Bundle Trust Board Meeting in Public Session 3 March 2020

PLEASE NOTE THAT ALL OF THE AGENDA TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1 09:15 - Introduction, Welcome, Chair's Opening Remarks and Health and Safety
Chair

2 09:20 - Public Questions
Chair

3 09:35 - Apologies for Absence
Chair

4 09:40 - Declarations of Interest
Chair

5 09:45 - Minutes of the meeting held on 4th February 2020
Chair

Item 5 Public Board Minutes February 2020v3.docx

6 09:55 - Matters arising from the previous meeting/action log
Chair

Item 6 Public Action log February 2019.docx

7 10:05 - Chief Executive Horizon Scan Including STP
Chief Executive

Item 7 Chief Executive's Report.doc

8 10:25 - Patient/Staff Story
Director of Nursing

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

9 10:45 - BREAK

10 Strategic Objectives

11 10:55 - Providing consistently safe, responsive, high quality care SO1

11.1 Assurance and Risk Report from the Quality Governance Committee
Dr Gibson

Item 11.1 QGC Upward report February 2020 v3.doc

11.2 NHS Improvement Infection Prevention and Control Visit
Director of Nursing

Item 11.2 IPC paper.doc

Item 11.2 Appendix 1 ULHT IP visit report DRAFT.docx

Item 11.2 Appendix 2 Trust IPC Response.pdf

11.3 11:25 - CQC Winter Assurance Visits
Director of Nursing

Item 11.4 CQC Section 31.doc

Item 11.3 CQC pilgrim hospital 20200227.pdf

Item 11.3 CQC lincoln county hospital 20200227.pdf

11.4 Patient Safety Report
Medical Director

Item 11.5 Trust Board - Patient Safety Incidents Report - March 2020.pdf

Item 11.5 Appendix I - Patient Safety Incidents Dashboard - February 2020.pdf

12 11:30 - Providing efficient and financially sustainable services SO2

12.1 Assurance and Risk Report from the Finance, Performance and Estates Committee
Gill Ponder

Item 12.1 FPEC Upward Report February 2020 v2.docx

12.2 Car Parking

Chief Operating Officer

Item 12.2 Car Parking Update February 20200211.docx

13 12:00 - Providing services by staff who demonstrate our values and behaviours SO3

13.1 Assurance and Risk Report from the Workforce and Organisational Development Committee

Sarah Dunnett

Item 13.1 Workforce &OD Upward Report v.doc

13.2 Staff Survey Results

Director of People and OD

Item 13.2 Public Board - NSS Results 2019.doc

13.3 Freedom to Speak Up Quarterly Report

Freedom to Speak Up Guardian

Item 13.3 FTSU Update Report.docx

14 Providing seamless integrated care with our partners SO4

15 Performance

Director of Finance and Digital

15.1 12:20 - Integrated Performance Report

Item 15.1 Integrated Performance Report - Trust Board.pdf

16 Risk and Assurance

16.1 12:35 - Risk Management Report

Item 16.1 Trust Board - Strategic Risk Report - March 2020.pdf

Item 16.1 Appendix I - Strategic Very High & High Risks - February 2020.pdf

Item 16.1 Appendix II - Very high & High Operational Risks - February 2020.xlsx

Item 16.1 Appendix III - Risk Scoring Guide - July 2019.pdf

Item 16.1 Appendix IV - Risk management process Jan 2020.pdf

16.2 12:45 - Board Assurance Framework 2019/20

BAF 2019-20 Front Sheet March 2020.docx

BAF 19-20 v25.02.2020.xlsx

17 Strategy and Policy

18 12:55 - Board Forward Planner

Trust Secretary
For Information

Item 18 Public TB Board Forward Planner 2019 v 4.doc

19 13:00 - ULH Innovation

Assistant Director Communications
For Information

Item 19 Innovation report - March 2020.docx

20 Any Other Notified Items of Urgent Business

21 The next meeting will be held on Tuesday 7th April 2020 at 9.15am

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.

Agenda Item 5

Minutes of the Public Trust Board Meeting

Held on 4th February 2020

Boardroom, Lincoln County Hospital

Present

Voting Members:
Mrs Elaine Baylis, Chair
Dr Chris Gibson, Non-Executive Director
Mrs Liz Libiszewski, Non-Executive Director
Mrs Sarah Dunnett, Non-Executive Director
Miss Victoria Bagshaw, Director of Nursing
Mr Paul Matthew, Director of Finance and Digital
Mr Geoff Hayward, Non-Executive Director
Mrs Gill Ponder, Non-Executive Director
Mr Andrew Morgan, Chief Executive
Dr Neill Hepburn, Medical Director
Mr Mark Brassington, Director of Improvement and Integration/Deputy Chief Executive

Non-Voting Members:
Mr Martin Rayson, Director of People &OD
Mr Simon Evans, Chief Operating Officer

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mrs Anna Richards, Associate Director of Communications
Ms Cathy Geddes, Improvement Director, NHS Improvement
Dr Maria Prior, Healthwatch Representative

Apologies

001/20	**Item 1 Introduction** The Chair welcomed members of staff and public to the meeting. The Chair welcomed Dr Prior to the meeting who would be the Healthwatch representative and Mr Simon Evans as Chief Operating Officer. Thanks were expressed to Victoria Bagshaw for the support and leadership she had provided in the interim Director of Nursing role. Dr Karen Dunderdale was observing the meeting and would commence with the Trust on the 24th February as the Director of Nursing.
002/20	**Item 2 Public Questions** **Q1 from Sue McQuinn** **The government has published the following information:** **"From April, all 206 hospital trusts in England will be expected to provide free car parking to groups that may be frequent hospital visitors, or those disproportionately impacted by daily or hourly charges for parking, including:**

	• **blue badge holders** • **frequent outpatients who have to attend regular appointments to manage long-term conditions** **Free parking will also be offered at specific times of day to certain groups, including:** • **parents of sick children staying in hospital overnight** • **staff working night shifts** **The government will work with the NHS and others to ensure that it:** • **spreads existing good practice from NHS organisations applying current exemptions effectively to others** • **uses the NHS standard contract if needed to ensure compliance** • **assesses where capital investment could help to improve the experience of patients and visitors"** **Could the board please advise what steps it is taking to implement the changes described? What plans are being made to ensure the public, visitors & staff, are aware of the new concessions?** The Chief Operating Officer responded: The Trust had received the bulletin referred to and had immediately started to look at systems and processes to enable those who would be entitled to access free car parking and to avoid a burdensome process. Further clarity was awaited from the centre as there had been no further dialogue, this was expected imminently to supplement the detail already received. Once received the detail would be worked through to consider how the system would be publicly described. There was a need to be mindful of recent experiences and to reflect that in any of the communications going forward.
003/20	**Q2 from Jody Clark** **Looking through the agenda and knowing the pressures faced over the winter period. It was disappointing to see that 56 beds were closed due to lack of staffing, with sickness for stress and anxiety, being the main reason for absence.** **Can you tell me what steps are being taken to address these issues?** The Chief Operating Officer responded: In order to provide clarity, the bed closures took place on Christmas eve, Christmas day and continued in to boxing day. At the time of the bed closures the Trust had experienced 80 empty beds, as such the closure of 56 did not pose a risk but reflected the staffing position. The staffing position was such due to a combination of sickness and a reduction in fill of agency and locum staff. The issues described were a contributing factor to the closure and the Trust would like to provide assurance that a wellbeing programme is in place with additional measures built in over the winter period. These additions included resilience training, financial hardship training and financial wellbeing, these actions are to support staff to remain healthy and able to work through the difficult Winter period.
004/20	**Q3 from Alison Marriott**

	In November 2019 you advertised for patient/public representatives to attend a meeting at Pilgrim Hospital on 27th November, to look at options for the redesign of Pilgrim A&E, following the award of £21 million funding. I received the invitation and offered to attend, but was told the event was full. Can you please answer the following question which I submitted at the time, and to which no answer has yet been received: How many parents with children currently under the age of 16 are due to attend? How many patient/public representatives are due to attend overall? The Director of Improvement and Integration/Deputy Chief Executive responded: The meeting referenced was the first of many to take place as part of the design group for the Pilgrim build. Two patient and public representatives had been asked to join the team. Given the particular experience of Ms Marriott in relation to children and young people the Trust will also be asking for her to join the group, particularly in respect of the paediatric build.
005/20	**Item 3 Apologies for Absence** There were no apologies for absence
006/20	**Item 4 Declarations of Interest** The Chair advised that she would be standing down from her role with the Lincolnshire Action Trust Board on 4th March 2020. The Trust Secretary advised that due to recent changes within the Executive Team a review of declarations of interest would be undertaken.
007/20	**Item 5 Minutes of the meeting held on 3rd December 2019 for accuracy** The minutes were agreed as a true and accurate record subject to the following amendments: 1860/19 – Should read – mental not metal 2003/19 – Should read – financial year not calendar year. 2036/19 – Should read –divisional matrons not operational managers 2079/19 – Should read – There would be a need to use figures rather than percentages
008/20	**Item 6 Matters arising from the previous meeting/action log** 884/19 – National Urgent Care pathway changes – The national review was awaited and would form part of the operational framework due to be published. Further guidance was expected in March. The Chief Operating Officer would report back to the Board once guidance had been received. Complete 1062/19 – People Strategy – Deferred to 3 March 2020 1186/19 – QGC Assurance report – Deferred to 3 March 2020 1641/19 & 1642/19 – NHS Improvement Board Observations and actions – Audit Committee reviewed actions in Jan meeting. Will review again in April

	1679/19 – Patient/Staff Story – Remained a work in progress. Policies and processes had been reviewed and were deemed fit for purpose. The issue was ensuring that these were followed at the point at which a staff member left the site. Operations Centre staff will be advised again of the policies, procedures and responsibilities, complete. 1747/19 – Assurance and Risk Report Finance, Performance and Estates Committee – Update included within upward report however further work required, deferred to 3 March 2020 2026/19 – Patient Safety report – Work to be concluded on report in March, deferred to 3 March 2020 2048/19 – CQUIN Medicines Optimisation workforce review – Discussions were taking place with external support and conversations had taken place with Pharmacy staff. Complete
009/20	**Item 7 Chief Executive Horizon Scan including STP** The Chief Executive presented the report to the Board, thanking the Director of Improvement and Integration/Deputy Chief Executive for preparing the report.
010/20	**System Issues** The Board were advised that the system remained under significant pressure through the winter period, this was a national issue and not specific to the Trust. A number of actions were being undertaken to support the system with the priority to ensure services remained as safe as possible. There had been recent news coverage regarding the 4 hour standard across the country however it was clear that the focus would remain on keeping patients and staff well and not chasing targets.
011/20	Planning for 2020/21 remained in progress with the Long Term Plan (LTP) for Lincolnshire requiring finalisation. Following the election that had been further clarity provided on the sign off mechanisms of the LTP along with planning guidance for the next year.
012/20	Within the planning guidance there had been clear messages regarding capacity within the NHS and a strong push for further bed capacity, this had been an interesting change in policy direction. There was also the requirement for Trusts to achieve 92% bed occupancy rates, this had previously only been good practice. This would result in the need for additional capacity within the system.
013/20	The system had signed up to Integrated Community Care however there was a need for more bed capacity and lower occupancy levels. The Trust would need to be clear regarding stretch target and expectations of Commissioners. Activity levels would need to be based on reality in order to ensure these were not overoptimistic and undeliverable. Further work would be required to ensure appropriate activity levels were set.
014/20	The Board were advised that system finances remained challenged, the system would need to ensure that the control total for the year was delivered however, consideration would also be needed regarding future year trajectories.
015/20	The deadline for leaving the European Union had passed on 31st January 2020. NHS planning had been conducted on the assumption of leaving with no deal, formal reporting had now been stood down.
016/20	**Trust Specific issues**

	The Chief Executive reiterated the changes made to the executive leadership team advising that the Chief Operating Officer now held responsibility for estates and facilities within the Trust, this was no longer a separate directorate.
017/20	Dr Dunderdale would be joining the Trust on the 24th February 2020 in to the Director of Nursing role. The Chief Executive expressed personal thanks to Miss Bagshaw for stepping in to the interim role and for the work that had been undertaken.
018/20	It was highlighted to the Board that although the Trust were reporting on plan financially, the underlying position was a variance to plan of £19m. The Trust had been able to report on plan due to various support and technical adjustments, significant work remained in order to end the financial year in an acceptable position. The Trust were still hoping to report a £70.3m deficit at year end.
019/20	The National Staff Survey had closed and the Trust had achieved the highest response rate to date. Analyses of the result was being undertaken but were currently embargoed.
020/20	Mrs Dunnett advised that the Integrated Community Care programme work stream was still embryonic in development. It was suggested that there may need to be consideration of a Board Development session in order to update the Board on the position of supporting the clinical strategy moving forward.
021/20	The Chair confirmed that it would be appropriate to receive updates and that these would be received through the agreed governance process of the Executives. The formal mechanisms of reporting required some finalisation.
022/20	Dr Gibson highlighted that in order to continue to progress the Acute Services Review (ASR) would need to be completed and questioned the current position.
023/20	The Chief Executive advised that this formed a key part of the LTP that still required regional and national sign off prior to public consultation being undertaken regarding the ASR. A pre-consultation business case required producing that would also require regional and national sign off.
024/20	Ultimately the consultation was a legal matter for the Clinical Commissioning Groups.
025/20	The Chair noted that there was a need to ensure traction on a number of the aspects within the ASR. There had been a step change in the past year to develop relationships with Commissioners and this would need to be continued in order to allow the Trust to inject realism in to future plans. The Trust Board: • **Received the report**
026/20	**Item 8 Patient/Staff story** The patient story due to be presented to the Board had been deferred due to illness.
	9 BREAK
	Item 10 STRATEGIC OBJECTIVES
027/20	**10.1 Care Quality Commission Update**

	The Director of Nursing presented the paper to the Board updating on progress with the must do and should do actions from the 2019 Care Quality Commission (CQC) reports noting the required alignment with the Integrated Improvement Plan and clarity on reporting processes.
028/20	The Board were advised that the overall plan would be held by the Quality Governance Committee to ensure this remained on track to deliver however; the Committee would not review those areas in detail for which it was not responsible.
029/20	A key weekly working group had been established to ensure there was clarity on the issues and reporting was aligned to new project documentation. The Board were advised that a small number of actions had been closed with a wider number nearing completion. There remained a number of actions in progress.
030/20	Mrs Dunnett queried if there had been any outstanding must and should do actions from previous inspections or if there were any actions where embeddedness was uncertain.
031/20	The Director of Nursing confirmed that the plan included all previous actions and the embedding of previous actions should be an aspect of business as usual. This would be seen through relevant sub-group reporting.
032/20	The Chair noted that the difference which needed to be seen was through the task and finish group that functioned on an evidence base, this would allow for the Quality Governance Committee to carry out the appropriate due diligence.
033/20	Mrs Ponder asked for assurance that the Trust could demonstrate that progress had been made at the expected point in time. Confirmation was provided that this would be incorporated within the project management. The Board considered the need to ensure that the approach supported delivery and allowed the Committees to be assured of the delivery.
034/20	Should reporting to the Committees not be as expected the Board would be advised in order to ensure oversight was maintained. The Trust Board: • **Received the noted progress in terms of delivery of improvement against the CQC must and should do actions**
035/20	**10.2 Integrated Improvement Plan** The Director of Improvement and Integration/Deputy Chief Executive presented the Integrated Improvement Plan (IIP) to the Board which reflected the work from the board development sessions.
036/20	The plan outlined the clear direction for the organisation in order to enable improvements to be made, covering a 5 year period from 2020 – 2025 that aimed to deliver the revised Trust vision of Outstanding Care, Personally Delivered.
037/20	The plan detailed the 5-year priorities along with the key outcomes that would be reported to the Board. The work due to be undertaken in year one had been outlined against the strategic objectives of Patients, People, Services and Partners. Clear measures to track the impact in year had been developed, with delivery through normal governance processes and teams with some additional capacity. Progress would be tracked through the Project Management Office.

038/20	Executive Leads were being assigned to the outcomes for year one of the plan and project leads were undertaking development of the project documentation. The first year projects had formed the framework for divisional plans within the annual planning cycle. This was currently being worked through with the division to ensure the framework set as a Board could be translated to the divisions, specialities and services.
039/20	Work would be undertaken with external support to conduct an assurance check to ensure that the year one plan was aligned to delivery and resources available.
040/20	The proposed launch of the plan would commence during March with the Boards approval. There would be a series of face to face sessions led by Executives and deputies in order to reach circa 80% of staff and talk through the importance of the plan and the role staff have to deliver.
041/20	Branding of the plan was underway with the communications team to ensure that this became embedded as part of the Trust's identity.
042/20	The Board held discussion regarding a joined up approach with regards to the delivery of the plan, and the opportunity to talk with staff about the behaviour refresh and ensuring that objectives and priorities became an integral part of the appraisal process.
043/20	The existing appraisal system did have the expectation of being joined up with objectives however included within the plan there was a refresh of the appraisal process. This would be less about the paperwork and process but about individual performance management. Currently 1 on 5 staff did not have an appraisal.
044/20	The operational excellence work would undertake three aspects, mapping of the IIP to divisions, ensuring they were set up to deliver, put a model cell in to surgery to support performance management and to work with the Board regarding the change in conversation with the divisions regarding performance management.
045/20	Concern was raised that the previous work completed by external consultants within outpatients had not been sustainable. The Board were advised that things put in place had been delivered and maintained however there had been additional pressures within outpatients. The new work scheduled would specifically be around pathway redesign and would be a phased approach with 2 specialities, followed by 50% support and the final wave would see further reduced support. The wider questions would in fact be regarding the capacity and capability within the organisation to change direction.
046/20	Mrs Ponder queried the communication with stakeholders for the IIP. The initial focus would be on communication internally with staff followed by work to develop an external launch to stakeholders.
047/20	The Director of Improvement and Integration/Deputy Chief Executive identified that the development of the programme for delivery of the IIP was underway and being developed through the same pathway as that of the improvement programme.
048/20	Concern was raised regarding the current Board Assurance Framework and how those objectives committed to had not been delivered in year. A marked difference for the delivery of the IIP that had been suggested would need to be seen going forward.
049/20	The Director of Improvement and Integration/Deputy Chief Executive agreed to present back to the Board the building of the programme for delivery in order to identify how the changes made would be maintained and embedded.

	Action: Director of Improvement and Integration/Deputy Chief Executive, 5 May 2020
050/20	In the most part the IIP had been received well by the divisions and accepted in to the divisional plans and the next layer of planning had commenced.
051/20	The Chair questioned how the Trust would be launching the IIP to external stakeholders given the Trust wished to change the narrative of the organisation with partners. There would be a need to build on the communications and be clear about future intentions.
052/20	The move forward would require embedding in to appraisals and objectives for staff and ensure the appraisal is linked to annual increments with a focus on behaviours and delivery of objectives. The Trust Board: • **Approved the IIP for adoption and implementation** • **Approved the plan to launch communications with staff**
	Item 11 Providing consistently safe, responsive, high quality care SO1
053/20	**Item 11.1 Assurance and Risk Report Quality Governance Committee** The Chair of the Quality Governance Committee, Mrs Libiszewski provided the assurances received by the Committee at the December 2019 and January 2020 meetings.
054/20	The Committee had received an update with regard to Infection Prevention and Control, work had been led by the Director of Nursing and a further report would be considered by the private Board.
055/20	There had been a total of 9 Never Events reported and work was being undertaken by the Improvement Director with the Medical Director, a detailed report had been received at the January meeting following the safety culture visit to a London trust.
056/20	The Committee were not assured in relation to reporting on the deteriorating patient and further work had been requested.
057/20	The regular assurance report had been received from the Quality and Safety Oversight Group however it was noted that the sub-structures were not supported as a result of vacancies and temporarily filled posts. This issue had been referred for further consideration by the Workforce and Organisational Development Committee.
058/20	Concerns noted by the Committee regarding prioritisation of estates repairs had been highlighted to the Finance, Performance and Estates Committee.
059/20	A thorough review of safeguarding reporting had been conducted and 2 high rated risks and actions related to the Care Quality Commission (CQC) had been reported.
060/90	The Committee noted the lack of quality of Quality Impact Assessments across the organisation and the impact of the assurance process and the link to improvements for patients. The Committee requested a review of the process.
061/20	Paediatric reporting had been requested regularly and provided assurances including those against the CQC findings.

062/20	From the December report the Board were alerted to concerns within ophthalmology and partial booking waiting lists. In January the harm review process update was received and the Committee requested clarity that changes were being made to pathways. Assurance was required that processes were being followed.
063/20	The Board were advised from the January Committee that performance in respect of the Quality Account was not where it had been expected and concern was noted regarding delivery. The proposed 2021 priorities were received and the Committee noted the ambition to have 9 priorities however only 6 had been reported to the Committee. The Committee requested delegated authority from the Board to approve the priorities.
064/20	The Committee were concerned that the risk register review process was not sufficient due to the extension of due dates. This was not felt to be a specific issue to the Committee however it was requested that this was considered to ensure the register was regularly updated.
065/20	The Committee had received the first draft of the must and should do CQC action plan, a number of discrepancies had been highlighted however these had been resolved prior to presentation to the Board.
066/20	The Committee also requested delegated authority from the Board to agree the CNST maternity work due to the timing of sign offs required, this would allow the business to be addressed in a timely manner.
067/20	The Quality and Safety Oversight Group (QSOG) had been created in order to give oversight and review by executives prior to reporting to the Committee, this remained at a formative phase and there was a need for confidence that this was working with rigour. Divisions were now attending the meeting and reporting was improving.
068/20	The Medical Director noted the developing change in the way divisions were approaching governance. The speciality groups were conducting the technical work and divisions were working beside them. Work was progressing in order to ensure that assurance was provided by the divisions. It was noted however that the divisions were developing at varying paces.
069/20	The engagement of the divisions appeared to be that they were passive participants in the groups that sat beneath QSOG rather than owning and engaging with the issues. There was a reliance on the specialist teams to advise of issues.
070/20	Part of the issue was felt to be the vacancies within the divisions.
071/20	Efforts to fill the Trust Operating Model structure was ongoing. A development programme was in place for the triumvirate group and management below them. The fundamental problem remained the gap in numbers and capability.
072/20	Work was ongoing with the divisions to provide the capability to identify issues and articulate those things that could not be delivered, the reasons why and those critical elements that needed to be addressed.
073/20	The Board were clear that the governance structure and processes were known to the divisions however there were gaps in the structure that supported this. QSOG receive reported on the maturity of the development of governance, it remained immature but was developing. A more prescriptive piece of work could be considered however those staff with the required expertise would still need to be identified or appointed.
074/20	The Chief Executive noted that the Improving ULHT paper had included the further embedding of leadership structures, this included divisions. If a post had been created and

	budget was there this post would need to be filled. The paper also identified the need for a standard operating procedure for the divisions. This was to provide clarity on the authority to act that the divisions had been given and what support would be provided by business partners and other corporate functions. There was a need to ensure that support was provided to divisions to ensure they were successful.
075/20	The Director of Nursing noted that this was being addressed as part of the capability work rather than a focus on numbers. There was a need for the ability of matrons and operational managers to work in a matrix and layered way.
076/20	The Integrated Improvement Plan included work to be undertaken on governance and the discussions held regarding the Improving ULHT paper had been lifted across in to the plan. The manual produced from the introduction of the Trust Operating Model structure required embedding.
077/20	The Chair was assured that the action was included within the Integrated Improvement Plan however requested a review of the Trust Operating Model and governance to be presented to the Board. **Action: Director of Improvement and Integration, 7 April 2020**
078/20	The Chair refocused discussion back to the update received from the December Committee meeting noting the lack of assurance around key areas. Another element was the referral of items across the Committees, the Board were asked if referrals were working.
079/20	The Board were positive about the referrals being made however noted that there was a lag of reporting due to the point at time that the Committee took place. Consideration would be given to how referred items could be dealt with sooner. **Action: Trust Secretary, 3 March 2020**
080/20	The Chair requested a focus on the harm review update from the January Committee noting that it was understood from the CQC that granularity of data was not being seen in order to report an exact position to the Board.
081/20	Mrs Libiszewski noted that this particularly related to partial booking waiting lists, there were a sizeable number of patients on the list and it was not clear if harm reviews had been conducted.
082/20	It was noted that there could be an impact on the reputation of the organisation should the Quality Account priorities not be delivered. There had been a request for these to be achieved however some were linked to the patient survey and family and friends test. These were not seeing any improvement currently and it was unlikely this would improve.
083/20	QIA assessments were not being seen through the Committee and there was a need to move in to an improved position. The Improvement Director offered an external review of the process.
084/20	The Director of Nursing noted that this had been undertaken by NHS Improvement six months previously to develop the current documentation however this was cumbersome. There was a need to consider the system development of the QIA and internal work would need to be dovetailed with the system.
085/20	Development of the Project Management Office would support the completion of QIAs and ensure that full information was received by the QIA panels. This would provide greater

	coverage to address gaps however an external view would be useful on how documentation could be simplified.
086/20	The Chair noted the escalations to the Board around safety culture, Never Events and Quality Account priorities and the request for delegated authority to sign off the maternity CNST. The Trust Board: • **Received the assurance report** • **Approved delegated authority of CNST and the quality account priorities to the Quality Governance Committee**
087/20	**Item 11.2 Patient Safety Report** The Medical Director presented the report.
088/20	The level of incidents remained reasonably consistent. There had been 13 serious incidents declared in December, two of which were Never Events.
089/20	It was noted that due to a change in the reporting mechanisms for duty of candour there had been a reduction in reporting, this had demonstrated this process was not embedded in to clinical teams.
090/20	The Medical Director confirmed that this formed the reasoning to undertake safety culture work, this would replicate the work previously carried out in relation to mortality. The process was currently being developed and would take place over the year.
091/20	Due to the number of Never Events that had been reported the Trust were under additional review from the regional teams. Once developed the safety culture process would be presented to the Quality Governance Committee.
092/20	Mrs Dunnett questioned if there had been any themed work undertaken to learn from diagnostic incidents due to the high number. It was confirmed that this had not been undertaken and would need to form part of the overall work being undertaken in relation to Never Events and safety culture, the report would be presented to the Quality Governance Committee. The Trust Board: • **Received the update**
	Item 12 Providing efficient and financially sustainable services SO2
093/20	**Item 12.1 Assurance and Risk Report Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Mrs Gill Ponder provided the assurances received by the Committee at the December 2019 meeting.
094/80	The key points the Board were asked to note included the lack of assurance regarding estate, in particular the work that was requested on the Progress Living contract in order to track the impact of actions being taken. The Committee had also been alerted to the increased risk score for water safety, it was noted however that a number of measures were in place to mitigate the risk.
095/20	There was a £236m backlog within estates regarding mechanical risk and an increased risk to the Trust's regulatory obligations as a result of the backlog.

096/20	Concern was raised regarding the HSE improvement notice relating to confined spaces as the Committee had been advised that the submission made would close the notice. It had transpired that there was a second element in relation to training of staff that the Committee had not been sighted on. Further work had been requested.
097/20	The Committee were assured in respect of fire compliance including both the costs and completion of the programme.
098/20	Trust finances were not assured with the continuing theme around pay and the grip and control held by the Trust. The Committee had been asked to support capital borrowing in line with plan and the Committee supported the recommendation for approval by the Board.
099/20	Concern was raised regarding the Cost Improvement Plan stalling in terms of progress made and ability to deliver savings.
100/20	There had been previous discussions regarding the medicines optimisation CQUIN which would be delivered over 2 years however would impact on the current year.
101/20	There had been further deterioration of the 4 hour A&E standard with clear issues due to increased acuity, attendances and ambulance conveyances. The Committee had requested assurance on the steps taken within the winter plan.
102/20	The Committee noted the improvement in planned care waiting lists. There had only been 2 of the 9 cancer standards achieved in October.
103/20	The assurance rating within the Board Assurance Framework for objective 2a was considered and at the point at which the Committee met in December there had been an improvement from red to amber.
104/20	The Director of Finance and Digital noted that the reference to charitable funds being used to support the addressing of the mechanical backlog was inaccurate and charitable funds would not be utilised.
105/20	Dr Chris Gibson provided the assurances received at the January 2020 meeting and noted that despite extending the meeting it had not been possible to complete the agenda with a number of items deferred.
106/20	The Committee received an update on fire safety and noted the scale of the completion of the programme and the benefits generated. Further assurance was required regarding the finances and the timescale set by the fire service to complete the work.
107/20	The Committee received a paper reviewing the introduction of the ANPR system and felt this had been an honest review of the challenges faced. It had identified the benefits of using the system and these were beginning to be seen in available information. There had also been initial proposals received regarding future parking tariffs however this had been superseded by national guidance. The paper would be presented to a future Board meeting.
108/20	The Committee had reviewed the telephony contract award which would be discussed in detail at the private Board meeting.
109/20	Finance receive limited assurance due to underlying pay pressures, there was a suggestion that agency costs were plateauing.

110/20	The Health and Safety Group assurance report was unable to resolve the concerns that had arisen from a historical incident involving a hoist. There was a specific request from the Committee for clarity on the number of staff requiring training and the numbers actually trained. There was frustration expressed by the Committee that this was still to be clarified.
111/20	The 4 hour standard was not the position the Trust wished to be in however it had been noted that in recent months the Trust was one of the most improved in the country. There had been improvements seen in streaming and urgent care and the reconfiguration programme had been completed on time. This had supported the improvement but demand remained high.
112/20	It was noted with the cancer standards that there was a steady deterioration of pathology waiting times and the partnership with the pathology board was welcomed by the Committee.
113/20	Regarding the increased risk in relation to water safety, a capital funding bid was being placed with NHS England/Improvement in order to seek support.
114/20	Mrs Libiszewski reiterated the frustration in relation to the Health and Safety issue and inability to identify staff trained in the use of equipment. This had not enabled the Trust to demonstrate that its duty had been carried out. It was acknowledged that this had taken longer to identify than it should.
115/20	Work was being completed in order to have the ability to provide staff member with the competency of the equipment required and the level of training requiring completion.
116/20	It was noted that the work being undertaken in relation to water safety was a replication of the actions undertaken for fire safety with regard to the emergency capital bid. The issue was not currently on the external radar and there would be no allocated pot of funding to access. The Trust had recognised the need to address the issue. Work was being undertaken and reassurance on this could be provided.
117/20	The Chief Executive noted that there was pressure regarding the rebuilding of the NHS nationally and that the current estate and backlog issues were wider than the Trust. It was hoped that the recognition of underinvestment would support improvement moving forward.
118/20	The Trust would need to be in a position to make applications that linked to the Trust objectives as funding support became available.
119/20	The Director of Finance and Digital noted that there was a national review of funding for special measure Trusts, feedback was being provided by the Trust on how capital currently worked. Part of this work would look at the capital spend for financial special measure Trusts.
120/20	The Board noted the need to review the size of the agendas for both the finance and quality committees as there was concern that there was an impact on the ability to discharge responsibilities.
121/20	Linked to this was the move of estates under the Chief Operating Officer. There was a review of capacity and capability to ensure that this was deliverable, there had been a clear message to the Chief Operating Officer to ensure that there was the ability within the departments to deliver.
122/20	The Chief Operating Officer noted that this tied in to the discussions that had been held and if the Trust were smart about using initial capital funding then a number of high impact issues could be dealt with swiftly. This would then provide a different capability of the estates function.

	The Trust Board: • **Received the assurance report**
123/20	**Item 12.2 Winter Plan Update** The Chief Operating Officer presented the report to the Board advising that the winter period by definition commenced 1st December, the actions described within the report commenced on 1st December 2019.
124/20	The Board were reminded that the Trust were one of only 20 organisations with improved performance during December and had been the 4th most improved organisation in the country. This did not however take away from the condition and access issues that were experienced by patients during the period. The Trust were far from the level of performance and access standards it aimed to deliver.
125/20	The demands experienced were greater than planned for in respect of attendances, admissions and ambulance conveyances. The Trust had also needed to shut beds and manage occupancy in a way it would not normally due to staffing issues over the Christmas period.
126/20	There had been benefit seen from the introduction of safety huddles alongside the development of the service, this had resulted in to a joined up approached from individual services. The Urgent Treatment Centre had enabled additional space within majors due to seeing patients in a timely manner.
127/20	Funding had been committed to by the local authority and there was a need to ensure that this was focused in the right places to support services.
128/20	The Chief Operating Officer advised that the midpoint review would be undertaken during February to enable a greater level of assurance to be provided regarding the spend and impact.
129/20	The Board discussed the impact that could have been see if there had been extreme weather. The Board were advised that extreme weather events did not impact the Trust as patients often made different choices. This would usually result in a reduction in demand and conveyances would alter to those most acutely unwell. A sustained reduction in temperature posed more of an issue for the Trust.
130/20	The Chief Operating Officer stated that the Trust were prepared in response to the recent coronavirus outbreak. Preparation was being undertaken through infection, prevention and control and emergency planning. The current risk level had been reported as moderate.
131/20	This remained a lower risk than flu however there was a need to ensure that the Trust did not deviate from how flu was managed due to the change in the countries flu profile. Services had been tested and were aware how to respond to suspected coronavirus patients. The Trust had supported the NHS England response to patients who were not acutely unwell but had triggered the need to be tested and managed.
132/20	The Director of Nursing confirmed that actions had been taken by staff and plans were in place however the Trust had gone further than the national guidance on how staff, patients and the public would be protected. The Trust Board: • **Received the update**

133/20	**Item 12.3 Annual Planning Update** The Director of Improvement and Integration/Deputy Chief Executive presented the update to the Board noting that this provided a view of the current progress for the current framework.
134/20	The financial plan was reported as delivering and on plan however it was reiterated that this was due to the significant support being received from the Clinical Commissioning Groups. The report was factually correct but masked the true position of how delivery had been achieved.
135/20	Mrs Libiszewski noted that there was a need to consolidate the approach to the under pinning strategies of the Trust detailed in the report.
136/20	It was confirmed that the position demonstrated was correct as the paper was reporting for 2019/20 however going forward this would need to be addressed. The Trust Board: • **Received the report and noted the progress**
	Item 13 Providing services by staff who demonstrate our values and behaviours SO3
137/20	**Item 13.1 Assurance and Risk Report Workforce and Organisational Development Committee**
138/20	The Chair of the Workforce and Organisational Development Committee, Mr Geoff Hayward provided the assurance received by the Committee at the December 2019 and January 2020 meetings.
139/20	Mr Hayward noted that the key points to note from the December meeting were the ongoing improvements to the guardians of safe working reporting and the approach to medical engagement with more staff attending the sessions.
140/20	Mrs Libiszewski noted the lack of assurance regarding salary overpayments and suggested that this needed to be supported by both finance and the HR Business partners as there did not appear to be collaborative working.
141/20	The Director of Finance and Digital advised that work had been undertaken regarding overpayments however there was a need to recognise the recent move to an electronic system. Reporting from the system would improve and allow issues to be resolve, it was expected there would be a step reduction from the introduction of the system.
142/20	Mr Hayward noted that the key points from the January meeting had been the assurance received regarding the NHS People Plan and the alignment to the Trusts plan.
143/20	Challenge had been given regarding vacancies not filled by agency or temporary staff and the view had been taken that the Trust was fully staffed. The Committee had identified that the message to staff would need to alter if this was in fact the position.
144/20	The Committee were keen to consider the quality and efficiency of staff and where roles were filled with temporary staff that these were filled correctly. The Medical Director confirmed that this underpinned the issues being seen within the Trust and that there was a need to develop the support in place to identify capability.

