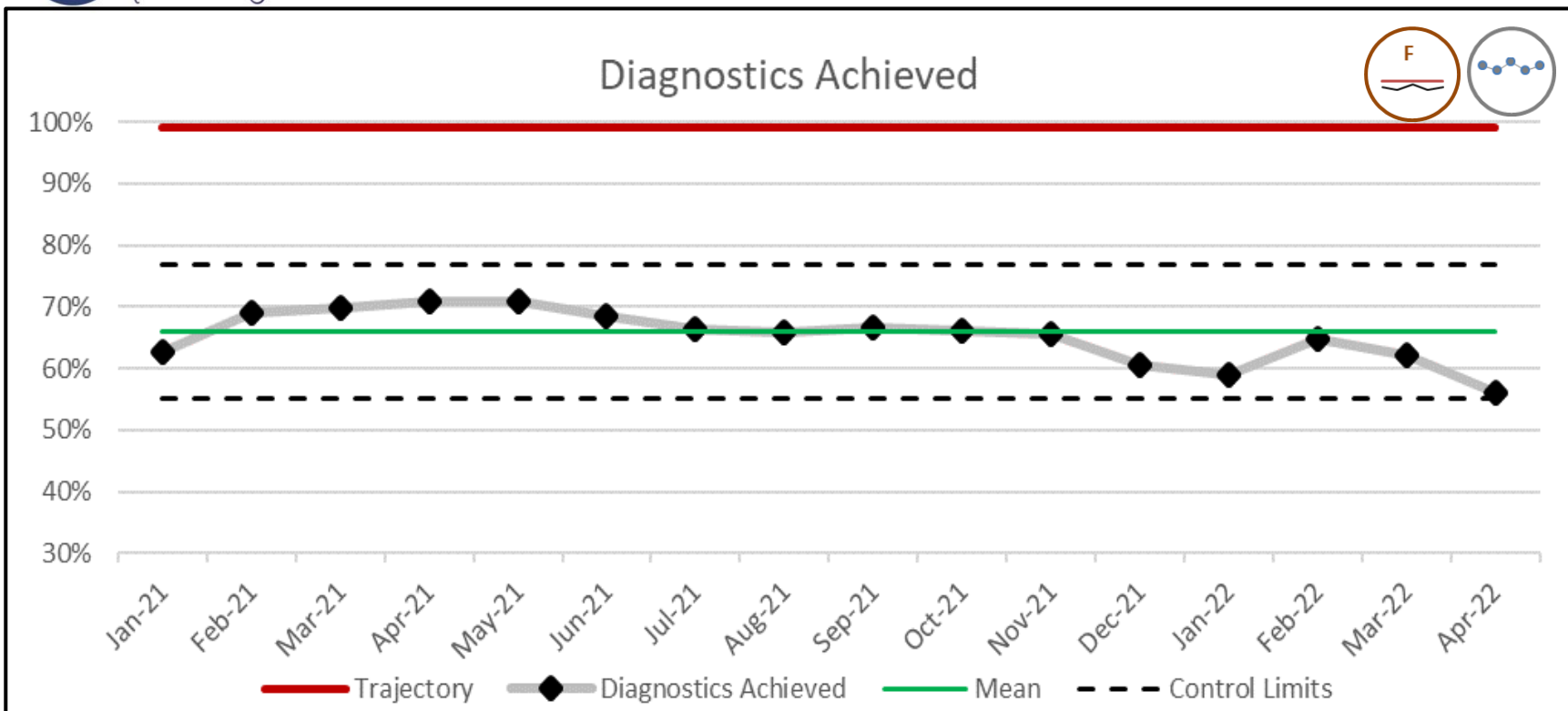

Apr-22
56.03%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 56.03% for April 2022 against the 99.00% target.

Issues:
CT, MRI Dexa have lost capacity due to the LCH fire, All areas have lost capacity due to social distancing, demand is still higher than capacity for some procedures so causing increased backlogs for some specialities and increasing the number of breaches declared each month for those specialities. Increase demand in Ultrasound due to Mediscan being stopped by the CQC this has caused an additional 3000 scans in Feb 2022 compared to Feb 2021 AQP, Cardiac Echoes have a considerable backlog due to a lack of capacity. Mobile inpatient scanners have reduced capacity compared to the internal scanner. The MRI pad at GDH is still not available which is causing many breaches now.

Actions:
Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes. Additional US lists are happening but not enough to deal with the additional 2000- 3000 scans. 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. Mobile scanners are being sourced and ambulance support is also being sourced to support MRI scanning.

Mitigations:
All waiting lists are being monitored and where 50% of the waiting list is over 6 weeks we are being asked to complete a clinical validation for each patient, and assign a D code to that patient. Going forward every new referral will have a D code assigned to each patient. This will make sure all patients are seen in clinical urgency. Additional list for ultrasound and echo. Business case being complied for additional Ultrasound capacity. Dexa is awaiting replacement as fire damaged.

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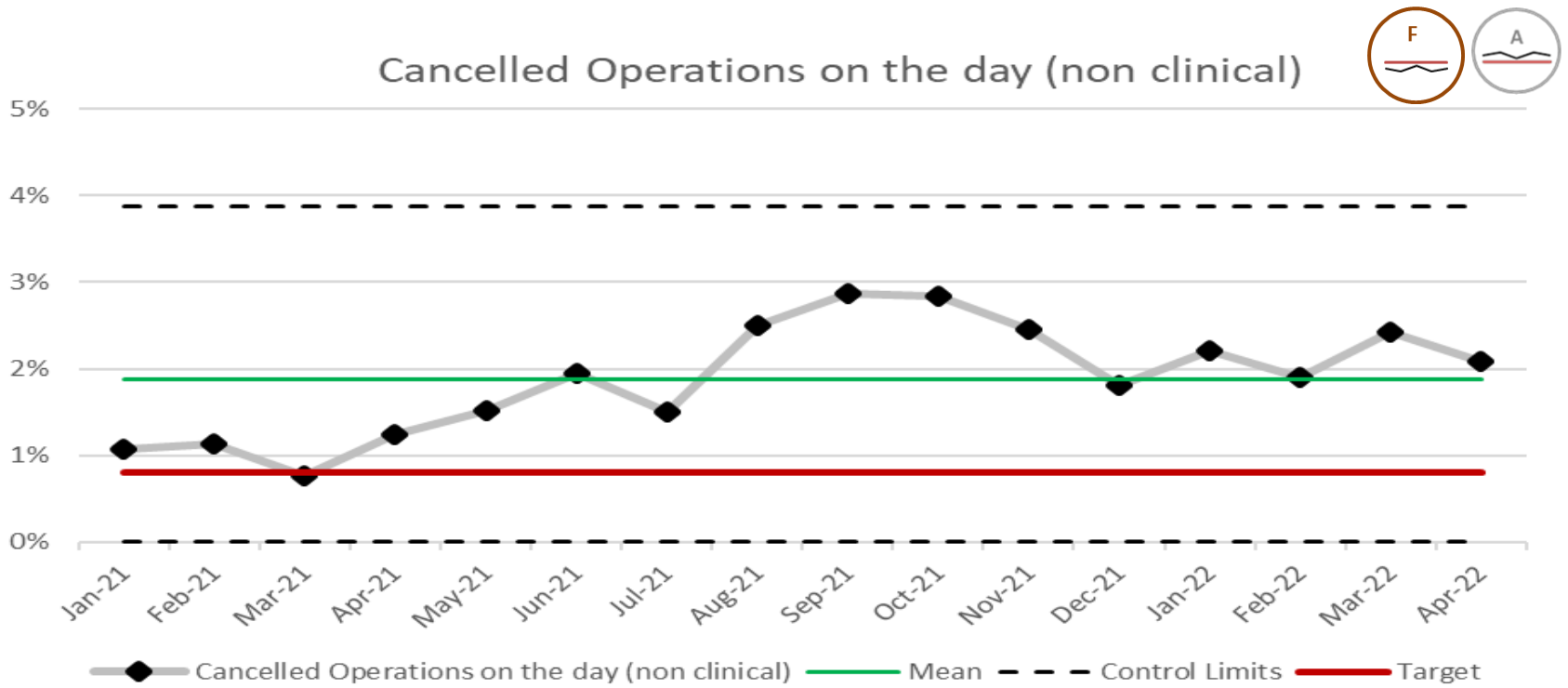

Apr-22
2.09%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
April shows a decrease in patients who have had their operation cancelled on the day of surgery however remains above the agreed trajectory of 0.8%.

Issues:
The top 3 reasons for same day non-clinical cancellations for April are identified as

- No medical staff;
- Lack of time;
- No theatre staff.

Actions:
The team are working closely to identify potential complications in order to reduce on the day cancellations.
Surgical Division continue to undertake twice weekly meetings to focus on plans for our longest wait patients, which is evident in the reducing numbers.

Mitigations:
The increased number of cancellations due to staffing gaps has increased due to sickness absence which has significantly improved at this point.
The TACC team are completing an audit of on the day cancellations (non-clinical) in order to better identify causative factors and provide resolutions.

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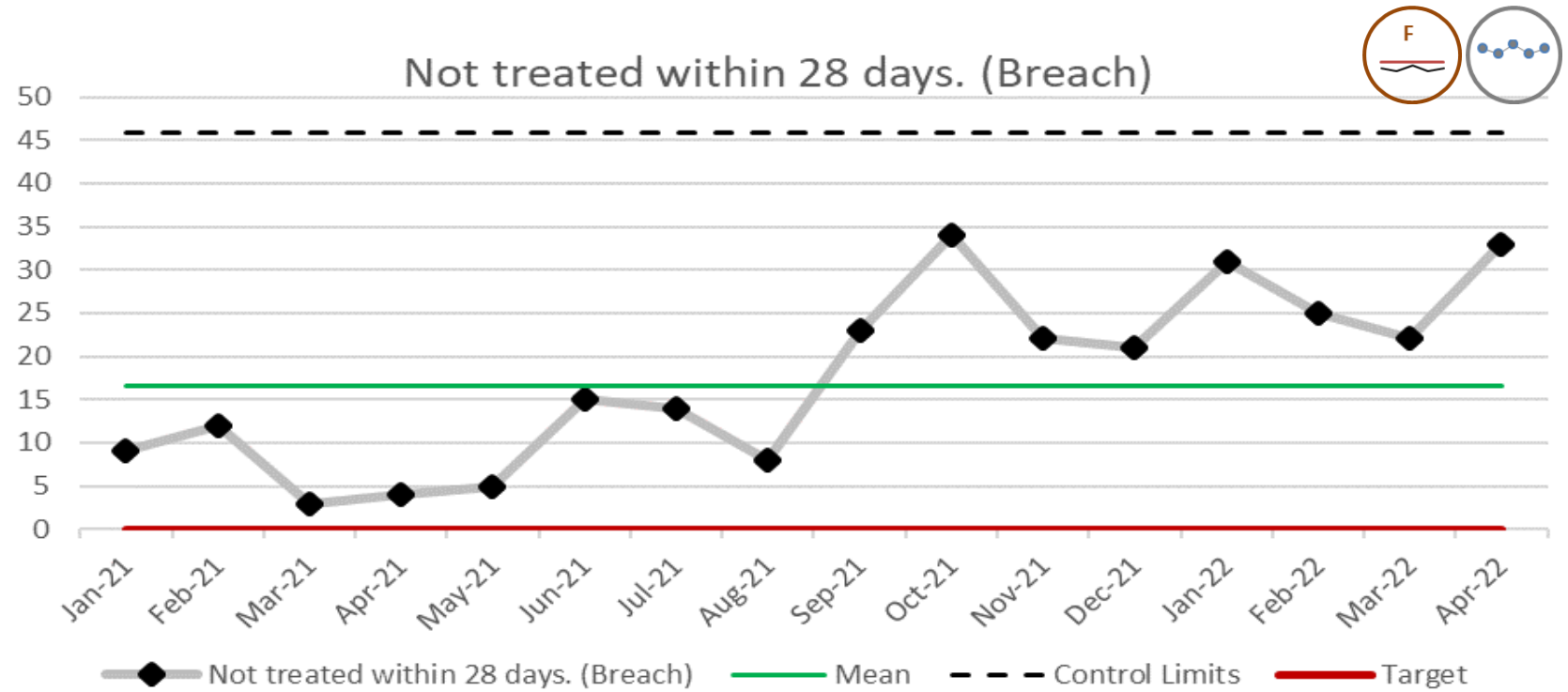

Apr-22
33
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 April is 33, which is a significant increase from 22 in March.
The agreed target of zero has not been achieved.

Issues:
Within surgery, limited theatre availability due to annual leave and clinician sickness has reduced ability to re date patients within our 28 day timescale.

There has been further reduced pre assessment and waiting list clerk availability, however this is now improving and will benefit the refilling of lists at short notice.

Actions:
Within surgery, the teams continue to work together to reschedule patients who have experienced any on the day non-clinical cancellations, identifying any requirement for additional capacity

Mitigations:
Surgery are focussing on increasing utilisation of lists and identifying underutilisation at an earlier point to ensure sufficient capacity to plan patients.

Utilisation is expected to improve with recent COVID testing guidance, which means we can fill lists with less notice if patient cancellations occur.

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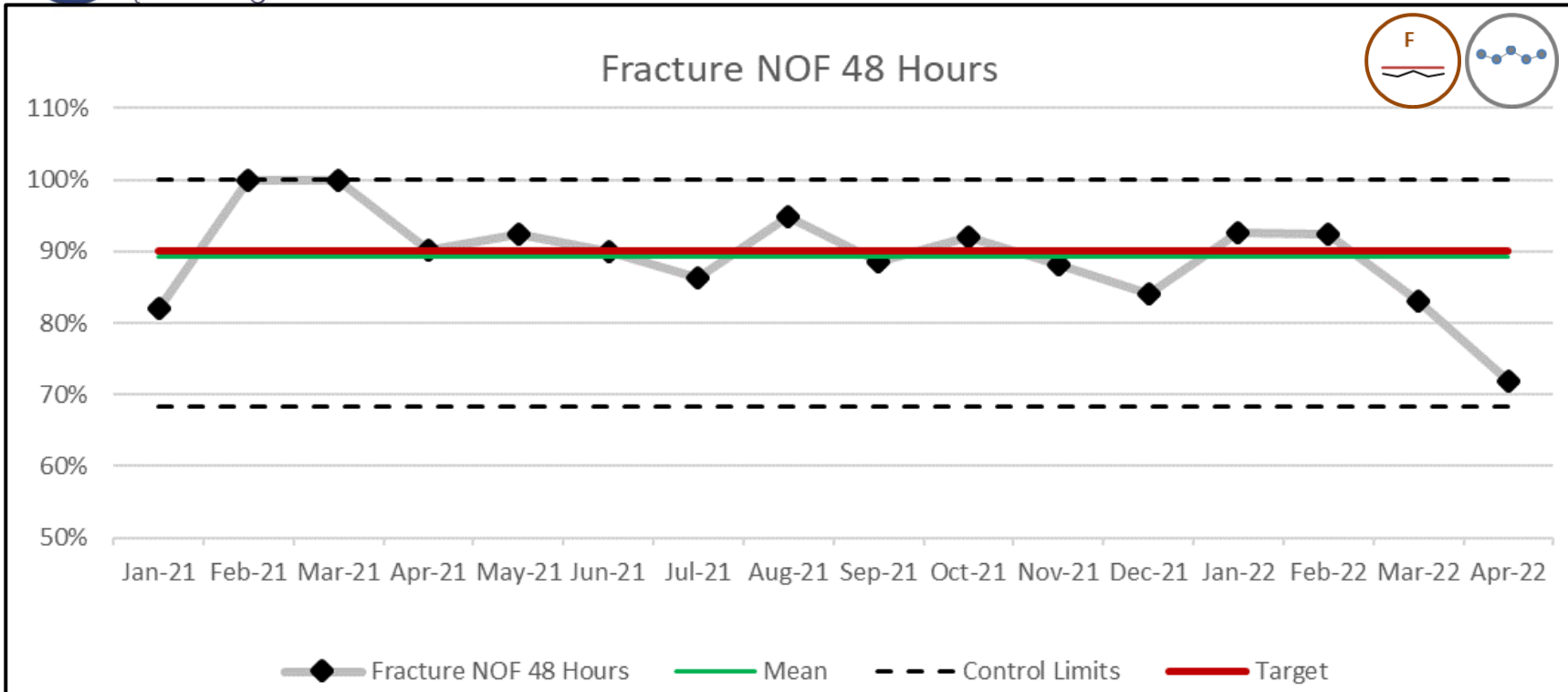


Apr-22
71.95%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

April performance out turned at 71.95% against the agree target of 90%

Both sites underperformed with PHB at 77.78% and LCH 64.86% which has led to deterioration against previous 3 months.