145/20	The Director of People and Organisational Development noted that the Trust would likely always be dependent on temporary workers however needed to continue to increase the percentage of permanent staff.
146/20	The Director of Nursing noted that the vacancies for HCAs had been an internal stretch challenge and that this had provided a reflection of where the Trust sat regionally as an outlier. Significant progress to recruitment would be reported to the next Committee meeting.
147/20	The Board were advised of the improvement demonstrated in the initial results from the staff survey however these would be reported when the embargo lifted.
148/20	The Chair questioned the lack of assurance regarding KPIs and job planning. It was noted that there was 70% completion of job plans and the Trust were clear where the gaps remained. A number of those outstanding could be signed off without the need to be sent to a consistency panel.
149/20	There was concern regarding the Emergency Department and the capacity to deliver however this was an area of focus. Job plans would be in place by the end of the year. Future job plans would be linked to capacity and savings based on the organisations direction of travel. The commencement of the e-rostering project would assist in the quality of job plans in place. The Trust Board: • **Noted the assurance report**
	Item 14 Providing seamless integrated care with our partners SO4/
150/20	**Item 14.1 Healthy Conversation 2019 Final Report** The Chief Executive presented the report to the Board advising that this had been produced by the Sustainability and Transformation Partnership (STP) Director of Communications and Engagement. This would be received by all Boards within Lincolnshire.
151/20	The paper had been received for information and comment, summarising the process, activates undertaken and the feedback received. The intention was for the feedback to inform the systems Long Term Plan with the final report aiming to be published early March 2020.
152/20	The paper clearly outlined that engagement activities had included face to face, website and digital to ensure that previous criticism towards engagement had been addressed.
153/20	Mrs Dunnett welcomed the report and the exercise that had been undertaken but questions the 'so what' and 'what next' aspects of the report. There was a need to think innovatively about those key areas of concern held by the public.
154/20	The Chief Executive noted that the process of engagement that had been followed would need to become the norm to support the public to have confidence and trust in the work that would be undertaken.
155/20	The Trust Board support the publication of the final Healthy Conversation 2019 report and requested that thanks were passed to the STP Director of Communications and Engagement for the work undertaken. The Trust Board: • **Received the report** • **Supported publication of the final report**

	Item 15 Performance
156/20	**Item 15.1 Integrated Performance Report** The Chair surmised that the main issues had been discussed through the Committee upward reports and invited that Executive Directors to alert the Board to any further issues.
157/20	The Director of Nursing noted that at the point of writing the narrative regarding three falls incidents in December 2019 where the patient had died was correct. These were now all going through the serious incident process One of the incidents had subsequently been confirmed as a collapse.
158/20	Mrs Libiszewski questions the significant proportion of December data that had not been reported in the February report.
159/20	The Director of Finance and Digital advised that this was understood to be a timing issue however would investigate. There had been discussion held at the Finance, Performance and Estates Committee regarding the need to clearly identify those indicators where data was not available versus data not submitted. Work would continue to ensure timely data was provided. There remained too much manual intervention in the processes and there was a need to consolidate and bring this together in to automated reporting where possible.
160/20	The Chair questioned if the data to support the Integrated Improvement Plan (IIP) would be available from systems rather then spreadsheets.
161/20	The Director of Finance and Digital advised that there was an action within the IIP for this to be addressed to ensure appropriate data reporting and development of the kite marks. Staff would also need to understand the importance of data capture in order to support reporting.
162/20	The Chief Operating Officer noted that the dashboard had been produced on the 16th January 2020 and due to the various national deadlines questioned if it could it be acceptable for the Committees to consider un-validated intelligence. The data would then be validated prior to being reported to the Board.
163/20	The Director of Finance and Digital confirmed that there was full sight on the need to reduce data presented to the Board however background work was required. Time would be needed to set up what was required and work on a model with external support. It was hoped that the Board would be able to receive a streamlined report in May 2020.
164/20	Mrs Libiszewski requested an update on breast cancer services. The Chief Operating Officer confirmed that this had been discussed at the January Finance, Performance and Estates Committee.
165/20	There had not been little impact on the 62 day treatment standard and whilst the 2 week wait standard was not achieved there had been a reduction in the wait from 21 days to 17 days. The issues seen during November and December had been due to surgeon availability. This had been resolved temporarily, however the service remained fragile. The Trust Board: • **Received the report**
	Item 16 Risk and Assurance

166/20	**Item 16.1 Risk Management Report** The Medical Director presented the report to the Board noting that the highest strategic risks remained unchanged.
167/20	There had been an increase in ratings for water safety and infrastructure along with information governance compliance. A new risk relating to overcrowding at Pilgrim in the emergency department had been added.
168/20	The Diagnostics Business Unit raised the risk rating relating to the ageing of a substantial amount of equipment, this was now accurately reflected within the register.
169/20	A discussion took place regarding how the Committees reviewed the risk registers on a monthly basis and the level of assurance being provided within the updates. Expectations were confirmed and where required additional support would be offered to Committee chairs in order to ensure thorough reviews were undertaken.
170/20	Mrs Dunnett noted that audit work was being undertaken in relation to the Sustainability and Transformation Partnership risks, once completed it would allow the Trust to consider the risks and ensure any mitigation required was applied.
171/20	The Chair felt this would form part of the Trusts Integrated Improvement Plan and there would be a need to ensure that this work was integrated.
172/20	The Board noted that there remained concerns regarding the timeliness of updates within the register. The report would require quality assuring prior to being presented to the Board. **Action: Medical Director, 3 March 2020** The Trust Board: • **Received the report** • **Accepted the top risks within the register**
173/20	**Item 16.2 BAF 2019/20** The Trust Secretary presented the paper to the Board noting that there had been a more detailed work through from the Workforce and Organisational Development Committee resulting in additional detail for assurances and mitigation of gaps.
174/20	The Chair noted that this had been worked with for the past year and there had been no improvement in the ratings, this demonstrated that there did not appear to have been a shift forward on the objectives that had been set.
175/20	It was acknowledged however that work is undertaken in a fluid environment and the BAF needed to reflect gaps in assurance functions.
176/20	The Trust Board accepted that the document reflected the current position of the Trust. The Trust Board: • **Received the Board Assurance Framework**
177/20	**Item 16.3 Assurance and Risk Report from the Audit**

	The Chair of the Audit Committee, Mrs Sarah Dunnett provided the assurance received by the Committee at the January meeting.
178/20	The Committee agreed the external audit plan for 2019/20 and were assured that this was consistent with the Trusts own yearend timetables.
179/20	A number of internal audit reports were in the final stages of productions and the Committee were assured that there would be completed by year end and an additional telephone meeting had been arranged prior to the year end sign off any outstanding reports.
180/20	The draft internal audit plan for 2020/21 was received and there was a need to ensure maximum assurance was gained across the areas of concern. The final plan would be received at the April Committee meeting.
181/20	The Committee were assured regarding counter fraud however noted that the resource was stretched. The Director of Finance and Digital was currently reviewing the counter fraud resource.
182/20	The Corporate Governance Manual was received and recommended to the Board for approval. It was noted that the only additional items had been changes to the scheme of delegation.
183/20	The Committee noted that work was required to ensure avoidance of duplication of reports through the Committees, Audit Committee and to the Board.
184/20	The Sustainability and Transformation Partnership (STP) governance work was underway looking at how risks were managed within the STP however the Committee were not assured in respect of risks relating to the STP.
185/20	Mrs Dunnett advised the Board that the external auditors wished to increase the fee for this year and discussions would be held between the Director of Finance and Digital and the auditors. The fee increase was being driven by a change in the definition of a high profile client by the national body. The Board were advised that Pricewaterhouse Coopers had not bid for the new contract with the Trust and would not extend the current contract. There would be a new external auditor for the Trust from April 2020 at an increased fee. The Trust Board: • **Received the report**
186/20	**Item 16.4 Trust Corporate Governance Manual – Standing Orders, Standing Financial Instructions and Scheme of Delegation** The Trust Board received the Corporate Governance Manual and were advised that this had been considered by the Audit Committee and reviewed by internal and external audit, as well as the Local Counter Fraud Specialist.
187/20	All who had reviewed the document were satisfied with the content. The Trust Board therefore agreed to the approval of the corporate governance manual. The Trust Board: • **Approved the Corporate Governance Manual – Standing Orders, Standing Financial Instructions and Scheme of Delegation**
	Item 17 Strategy and Policy

188/20	**Item 17.1 Amendment to Voting Rights for Trust Board** The Trust Board received the proposed amendments to the voting rights. These had been put forward to the Board due to the change of Executive Directors.
189/20	The Trust Board approved the amendments to the voting rights with immediate effect. The five voting members of the executive would be • Chief Executive • Medical Director • Director of Nursing • Director of Finance and Digital • Director of Improvement and Integration/ Deputy Chief Executive The Trust Board: • **Approved the voting rights of the Board**
190/20	**Item 18 Board Forward Planner** For information The forward planner would be updated once the Integrated Improvement Plan was in place, this would then be reflected through the Committees.
191/20	**Item 19 ULH Innovation** The Board had received the innovation papers for information. Congratulations would be passed to staff within Clinical Engineering for the work undertaken as part of the Quality, Service improvement and Redesign programme.
192/20	The second paper received was in relation to the Veteran Aware accreditation achieved by the Trust. Thanks were given to the Medical Director who had supported the work undertaken to achieve the accreditation for the Trust. The Trust Board: • **Received the reports**
193/20	**Item 20 Any Other Notified Items of Urgent Business** The Chair advised the Board the Chief Executive's secondment with the Trust, that had been due to finish at the end of March, had been approved for extension by the Remuneration Committee. The Chief Executive would continue with the Trust until 31st March 2022.
194/20	The Board were advised that Mr Shaun Lyons had been appointed as Chair by the Clinical Commissioning Groups, this appointment would be effective from 1st April 2020.
	The next meeting will be held on Tuesday 3 March 2020, Boardroom, Lincoln County Hospital, Lincoln

Voting Members	5 Feb 2019	5 Mar 2019	2 Apr 2019	7 May 2019	4 June 2019	2 July 2019	6 Aug 2019	3 Sept 2019	1 Oct 2019	5 Nov 2019	3 Dec 2019	4 Feb 2020
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X

Chris Gibson	X	X	X	X	X	X	X	X	X	X	X	X
Geoff Hayward	A	A	X	A	X	X	X	A	X	X	X	X
Gill Ponder	X	X	A	X	X	X	X	A	X	X	X	X
Jan Sobieraj	X	X	X	X	X							
Neill Hepburn	X	X	X	X	X	X	X	A	X	X	X	X
Michelle Rhodes	X	X	A	X	X	A	A	X				
Kevin Turner	X	X	X	X	X	X	A					
Sarah Dunnett	X	X	X	X	X	X	A	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	A	X	X	X
Alan Lockwood	X	A										
Paul Matthew	X	X	X	X	X	X	A	X	X	X	X	X
Andrew Morgan						X	X	A	X	X	X	X
Victoria Bagshaw									X	X	X	X
Mark Brassington									X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
4 June 2019	884/19	National urgent care pathway changes	Board to receive update when available.	Brassington, Mark	~~30/09/2019~~ ~~5/11/2019~~ 04/02/2020	The national review was awaited and would form part of the operational framework due to be published. Further guidance was expected in March. The Chief Operating Officer would report back to the Board once guidance had been received. Complete
2 July 2019	1062/19	People Strategy	Develop some ambitious outcomes, built up with colleagues within the divisions. Through ET in first instance. Develop forward plan for rest of this year. Strategy back when ready	Rayson, Martin	~~06/08/2019~~ ~~04/02/2020~~ 03/03/2020	Awaiting completion of Integrated Improvement Plan. Decision to be made to confirm if still required as separate strategy.
6 August 2019	1186/19	QGC Assurance report	Review of window cleaning impact on cleanliness audit	Evans, Simon	~~03/09/2019~~ ~~3/12/2019~~ ~~04/02/2020~~ 03/03/2020	QIA being revisited then being reconsidered at CRIG. Upward reporting through QGC to Board.

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

1 October 2019	1576/19	Smoke Free ULHT	Post implementation review to be presented to the Board	Rayson, Martin	07/04/2020	
1 October 2019	1641/19	NHS Improvement Board Observations and actions	Updated action plan to be presented to the Board	Warner, Jayne	~~03/12/2019~~ ~~4/12/2019~~ 07/04/2020	Audit Committee reviewed actions in Jan meeting. Will review again in April
1 October 2019	1642/19	NHS Improvement Board Observations and actions	Audit Committee to receive reports and action plans	Warner, Jayne	~~14/10/2019~~ 07/04/2020	Audit Committee reviewed progress at January 2020 meeting. To review again in April
5 November 2019	1679/19	Patient/Staff story	Assurance required by the Board that whilst the Trust policy was under review that staff who go off site during their shift were tracked	Brassington, Mark	3/12/2019	Work in progress. Policies and processed had been reviewed and were deemed fit for purpose. The issue was ensuring that these were followed at the point at which a staff member left the site. Complete
5 November 2019	1747/19	Assurance and Risk Report Finance, Performance and Estates Committee	Business case review of fire works to be completed and reported back to Finance, Performance and Estates Committee detailing spend	Matthew, Paul	~~3/12/2019~~ 03/03/2020	Due to FPEC in January. Report back to TB Feb Update included within upward report however further work required

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

3 December 2019	2026/19	Patient Safety Report	Question to the Executive Team regarding the triangulation of the information presented to the Board in relation to the operational pressures being faced by the organisation at the time. A one page report would be sufficient until more meaningful reporting was in place.	Matthew Paul	~~4/02/2020~~ 03/03/2020	Work to be concluded on report in March, deferred to 3 March 2020
3 December 2019	2048/19	CQUIN Medicines Optimisation workforce review	The Improvement Director offered to contact the Pharmacy Lead from NHS England/Improvement for support.	Hepburn, Neil	4/02/2020	Discussions were taking place with Richard Seale and conversations had taken place with Pharmacy staff. Complete
4 February 2020	049/20	Integrated Improvement Plan	Board to receive IIP programme of delivery, identifying how changes would be maintained and embedded	Brassington, Mark	05/05/2020	
4 February 2020	077/20	Assurance and Risk Report Quality Governance Committee	Review of TOM and governance to be presented to the Board	Brassington, Mark	07/04/2020	
4 February 2020	079/20	Assurance and Risk Report Quality Governance Committee	Consideration of how referred items between Committees could be addressed sooner	Warner, Jayne	03/03/2020	Items would now be referred immediately to lead executive by Deputy Trust Secretary to remove month long delay in referral. Complete
4 February 2020	172/20	Risk Management Report	Risk Report to be quality assured prior to presentation to the Board	Hepburn, Neill	03/03/2020	

Agenda Item: 7

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Andrew Morgan, Chief Executive
Date:	3 March 2020
Healthcare standard	

Title:	Chief Executive's Report

Author/Responsible Director: Andrew Morgan, Chief Executive

Purpose of the report:

To provide an overview of key strategic and operational issues.

The report is provided to the Board for:

Information	√	Assurance	
Discussion	√	Decision	

Summary/key points:

This report is for discussion and information. It provides a high level overview of both System and Trust specific issues.

Recommendations:

The Trust Board is asked to:

- Note the content of this report
- Discuss progress against System and Trust specific issues and note where good progress has been made and where additional work is required.

Strategic risk register	**Performance KPIs year to date**
Resource implications (eg Financial, HR)	
Assurance implications	
Patient and Public Involvement (PPI) implications	
Equality impact	
Information exempt from disclosure	
Requirement for further review?	

System Issues

a) Organisations across the system have put in place arrangements relating to the containment of the Coronavirus. These arrangements comply with the guidance issued by Public Health England

b) All organisations are working in the remaining weeks of the financial year to try and deliver a financial outturn that is no worse than a combined £95m deficit. This must be compared to the original control total for the system of a deficit no greater than £65m. A piece of work is being commissioned to better understand how and why the financial situation has deteriorated and what lessons need to be learned going in to 2020/21

c) The system has been set a revised financial trajectory of a combined deficit of £51.811m in 2020/21. If this is delivered, this would result in the receipt of £53.911m from the national Financial Recovery Fund (FRF), leading to an outturn of a surplus of £2.101m for the year

d) Further detailed work is being done to produce the first draft of the Lincolnshire Operational Plan for 2020/21. This needs to be submitted to NHSE/I by 5th March. The Lincolnshire Co-Ordinating Board has discussed how best to secure Board and Governing Body assurance and sign-off of the plan

e) The next system review meeting with NHSE/I takes place on 4th March. This will focus on the key performance metrics including urgent and emergency care, cancer waits, waiting times, mental health out of area placements, learning disability transforming care programme and the financial position. Progress towards an ICS is also likely to be discussed

f) The Joint Working Executive Group (JWEG) is meeting on 26th February to discuss progress with the establishment of the shadow Integrated Care System

g) The three NHS provider organisations in the county (ULHT, LCHS and LPFT) have agreed to enter into a more structured strategic partnership and alliance arrangement in order to support service transformation in the Lincolnshire system. This is likely to take the form of a signed agreement. It is anticipated that this will be extended to include Primary Care Networks (PCNs) following a positive half-day development session held with PCNs on 13th February

h) Sarah Furley has now left her post as Programme Director for the STP, following her appointment to a Director post at Nottinghamshire Healthcare NHS FT. Peter Burnett has replaced Sarah and joins on secondment from NHSE/I where he was an Assistant Director of Strategy and Transformation. Pete will bring some of his NHSE/I

responsibilities with him in his new role, bearing in mind that Lincolnshire was his patch at NHSE/I.

Trust specific issues

a) At Month 10, the Trust is reporting a deficit of £39.774m compared to the plan of a deficit of £36.527m. This is an adverse variance of £3.247m. The underlying position is however a negative variance to plan of £23.048m once transitional relief and other flexibilities are taken into account. Excluding year-end support from the Lincolnshire CCGs, which will ensure the Trust achieves the control total of a deficit of £70.3m, the forecast year-end position if the remaining risks are not mitigated is a deficit of £95.2m

b) The results of the national NHS staff survey 2019 have now been published. The survey took place in September/October 2019. The Trust had a 50% response rate, which is a record high response rate for the Trust. There was a positive upward movement in the majority of responses compared to 2018 but the Trust is still some way off reaching the average for acute Trusts. Although the improvement is welcome and the responses seem to indicate that the Trust is going in the right direction, there is a considerable amount of work still to be done. This is a key feature of the Trust's Integrated Improvement Plan

c) Throughout March, there are a number of 'Big Conversation' briefing sessions with staff about the Integrated Improvement Plan. The sessions are being run at different locations and at different times of the day and night in order to make it as easy as possible for staff to attend one of the sessions

d) It is anticipated that the CQC will publish their reports following their quality visits to the Emergency Departments at Lincoln County Hospital and Pilgrim Hospital, in the week commencing 24th February

e) Dr Karen Dunderdale has now commenced as the Trust's new Director of Nursing

f) Plans are being developed for the Trust to undertake a Well-Led self-assessment as part of the ongoing development of the Board and in readiness for a future CQC inspection

g) The next ELT development session with Mark Withers, the Trust's external OD partner takes place on 28th February. The focus of the session takes account of the new membership of the ELT and will address themes relating to culture, leadership behaviours and trust.

Agenda Item

NHS
United Lincolnshire Hospitals
NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	24th February 2020
Chairperson:	Chris Gibson, Non-Executive Director
Author:	Jayne Warner, Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme. The Committee worked to the 2019/20 objectives.
	Lack of Assurance in respect of SO 1a Issue: Delivering harm free care Lack of assurance QGC Performance Report - Open incidents awaiting investigation. The Committee were advised that around 50% were beyond the 4 week deadline (~~-~~approx. 2250) The longest overdue incident was 18 months old. The Clinical Governance team were working with divisions to address the backlog and avoid creating any further backlog. The Committee were advised that a new trajectory for clearing the overdue cases was going to the March QSOG meeting. A harm review had been carried out. Lack of assurance QGC Performance Report -Medication Incidents and Harm. The Committee ~~asked for a review of the~~queried the reported trend in the % of medication incidents causing harm~~,~~. ~~N~~noting that the classification "causing harm" included ~~harm~~ incidents from low harm through to death. The Medical Director reported that a review of the "harm" classification process would be undertaken. Lack of assurance QGC Performance Report -The Committee were alerted to a fall leading to death. This incident was going through the RCA process. The Committee noted that in the previous month there had been three falls leading to death. However, one of those incidents had now been confirmed as a result of collapse. The Committee ~~were advised that whilst Trust data was rebased on monthly basis this was not the case with the national safety thermometer meaning that collapses will remain within the data.~~noted that overall falls performance was better than the national average. Lack of assurance QGC Performance Report - Category 2 pressure ulcers. The Committee noted that there had been a spike in December. This would be investigated to understand whether it was related to delays in

	reporting. Source of assurance QGC Performance Report - The Committee noted the ~~rise in~~issue of Post partum haemorrhage was addressed within the Maternity update. A deep dive had been completed which identified a need for improved recognition of high risk women and improved management of the third stage of labour. An action plan was in place and there would be ongoing audit to monitor progress. Source of assurance Upward report from Quality and Safety Oversight Group – The group had received the Annual Report from the Lincoln HIT Team. The group had noted that falls were an issue for one particular ward area at Boston. The Committee noted that this was a ward with high acuity. The Deputy Director of Nursing advised that this was one of the wards for which the staffing review presented to the February Trust Board had requested increased staffing. The Committee noted the increasing detail and quality of QSOG reports. Source of assurance Research Upward Report – The Committee received a refreshed Governance approach for RD&I. The Committee discussed the route for reporting and agreed that this should be considered as part of the wider review of the Quality and Safety Oversight Group. A recent internal audit report had identified a large number of areas requiring improvement. The action plan to address these was reviewed. Lack of Assurance Infection Prevention and Control Visit – The Committee noted that there was challenge around how sighted the IPC Group and the Committee had been on the issues which were raised during and after the visit. The Trust had engaged external support. The Deputy Director of Nursing acknowledged that ~~there was an issue that~~some of the processes in place for assessing cleanliness had given ~~a~~ false positive results. The Trust had initiated with immediate effect walk rounds for the IPC lead. An action plan in response to the issues would be shared with the Committee in March and then Trust Board in April. Lack of Assurance Clinical Audit Report – The Committee were advised that the Trust was taking part in both National and Local audits but the results were not always good, and the learning was ~~Trust were~~ not always disseminated~~clear on the learning as a result~~. There was variation between sites and divisions in engagement. The Committee asked that the clinical effectiveness ~~committee~~ group identify what the risks were from the report and what the level of assurance was. Source of assurance Family Health Update- The Committee received an update on maternity services. In future the Committee would receive the

	maternity dashboard within the report. The Committee received a proposal in respect of Neonatal services proposing a return to 32 weeks gestation for Pilgrim SCBU in February 2020 and 27 weeks for Lincoln Neonatal unit from August 2020. The Committee were advised that the Neonatal network was supportive of the proposal. The Committee agreed that the paper would be merged with that relating to the wider paediatric model and presented to the Trust Board in April. Lack of assurance NICE Q3 Report – The Committee were advised that the Trust were not compliant with all of the NICE ~~guidance baseline~~Clinical Guidelines assessments, nor the NICE Technology Appraisals. Some of the latter dated back more than 10 years. The Chief Pharmacist reported that a risk based approach to the backlog of Technology Appraisals was in place.~~Committee noted that risks had not been assessed and the non compliance was not planned.~~ Source of assurance 2020/21 CQUIN scheme proposal - The Committee were advised that the 5 proposed schemes had been agreed as a system. The schemes were aligned with the Trust Integrated Improvement Plan and the Quality Account priorities. Work would now commence on the measures. The Committee would receive quarterly report. Source of assurance Quality Account Priorities – The Committee received and approved the quality account priorities and commended the clear ~~which were~~ align~~ed~~ to CQUIN schemes and the IIP. Lack of Assurance Medicines Optimisation Report – The Committee noted that the aseptic temporary unit was now in place at Pilgrim and expressed thanks to the staff for their work in ensuring continuity of supply. The Chief Pharmacist reflected on the medication incidents causing harm data. The report included detail of absolute numbers rather than just percentages, which were ~~.~~ S~~s~~till above peer and national median. The actions proposed were to ~~i~~dentify~~ied a~~ trend~~s~~ in respect of specific drugs and improve ~~. Actions taken in target areas. E~~engagement with the pharmacy team. ~~Risks within the NICE TA backlog. Trying to risk assess the TAs to see which tackle first. Risk need bringing to committee attention.~~ Lack of Assurance CQC Must Do and Should Do Actions – The Committee noted that they had not received a report of progress against the must and should do CQC actions. The Committee noted that the System Improvement Assurance Group were expecting a detailed report in March. The Committee agreed to escalate this to Trust Board.
Issues where assurance remains outstanding for escalation to the Board	As recorded above the progress against the must and should do actions from the CQC report was not available. To escalate to Board

Items referred to other Committees for Assurance	No items referred to other committees
Committee Review of corporate risk register	The Committee reviewed the risk register noting that there had been no major changes to the document.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee noted that the Board Assurance Framework had been reviewed since the last meeting. The Committee noted that the BAF was in the process of being realigned to the IIP for 2020/21.
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	No areas identified.

Attendance Summary for rolling 12 month period

Voting Members	F	M	A	M	J	J	A	S	O	N	D	J	F
Elizabeth Libiszewski Non-Executive Director	X	X	X	X	X	X	A	X	X	X	X	X	A
Chris Gibson Non-Executive Director	X	X	A	X	X	A	X	A	X	A	X	X	X
Alan Lockwood Int Non-Executive Director	A	A											
Neill Hepburn Medical Director	X	X	X	D	X	X	X	X	X	X	X	X	X
Karen Dunderdale Director of Nursing													X
Michelle Rhodes/ Victoria Bagshaw Director of Nursing	X	X	X	X	X	X	X	D	X	X	X	X	X

X in attendance A apologies given D deputy attended

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Quality Governance Committee**
From:	Victoria Bagshaw – deputy Chief Nurse Kevin Shaw – Lead IPC Nurse
Date:	20th February 2020
Healthcare standard	

Title:	NHSEI infection Prevention and Control Visit to the Trust.

Author/Responsible Director: Director of Nursing/ Director of Infection Prevention and Control

Purpose of the Report: To update QGC on the recent Infection Prevention and Control (IPC) visit by the NHSEI regional Infection Prevention (IP) lead and subsequent actions taken by the Trust

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Information	X

Summary/Key Points:

NHSEI visited the Trust on the 21st and 22nd January 2020. The visit was requested following the findings identified in the CQC report released in October 2019. As such, the Trust was assessed as NHSEI IP internal escalation level AMBER. Following this visit and the IP breaches observed across the two sites but more noteworthy at the Lincoln site, the Trust has been escalated to RED.

The issues identified fall into the following areas:

- Governance including
  - The focus and detail of speciality Governance and escalation of issue through the corporate governance structure
  - Estates ownership and lack of timely resolution of environmental issues
- General environmental cleaning and standards
- Clinical cleaning and standards

The letter from the IP lead at NHSEI following the visit is attached at appendix 1. The Trust responded immediately to the escalation with a number of immediate actions these are captured in the attached Trust response letter at appendix 2.

Governance: A number of the issues raised during the visit, had been identified over the past 12 months by the Director of Nursing/Director of Infection Prevention and Control and had been escalated through the Trust governance processes to Quality and Safety Oversight Group and Quality Governance Committee. Whilst actions had been put in place to both mitigate and resolve these risks, the reporting into IPC was not robust so escalations did not reflect the depth and breadth of the organisational risk. Further work has been undertaken to strengthen Governance, including through a review of the IP standard within the accreditation programme, increased IP Audit visits by the IPC nurses to wards and IP focused visits by the Divisional nurses and their teams. Regular reports from these will be provided to the Infection Prevention Group and through the subgroups to Quality Governance Committee and subsequently Trust Board.

A review of the internal estates systems, processes and governance is being undertaken. A visit has been arranged to an NHSEI recommend Trust that has good estates process. The Trust is also in the process of securing an external consultant who will

- Review the process for managing risk of minor works/backlog maintenance
- Review the existing backlog maintenance with this process and prepare necessary cases and actions plans for resolution.

General environmental cleaning and standards: deep cleaning has been undertaken in the areas that were specifically identified. These have been reviewed and signed off by the Deputy Chief Nurse and Lead Nurse for Infection Prevention Control (IPC). The lead nurse for IPC is working with the estates team to undertake the actions identified with the Trust immediate response related to education, training and cleaning sign off. The Acting Director of Nursing, immediately following the visit, reviewed all cleaning Cleanliness Audits for the Trust and requested additional actions for further cleaning.

Clinical cleaning and standards: Immediately following the visit, responsibility for clinical cleaning was discussed with the nursing teams (ward sisters, lead nurses and Divisional nurses) and the Acting Director of Nursing reiterated expectations and standards. All actions outlined in the letter have commenced. Further to this, the trust has identified its intention to adopt the recently relaunched national Matrons Handbook, which makes clear reference to matron responsibilities for Infection Prevention.

Further immediate improvements and actions have been completed. A comprehensive action plan based around the hygiene code is being finalised. This will be discussed and refined further through the IPC Trustwide Group and escalated through the governance structure to Quality Governance Committee. The issues raised by this visit were discussed at the February next Quality Governance Committee.

Additionally NHSEI have requested

- The draft report is accuracy checked within 5 working days. – **Action Complete**
- The report with the Trust Board within 10 working days and confirm by email that this has been undertaken – **Action Complete**
- An NHSEI review visit is scheduled for 20th May 2020 to review progress and re-assess the escalation level

Infection Prevention and Control Assurance / Escalation Report
February 2020

1. Introduction

This report is intended to highlight the issues identified during the visit undertaken by NHS England and Improvement on the 21st and 22nd of January 2020 and the subsequent actions put in place to address them.

The visit was initiated based on a 'must do' action within the CQC report, which related to hand hygiene failures in Children's and Young Persons services, and the concerns highlighted by the CQC relating to care in the Emergency Departments. As such, the Trust was assessed as NHSEI IP internal escalation level AMBER. During this visit, IP breaches were observed across the two sites but more noteworthy at the Lincoln site, as a result the Trust has been escalated to RED. It was recognised that a number of the issues were symptomatic of a number of long-term issues in the Trust.

2. Key findings

The specific areas of concern identified were across three areas:

- Governance including
    - The focus and detail of speciality Governance and escalation of issues through the corporate governance structure
    - Estates ownership and lack of timely resolution of environmental issues
- General environmental cleaning and standards
- Clinical cleaning and standards

There were some aspects of good practice noted including the improved level of hand hygiene and dress code compliance. This showed improvements on the findings from the CQC report. Other notable improvements identified on Pilgrim site where the Children's and Young Persons Ward, which the NHS England and Improvement team gave a green rating.

3. Findings from the NHSEI visit.

Following the visit the Acting Director of Nursing / Director of Infection Prevention and Control (DIPC)) convened at meeting to discuss the Trust response and to ensure that robust and effective actions are in place to manage the identified issues. These will be incorporated in the Trusts action plan mapped to the Hygiene Code and progress against these reported monthly to the Trust IP Group

The letter from the IP lead at NHSEI following the visit is attached at appendix 1 and details the areas where the Trust is not meeting expected IP standards. The Trust responded immediately to the escalation with a number of immediate actions these are captured in the attached Trust response letter at appendix 2.

The Trust assessment of the findings showed that significant work was needed to improve the systems and processes used to assess, support and improve IPC standards in ULHT. Further input with housekeeping teams to ensure a better understanding of IP fundamental principles and cleaning and with clinical teams regarding their responsibilities needs to occur. This work will be supported by a

process that will effectively monitor and escalate IPC concerns or lack of progress to the appropriate level with oversight by the DIPC.

4. Planned Actions

Immediate actions were taken in the 48 hours following the visit. There are captured in the Trusts response letter, which the NHSEI IP lead responded to confirm this was an appropriate and comprehensive response.

A detailed plan aligned to the hygiene code which describes a series of robust and sustainable actions designed to address the identified issues is being finalised. Delivery and scrutiny of this on a continuous basis reported through the Trusts governance will be used to provide assurance through the governance process.

4.1 Governance:

A number of the issues raised during the visit, had been identified over the past 12 months by the Director of Nursing/Director of Infection Prevention and Control and had been escalated through the Trust governance processes to Quality and Safety Oversight Group and Quality Governance Committee. Whilst actions had been put in place to both mitigate and resolve these risks, the reporting into IPC was not robust so escalations did not reflect the depth and breadth of the organisational risk. A review of reporting process and the sources of evidence provided to the Trustwide IP Group has been undertaken. This includes;

- A review of the IP standard within the accreditation programme to ensure it continues to meet all aspects of the Hygiene code and reviews the areas raised during the visit. The IP outcomes from ward accreditation will be reported through monthly to the Trust wide IP group.
- Increased standardised IP Audit visits to wards and departments by the IPC nurses. The change in audit process introduced by the Lead for IPC in April 2019 was intended to provide more focused support Ward and Department leaders to develop improvement plans to achieve green for the IPC metrics. This was based on the assumption that there was a robust process for good identification of IPC lapses in basic cleanliness and hygiene standards. The outcomes from these visits will br incorporated into the monthly Trust wide IP Group in addition to the direct feedback which is provided at the time to ward and departments.
- IP focused visits by the Divisional nurses and their teams, the outcome from these will be discussed in the Disional IP groups and tracked through the Divisional clinical cabinets governance reports also report through the the Trusst wide IP Group.

the triangulation provided through this additional activity is expected to strengthen Governance and escalation to the Infection Prevention Group and through the subgroups to Quality Governance Committee and subsequently Trust Board.

A review of the internal estates systems, processes and governance is being undertaken and the Estates and Facilities directorate and the IPC team will develop a risk based system to address the areas identified regarding poor governance and management of reported issues. There is currently no system in place to grade (by risk) a maintenance task for a clinical area. There is also no process to escalate when these priority works are not completed within the designated timescales. The new system being developed by Estates and the IPC team with assistance from a partner organisation (UHNM) will address the system failings identified by NHS England and Improvement. Additionally an external consultant has been appointed to work in the Trust to immediately

- Review the process for managing risk of minor works/backlog maintenance
- Review the existing backlog maintenance with this process and prepare necessary cases and actions plans for resolution.

4.2 General environmental cleaning and standards:

The governance and assurance process relating to IPC was not robust and some of the systems used to gain assurance including the MIC4C cleaning audits did not present an accurate assessment of the expected standards of hygiene within our care settings. Deep cleaning has been undertaken in the areas that were specifically identified. These have been reviewed and signed off by the Acting Director of Nursing and Lead Nurse for IPC. The lead nurse for IPC is working with the estates team to undertake the actions identified with the Trust immediate response related to education, training and cleaning sign off. The DIPC has reviewed all Cleanliness Audits for the Trust and requested additional actions for further cleaning.

The IPC Specialist Nurses, along with their respective Ward and Department managers and Link Nurses have been tasked with undertaking an audit of each clinical area to demonstrate the expected level of cleanliness and hygiene for IPC compliance. After this, the follow up audit will be undertaken by the Ward and Department managers under the supervision of the IPC Nurse Specialists to ensure that as a system we have confidence at an operational level that managers are aware of the expected standards.

4.3 Clinical cleaning and standards:

Immediately following the visit, responsibility for clinical cleaning was discussed with the nursing teams (ward sisters, lead nurses and Divisional nurses) and the Acting Director of Nursing reiterated expectations and standards.

An initiative called 'Brilliant Basics' aimed at reinforcing the key messages around fundamentals of care delivery. The IPC aspect of this has been pulled forward from 1st April to commence in February 2020. The initiative has been modified from the original concept and now will have monthly themes covering all aspects used in the Ward Accreditation metrics focussing on expectations that all wards and departments will move to GREEN and what they need to do to achieve this. This will start with IPC and regular key messages, projects and competitions will be used to drive these key messages in clinical areas.

To support the Ward Accreditation system, a member of the IPC team will support the Quality Matrons on each Ward Accreditation. This will ensure consistency in the IPC metrics and ensure that the cleanliness and hygiene areas are properly assessed. The IPC team can then work with the respective Ward and department managers to develop an action plan to address areas that did not meet expectations during the Accreditation visit and ensuring that ward sisters and link nurses are undertaking their own assessments of their environments, cleanliness and IPC in a robust manner.

Specific focused work has been commenced with ward sisters and link nurses to ensure they are clear about IP audit, escalation the information available to staff and patients about IP in their areas. This includes enhanced IP audits and golden hours.

There is an intention to adopt the relaunched 'Matrons Handbook'. This is a new national document to reinvigorate the role of the Hospital Matron, which will also support the IPC roles and responsibilities and will reinforce the key role of the Matron with IPC practice standards in their respective areas of responsibility. The matrons

are involved in the adoption and launch of the handbook and the IPC Nurse Specialists will provide advice and support to the Matrons to ensure that they are well prepared for this role.

5. Conclusion

Although the report findings were disappointing, the teams are confident that those findings can be rectified quickly. Trust board are asked to note the immediate actions that have been taken to address the poor performance.

The environmental and clinical cleanliness issues are being addressed and overseen by the Trusts Lead nurse for IPC to ensure all immediate cleanliness. Priority IP estate work has already commenced.

The governance structures regarding reporting and escalating concerns regarding Estates and Facilities matters will, once in place, address the issue of managing priority tasks in clinical areas.

A detailed improvement plan mapped against the hygiene code is being finalised and will be discussed at the IP Group and then shared with Quality Governance Committee and Trust Board.

A review visit by the NHSEI IP Lead will be undertaken on 20th May 2020 to review progress and re-assess the escalation level.

Birmingham Office
St Chads Court
213 Hagley Road
Birmingham

23rd January 2020

Victoria Bagshaw: Director of Nursing.
United Lincolnshire Hospitals NHS Trust.
Greetwell Road,
Lincoln,
LN2 5QY.

Dear Victoria and Kevin
Re: *NHS Improvement Infection Prevention (IP) visit; 21st and 22nd January 2020.*

I would like to thank you for organizing the visit to United Lincolnshire NHS Trust on the 21st and 22nd January 2020. The visit was requested following the findings identified in the CQC report (Appendix2) released October 2019. As such, the Trust was assessed as NHSEI IP internal escalation level AMBER. Following this visit and the significant IP breaches observed across the two sites but more noteworthy at the Lincoln site, the Trust has been escalated to RED.

I was accompanied today by Vanessa Wort: Deputy Director of Nursing and Quality. At your request the IP lead from the Local Authority joined the visit as the Clinical Commissioning Group (CCG)does not have an IP lead.

Feedback on the concerns identified was provided prior to leaving the Trust. Your staff accompanied us during the clinical visits and took photographs for your assurance on what was observed (see appendix).

.

Key themes identified:

- Governance:
  - Failure of estates to report by escalation to the IP committee their inability to address high risk repairs in a timely manner.
  - Poor attendance by committee members at the IP committee.
  - Drift on IP committee action plans.
- Failure of estates to undertake remedial action on high risk item e.g. hand wash basins.
- Staff have been informed by estates that repairs not carried on key safety items due to finance restrictions.
- Mattress/Gurney ingress on the majority of items checked.
- Staff unaware of their roles and responsibilities in relation to IP.
- COSHH breaches.
- Legionella risks not addressed.
- Cleaning assurance failures.
- Kit store under U bend of sinks.
- Dirty nursing equipment.
- Crash trollies signed as being cleaned daily by registered nurses but were in fact very dusty.

I would urge the Trust to take immediate action to:

- Raise awareness of their staffs roles and responsibilities for IP.

- Undertake an immediate review of all mattresses/Gurney tops to identify the overall risk.
- Request an immediate report from estates identifying top three IP risks (e.g. hand wash basins etc). Identifying when work was initially logged, outstanding work required and planned correction date.
- Address the communication that has gone to staff that estates issues will not be addressed due to finance. I am concerned that this will stop staff from reporting issues

Summary of visit.
The visit consisted of a review of:
- Key IP Trust documents.
- Discussions with staff.
- Visits to the clinical areas

HCAI data:
C. difficile: 53/110
Lapse in care: 17 for Q1-2
MRSAb= 3

HCW flu vaccination uptake: w/e 5th January 2020 = 67%

Documents: You kindly sent me a variety of documents to review prior to the visit.
My comments are:
IPC Assurance report dated 11th December 2019:
Document shows discussion around cleaning, Hygiene Code gap analysis, concerns and actions being undertaken. However, it does not always note what actions are being undertaken e.g. blood culture contamination at Pilgrim is 6% but no actions noted.
Hand Hygiene Audits: appear to be around 80%; is this self-assessment or peer review?
Clostridioides difficile/MRSA themes: themes identified but no actions noted or success of interventions.
Annual Report: reviews against the Hygiene Code.
IP Committee Terms of Reference: last reviewed in 2013- out of date. **ADVISE** that this requires addressing as a priority.
Bundle packs from IP committee. General comments:
- Chaired by DIPC/deputy.
- Poor attendance and according to the ToR these do not appear to be quorate e.g. poor attendance, lack of admin support, no microbiologist in attendance etc.
- Poor report submission by those who are expected to attend.
- Clear drift on action plan timeline due to poor attendance and lack of assurance submission.

Therefore, there appears to be poor oversight and governance of IP. **ADVISE** that this requires addressing as a priority.
Web page:
- DIPC annual report published.
- Flu discussed.
- Patient leaflets are out of date e.g. C. difficile, MRSA, isolation. **ADVISE** that this requires addressing.

Two-year plan: discusses assurance against the hygiene code and risk assessment.
Divisional IP action plan: not dated from when it started, no progress identified, but has been reviewed in December 2019.

Discussion:

IP team:

- The IP team is led by the Band 8C. The team consists of x2 Band 7s, X4 Band 6s and x1 Band 3. The team does not have a data analyst, this will be part of the Band 3 role.
- The Team meets with the DIPC weekly.
- The IPS audit toll in addition to locally developed tolls are used for assurance.
- IP is in everyone's' job description.
- Mandatory training compliance is currently at 89%- the team are working on this.
- Hygiene Code compliance is around 97%.
- The trust holds an IP risk register.
- The IP team would be part of the Winter pressures group- however this is now "business as usual" and not just for Winter.
- The area has a newly formed health economy group to look at delivering the Gram negative agenda.
- The team uses a RAG rating system for ward accreditation. We were advised that there are no wards at Lincoln site which are Green. **ADVISE:** To review approach as there should be an expected improvement or questions asked why staff are not delivering a safe environment in a timely manner. Static Amber is not acceptable and practices observed in the clinical areas need attention.

Estates:

- The Trust has an authorizing engineer (AE) for Water: Water Solutions. AEs for decontamination and ventilation are out for tender.
- The executive with Board responsibility is the Chief Operating Officer.
- Estates strategy is being finalized.
- Key risks: estates and water.
- Back log maintenance= £250 million.
- 5 year strategy for ward refurbishment.
- The trust has an aspergillus policy.
- The estates team involves the IP team in refurbishments as per HBN 00-09.
- ERIC returns are completed.
- NHS PAM is not yet completed- this is on the risk register.
- Water Safety group involved clinicians.
- Contractors receive IP training requirement as a part of their contracts.
- Written reports are presented to IP committee.
- **ADVISE**: on walking around the wards there are some significant estate issues- therefor advise a strengthened report by escalation of key outstanding risks.

Cleaning:

- The Trust has confirmed they have a cleaning policy which denotes roles and responsibilities and each ward has a cleaning schedule.
- The ED does not have 24hr cleaning. There is a gap of around 6hrs overnight. When required theatres provide cover. **ADVISE** to review the impact this has on theatres and whether an alternative approach is required.
- Cleaning products are standardized: Chlorclean and HPV.
- Cleaning terminology is standardized: RAG.
- Written reports are provided to the IP committee.
- MiC4C audit toll is used.
- Cleaning audit results are provided for both pre and post corrective actions.
- **ADVISE**: The clinical visist identified that the RAG rated cleaning process is not being followed. Red rated cleaning in ED had not been undertaken to an acceptable standard

which left the environment dirty. **QUESTION:** Are you assured that your training and audit process is robust?

Clinical visits;
Boston site: Visit areas chosen by the Trust.
Ward 5 (assessed by the Trust as GREEN- confirmed following the review).
Positive Observations.

- Gel at point of use.
- Hand hygiene compliance.
- Cleaning schedule displayed: **ADVISE** to version control.
- Crash trolley clean.
- Environment clean.
- Equipment clean.
- IV documentation.
- Urinary catheter documentation.
- Bare below the elbows (BBE).

Observations Requiring Attention.

- Water jugs are hand washed.
- Kit stored under the U bend.
- Shelving needed repairing.
- More Danicentres required.

CYP Ward.
Staff discussed the actions undertaken following the CQC visit e.g. quality improvement projects, reviewing IP link champion role, compliance audits, patient involvement, review of documentation, clinical engagement.
Positive Observations.

- Hand hygiene,
- BBE
- Protective clothing.
- Crash trolley clean.
- Environment clean.
- Equipment generally clean.
- Hand gel at point of use.
- Carpet being removed in clinical area.
- Clean bed space was clean.
- Cleaners trolley was clean.

Observations Requiring Attention.

- Kit under U bend.
- Confusion over which colored aprons to use.
- Need Danicentres.
- Baby changing mat had ingress- immediately removed.
- High dust in clinical room

Emergency Department.
Positive Observations.

- Cleaning schedule.
- Hand hygiene

- PPE.
- BBE.
- Sharps boxes labelled and temporary closure activated/

Observations Requiring Attention.

- IP advice at ED entrance.
- Striker mattresses had ingress: **ADVISE** to review audit assurance methods.
- Dirty kit in store room.
- Store room floor dirty.
- Waste trucks not locked.
- Waste storage area not locked.
- Confidential waste not stored in locked area.
- Green is clean stickers are not being used appropriately and providing false assurance.
- Dressing trolley rusty.
- Chairs ripped.
- Kitchen: in a very poor state of repair. DIPC will escalate.
- High dust.
- COSHH: So-chlor in unlocked room- last checked in 2017.
- More gel sanitizer required at point of use in trolley wait area.
- ABG machine in busy area.
- Overfilled waste bins.
- Unused water outlets are not being flushed.

<u>NNU laundry.</u>

Observations Requiring Attention.

- Maintenance schedule required.
- SOP required.
- Safe storage of washing products required.
- A full review of articles which can be laundered is required.
- Lock on door required.

<u>Lincoln site: Visit areas chosen by the Trust.</u>

Emergency Department.

Positive Observations.

- Chairs intact in reception.
- Gel at point of use.
- Toilets clean.
- PPE available.
- Safety needle devices available.
- Disposable tourniquet in use.
- PAT slide off floor.
- BBE

Observations Requiring Attention.

- Water drinks fountain dirty.
- Nursing kit dirty.
- Linen exposed.
- Advise clear identification of the hydration station.
- Ripped chairs.
- Overfull sharps boxes.

- Blood splashes.
- Dirty dressing trolley.
- Heavily blood stained trolley under the mattress.
- Hand wash basin broken.
- 222 trolley very dirty but signed daily to say it had been cleaned.
- Unsecured O2 cylinder.
- Broken tray.
- Dusty floor.
- XS high dust in area that had been red cleaned this week.
- Mattress ingress in each mattress checked.
- High dust on procedure lights.
- High dust on curtain rails.
- IV fluids disposed of down hand wash basins.

Corridor: waste trucks unlocked.

Waddington Ward: assessed by trust as AMBER for IP. My assessment would be RED.
Positive Observations.

- Housekeepers trolley clean.
- Housekeepers room tidy.
- BBE.
- Wipes on BP machines.
- Bins working.
- Curtains dated.
- Gel at point of use.
- Sluice clean.
- VIP scores monitored.

Observations Requiring Attention.

- Kitchen trays damaged.
- Kit stored under U bend.
- Waste room: linen and waste not segregated.
- Cleaners using dressing trolley.
- 222 trolley dirty; signed each day saying it had been cleaned.
- BP machines dirty.
- Pill crushers left dirty.
- Medicines left in medicine trolley drawer.
- Sticky tape under table.
- Wrong colored aprons in use.
- Confidential waste bagged up and left in patient accessible area.
- Fan dirty.
- Mattress ingress.
- Equipment trolley dusty.
- Gurney trolley dusty.

Hatton Ward: assessed by trust as AMBER for IP. My assessment would be RED.
Positive Observations.

- Sharps box signed for.
- Kitchen trays.
- Mattress decontamination label in use.
- VIP scores monitored.
- Gel at point of use.

- BBE.

Observations Requiring Attention.

- Kit under U bend.
- Food disposer broken for several weeks.
- Dirty fans.
- Dirty bathroom chair.
- Brown matter under toilet roll dispenser.
- Damaged hand wash basin seal.
- Damaged handwash basin- identified 2nd Jan, coffee stained- Legionella risk from not flushing and MDRO risk by putting coffee etc down the sink.
- No PPE in sluice.
- Tooth brushes in sluice.
- Single use items are being used multiple times and being returned for use in cupboard e.g. skin prep.
- COSHH: skin prep expired in 2018.
- COSHH: unlocked product in sluice as key in cupboard door.
- Octenisan stored in sluice.
- Staff advised by estates that sink could not be fixed as there wasn't the money.

Huntleigh Mattress store

Observations Requiring attention.

- Very dirty floor.
- Dirty plinths.

Arjo Mattress store

Observations Requiring attention.

- X2 extremely dirty hand wash basins.
- Legionella risk from not flushing hand wash basins.

NHSEI:

- If we can support you in any way please do not hesitate to contact us.
- As agreed I will send you the roles and responsibilities slide deck we have used previously to alert staff to their professional responsibilities.
- We would advise the Trust asks the CCG to undertake IP Nurse led supportive visits (as a peer reviewer) to support the trusts journey.

Next Steps

- A review visit will be undertaken in 20th May 2020 to review progress and re-assess the escalation level.
- Please discuss the report with the Trust Board within 10 working days and confirm by email that this has been undertaken.
- Please develop an IP action plan around the Hygiene Code to address the concerns identified.

Kind regards

Debs

Dr. Debra Adams OBE | Assistant Director of Infection Prevention and Control Advisor. NHS Midlands.

T 07972 589189

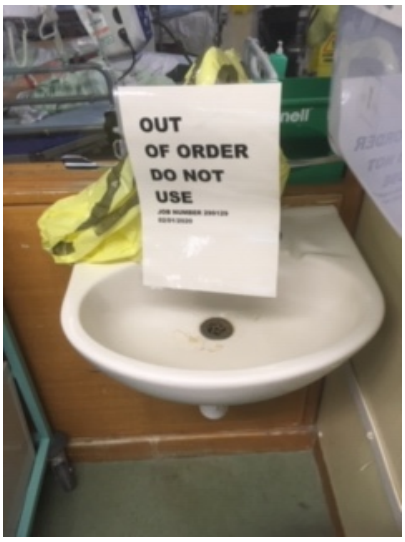
E Debra.adams2@nhs.net | W improvement.nhs.uk

Birmingham Office | St Chads Court | 213 Hagley Road | Edgbaston | Birmingham | B16 9RG

C.C.

- NHS England/NHS Improvement.

Appendix 1: Photographs provided by IP lead taken during the visit.

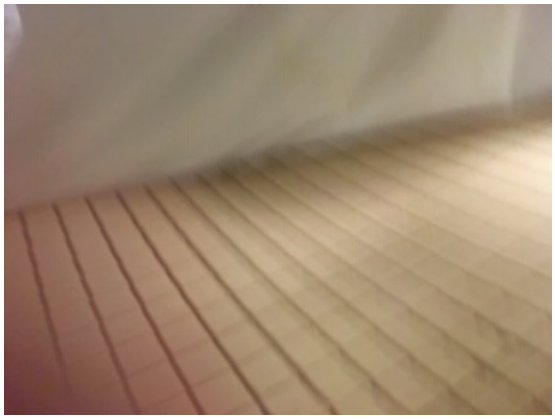


Hatton ward

Mattress store

Lincoln ED

Lincoln ED



Lincoln ED

Post RED clean in ED

Legionella risk

Appendix 2: IP concerns identified within the CQC report

CQC findings:

Pilgrim. Children and Young people's services

The trust **must** ensure all staff comply with good hand hygiene practice. Regulation 12(2)

The trust **should** ensure plans are in place to assess staff adherence to infection prevention and control principles, in particular in relation to infection control high impact interventions. Possible breach of regulation 17(1)

Staff did not consistently follow good hand hygiene practice, increasing the risk of infection.

Hand hygiene audit results showed staff compliance with the trust standards were inconsistent for labour ward and M1 maternity ward.

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

Lincoln County Hospital
Main Entrance
Greetwell Road
Lincoln
LN2 5QY

Tel: 01522 573982
Email: victoria.bagshaw@ulh.nhs.uk

Dr Debra Adams OBE
Assistant Director of Infection Prevention and Control
NHS England and Improvement – Midlands Region
St Chads Court
123 Hagley Road
Edgbaston
Birmingham
B16 9RG

31 January 2020

Dear Debra

NHS IMPROVEMENT INFECTION PREVENTION VISIT; 21ST AND 22ND JANUARY 2020

Thank you for your comprehensive visit, report and offer of support. Further to your letter dated 23rd January 2020, I can confirm that I have diared your visit for 20th May 2020 to review progress and re-assess the escalation level. Also that your report letter and this response has been agended for discussion at our Private Board session on 4th February 2020.

I can confirm that there is one accuracy change required (page 2, item 4 should read 'there are no wards in the Trust rated green for the IPC metrics), and please can I note that at the time of your visit w/e 24th January our Health Care Worker flu vaccination uptake Trust rate had improved to 74%.

Please find below responses to the specific concerns identified in your letter.

1. *IP Committee Terms of Reference: last reviewed in 2013- out of date.* ***ADVISE*** *that this requires addressing as a priority*.

The Committee Terms of Reference (ToR) were revised in July 2017. Unfortunately, these were not uploaded to the website however, they are available if requested. The Trust has recently revised those ToR to align with the new governance structure and these will be approved at the February Trustwide Infection Prevention Group and following ratification they will be uploaded to the website.

2. *Bundle packs from IP committee There appears to be poor oversight and governance of IP.* ***ADVISE*** *that this requires addressing as a priority.*

The DIPC has recognised the poor attendance, quoracy and lack of timely written reports and this formed a significant discussion item at the IP Group on 8th January 2020, where the chair reminded all in attendance of their responsibilities and expectations going forward. This was captured in the escalation report to Quality and Safety Oversite Group (QSOG) where there was a further extensive discussion and commitment from Divisions to meet their responsibilities. Immediately following the January meeting, the DIPC wrote to members of

the IP Group and Divisional Triumvirates who were not present to remind them that attendance at this meeting, requested confirmation of the name of their representative and reissued the ToR. Going forward, attendance, production of reports and completion of actions will be actively monitored, addressed and escalated.

The sub groups to the IP Group have moved from site-based meetings to Divisional meetings, and a standardised agenda template and clear divisional governance structure for IP has been put in place. It is expected that this will make the engagement, ownership and accountability processes more transparent.

Following your visit, the DIPC has personally met with the Divisional Nurses and members of the IP Group to discuss their IP responsibilities and that they will be held accountable for their respective levels of engagement. The issues raised through your visit have been discussed with the Executive Team and as previously identified, a discussion has been agended at Trust Board on 4th February. Time has been set aside at the next IP meeting to discuss the issues raised and confirm a detailed action plan, this will be escalated for further discussion at QSOG and Quality Governance Committee.

3. *Web page: Patient leaflets are out of date e.g. C. difficile, MRSA, isolation.* ***ADVISE*** *that this requires addressing.*

The most up-to-date version of patient leaflets are now visible on the website. Links will be added for patients and public to access up to date information on relevant IP topics. A process has been put in place within the IP team to ensure that the website is continuously kept updated.

4. *IP team: The team uses a RAG rating system for ward accreditation. We were advised that there are no wards in the Trust which are Green rated for IPC.* ***ADVISE:*** *To review approach as there should be an expected improvement or questions asked why staff are not delivering a safe environment in a timely manner. Static Amber is not acceptable and practices observed in the clinical areas need attention.*

A continuous improvement approach is used within the ward accreditation process and each year achievement of the standards is more difficult. The IPC Lead Nurse and nurse specialists have been asked to provide direct support to the Ward Accreditation process to ensure that the Quality Matron team are providing a robust assessment using the same approach as the IP team. The Trust is reaffirming the principles of Ward Accreditation through the introduction of the 'Brilliant Basics' approach and following the visit has altered the schedule so the first monthly Brilliant Basics focus will be on IP.

Focused work will be undertaken with the ward and department link nurses at their next meeting about accreditation.

5. *Estates:* ***ADVISE****: on walking around the wards there are some significant estate issues- therefor advise a strengthened report by escalation of key outstanding risks.*

It is clear that robust and sustainable risk based Estates and Facilities programmes need to be implemented. The Trust is seeking advice from the IP Lead Nurse and Estates team at University Hospitals North Midlands NHS Trust (UHNM) to review their estates escalation process and understand what good looks like. With support from the NHSEI Improvement

Director, a specific plan is being developed with the Estates team to improve the Estates management processes, this will form part of the action plan.

Estates work has commenced against all issues which were raised at the time of the visit.

A comprehensive list, by ward/department, is being collated by estates with the ward and department sisters and IP Team, which identifies all the current outstanding IP environmental issues. This will be completed within the next 2 weeks and the process to address these immediate concerns discussed with the Executive Team.

6. *<u>Cleaning:</u> The ED does not have 24hr cleaning. There is a gap of around 6hrs overnight. When required theatres provide cover.* ***ADVISE*** *to review the impact this has on theatres and whether an alternative approach is required.*

This issue is on the risk register. An options appraisal has been requested from the estates team that provide housekeeping services out of hours without disrupting other services. This will be brought to Executive Team for initial discussion within the next 4 weeks.

7. ***ADVISE****: The clinical visit identified that the RAG rated cleaning process is not being followed. Red rated cleaning in ED had not been undertaken to an acceptable standard which left the environment dirty.*

The IPC team are working with the Trust facilities leads to ensure that there is absolute clarity regarding the standards of cleanliness expected for a RAG cleaning protocol. This will also form part of the discussion with UHNM.
Spot audits will be undertaken by the IP team across all areas of the Trust including ED.
The DIPC and Deputy DIPC will reinstate the environmental visits and walkarounds with the Chief Operating Officer and Director of Estates.

8. *Are you assured that your training and audit process is robust?*

IPC team are re-introducing the equipment and environmental audit process across all areas in the Trust. A standard template has been developed and these will be conducted by the IP nurses as a training process with the Ward/Department managers and IP Link Nurses.

The IP Lead Nurse has been asked to review the general cleaning training given to the house keeping team and the deep cleaning training.

The link nurse training is being reviewed following the visit to ensure all the issues raised through the visit are being addressed. This includes strengthening the understanding and confidence of Link nurses in local ward/department audit and escalating concerns.

9. *<u>Clinical visits:</u> Ward 5 Cleaning schedule displayed:* ***ADVISE*** *to version control*.

This issue has been escalated to Central Facilities teams to re-issue version controlled cleaning schedules. The IP nurses will audit wards and department during their visits w/c 3rd February to ensure the correct versions are on display.

10. *<u>Emergency Department Lincoln:</u> Striker mattresses had ingress:* ***ADVISE*** *to review audit assurance methods.*

The newly reinstated IPC audit programme will include the weekly mattress checks and the expectation will be for these weekly audits to be checked by ward/dept managers to ensure mattresses are clean and safe for patient use.

A review of the bed management system is being commissioned to ensure in future the Trust has good systems for bed and mattress management.

The DIPC has requested an urgent deep clean to be undertaken on all the mattress stores across all Trust sites. The lead nurse has been asked to ensure a regular review of the mattress store occurs as part of his trustwide environmental visits, also to ensure that a robust cleaning schedule is in place.

The IP and Tissue Viability teams have been asked to undertake an immediate review of all mattresses/Gurney tops to identify the overall risk. This report, identification of risk level and any immediate and medium term actions will be brought back to the Trustwide IP Group for discussion and assurance.

I can confirm that as previously indicated actions are already being taken to address the specific issues raised in the 'Observations Requiring Attention' sections within this report. These will also be added to the Trust IPC action plan, against the Hygiene Code, and managed through IPC committee and upwards to QSOG and QGC. A comprehensive suite of metrics will be used to ensure both achievement and sustainability of the improvements.

In addition to the IPC support to wards/department, increased IP audit and the ward accreditations, following discussions between the CCG Chief Nurse and ULHT Director of Nursing, the Trust IPC lead and CCG teams will undertake monthly roving audits for quality and safety assurance.

The Director of Nursing meets with the sisters and charge nurses weekly and has raised awareness with them of their roles and responsibilities for IP. The written document shared with the Trust post meeting has been cascaded out to all staff and matrons have been asked to have a discussion about this during their 'Golden Hour' visits.

The Director of Nursing has discussed the issue raised during the visit regarding '*communication that has gone to staff that estates issues will not be addressed due to finance*.' With the sister/charge nurses and the Divisional nurses and confirmed this is incorrect and the actions that are being taken to resolve the outstanding estates environmental issues.

The IP Lead Nurse and Director of Nursing are working with the Communications team to undertake some focused communication about IPC.

An immediate report from estates has been requested identifying the top three IP risks, identifying when work was initially logged, outstanding work required and planned correction date. Once the detailed ward review of outstanding estates work has been undertaken this report will be re-run and will be reviewed by the IP lead Nurse to ensure appropriate immediate actions are taken and risks are identified correctly on the risk register.

Thank you again for your offer of support and I would like to confirm that the Trust fully accepts the findings from your visit and is committed to addressing the concerns raised. I hope that the above gives you the additional information and assurance you requested. Should you require any further information then please let me know.

Yours sincerely

Victoria Bagshaw
Director of Nursing

From:	David Cleave Divisional Nurse Division of Medicine Victoria Bagshaw – Deputy Chief Nurse
Date:	20/02/2020
Healthcare standard	

Title:	Section 31 Update report from winter assurance visits

Responsible Director: Karen Dunderdale – Director of Nursing

Purpose of the report:
To update Trust Board on the actions taken to meet the section 31 condition applied following the CQC winter assurance visits to the Emergency Departments at Lincoln Count and Pilgrim Hospitals.

The report is provided to the Board for:

Decision		Discussion	X
Assurance		Information	X

Summary/key points:

Two CQC visits took place in January 2020 to the Emergency departments at Lincoln County Hospital and Pilgrim Hospital Boston as part of a series of visits to Emergency Departments made in response to winter pressures nationally.

These visits resulted in further section 31 notices being imposed for PHB which include 6 conditions that:

- Patients commence active treatment within 60 minutes of arrival
- Patients are cared for in an appropriate area
- Patients are effectively tracked on their pathway
- Patients are monitored for deterioration
- Escalation procedures are followed
- There is adequate capacity to deal with resuscitation

The attached paper describes the actions taken and improvements to date that are incorporated into the weekly report to the CQC.

Recommendations:

For Trust Board to note the actions taken in response to the section 31.	
Strategic risk register Delivery of care which falls outside regulatory compliance	**Performance KPIs year to date**
Resource implications (eg Financial, HR) Ongoing recognition of additional financial and people investment to improve quality and safety with the Emergency Department	
Assurance implications Poor assurance due to failure to meet statutory requirements	
Patient and Public Involvement (PPI) implications Reduction in public confidence	
Equality impact	
Information exempt from disclosure	
Requirement for further review?	

Section 31 Update report following the winter assurance visits to Pilgrim Hospital Emergency Departments

1. Introduction

Two CQC visits took place in January 2020 to the Emergency departments at Lincoln County Hospital and Pilgrim Hospital Boston as part of a series of visits to Emergency Departments made in response to winter pressures nationally.

These visits resulted in further section 31 notice being imposed for Pilgrim Hospital, Boston which includes 6 conditions that:

- Patients commence active treatment within 60 minutes of arrival
- Patients are cared for in an appropriate area
- Patients are effectively tracked on their pathway
- Patients are monitored for deterioration
- Escalation procedures are followed
- There is adequate capacity to deal with resuscitation

The Trust is providing weekly reports to the CQC on the actions that have been taken and the resulting improved outcomes.

2. Trust Actions

To deliver improvements, which demonstrate the Trust is meeting the requirements of the section 31, the Division has worked with corporate teams to put in a programme of work that is detailed below. Whilst compliance with the conditions has not yet been achieved, some improvements have been noted.

Condition 1. ***The registered provider must ensure that it implements an effective system to ensure that all patients who present to the emergency department at Pilgrim Hospital, Boston, commence active treatment within 60 minutes of arrival***

A key focus has been on “floor leadership”, and to this end the Division has put training for senior doctors (EPIC) on both main sites which sets key expectations around the role in order to improve consistency. Full details of the training package are in section 3b of the appendix. Training has been extended to middle grade tiers and this includes training around the importance of safety huddles and prioritisation of patients.

Nurse Leadership is also a key factor, and the Division has agreed a revised more robust leadership model with a new “Senior Sister” in overall charge of a 24hr team of band 7 Sisters.

In addition to work on leadership, the Division has undertaken a comprehensive review of demand and capacity for medical staff, which demonstrates medical capacity is a significant factor in delays. Following a Board presentation in February the Board approved a substantially uplifted

rota for medical staff. The Division are already out to recruit with the aim being to implement the new rota from April 2020.

SITE	Current Funded Establishment	50% (agreed plan)	65%
Lincoln	18WTE MG 12 WTE juniors 9 WTE Consultants	29WTE MG 12 WTE juniors 12WTE Consultants	35 WTE MG 12 WTE juniors 12 WTE Consultants
Pilgrim	18WTE MG 11 WTE juniors 9WTE Consultants	25WTE MG 12 WTE juniors 12 WTE Consultants	30 WTE MG 12 WTE juniors 12 WTE Consultants

Condition 2. ***The registered provider must ensure that there are systems in place across the emergency department at Pilgrim Hospital Boston so that patients are assessed and cared for in the area appropriate for their acuity at all times***

The Division has revised the safety huddle process to ensure that the sickest patient and the most at risk patients in the department are always highlighted to the nurse in charge and discussed. This is reflected in an updated huddle checklist included in the appendix

The Division has also taken steps to assure that staff in charge have a plan to provide step down cubicles for resuscitation patients when demand for resuscitation beds exceeds the four available. Spot checks have been undertaken during divisional assurance rounds. Following the Board presentation, Trust Board have agreed in principle to fund additional equipment for these step down cubicles which will provide enhanced level of monitoring. The equipment list has been agreed and the associated case is following normal processes for procurement.

In order to ensure that patients who are nursed outside of a cubicle or remain under the care of EMAS are properly assessed we have introduced a Standard Operating Procedure for reducing ambulance delays. This sets out clear standards for frequency of monitoring for patients awaiting handover, and these standards are monitored as part of daily assurance. Additionally, all long delays are now subject to harm reviews undertaken collaboratively with the CCG weekly. To date these harm reviews have identified one patient in February with moderate harm. This incident is being investigated and will be reported through the Trust's governance process for Serious Incidents.

A particular concern for the emergency department staff, and identified during the visit, was the cohorting of four patients in the central floor area at Pilgrim

Hospital. The process has now been reviewed and a new protocol for non-cubicle care is in place. This has resulted in a dramatic reduction in the use of this central area overall. Whilst it is still used during extreme pressure, this happens with Gold level oversight, is time limited, and limits this area to two patients (not side by side). This process is being taken through the Trust Quality Impact Assessment process.

Condition 3. ***The registered provider must ensure that the systems make provision for effective monitoring of the service user's pathway through the emergency department at Pilgrims Hospital Boston.***

The department has implemented a "red flag" system which covers patients with DKA, sepsis, paediatric or other vulnerable patients. The Nurse in Charge will always request an update on red flag patients at safety huddles, as well as between times to ensure the appropriate pathway continues to be followed. Red flag patients are targeted as part of divisional assurance notes reviews.

The pathways are also monitored from a patient experience perspective through daily-formalised patient feedback, in which the Nurse in Charge speaks to 5 patients about their care. This is in addition to the Trust's agreed FFT process. This is showing that whilst the large majority of patients are happy with their care and their experience, improvements are required both in terms of aspects of care which patients may chose not to complain about but from a clinical perspective do not represent a high quality and safe experience of care. The perceived attitude of health care workers in 10% of FFT responses is an area of focus.

Condition 4. ***The registered provider must ensure there are appropriate systems in place to monitor the condition and risk of deterioration for all patients awaiting admission (e.g. on ambulances or in corridor areas awaiting triage) to the emergency department at Pilgrims Hospital Boston***

Following Divisional concerns around the decision making and competence of unregistered paramedic technicians in the PHP role, the Division took the decision to deploy a 100% registered workforce in this key role. Whilst this has a temporary impact on fill rate, this has enabled the team to ensure that all staff assessing patients in vehicles or in corridors are appropriately trained to do so. The Standard Operating Procedure for ambulance handover described in Condition 2 (above) sets out key standards for the monitoring of patients awaiting handover. This is reviewed as part of daily assurance, and all patients who experience a delay of greater than 120minutes are subject to harm review. The SOP is available with the appendix document.

Condition 5. ***The registered provider must ensure that appropriate emergency department escalation procedures are maintained and followed by all staff including at times of peak capacity and demand at Pilgrim Hospital Boston.***

The full capacity protocol and non-cubicle care protocol have been recirculated throughout the trust including to all Silver and Gold commanders and are reviewed at the 3 x daily bed meetings.

There is a clear process in place, through the three times daily capacity and performance meetings, to ensure at busy times capacity of clinicians to provide safe care within the Emergency Department is protected. In addition to the improved established processes through the Division, the Deputy Chief Nurse and Chief Operating Officer have supported the team to adapt their daily assurance processes and these are being discussed on a daily basis.

6. The registered provider must ensure that at all times, there is sufficient capacity in the emergency department to accommodate all patients at risk of deterioration or who require time critical care and treatment; this must be provided in an appropriate clinical setting

As described in section 2 above, both main Emergency Departments have created designated step down cubicles so that patients who are moved out of resuscitation in response to high demand for resuscitation beds will still receive enhanced monitoring. As described above, the Board has agreed to fund additional equipment for these enhanced monitoring cubicles.

The criteria for patients requiring resuscitation verses those patients who require enhanced monitoring or normal cubicle care is being reviewed by the clinical lead for ED and a trust wide standard developed.

Whilst patients awaiting ward admission who deteriorate should receive input from the Critical Care Outreach Team, this was not well utilised within ED. The Division have therefore reinforced the existing protocol for in-reach into ED by CCOT for patients awaiting a ward bed, and are monitoring with CCOT the number of calls made.

3. Daily Assurance

In addition to the above actions, the Division has also implemented a comprehensive daily assurance process, which covers all key safety concerns in line with CQC domains, alongside a range of other environmental and quality metrics. Using a fresh eyes approach, the development of this assurance template was made in conjunction with colleagues from NHSEI and the Acting Director of Nursing and Chief Operating Office. These metrics are reported through at the capacity and performance meetings and will form the basis of the regular safety Huddles with the Emergency Department.

The assurance document has been developed in a format that allows tracking of progress over time. The Division also tracks and reports back to the CQC upon 3 measures around patients not seen within 60 minutes, patients who leave ED without being seen, and the count of patients who receive care outside of a designated cubicle.

The most recent CQC report which incorporates the weekly data is attached at appendix 1.

4. Conclusion

Trust Board are asked to note the actions taken since the section 31 conditions have been put in place and the regular reporting to the CQC. It is expected that by the next Trust Board report the amount of data collected will provide a clearer view of improvements including the impact and outcomes for patients. This increase triangulated data will proved improved assurance to the Quality Governance Committee.

Appendix to report:
Weekly CQC Section 31 report

Appendix_ REPORT 5
Section 31 200221.do

Pilgrim Hospital

Quality Report

Pilgrim Hospital Boston
Sibsey Road
Boston
Lincolnshire
PE21 9QS
Tel: 01205 364801
Website: www.ulh.nhs.uk

Date of inspection visit: 7 January 2020
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall summary

We carried out an unannounced focused inspection of the emergency department at Pilgrim Hospital, Boston on 7 January 2020, in response to concerning information we had received about the care of patients in this department. At the time of our inspection the department was under adverse pressure. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology. We found that:

The department was too small for the number of patients attending. This impacted on how patient flow could be managed. It also resulted in patients being treated in corridors or the central space of the department and having their dignity compromised. The department was not compliant with several standards

Patients who self-presented were triaged in line with national guidance. However, some patients continued to wait considerable time before being clinically assessed and treated.

The service did not have enough permanent nursing or medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment, relying on substantial numbers of bank and agency staff. However, managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Some staff did not treat patients with compassion and kindness nor did they respect their privacy and dignity. The crowded nature of the department resulted in some conversations taking place with other patients present.

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

Leaders lacked the skills and abilities to run the service. Poor clinical leadership resulted in poor situational awareness when risks within the service increased. Local leaders did not fully understand or manage the priorities and issues the service faced; the continued to not be able to find sustainable long-term solutions.

Summary of findings

The service did not have a specific vision at service level for what it wanted to achieve or a clear strategy to turn it into action, developed with all relevant stakeholders. There were some plans in place which were aligned to local plans within the wider health economy.

The service monitored activity and performance however this was not driving the necessary improvements.

As a result of this inspection, we have identified areas which the trust make take to ensure they comply with relevant elements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 fundamental standards.

Areas the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the hospital MUST take to improve to:

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments and within defined timescales. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that consultant and nurse cover in the department meets national guidelines. Regulation 12 (c)
- Fully implement the trust wide actions to reduce overcrowding in the department.12 (2) (a) (b) (i)
- The trust must ensure that the privacy and dignity of patients receiving care and treatment in the emergency department is maintained at all times. 10(1)

Following this inspection, we have taken urgent enforcement action, to impose conditions on the trust's registration to make urgent improvements in the quality and safety of care for patients.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Contents

Summary of this inspection

Background to Pilgrim Hospital

Urgent and emergency services are provided by the trust at three sites across Lincolnshire: Lincoln County Hospital, Pilgrim Hospital, and Grantham and District Hospital.

The emergency departments based at Lincoln County Hospital and Pilgrim Hospital provide consultant-led emergency care and treatment 24 hours a day, seven days a week to people across Lincoln and the North Lincolnshire area. Grantham and District Hospital closes overnight.

(Source: Routine Provider Information Request (RPIR) – Acute context)

Details of emergency departments and other urgent and emergency care services

Lincoln County Hospital

- Accident and emergency department
- Paediatric emergency service
- Ambulatory care bay

Pilgrim Hospital

- Accident and emergency department
- Ambulatory emergency care

Grantham and District Hospital

- Emergency assessment unit
- Assessment and ambulatory care
- Accident and emergency department

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Pilgrim Hospital, Boston is a large district general hospital located on the outskirts of Boston. At Pilgrim hospital, the urgent and emergency services consist of the emergency department (ED) and an Ambulatory Emergency Care (AEC) unit.

The ED has a waiting and reception area, two triage rooms, 10 major cubicles, three minor cubicles, one 'fit to sit' room, a see and treat room, a plaster room, a clean procedure room, four resus bays, three rapid assessment and treatment (RAT) cubicles, one waiting room and a quiet relative's room which was also used as a mental health assessment room.

AEC is open Monday to Friday, 08:30am to 10:30pm and has six beds and two seated areas

Pilgrim Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy, before transfer to the major trauma centre at a neighbouring NHS trust.

Trust activity for the emergency department from September 2018 to August 2019:

- 146,586 A&E attendances (-0.5% change compared to the same time 2017/18)
- 23,727 Children attendances (-8% change compared to the same time 2017/18)
- 52,535 ambulance attendances (+6% change compared to the same time 2017/18)
- 5% patients left without being seen (0% change compared to the same time 2017/18)
- 7.5% re-attendances within 7 days (0% change compared to the same time 2017/18

Trust activity for the preceding 6-weeks to 22 December 2019 was reported as follows:

- 48% of patients are admitted, transferred or discharged within four hours. This is significantly worse than the England average.
- 24-26% of patients were seen by a clinician within 60 minutes.
- On average, between 25 and 40 ambulances a day experienced delays of 60 minutes or more from arrival to handing over their patient to trust staff.
- The number of emergency admissions (referred to as the conversion rate which relates to the number of patients who present to an emergency department and who are subsequently admitted for ongoing care and treatment) was on average 31%.

Inspection and regulatory history

Between December 2012 and July 2019, we have inspected urgent and emergency care services at Pilgrim

Summary of this inspection

Hospital, Boston ten times. We have previously taken urgent enforcement action where we have considered the quality of care and safety of patients was not within expected standards.

Our inspection team

Our inspection team included a CQC inspector and two specialist advisor's consisting of the national professional advisor for urgent and emergency care and a senior nurse whose background was in emergency care.

The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection for Midlands region.

How we carried out this inspection

This was a focused unannounced inspection of the emergency department at Pilgrim Hospital, Boston on 7 January 2020.

We did not inspect the whole core service therefore we have not reported against or rated the effective domain. We did not inspect any other core service or wards at this hospital however we inspected the emergency department at Lincoln County Hospital using the same inspection methodology on 6 January 2020.

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry however because we took urgent enforcement action, we have rated this service in line with our published policy position.

Inadequate

Urgent and emergency services

Safe	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Summary of findings

The department was too small for the number of patients attending. This impacted on how patient flow could be managed. It also resulted in patients being treated in corridors or the central space of the department and having their dignity compromised. The department was not compliant with several standards

Patients who self-presented were triaged in line with national guidance. However, some patients continued to wait considerable time before being clinically assessed and treated.

The service did not have enough permanent nursing or medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment, relying on substantial numbers of bank and agency staff. However, managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Some staff did not treat patients with compassion and kindness nor did they respect their privacy and dignity. The crowded nature of the department resulted in some conversations taking place with other patients present.