Issues:

Increase in trauma demand over recent months, particularly during BH weekend in April.
High vacancy rate in theatres which limits capacity for additional theatres.
Due to increase in trauma demand and the types of injuries seen, certain procedures have been clinically prioritised ahead of NOF patients.
Delays for NOF's included reduced theatre capacity, patients medically unfit to proceed and the need for specialist surgeon availability due to complexities.
UTAH hub not in place which will support quicker turnaround of diagnostic needs for NOF patients. This will also help create ring fenced NOF beds.

Actions:

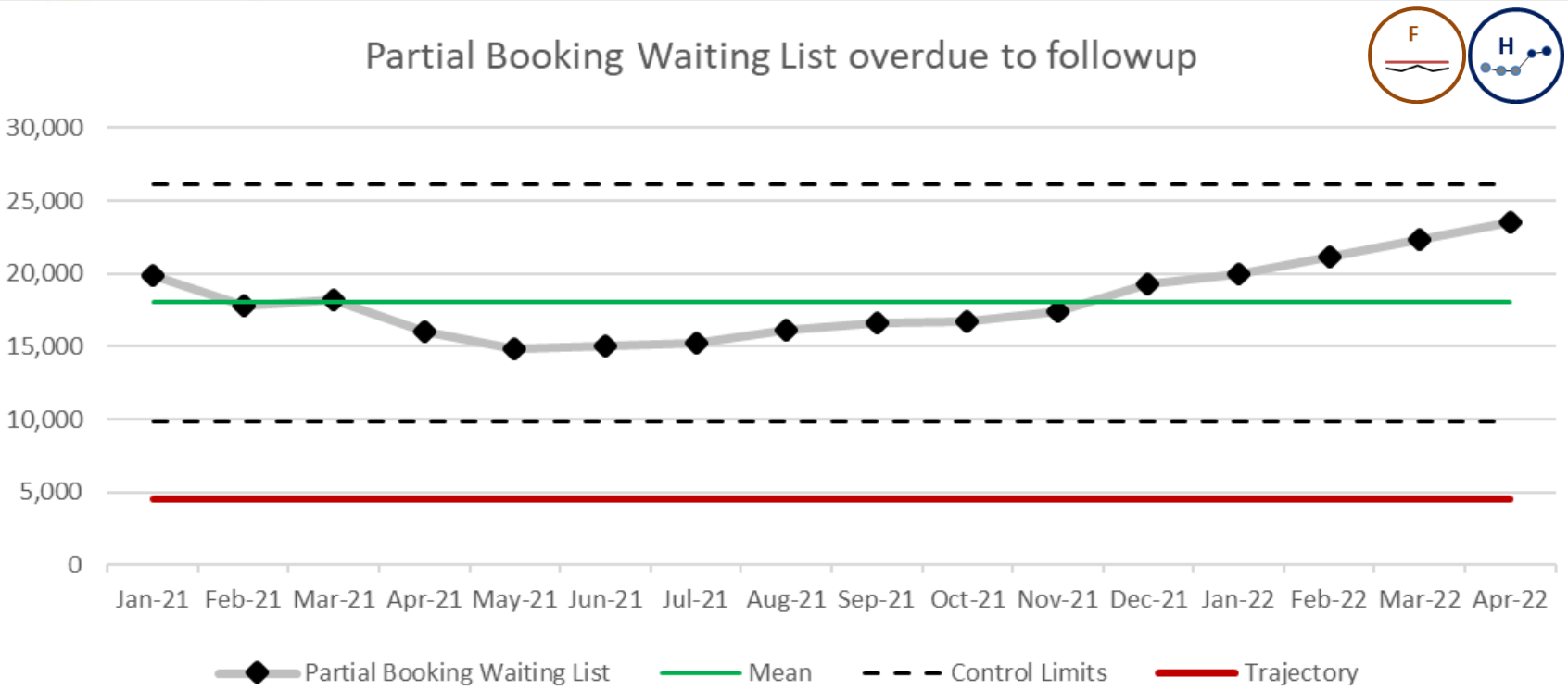
NOF pathway project ongoing to ensure pathway from EMAS response through to patient discharge post-surgery being fully optimised and responsibilities/protocols are clear.
Forward planning of theatre lists required based on historical peaks in activity seen.
'Golden patient' initiative to be fully implemented.
Ensure robust processes in place to utilise Trust wide trauma capacity and beds.
Additional Specialty Trauma lists identified to Theatre to ensure prioritisation of Theatre staffing ensuring minimal cancellations and backlog of trauma.
Additional trauma lists continue to be identified over BH weekends for future BH dates

Mitigations:

Ensure trauma lists are fully optimised.
Reduce 'on the day' change in order of the trauma list where clinically appropriate.
Daily attendance at the trauma meeting by the clinical business unit to improve communication, visibility of current position and increased support for theatre utilisation and extra capacity needed.
Alternative #NOF pathways created on Digby Ward.
Once daily additional CBU review of trauma and plans to ensure capacity maximised for clinical priority.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-22
23,562
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 23,562 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. The Trust is working through the recovery of diagnostic capacity for outpatients since the fire in the diagnostic area.

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. Currently the Trust is out to procurement for a validation team to review the PBWL patients and discussing priorities for this team. The Trust is discussing a standardised validation process for all specialties to follow.

Mitigations:
Supporting organisational priorities in ED and urgent care taking individual outpatient clinics down, if support required across the sites (site/patient flow and theatres) or so a clinician can support the wards at short notice.

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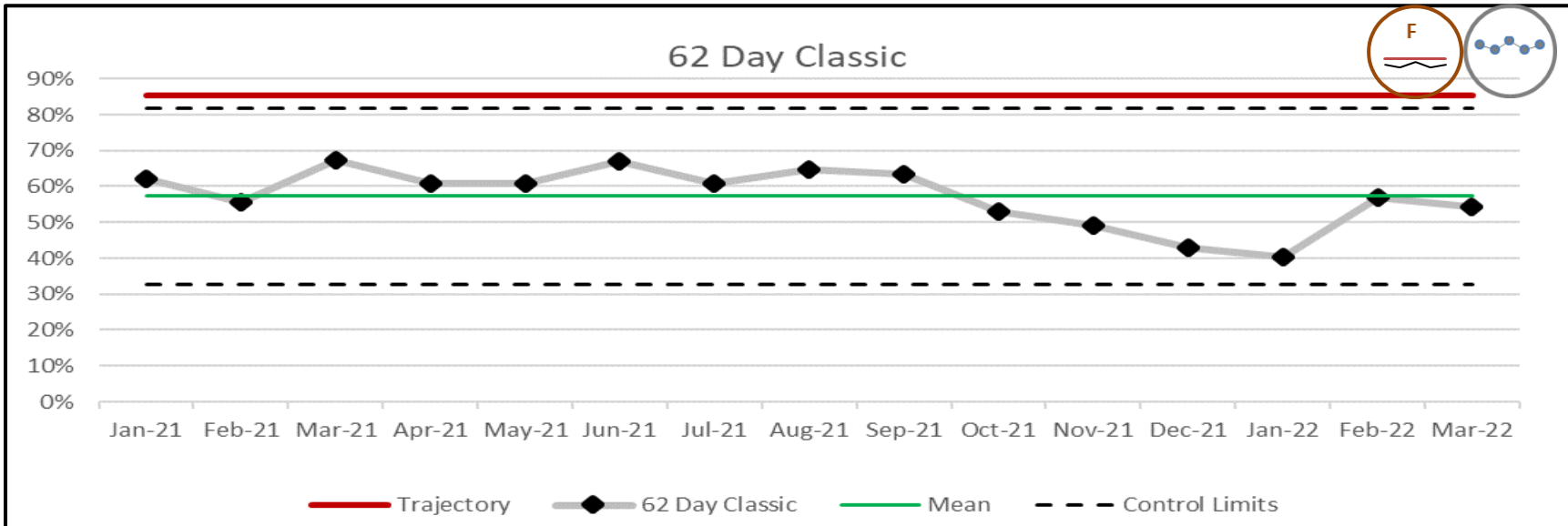
NHS United Lincolnshire Hospitals NHS Trust



Mar-22
54.17%
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 54.17% against an 85.4% target.

Issues:

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

Pressure on diagnostic services following the fire in Radiology at LCH.

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 'effectiveness' period). 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. One Locum Medical Oncologist Locum has started in post in May. Other posts are still going through recruitment processes. There is a significant lack of consultants nationally and very few available from agency.

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.

Capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to anaesthetic assessment capacity.

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 and will alleviate capacity issues once up and running.

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.

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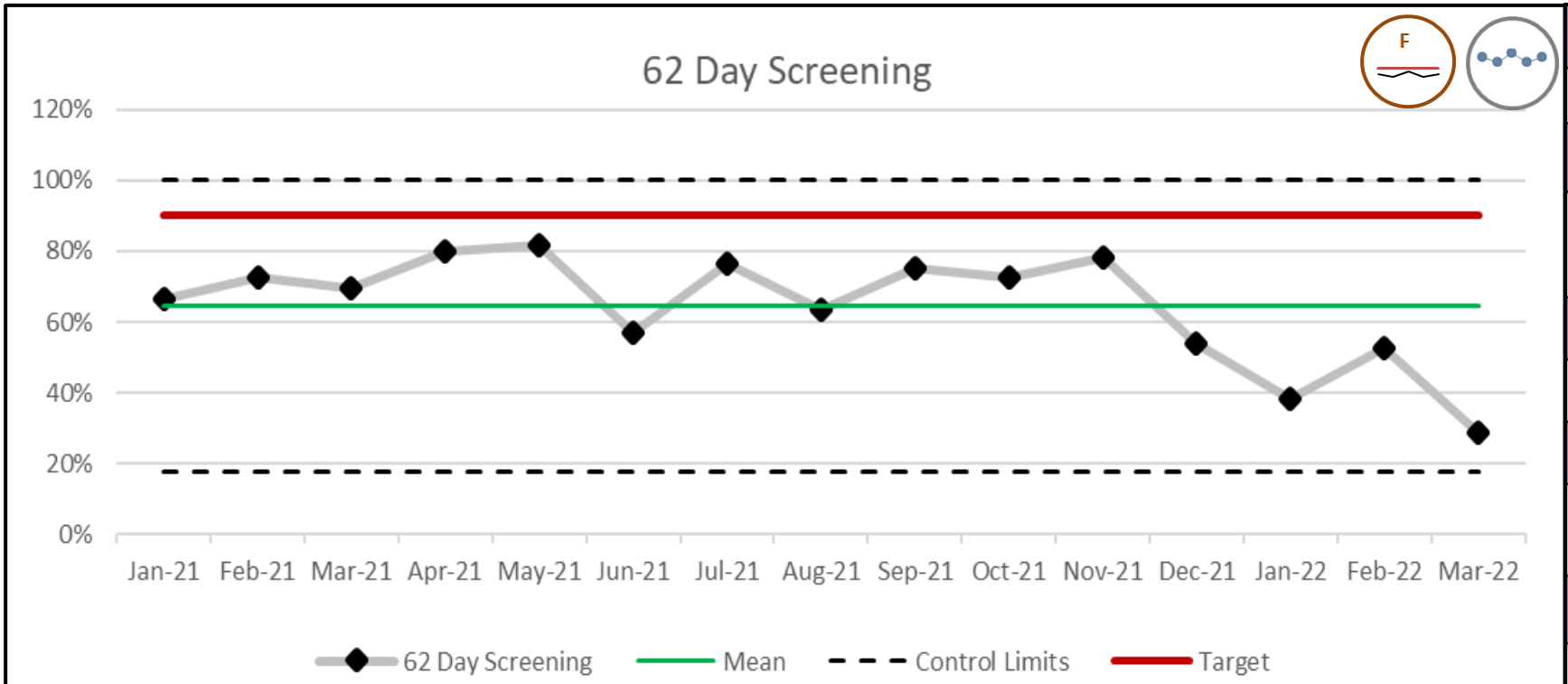

Mar-22
28.57%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 28.57% 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.

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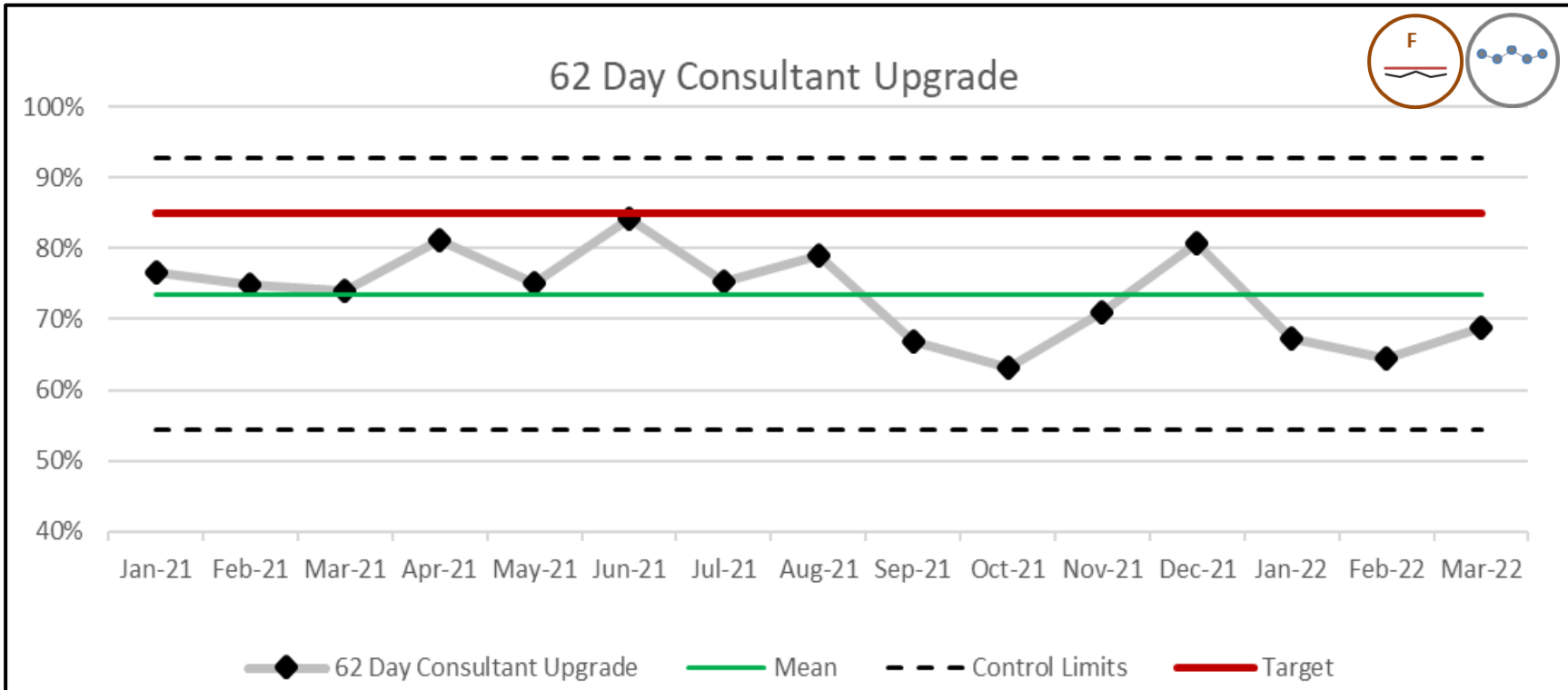

Mar-22
68.82%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 68.82% against an 85% target.