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

Leaders lacked the skills and abilities to run the service. Poor clinical leadership resulted in poor situational awareness when risks within the service increased. Local leaders did not fully understand or manage the priorities and issues the service faced; the continued to not be able to find sustainable long-term solutions.

There were a range of improvement plans and initiatives to address longstanding challenges across the emergency care pathway. There was however, no defined current vision at service level for what it wanted to achieve or a clear strategy to turn it into action, developed with all relevant stakeholders.

The service monitored activity and performance however this was not driving the necessary improvements.

Inadequate

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

Environment and equipment

The department was too small for the number of patients arriving. This impacted on how patient flow could be managed It also resulted in patients being treated in corridors or the central space of the department and having their dignity compromised. The department was not compliant with several standards.

- On our arrival on 7 January 2020, the hospital was at operational performance escalation level four. 33 patients required admission to hospital having been reviewed by specialty teams. A shortage of hospital in-patient capacity was preventing admissions and these patients were being cared for in the central area of majors, as well as being located in the plaster room, along the main ambulance arrival corridor (three patients), and also nine patients receiving care in chairs located throughout the emergency department. The resuscitation and major's areas were both operating at full capacity as was the integrated assessment centre (IAC). This meant there was extremely limited capacity for patients who required resuscitation, or those patients who required management in an appropriately equipped clinical bed space. Further, the congestion of the department resulted in very limited space to move patients, therefore creating unintended fire hazards. The longest wait in the department was 20 hours and 20 minutes as at 10am on 7 January 2020. Two senior staff spoken with had reported that overnight, four patients had experienced delays of more than four hours from arrival by ambulance to being moved in to the emergency department.
- Overall the department was not compliant with standards recommended by the Psychiatric Liaison Accreditation Network (PLAN), Intercollegiate Committee for Standards for Children and Young People in Emergency Care and Health Building Note 15-01: Accident and Emergency Departments. The department was congested at the time of the inspection. Poor organisational flow resulted in patients being cared for in the central area of the majors department, on trolleys. Staff had worked to limit the number of patients on trolleys in this area. Four patients were being managed continually in this area during the inspection. We had previously found up to six patients were being nursed in this area. Despite the reduction in trolleys, the area did not lend itself to protecting patients privacy and dignity. Patients remained in close proximity to one-another, therefore impacting on the ability for patients to be sufficiently spaced for infection control purposes.
- The resuscitation area operated at full capacity for the duration of the inspection. Department staff worked tirelessly to try and stabilise patients as quickly as possible in order further resuscitation space could be created to meet demand. We noted one case in which a patient was held on an ambulance for over an hour despite the paramedic twice raising their concerns about the patient's deteriorating condition. A clinical space was eventually found in the rapid assessment area however the patient requiring increased care and treatment and was subsequently relocated to a resuscitation bed. Staff caring for the patient were clearly distressed because of the delay the patient had experienced which had likely increased the level of care and treatment the patient required. We further noted a second case in which a patient remained on an ambulance despite having chest pain and having a complex medical history. There was no appropriate monitored bed space for the patient to be relocated too and so hospital staff had been required to commence an assessment of the patient whilst they remained on the ambulance.

Assessing and responding to patient risk

Patients who self-presented were triaged in line with national guidance. However, some patients continued to wait considerable time before being clinically assessed and treated.

- The department had a triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours. After initial registration, patients experienced delays in being seen and treated by a clinical decision maker. We saw five patients arriving by ambulance remained on the ambulance between 20-68 minutes

waiting to enter the department. At 11:30, four patients remained on ambulances including a patient who arrived with chest pain. The patient had a complex medical history and had received three doses of strong pain medicines to help manage their symptoms. The patient received an initial assessment from the pre-hospital practitioner (PHP) whose role it was to oversee the clinical condition of patients who could not be moved immediately in to the emergency department. It was reported the patient had been assessed by the consultant but there was no handwritten contemporaneous record of this. The PHP reported the patient had had an ECG and bloods taken and the consultant had determined it was safe for the patient to remain on the ambulance. The patient was moved in to the department one hour after arrival. It was the professional view of the National Professional Advisor for urgent and emergency care that the patient should, in light of their medical history, been prioritised and moved more quickly in to a monitored bed space for close clinical observation and management. A lack of appropriate clinical space in the department prevented this from happening.

- At 13:00, five patients were on ambulances and two patients in the ambulance corridor. One patient remained on an ambulance with a national early warning score of six. The patient was reported to be septic and had a delay of 20 minutes before being offloaded to trust staff
- A third patient was conveyed by ambulance due to an acute presentation of urinary retention (blocked urinary catheter). It was noted the patient was in severe pain and had been escalated twice by the paramedics to the nurse in charge. The patient was very agitated and was subsequently escalated to the hospital ambulance liaison officer (HALO). The PHP was attempting to create capacity by escalating to the nurse in charge and by transferring patients to the GP streaming service located at ED reception however no member of nursing staff had been to assess the patient. An hour and ten minutes after they first arrived, the patient was called in to rapid assessment and initial treatment (RAIT). An initial assessment of the patient recognised them as being acutely unwell. The patient was quickly moved to resuscitation due to a deteriorating picture. They were reviewed by the ED consultant and a working diagnosis of urosepsis was recorded. The observations for the patient at that time were deranged suggesting the patients condition was deteriorating. Intravenous antibiotics were prescribed at 14:04; but not administered until 14:34. This was approximately two hours after arrival; Oxygen was not prescribed nor administered despite pulse oximetry of 90%. The management of this patient was contradictory to the national sepsis six care bundle. A similar incident was reported on 16 August 2019 when a patient presented with frank haematuria (fresh blood present in the urine). The patient's national early warning score was recorded as seven. No sepsis screen had been completed. The patient was treated for a very low blood pressure and shock due to significant blood loss. The ED team had not considered sepsis despite the surgical team noting possible septic shock presentation.
- During the inspection we reviewed 15 sets of patient records. We noted one patient had arrived by ambulance and was triaged as a category two patient. A medical review of the patient was carried out at at which point a focal infection was considered. The medical notes made no reference to sepsis despite the presentation. Intravenous fluids were prescribed and to be administered over four hours. The NEWS for the patient was seven. At 14:00, the patient was transferred to the resuscitation area and intravenous antibiotics were administered approximately three hours after the patient arrived. An intensive care review was completed at which point it was suggested the ED team commenced management of hyperkalaemia (a high potassium level which can lead to heart arrythmia's and other life threatening symptoms); appropriate fluid resuscitation and appropriate management of hypoglycaemia. These recommendations suggested the ED team had initially failed to fully assess and actively treat the deranged values recorded on the blood samples taken from the patient when they first arrived in to the department. Prior to the inspection we reviewed all incidents reported by the department between June 2019 and December 2019. We noted one case reported at the trusts other emergency department in November 2019 whereby a patient arrived to the ED. The patient was examined by a doctor and was to commence on the hyperkalaemia pathway which had been prescribed by a foundation grade doctor. The initial stage of treatment had been commenced however it was reported no further intervention had commenced prior to the patient being transferred to the Medical Emergency

Assessment Unit at 17:00. At 18:35 it was reported the patient deteriorated and died. These incidents suggested a lack of learning across the organisation and continued to present a risk to patients.

- On 6 January 2019 a patient presented with fever and nausea. It was noted in their notes they were a type two diabetic. Urosepsis was considered at 01:33 due to an increasing NEWS score as a consequence of deterioration in the patients condition. Antibiotics were prescribed at 02:37am. During the post take ward round, the medical consultant requested routine monitoring of blood glucose levels due the patient having a history of type two diabetes; this diagnosis was known to nursing staff as a note had been made on the patients paper attendance record at the triage stage. We noted that only one blood glucose level had been recorded as at 11:00 when notes were reviewed. We have previously raised concerns over the management of patients with diabetes across the emergency departments at Pilgrim Hospital and the trust's other emergency department at Lincoln County Hospital. We further note STEIS reference 2019/10581 which relates to the management of patients in diabetic ketoacidosis. We found that changes to practice had been introduced at Lincoln County hospital during our inspection of that emergency department on 6 January 2019. These changes included the diagnosis of diabetes being visible on the trusts patient information system, so as to alert staff. However, this was not the case at Pilgrims Hospital. We therefore have concluded there remains a lack of embedded learning following serious incidents.
- A pre-alerted patient was conveyed by ambulance and arrived at 20:32. The patient was triaged but was not clinically assessed until 03:02. The working diagnosis was sepsis and so intravenous fluids and antibiotics were commenced. These were administered at 04:14, therefore meaning the patient was not exposed to timely clinical management.
- On 01/01/2020 a patient having recently had chemotherapy within the previous six weeks, presented with neutropenic sepsis. The patient arrived at 09:20 and it was assuring to note a sepsis bundle had commenced at 09.25. However, antibiotics were not administered until 10:45, resulting in the patient falling outside the one-hour golden window. Management of neutropenic septic patients remains an area which requires significant improvement. A review of NRLS identified 23 failed door to needle neutropenic septic patients between July and December 2019 suggesting a lack of embedded or sustained improvement.
- We noted a serious incident report which reported a patient presented with a two-day history of chest pain, shortness of breath and nausea. The patient was diagnosed as suffering gastritis. The patient remained in the emergency department until they were transferred to the integrated assessment centre. A senior clinical review at requested additional clinical interventions including an ECG blood samples. There was a delay in the results of these tests being shown to a senior clinical decision maker. The patient was subsequently escalated, and staff instigated the acute coronary syndrome pathway. The patient was referred to the cardiac catheter laboratory at Lincoln County however the patient subsequently died awaiting treatment. We were told during the inspection that learning from the serious incident included ensuring all patients presenting with chest pain would receive an ECG within ten minutes of arrival. During the inspection we noted a patient presented with chest pain. An ECG was not carried out for approximately 30 minutes at which time the patient was moved to the resuscitation room for rapid consultant review then timely transfer to coronary care unit on-going management. On 05/01/2020 a patient presented with chest pain. The first recorded ECG in the notes was not carried out until for approximately two hours after the patient first arrived. We therefore concluded there remained a lack of embedded or sustained improvement or robust learning from this serious incident as staff were not following the revised guidance of completing an ECG within ten minutes for all patients presenting with chest pain. This therefore meant there is a residual risk to patients who may present with such symptoms.

Nursing staffing

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment relying on substantial numbers of bank and agency staff. However, managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

- The number of nurses and healthcare assistants on all shifts in each clinical area did not always match the planned numbers. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. However, in order to do this, they needed to make use of significant numbers of bank and agency staff.
- We reviewed a range of rotas dating from 8 November to 6 January 2020. We were informed by the lead nurse that following a review, there had been a reduction in the number of nurses deployed during both day and night shifts, which took effect from 6 January 2020. This meant 11 nurses and six healthcare assistants were rostered to support the department as compared to the historic 12 nurses and six healthcare assistants.
- The department had a combined vacancy rate of 63% across the nursing workforce. This meant that on every shift we reviewed, the department relied on agency staff to support them and ranged from one agency nurse on a shift through to eight agency nurses. Senior nursing staff reported the challenges of trying to complete a rota which was sufficiently staffed with people who had the right skills and experience to ensure the department remained safe. It was recognised by the local leadership team that shortage of substantive staff and appropriate skill mix generated an inherent risk in the department, for which there remained no long-term solution. The matron had amended the recruitment campaign to ensure that any prospective employee could be deployed across any of the hospital sites within the group, as compared to recruiting individuals to an individual location only.
- The service did not meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children's nurses on each shift. The trust recognised this as an area for improvement and had worked with practitioners from neighbouring trusts to up-skill and improve the competency of nurses allocated to care for children. There was one paediatric trained nurse on duty 24 hours a day who operated from a single cubicle which was located in the adults majors area. . There was a separate paediatric waiting room however this was isolated from the rest of the department. This meant staff could not directly observe the area and therefore meant any child at risk of deterioration whilst in the waiting room may not have been recognised.

Medical staffing

The service did not have enough permanently employed medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed staffing levels and skill mix, recruited sufficient locum doctors and gave those locum staff a full induction.

- There were eight whole time equivalent consultants in the department; only one consultant was substantive and was the only one on the general medical council specialist register. Other consultants were in the process of preparing for the certificate of eligibility for specialist registration (CESR) (a GMC initiative which supports doctors to register as a consultant, first having joined a specialist registrar, when individuals have either trained in non-approved posts or they have entered an approved training post at a later starting point and completed the rest of the programme and gained the remaining competencies). A number of doctors had competed a limited number of components of the Fellow of Royal College of Emergency Medicine exam to enable them to join the specialist register.
- There was no designated consultant who was registered as a specialist paediatric emergency medicine consultant. This was despite the department seeing around 10,000 children per year and was listed as a key requirement in the Royal College of Paediatrics and Child Health: Facing the Future - children and young people in emergency care settings.
- Consultants were present in the department from 08:00 hours to 21:00 hours Monday to Friday and between 09:00 and 21:00 at the weekends.
- Middle grade cover included five trust grade doctors. The rota was mainly covered by agency locums. This was recognised as a major concern by the local team because they considered there were not enough senior doctors present to manage seriously ill patients and to also supervise junior doctors. A lack of substantive consultants to support junior doctors was recognised as

a factor for the department not being able to accept junior trainee doctors and therefore further hindered the trusts ability to recruit sufficient doctors to meet the needs of the population.

- We spoke with five junior doctors during the inspection. They each reported they received appropriate supervision from more senior doctors and were complimentary about the teaching sessions which were held weekly. However, individual doctors told us they felt the lack of capacity in the department contributed to delays in being able to see and assess patients. Some doctors reported they would recommend the department to other junior doctors as a good place to work, whilst others reported they would not recommend it to more junior doctors due to the high intensity of the work load.

Are urgent and emergency services caring?

Inadequate

Compassionate care

Some staff did not treat patients with compassion and kindness nor did they respect their privacy and dignity. The crowded nature of the department resulted in some conversations taking place with other patients present. The individual needs of patients was not always considered or acted upon. Staff did not always provide appropriate emotional support to patients.

- Due to the congested and crowded nature of the department, a large proportion of patients were receiving care in non-clinical areas including the central bay of the major's area or in corridor's. We observed on multiple occasions when staff failed to support patients in protecting their privacy. We observed the matron worked hard to ensure frail elderly patients were covered however this was not sustainable, resulting in some patients falling in to a state of undress.
- We spoke to nine patients and their relatives during our inspection of the emergency department. Four patients were confused as to what was happening; they were not aware of their clinical treatment plans despite having been in the department for extended periods of time. There was a general consensus from patients the environment was not fit for purpose and offered no privacy. Long waiting times and a lack of space for relatives to sit was also reported as a frustration by those using the service. We noted occasions when elderly relatives were having to stand by beds or occupied chairs because a lack of space in the department meant there was no space for additional seats to be found. One patient who was nauseous and at times actively vomiting was held in the central area of the ED due to a lack of cubicle spaces. One elderly patient remained on a trolley for the duration of our inspection. The patient was located by a door and had very little input from nursing staff for the duration of their stay. Despite being located by a door which was frequently used, the patient was only afforded one blanket despite it being a cold day. Nursing staff had not considered the holistic needs of the patient.
- The percentage of patients who would recommend urgent and emergency care services has consistently been worse than the national average since July 2017.
- We had previously reported concerns with how well the nursing leadership of the department managed other health professionals during times of increased departmental activity. We had previously seen on an inspection an altercation between the nurse-in-charge and a paramedic who was concerned about the care of their patient, who in the opinion of the paramedic, required rapid treatment. At this inspection we observed a senior paramedic twice escalate concerns over the condition of their patient who remained on an ambulance. Despite the paramedic having given the patient morphine to manage their pain, the nurse-in-charge was dismissive of the paramedic's concerns and did not afford sufficient priority to meet the needs of the patient who had underlying neurological deficit and so was at increased risk of distress.
- Patients told us they had been treated well and with kindness. When we observed care and treatment being given we noted this almost always to be the case. We observed that, at times, staff did not always give patients and/or their relatives support to cope emotionally with their care, treatment or condition. We observed the time staff spent with patients was limited because they were busy. This resulted in staff adopting a task-orientated approach to providing care as compared to providing holistic patient centered care. We noted on one occasion, a patient who was clearly distressed and

disorientated, being cared for in the central area. Nursing staff did not stop to consider emotional needs of the patient, nor did they provide any assurances to the patient.

- The crowded nature of the department resulted in some conversations taking place with other patients present. This was particularly noted for those patients receiving care in the corridor, main bay and the seated area within majors.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Inadequate

Access and flow

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

- Front line staff reported they were on operational pressure escalation level (OPEL) four at the time of the inspection. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care.
- NHS Trusts are required to monitor and report nationally the percentage of patients who attend ED and get seen, discharged or admitted within four hours of arrival. This is known as the Emergency Access Standard (EAS). The NHS standard requires 95% of patients to spend less than four hours in ED. Lincoln County Hospital has consistently not met this target in any month between January 2019 and December 2019. On the day of the inspection, performance against the access target was reported to be 59.7% as at 13:45. 53 patients were in the department and eight patients had a decision to admit but no bed was available for them to be transferred too.
- There was evidence that the lack of flow had a direct negative impact on patient safety, quality of care, privacy, dignity and confidentiality. Some patients had been managed on the corridor for the entirety of the time there. Many of these patients were elderly and could be anticipated that they may have reduced mobility and additional care needs. Due to lack of space in the corridor there were many patients on trolleys rather than on beds. The environment was inappropriate to meet patients care needs for extended lengths of time such as feeding, toileting, mobilising and sleeping. Patients reported that due to the noise, light and activity in the majors and corridor, they had been unable to rest comfortably.

Median time from arrival to treatment (all patients)

- Managers monitored waiting times and tried to make sure patients could access emergency services when needed and received treatment within agreed time-frames and national targets.The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard and was much worse than the England average from November 2018 to October 2019. The median time to treatment on the day of inspection was approximately 26%.

Percentage of patients waiting more than 12 hours from the decision to admit until being admitted

- Over the 12 months from December 2018 to November 2019, 12 patients waited more than 12 hours from the decision to admit until being admitted.The trust reported 0 patients in all months apart from March (one patient)and November 2019 (11 patients).

Percentage of patients waiting more than four hours from the decision to admit until being admitted

- From December 2018 to November 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

Inadequate

Urgent and emergency services

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

- From November 2018 to October 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average.

- The resulting fact of poor departmental flow was patients experiencing extended stays in the department. Staff reported they could not accept new patients who arrived by ambulance. We observed this to be the case during the inspection. This resulted in patients having to wait on ambulances until there was sufficient space in the department for the patient to be clinically assessed and their care and treatment commencing.
- We observed patients being cared for on trolleys throughout the department and have discussed this further in the safe domain. The executive team recognised the management of patients on trolleys for extended periods was far from optimal in that patients could not get comfortable and nursing staff could not provide consistent pressure area care due to the limited surface area of the trolley, allowing for regular repositioning of patients.
- Patients were provided with blankets and pillows however due to the high level of foot traffic, and general noise levels, patients who required admission to a hospital bed found it difficult to rest.

Are urgent and emergency services well-led?

Inadequate

Leadership and culture

Leaders lacked the skills and abilities to run the service. Poor clinical leadership resulted in poor situational awareness when risks within the service increased. Local leaders did not fully understand or manage the priorities and issues the service faced; they continued to not be able to find sustainable long-term solutions.

- We had previously reported that appropriate arrangements had not been made to address the risks presented by gaps in clinical leadership capacity. At the time the existing clinical lead was scheduled to take extended planned leave, the trust executive team had approached existing ED consultants to seek a lead to cover the trust wide emergency clinical lead role. However, no-one volunteered to accept the role. and so arrangements were made for two individuals to adopt local, hospital based leadership instead. This resulted in the being no over-arching clinical leadership of emergency care services within the trust.
  - The trust board had opted to streamline the organisational structure. However, despite both internal and external recruitment campaigns, the trust had experienced difficulties in recruiting a substantive divisional director to oversee and lead the medicine and urgent care division. This created further risks in the governance and oversight of the service.

- The emergency physician in charge (EPIC) role was not consistently fully effective and was an area we had previously reported as requiring significant improvement. The aim of the role was to provide overall senior clinical responsibility for the emergency department in line with Royal College of Emergency Medicine guidance between 08:00 and 24:00. The role was intended to ensure safe and effective care, appropriate escalation and achievement of performance standards. This was not happening when we inspected. The EPIC lacked any situational awareness as to the increasing occupancy and associated risks of the emergency department. There was a lack of cohesive working between the nurse in charge and the EPIC which further suggested risks were not being effectively managed. This was acknowledged as an area for improvement by the trust executive team.

Vision and strategy for this service

The service did not have a specific vision at service level for what it wanted to achieve or a clear strategy to turn it into action, developed with all relevant stakeholders.There were some plans which were aligned to local plans within the wider health economy.

- We had previously reported the trust had a vision and a set of values stated in 'Shaping our future for 2021 and beyond.'
- The trust had a programme management approach to develop urgent care across the trust which dovetailed with local system partner's arrangements. However, staff

were not clear on what the strategy was, other than the need to recruit doctors and nurses. The trust had received capital funding from government-led initiatives for the development of the emergency department at Pilgrims Hospital, Boston. A business case to secure the funds was scheduled to be submitted in March 2020. However, the trust reported that current HM Treasury requirements meant there would be significant delays between each stage of the application process, therefore resulting in a final ED build occurring around quarter four of 2020/2021. There remained no costed strategy at site level which combined quality and safety improvement.

- There was significant focus being placed on the new build. During the inspection, we were informed the acting clinical lead had been appointed substantively as the local clinical lead, reporting direct to the trust-wide lead for urgent and emergency care. Their vision was to address the "Back-door" challenges of the department. Despite us probing workforce challenges, sustainable change programmes, quality, and safety, the clinical lead did not specifically recognise these as priority areas. It was considered the clinical lead was orientated on generating capacity in the department which would lead to improvements in patient experience, quality and safety, but without considering the actions required to be taken with the emergency department itself, including the development of clinical leaders for example.
- Some plans partially addressed issues. A new divisional workforce plan had delivered improvements in reducing the nurse vacancy rate at Lincoln County Hospital however there remained an extensive nurse vacancy rate at Pilgrim Hospital, Boston. The lack of a trust-wide clinical lead and the challenges in appointing to the divisional director role had likely impacted on the pace of change within the service. The trust reported there was an ED improvement plan as part of the Urgent Care Improvement Plan, which addressed the vision and direction of travel for the department. This plan integrated with other system partners to consider actions required across the system to reduce attendances, reduce conveyances, and improve handover. However, a lack of strategic planning which delivered identifiable outcomes in a sustainable and meaningful way which considered risks across the whole emergency care pathway through Lincolnshire had resulted in inequity in how the workforce was deployed, thus generating increased risk and poor patient experience and quality of services at one site over another. The trust reported there was however, a revised and agreed nursing workforce plan which considered a trust-wide recruitment plan that focused on both domestic and international recruitment. There was a focused work plan agreed with local universities and Health Education England to improve the knowledge and skills of staff caring for children and young people. This also included offering training to existing nurses to obtain a 2nd registration of child branch.

Governance, risk management and quality measurement

The service monitored activity and performance however this was not driving the necessary improvements.

- Data relating to performance was clearly displayed in the unit. Staff openly discussed performance and what it meant for patients. Whilst new models of care and nursing assessments had been devised in an attempt to manage the safety of the department, there was a lack of awareness or consideration given to national quality standards. Further, there seemed little understanding or robust solutions to tackle concerns which had existed for a number of years and for which we have consistently reported areas requiring improvement. We had seen little or no improvements in some cases, including nurse recruitment, patient flow and respecting the privacy and dignity of patients.
- The lack of trust-wide leadership may have contributed to the lack of systematic improvements being made following incidents. For example, we reported a lack of learning from incidents which had occurred at Lincoln County Hospital, but which were applicable to the delivery of care at Pilgrim Hospital, Boston. Staff working at Pilgrim Hospital were not aware of serious incidents which had occurred in other services, nor those incidents which had taken place at Lincoln County Hospital. Where lessons had been learnt from previous incidents, there was a lack of sustained improvement. For example, staff were failing to undertake ECGs within ten minutes for patients who presented with chest pain as observed during the inspection and from having reviewed patient notes. We further noted a lack of embedded change in relation to the management of

patients who presented with conditions such as hyperkalaemia or hypoglycaemia despite there having been previous serious incidents resulting in harm or death.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
Action the hospital MUST take to improve to:

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments and within defined timescales. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that consultant and nurse cover in the department meets national guidelines. Regulation 12 (c)
- Fully implement the trust wide actions to reduce overcrowding in the department.12 (2) (a) (b) (i)
- The trust must ensure that the privacy and dignity of patients receiving care and treatment in the emergency department is maintained at all times. 10(1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. 1. The provider should ensure that patients who present to the emergency department commence active treatment within a defined period of time as set out on the Providers Certificate of Registration. 2. The registered provider must ensure that there are systems in place across the emergency department at Pilgrim Hospital Boston so that patients are assessed and cared for in the area appropriate for their acuity at all times. 3. The registered provider must ensure that the systems make provision for effective monitoring of the service user's pathway through the emergency department at Pilgrims Hospital Boston. 4. The registered provider must ensure there are appropriate systems in place to monitor the condition and risk of deterioration for all patients awaiting admission (e.g. on ambulances or in corridor areas awaiting triage) to the emergency department at Pilgrims Hospital Boston. 5. The registered provider must ensure that appropriate emergency department escalation procedures are maintained and followed by all staff including at times of peak capacity and demand at Pilgrim Hospital Boston.

This section is primarily information for the provider

Enforcement actions

6. The registered provider must ensure that at all times, there is sufficient capacity in the emergency department to accommodate all patients at risk of deterioration or who require time critical care and treatment; this must be provided in an appropriate clinical setting.

9. The registered provider must ensure the privacy and dignity of patients receiving care and treatment in the emergency department is protected at all times.

Lincoln County Hospital

Quality Report

Greetwell Road
Lincoln
Lincolnshire
LN2 5QY
Tel:01522 512512
Website: www.ulh.nhs.uk

Date of inspection visit: 6 January 2020
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall summary

We carried out an unannounced focused inspection of the emergency department at Lincoln County Hospital on 6 January 2020 in response to concerning information we had received about the care of patients in this department. At the time of our inspection the department was under adverse pressure. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology.We found that:

- Ambulance handover delays remained a challenge, with some patients experiencing delays of more than 100 minutes from arrival by ambulance to being handed over to trust staff for commencement of care and treatment. Whilst the trust had procedures in place for assessing patients who could not be handed over within 15 minutes from arrival, staff were not consistently following these procedures; further, the trust had a lack of robust assurance and oversight for ensuring such procedures were consistently followed.
- Patients did not always see a senior clinical decision maker within nationally defined timescales resulting in delays in them starting their treatment.
- Patients could not always access the service when they needed to due to overcrowding.
- The service continued to lack a specific local vision to address longstanding issues including the provision of services for children.
- Patients remained on assessment trolleys for extended periods of time. The trust reported the number of patients who sustained pressure damage however there was not an effective means of addressing this. We raised this as an area of concern with the trust and asked them to take remedial action to address this.

As a result of this inspection, we have identified areas which the trust make take to ensure they comply with relevant elements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 fundamental standards.

Areas the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of findings

Action the hospital MUST take to improve to:

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments and on appropriate beds. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that consultant and nurse cover in the department meets national guidelines. Regulation 12 (c)
- Fully implement the trust wide actions to reduce overcrowding in the department.12 (2) (a) (b) (i)

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Contents

Summary of this inspection

Background to Lincoln County Hospital

Lincoln County Hospital is a type one emergency department based in the city of Lincoln. The hospital is a designated major trauma unit; this means patients sustaining major trauma injuries through road traffic incidents or other similar modes of injury can be stabalised, and in some cases treated at Lincoln County Hospital, or alternatively, transferred to a major trauma centre.

The department includes:

- 15 major's cubicles
- Three minor's cubicles
- Four resuscitation bays
- Five rapid assessment and treatment beds

Trust activity for the emergency department from September 2018 to August 2019:

- 146,586 A&E attendances (-0.5% change compared to the same time 2017/18)
- 23,727 Children attendances (-8% change compared to the same time 2017/18)
- 52,535 ambulance attendances (+6% change compared to the same time 2017/18)
- 5% patients left without being seen (0% change compared to the same time 2017/18)
- 7.5% re-attendances within 7 days (0% change compared to the same time 2017/18

Trust activity for the preceding 6-weeks to 22 December 2019 was reported as follows:

- 48% of patients are admitted, transferred or discharged within four hours. This is significantly worse than the England average.
- 24-26% of patients were seen by a clinician within 60 minutes.
- On average, between 25 and 40 ambulances a day experienced delays of 60 minutes or more from arrival to handing over their patient to trust staff.
- The number of emergency admissions (referred to as the conversion rate which relates to the number of patients who present to an emergency department and who are subsequently admitted for ongoing care and treatment) was on average 31%.

Inspection and regulatory history

Between April 2014 and July 2019, we have inspected urgent and emergency care services at Lincoln County Hospital four times. We have previously taken urgent enforcement action where we have considered the quality of care and safety of patients was not within expected standards.

Our inspection team

Our inspection team included a CQC inspector and two specialist advisor's consisting of the national professional advisor for urgent and emergency care and a senior nurse whose background was in emergency care.

The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection for Midlands region.

This inspection was attended by the Chief Inspector of Hospitals, Professor Edward Baker.

How we carried out this inspection

This was a focused unannounced inspection of the emergency department at Lincoln County Hospital Hospital on 6 January 2020.

We did not inspect the whole core service therefore we have not reported against, or rated the effective or caring domains. We did not inspect any other core service or wards at this hospital however we inspected the emergency department at Pilgrim Hospital, Boston using the same inspection methodology on 7 January 2020.

Summary of this inspection

During this inspection we inspected using our focused inspection methodology. Because we issued requirement notices, we rated this service. In line with previous ratings, we rated the safe, responsive and well-led domains as inadequate.

Inadequate

Urgent and emergency services

Safe	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Summary of findings

We carried out an unannounced focused inspection of the emergency department at Lincoln County Hospital on 6 January 2020 in response to concerning information we had received about the care of patients in this department. At the time of our inspection the department was under adverse pressure. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology. We found that:

- The design and layout of the emergency department did not consistently keep people safe.
- Ambulance handover delays remained a challenge, with some patients experiencing delays of more than 100 minutes from arrival by ambulance to being handed over to trust staff for commencement of care and treatment. Whilst the trust had procedures in place for assessing patients who could not be handed over within 15 minutes from arrival, staff were not consistently following these procedures; further, the trust had a lack of robust assurance and oversight for ensuring such procedures were consistently followed.
- Patients did not always see a senior clinical decision maker within nationally defined timescales resulting in delays in them starting their treatment.
- Patients could not always access the service when they needed to due to overcrowding.
- The service continued to lack a specific local vision to address longstanding issues including the provision of services for children.
- Patients remained on assessment trolleys for extended periods of time. The trust reported the number of patients who sustained pressure damage

however there was not an effective means of addressing this. We raised this as an area of concern with the trust and asked them to take remedial action to address this.

Inadequate

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

Environment and equipment

The design, maintenance and use of facilities and premises did not consistently keep people safe.

- We previously reported some facilities did not meet Royal College of Paediatrics and Child Health (RCPCH) standards for children. The trust previously reported they did not see enough children to comply with these standards. However, the most current guidance, "Facing the future: standards for children in emergency care settings" no longer differentiates department activity versus compliance with the standards. Instead, current guidance recommends that all providers who see and treat children and young people should strive to meet the national standards in order to enhance the quality and safety of services.
- At this inspection, a waiting area had been created to accommodate children who were waiting to be seen. Although efforts had been made to identify a space which was audio-visually separate from the main adult waiting room, the allocated space was not appropriate in that immediately outside the room, seating allocated for parents and carers was routinely used by adults waiting to be seen. A stud wall had been erected as a means of trying prevent adults waiting from having direct line of sight to the children's waiting area. However, we noted this blocked the line of sight for clinical staff and therefore introduced additional risk in that staff did not have capacity to view children and to identify a patient at risk of deterioration. Whilst we observed adults using the area directly outside the children's waiting room, departmental staff further reported that patients conveyed to the department by police, and individuals in police custody, or those residing at the local prison, would sit in the area directly outside the waiting room. Although not witnessed, we concluded there was a risk infants, children and young people could be required to share waiting areas with patients who were aggressive, violent, or those who were distressed. This was contradictory to national best standards. The provision of services for children and young people was recognised as a significant challenge for the organisation. However, there remained no formalised strategy or long term plan for resolving the issue, in part because of a lack of space in the emergency department to create a dedicated area.
- During the inspection, there was sufficient space to accommodate patients. Patients arriving by ambulance were handed over with no delay; patients were cared for in cubicles or other appropriately designated clinical areas. However, data suggested there remained a lack of sufficient capacity across the hospital to meet local needs during times of peak activity. On our arrival at approximately 12:30, there were 41 patients in the department; eight patients were awaiting an inpatient bed with the longest wait recorded as 16 hours. During the week leading up to Christmas 2019, national data reported the number of patients arriving by ambulance who experienced delays of 60 minutes or more before being handed to trust staff ranged from 25 to 40 patients per day. United Lincolnshire Hospitals NHS Trust was reported as the worst performing trust during this time period. National standards set by the Royal College of Emergency medicine We were informed that during times of peak activity, if there was insufficient capacity in the department for patients to be handed over, patients would be held on ambulances until such time that patients could be transferred in to the emergency department. We were told there was a new system by which trust nursing staff would continue to clinically assess patients on ambulances, within 15 minutes to ensure it was appropriate for them to remain on the ambulance; where staff identified a patients as requiring time critical care or treatment, these patients would be transferred directly in to the emergency department. Because there was sufficient capacity to enable staff to offload ambulances quickly, on 6 January, we could not assess the effectiveness of this new process. However, we heard via the trust bed meeting at 16:00 on 7 January 2020 that patients were being delayed in being transferred in to the department, with one patient waiting 109 minutes on an ambulance. It was further reported during the bed meeting that due to poor communication, staff working in the ED were not clinically assessing those patients being held on ambulances. This was contrary to the new revised standard operating procedure and therefore meant the trust executive team could not be assured all patients were being clinically assessed within 15 minutes.

Inadequate

Urgent and emergency services

- Prior to the inspection we reviewed all clinical incidents relating to urgent and emergency care services across United Lincolnshire Hospitals NHS Trust for the period of 1 June 2019 to 1 December 2019. We noted a number of incidents related to staff from other departments reporting patients being admitted to wards from the emergency department (ED) with grade two pressure ulcers which had not previously been recognised, therefore potentially meaning the damage was caused whilst patients were in the ED. Tissue viability was an area which we had previously raised concerns about and had issued the trust with regulatory actions requiring them to make improvements. Although this action was directed towards standards of care at Pilgrim Hospital, Boston, due to a divisional structure adopted by the organisation, we would have expected standard actions to have been taken across both emergency departments. We noted that all patients in the department were being nursed on trolleys. We discussed the increase in potential department acquired grade two pressure ulcers with staff. They reported that due to a lack of space in the department, and a lack of bed frames across the organisation, it was necessary to care for patients on trolleys. Staff described action being taken to address the issue, including the availability of pressure relieving equipment such as air mattresses. We raised this with the interim director of nursing who reported the trolleys had been equipped with mattresses designed for patients at risk or very high risk of pressure damage. A review of the mattress specification suggested the mattresses were only suitable for patients "Waiting for treatment" as compared to being kept on the mattress for extended periods of time. We observed frail elderly patients remaining on trolleys for extended periods of time, therefore pre-disposing those individuals to the risk of harm due to not being nursed on an appropriate bed. Whilst we observed some patients being nursed on trolleys being provided with supplementary pressure relieving devices such as air mattresses there were occasions when this did not happen. In one case, an elderly patient who had been identified as being at high risk of skin damage had been on a trolley for six hours and had not been placed on an air mattress or other pressure relieving device. The lack of action by nursing staff could have predisposed the patient to what could have been avoidable harm. This was despite CQC having previously raised concerns, and for which the trust had adopted an action plan. We considered there had been limited overall improvement in this area, for which concerns had existed since 2018.
- We checked a range of specialist equipment, including adult and children's resuscitation equipment. Equipment was clean and organised, and a review of equipment checklists showed that daily checks had routinely completed.Clinical waste was segregated and stored appropriately.

Assessing and responding to patient risk

Patients who self-presented were triaged in line with national guidance. However, some patients continued to wait considerable time before being clinically assessed and treated.

- The department had a triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours. Improvements had been made since our last inspection which ensured streaming and triage processes for patients who self-presented to the department. Previous processes involved employees from both a community provider who was commissioned to provide urgent care services, and a nurse from Lincolnshire Hospitals NHS Trust. A member of the community trust was now located at the main reception and was trained to direct patients to the most relevant clinical pathway which was either via urgent care services; the majors department or direct to the resuscitation room if necessary. A new triage area had been created specifically for a trained nurse to clinically assess children who presented and who had been streamed to be seen in the majors area. Adults were seen by a trained triage nurse who was further supported by a healthcare assistant or associate nurse. Basic interventions including ECGs and blood tests could be carried out by the triage team if the patients condition warranted such intervention. We observed patients being called through to the triage team in a timely fashion. Staff took basic medical histories and undertook physical observations including blood pressure, heart rate, neurological observations where

appropriate and physical examinations for patients presenting with minor injuries. We observed nursing staff giving appropriate consideration to the emotional well-being of patients during the triage process, as well as considering safeguarding concerns with one good example or appropriate escalation being observed during the inspection.

- We reviewed 16 sets of patients records. There were examples when patients waited periods of three hours before a triage assessment was completed when arriving by ambulance. This included one patient who was listed as a category two patient and should have therefore been seen by a nurse immediately and then by a doctor within 15 minutes. The patient arrived in to the department at 12:46 but was not triaged until 15:49; the patient was subsequently seen by a doctor at 17:00, some four hours after they first arrived. A second patient arrived at approximately 10am but was not triaged until 11:15. Although the patient was subsequently seen by a doctor at 11:40 and a diagnosis of possible sepsis was considered, antibiotics were not commenced until 13:49. The trust recognised that further work was required to ensure patients were assessed in a timely way and that treatment was commenced according to the clinical needs of the patient. The trust reported an improving picture in relation to the timely commencement of assessment of sepsis with 91.1% of adults and 90.1% of children having a sepsis screen completed within one hour of arrival.
- A review of incidents suggested there remained challenges with ensuring patients who presented with a condition referred to as neutropenic sepsis were managed in accordance with national and local best practice standards. Incident investigations suggested clinical and nursing staff were not routinely considering "Red flag" conditions such as patients who had had chemotherapy in the last six weeks; patients with haematological or oncological malignancies; patients who had previously had stem cell therapy or patients with chronic neutropenia. The departments neutropenic sepsis pathway remained in draft format; staff we spoke with were not all familiar with the pathway and senior staff recognised further work was required to ensure this specific patient cohort were treated in accordance with local protocols.
- Standards set by the Royal College of Emergency Medicine states initial clinical assessment should take place within 15 minutes of arrival. Trust board papers report varied performance against this metric:
  - August 2019 - 82.5% of patients were triaged within 15 minutes
  - September 2019 - 75.2%
  - October 2019 - 82.3%
  - Overall year to date performance (to October 2019) was reported as 79.3%
- As a result of the inspection of the urgent and emergency care service in June 2019, the Care Quality Commission imposed conditions on the providers registration requiring them to ensure that all children were clinically assessed within 15 minutes. As part of the action taken, the trust was required to report routinely, department performance against this standard. The trust reported that for the weeks commencing 18 and 25 December 2019 respectively, 70.8% and 80% of children and young people who arrived by ambulance were clinically assessed within 15 minutes. For the same time period, 61.5% and 78.4% of children and young people who self-presented (or accompanied by a parent/carer) were clinically assessed within 15 minutes. This was reported to be an improving position however staff recognised further work was required to ensure the trust complied with regulatory requirements and met national best practice standards.
- The trust undertook a joint initiative with the local ambulance trust to improve overall ambulance handover performance in order to initially eradicate patients waiting more than 120 minutes from arrival to being handed over. Despite a range of initiatives, the trust had failed to achieve this target as of 22 December 2019. The trust reported the following data-set for performance against the 15 minute handover target for Lincoln County Hospital:
  - October 2019 - 24.7% and 8.2% of patients arriving by ambulance experienced delays of more than 60 minutes and 120 minutes respectively.
  - November 2019 - 22% and 6.3% of patients arriving by ambulance experienced delays of more than 60 minutes and 120 minutes respectively.
  - December 2019 - 27.6% and 10.1% of patients arriving by ambulance experienced delays of more than 60 minutes and 120 minutes respectively.
- Senior staff recognised the importance of supporting ambulances to handover their patients quickly in order

they could return to service to support other patients in need in the community. It was reported a new process had been introduced, with a standard operating procedure being developed in partnership with the trust and local ambulance service which would ensure that any patient delayed in being handed over would be clinically assessed within 15 minutes. This was to ensure the doctors and nurses responsible for the department would be aware of who was waiting and to help identify any patient requiring time critical care and treatment. Because the department was able to offload all patients arriving by ambulance in a timely way during the inspection, we were not able to assess the effectiveness of this new process. However, whilst we were inspecting the ED at Pilgrim Hospital on 7 January 2020, we opted to attend a trust-wide bed meeting. At this meeting it was reported the ED at Lincoln County Hospital was under immense pressure and four ambulances had been delayed by up to 109 minutes resulting in patients being held on ambulances. It was further reported at the 7 January bed meeting that due to a communication error, nursing staff had not been clinically assessing patients who were being held on ambulances. This meant there was a reliance on ambulance trust staff recognising and escalating any deteriorating patient. Local senior nurses had recognised the lack of clinical assessment and reiterated the revised standard operating procedure to ensure all patients were clinically assessed within 15 minutes.

- The national early warning score (NEWS2) system and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). NEWS2 is a point system implemented to standardise the approach to detecting deterioration in patients' clinical condition. We looked at 16 electronic NEWS/PEWS records and saw that they were completed correctly and within defined time frames. A patient information screen located in the department had the most current NEWS score clearly viewable to all staff. This acted as a prompt for staff; colour coding of NEWS scores meant staff could quickly see who the sickest patients were, determined by their NEWS score. Where a patient had a high NEWS score, the screen was locked when the next set of observations were due; this again acted as a prompt for a staff member to reassess the clinical condition of the sickest patients.

Nursing staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. However, managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

- The ED used a combination of the baseline emergency staffing tool and national emergency department staffing recommendations, to ensure the department was staffed appropriately. This outlined how many registered nurses were needed to safely staff the department. The tools looked at the acuity of patients and how many were in the department at certain times of the day. In response to previous concerns raised by CQC in regards to the management of sick children, new competencies and assessment frameworks had been introduced for nurses responsible for caring for children. A competent nurse was scheduled to work on each shift and records confirmed this was happening. Registered children's nurses were employed by the department however, as is similar with the national position, there were only limited numbers employed. As a result, only those nurses who had completed the competency and assessment frameworks, and who had completed additional life support training, were rostered to cover the children's service
- The ED was staffed with 12 registered nurses and five healthcare assistants during the day and three healthcare assistants at night. One healthcare assistant was rostered to support the twilight period in order there were sufficient staff available during peak times. We reviewed rota's dating from 4 November 2019 through to 5 January 2020. On two days, the number of registered nurses available was lower than the number required however there had been an increase in the number of health care assistants deployed. There remained a heavy reliance on agency staff to support the rotas, in part because the department had five whole time equivalent vacancies for band five nurses and two vacancies for band six nurses. Staff reported

changes to clinical roles including that of the clinical co-ordinator and flow co-ordinator. It was reported these roles had historically worked independently of one another, however the department matron who had been seconded to the role, considered it was more appropriate for one senior nurse to assume overall responsibility for the department each shift. As a result, 5.49 whole time equivalent band seven roles had been approved and were actively being recruited to at the time of the inspection.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.

- On commencement of the inspection at approximately 12:30. the department was being managed and clinically led by an experienced consultant. There was appropriate numbers of doctors available to see and treat patients in a timely way. However, we noted that following a change to the consultant in charge, flow through the department started to slow down. The time patients waited to be seen and treated by a senior decision maker started to increase and there was little situational awareness from the consultant-in-charge and nurse-in-charge (flow co-ordinator) to address this. This resulted in patients waiting extended periods of time before their treatment started. At approximately 13:45 it was reported the number of patients who were seen and a plan of care prescribed by a senior decision maker within 60 minutes was 26%. We raised this with the executive team who acknowledged significant work was required to ensure clinical leaders had the right skills and experience to ensure the department was managed effectively.
- However, during the inspection we observed good clinical decision making skills for those patients being managed in the resuscitation area. We noted clinicians used evidence based, nationally aligned clinical protocols for the management of patients who were septic or who had presented with an acute exacerbation of their chronic condition. During the inspection, one senior medic was present in the resuscitation area at all times.
- Although there had been improvements to the number of doctors employed since our last inspection, there remained gaps on the medical staffing rota. This was recognised as being a significant risk for the department and was captured on the departments risk register. Further work was being undertaken to address medical workforce challenges. Consultants were however providing extended levels of cover and were available in the department from 08:00 to 00:00 Monday to Friday. The senior leadership team recognised the need for them to source and recruit a consultant who was a specialist in paediatric emergency medicine due to the numbers of children seen and treated in the department.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Inadequate

Access and flow

Patients could not always access the service when they needed to due to overcrowding. Some patients had long delays in accessing emergency care and treatment.

- Front line staff reported they were on operational pressure escalation level (OPEL) three at the time of the inspection. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care. National criteria define OPEL three as "Four hour access target significantly compromised; significant numbers of handover delays; patient flow significantly compromised".
- NHS Trusts are required to monitor and report nationally the percentage of patients who attend ED and get seen, discharged or admitted within four hours of arrival. This is known as the Emergency Access Standard (EAS). The NHS standard requires 95% of patients to spend less than four hours in ED. Lincoln County Hospital has consistently not met this target in

any month between January 2019 and December 2019. On the day of the inspection, performance against the access target was reported to be 59.7% as at 13:45. 53 patients were in the department and eight patients had a decision to admit but no bed was available for them to be transferred too.

Median time from arrival to treatment (all patients)

- Managers monitored waiting times and tried to make sure patients could access emergency services when needed and received treatment within agreed time-frames and national targets.The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard and was much worse than the England average from November 2018 to October 2019. The median time to treatment on the day of inspection was approximately 26%.

Percentage of patients waiting more than 12 hours from the decision to admit until being admitted

- Over the 12 months from December 2018 to November 2019, 12 patients waited more than 12 hours from the decision to admit until being admitted. The trust reported 0 patients in all months apart from March (1 patient) and November 2019 (11 patients).

Percentage of patients waiting more than four hours from the decision to admit until being admitted

- From December 2018 to November 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

- From November 2018 to October 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average.

- The resulting fact of poor departmental flow was patients experiencing extended stays in the department. Staff reported that at peak times, they could not accept new patients who arrived by ambulance. This resulted in patients having to wait on ambulances until there was sufficient space in the department for the patient to be clinically assessed and their care and treatment commencing.
- We observed patients being cared for on trolleys throughout the department and have discussed this further in the safe domain. The executive team recognised the management of patients on trolleys for extended periods was far from optimal in that patients could not get comfortable and nursing staff could not provide consistent pressure area care due to the limited surface area of the trolley, allowing for regular repositioning of patients. Patients were provided with blankets and pillows however due to the high level of foot traffic, and general noise levels, patients who required admission to a hospital bed found it difficult to rest.
- The hospital had developed a number of simple same day emergency care pathways and services which aimed to avoid admission and speed up treatment. In June 2019, the trust had launched an ambulatory care same day emergency centre. This was led by advanced care practitioners with a consultant. The service aimed to divert from the emergency department up to 25 patients/day with certain day case treatable issues such as deep vein thrombosis, chest pain or cellulitis. At the time of this inspection it was reported the conversion rate through to the same day emergency care service was lower than the trust had aspired for. This was in part due to the fact the service had been relocated on a number of occasions. Staffing challenges had further hampered the effectiveness of the service. Since our last inspection, the service had since been relocated to the emergency department in part to help enhance the visibility of the team.

Inadequate

Urgent and emergency services

Are urgent and emergency services well-led?

Inadequate

Leadership and culture

Operationally, leaders lacked the skills and abilities to run the service. Although they understood and managed the priorities and issues the service faced, they continued to not be able to find sustainable long-term solutions.

We had previously reported that appropriate arrangements had not been made to address the risks presented by gaps in clinical leadership capacity. At the time the existing clinical lead was scheduled to take extended planned leave, the trust executive team had approached existing ED consultants to seek a lead to cover the trust wide emergency clinical lead role. However, no-one volunteered to accept the role. and so arrangements were made for two individuals to adopt local, hospital based leadership instead. This resulted in the being no over-arching clinical leadership of emergency care services within the trust.

The trust board had opted to streamline the organisational structure. However, despite both internal and external recruitment campaigns, the trust had experienced difficulties in recruiting a substantive divisional director to oversee and lead the medicine and urgent care division. This created further risks in the governance and oversight of the service.

The emergency physician in charge (EPIC) role was not consistently fully effective and was an area we had previously reported on as requiring significant improvement. The aim of the role was to provide overall senior clinical responsibility for the emergency department in line with Royal College of Emergency Medicine guidance between 08:00 and 24:00. The role was intended to ensure safe and effective care, appropriate escalation and achievement of performance standards. This was not happening when we inspected. Although we noted some individuals had the ability to lead the service effectively and safely. changes to staffing throughout the shift resulted in people not having the situational awareness to manage the department. This was acknowledged as an area for improvement by the trust executive team.

Vision and strategy for this service

The service did not have a specific vision at service level for what it wanted to achieve or a clear strategy to turn it into action, developed with all relevant stakeholders. There were some plans which were aligned to local plans within the wider health economy.

We had previously reported the trust had a vision and a set of values stated in 'Shaping our future for 2021 and beyond.' This included a site level vision for Lincoln County Hospital which included a 24/7 emergency department fronted by an Urgent Care Centre with GP streaming, and a 24/7 paediatric emergency department. This strategy was new and the extent to which it had been reflected in divisional planning varied.

For the emergency department at Lincoln, strategic planning to turn the vision into action was fragmented and incomplete. The trust had a programme management approach to develop urgent care across the trust which dovetailed with local system partner's arrangements. However, staff were not clear on what the strategy was, other than the need to recruit doctors and nurses. The trust had received capital funding from government-led initiatives however this investment was being directed towards enhancing emergency care services at Pilgrims Hospital, Boston. There remained no costed strategy at site level which combined quality and safety improvement, workforce planning and training, meeting the RCEM and RCPCH standards, and meeting the needs of children and the full range of patient's individual needs.

Some plans partially addressed issues. A new divisional workforce plan had delivered improvements in reducing the nurse vacancy rate at Lincoln County Hospital however there remained an extensive nurse vacancy rate at Pilgrim Hospital, Boston. The lack of a trust-wide clinical lead and the challenges in appointing to the divisional director role had likely impacted on the pace of change within the service.The trust reported there was an ED improvement plan as part of the Urgent Care Improvement Plan, which addressed the vision and

direction of travel for the department. This plan integrated with other system partners to consider actions required across the system to reduce attendances, reduce conveyances, and improve handover. However, alack of strategic planning which delivered identifiable outcomes in a sustainable and meaningful way which considered risks across the whole emergency care pathway through Lincolnshire had resulted in inequity in how the workforce was deployed, thus generating increased risk and poor patient experience and quality of services at one site over another. The trust reported there was however, a revised and agreed nursing workforce plan which considered a trust-wide recruitment plan that focused on both domestic and international recruitment. There was a focused work plan agreed with local universities and Health Education England to improve the knowledge and skills of staff caring for children and young people. This also included offering training to existing nurses to obtain a 2nd registration of child branch.

Governance, risk management and quality measurement

The service monitored activity and performance however this was not driving the necessary improvements.

Data relating to performance was clearly displayed in the unit. Staff openly discussed performance and what it meant for patients. Whilst new models of care and nursing assessments had been devised in an attempt to manage the safety of the department, there was a lack of awareness or consideration given to national quality standards. For example, clinical pathways including the standard management of patients who presented with fractured femurs had not been considered or implemented in the department. Challenges in staffing and various departmental moves had meant the same day emergency care model had not delivered the expected results to alleviate pressure on the emergency department.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments and on appropriate beds. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that consultant and nurse cover in the department meets national guidelines. Regulation 12 (c)
- Fully implement the trust wide actions to reduce overcrowding in the department.12 (2) (a) (b) (i)

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i) • The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments and on appropriate beds. Regulation 12 (2) (a) (b) (i) • The trust must ensure that consultant and nurse cover in the department meets national guidelines. Regulation 12 (c) • Fully implement the trust wide actions to reduce overcrowding in the department.12 (2) (a) (b) (i)

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Medical Director
Date:	March 2020

Title:	**Patient Safety Incidents Report**

Responsible Director: Dr Neill Hepburn, Medical Director.

Author: Paul White, Risk Manager

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

- Trends in the volume and type of patient safety incidents reported
- Trends in the volume and type of Serious Incidents (SIs) declared
- Performance in managing Serious Incident (SI) and Divisional investigations
- Performance in managing reported incidents
- Compliance with the statutory Duty of Candour

The Report is provided to the Committee for:

Decision		Discussion	✓
Assurance	✓	Information	

Summary/Key Points:

- The Patient Safety Group reviews the Patient Safety Incidents Dashboard every month and identifies areas of concern for further analysis and action where necessary; this report is then presented to the Quality Governance Committee (QGC); a copy of the most recent report is attached as **Appendix I**. Key points to note are as follows:
  - 1194 patient incidents were reported in January 2020, which is consistent with the monthly average of 1123 for 2019/20 so far; Pilgrim Hospital has reported 45.7% of all patient incidents so far this financial year; Lincoln County 45.2%
  - There were 18 significant harm incidents (those resulting in Moderate harm; Severe harm; or Death) reported in January 2020, which is below the average of 19.5 per month so far in 2019/20; 16 of those incidents actually occurred in January
  - The Trust declared 16 Serious Incidents in January 2020, compared with an average of 17 per month so far in 2019/20; 5 of those incidents actually occurred in January
  - 63.9% of Serious Incidents so far this financial year occurred within Medicine Division
  - There were 38 Serious Incident investigations open at the end of January, 2 of which were overdue their deadline to the CCG (the first overdue this financial year)
  - Compliance with the Duty of Candour was 100% (in person) and 96% (written follow-up) in December (1 non-compliant incident)
  - The number of open incidents has not been reduced to below 4,500 since monitoring began at the start of this financial year, indicating that there continues to be no significant progress in addressing the backlog

Recommendations:

- That the Trust Board considers the content of the report and identifies any further action required

Strategic Risk Register	**Performance KPIs year to date**
Patient safety risks that are identified as strategic risks are included in the Board Assurance Framework (BAF).	This report details the Trust's performance with regard to the timely completion of incident investigations and compliance with the statutory Duty of Candour.

Resource Implications (e.g. Financial, HR):
In order to support improvements in the incident management process the Trust has invested in the further development of the existing Datix system, to include the introduction of management dashboards and web-based versions of the Complaints and Claims modules. Staffing resources within the risk team are currently under review as part of an on-going restructure within the Clinical Governance directorate.

Assurance Implications
The content of this report will support the Trust Board in its regular review of the effectiveness of existing strategies and policies relating to patient safety, providing assurance against regulatory requirements and expectations.

Patient and Public Involvement (PPI) Implications
An essential aspect of the incident management process is the delivery where appropriate of an apology when something has gone wrong with a person's care and, in the case of a Serious Incident the sharing of the final report with affected patients or their representatives.

Equality Impact
The policies and processes associated with incident management have been assessed for equality impact and no outstanding issues have been identified.

Information exempt from Disclosure – No

Requirement for further review? No

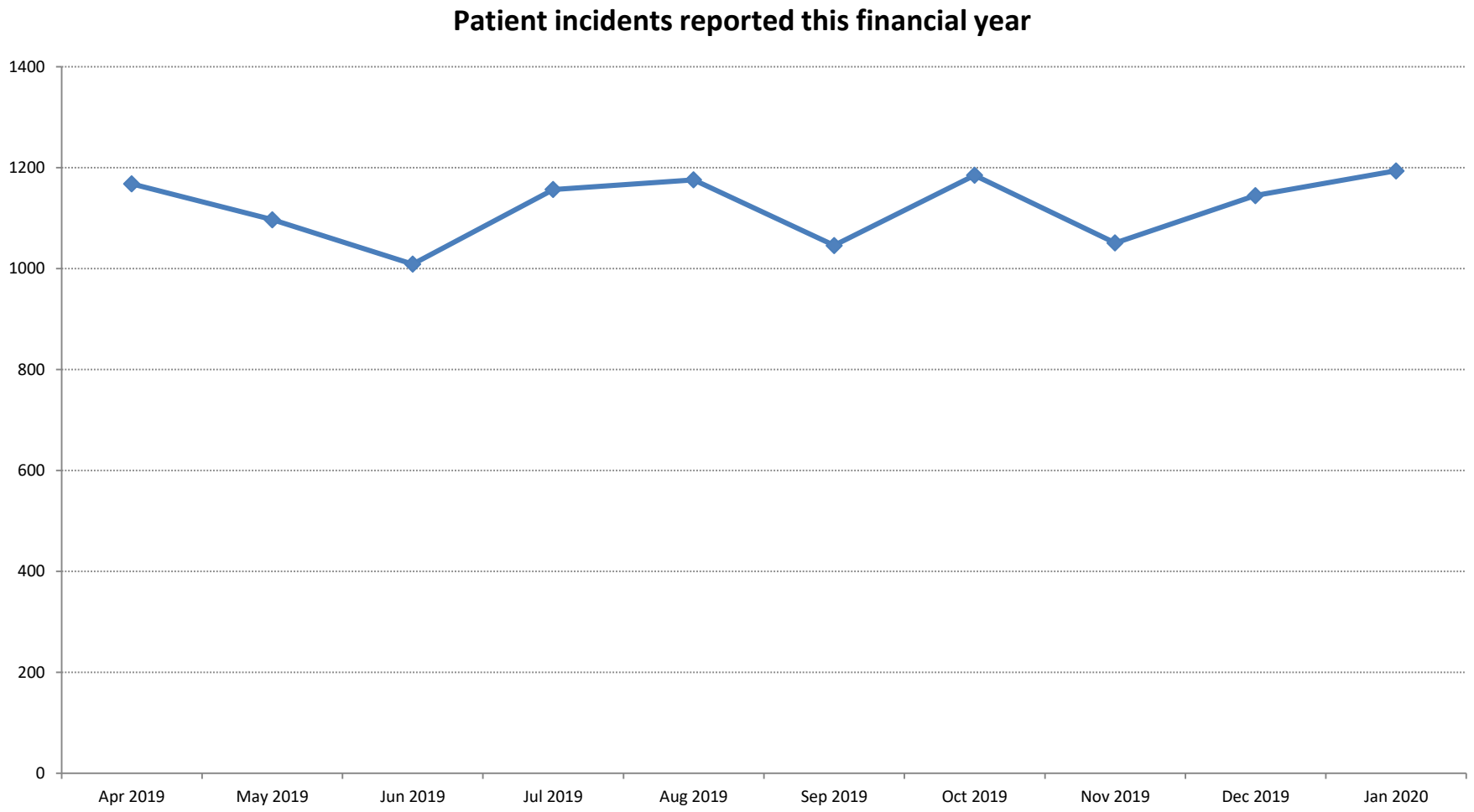
Patient Safety Incidents Dashboard

February 2020

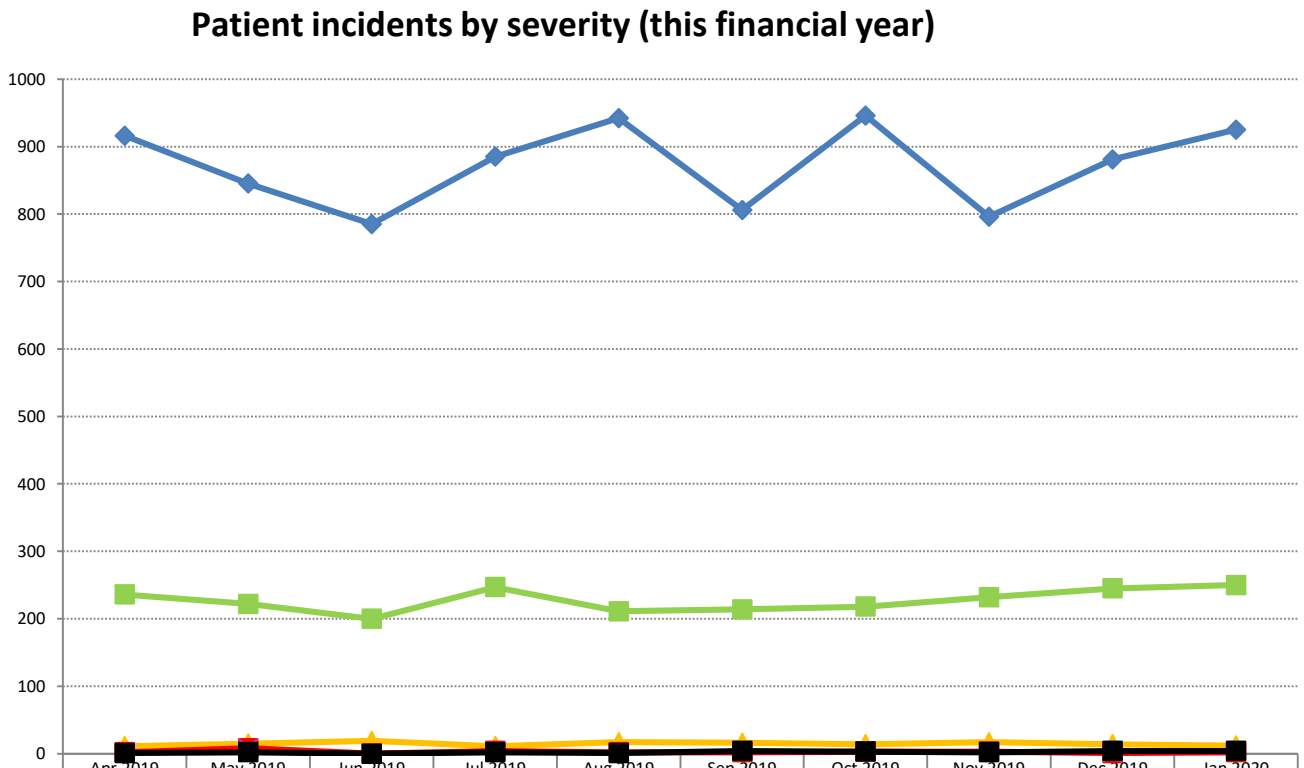
Author: Paul White, Risk Management Lead

Contents

1a. Patient incidents



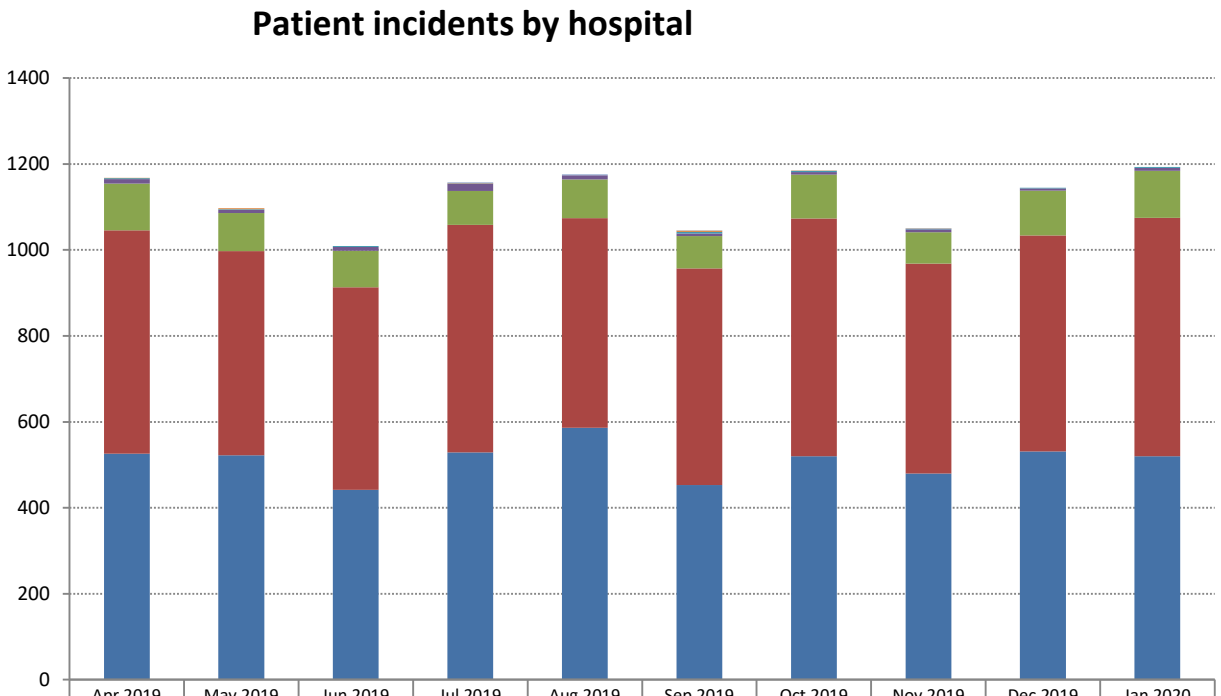
1b. Patient incidents



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
1 - No harm	916	845	785	885	942	806	946	796	881	925
2 - Low Harm	236	222	200	247	211	214	218	232	245	250
3 - Moderate Harm	11	15	19	11	17	16	14	17	14	12
4 - Severe Harm	2	8	0	4	2	2	3	3	1	2
5 - Death	1	2	0	2	1	4	3	2	4	4

YTD TOTALS	YTD %
8727	77.9%
2275	20.3%
146	1.3%
27	0.2%
23	0.2%

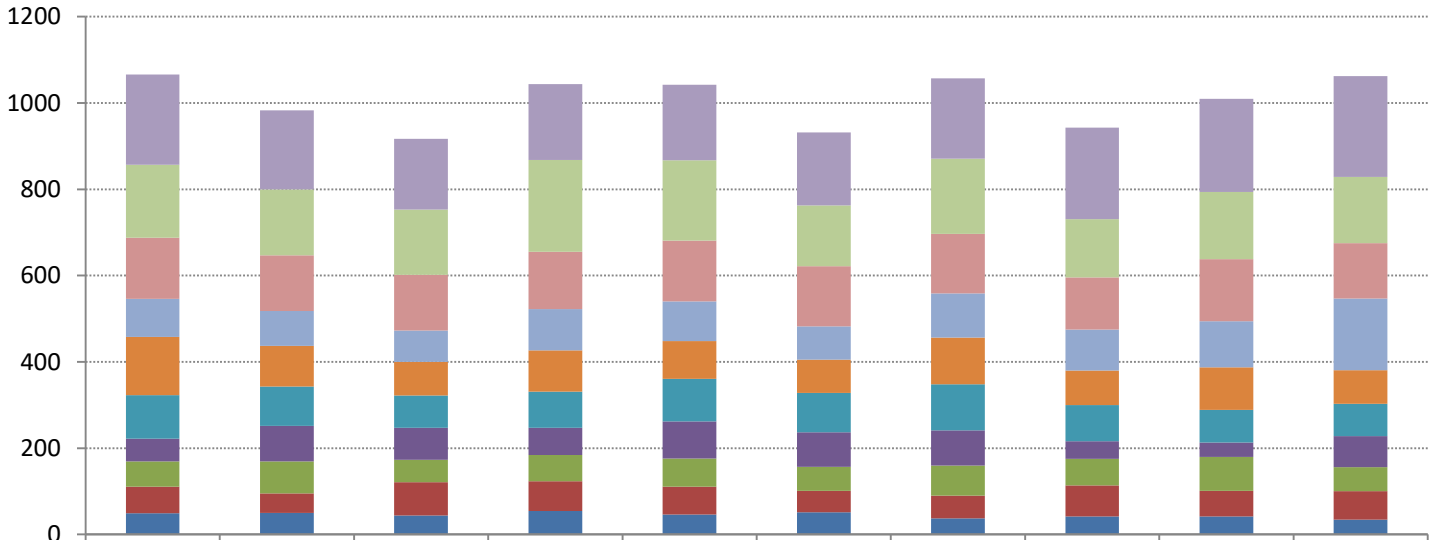
1c. Patient incidents



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	YTD TOTALS	%
John Coupland Hospital, Gainsborough	0	0	0	1	2	1	0	1	0	0	5	0.0%
Skegness Hospital	1	2	0	1	0	3	1	1	0	0	9	0.1%
Spalding Hospitals	2	2	2	1	0	4	3	1	2	2	17	0.2%
County Hospital, Louth	11	7	9	17	10	6	6	7	5	7	78	0.8%
Grantham & District Hospital	108	89	85	79	90	75	102	73	104	109	804	8.0%
Lincoln County Hospital	520	475	471	529	488	504	553	488	503	555	4534	45.2%
Pilgrim Hospital, Boston	526	522	442	529	586	453	520	480	531	520	4589	45.7%

1d. Patient incidents

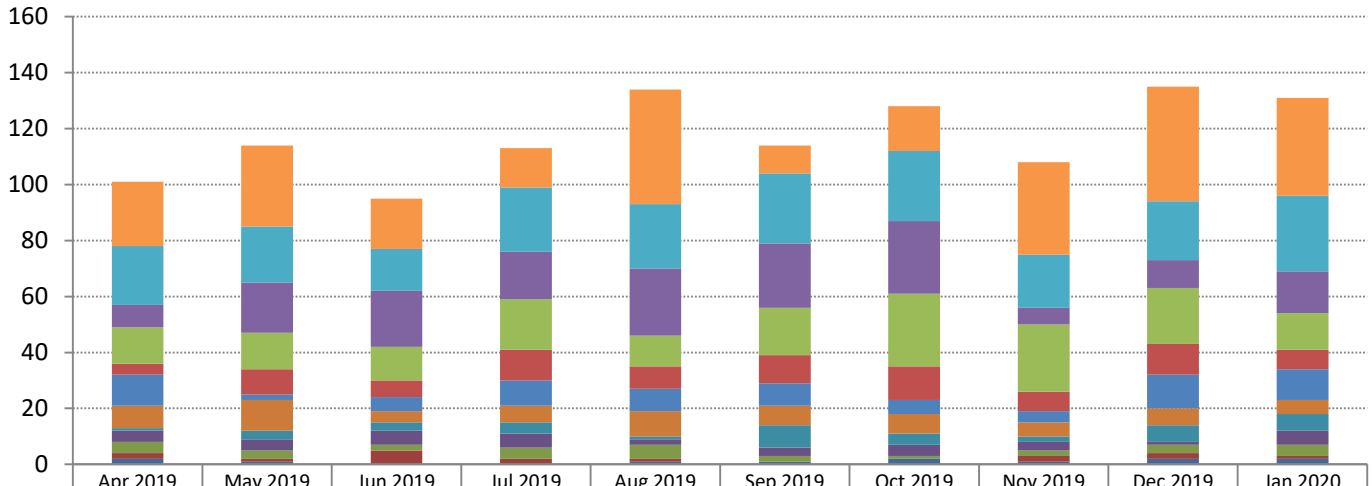
Patient incidents by category (Top 10)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Patient Accidents/Falls	209	183	164	176	175	169	186	212	216	233
Medication/Biologics/Fluids	169	153	151	213	186	141	174	135	156	154
Diagnostic Processes/Procedures	142	129	129	133	141	140	138	121	144	128
Pressure Ulcers	88	81	73	95	92	77	103	95	107	166
Administrative Processes	135	94	78	96	87	77	108	80	98	78
Documentation	101	91	75	84	99	91	107	84	76	75
Behaviour	53	83	74	63	86	80	81	41	33	72
Communication	58	74	52	61	65	56	70	61	79	56
Maternity Care	62	45	77	69	65	50	53	72	59	66
Therapeutic Processes/Procedures	49	50	44	54	46	51	37	42	42	34

1e. Patient incidents

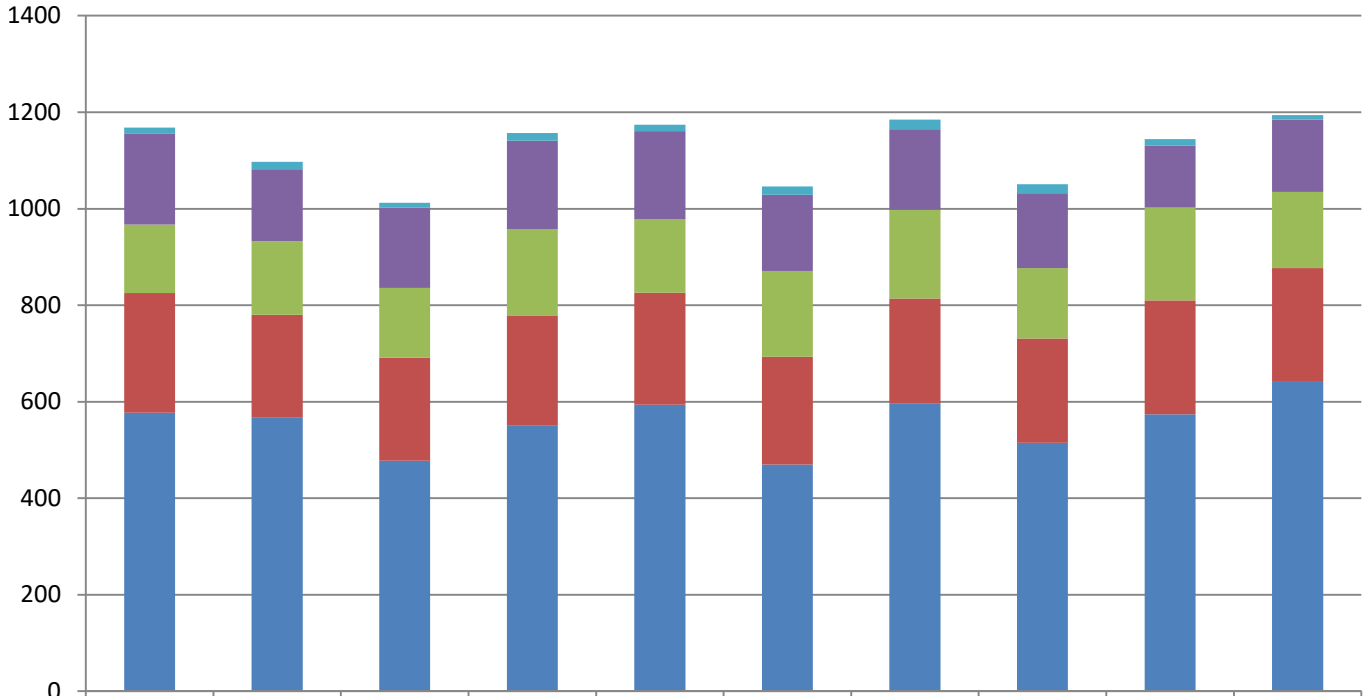
Patient incidents by category (outside Top 10)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Blood/Plasma Products	23	29	18	14	41	10	16	33	41	35
Medical Devices, Equipment, Supplies	21	20	15	23	23	25	25	19	21	27
Neonatal/Perinatal Care	8	18	20	17	24	23	26	6	10	15
Infection Control Incident	13	13	12	18	11	17	26	24	20	13
Personal Property/Data/Information	4	9	6	11	8	10	12	7	11	7
Injury of unknown origin	11	2	5	9	8	8	5	4	12	11
Anaesthesia Care	8	11	4	6	9	7	7	5	6	5
Nutrition Food/Meals from Kitchen	1	3	3	4	1	8	4	2	6	6
Unexpected Deaths or Severe Harm	4	4	5	5	2	3	4	3	1	5
Exposure to Environmental Hazards	4	3	2	4	5	2	1	2	3	4
Nutrition Pharmacy Products	2	1	5	2	1	0	0	2	2	1
Medical Gases/Oxygen	2	1	0	0	1	1	2	1	2	2