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

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

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

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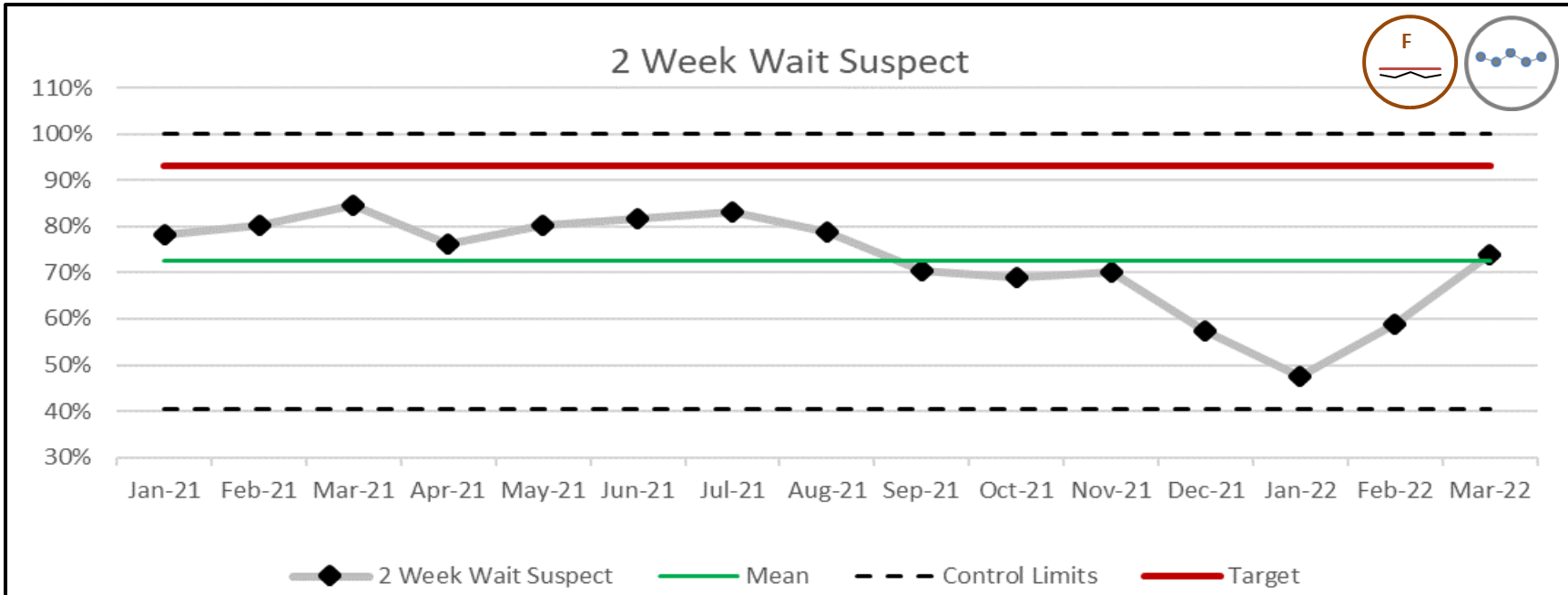

Mar-22
73.90%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 73.90% 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 9.6%: - 35.2% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Lung (40.4%), Gynaecology (58.6%), Brain (60.0%), and Urology (69.2%)

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 direct access testicular pathway was implemented on 11th April 2022. The Trust is actively seeking to implement RDC pathways for brain, haematuria and Upper GI at the earliest opportunity. A pathway review for gynaecology and a direct access ultrasound pathway has also been identified as a priority for 2022.

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

Overseas recruitment is underway for gastroenterology consultants / Specialty Doctors. 2 posts are in place to commence from June '22 – dates are yet to be confirmed. A substantive consultant has also returned from 3rd May '22.

These and other key action progress are tracked through the Urgent Care Cancer group chaired by the Medical Director and run with full system partner involvement.

Mitigations:

A Respiratory consultant post has also needed to go back out to tier 2 agencies due to continuous delays. A Locum consultant post has been appointed to for 12 months at PHB with a provisional start date in August. A meeting is in place for 16/05/2022 to discuss potential radiology led criteria-based discharge due to increase in CT triage numbers, following model in place at SFH. Work is ongoing within the CCG to repatriate Spirometry back to GP practises and into Community Diagnostic Centres.

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 Clinics commenced in post in April and will improve FOC and TPLA capacity.

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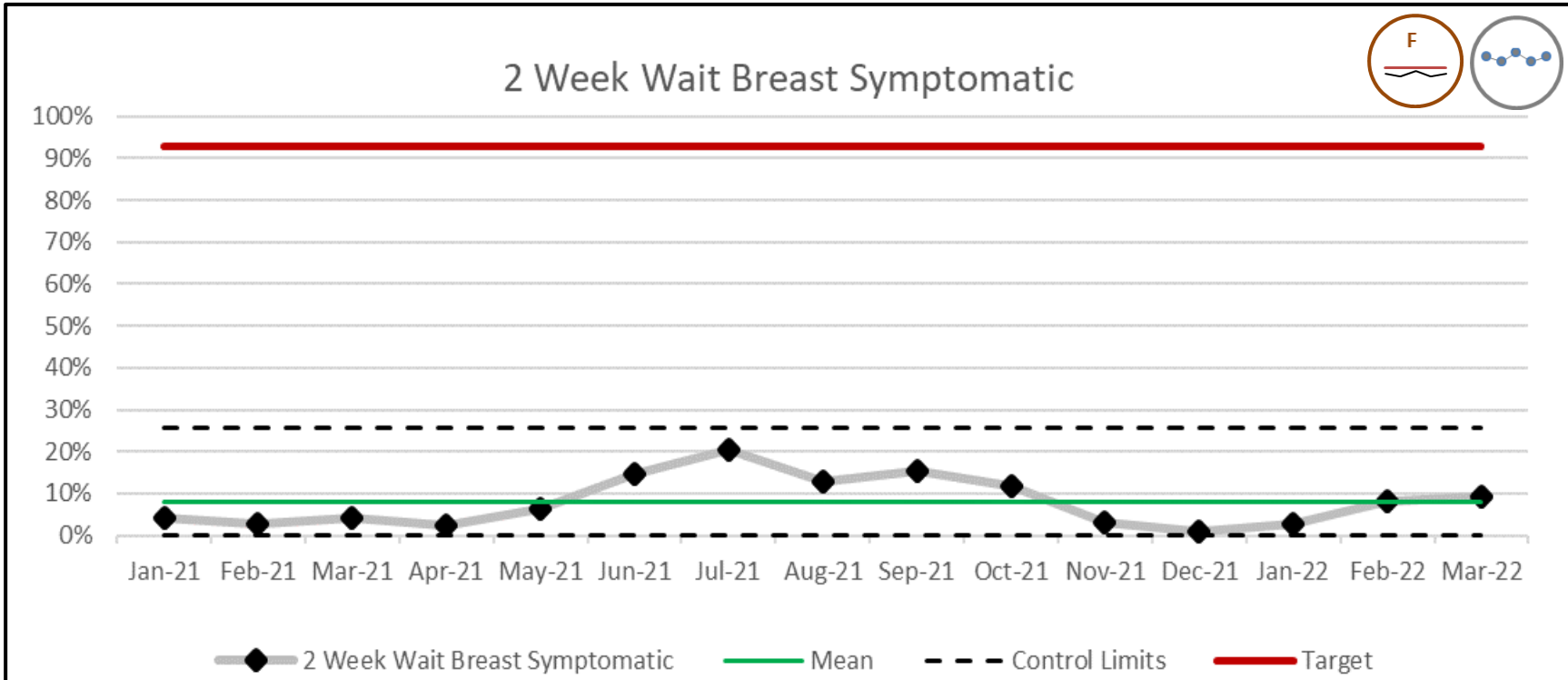

Mar-22
9.30%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 9.30% against a 93% target.

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

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

Mitigations:
A mastalgia pathway is now up and running with primary care and system partners which has the potential to reduce inbound referrals by circa 15%.

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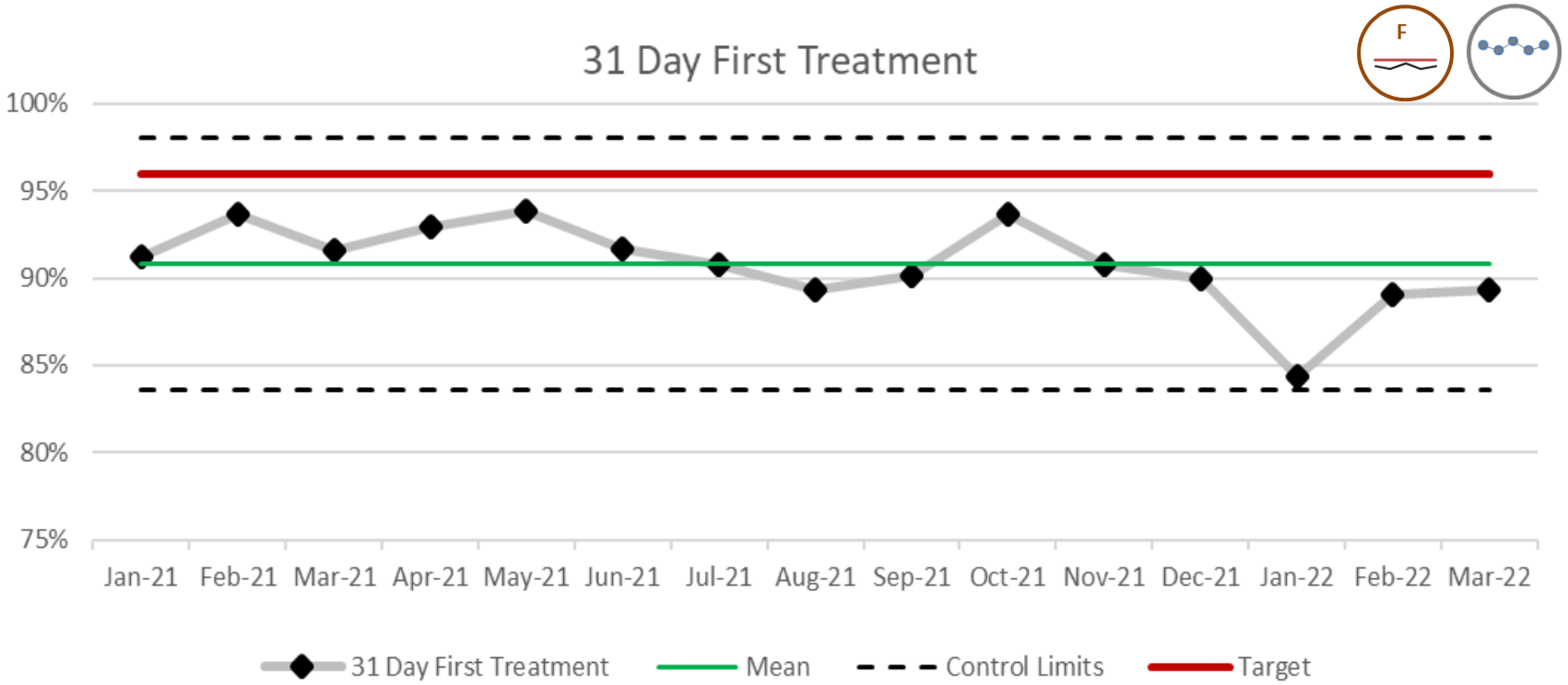


Mar-22
89.29%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

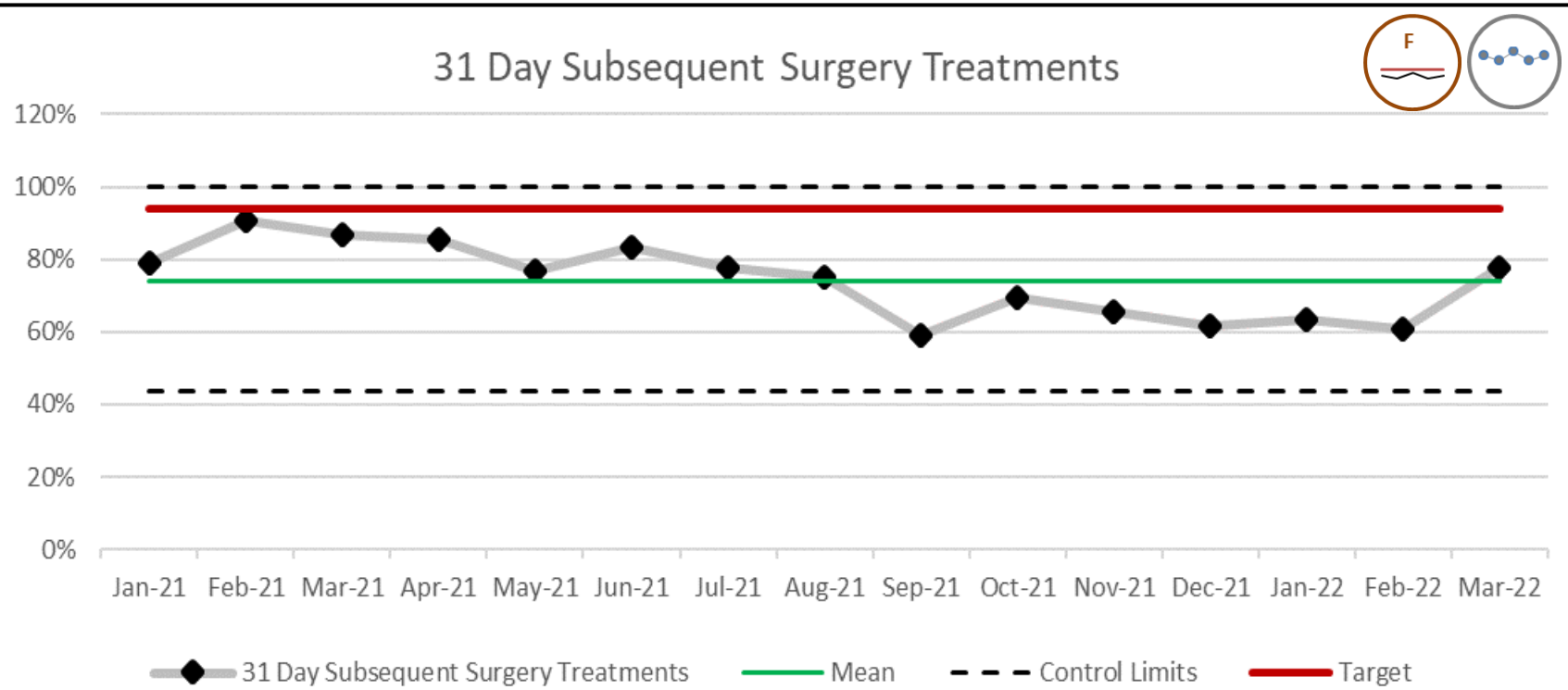
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 89.29% against a 96% target.

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

Actions:
One Locum Medical Oncologist Locum has started in post in May. Other posts are still going through recruitment processes. 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 capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to anaesthetic assessment capacity.



Mar-22
77.78%
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 77.78% 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.

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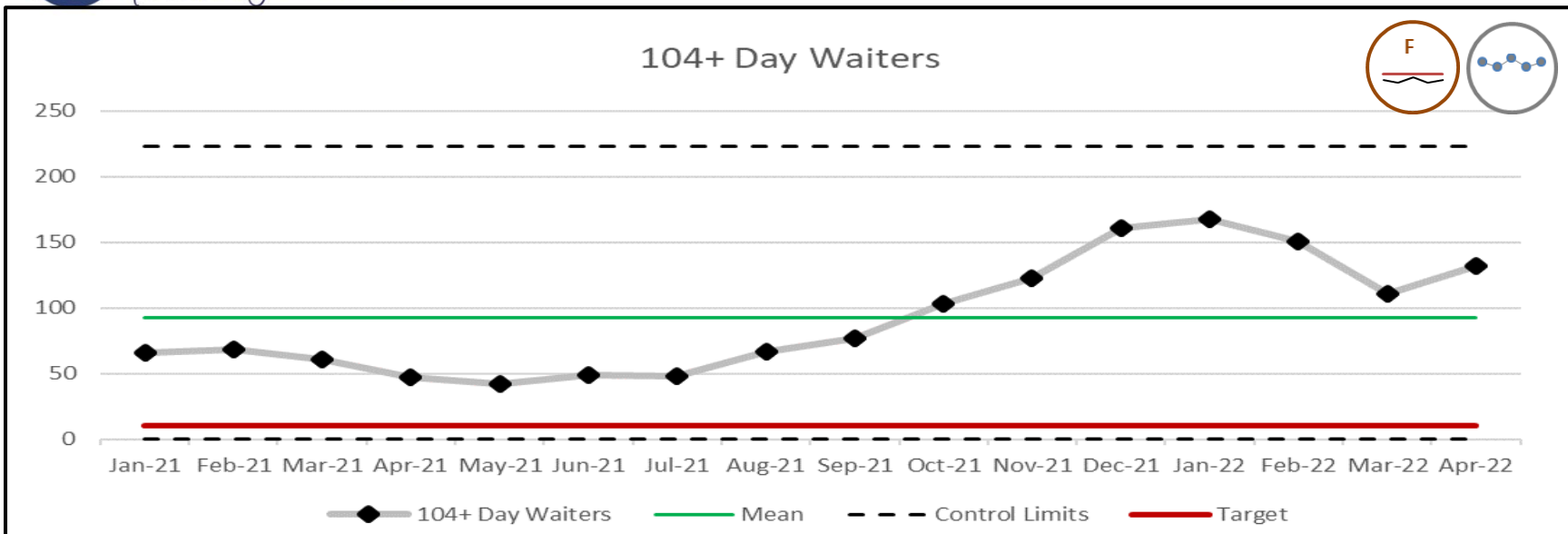


Apr-22
132
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Number of cancer patients waiting over 104 days.