1f. Patient incidents

Patient incidents reported this financial year (by division)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	MONTHLY AVERAGE
Corporate	12	15	10	16	13	17	20	19	13	9	14
Family Health	189	149	166	183	183	158	167	155	129	150	163
Clinical Support Services	142	153	145	179	152	178	184	146	192	158	163
Surgery	248	212	213	228	232	223	218	216	236	234	226
Medicine	577	568	478	551	594	470	596	515	574	643	557

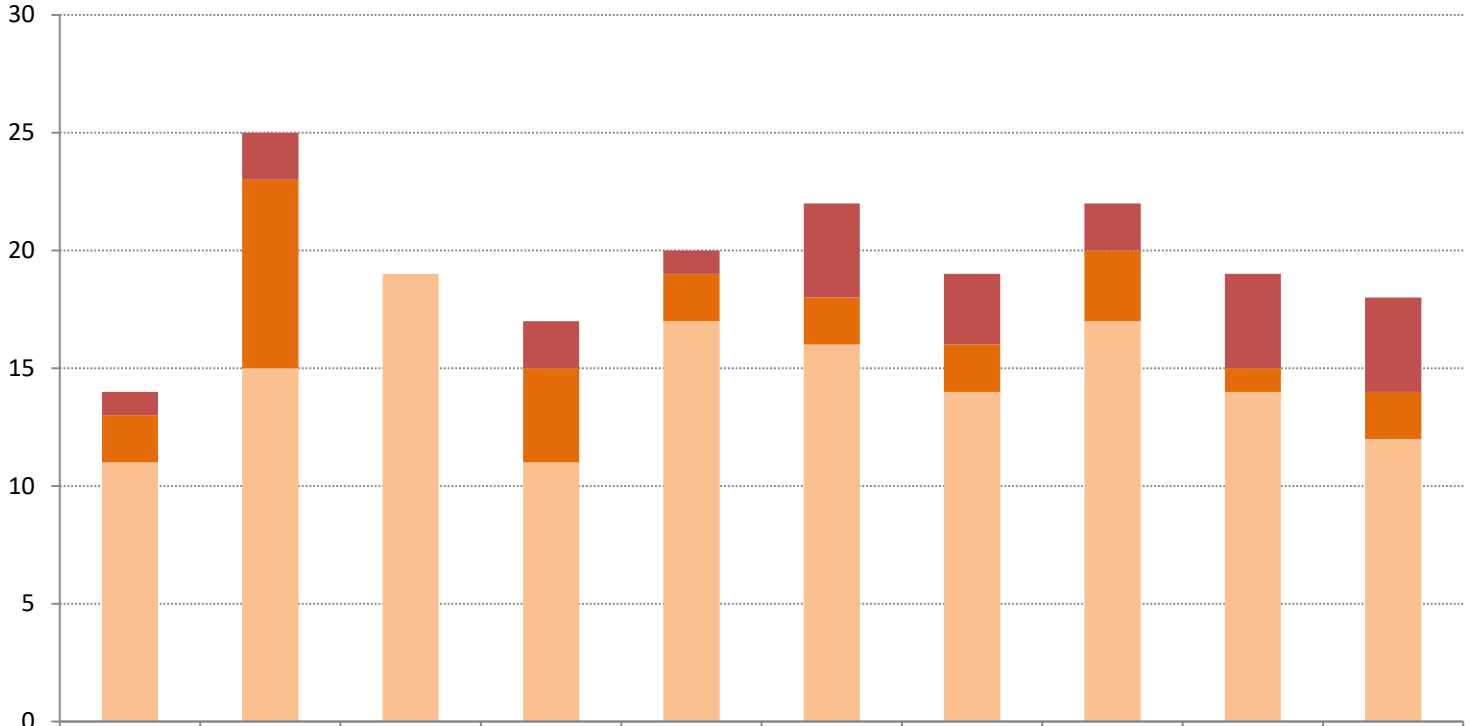
1g. Patient incidents

Analysis

- 1194 patient incidents were reported in January 2020, which is consistent with the monthly average of 1123 for 2019/20 so far; Pilgrim Hospital has reported 45.7% of all patient incidents so far this financial year; Lincoln County 45.2%
- Medicine Division reported 643 patient incidents in January, much higher than the monthly average of 557 in 2019/20; all other divisions reported a typical number of incidents
- Patient accidents / falls remains the highest volume incident category in 2019; 233 incidents were reported under this category in January, the highest number in any month of 2019-20 (December 2019 was the previous highest); all but one (No harm) occurred in January
  - 1 incident resulting in Death (at Pilgrim)
  - 1 Moderate harm (at Grantham)
- There were 166 ‘Pressure Ulcer’ incidents reported in January, also the highest number in any month of 2019-20 and double the monthly average from Quarter 1 (April – June 2019); 1 Low harm and 1 No harm occurred in December
  - 2 Moderate harm incidents (both at Pilgrim

2a. Significant harm incidents

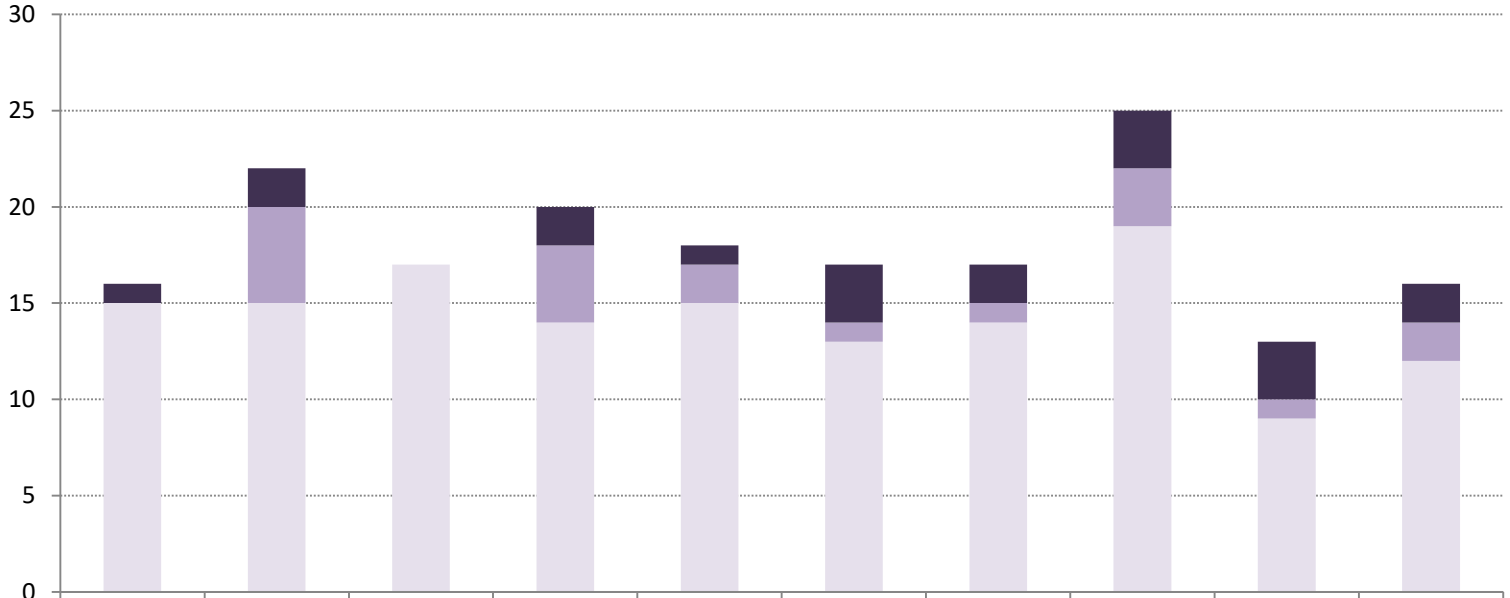
Significant harm incidents this financial year by reported date



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
5 - Death	1	2	0	2	1	4	3	2	4	4
4 - Severe Harm	2	8	0	4	2	2	2	3	1	2
3 - Moderate Harm	11	15	19	11	17	16	14	17	14	12

2b. Significant harm incidents

Significant harm incidents this financial year by incident date

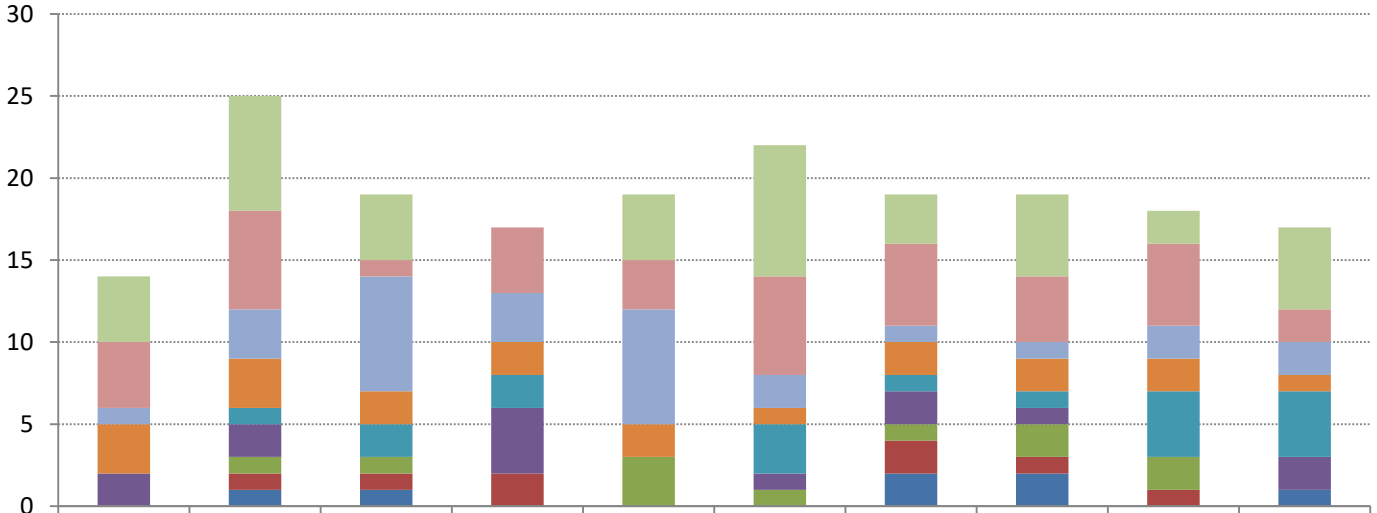


	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
5 - Death	1	2	0	2	1	3	2	3	3	2
4 - Severe Harm	0	5	0	4	2	1	1	3	1	2
3 - Moderate Harm	15	15	17	14	15	13	14	19	9	12

Not shown: 1 incident that occurred in 2015/16; 2 incidents that occurred in 2017/18; and 11 incidents that occurred in 2018/19

2c. Significant harm incidents

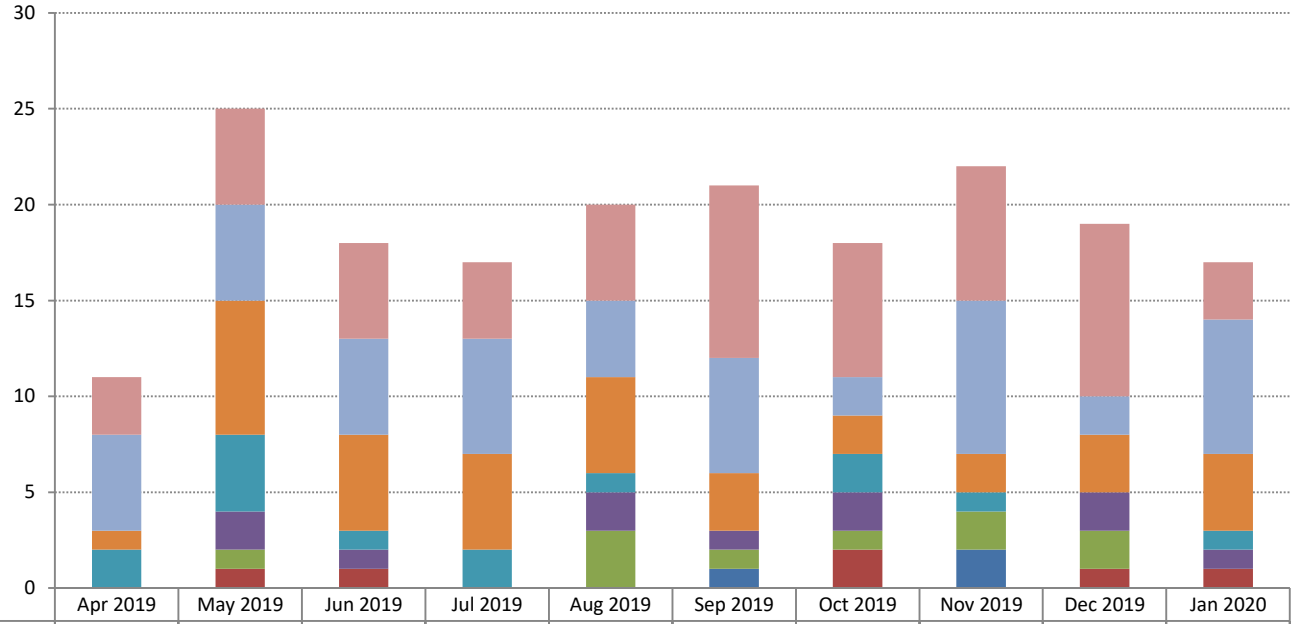
Significant harm incidents by category (more than 2 incidents)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Diagnostic Processes/Procedures	4	7	4	0	4	8	3	5	2	5
Patient Accidents/Falls	4	6	1	4	3	6	5	4	5	2
Pressure Ulcers	1	3	7	3	7	2	1	1	2	2
Therapeutic Processes/Procedures	3	3	2	2	2	1	2	2	2	1
Medication/Biologics/Fluids	0	1	2	2	0	3	1	1	4	4
Unexpected Deaths or Severe Harm	2	2	0	4	0	1	2	1	0	2
Maternity Care	0	1	1	0	3	1	1	2	2	0
Administrative Processes	0	1	1	2	0	0	2	1	1	0
Infection Control Incident	0	1	1	0	0	0	2	2	0	1

2d. Significant harm incidents

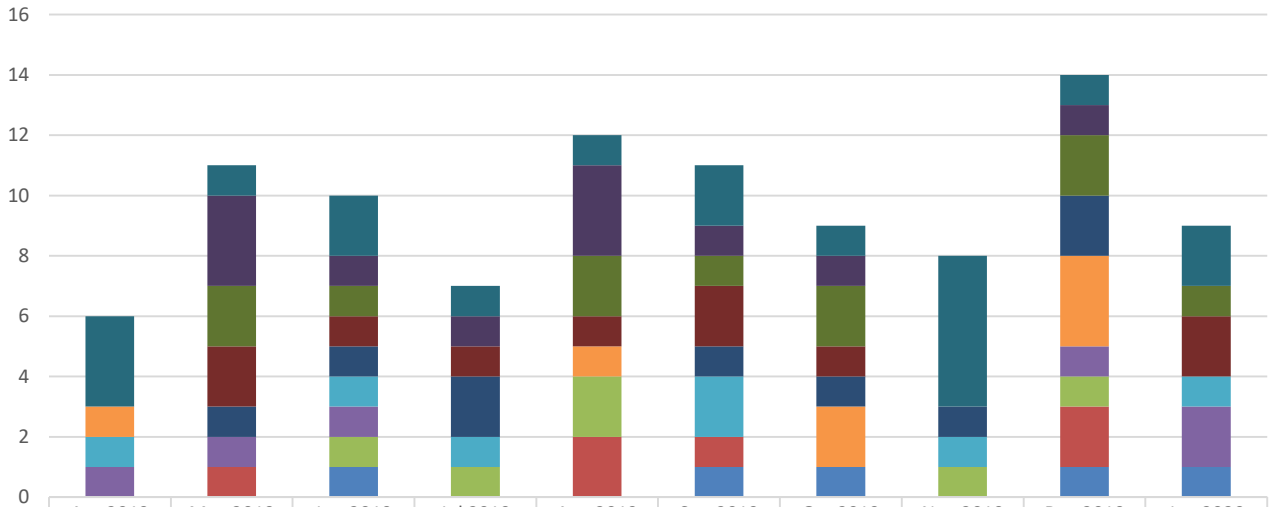
Significant harm incidents by location type (more than 2 incidents)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Wards @ Lincoln	3	5	5	4	5	9	7	7	9	3
A&E and Assessment units (IAC, AMSS, SAU, EAU, etc.)	5	5	5	6	4	6	2	8	2	7
Wards @ Pilgrim	1	7	5	5	5	3	2	2	3	4
Outpatient Department/Services OPD/Clinic Area	2	4	1	2	1	0	2	1	0	1
Operating Theatre	0	2	1	0	2	1	2	0	2	1
Women and Children	0	1	0	0	3	1	1	2	2	0
Other	0	1	1	0	0	0	2	0	1	1
Radiology/Radiotherapy/Diagnostics	0	0	0	0	0	1	0	2	0	0

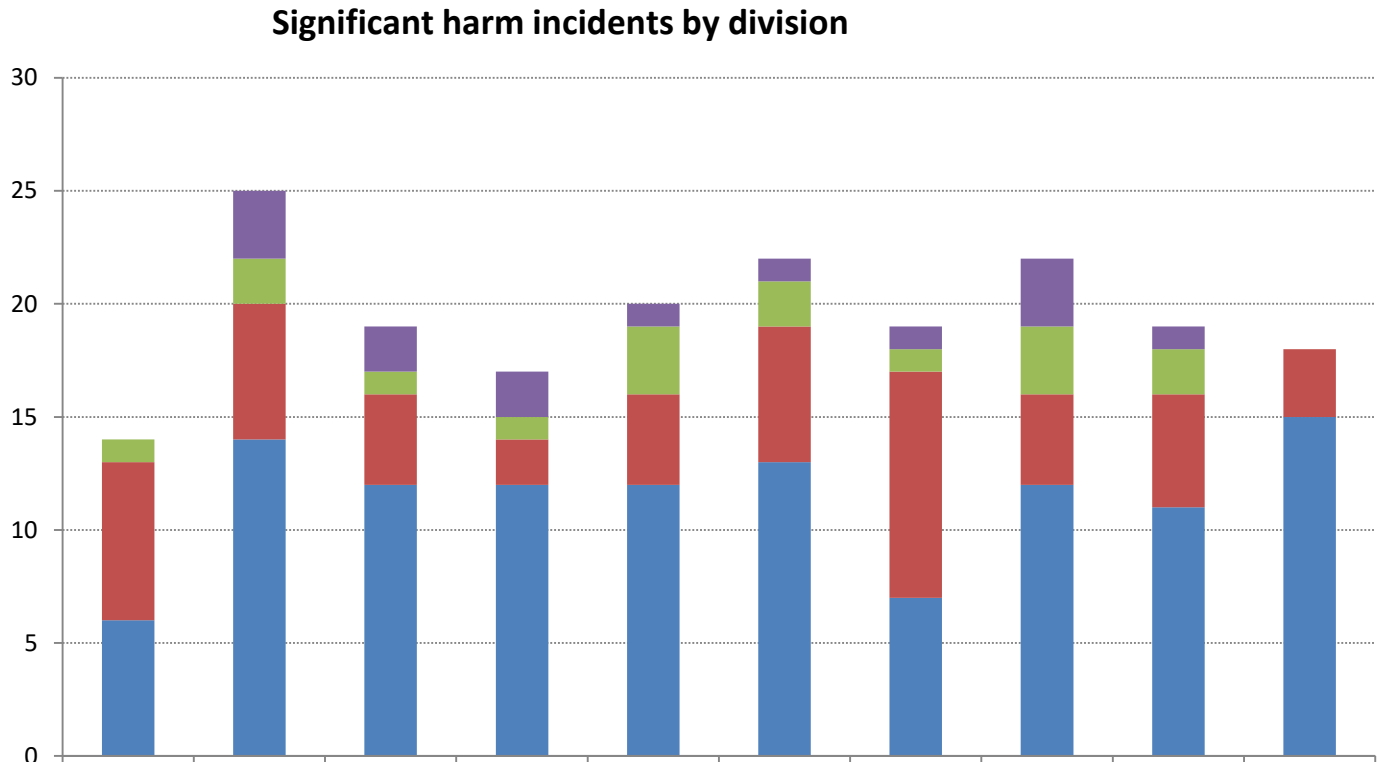
2e. Significant harm incidents

Significant harm incidents by location (5 or more incidents)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Accident and Emergency Department (Lincoln)	3	1	2	1	1	2	1	5	1	2
Ward 6A	0	3	1	1	3	1	1	0	1	0
Operating theatre	0	2	1	0	2	1	2	0	2	1
Accident and Emergency Department (Pilgrim)	0	2	1	1	1	2	1	0	0	2
Carlton-Coleby Ward	0	1	1	2	0	1	1	1	2	0
Neustadt-Welton Ward	1	0	0	0	1	0	2	0	3	0
Integrated Assessment Centre	1	0	1	1	0	2	0	1	0	1
Ward 7A	1	1	1	0	0	0	0	0	1	2
Lancaster Ward	0	0	1	1	2	0	0	1	1	0
Labour Ward - Pilgrim	0	1	0	0	2	1	0	0	2	0
Dixon Ward	0	0	1	0	0	1	1	0	1	1

2f. Significant harm incidents



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Clinical Support Services	0	3	2	2	1	1	1	3	1	0
Family Health	1	2	1	1	3	2	1	3	2	0
Surgery	7	6	4	2	4	6	10	4	5	3
Medicine	6	14	12	12	12	13	7	12	11	15

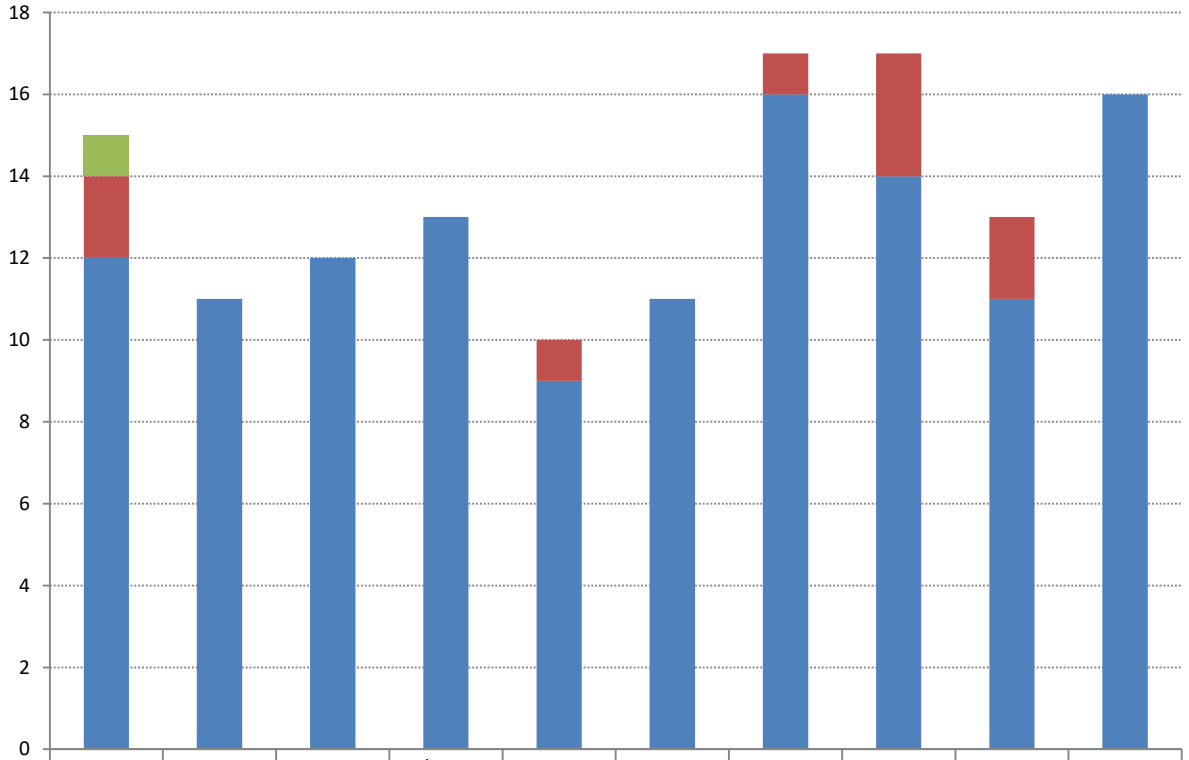
2g. Significant harm incidents

Analysis

- There were 18 significant harm incidents (those resulting in Moderate harm; Severe harm; or Death) reported in January, which is below the average of 19.5 per month across 2019/20 (these figures are subject to change as a number of these incidents are currently undergoing the Rapid Review process)
- Of these 18 incidents, 16 actually occurred in December (as some incidents are reported retrospectively)
- 15 of the 18 incidents reported in January occurred within Medicine Division, and 58.5% of incidents in the financial year to date
- The most frequent reported incident categories for significant harm incidents remain 'Diagnostic processes' and 'Patient accidents / falls'
- There have been 8 Medication incidents across 7 locations resulting in significant harm in the last 2 months, compared with 10 in the previous 8 months; 5 were Moderate harm, 2 Severe harm and 1 Death (all currently under investigation)
- Wards at Lincoln County account for 29.2% of all significant harm incidents; A&E and Assessment Units 25.6%; Wards at Pilgrim 19.0%

3a. Serious Incidents

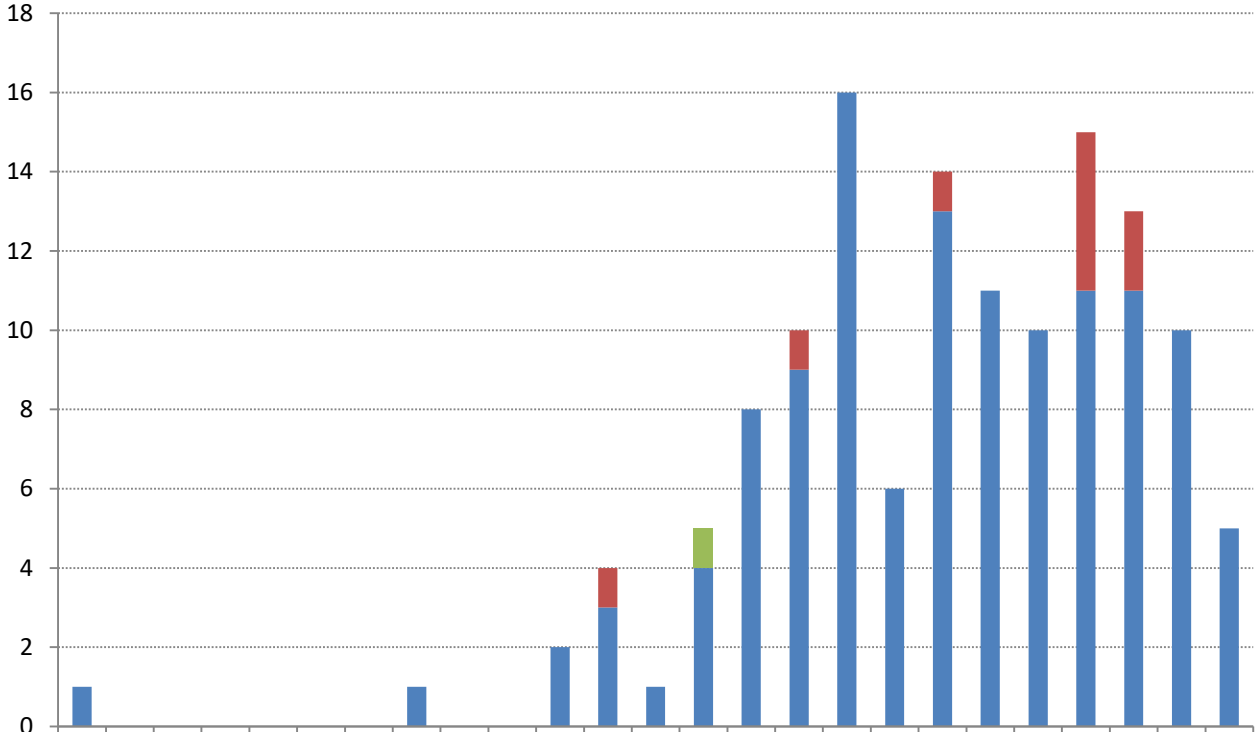
Serious Incidents reported on StEIS this financial year (by StEIS report date)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Independent Serious Incident investigation (StEIS)	1	0	0	0	0	0	0	0	0	0
Never Event Serious Incident (StEIS)	2	0	0	0	1	0	1	3	2	0
Serious Incident (StEIS)	12	11	12	13	9	11	16	14	11	16

3b. Serious Incidents

Serious Incidents declared this financial year (by incident date)

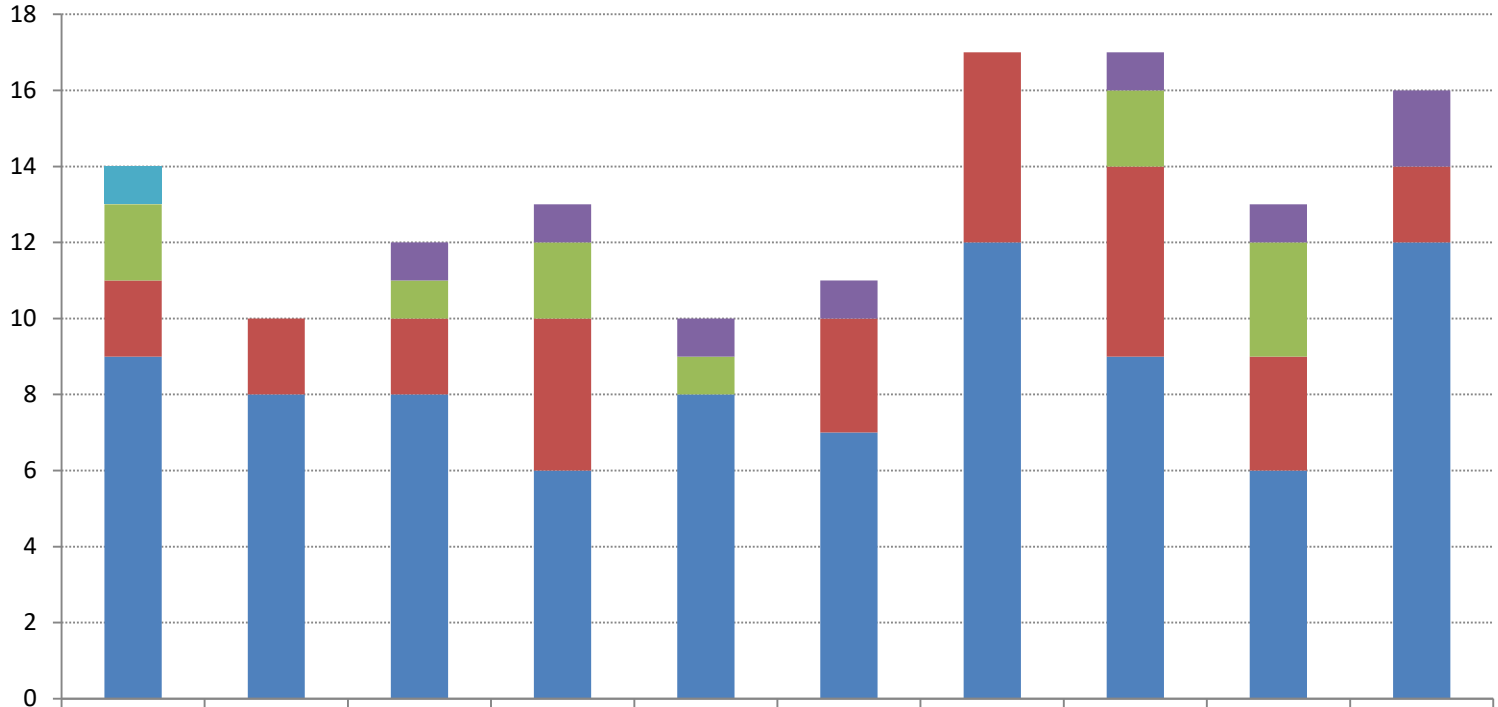


	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Independent Serious Incident investigation (StEIS)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Never Event Serious Incident (StEIS)	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	1	0	0	4	2	0	0
Serious Incident (StEIS)	1	0	0	0	0	0	0	1	0	0	2	3	1	4	8	9	16	6	13	11	10	11	11	10	5

Not shown: one Serious Incident that occurred in October 2015

3c. Serious Incidents

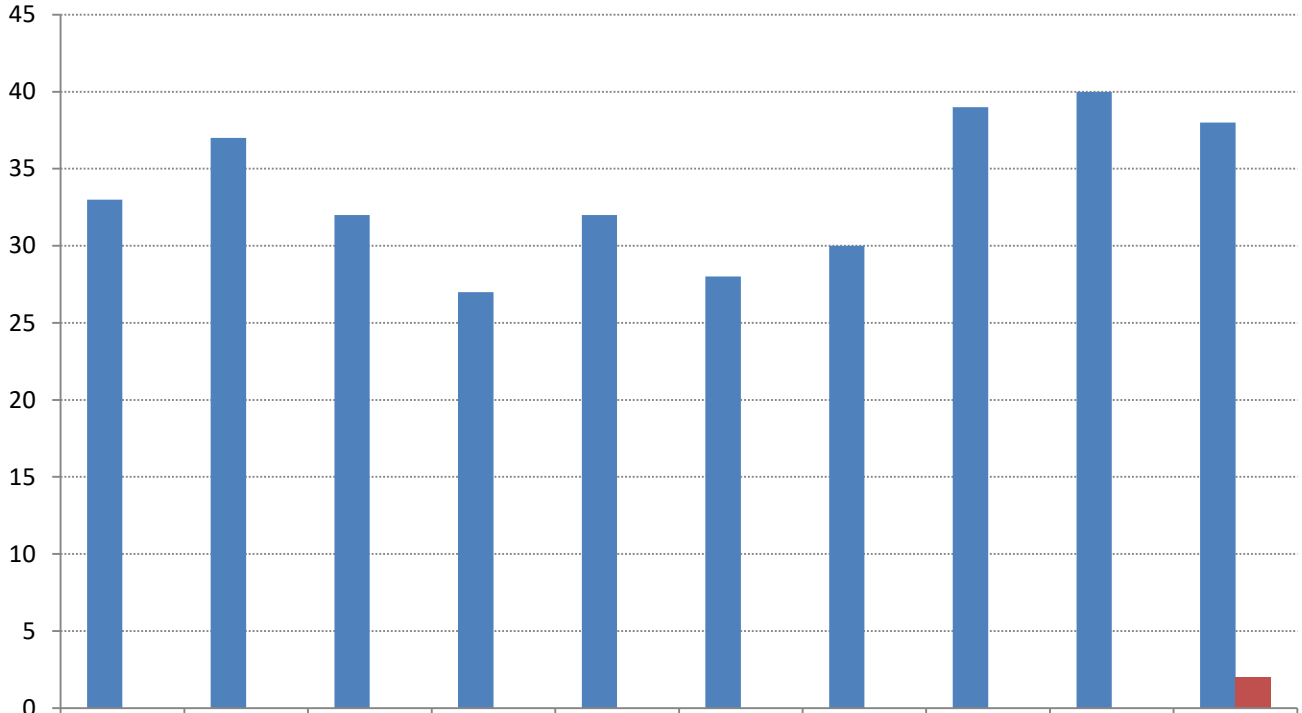
Serious Incidents this financial year (by division)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Corporate	1	0	0	0	0	0	0	0	0	0
Clinical Support Services	0	0	1	1	1	1	0	1	1	2
Family Health	2	0	1	2	1	0	0	2	3	0
Surgery	2	2	2	4	0	3	5	5	3	2
Medicine	9	8	8	6	8	7	12	9	6	12

3d. Serious Incidents

Serious Incidents open & overdue at the end of the month



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Serious Incidents open	33	37	32	27	32	28	30	39	40	38
Serious Incidents overdue	0	0	0	0	0	0	0	0	0	2