What the chart tells us:

As of 11th May the 104 Day backlog was at 132 patients. The agreed target is <10.

The current position by tumour site is as follows: -
89 Colorectal
14 Urology
11 Upper GI
7 Lung
3 Gynaecology
2 Haematology and
1 each Brain, Breast, Skin, Sarcoma, Head & Neck and CUP

Issues:

The impact of critical and major incidents on Trust activity and patient pathways.
Pressure on diagnostic services following the fire in Radiology at LCH.
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 'effectiveness' period) – this is starting to improve.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. 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 18% 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:

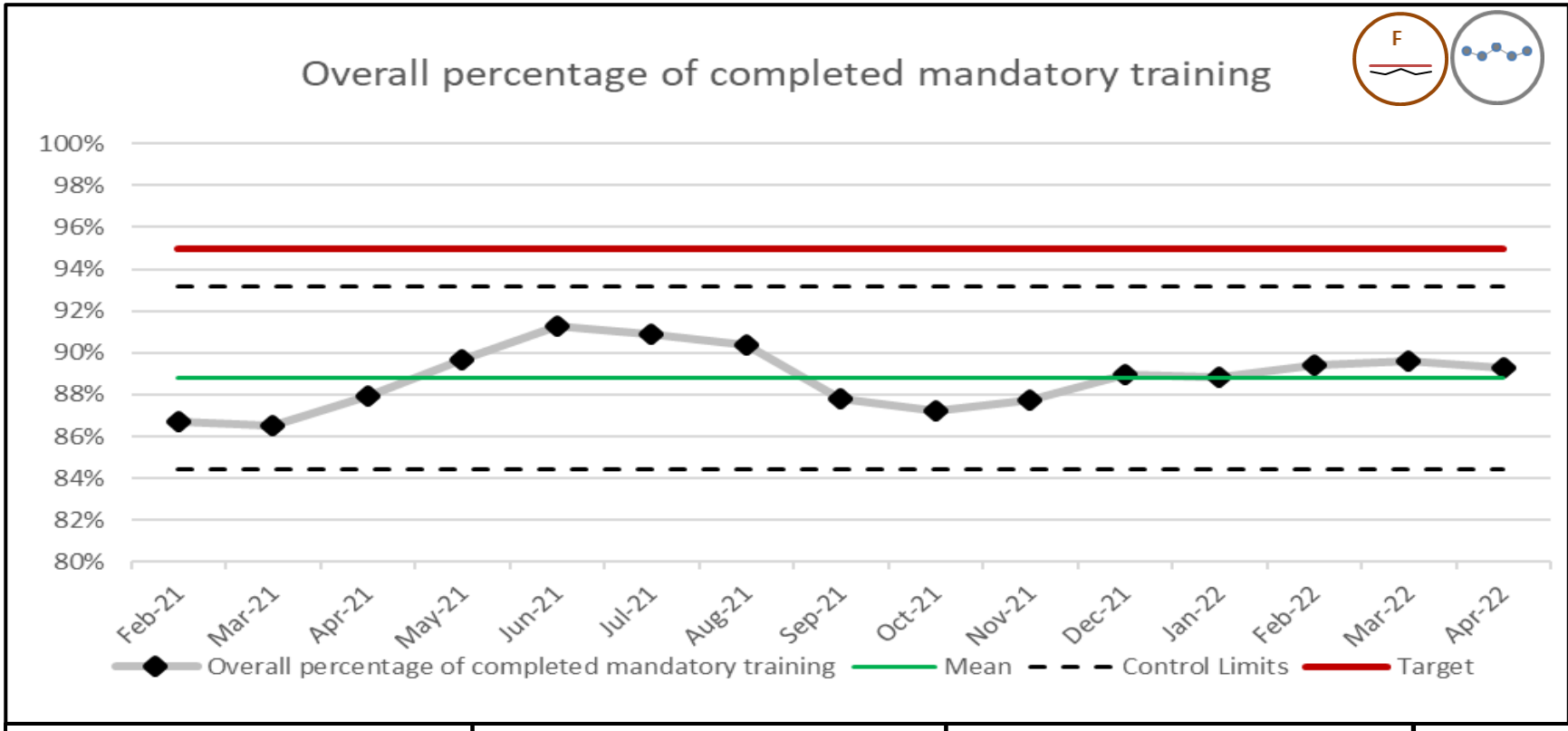
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program. One Locum Medical Oncologist Locum has started in post in May. Other posts are still going through recruitment processes. There is a significant lack of consultants nationally and very few available 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.
Capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to anaesthetic assessment capacity.
A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Feb-22	Mar-22	Apr-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	89.41%	89.59%	89.27%	89.27%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	10.24%	10.36%	10.55%	10.55%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.07%	5.11%	5.21%	5.21%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	13.96%	14.42%	14.67%	14.67%		F	H	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	53.63%	54.30%	54.06%	54.06%		F	B	



Apr-22
89.27%
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 but remains stationary.

Issues:
- Protected time for learning continues to be a challenge for staff – especially front line staff.
- Anecdotal feedback reports lack of time to access core learning while on shift and difficulties to access from home devices.

Actions:
- The lack of a central learning and development team has been added on the risk register.
- Discussion around protected time for training has not progressed.
- SHRBP's continue to work with their Areas and support compliance.

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.

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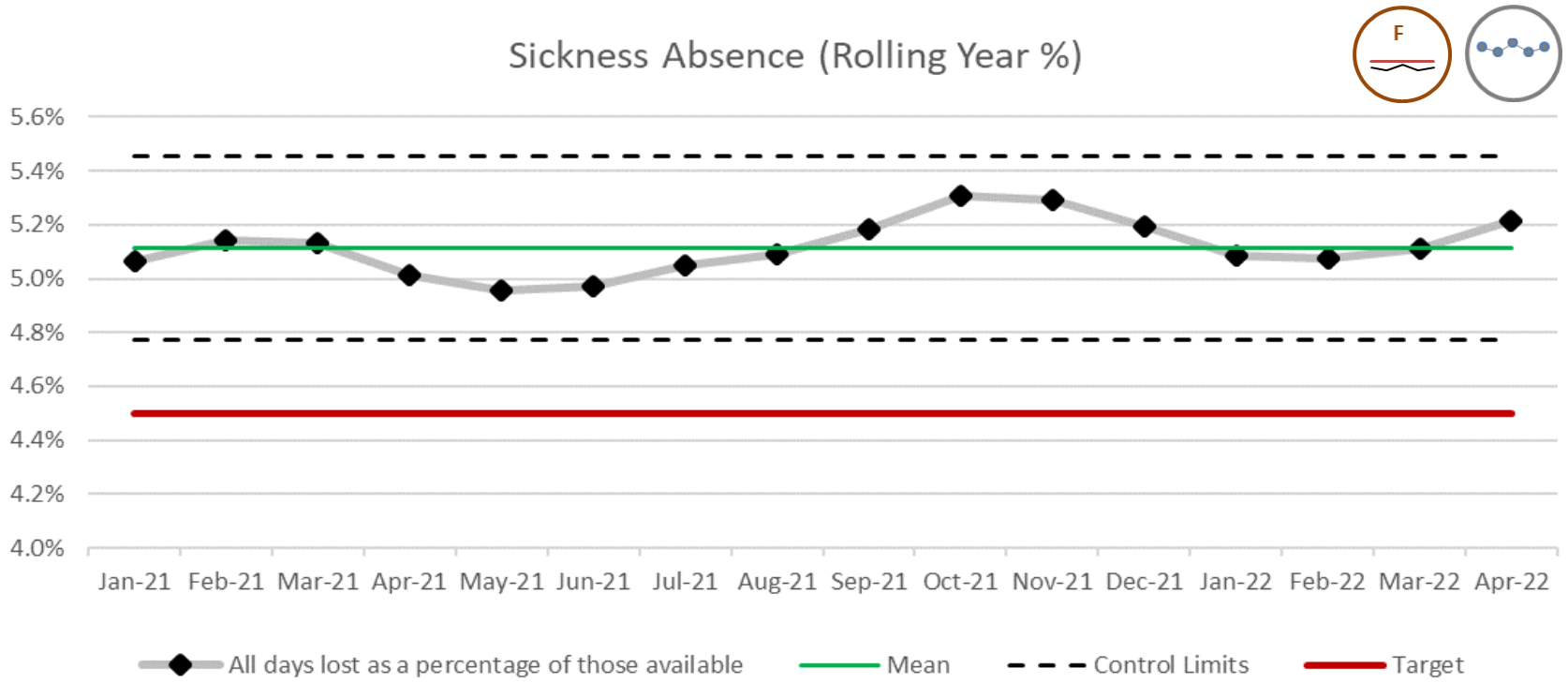
NHS United Lincolnshire Hospitals NHS Trust



Apr-22
5.21%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The trend has increased by 0.10% to 5.21% which is still above the target of 4.5%.

Issues:
- The COVID absences are starting to show a decrease which is reflective of the national picture.
- Lack of engagement of using the AMS system requires managers to become re-engaged.

Actions:
- Extensive work is continuing to get full engagement of using Absence Management System (AMS) Trust wide.
- Support from Empactis continues with 2 remaining Divisions to confirm dates.
- Roll out programmes are being compiled to cascade this engagement work through each Division.
- SHRBP's continue to work with divisional leads to ensure that the system is being used to log absences correctly, support the wellbeing of employees and monitor attendance.
- All cases in Case Manager are being reviewed and all data is being cleansed in AMS.
- The introduction of LTS Absence meetings with HRBP's, ER Advisers, Divisional Leads and Occ Health have commenced.

Mitigations:
See Actions.

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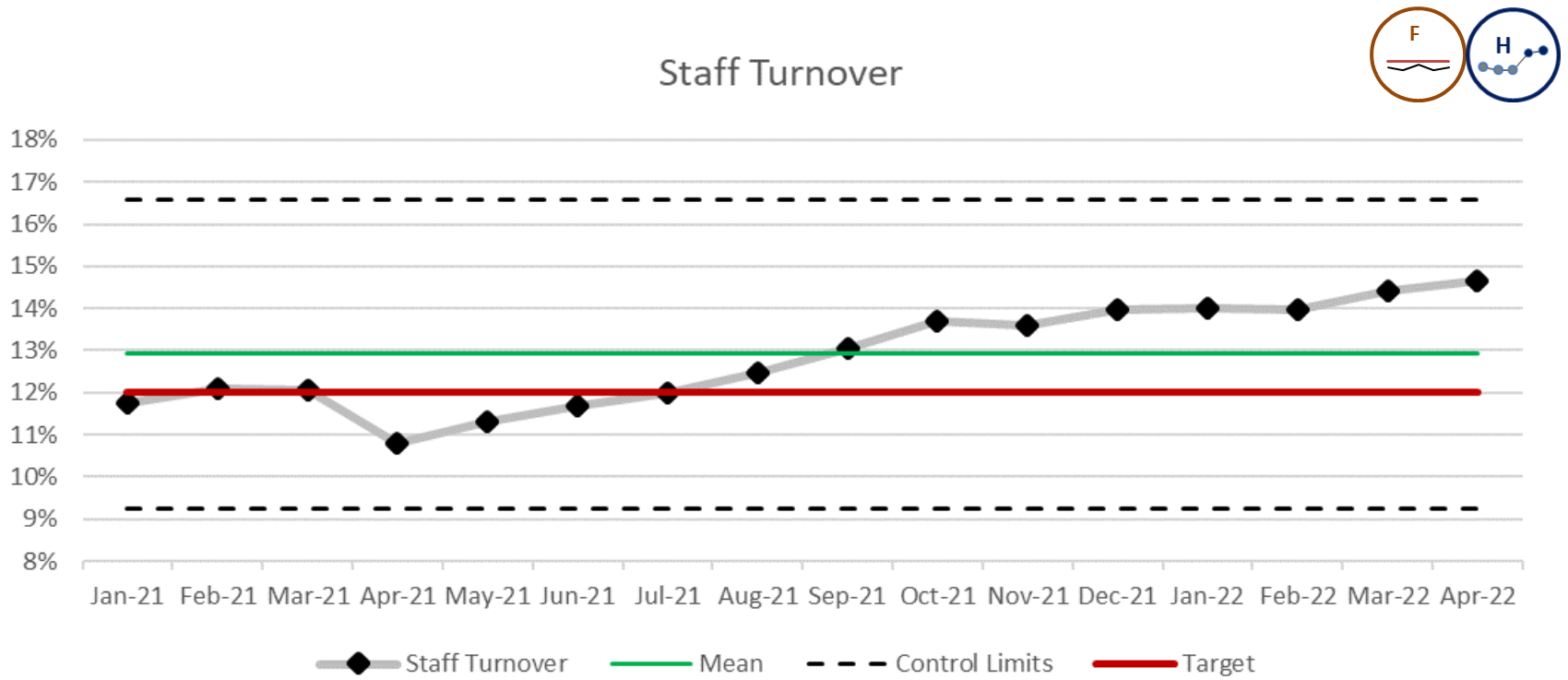

Apr-22
14.67%
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
12%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

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 support from managers, development opportunities, flexible working opportunities and relocations, continues to be one of the main reasons for people leaving.

The reasons are the same month on month.

Actions:

- A Culture and leadership OD manager has been appointed and should start in July 22
- A new suite of leadership and management training is being introduced in June 22. Flexible working clinics offered by OD to all managers
- A retention manager has been appointed and will start 30th May 2022.