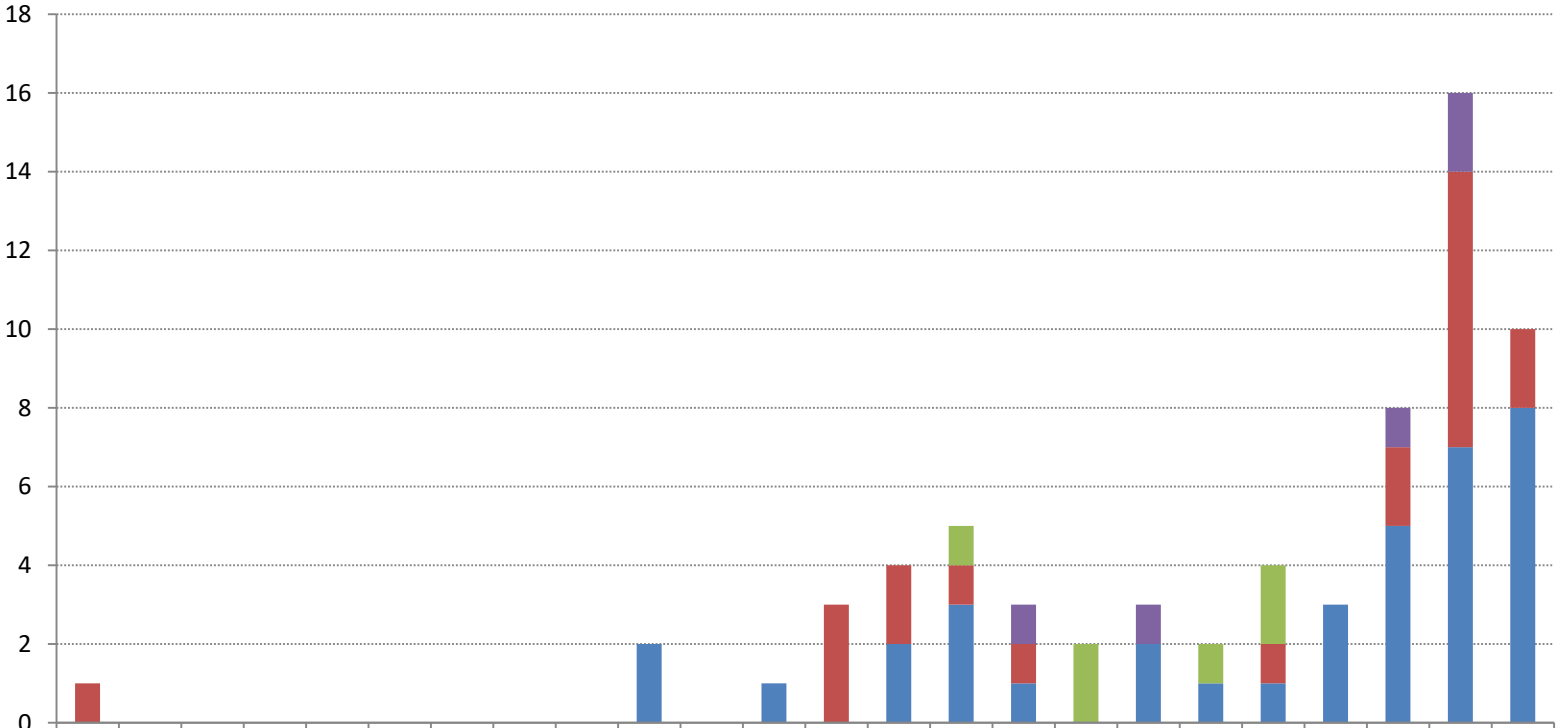
3f. Serious Incidents

Analysis

- The Trust declared 16 Serious Incidents in January 2020, compared with an average of 17 per month for 2019/20; 5 of those incidents actually occurred in January
- 63.9% of Serious Incidents declared so far this year occurred within Medicine Division
- None of the Serious Incidents declared in January were Never Events
- 9 Never Events have been declared this financial year (to the end of January):
  - 4x Wrong site surgery (3 in Theatres; 1 in Outpatients)
  - 1x Wrong implant / prosthesis (Theatres)
  - 1x Wrong route administration of IV medication (A&E)
  - 2x Retained foreign object post procedure (1 in Theatres; 1 in Pilgrim Labour Ward)
  - 1x Mis-placed naso-gastric tube (Medical Ward)
- There were 38 Serious Incident investigations open at the end of January, 2 of which were overdue their deadline to the CCG (the first overdue this financial year)

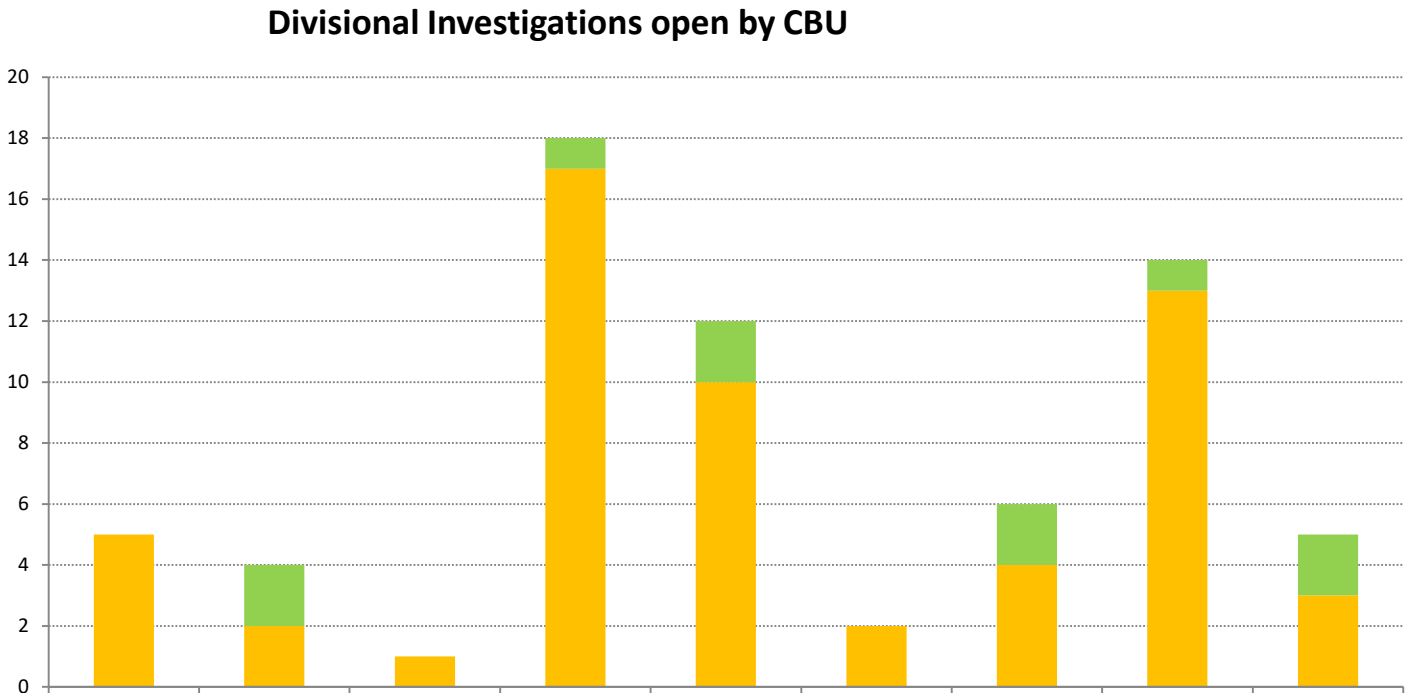
4a. Divisional Investigations

Divisional Investigations open (by division)



	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020
Clinical Support Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	1	2	0
Family Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0	1	2	0	0	0	0
Surgery	1	0	0	0	0	0	0	0	0	0	0	0	3	2	1	1	0	0	0	1	0	2	7	2
Medicine	0	0	0	0	0	0	0	0	0	2	0	1	0	2	3	1	0	2	1	1	3	5	7	8

4b. Divisional Investigations



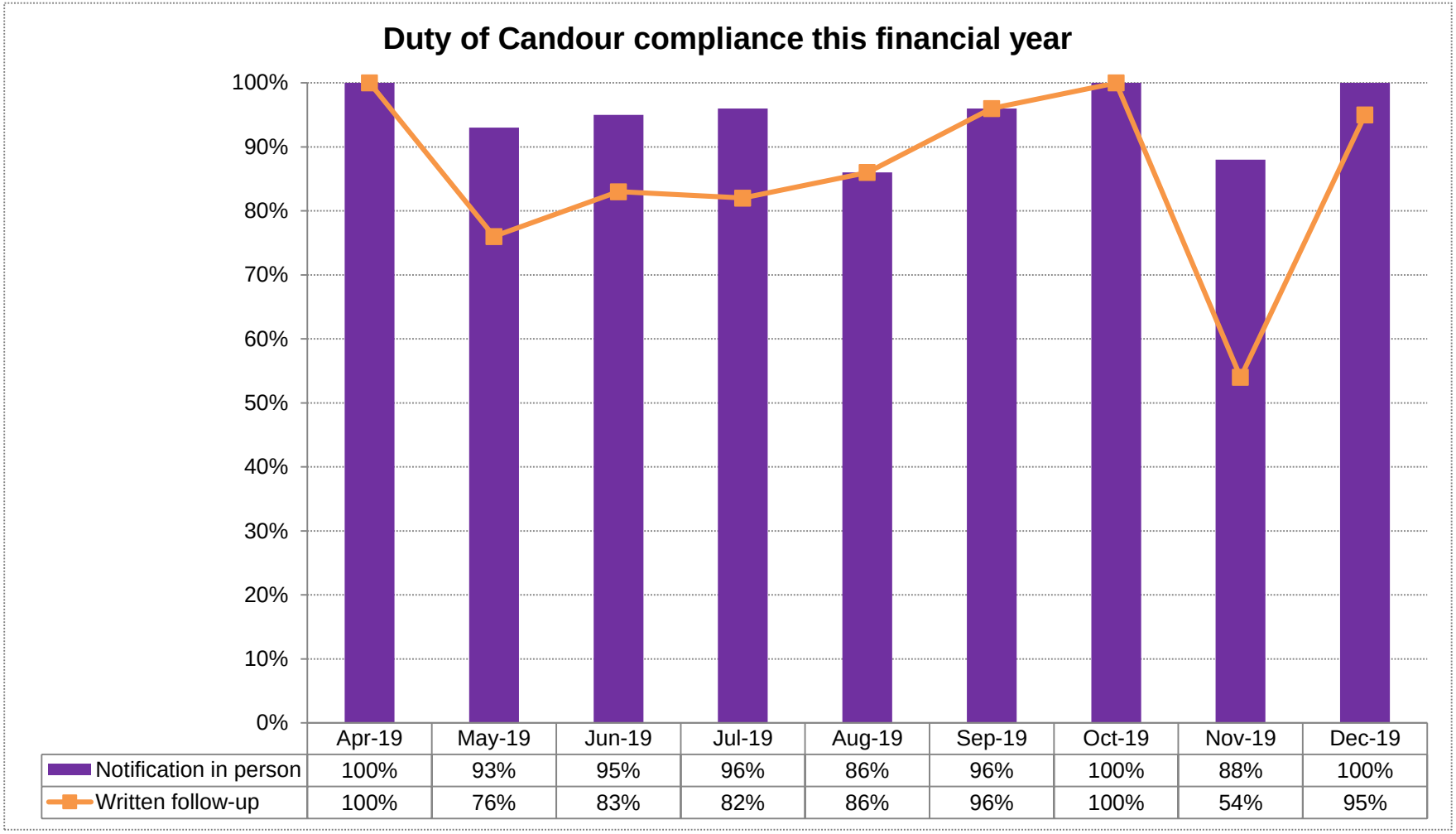
	Cancer Services CBU	Cardiovascular CBU	Children & Young Persons CBU	Specialty Medicine CBU	Surgery CBU	Theatres & Critical Care	Trauma & Orthopaedics and Ophthalmology CBU	Urgent & Emergency Care CBU	Women's Health and Breast CBU
Complete, awaiting ULHT sign off	0	2	0	1	2	0	2	1	2
Under Investigation	5	2	1	17	10	2	4	13	3

4c. Divisional investigations

Analysis

- There were 67 open Divisional Investigations at the end of January
- 36 open DIs were in Medicine Division, 20 in Surgery Division
- Of these, 10 are complete and awaiting divisional approval:
  - Cardiovascular (2)
  - Specialty Medicine (1)
  - Trauma & Orthopaedics and Ophthalmology (2)
  - Urgent & Emergency Care (1)
  - Women's Health & Breast (2)
  - Surgery (2)
- Some of this increase in the number of Divisional Investigations is due to a more robust application of the Serious Incident criteria by the Pressure Ulcer Scrutiny Panel, resulting in fewer Serious Incidents being declared and Divisional Investigations requested instead
- Additional support is being provided to divisions to facilitate the timely completion and improved management oversight of these investigations

5a. Duty of Candour



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Notification in person	100%	93%	95%	96%	86%	96%	100%	88%	100%
Written follow-up	100%	76%	83%	82%	86%	96%	100%	54%	95%

5b. Duty of Candour

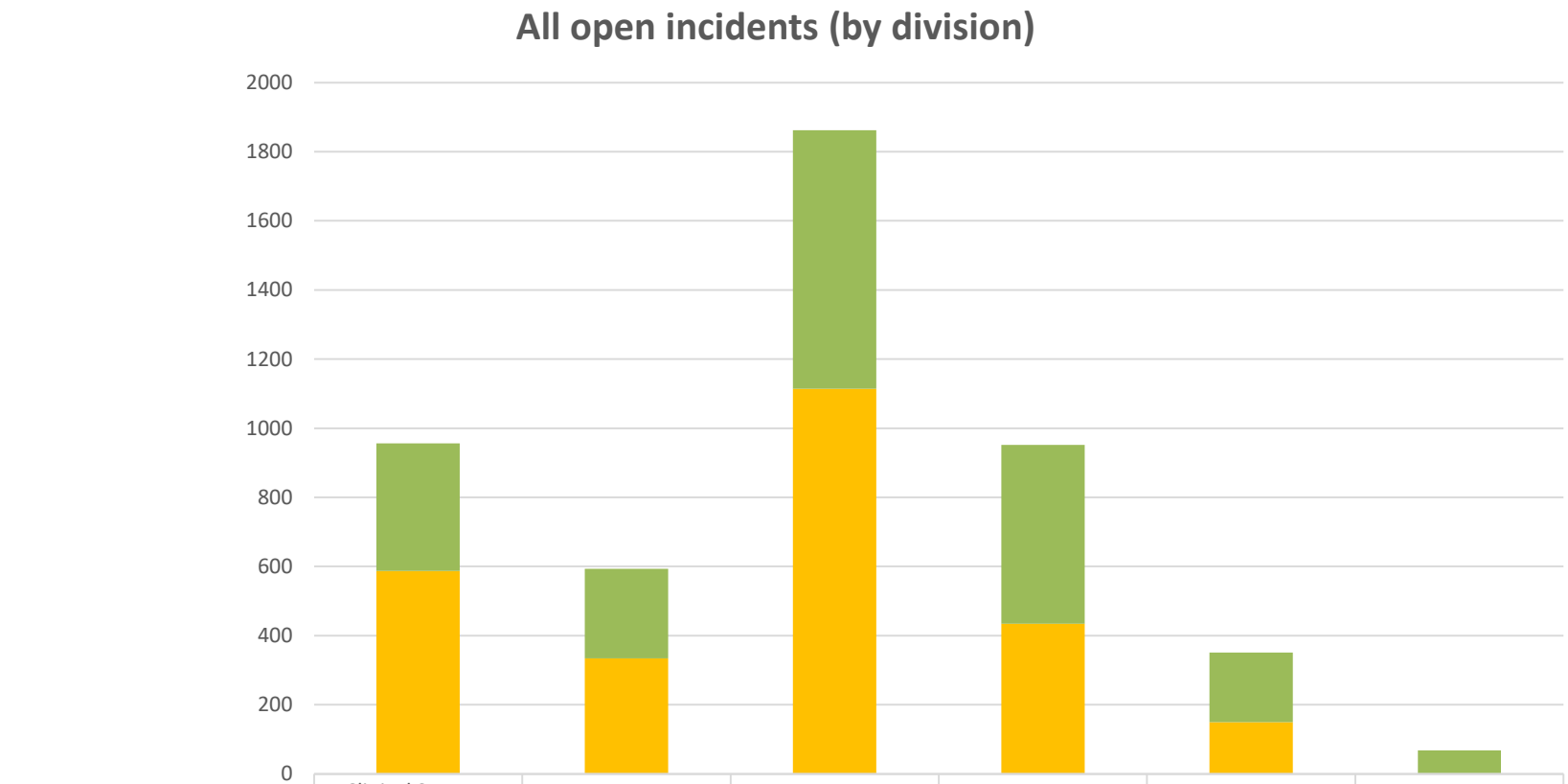
Duty of Candour compliance by Division December 2019)	Yes, notification in person has been provided	Yes, written follow-up has been provided	Written follow-up has been declined	No, written follow-up has not yet been provided	Total
Medicine Division					
Cardiovascular CBU	2	1	1	0	2
Specialty Medicine CBU	7	5	2	0	7
Urgent & Emergency Care CBU	2	1	1	0	2
Surgery Division					
Surgery CBU	1	1	0	0	1
Theatres & Critical Care CBU	1	1	0	0	1
Trauma & Orthopaedics and Ophthalmology CBU	3	3	0	0	3
Family Health Division					
Women's Health and Breast CBU	2	1	0	1	2
Clinical Support Services Division					
Cancer Services CBU	1	0	1	0	1
Total	19	13	5	1	19
	100%	95%		5%	

5c. Duty of Candour

Analysis

- Duty of Candour (in person notification) compliance in December 2019 was 100% (0 non-compliant incidents)
- Written follow-up compliance in December 2019 was 96% (1 non-compliant incident in Family Health Division)
- As of the end of October financial penalties imposed by the CCGs for non-compliance with Duty of Candour were estimated at £35.7k (an average of £5.1k per month) based on with-holding the cost of each affected patient's treatment
- An additional Quality Assurance step has been added to the incident review process to confirm that the rationale for not completing Duty of Candour within 10 working days is acceptable

6a. Incident management performance



	Clinical Support Services	Corporate	Medicine	Surgery	Family Health	No division
Under Investigation	369	259	748	518	201	68
Holding area, awaiting review	587	334	1114	434	150	0

6b. Incident management performance

Analysis

- As of 4th February 2020 the Trust had 4782 open incidents on the Datix system
- This is 37 fewer than were open at the start of January
- The number of open incidents has not been reduced to below 4,500 since monitoring began at the start of this financial year, indicating that there continues to be no significant progress in addressing the backlog
- If the Trust were up to date with incident reviews in line with the Incident Management Policy there would be no more than 2,000 incidents open at any one time

Agenda Item

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Cor
Date of meeting:	20 February 2020
Chairperson:	Gill Ponder, Non-Executive Director
Author:	Jayne Warner, 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 committees according to an established work programme.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Draft Estates Strategy Reason for lack of assurance: The Committee were pleased to receive a first draft of the Estates Strategy which had been produced with the support of external consultants. The Committee noted however that the strategy required updating in line with current plans and clinical strategy and consideration by the full board. Actions requested by the Committee: The Committee requested that the document be updated in line with current plans. The strategy should then be summarised in a way which could be presented to the Board. This should allow the Board to make decisions based on available capital, risk, mitigations and system implications. This would be shared with the Committee at a future meeting before sharing at Board.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services **Issue:** Assurance Report Estates, Infrastructure and Environment Group Reason for lack of assurance: The Committee heard that the position with water safety was an improving picture, however was not entirely resolved. There had been a significant reduction in 'counts'. Reason for lack of assurance: Infection Prevention and Control visit. A number of estate issues had been highlighted. Reason for lack of assurance: Compliance actions in respect of confined spaces had been taken quickly, although these were still outstanding with HSE. Work continued on the plan for longer term way that confined spaces work was managed by the Trust.

	Lack of assurance: Fire costs. The Committee questioned whether the completion of fire improvement works shown as 100% for the end of March would enable the Trust to apply to close the fire enforcement notices with Lincolnshire Fire and Rescue. The Committee were advised that what remains outstanding is a coverall. Action requested by the Committee: Committee asked for this to be summarised in the next report that is brought to the Board, which should clearly show which notices had been closed and when the remainder would be closed. It should also show how much of the funding allocated had been spent and the amount needed to close the remaining notices. The Committee noted that risks relating to fire are still rated as very high and challenged whether the amount of work done had reduced the risk. The Committee asked for a review of each of the fire risks. One page report to be taken to Board as agreed by Committee to close the Board action. Lack of Assurance: Energy Performance Contract. The Committee were not clear that the report provided appropriate assurance. The Committee highlighted that what they were seeking was assurance that the contract would be on time and on budget and would deliver what it was expected to. Action requested by the Committee: Committee would want assurance that plan and milestones are in place and are being met. Lack of Assurance over contract with Progress Housing: The Committee were advised that there had been a change in occupancy. Fewer families. The issue with fill was mainly in Grantham and Boston. Action requested by the Committee: The Committee suggested that a new approach was needed. A Strategic review of the use of the accommodation and a future plan was requested.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Health and Safety British Safety Council Audit- Anticipate the Trust achieving 3 stars. H&S meetings need better representation through the divisions. The Committee asked that this was picked up as a matter of urgency with the operational teams. HSE Risk of Enforcement Action: The Committee were advised that the Trust remained at high risk of enforcement action or prosecuting by HSE. Significant gaps in backlog and regular maintenance of the estate existed due to lack of available capital and revenue funding. There was £102m of statutory risk out of a backlog maintenance value of £236m. The areas of most concern were water, mechanical infrastructure

	and electrical infrastructure, due to the age of the equipment. The situation continued to get worse each year without additional investment. Mitigations with water had reduced the risk, but the Board would need to discuss whether to apply for further external funding to address the risks. Action requested by Committee: The Committee agreed that the Board should be sighted on this risk to inform a discussion about risk appetite and action to be taken.
	Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Car parking The Committee considered the paper ahead of it being taken to Board. The report highlighted changes to charging and future plans. Action requested by Committee: Need to understand the cost of the Secretary of State changes and add these in to the report.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Finance Report Reason for lack of Assurance: The Committee were advised that at Month 10 the Trust was reporting a deficit of £62m, £3.2m adverse variance to plan. Pay continued to be the main issue for the Trust. January had seen a reduction in the agency bill by £360k. Agency spend in February appeared to be creeping up again which would impact the year end forecast. The year end position now would be £95.2m without any mitigating actions, which was likely to reduce to £92.8m with delivery of mitigating actions in place. Month 10 had £628k adverse movement including radiology pay arrears, other pay increases, estates non pay and other miscellaneous. The Committee expressed concern that the number continued to move on a monthly basis. There did not appear to be the necessary level of control. The Committee noted that elective activity was more predictable so it was easier to achieve the savings. The Committee challenged what more could be done to push the position in Feb/March. The Committee were advised of the additional non pay procurement controls. Financial recovery meetings were in place with each division, with particular focus on Medicine. The Committee asked what was going to change to enable the Trust to meet its control total next year and also challenged the controls being put in place to make sure that the plans exist right at the start of the year

	for 2020/21, so action could be taken immediately if there was an adverse variance. The Committee were asked to support the request to the Board for delegated authority to the Director of Finance and Digital, Chief Executive and Chair to submit an exceptional working capital loan request of up to £5m for drawdown in April 2020. The Committee noted that the requirement for borrowing was dependent on the precise nature of changes to the cash regime in 2020/21 and may therefore not be necessary. The Committee recommended approval by the Board of the delegated authority.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Use of Resources The Committee received the Use of Resources report noting that the actions required to be taken in response would be included with the Integrated Improvement Plan (IIP). Next step link to IIP.
	Lack of assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Urgent Care Reason for lack of assurance: The Committee noted some continued improvement in trajectory. Grantham achieved standard for first time since September 2019. The Trust had also seen a 3.9% decrease in ambulance conveyances between December and January, but these were still above plan. NHSEI had recognised an improving trend. In January the Trust went to OPEL level 4 eight times which was an improvement on previous months. UTC were seeing large numbers of patients. In February Medicine Division had presented a case to board about staffing. Board agreed to explore further and support the required investment to achieve 50% of attenders being seen within first hour of arrival. The Committee were advised of the success of a Multi-agency discharge event. Lincolnshire achieved best level of discharge in December. But in January length of stay was increasing. The cause of this steady increase was being investigated.

	Actions requested by the Committee: The Committee noted that they could not be assured but were seeing evidence of improvements resulting from planned actions, but this trend needed to be sustained.
	Lack of Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Planned Care Improvements in Diagnostics had been seen but were still below trajectory. Issues within urology planned and urgent care. New recruitment to deputy COO planned care The Committee were advised of continued improvement in waiting lists. Planned care intensive support team visit had resulted in 12 recommendations. These would be shared at the March meeting with proposed actions.
	Lack of assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Cancer Constitutional Standards Reason for lack of assurance: The Committee were advised that the Trust achieved 3 of the 9 cancer standards during December. 31 days to 1st treatment 31 days to subsequent treatment drug 31 day subs RT standards The Breast 2ww position was unacceptably low due to the reduced availability of the temporary workforce. Still at risk with this. Maintaining 62 days. Plan had been put in place but loss of locum consultants meant this was not achieved. Performance erratic. Actions requested by the Committee - The Committee asked when the performance would be recovered. Plans were being put in place to maintain 3 standards and then step up to achieving others. 12 week improvement plan. More detail would be provided next month.
	<u>Assurance in respect of other areas:</u> <u>Committee Dashboard:</u> The Committee dashboard would be updated for the March meeting in line with the revised IIP, BAF, ToR and work programme for the Committee. <u>NHS Improvement Observation Action Plan:</u> Continue to be received monthly until actions closed.

Issues where assurance remains outstanding for escalation to the Board	The Committee wanted the Board to be sighted on the potential risk of prosecution for inability to meet statutory maintenance obligations due to lack of funding and had requested an assurance report on the actions being taken to mitigate these risks in each area, including electrics, water, asbestos and the mechanical infrastructure.
Items referred to other Committees for Assurance	The Committee agreed a report in relation to cyber security assurance which would be submitted to the Audit Committee in April to allow them to meet the requirements of the Audit Committee Handbook.
Committee Review of corporate risk register	The Committee received the corporate risk register and noted that there had been no material change to the corporate risk profile or very high and high risks.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee was assured that the SRR/BAF was reflective of the key risks in respect of the strategic objectives of the organisation. Assurances received were noted and updates would be made to the BAF to reflect discussions. The Committee reflected that objective 1B required further detail to demonstrate that the Trust did now have a metric but were not meeting this. On consideration the Committee felt that objective 2A could be recommended to Board to move from RED to AMBER.
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	M	A	M	J	J	A	S	O	N	D	J	F
Gill Ponder, Non-Exec Director	X	X	X	X	X	X	X	X	X	X	A	X
Geoff Hayward, Non-Exec Director	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson, Non-Exec Director	X	A	X	X	A	X	A	X	A	X	X	A
Deputy Chief Executive	A	A	A	X	X	X						
Director of Finance & Digital	X	X	X	X	X	X	X	D	X	D	X	X
Chief Operating Officer	X	X	X	X	D	D	X	D	X	X	X	D
Director of Estates and Facilities	A	X	D	X	X	D	X	X	D	X	D	X

X in attendance A apologies given D deputy attended

To:	Finance Performance and Estates Committee
From:	Simon Evans, Chief Operating Officer
Date:	13th February 2020
Healthcare Standard	Outcome 10 Safety and Suitability of Premises
Title:	Progress and Future Developments for Car Parking at ULHT

Author/Responsible Director: Paul Boocock Director of Estates and Facilities, Ian Hayden Associate Director of Estates and Facilities Operations, Simon Evans Chief Operating Officer

Purpose of the report: This paper incorporates three aspects of car parking. The review of the ANPR system and feedback, recommended action on pricing changes and a brief update on options being pursued to deliver a future fit for purpose car parking solution.

The report is provided to the Board for:

Decision		Discussion	X
Assurance		Information	X

Summary/key points:

- We recognise the difficulties the introduction of the new ANPR system created during implementation and sincerely apologise to anyone affected during that period of time.
- The ANPR system continues to be developed and adopted, many of these advancements have been deployed nationally.
- A statement setting out a new approach for parking by government Health Secretary Matt Hancock and issued by the Department of Health and Social Care on 27th December 2019 details how improved technology will reduce burdens for hospitals and take away stress for visitors. In this statement ANPR is proposed as a practical parking option that can make the most difference quickly to improve parking.
- The benefits that were set out to be achieved in modernising the systems are being achieved and parking issues raised with PALS have significantly reduced as the system is adopted.
- The ongoing management of the ParkingEye contract is established and approached from a collaborative perspective by all parties.
- During implementation of ANPR, the Trust received numerous complaints regarding the step change in the tariff from £1.70 for the 1st hour to £4.70 for up to 4 hours
- A selection of tariffs have been reviewed and the preferred will generate an additional £19k income per annum
- If the current prices had been raised by CPI, the additional income would have been £42k
- Included in the new tariff is the first 30 minutes free
- This tariff structure is proposed to commence 1st April 2020 subject to confirmation of ParkingEye signage changing and technical implementation
- In addition to changes in tariff from April changes announced by SoS for free parking for a number of groups of visitors and patients will also be developed and implementation will begin
- We recognise that Car Parking faciltiies across ULHT do not provide patients, staff and visitors with the access and level of service we would like and that they expect.
- Future options are being developed that include the potential partnership of private and government organisations that will support the development of fit for purpose facilities that both provide the

necessary capacity, and quality of car parking required.
Recommendations: To note the contents of the report prior to being submitted to FPEC and then onwards to Trust Board.
Strategic risk register – N/A | **Performance KPIs year to date N/A**
Resource implications (eg Financial, HR) – National changes in
Assurance implications – An assurance governance process is in place within the UEC Improvement Programme, both vertically, with integration within the system through the emergency care strategy group and A&E Delivery Board, and horizontally through executive led internal assurance groups. There are no assurance implications at this time.
Patient and Public Involvement (PPI) implications – Patient and visitor feedback has been sought as part of feedback processes. Ongoing engagement about future options will incorporate patient and visitor feedback on possible solutions as well as any future business cases that will also include stakeholder analysis.
Equality impact – As part of future option selection an Equality Impact Assessment will be completed.
Information exempt from disclosure – No
Requirement for further review? Yes

ULHT Car Parking Update, Progress and Update on Future Direction

1.0 Introduction & Purpose

This paper seeks to give updates on three key aspects of Car Parking at ULHT. The paper incorporates updates on Automated Number Plate Recognition systems in place across hospitals at ULHT, a review of pricing on feedback from patients as well as a brief articulation of future options being considered to deliver fit for purpose car parking in the future.

The paper is not intended to be an exhaustive review of all aspects of Car Parking, but does seek to highlight and inform on three aspects of what is a very challenging element of Estates and Facilities management in the Trust. Future reports will be developed that further articulate solutions in more detail and seek to give assurance of fit-for-purpose parking facilities across all sites.

2.0 ANPR

2.1 Background

ULHT implemented a new car parking system through ParkingEye in November 2018.

The previous system was end of life, no longer supported by the supplier, frequently broke down and required replacement. Initially there were deployment faults due to mobile network signal issues which had previously passed pre-installation testing and not enough kiosks in the period while adoption of pre-registration and change over took place. These issues were addressed by ULHT and ParkingEye as quickly as possible.

2.2 Introduction

NHS National guidance *Health Technical Memorandum (HTM) 07-03 NHS car-parking management: environment and sustainability* sets out that car-parking has a large bearing on people's experience of the NHS and influences perceptions of local healthcare facilities.

It advises that to ensure the patient and visitor experience is as pleasant as possible, journeys to and from our hospitals should be kept as straightforward as possible. Worry, concern and unnecessary stress should be removed wherever possible.

With this in mind along with modernising its parking infrastructure to make it more seamless to use and bring it up to date, ULHT is developing its Travel Plan in collaboration with Lincoln City Council and local partners.

2.3 Rationale for change to the car parking system

Before replacement with Automatic Number Plate Recognition (ANPR) a barrier entry/exit system was in operation with cash payments only available.

The key matters which led to the consideration of a replacement system included;

- Our existing car parking system was over 10 years old and no longer supported by the manufacturer.
- It suffered from frequent breakdown and disruption, leading to it frequently being taken out of service for lengthy periods. This led to loss of access control and an unmanaged site with access difficulties.
- It offered only a basic level of old generation technology, for example no additional payment options were on offer beyond cash nor were any automated payment systems possible.
- It was inefficient from an administrative overhead and maintenance perspective and couldn't be developed and advanced over time. There was no access to live car parking data and monitoring of demand and car park use over time.
- Staff commonly complained about having to display a permit when they paid for parking and frequently asked for a way to link their vehicle while it was on-site with their payment arrangements. They were often perplexed as to why we couldn't have an up-to-date database of vehicles in this manner.

- Staff and visitors both wanted a way to reduce queuing and wasted time which was a common occurrence using the existing unreliable barrier system.

- Our ambition was to introduce a replacement system at no equipment or installation cost to ULHT to preserve limited funds for patient care.

To continue to have a viable car parking management system in place into the future clearly it required the existing to be completely replaced and offered the opportunity to resolve longstanding issues and to completely modernise the car parking management as we look forward to developing our Travel Planning strategies.

The ambition of any replacement system included;

- To improve the experience of staff and visitors using the car parks at ULHT by reducing queuing and waiting and to offer flexible registration options, introducing automation where possible.

- Remove barriers and the consequential problems with queuing particularly when those barriers inevitable break down.

- For those that choose it, allowing pre-registration of their vehicle thereby eliminating queues at payment machines and allowing for drive-in / drive-out capability with no need to interact with car parking infrastructure at all. In effect helping to eliminate worry, concern and unnecessary stress as HTM 07-03 recommends.

- Introduce modern payment options that are widely available elsewhere in everyday life.

- Introduce automated systems to reduce administration overheads and improve efficiency.

- Introduce improved security by the capture of vehicle registrations by ANPR.

- Achieve an up-to-date database of staff accessing the car parks.

- Achieve data capture for the use of car parks to monitor occupancy and develop strategies for future management models

2.4 ANPR installation, adoption and ongoing management

It is common knowledge that the introduction of the ANPR technology was challenging for what is a far-reaching technological change resulting in adverse reputational publicity and difficulties for those using the system for a period of time in excess of anticipated normal adoption and change over.

In addition although the use of ANPR technology is becoming more widespread in public car parks and in the NHS, the introduction of a new technology could be anticipated to require some familiarisation and learning and that process was made more difficult by infrastructure system faults and time taken at kiosks by visitors for each transaction.

Although we have received several reports from some users that praise the systems simplicity and ease of use, although naturally these positive reflections are less likely to be widely reported.

2.5 System installation challenges

The main issues we encountered quickly after introduction were the following:

- 4G ANPR camera and kiosk communication faults.
- Unfamiliarity with the change from the old technology to ANPR.
- The number of kiosks provided and some difficulty using them.
- Administration workload of transferring all existing vehicle registrations.
- Transcription errors while registering vehicle registrations.

Although with car parking being a particularly sensitive issue in the NHS and some adverse publicity being anticipated, these factors contributed together leading to the higher levels of dissatisfaction that we experienced and the scrutiny by media and local campaigners.

2.6 Resolutions and system improvements

The following improvements and developments have been made and the system continues to be advanced over time.

- The 4G communication issues have been resolved with landlines.
- The number of kiosks have been increased and covers and lighting have been installed.
- Over 400 new staff users who were previously not registered at all using the old technology have now been registered.
- We have granular occupancy data for the individual car parks and time band information with volumes.
- There are 900 transactions per month now using the good2go drive in and drive out system.

- A 'Blue Badge Holder' pre-registration system requiring the visitor to register their vehicle once only and they can then visit any kiosk and pay a reduced rate. To date nearly 20,597 Blue Badge Holders have opted to use the pre-registration system, 300 per month use the system.

- Also for Blue Badge, introduction of the 'good2go' website pre-registration facility enabling drive in and out without the need to find, travel to and use a kiosk at all.

- A simple free voucher is now provided for concessionary and free parking, 5,900 were issued in June and 21,638 for the three months between August and October.

- The Oncology department use a keyboard or a free voucher is issued and scanned at a kiosk. Therefore recording and transcription errors and administration workload has been reduced.

- Additional signage, posters and banners have been installed

- Introduction of the 'PermitMe' permit system has been introduced for staff for daily permits, 1,078 staff have registered. All staff choosing to pay daily including bank and agency (who can't be deducted from salary) can now use this system, preventing transcription errors and reducing administration.

- Adoption of the system is more positive with card payments at Lincoln now exceeding cash payments, Grantham and Pilgrim are operating at approximately 50% card payments.

- The number of contacts concerning difficulties during the immediate post installation period has significantly reduced.

- The terminal software has been upgraded, making them easier to use.

- It is likely that we will operate at a higher baseline level of interaction with staff and public than pre-ANPR simply due to the fact that we now have a functioning management system in place which will require communication and intervention in some individual cases.

2.7 Contractor management

Fundamentally, ULHT have the responsibility to organise the tender and contract to meet the specification for the new system and the contractor has the responsibility to deliver against those requirements.

It is clear that despite assurances about their ability to deliver on the size and scale of the ULHT project and being nationally the largest provider of ANPR services of this type, there were some learning points. With the system faults and lack of sufficient payment terminals being key issues (noting though that all of the bidders had proposed the same number) and the deployment going live in inclement cold winter weather.

In discussions with them, ParkingEye are acutely aware that the ULHT deployment risks their own national reputation, ULHT being one of the largest reference sites that they have.

They have indeed been responsive to our requests for additional facilities, to cancel charges when we have requested them and to deploy additional payment terminals. They have reacted in a collaborative spirit and have not challenged these requests or refused to assist us.

Indeed they reflect a contractor who also wants the partnership to be successful, for the ANPR system to work as intended and ULHT and users to gain the technological benefits it brings with it.

Some the difficulties encountered could have been avoided with a retrospective view and ParkingEye have taken the learning from the ULHT deployment into their deployments elsewhere.

When considering the impact of the new system consideration needs to be given to attempting to separate the adoption and change in technology matters from those of clear system faults, both of which can and did adversely affect experience of interacting with the technology.