Mitigations:
See actions

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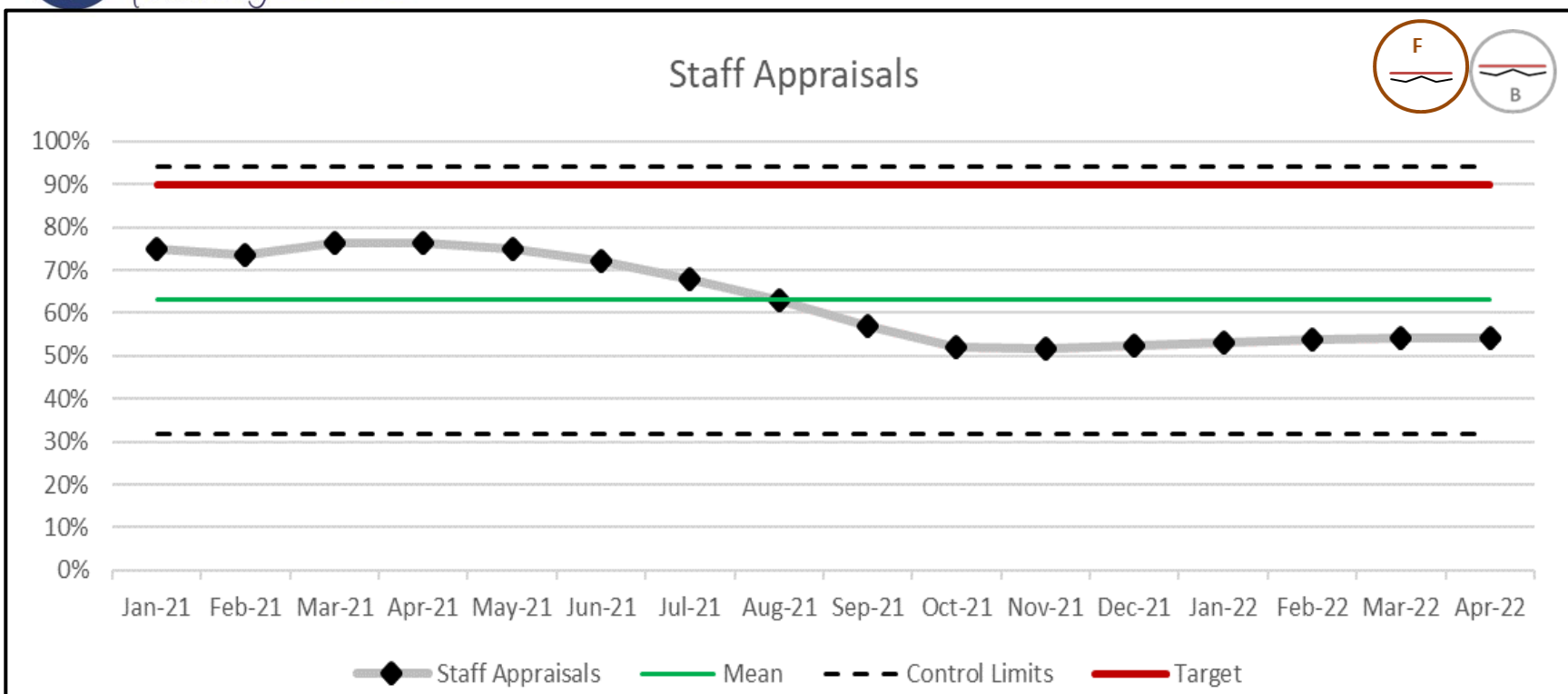

Apr-22
54.06%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 54.06%.

What the chart tells us:
Operational pressures and staffing challenges continue to impact appraisal completion rates. The completion rate slightly increased in April and stagnates in May.

Issues:

- Operational pressures are causing an impact on completion.
- Appraisal discussions stood down in previous months still felt in April 22 due to back log.
- Staffing issues and increased turnover impact availability of staff to attend appraisals with manager working clinically.

Actions:

- Appraisal completion to be focussed through the divisions regardless of operational pressures – strong message to go out from Director of People and OD to the divisions.
- Appraisal clinics offered by OD to all who require support. Specific focus for Estates and facilities to bring rates up in May 2022.
- Managers training from June 2022.

Mitigations:
See actions

Financial Position Month 01 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

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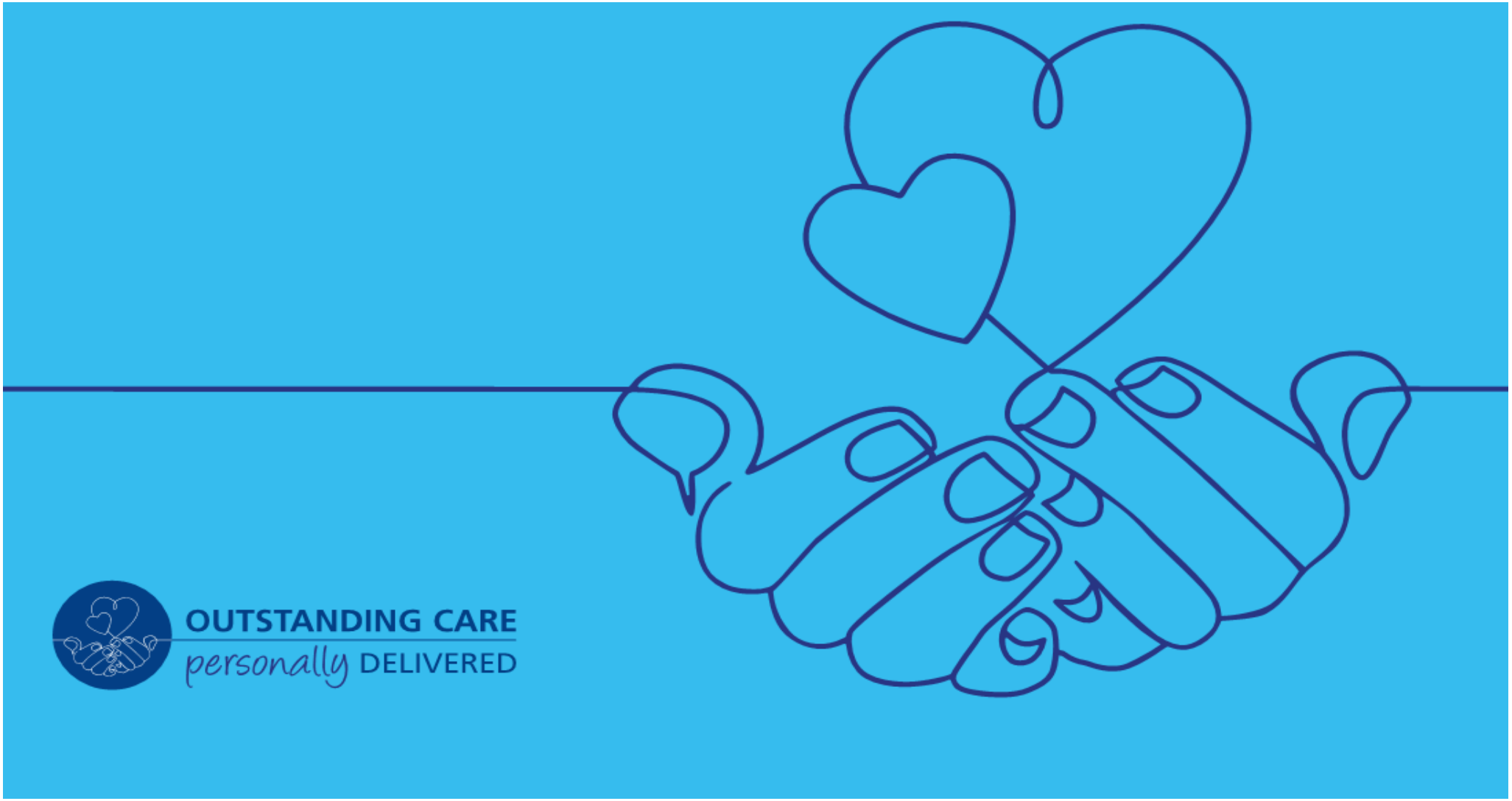

Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)

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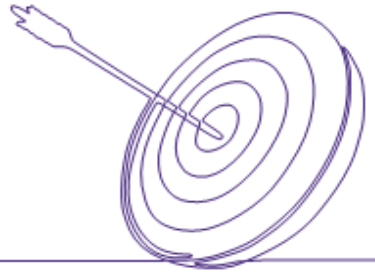
	Current Month			Forecast		
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Patient Care Activities Income	52,493	52,593	100	621,526	621,526	0
Other Operating Income	2,815	3,327	512	35,694	35,694	0
Substantive Staff	(30,268)	(30,286)	(18)	(360,279)	(360,279)	0
Agency Staff	(3,142)	(3,934)	(792)	(26,587)	(26,587)	0
Bank Staff	(2,969)	(4,021)	(1,052)	(38,800)	(38,800)	0
Apprentice Levy	(149)	(143)	6	(1,800)	(1,800)	0
Non Pay	(16,968)	(16,192)	776	(209,062)	(209,062)	0
Depreciation	(1,670)	(1,444)	226	(18,790)	(18,790)	0
Net Financing	(629)	(589)	40	(7,740)	(7,740)	0
Other Gains / Losses	0	0	0	0	0	0
Surplus/Deficit	**(487)**	**(690)**	**(203)**	**(5,838)**	**(5,838)**	**0**
Below Line Adjustments	55	54	(1)	27	27	0
Adjusted Surplus/Deficit	**(432)**	**(636)**	**(204)**	**(5,811)**	**(5,811)**	**0**

- The above table shows that the Trust submitted a financial plan for 2022/23 of a £5,811k deficit, and that the Trust delivered a £636k deficit in April (£204k adverse to a planned deficit of £432k).
- Financial Reporting for Month 1 is reduced due to the fact that the financial plan was not submitted until 28 April and completion of budget setting has been prioritised in May. The national requirements for external reporting were also reduced to headline pay actuals only.
- A further financial plan submission is required in June to take account of expected additional national funding for 'excess' inflation and pressures - the additional funding comes with the expectation that systems and organisations within them will further improve their plan positions.

Finance Spotlight Report



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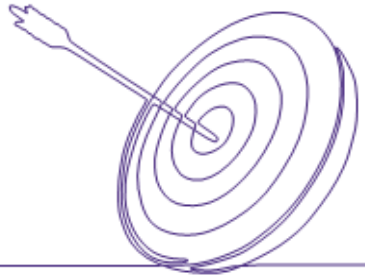
The Income position is £0.6m favourable to plan:

- The position includes c£0.2m of accrued income for CDC and Ockenden (both of which are currently outside of the current contract value) to offset related expenditure.
- The position includes c£0.3m of accrued income re the Radiology fire to offset related expenditure; the financial plan did not include the I&E impact of the Radiology fire.
- These favourable variances to plan have been reduced by under delivery on pass-through income which is reflected in the non-pay variance.

The Pay position is £1.9m adverse to plan and is a serious area of concern driven by non-substantive pay:

- **Substantive Pay is breakeven** – Substantive Pay would be £0.1m under spent were it not for the additional expenditure in relation to CDC, Ockenden and the radiology fire for which we have an offset in income (as outlined above).
- **Agency Pay is £0.8m adverse to plan** – Agency expenditure of £3.9m in April is in line with trend; however, the plan assumed that savings of £476k in Agency Pay would be delivered in April; this suggests that if any savings have been made in April, then they have been offset elsewhere in Agency expenditure; the position reflects higher than planned bed numbers, sickness levels and vacancies.
- **Bank Pay is £1.1m adverse to plan** – Bank Incentive rates were not in the plan, but Incentive rate costs (to be quantified – information requested) were incurred in April; Bank Pay (like Agency Pay) reflects higher than planned bed numbers, sickness levels and vacancies.

Finance Spotlight Report



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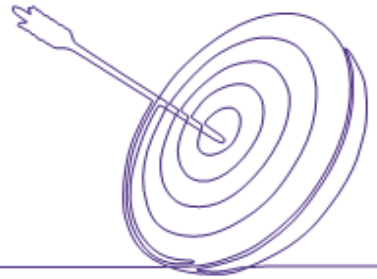
- The Non-Pay position is £1.0m favourable to plan including Depreciation which is £0.2m favourable to plan [this level of under spend is not expected to continue] and Other Non-Pay which is £0.8m favourable to plan; Non Pay (technical) CIP savings have been delivered in line with plan, such that the variance is being driven by lower than planned activity levels (including pass-through expenditure).

- The plan assumed that we would deliver CIP savings of £25,124k (3.6%) in 2022/23; the CIP plan assumed savings of £1,143k in April comprising £476k in Agency Pay and £667k in Non Pay. While we have not reported CIP delivery in April, the Month 1 position includes the release of £667k of technical CIP in Non Pay, which is in line with the plan's expectation that technical savings of £4.0m would be released in Non Pay over the first 6 months.

- Capital funding levels for 2022/23 agreed through Trust Board & FPEC, show a plan of c£41.0m. Capital spend incurred at M1 equated to c£0.2m.

Finance Spotlight Report



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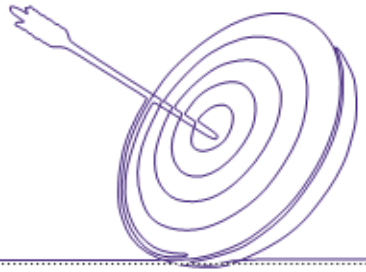
- The April 2022 cash balance is £77.6m which is a decrease of £10.7m against the March year- end cash balance of £88.3m.

- BPPC performance is 88% / 74% by value / volume of invoices paid for April 22. This compares to the full year performance in 2021/22 of 89% / 83%. While performance has started to improve following the introduction of the new finance system in December 2021, a backlog remains and can be seen in the heightened level of trade creditors and has manifested through the reduced performance against the BPPC target.

Balance Sheet



NHS
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	31-Mar-22	30-Apr-22	
	£000	Plan £000	Actual £000
Intangible assets	7,675	7,497	7,497
Property, plant and equipment	267,262	267,510	266,706
Right of use assets		10,841	-
Receivables	1,848	1,848	1,870
Total non-current assets	**276,785**	**287,696**	**276,073**
Inventories	6,006	6,006	6,039
Receivables	15,520	22,987	22,692
Cash and cash equivalents	88,297	72,045	77,640
Total current assets	**109,823**	**101,038**	**106,371**
Trade and other payables	(89,018)	(80,726)	(79,129)
Borrowings	(554)	(3,149)	(403)
Provisions	(8,773)	(8,895)	(8,990)
Other liabilities	(1,130)	(1,130)	(6,971)
Total current liabilities	**(99,475)**	**(93,900)**	**(95,493)**
Total assets less current liabilities	**287,133**	**294,834**	**286,951**
Borrowings	(3,471)	(11,731)	(3,623)
Provisions	(3,183)	(3,153)	(3,090)
Other liabilities	(11,572)	(11,530)	(11,530)
Total non-current liabilities	**(18,226)**	**(26,414)**	**(18,243)**
Total assets employed	**268,907**	**268,420**	**268,708**
Financed by			
Public dividend capital	704,180	704,180	704,178
Revaluation reserve	27,754	27,696	29,236
Other reserves	190	190	190
Income and expenditure reserve	(463,217)	(463,646)	(464,896)
Total taxpayers' equity	**268,907**	**268,420**	**268,708**

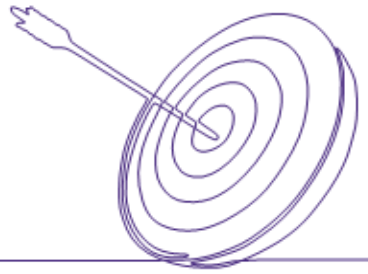
Note 1: The April Plan incorporates the estimated impact associated with the introduction of IFRS16.
The impact in balance sheet terms is to recognise 'Right of Use' assets with the offset being an increase in Borrowings.
The April actuals do not include the IFRS 16 impact at present whilst the final impact is assessed. This will be incorporated into the May report.

Note 2: Payables, Receivables and Cash have each been impacted by the migration to the new finance system and disruption to BAU processing. Whilst now operating at close to normal levels, these elements of working capital are expected to return to 'normal' business levels in the next few months.

Note 3: Trade and other receivables continue to be supressed below pre-pandemic levels and will remain so throughout 2022/23 with the continuation of block contract payments.

Note 4: Trade Payables and other payables are circa £10-15m higher than would be normally be expected. This being driven by the heightened level of capital creditors associated with the 2021/22 programme and also the remaining finance system 'backlog.'
The payables balance of £79m is broadly split between:
Staff related creditors £17m, Trade Payables / accruals £34m, Capital creditors £11m and Tax / Superannuation £17m.
BPPC and aged creditor performance have been impacted by the system implementation and are reported at.

Cashflow reconciliation– April 2021– March 2022



United Lincolnshire Hospitals NHS Trust

	31-Mar-22	30-Apr-22	
		Plan	Actual
	£000	£000	£000
Operating surplus / (deficit)	549	142	(101)
Depreciation and amortisation	15,736	1,670	1,444
Impairments and reversals	7,340	-	-
Income recognised in respect of capital donations	(27)	-	-
Amortisation of PFI deferred credit	(503)	(42)	(42)
(Increase) / decrease in receivables and other assets	11,261	(7,467)	(7,240)
(Increase) / decrease in inventories	504	-	(32)
Increase/(decrease) in trade and other payables	9,745	(1,009)	809
Increase/(decrease) in other liabilities	(457)	-	5,841
Increase / (decrease) in provisions	5,860	122	163
Net cash flows from / (used in) operating activities	**50,008**	**(6,584)**	**841**
Interest received	34	-	42
Purchase of intangible assets	(994)	-	-
Purchase of property, plant and equipment	(35,132)	(9,500)	(11,540)
Proceeds from sales of property, plant and equipment	148	-	-
Net cash flows from / (used in) investing activities	(35,944)	(9,500)	(11,498)
Public dividend capital received	26,610	-	-
Capital element of finance lease rental payments	-	(160)	-
Interest paid	(1)	-	-
Interest element of finance lease	-	(8)	-
PDC dividend (paid)/refunded	(6,418)	-	-
Net cash flows from / (used in) financing activities	20,191	(168)	-
Increase / (decrease) in cash and cash equivalents	**34,255**	**(16,252)**	**(10,657)**
Cash and cash equivalents at 1 April - brought forward	54,042	88,297	88,297
Cash and cash equivalents at period end	**88,297**	**72,045**	**77,640**

Note 1: Cash held at 30 April was £77.6m against a plan of £72.0m.

Note 2: Principle reasons for the cash variance to plan of £5.6m are:

- An increase in NHS deferred income associated with quarter 1 payments from Health Education England income £3.5m and also block payments made by NHS England £1.8m.

Note 3: Underlying cash balances remain significantly increased on 2019/20 levels primarily due to:

- The continued block payment regime
- The remaining backlog associated with the implementation of the new finance system.
- Receipt in March 21 of £7.1m to cover future outgoings associated with accrued annual leave.
- Increased levels of capital creditors.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*Tuesday 7 June 2022*
Item Number	*Item number allocated by admin*
Strategic Risk Report	
Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Paul White, Head of Risk & Governance*
Report previously considered at	*Trust Leadership Team (May 2022)*

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

Risk Assessment	*Not Applicable*
Financial Impact Assessment	*Not Applicable*
Quality Impact Assessment	*Not Applicable*
Equality Impact Assessment	*Not Applicable*
Assurance Level Assessment	*Significant, with some improvement required (based on Internal Audit Report – March 2022)*

Recommendations/ Decision Required	*The Trust Board is invited to review the content of the report.*

Executive Summary

This Strategic Risk Report focuses on the highest priority risks to the Trust's objectives as defined within the Board Assurance Framework (BAF):

- There are 9 quality and safety risks currently rated Very high (20):
  - The risk of serious patient harm due to a fall has increased in rating from High (16) to Very high (20)
  - The medicines supply risk linked to the eFinancials system (previously rated Very high, 20) has been closed following discussion at the Risk Register Confirm & Challenge Group in April
- There are also 5 quality and safety risks with a current rating of High (15-16); this includes 1 increased rating (Maternity environment). 1 risk has been closed since the last report (interventional radiology suite at Lincoln)
- Workforce risk remains very high within the Trust, particularly in relation to staffing capacity and morale; there are 3 Very high risks (scoring 20-25) at present
- Staffing capacity risks to the delivery of Stroke; Oncology; and Respiratory services are rated High (16)
- There are 0 active finance, performance and estates risks that are rated Very high (20-25) and 4 that are rated High (15-16).
- The highest priority finance, performance and estates risks at present relate to the cost of temporary clinical staff; fire safety Trust-wide; information governance; and the continuity of water supply at Pilgrim Hospital.
- The fire safety risk associated with storage of acetylene has reduced substantially since the last report.
- A reassessment of the ICT critical infrastructure risk has taken place and an update has been included in the most recent report to FPEC; the revised rating is High risk (16)

Purpose

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

- Review the management of significant risks to strategic objectives.
- Evaluate the effectiveness of the Trust's risk management processes.

1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). Details of all active Very high and High risks (15-25) are provided in **Appendix A**, organised by strategic objective and current risk rating however a summary of Very high risks is provided below in sections 2.3-2.10. Moderate and Low risks (12 and below) are managed at divisional level.

1.2 The Risk Register Confirm and Challenge Group continues to meet on a monthly basis, reviewing all High and Very high risks as well as receiving presentations from clinical and corporate business areas on a rotational basis to enable constructive feedback to be provided.

1.3 Active risks that have a performance, service continuity and reputation impact as well as a quality of care impact are reported to the Quality Governance Committee as the lead for assurance. In addition, the Finance, Performance & Estates Committee now receives regular updates on progress with managing these risks so as to maintain oversight from a performance and reputation perspective.

1.4 Similarly, the People and Organisational Development Committee also receives a regular report on workforce risk as assurance lead, with a summary of Very high workforce risks that have a potential quality and safety impact also being reported to the Quality Governance committee for information.

2. Trust Risk Profile

2.1 There 260 active risks currently recorded on the Trust risk register. There are 12 risks with a current rating of Very high (20-25) and 12 rated High (15-16).

2.2 **Table 1** shows the number and proportion of active risks by current rating:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
0 (0%)	**35** (14%)	**191** (76%)	**12** (5%)	**12** (5%)

Strategic objective 1a: Deliver harm free care
Assurance lead: Quality Governance Committee

2.3 There are currently 7 Very high risks to this objective (an increase of 1 since last month):

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	Currently being reviewed
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	Currently being reviewed

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	Currently being reviewed
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.	Currently being reviewed
4624	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	Very high risk (20)	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents, monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	25/05/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4622	If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients.	Very high risk (20)	- Safety Culture Project, part of Integrated Improvement Plan (IIP) - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previously called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ	09/05/2022
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	25/05/2022

2.4 The risk of serious patient harm as a result of a fall (4624) has increased in rating since the last report, from High (16) to Very high (20), following review within the Nursing Directorate. Details of this updated risk were included in this month's Quality and Safety Risk Report to QGC and it was discussed at the Risk Register Confirm and Challenge Group on 25 May.

Strategic objective 1b: Improve patient experience
Assurance lead: Quality Governance Committee

2.5 There are currently no Very high risks to this objective (the same position as last month). However, the risk of a poor patient experience due to issues with the Maternity services environment has increased in rating from Moderate (12) to High (15) on review within Family Health division. Details are included in Appendix A.

Strategic objective 1c: Improve clinical outcomes
Assurance lead: Quality Governance Committee

2.6 There are currently 2 Very high risks to this objective (a reduction of 1 since last month):

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.	12/04/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4828	If information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a reduced likelihood of a positive clinical outcome and possibly causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust.	17/05/2022

2.7 The risk of potential missed payments to pharmaceuticals suppliers following introduction of the new Financials system, previously rated Very high (20) was considered by the Risk Register Confirm and Challenge Group in April. The Group agreed that the description and rating of the risk did not accurately reflect the current position, as there was not a significant risk to the medicines supply chain. It was decided that any residual issues with the eFinancials system would be addressed collaboratively by Pharmacy and Finance and that the risk could be closed.

2.8 The risk related to the interventional radiology suite at Lincoln County Hospital, previously rated High (16) was closed on review within Clinical Support Services division as implementation of a replacement is now in progress.

Strategic objective 2a. A modern and progressive workforce
Assurance lead: People & OD Committee

2.9 There are 2 Very high risks to this objective (the same position as last month):

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.	Currently being reviewed
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.	Currently being reviewed

Strategic objective 2b. Making ULHT the best place to work
Assurance lead: People & OD Committee

2.10 There is 1 Very high risk to this objective (the same position as last month):

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

2.11 A full review and refresh of the People and OD risk register is currently taking place and was discussed at the Risk Register Confirm and Challenge Group on 25 May. The revised risks, alongside the existing risk register, will be included in the next report to the People and OD Committee.

Strategic objective 2c. Well-led services
Assurance lead: Audit Committee

2.12 There are no Very high risks to this objective (the same position as last month).

Strategic objective 3a: A modern, clean and fit for purpose environment
Assurance lead: Finance, Performance & Estates Committee

2.13 There are no active Very high risks to this objective (the same position as last month).

2.14 The risk related to storage of flammable and / or explosive substances has been reduced from High (15) to Low (5) as all acetylene has now been removed from Trust sites. Temporary use will be restricted and subject to full risk assessment and method statement in a controlled manner.

Strategic objective 3b: Efficient use of our resources
Assurance lead: Finance, Performance & Estates Committee

2.15 There are no active Very high risks to this objective (the same position as last month).

Strategic objective 3c: Enhanced data and digital capability
Assurance lead: Finance, Performance & Estates Committee

2.16 There are currently no Very high risks to this objective (the same position as last month).

2.17 The risk of critical ICT infrastructure failure has been reassessed with an updated rating of High (16), which has been included in the most recent report to FPEC.

Strategic objective 4a: Establish new evidence based models of care
Assurance lead: Finance, Performance & Estates Committee

2.18 There are currently no Very high risks to this objective (the same position as last month).

Strategic objective 4b. To become a University Hospitals Teaching Trust
Assurance lead: People & OD Committee

2.19 There are currently no Very high risks to this objective (the same position as last month).

3. Conclusions & recommendations

3.1 The most significant risks within the Trust at present relate to:

- the recovery of planned care pathways;
- the level of emergency care demand;
- the availability of accurate patient information;
- the recruitment of medical and nursing staff;
- staff morale;
- patient harm from falls;
- delays to echocardiograms; and
- the ability to learn lessons from previous patient safety incidents.

3.2 The Trust Board is invited to review the content of the report.

Appendix 1: Details of all active Very high and High risks (15-25)

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective												**1a. Deliver Harm Free Care**													
4803	Physical or psychological harm	Evans, Simon	Skinner, Maxine		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
4877	Physical or psychological harm	Evans, Simon	Maitland, Angus		28/03/2022	20	Risk assessments	Surgery				If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care admitted pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	23/03/2022	Extremely likely	High	Very high risk	20	Planned care recovery plan (non-admitted / outpatients) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	30/04/2022
4878	Physical or psychological harm	Evans, Simon	Maitland, Angus		28/03/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU			If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care non-admitted pathway & booking systems / processes (outpatients) - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Outpatient Recovery Group; Reports through Divisional PRMs (for performance), and FPEC and System Planned Care Group - Clinical Harm Oversight Group	2ww first O/Ps back within national target Urgent 1sts 90% <13 weeks by 31.03.23 Time critical follow ups (452/2657 overdue) – target to eliminate (mainly neurology, cardiology, rheumatology) by 31.03.23 RTT non-admitted: Clear >104wws by 31.03.22 Clear >78wws by 31.03.22 (with few remaining by 30.06.22) Clear >65wws by 30.09.22 Clear >52wws by 31.12.22	23/03/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	30/04/2022
4879	Physical or psychological harm	Evans, Simon	Maitland, Angus		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Cancer Centre		If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	23/03/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	30/04/2022

Appendix 1: Details of all active Very high and High risks (15-25)

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4622	Patient safety (physical or psychological harm)	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group	09/04/2018	20	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	If the Trust fails to learn lessons when 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"	09/05/2022	Extremely likely	High	Very high risk	20	- Establishment of Patient Safety Improvement Team - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previoulsy called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ - Prepare for implementation of new Patient safety Incident Response Framework (PSIRF) in 2022 (replacement for Serious Incident Framework)	- Patient Safety Improvement Team now established within Clinical Governance - Datix CloudIQ has been approved for connection to the new national learning system - Case of need for Datix CloudIQ approved in principle; implementation to be planned Directorate review (April 2022) - agreed that this would remain Very high (20) subject to learning lessons work being completed and evidence that repeated incidents are reducing	Low risk	31/01/2019	31/03/2023	31/05/2022
4624	Physical or psychological harm	AD4 (Deleted User)	Addlesee, Sarah	Patient Falls Steering Group	08/11/2021	16	Aggregation of Incident/Claims & Complaints/PALS	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	National policy: - NICE Clinical Guideline CG161: Assessment and prevention of falls in older people (2013) - PHE Falls and fracture consensus statement: Resource pack (2017) ULHT policy: - Falls Prevention and Management Policy (approved April 2021, due for review March 2023) ULHT governance: - 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: The numbers of reported falls incidents are demonstrating an increasing upward trend therefore will not achieve the strategic objective to deliver harm free care. - Operational pressures have resulted in some patients having prolonged periods sitting in Emergency Departments whilst awaiting assessment and for inpatient beds to become available. This may contribute to an increase in some patients overall frailty level and subsequent deconditioning which increases the vulnerability to an individual falling. - Longer length of stays have demonstrated a correlation to risk of a patient falling whilst in the care of the Trust. - Audits of compliance with Trust policy / evaluation of training / training compliance rates: There is no dedicated Falls team available within the Trust.	25/05/2055	Extremely likely	High	Very high risk	20	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	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. Initial business case for a dedicated falls team resource to be presented to CRIG in April 2022. Collaborative work with Quality and Improvement teams to review and coordinate existing work being undertaken in Divisions and Corporately into one overarching improvement plan. Risk rating increased to Very high (20).	Low risk	31/12/2021	31/03/2023	31/05/2022
4789	Physical or psychological harm	Wall, Mrs Tracey	Spendlove, Mrs Clare	Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	25/05/2022	Extremely likely	High	Very high risk	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	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

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4625	Patient safety (physical or psychological harm)	Dunderdale, Karen	Vaughan, Natalie	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) Contract management of 3rd party service providers: - Sterile services (Steris) - Microbiology services (Pathlinks)"	- 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
4646	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Patient Safety Group	14/12/2021	20	Policy/Protocol Issues, Risk assessments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21	23/03/2022	Quite likely	High	High risk	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB scheduled from Feb / Mar 22. Risk discussed at Risk Register Confirm & Challenge Group on 23 March 2022. Still inconsistencies with timeliness against BTC standards, particularly at Lincoln, and inability to ring-fence beds. Agreed that risk remains high but has reduced. Recommendation for rating to change from 20 to 16.	Low risk	30/09/2022	30/09/2022	30/06/2022
4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors.	1. IV medicines ready to use (pre-prepared in clinical area) kept for 24 hours. 2. To minimise the risk of microbiological contamination and minimise the risk of infection, administration of injections and infusion prepared in a clinical area should be performed immediately after preparation and ideally within 30 minutes of preparation. 3. To minimise the risk of wrong dose/drug/patient errors, the identity of all injectable medicines must be assured. If the preparation (syringe or IV bag) leaves the hands of the person who prepared it and/or the entire injection or infusion process is not under the direct supervision of that person, the syringe or IV bag must be labelled. Infusion Labels must include as a minimum: - the name & dose or strength of the drug and diluent (including units of measurement) - the date and time of preparation - the name of the person who prepared it. Bolus Labels must include as a minimum: - the name & dose of the drug.	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	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

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Strategic Objective												**1b. Improve patient experience**													
4701	Reputation	Grooby, Mrs Libby	Upjohn, Emma		13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	13/04/2022	Reasonably likely	Extreme	High risk	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15	Low risk	31/03/2025	31/03/2025	30/09/2022
Strategic Objective												**1c. Improve clinical outcomes**													
4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	If information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	17/05/2022	Extremely likely	High	Very high risk	20	Planned introduction of an auditable electronic prescribing system across the Trust.	Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20.	Low risk	31/03/2022	30/09/2022	30/06/2022
4731	Physical or psychological harm	Evans, Simon	Parkin, Mr Lee	Medical Records Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	12/04/2022	Extremely likely	High	Very high risk	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Digital Hospital Group.	Low risk	30/06/2018	31/03/2023	31/05/2022

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Strategic Objective												**2a. A modern and progressive workforce**													
4669	Service disruption	Matthew, Mr Paul	Taylor, Karen	Workforce Strategy Group	12/01/2022	25	Workforce Metrics	Corporate	People and Organisational Development	Operational HR	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of registered nurses then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	ULHT policy: - Nursing workforce planning processes - Nursing recruitment framework & associated policies, training & guidance - Nursing rota management systems & processes - Nurse Bank & agency temporary staffing arrangements - Workforce management information ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Nursing vacancies & turnover rate. Nursing staff survey results relating to job satisfaction / retention.	02/11/2021	Quite likely	Extreme	Very high risk	20	Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding.	Workforce supply is a workstream in the Integrated Improvement Plan reflecting the priority within the NHS National People Plan. Programmes have been delayed by COVID. However vacancy rates have reduced over the last three months. The Director of Nursing has initiated a Nurse Transformation Programme to look at demand and supply issues around nursing.	Moderate risk	31/03/2022	31/01/2023	31/03/2022
4670	Service disruption	Matthew, Mr Paul	Taylor, Karen	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
4671	Service disruption	Matthew, Mr Paul	Low, Claire	Workforce Strategy Group	12/01/2022	16	Workforce Metrics	Corporate	People and Organisational Development	Operational HR	Trust-wide	If a substantial proportion of the Trust's workforce tests positive for Covid-19, or are required to self-isolate in accordance with government guidelines, then it may not be possible to maintain some services resulting in significant short-term disruption affecting the care of a large number of patients	National policy: - Government policy / guidelines on Covid testing and isolation ULHT policy: - Working Safely - Covid-19 Policy (Health & Safety Policy), approved July 2021 - Temporary staffing processes (bank / agency / locum) - Emergency planning processes and workforce contingency arrangements for Major, Critical and Business Continuity Incidents ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group; Health & Safety Group - Operational workforce governance arrangements	Frequency of workforce-related Major / Critical / Business Continuity incidents. Staff absence rates (Covid-related). Temporary staff usage rates.	02/11/2021	Quite likely	High	High risk	16	Occupational Health staff health checks & testing regime; Health and well-being offer to staff; Implementation of new Absence Management System (Empactis); use of bank / agency staff to fill rota vacancies; & operational command structure for Covid response.	Re-launch of staff health and well-being offer. Empactis launched with corporate staff in August and rolled out through to February 2020. Sick leave cover due to Covid is currently one of the top 4 reasons for use of temporary staff.	Moderate risk	31/03/2022	31/03/2023	31/03/2022
4741	Service disruption	Farquharson, Colin	Sanz Torres, Aurora A	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	12/04/2022	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	31/03/2023	30/06/2022
4780	Service disruption	Evans, Simon	Parmar, Anita	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 1: Details of all active Very high and High risks (15-25)

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4862		Ratcliff, Carl	Bland, Michael		22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU			Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting.	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	07/04/2022	Quite likely	High	High risk	16	Close working with Agency to try and recruit agency locums to temporarily fill gaps. Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff. Additional funding from Cancer alliance for Gastro and Resp to allow for additional Gen Med Locum to reduce burden on current workforce. Remote working in place to support outpatients where possible. Agency spend supporting out of hours workload - for example, covering the substantive consultants on calls to allow them to focus on Cancer work instead of on call - supporting patient care. SECRETARIAL PLAN: CT Triage Letter Typing Sandra Wileman 2ww/Routine Typing Danielle Abell Trina Sallabanks	Most recent update: Dear Carl, Following the catch up earlier, Claudia, Ashley and I have compiled our thoughts on what could go down to support the services..... Option Take down: Benefits Risks: 1 Do Nothing None • Cancer patients continue to wait prolonged periods for care. • Inpatient services at LCH and PHB continue to become extremely depleted • Welfare of current consultant workforce continues to suffer, potentially leaving to sickness / prolonged absence • Boston have only x2 Consultants, currently utilising support from already depleted LCH Team. (If annual leave / sickness, we have only 1 consultant on the Pilgrim site) 2 Grantham inpatient respiratory services (Preferred) • Releases x1 Agency Locum Consultant who can ?potentially? go over to Lincoln (as per previous agreement) • Releases a consultant to cover the rota to a 'safe' level • Non-compliance with ASR due to taking out inpatient respiratory services at GDH	Low risk	01/09/2022	30/12/2022	31/05/2021
Strategic Objective												**2b. Making ULHT the best place to work**													
4667	Service disruption	Matthew, Mr Paul	Low, Claire	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

Appendix 1: Details of all active Very high and High risks (15-25)

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
												3a. A modern, clean and fit for purpose environment													
4648	Physical or psychological harm	Evans, Simon	Davey, Keiron	Fire Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / 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 - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	04/04/2022	Reasonably likely	Extreme	High risk	15	- Statutory Fire Safety Improvement Programme based upon risk. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Capital investment programme for Fire Safety being implemented on the basis of risk. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	New Fire Alarm installed within Lincoln maternity Tower Block. Automatic openable vents for smoke removal to be installed by End of Jan 2022. Fire Risk assessments being undertaken on basis of risk priority. Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. Damper installation within ICU, Rainforest, Lancaster, Ashby to be completed Mid December 2021. Following incident at Lincoln A&E / X-ray in March 2022, risk assessments for fire and security are being reviewed.	Moderate risk	31/03/2022	31/12/2022	30/09/2022
4858	Service disruption	Parkhill, Michael Whitehead, Mr Stuart	Water Safety Group		10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant diruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	10/02/2022	Reasonably likely	Extreme	High risk	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	Scheme of work and design currently being produced.		30/10/2020	31/03/2023	30/06/2022
Strategic Objective												**3b. Efficient use of our resources**													
4664	Finances	Matthew, Mr Paul Young, Jonathan			11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	If the Trust does not significantly reduce its reliance upon a large number of temporary agency and locum staff in order to maintain the safety and continuity of clinical services, then it could have a substantial adverse impact on the ability to contain costs within the STP and Trust income envelope.	ULHT policy: - Financial strategy - Annual budget setting process - Capital investment planning process, programme delivery & monitoring arrangements - Key financial controls - Financial management information ULHT governance: - Financial review meetings held monthly with each Division - Divisional performance & accountability framework	Budget monitoring - temporary agency / locum staff	26/10/2021	Quite likely	High	High risk	16	Financial Recovery Plan schemes: recruitment improvement; medical job planning; agency cost reduction; workforce alignment	Impact of COVID on services, staff and subsequently the cost base, including increased use of incentive rates, agency staff and high cost consumables and drugs. COVID cost forecasts included in financial planning to provide oversight, control and governance.	Moderate risk	31/03/2022	31/03/2023	31/03/2022

Appendix 1: Details of all active Very high and High risks (15-25)

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective												**3c. Enhanced data and digital capability**													
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the required data protection / privacy impact assessment process is not followed consistently at the start of a system change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	National policy: - Data Protection Act 2018 - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy (approved May 2018, due for review May 2021) & supporting appendices ULHT governance: - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group - Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles	Internal audit review of data protection / PIA processes	24/03/2022	Quite likely	High	High risk	16	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process.	Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues. Reference to DPIAs in Data Security and Awareness mandatory training. Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required. Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data.	Low risk	31/03/2022	31/01/2023	30/06/2022

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7 June 2022*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2022/23	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure* • *Agree the proposed updates following the refresh of the Year 3 IIP*

Executive Summary

The relevant objectives of the 2022/23 BAF were presented to all Committees during May and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives with the exception of the new 2022/23 objectives. Assurance ratings provided have been confirmed by the Committees. The Quality Governance Committee following review have recommended that objective 1c Improve Clinical Outcomes be rated as Green.

Work has completed on the refresh of the Board Assurance Framework for 2022/23 following the approval of the year 3 Integrated Improvement Plan (IIP) by the Trust Board in May. It is recognised that the Board Assurance Framework will continue to develop as the year 3 IIP work is finalised.

New objectives for 2022/23 include:

Objective 3d: Improving cancer services access
Objective 3e: Reduce waits for patients who require planned care and diagnostics to constitutional standards
Objective 4c: Successful delivery of the Acute Services Review and Recovery Support plans

The additions of the objectives have been highlighted in the Board Assurance Framework in green text with updates offered to the Committees highlighted in blue text to enable a clear view of the changes at the beginning of the year.

Red text has been presented in the Board Assurance Framework to demonstrate items proposed for removal, which no longer feature as a project/priority within the year 3 IIP. Through the review process during June these removals will be considered by Executive Directors to confirm if these should remain to support delivery of the objective and will be confirmed by the Committees.

The following assurance ratings have been identified:

Objective		Rating at start of 2022/23	Assurance Rating (May)
1a	Deliver harm free care	**Green**	**Green**
1b	Improve patient experience	**Amber**	**Amber**
1c	Improve clinical outcomes	**Amber**	**Green**

2a	A modern and progressive workforce	**Red**	**Red**
2b	Making ULHT the best place to work	**Red**	**Red**
2c	Well led services	**Amber**	**Amber**
3a	A modern, clean and fit for purpose environment	**Amber**	**Amber**
3b	Efficient use of resources	**Amber**	**Amber**
3c	Enhanced data and digital capability	**Amber**	**Amber**
3d	Improving cancer services access		
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards		
4a	Establish new evidence based models of care	**Amber**	**Amber**
4b	To become a University Hospitals Teaching Trust	**Red**	**Red**
4c	Successful delivery of the Acute Services Review and Recovery Support plans		

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2022/23 - May 2022

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

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Programme of work in place to implement the requirements of the National Patient Safety Strategy (culture and systems)(PSG) Human Factors faculty in place and face to face training restarted. Commencing next steps of cultural work with external agency. Pascale survey work continues to be undertaken. Safe to Say Campaign launched.			Safety Culture Surveys Action plans from focus groups and Pascal survey findings. Regular update reports to the Patient Safety Group and upwardly reported to QGC and through TLT. Theatre Safety Group reporting progress against a Quality Improvement plan to PSG.	Surgery currently reporting into the Theatre Safety group on progress against Safety Culture. Other divisions due to commence upward reporting to PSG but not yet in place.	Where possible, safety conversations have been taking place with staff.		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)			Upward reports from QGC sub-groups 6 month review of sub-group function Annual review of QGC takes place.				
						Effective sub-group structure and reporting to QGC in place (CG)			Sub-Group upward reports to QGC				

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamination and other estates- related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		
						Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). Infection Prevention and Control BAF in place and reviewed monthly (IPCG)	Non-compliance with some aspects of the Hygiene Code.	Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC. IPC policies have been updated / developed / written in line with the timetable. •Estates and Facilities/Decontamination Lead has made good progress with estates and facilities work and is awaiting a place on a specialist decontamination course. • Good progress with achieving and sustaining standards of environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve Very good progress with work to achieve compliance with new National Standards of Cleanliness directive and this continues to be taken forward via a Task and Finish Group with monthly monitoring by the IPCG • Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG (PSG)	Gaps in the number of structured judgement reviews undertaken - 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 which is a sub-group of QGC. Appointment of a Clinical Harm and Mortality Manager Investigation training will be addressed as part of the implementation of the PSIRF and National Patient Safety Strategy. Plan to refocus PRM with a specific focus on quality and safety.	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports Strong divisional reporting to MORALs	Divisional reporting to PSG has commenced although this is not yet embedded.	Divisions present focussed pieces of work to PSG on issues that arise based on the data received. There is strong Divisional representation at PSG each month.		
						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		

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						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training occurs through MNOG.		
						Appropriate policies and procedures in place to ensure medical device safety (PSG)	Lack of assurance regarding staff training on the medical devices	Implementation of a central database of medical device user training records					
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA (Ensuring early detection and treatment of deteriorating patients) (PSG)	Number of incidents occurring regarding lack of recognition of the deteriorating patient Maturity of some of the sub-groups of DPG not yet realised	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas	Identified at PSG that further work is required to breakdown incident categories pertaining to the deteriorating patient.	Deep dive commissioned at PSG for presentation to the April meeting.		
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	New funding needed to continue restraint training delivery. Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months. Further work has taken place with LPFT to consider a joint approach to training - awaiting options paper from LPFT	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting from Mental Health/ Learning Disability and Autism Oversight Group	No active Restraint training available within the trust	Small business case paper being submitted for funding decision at the end of March 2022 - if successful plan to start training delivering in July 2022. Adhoc session being delivered to Security providers to ensure appropriately trained Datix being monitored by safeguarding team to ensure review of any restraint incidents		

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						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG)	Gap in current policy identified meaning that not all responses from divisions are received / recorded. Improvement demonstrated in the number of overdue alerts	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads(CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				
						Enhance patient safety by learning from incidents, specifically:- • Maternity Services (Personalised Care) • Medication Management • Diabetes Management (DKA) • Infection Prevention and Control • Urgent and emergency care			• SHMI Performance • Reduction in moderate & severe harm and death incidents • Maternity (Compliance with Ockenden recommendations and compliance with CNST) • Reduction in medication incidents leading to moderate & severe harm or death. • Reduction in DKA incidents resulting in moderate & severe harm or death. • Achievement of the IPC BAF				

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity Meeting stood down due to operational pressures. The group meets monthly, has developed a work reporting plan Papers reviewed and Chair's report provided. Any risks to quality and safety are discussed at the relevant cell meeting, e.g., quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.		Upward reports to QGC monthly and responds to feedback Review of ToR in July 2021. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Divisional assurance reports to PEG providing limited assurance; further work needed to improve this. Will be monitored through PEG.	Head of Pt Experience revising divisional assurance report template and have discussions with divisional clinical leads re: requirements for the reports. Template approved through PEG Nov 21	Quality Governance Committee	**Amber**
						Patient Experience & Carer plan 2019-2023 (PEG)	Number of objectives in the plan paused due to Covid Pandemic; this means the plan need a full review.	Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level. Patient & Carers Experience Plan to be reviewed by end Sept 21 and present to Oct PEG	Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports.	Limited assurance until the plan is reviewed.	Plan is being reviewed with a draft final date of end of January 22.		
						Quality Accreditation and assurance programme which includes section on patient experience. (PEG)	Lack of alignment of findings in accreditation data to patient experience plans. Ward / Dept review visits paused due to operational pressures	Head of pt experience to have access to accreditation data. Deep dives into areas of concern as identified in quality meetings and accreditation reports. Update reports to PEG and QGC as required. Matrons audits continue to take place. Any risks to quality and safety identified are discussed at the quality cell and issues escalated to gold as appropriate.	Reports to PEG and upwardly to QGC	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support.		
						Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging Sensory Loss group upwardly reports to Patient Panel.	Upward reports and minutes to the Patient Experience Group IIP reporting to Support & Challenge group.	Diversity of patient engagement and involvement.	CCG exploring dev of a Health Inequalities cell to combine efforts in reaching out. Date not yet secured. ULHT Experts by Experience project progressing with Mastalgia Expert ref group (ERG)established, Cancer Board recruiting 2022 discussions continue with Gastro & CYP (Expert Families).		

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						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Inconsistency in applying end of life visiting exceptions.	Exceptions guidance re-issued. Monitor through complaints & PALs.	Report to PEG through complaints & PALs reports; upward reports from Visiting Review working group. Visiting experience section within complaints & PALs reports.		Complaints/PALs reports to include visiting concerns; div ass reports to include visiting related issues. Visiting review indicates inconsistency in EoL visiting; criteria and process being strengthened. Request to ME's to ask relatives about visiting experience at EoL.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports not being received by PEG	Head of Pt Experience to discuss with EDI lead to agree a way forward. Head of Pt Experience & EDI lead meeting to agree a way forward. Links to Reaching Out IIP project.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic;	PLACE Lite continues & reports to PEG.		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients							
						Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust.			Effective upward reporting to QGC from reporting groups.	Divisional reports still in their infancy.	Verbal updates provided by divisional representatives at the group.		
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	GIRFT activity continues to be reduced nationally due to the pandemic.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Current reporting has tended to focus on process rather than improved outcomes.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (CEG) with quarterly reports to QGC (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed and workshops planned with leads, led by the Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates meaning that reporting to QGC is not as up to date as expected.	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate Meeting to take place with Medical Director and Audit Leads to discuss role and expectations, however attendance has been impacted by operational pressures.		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG)			Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	None identified	Quality Governance Committee	**Green**
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	None identified		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)	None identified.	None identified.	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down during COVID-19	National reports to be presented at Governance Meetings once produced		
						Process in place for implementing requirements of the CQUIN scheme.	Currently stood down	Currently stood down	Currently stood down	Currently stood down	Currently stood down		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.					
						Enhance clinical effectiveness by ensuring that care delivered to patients is based on evidence based, best practice leading to improved clinical outcomes			Implementation of the SAFER bundle				

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SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)	Awaiting sign off of system people plan (delivery plan reviewed and objectives agreed annually in Q4)	System People Team System Workforce Cell	System PP - Each 'pillar assigned system lead Progress/assurance reported to People Board (quarterly) Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan Setting priorities 22-23 - away day (18/03)		Presentation of system progression and oversight being delivered to PODC on 15th March 2022. A day planning session has been held for the 22/23 priorities which are being presented at the next People Board for signoff in April 2022. Priorities for 22/23 agreed and approved at People Board in April. Consideration for PODC whether this is still 'red' rating from an assurance perspective suggest that its is medium.		
						Workforce planning and workforce plans	Overall vacancy rate declining but increasing for clinical roles.	IIP Project - Embed robust workforce planning and development of new roles	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division.	Some areas remain hard to fill and therefore difficult to fully mitigate risk. Challenges in obtaining meaningful information from Trac, due to Recruitment team capacity issues.	Regular reviews take place with Divisions through workforce analyses and a plan for every post; alternatives and workforce mix are considered and where national workforce shortages identified then focus is on overseas recruitment. Current workforce planning being undertaken in conjunction with our SHRBP and finance colleagues. Draft narrative have been prepared to support the workforce requirements for the Trust, further work is required to align to activity demand and capacity before the final submission date. A review of the first draft submission has taken place with Adrian Tams leading this piece of work on behalf of workforce. Further work moving forward to pull together a workforce planning process and stakeholder to ensure a more seamless and HR/recruitment approach moving forward. A Tams now on secondment for 6 months with ULHT from NHSI/E.		

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2a	A modern and progressive workforce	Director of People and Organisational 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. Support is being received from NHSI/E and additional capacity has now been recruited to support the cohort recruitment of HCSW. A review of the process around how we recruit consultants to the Trust has also commenced. Additional training has been provided for the Recruitment team from NLAG and training from TRAC is due to take place in April.	People and Organisational Development Committee	Red
						Focus on retention of staff - creating positive working environments System retention role secured (8a) appointment pending	IIP projects on hold	IIP Projects (subject to review further to IIP reset) Appraisal - deep dive planned Dec21 Mandatory training - currently in scope Talent management - held National Talent Management Framework launched, Lincs system identified as pilot site for launch (to be discussed 4/5/22)	Regional Midlands Talent Board Model Employer ambition appraisal/mandatory training compliance	Appraisal and training compliance levels not at expected level Appraisal Improvement Plan (Apr'22) to address low compliance / improve quality of conversations and process - proposal for ELT/TLT - May'22			
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff - To be discussed following review of development offer (on hold)					
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	The reports are run daily and any abnormalities are considered in the context of the national and regional position. The pandemic and the critical incidents the Trust is in has impacted on usual trends. AMS data is reviewed regularly and reported into Divisions on accuracy. Data currently for absence is inline with national reporting. AMS Project is being relaunched with a training roll-out plan and SHRBP support. The AMS project has been relaunched and additional capacity identified. Training has started to be rolled out with divisions and a position paper is currently being prepared. Reporting will start to feature as part of the Workforce Cell meetings and monthly one to ones with key HR staff. Work continues with the training and roll-out previously hindered by COVID and being		

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											hindered by COVID and being stood down.		
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Agreed - establish ULHT Learning, Education and Development service Proposed Education/Learning service - under review	IIP projects in early stage of delivery	IIP projects - education and learning Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year Mandatory training improvement plan (pending subject to proposed Education&Learning team) System LEAD (Learning, Education and Development) Board to provide system oversight (proposed)				
						Creation of robust Workforce Plan • Values based recruitment and retention • Maximising talent management opportunities • Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn'			Improved vacancy rates				
						Improve the consistency and quality of leadership through:- • Improved mandatory training compliance • Improved appraisals rates using the WorkPal system • Developing clear communication mechanisms within teams and departments			Appraisal rates and training development				
						Providing a stable and sustainable workforce by:- • Ensuring we have the right roles in the right place through strong workforce planning • Reducing vacancy rates and ensuring that posts are filled through a positive and values recruitment approach • Reducing our agency staffing levels/spend • Strengthening the Medical Workforce Job Planning processes							

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	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 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Programme Group upward report	Delivery of agreed output	Improved function of group and reporting to be in place for November report		
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc. 'Themed' You Said, We are Doing campaign		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey scores: morale / engagement / recommend as place to work and place to receive care / care prioritised / 7 people promise themes				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT)		L&M programme reset from April - piloting new programme (subject to approval)	Pulse surveys - " Have your say"		Proposal to be shared with ELT (Dec'21): gradual introduction of L&M activities NB. L&M apprenticeship on going		
						Perception of fairness and equity in the way staff are treated	EDI Group (report to PODC) live from Dec 2021	IIP Project - Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation EDI Group membership reset - to ensure representation and coverage Anti Racism Strategy	Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NNSS	WRES/ WDES/MRES	Currently developing WRES and WDES action plans and internal audit to deliver the first actions for the 31.12.21 WRES/WDES and Internal Audit actions being monitored through Committee		
						Staff networks	Some staff networks stronger than others	Continued work to embed the networks and provide them with effective support Following recruitment of new SN Chairs - agree Universal Terms of Reference Support groups in developing strategic objectives for the next 12 months	Protect our staff from bullying, violence and harassment - measure through National Staff Survey		Governance for EDI Recruitment process for SN Chair/VC - Feb'22		

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						Demonstrate that we care and are concerned about staff health and wellbeing		EAP approved - implementation from May'22	System Health & Wellbeing Board Linc People Board	OH KPIS to be agreed (for reporting to PODC) System Hub activity Wellbeing activity (upward report to PODC)	Commence reporting from 2022		

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						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian		Junior doctor forum	Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee		Junior Dr Survey results (alignment with NNSS21 findings)		
						Embed a compassionate leadership approach through our Culture & Leadership Programme			Improved Pulse survey results				
2c	Well led services	Chief Executive	Current risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes 4 sessions during Oct / Nov 21 Risk Register Confirm and Challenge Group ToRs Upgrade to datix system Full Risk Register review	Updated Policy and Strategy document for approval at December 21 Risk Register Confirm and Challenge meeting - Meeting Cancelled Covid pressures	Consider at January meeting	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**
						Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6			
						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy 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				

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						Ensure system alignment with improvement activity							

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SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Interim case for £9.6M of CIR continues in to 2021/22. Will reflect priority areas in the Estates 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.	Finance, Performance and Estates Committee	**Amber**
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response.		
						Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID		MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating. 6 facet survey review commencing in Jan 22. Specification drafted for full 6 facet survey with tender process to start in Jan 22	IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not. The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill. Review of 6 Facet Surveys will commence as part of HIP Bid (Referral in Estates Strategy)		

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						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report				
						Implement Year 1 of our Estates Strategy							
	Efficient use of our	Director of	Efficiency schemes do not cover extent of savings required. Continued reliance on agency and locum staff and use of enhanced bank rates to maintain services at		CQC Well Led	Delivering £25m CIP programme in 22/23	Operational ownership and delivery of efficiency schemes Detailed delivery plans supported by clear timelines and metrics	Divisional Financial Review Meetings - PRMs improvement steering group	Delivery of Improvement steering group CIP	Ability of clinical and operational colleagues to engage due to service pressures.	Gaps are being reviewed monthly with Divisions through FRMs	Finance, Performance	
						Delivering financial plan aligned to the Trust and Lincolnshire System financial plan / forecast for 2022/23	Urgent and unplanned Restore and Covid related costs	Lincolnshire ICS financial plan Lincolnshire System collective management of financial risk Savings plan, monitoring and reporting. Risk/gain share mechanism at ICS level	Delivery of the Trust and System financial plans for 22/23	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the ICS reporting structure including Finance Leadership Group Reporting to ICS CEOs		
						Reduce agency spend through workforce programme	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans.	Through the Medical and Nursing Workforce Transformation Groups and through Improvement Steering Group		
						Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q1 22/23	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 and 21/22 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust from Q1 22/23. Supported by refreshed costing strategy.	SLR and PLICs information	Ability of clinical and operational colleagues to engage due to service pressures.	Improvement in the CQC Use of Resources is part of the Trust 22/23 IIP		

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3b	Efficient use of our resources	Finance and Digital	substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure (as a result of unforeseen events)	4664	CQC Use of Resources	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.	Finance, Performance and Estates Committee	**Amber**
						Working with system partners to deliver the Lincolnshire financial plan for 22/23.	Urgent and unplanned Restore and Covid related costs	Lincolnshire System financial plan Lincolnshire System collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for 22/23	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the ICS reporting structure including Finance Leadership Group upwards to the CEOs		
						Detailed workforce and activity modelling aligned to resource requirements to support Trust and System Restoration.	Impact of covid and increasing acuity of NEL patients creating bed and staffing resource pressures to deliver planned care plan.	Trust Restoration plan. Lincolnshire System activity plan Lincolnshire System collective management of restoration of planned care activity	Reporting against the Trust and System Restoration plan and national Trajectories.				
						Collaboratively work to develop an evidence based approach to more efficient services							
3c	Enhanced data and digital capability	Director of Finance and Digital	Approval of OBC for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure		CQC Responsive	Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal		EMAS, GPs, mental health, community, social care and care homes data now also available within the Care Portal.	Finance, Performance and Estates Committee	**Amber**
						Commence implementation of the electronic health record Development and approval of OBC		Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of OBC		EPR OBC to be approved by NHSE/I OBC requirements being worked through with NHSE/I		
						Undertake review of business intelligence platform to better support decision making			Delivering improved information and reports Implement a refreshed IPR	IPR refresh for 22/23. Completed for Jan 2022	Steady implementation of PowerBI through specific bespoke dashboards and requests.		
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues						

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						Improve end user utilisation of electronic systems	Business case for additional staff under development						
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion.		
3d	Improving cancer services access	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Cancer Care	Recovery post COVID and risk of further waves Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Percentage of patients waiting 52 weeks or more 28 Day Faster Diagnostics			Finance, Performance and Estates Committee	
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Planned Care	Recovery post COVID and risk of further waves Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Percentage of patients waiting 52 weeks or more 28 Day Faster Diagnostics			Finance, Performance and Estates Committee	
SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
			Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and other planning priorities puts an			Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed.		
						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				

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			added constraint on time, capacity and headspace to engage with the ICS agenda.			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				

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4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor institutions		CQC Caring CQC Responsive CQC Well Led	Support Creation of ICS - Lincolnshire designation July 2022	Delay to review and adoption of legislation Clarity of roles and responsibilities as part of the ICS	Weekly ICS meetings Provider Collaborative Steering Group	SLB reports and upward reports by CEO / Chair	Impact of ICS and our role within it	key role as part of the provider collaborative steering group. Active stakeholder management of key roles.	Finance, Performance and Estates Committee	**Amber**
						Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team	Awaiting outcome of themes from consultation	Attendance at Consultation Steering Group by Deputy Director of Strategy and Planning, leading the ASR work on behalf of ULHT	SLB reports and upward reports by CEO / Chair	Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational	Flexible engagement approach from Strategy & Planning Team to allow for detail to be captured around operational demands at times when		
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress	Disruption due to COVID has resulted in a less mature approach to strategy deployment, broad understanding across the organisation, progress on building capacity and capability.	ELT/TLT oversight Board / system reporting	Weekly team meetings- reflected in IIP reports	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh		
						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution an play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration ULHT anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Scope what a good effective partnership look like Stakeholder mapping & engagement plan Develop appropriate comms for the Lincolnshire ICS and our provider collaborative	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS		
						University Hospital Teaching Trust Status Developing a business case to support the case for change	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee		R&I remain a key stakeholder on the project and are engaging with the University of Lincoln Research Team through meetings to ensure that can move towards a potential joint research office function if required (in line with UHA Guidance). R&I Team will continue to review their strategy in line with any changes to this effect. This will also include any changes of direction as a direct result of the Business Case outputs.		

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4b	Becoming a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Increasing the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increased clinical academics and RCF funding Funding for Clinical Academic posts	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position The meeting schedule for 2022/23 is being finalised in May 2022, and will be inclusive of R&I, HR and Finance.	People and Organisational Development Committee	**Red**
						Improve the training environment for students	Ensuring that, due to the revised UHA guidance we are able to offer the facilities required for a functioning clinical academic department	The gaps are being managed through the revision of the library and training facilities. This will meet the criteria within the UHA guidance	GMC training survey Stock check against checklist Internal Audit - Education Funding		Ongoing work within the Medical Education Centre nearing final stages of overall completion (as per Trust regular communications updates) and this will then provide a better learning environment for students on a sustainable basis. This will be evidenced with our application.		
						Developing an MOU with the University of Lincoln	This is now a requirement of the UHA guidance. Historically this has not been required.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy. MOU will be developed once the Joint Strategy has been signed off.	RD&I Strategy and implementation plan agreed by Trust Board	Drafts in place which broadly cover joint research and teaching approach across the organisations, unable to outline in strategy financial commitment	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group The meeting schedule for 2022/23 is being finalised in May 2022, and will be inclusive of R&I, HR and Finance.		
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	Evidence bound by UHA requirements	Portfolio of evidence is being captured and is available on the shared drive	Roadmap developed to identify required evidence for portfolio	Clear understanding of rigidity of UHA requirements	Discussions being held to clearly identify opportunity for movement within guidance		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	HRBP at ULHT is part of the Steering Group to assist with working through the contractual issues	ULHT healthcare roles plan increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible.		

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4c	Successful delivery of the Acute Services Review and Recovery Support plans		Outcome of ASR review and any subsequent challenge may delay implementation of the first phase of fragile services Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data) Engage with services to develop plans as to how best to approach a clinical review, Provide feedback on Public Consultation of ASR	Clinical service strategy and heat map currently being developed Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy	Process being developed to identify services for review. This includes the development of a HEAT Tooll to identify areas where services are not meeting targets, such as RTT, Cancer, Finance data.	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning Publish ULHT clinical service strategy end of 2022/23 Flexible engagement approach from Strategy & Planning Team to allow for detail to be captured around operational demands at times when Divisional Teams are available on an ad hoc basis. This is to ensure delivery of the ask with regards to collation of ASR public consultation feedback and subsequent implication. ASR Public communication ongoing and support within Strategy & Planning as required still in place.		

The BAF management process

The Trust Board has assigned each strategic objective of the 2021/22 Strategy to a lead assurance Committee. Outcomes under each strategic objective are aligned to a lead Committee or reserved for review by the Trust Board.

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

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

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

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7June 2022*
Item Number	*Item 13.3*
Audit Committee Upward Report	
Accountable Director	*Sarah Dunnett, Audit Committee Chair*
Presented by	*Sarah Dunnett, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

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

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

Executive Summary

The Audit Committee met via MS Teams on the 6th May 2022. The Committee met to specifically consider items relating to Internal Audit to support the delivery of the Head of Internal Audit Opinion:

Internal Audit

The Committee received a progress report from the Trust Internal Auditor providers noting delivery of 349 days against a total of 357 days in the agreed revised audit plan.

The Trust Internal Auditor Providers confirmed that a further four final reports had been issued since the last meeting: Data Security and Protection Toolkit (Partial assurance with improvement required), Estates Follow Up, Clinical Audit (Significant Assurance), Infection Prevention and Control (Partial assurance with improvement required). It was noted that a draft report had been produced for the Medicines Management Follow Up and fieldwork was underway for the Core Financial Controls (Post ledger testing).

The Committee raised concern in relation to the DSPT Audit report and whether the issues had been identified ahead of the audit work. The Committee were advised that reporting was through the Finance, Performance and Estates Committee who were alert to the challenges and were receiving updates on the mitigating actions being taken ahead of the annual submission in June 2022. It was noted that the report reflected a point in time in terms of the submission.

Head of Internal Audit Opinion

The Committee received the draft of the Head of Internal Audit Opinion noting that this could not be finalised until the final two audit reports were complete. The draft was providing the Trust with an overall opinion of Partial Assurance with Improvement Required. The Committee noted this was unlikely to change.

The Committee noted the impact on the opinion of the Trust grip on completing audit actions. These were now being presented to the assurance committees to secure additional focus.

The issues highlighted within the Estates review and the Recruitment Audit were particularly highlighted as areas of concern for the Trust. Noting that the Trust had received a no assurance audit report for Estates.

The opinion noted the implementation of new risk management processes in year and the progress with work to strengthen the risk register.

The Committee recognised the actions needed in the next 12 months to strengthen controls and build on the foundations of the work done in 2021/22.

Draft Annual Report

The Committee received the draft annual report noting that the key elements of performance and remuneration were still subject to validation by the respective teams. Committee members would share comments in relation to the report by mid May.

Draft Internal Audit Plan 2022/23
The Committee received the draft internal audit plan noting that Internal Audit were liaising with Executive Directors to determine broad scoping of the specific areas. The next update would be received at the June Committee meeting for final sign off.