Specific contract management includes;

- Contract meetings take place fortnightly to discuss and resolve issues and to manage developments. Contract meetings are fully documented and include action points.
- We have frequent contact with our designated key account manager, designated service manager and enforcement manager.
- Each appeal case is reviewed by agreed list of reasons for successful appeals with ParkingEye.
- Any cases involving oncology, paediatric, bereavement, or admission to a ward are automatically cancelled.
- ParkingEye patrol the sites assisting with queries and problems, at night we have security providing the same function.
- Performance reports are developed and include machine reliability, time periods vehicles are on site, payment methods by volume, and free or concessionary passes.
- Parking Eye have requested that ULHT are a reference site and are aware that we will inform their potential customers of the initial issues, mainly the under estimation of the amount of payment machines required, the reliance on the 4G network and the significant challenges of car parking in a health environment compared to all other car park facilities.

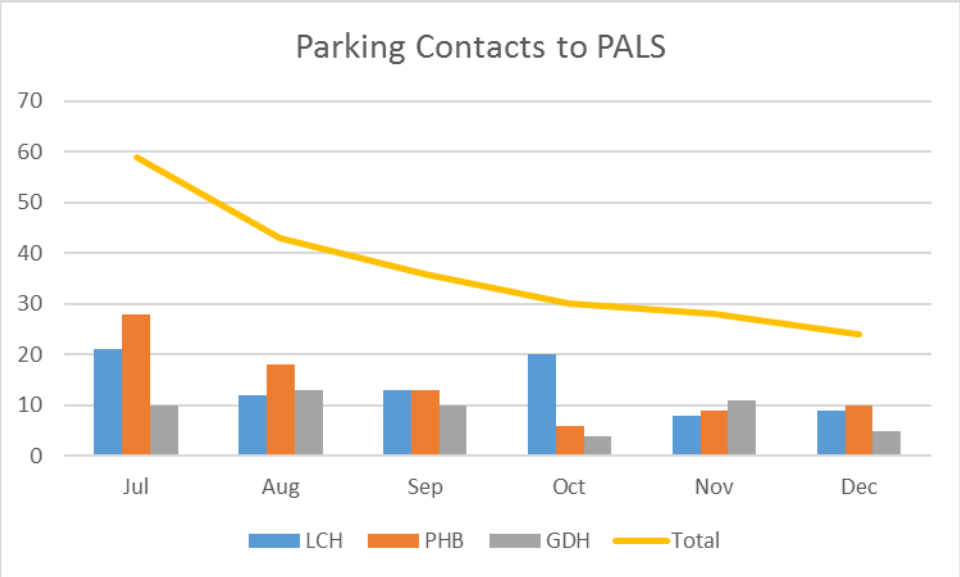
- **Observations and learning**

The wholesale adoption of new technology delivered at pace required significant visitor and staff familiarity to be established quickly, considerable administrative work to implement and, despite similar systems becoming more widespread, adoption needed from those that had become familiar with lightly regulated low technology access arrangements at ULHT.

The key matter is an installation that followed a reduced pace with enhanced commissioning would have allowed for familiarity to build and adoption to take place gradually over time reducing the peak of administration workload and some user dissatisfaction and confusion.

Replacement of dilapidated infrastructure following an accelerated programme can become vulnerable to delivery pressures taking precedence above those of practical and planned implementation. A phased lifecycle replacement approach would reduce the risk although the difficult circumstances presented by 'replacement-on-failure' can be commonplace throughout various infrastructure aspects in the estate and elsewhere.

Looking to the future, the system is being adopted, the complaints are reducing and the benefits originally intended set out earlier in the paper are being realised with positive feedback in some cases.



A close working management arrangement and monitoring has been established with ParkingEye who are committed to making the car park management system work for ULHT and its staff and visitors.

2.0 Pricing Change

Key Points:

- During implementation of ANPR, the Trust received numerous complaints regarding the step change in the tariff from £1.70 for the 1st hour to £4.70 for up to 4 hours
- A selection of tariffs were presented to Executive Team, the preferred option is shown below which will generate an additional £19k income per annum
- If the current prices had been raised by CPI, the additional income would have been £42k
- Included in the new tariff is the first 30 minutes free
- This tariff structure is proposed to commence 1st April 2020

Price option presented to FPEC:

Duration	Tariff
Up to 30 minutes	0
Up to 1 hour	£2.00
1 - 2 hours	£3.00
2 - 3 hours	£4.00
3 - 4 hours	£5.00
4 - 5 hours	
> 5 hours	

On the 27 December 2019 the Department of Health and Social Care issued national guidance for NHS Trusts in England, this set out the following:

From April, all 206 hospital trusts in England will be expected to provide free car parking to groups that may be frequent hospital visitors, or those disproportionately impacted by daily or hourly charges for parking, including:
•blue badge holders
•frequent outpatients who have to attend regular appointments to manage long-term conditions

Free parking will also be offered at specific times of day to certain groups, including:
•parents of sick children staying in hospital overnight
•staff working night shifts

The government will work with the NHS and others to ensure that it:
•spreads existing good practice from NHS organisations applying current exemptions effectively to others
•uses the NHS standard contract if needed to ensure compliance
•assesses where capital investment could help to improve the experience of patients and visitors

3.0 Future Direction

The Trust recognises that Car Parking facilities across ULHT do not provide patients, staff and visitors with a satisfactory experience. Historically prioritising capital funds to clinical estate and equipment have meant that investment on car parks have not received significant investment for a number of years.

In 2020 the Trust is investing £500,000 to develop car parks and address some of the issues patients, staff and visitors experience each day. Whilst this will lead to improvements across our carparks it is recognised that this is insufficient to completely address all the issues of quality of car parking facilities nor the overall capacity of car parking.

As a result, the Trust is developing future options that include the potential partnership of private and public organisations that can support the development of fit for purpose facilities. This is with a mind to develop both the necessary capacity, and quality of car parking required. It is expected that regardless of the partner selected on going collaboration with local government on commuter plans will continue.

The Trust welcomes the Secretary of States announcements around offering better car parking to patients staff and carers and the offer to review capital investment as part of improving experience to patients.

Report to:	Trust Board
Title of report:	Workforce and OD Committee Assurance Report to Board
Date of meeting:	12th February 2020
Chairperson:	Sarah Dunnett, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Workforce 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.
Assurances received by the Committee	**Lack of Assurance in regard to Workforce KPI Report** **SO Ref: SO3a** **Reason for lack of assurance**: The Committee received the key performance indicators. These had formally been received by the Board and were verbally updated by the Deputy Director of HR. Improvement was starting to be seen regarding recruitment due to the efforts being made, the Committee noted the success of HCA appointments. The Committee requested further detail on the impact of medical recruitment activities, including the work with partners on overseas recruitment. Agency use had reduced for the 4th consecutive month however it was noted that nursing remained challenged. The Committee were reassured by the improving trajectory in relation to the national staff survey and would receive the detailed findings and associated actions at the March meeting. It was noted that the Trust still had some way to go. The absence rate continued to increase. An action plan was in place although the impact had not yet been seen. A shift in culture was required regarding appraisal rates. The Committee sought assurance on improvement actions being taken and how these linked with the Trust wide improvement plan.
	Lack of Assurance in regard to Workforce Planning Review **SO Ref: SO3a** **Reason for lack of assurance**: The Committee received the detailed planning review noting that action was being taken to meet the deadline for the first draft submission. The Committee were advised that there had been a greater level of divisional engagements engagement. The Committee noted that this was work in progress. Significant effort was being made to align

	workforce requirements to activity and demand reflecting on performance challenges and bed capacity and ensuring that all clinical staff had sufficient training and support time. It was acknowledged that Trust plans needed to align with system plans.
	Lack of Assurance in regard to Cost Improvement Plans **SO Ref: SO3a** **Reason for lack of assurance**: The Committee received a verbal update being advised that the position remained largely unchanged. Recruitment improvement was likely to be below the £3.24m forecast due to delays in recruitment of consultant ED posts. The Committee were also advised that the Trust had not optimised the opportunity to reduce nurse agency due to increased bed capacity.
	Assurance in regard to Employee relations activity **SO Ref: SO3a** **Source of assurance:** The Committee were assured in respect of the process and action being taken to review and reduce employee relation activity and the improved diversity and equality analysis. Concern remained around performance given the position of the Trust and activity was not at the level that would be expected. The Committee were advised that the change to pay progression would alter and be aligned with appraisal, core learning and performance management. It was expected that this could impact on the number of cases.
	Lack of Assurance in regard to Fitness to Practice **SO Ref: SO3a** **Source of Assurance:** The Committee were advised that the drafted paper had been held back in order to allow the incoming Director of Nursing to provide input. There would be some cross over to employee relations activity, clarity would be needed to avoid overlap. The Committee agreed that the appropriate review should be sought from the incoming Director of Nursing. Consideration would be to be given to the presentation of data to ensure that this remained non-identifiable.
	Lack of Assurance in regard to Safer staffing **SO Ref: SO3a** **Reason for lack of Assurance:** The Committee received a verbal update advising that work was required to update safer staffing and provide further supporting narrative. Consideration of reporting was required to ensure that this was debated at the appropriate group and exception

	reported to the Committee. **Further action requested by the Committee:** The Committee requested that the Director of Nursing discuss with Executive colleagues the appropriate reporting route and expected exception reporting to the Committee.
	Assurance in regard to Medical E-Rostering **SO Ref: SO3a** **Source of Assurance:** The Committee were assured that the medical e-rostering project would successfully identify and resolve a number of issues within the Trust. The Committee were assured that a plan was in place. There would be an incremental role out of e-rostering however the Committee were assured that there was sufficient resource to deliver the 18 month project. An accepted process for job planning was now in place for 2020/21 and learning from the current year would be more robust.
	Lack of Assurance in regard to Medical Engagement Development Plan **SO Ref: SO3b** **Reason for lack of assurance:** The Committee received the overview report however requested that a further report was produced and reported back to the Committee which linked to outputs and outcomes in order to provide assurance and to understand the impact and reach of the plan.
	Assurance in regard to Gender Pay Gap **SO Ref: SO3b** **Source of assurance:** The Committee received the paper noting the requirement of the Trust to publish the data. The Committee were advised that there remained a gender pay gap within the Trust, this was driven by the number of females in lower grade roles against the number of males in higher grade roles. This was a pattern seen throughout the NHS It was noted there was a gap in clinical excellence awards primarily due to the greater length of experience for male medics, this impacted on the available awards. Action was being taken to develop the recruitment process not only to support females to apply to work at the Trust but to also ensure BAME groups were supported. The Committee agreed that the Trust needed to do more and specific action was being taken on

	- Focus on increasing the number of female applicants for the Clinical Excellence Awards - Ensuring that within new approach to talent development/management, ensure that there are no impediments to females progressing - Gather data through the recruitment process and take action where have evidence that females are disadvantaged in the process. The Committee approved the report for publication on the Trust website.
	Assurance in regard to NHSI Observations **Source of Assurance:** The Committee received an update on the actions and requested that these were closed down. Actions relating to the development of the Committee would be tied in to the wider work of the development of the Integrated Improvement Plan, 2020/21 Board Assurance Framework and Committee Terms of Reference and work programme.
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 considered the risk register and noted a number of risks with an action due date of 31 March 2020, these actions required review. The Committee discussed actions relevant to workforce that were not routinely seen by the Committee as these were reported elsewhere. It was agreed that a report be presented to the next Committee to provide oversight of the actions.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	No further areas identified.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

Voting Members	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**N**	**D**	**J**	**F**
Geoff Hayward (Chair)	No meeting	X	No meeting	X	No meeting	X	No meeting	X	X	X	X	A
Sarah Dunnett		X		X		X		X	X	A	X	X
Alan Lockwood		A										
Non-Voting Members												
Martin Rayson		X		X		X		X	X	X	X	X
Matthew Dolling				A		A		A	A			
Debrah Bates		X		A								
Simon Evans				X		A		X	X	A	A	A
Victoria Bagshaw								X	X	X	X	X

Agenda Item 13.2

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Martin Rayson, Director of HR/OD
Date:	3rd March 2020
Essential standards	

Title:	**2019 National Staff Survey Results**

Author/Responsible Director: Martin Rayson – Director of People & OD

Purpose of the report:
The report provides the Board with summary results for ULHT from the National Staff Survey conducted between September and end-November 2019 and to provide assurance that the issues identified are being addressed through the Integrated Improvement Plan.

The report is provided to the Board for:
The Board are invited to review the analysis and to assess whether the emerging Integrated Improvement Plan will address the issues evident in the staff survey results.

Summary/key points:
50% of staff responded to the survey in 2019, which is the highest percentage recorded for ULHT. For two thirds of the 80+ questions in the survey there has been an increase in the percentage of positive responses. However ULHT remains, in most case, some way below the average for acute trusts.

There has been a four point increase in the percentage of staff recommending ULHT as a place to work, but less than half of respondents do respond positively to that question.

The free text responses have been analysed alongside the data and the issues that cause most concern to our staff are, perceptions of bullying, the extent to which line managers demonstrate they value staff and are always equitable in the application of policies and the extent to which staff feel involved in change.

There is a close correlation between the issues and concerns of staff expressed through the survey and the workstreams within the Integrated Improvement Plan, which is reassuring in terms of the Trust framing the right response.

Recommendations:
The Board are invited to review the analysis and to assess whether the emerging Integrated Improvement Plan will address the issues evident in the

staff survey results.

Strategic risk register
This proposal supports delivery of the Board Assurance Framework Objective relating to “One Team”

Performance KPIs year to date

Recommend ULHT to a friend or family member as a place to work	2019/20 target - 46%	41% NSS 2018 56% Q2 FFT	45.1% NSS 2019

Resource implications (e.g. Financial, HR)
The resources required to address the issues in the 2019 staff survey will be set out in the Integrated Improvement Plan

Assurance implications
Whilst the results show a positive trend in most areas, the improvement is not sufficient to reduce the red RAG rating against the One Team objective in the BAF

Patient and Public Involvement (PPI) implications
None

Equality impact:
The staff survey results can be analysed by staff characteristics and some of that analysis is included in the report.

Information exempt from disclosure: No

Requirement for further review?
The survey will run again in September 2020

50% of staff responded to the staff survey in 2019, compared to 46% in 2018. Indeed the table below shows an improving trend over five years in response rates. The response rate in ULHT is higher than the average for acute trusts.

Year	2015	2016	2017	2018	2019
ULHT	33 %	39 %	45 %	46 %	50%
Average	41 %	43 %	44 %	44 %	47%

It is reassuring that the majority of the questions in the survey have seen an increase in positive responses. However, whilst we are moving in the right direction, we know

we still have work to do to catch up with the national average for acute NHS trusts and to be the employer that we aspire to be.

A key performance indicator for us is “I would recommend ULHT as a place to work”. The table below shows the ULHT score against the acute average and the best and worst in our benchmark group:

	2015	2016	2017	2018	2019
Best	76.8%	76.0%	77.2%	81.1%	78.9%
ULHT	50.9%	54.9%	44.0%	41.3%	45.1%
Average	60.3%	60.9%	60.7%	62.3%	62.5%
Worst	41.6%	41.4%	42.7%	39.3%	36.0%

There has been a four point improvement in the percentage of people who have responded positively to this question. However, this is less than 50% of respondent and is well short of the average. The free text within the survey results gives an indication of some of the issues that may be impacting on this score:

- The pressure on the NHS and this Trust from rising attendees
- The high reliance on agency staff
- Concerns about the impact of financial special measures
- The working/patient care environment and the age of some equipment
- The extent to which the Trust is concerned about staff well-being.

The national survey results are presented against a number of themes and there are summary scores for each of the themes. In the table on page 4 we have compared the theme scores with 2018 and with the average for acute trusts. A number of individual questions make up each theme and the table also shows the number of relevant questions where the positive responses have improved since 2018.

The particular questions where we have seen significant improvement are as follows:

- 62.5% of responding staff feel able to deliver the care they aspire to. This is an increase of 4.2 points compared to the last survey.

- Recognition and being valued have also seen some positive increases:
    - The recognition I get for good work has increased by 1.4 points since 2018 and 3.7 points since 2017
    - The extent to which my organisation values my work has increased by almost 2 points
    - Personal development has left you feeling valued, increasing by 3.5 points since 2018

- Feedback around the overall quality of appraisals has also steadily increased:
    - Helped me to improve how I do my job – increased by 1.6 points
    - Helped give me clear objectives – increased by 2.4 points
    - Left me feeling that my work is valued by my organisation – increased by 3.5 points
    - The biggest increase has been discussing Trust values at appraisal, which has increased by 5.9 points.

For the majority of these questions, the increase in 2019 has followed two years of decline and we remain below the average for acute trusts and significantly below the best performing trusts to which we aspire. We would want to build on these improvements and make a step change in positive scores, reflecting the strategic

objective for our people in the Strategic Framework, which is **to enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**.

Theme	2018 score	2019 score	Average	Question change
Equality, diversity and inclusion	**8.9**	**9.0**	**9.0**	4 out of 4 improved
Health and wellbeing	**5.4**	**5.5**	**5.9**	4 out of 5 improved
Immediate managers	**6.3**	**6.3**	**6.8**	2 out of 6 improved
Morale	**5.6**	**5.7**	**6.1**	8 out of 9 improved
Quality of appraisals	**5.0**	**5.3**	**5.6**	4 out of 4 improved
Quality of care	**7.0**	**7.2**	**7.5**	3 out of 3 improved
Safe environment – Bullying and harassment	**7.6**	**7.6**	**7.9**	3 out of 3 improved
Safe environment – Violence	**9.4**	**9.4**	**9.4**	0 out of 3 improved
Safety culture	**6.1**	**6.2**	**6.7**	5 out of 6 improved
Staff engagement	**6.5**	**6.5**	**7.0**	6 out of 9 improved
Team working	**N/A**	**6.1**	**6.6**	0 out of 2 improved

The areas of greatest concern from the survey results are as follows:

- The percentage of staff personally experiencing harassment and bullying over the last 12 months has reduced slightly. However, at 29.8% for bullying/harassment by patients and carers, 17.5% by managers and 23.4% by other staff, this is still higher than the average and represents an unacceptably high proportion of ULHT staff.

- The percentage of staff who have experienced physical violence by patients and carers has increased to 16.6%.

- The survey responses around the effectiveness of team meetings, feeling valued by immediate managers, levels of involvement and access to learning and development have seen slight decreases.

- The analysis of results by protected characteristics highlights concerns among BAME staff about levels of discrimination and the extent to which there is equality of opportunity.

Relevant survey information has been provided for each Divisional and Directorate management team. They are required to work with their staff on issues evident within their areas of work. We will frame our overall response within the Integrated Improvement Plan (IIP) and the table below shows the workstreams which related to the issues and concerns.

Issue	IIP Workstream
Harassment & bullying	• Embedding our values and behaviours • Adapting our responsibility framework and leadership programmes in line with the NHS Leadership Compact
Violence	• Developing a safety culture • Embedding our values and behaviours
Team meetings	• Reviewing the way in which we communicate with staff and involve them in shaping our plans • Adapting our responsibility framework and leadership programmes in line with the NHS Leadership Compact
Feeling valued	• Delivery of annual appraisals and mandatory training • Adapting our responsibility framework and leadership programmes in line with the NHS Leadership Compact • Agree and promote the core offer of ULHT, so our staff feel valued, supported and cared for • Implementing Schwartz Rounds
Levels of involvement	• Embed continuous improvement methodology across the Trust

	• Reviewing the way in which we communicate with staff and involve them in shaping our plans • Implementing a Shared Decision making framework
Access to learning & development	• Delivery of annual appraisals and mandatory training • Deliver personal and professional development
Discrimination/Equality of opportunity	• Creating a framework for people to achieve their full potential • Embedding our values and behaviours • Revise our diversity action plan for 2020/21 to ensure concerns around equity of treatment and opportunity are tackled • Embed Freedom to Speak

We will use the launch of the Integrated Improvement Plan in March to feed back on the results of the survey to staff and to emphasise our response through the Plan ("you said, we plan to do").

In addition we can address the underlying issues around morale through engaging staff in the strategic framework, giving them hope that through working collectively to improve, the Trust can address the longstanding challenges and help achieve staff ambitions to consistently deliver outstanding care and be the best place to work.

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Jayne Warner
Date:	3 March 2020
Essential Standards:	

Title:	Freedom To Speak Up Quarterly Report Oct - Dec 2019

Author/Responsible Director: Jayne Warner – Freedom To Speak Up Guardian

Purpose of the Report:
The report provides an update on our Freedom To Speak Up activities and quarterly data collection submitted to the office of the national guardian.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	Information	X

Summary/Key Points:

The Trust has a responsibility to listen to staff, to be open and responsive to concerns that are raised.

The report provides an update on the following

- Concerns raised with FTSU Guardian
- National Updates
- Actions taken
- Trend Analysis

Recommendations:
The Board are asked to note the latest freedom to speak up data.

Strategic Risk Register:	**Performance KPIs year to date**

Resource Implications (e.g. Financial, HR)

Assurance Implications:

Equality Impact

Information exempt from Disclosure
None

Requirement for further review?

Freedom to Speak Up Guardian

Update to Trust Board

Data Collection
The National Guardian's Office are collecting and publishing quarterly data on FTSU. The most recent data collection is now due, requesting data from the quarter Oct 2019 to Dec 2019

Reporting Period	Oct 2019 – Dec 2019
Number of issues raised	15
Number of issues raised anonymously	0
Number of issues raised with element of Patient Safety	3
Number of issues raised with elements of Bullying/ harassment	5
Did reporter describe having suffered detriment from speaking up	1
Staff Groups referrals came from	3 Admin and Clerical 2 AHP 3 HCSW 6 Nurses 1 other
Feedback Obtained	1

Whistleblowing Notifications

During Quarter 3 of 2019/20 (Oct to Dec 2019) there have been 0 notifications of whistleblowing to Human Resources.

There have been no new reports through the Local Counterfraud Service.

Issues highlighted Quarter 3
- HR Process
- Concerns about colleagues behaviours within teams
- Working arrangements
- Bullying

Detriment related to concern that bank shifts were not offered after issue was raised on ward.

Freedom to Speak Up Guardian

National Update

The National Guardian's Office have not published any further case reviews during 2019/20. Trusts are expected to use the findings from the reviews to identify where the findings of this review apply to their own circumstances and take appropriate action to apply the learning

described. When making this decision, other trusts should refer to the report's findings, rather than the actions of the trust in response.

Local Update

Freedom to Speak Up was highlighted with a "should do" action in the October 2019 CQC report. The report stated that "the trust should ensure there is an increased awareness of the role of the Freedom to Speak Up Guardian role. Possible breach of regulation 17(1)(2) ". Updates of actions being taken have been provided to the PMO. The difficulty has been in identifying an appropriate measure to assure the Trust that actions taken are having the impact of increasing awareness. The issue highlighted in the CQC report was evidenced as follows - The FTSUG had done work across the trust to improve their visibility this included visiting clinical areas across all sites, posters and a dedicated intranet page. During our focus groups with various staff groups and during our inspection of core services, very few staff knew of the FTSUG role or knew who the FTSUG was, this was the same at our last inspection.

The Guardian continues to liaise with other Guardians within Lincolnshire and across the wider region to share ideas for improving awareness.

The Guardian continues to have quarterly 1:1 meetings with the Chief Executive and six monthly meetings with the Non Executive Champion and Trust Chair specifically in relation to FTSU.

The Trust has launched the new network of FTSU Champions. There are now 13 identified Champions across 3 sites from a range of staff groups. Details of who the Champions are and how they can be contacted are on the Trust intranet page. In January eight of the Champions received the nationally recognised FTSU training. The group were really enthused and were looking forward to working as a team to support raised awareness of speaking up.

October 2019 was national FTSU Month and the Guardian worked with Communications to share the speaking up message with staff. The Guardian held Freedom to Speak Up drop in clinics on all 4 sites. These were published through Trust communications and the closed staff facebook page. Whilst turnout was low staff did react on social media to the posts supporting the idea and confirming that they hadn't known previously about the Guardian being available to staff.

October as a stand alone month saw the highest number of referrals to the Guardian since the post was introduced, demonstrating the benefit of sustained publicity to make sure the message was getting across.

The role of the Guardian continues to be included in the induction day for all staff and is also included as a presentation in person to the preceptorship programme for nurses.

Information about Speaking Up is being included in the information packs for the ULH

To:	Trust Board
From:	Paul Matthew, Director of Finance & Digital
Date:	3rd March 2020
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for January 2020

Author/Responsible Director: Paul Matthew, Director of Finance & Digital

Purpose of the report:
To update the Board on the performance of the Trust for the period 31st January 2020, provide analysis to support decisions, action or initiate change and set out proposed plans and trajectories for performance improvement.

The report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Information	

Summary/key points:
Executive Summary identifies highlighted performance with sections on key Successes and Challenges facing the Trust.

Recommendations: The Board is asked to note the current performance and future performance projections. The Board is asked to approve action to be taken where performance is below the expected target.

Strategic risk register New risks that affect performance or performance that creates new risks to be identified on the Risk Register.	**Performance KPIs year to date** As detailed in the report.

Resource implications (e.g. Financial, HR) None

Assurance implications The report is a central element of the Performance Management Framework.

Patient and Public Involvement (PPI) implications None

Equality impact None

Information exempt from disclosure None

Requirement for further review? None

Integrated Performance Report

Trust Board
February 2020

EXECUTIVE SUMMARY

Quality

There has been one unwitnessed fall in January, following which the patient passed away. This incident has been reported in accordance with the Serious Incident Framework. Focus on Falls Safety Support visits by the Frailty Nurse Specialist, Frailty Consultant Nurse and Corporate Head of Nursing have now commenced. Visits are scheduled across all sites in February, areas where falls serious incidents have occurred will be prioritised for early visits. Working with the ward teams a deep dive into falls specific to the area will be undertaken and recommendations made for any actions identified. It is planned to roll out the support visits to all wards during Q4/Q1 and to produce bespoke falls safety and learning plans. Focus on Falls Safety Newsletter is currently in development and will include lessons learnt for wider sharing. The current falls link nurse roles are being reviewed and refocussed. Commencing monthly site falls link nurse drop in clinics from February. Staff educational passport for frailty is in development with a plan to offer regular training sessions commencing in April 2020 on all aspects of frailty including falls. ULHT were actively involved at the first meeting of County wide Falls Stakeholder collaboration.

The level of harm from medication incidents from January 2019 – January 2020 continues to show a downward trend despite the number of incidents reported increasing. Staff are continually encouraged to report all medication incidents irrespective of harm. The speciality Pharmacists are supporting CBU governance to assist the Divisional teams with reducing harm from medication incidents. Due to the ongoing difficulties with the Aseptic Suites quality metrics are currently not being collected.

The Trust currently has one Patient Safety Alert that is overdue (Anti-barricade Devices) hospital). A programme of work has been taking place to address the requirements of the Estates & Facilities Alert and will be completed by the end of January 2020**.**

Duty of Candour written compliance for December 2019 was at 95% due to one non-compliant incident. This is a vast improvement from the previous month and support continues to be provided to the Divisions from the Risk and Incident team.

SHMI (September 2018 – August 2019) is at 109.5 which is within expected limits and a slight decrease from the previous reporting period. SHMI includes both death in-hospital and within 30 days of discharge. SHMI'S current in-hospital is 94.86. There are currently no alerting diagnosis groups within SHMI.

The percentage participation National Clinical Audit rate has continued to improve and is currently at 94.1% compared to a target of ≥98%. The National Ophthalmology Audit is currently not compliant and the latest update is that the Med-sight electronic patient software was planned to be up and running at the end of January 2020. Participation will be reported as "no" for the 19/20 Quality Account as retrospective data will not be available on Med-sight
The National Oesophageal Gastric Cancer Audit are currently not compliant with data submission however the latest update is that the position has changed from "nil" to 80 submissions. Please note full audit participation is confirmed via case ascertainment (that is number of expected cases and the number submitted for the audit period) for some national audits which are listed in the Quality Account we will not have confirmation that the Trust has fully participated from the national leads until the end of March 2020.

The Trust achieved 93.4% of eDDs being sent within 24 hours for January 2020, however, 96.2% of eDDs have been sent any time thereafter. The eDD has been modified to incorporate mandatory anticoagulant information as this has been identified as an area of concern by the GPs. Feedback from the GPs has been very positive since this introduction. A modified paediatric template has been sent to the paediatric team to review. A monthly dashboard has been developed and distributed monthly to all clinicians and managers.

Operational Performance

With particular note was the increase in 4 hour standard performance by 2.29%. This positions ULHT in the upper quartile of improving trusts against the standard. The number of >59 minute handover delays decreased by 19.69%. 857 in January verses 1067 in December. Conveyance saw a slight reduction but remains above plan. During January there were no breaches of the 12 hour Delayed Admission in ED standard. There were many more patients waiting for admission than in previous months. The trust escalated to a Critical incident twice during January with both LCH and PHB experiencing extreme pressure simultaneously for 2 consecutive days. Non Elective LOS has increased to its highest point in 16 months at 4.88%.

November saw RTT performance deteriorate slightly to 82.75%, a change from the previous run of improvements in Q3. Multiple specialties have shown improvements delivering the improved position
Other Zero Waiting indicators saw positive news with overall waiting list size improving once again from November, with December total waiting list reducing by 700. The incompletes position for December is now below the level of March 2018 and the lowest it has been all year.

In December the Trust achieved only three out of the nine cancer standards namely 31 Day First Treatment, 31 day subsequent Drug and 31 day subsequent Radiotherapy.

62 Day Cancer performance in December dropped below the previous October/November levels to 63.3%. The Trust's approach to Cancer improvement has been revised, placing more emphasis on pathway transformation and the move of the SRO to the Medical Director will give additional focus on the clinical and quality aspects. The CCGs are supporting the Trust with an Improvement Team following investment from the East Midlands Cancer Alliance. Recovery is reliant on achieving 7 day outpatient appointments, improving access to oncology and improvement across our diagnostic pathway which includes pathology and biopsies.

Unfortunately Breast 2ww position has remained unacceptably low due to the reduced availability of the temporary workforce. During this position we are maintaining treatment within 62 days unless there is additional

pathway complexity or patient choice adding delay. Though there was an active plan in place to return the specialty to booking patients within 14 days during January, this has proven challenging to accomplish, the critical issue being the loss of one locum consultant Breast Radiologist and a second locum potentially at risk.

Finance

YTD financial performance is £39.8m deficit, or £3.2m adverse to plan.

Excluding the £0.4m adverse movement to plan in relation to Passthrough, Income YTD is £13.9m favourable to plan including in line with plan £22.4m of PSF, FRF and MRET. However, the Income position includes £16.7m of transitional support from commissioners.

Excluding the £0.4m favourable movement to plan in relation to Passthrough, Expenditure YTD is £17.3m adverse to plan: Pay is £15.9m adverse to plan and Non-Pay is £1.3m adverse to plan. The YTD pay position includes £1.0m of non-recurrent technical FEP, without which Pay would be £16.9m adverse to plan. The adverse pay movement YTD is driven by higher than planned expenditure on temporary staffing: while substantive pay is £0.7m adverse to plan, bank pay is £3.4m adverse to plan and agency pay is £11.8m adverse to plan. The pay position is driven by lower than planned FEP savings delivery in relation to workforce schemes and temporary staffing pressures in relation to Medical and Nursing Staffing.

Excluding the £0.4m favourable variance in relation to Passthrough, Non Pay is £1.3m adverse to plan. However, the Non Pay position includes £1.5m of non-recurrent technical savings delivery, without which Non Pay would be £2.8m adverse to plan. Some variation to plan would be expected given the slower than planned savings delivery and higher than planned levels of Non Elective volumes. The majority of the movement to plan, though, is in relation to the level of non-clinical expenditure. This includes higher than planned expenditure in a number of areas e.g. ongoing support costs in relation to FSM, dual running for Community COIN (for which there is an offset within Income) and additional building & engineering costs in Estates. Non Pay expenditure is being reviewed to ensure that any expenditure which may be capitalised is treated accordingly and that Non Pay expenditure in general is minimised.

Overall, CIP savings of £13.7m have been delivered YTD or £5.5m less than savings of £19.2m planned YTD. Excluding non-recurrent technical savings delivery of £2.5m, CIP savings delivery is £8.1m adverse to plan YTD. The forecast excluding PSF, FRF and MRET is a deficit of £70.3m in line with plan.

Workforce

In January (M10), Year to Date (YTD) planned pay increased to 5.5% adverse to plan with the value increasing from £13.5M to £15.9M. This is because total pay run rate increased by £0.3M and the planned pay costs profile included a reduction in monthly run rate in month 10. The positive variance of actual income against planned income continues and partly accounts for the variance in pay with the remainder resulting from higher premium cost of agency staffing (to cover vacant clinical pots and addition resource required for higher than planned activity) and under delivery of workforce CIP, in particular reduction in medical staffing capacity.

The monthly run rate for total agency spend reduced further (-£350K) from Month 9 to Month 10 to £3.14M, and is the lowest monthly spend since April 19, however agency spend now exceeds that planned by 46.2% due to planned agency savings in Month 10.

Overall temporary medical staffing costs reduced in January with reductions in both medical agency demand and spend (The DE efficiency was up further 94.7%) Medical agency spend was below comparable monthly spend for 2018/19 again for the second month in a row.

Reported Nursing Agency costs decreased in January due to technical adjustments only with actual activity, fill rates and cost increases including off-framework use.

Whole Trust vacancy rate improved to a nine month low in January 20, despite being artificially inflated by the impact of continued scrutiny on the filling of all non-clinical posts. Improvement in the vacancy rates for the three priority groups continues to be consolidated despite higher than regional median levels of turnover.

Longer-term trends for Turnover remain positive, however, all the rates remain above national and regional benchmarks slowing the improvement in vacancy rate from recruitment. AHP rate has increased consecutively for the last four months.

Absence rate trend is of concern despite continued management focus. The number and length of longer-term absence is increasing.

Staff appraisal improved slightly but focus is on improving the quality and perceived value.

Core learning continues above 90% and whilst below target is consistent with local provider rates.

2019 NSS scores show some improvement. The number of unresolved Employee relations cases reduced from 51 to 41 in January.

Paul Matthew
Director of Finance & Digital
February 2020

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Nov-19	Dec-19	Jan-20	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Clostridioides difficile position	Safe	Our Patients	Director of Nursing	9	10	4	3	58		P		
	MRSA bacteraemia	Safe	Our Patients	Director of Nursing	0	1	0	0	2		P		
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, using trust per 1000 bed days formula	Safe	Our Patients	Director of Nursing	TBC	0.01	0.01	0.03	0.05				
	E. coli bacteraemia cases counts and 12-month rolling rates, per 1000 bed days formula	Safe	Our Patients	Director of Nursing	TBC	0.01	0.01	0.12	0.17				
	Never Events	Safe	Our Patients	Medical Director	0	3	2	0	9		P		Timeliness, Completeness, Validation, Process
	New Harm Free Care	Safe	Our Patients	Director of Nursing	99%	98.70%	98.60%		98.88%		F		Timeliness, Completeness, Validation, Process
	Pressure Ulcers category 3	Safe	Our Patients	Director of Nursing	4.3	1	2	5	29		F		
	Pressure Ulcers category 4	Safe	Our Patients	Director of Nursing	1.3	0	0	0	1		P		Timeliness, Completeness, Validation, Process
	Pressure Ulcers - unstageable	Safe	Our Patients	Director of Nursing	19/20 will be used as a benchmark	6	11	11	43				
	Stroke - Patients with 90% of stay in Stroke Unit	Caring	Our Patients	Director of Nursing	80%	87.70%	89.00%		83.84%		P	A	
	Stroke - Swallowing assessment < 4hrs	Caring	Our Patients	Director of Nursing	80%	74.60%	65.00%		75.79%		F		
	Stroke - Scanned < 1 hrs	Caring	Our Patients	Director of Nursing	50%	45.80%	56.30%		52.74%		P		
	Stroke - Scanned < 12 hrs	Caring	Our Patients	Director of Nursing	100%	98.60%	98.80%		97.96%		F		
	Stroke - Admitted to Stroke Unit < 4 hrs	Caring	Our Patients	Director of Nursing	90%	74.60%	44.90%		62.36%		F		
	Stroke - Patient death in Stroke	Caring	Our Patients	Director of Nursing	17%	9.20%	8.20%		8.81%		P		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Our Patients	Medical Director	100	110.06	109.43	109.50	110.07		F	B	
	Hospital Standardised Mortality Ratio - HSMR (rolling year data 3 month time lag)	Effective	Our Patients	Medical Director	100	92.8	92.15	93.49	91.49		P	B	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Nov-19	Dec-19	Jan-19	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Our Patients	Director of Nursing	90%	90.00%	88.90%	85.80%	88.27%		F	A	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Our Patients	Director of Nursing	90%	90.00%	82.00%	83.50%	92.55%		F		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Our Patients	Director of Nursing	90%	100.00%	90.00%	95.20%	86.50%		P		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Our Patients	Director of Nursing	90%	100.00%	100.00%	40.00%	63.50%		F		
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Our Patients	Director of Nursing	90%	91.70%	93.00%	90.50%	89.72%		P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Our Patients	Director of Nursing	90%	85.10%	89.00%	85.50%	76.96%		F		
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Our Patients	Director of Nursing	90%	94.50%	96.00%	95.00%	96.00%		P	A	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Our Patients	Director of Nursing	90%	88.60%	100.00%	88.80%	53.43%		F		
	Rate of stillbirth per 1000 births	Safe	Our Patients	Director of Nursing	4.2%	3.18%	2.79%	2.37%	2.93%		P	B	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Our Patients	Medical Director	14	17	13	16	135		F		Timeliness, Completeness, Validation, Process
	Catheter Associated Urinary Tract Infection	Safe	Our Patients	Director of Nursing	1	0	0	0	1		P		
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Our Patients	Director of Nursing	0.19	0.13	0.16	0.06	0.13		P		Timeliness, Completeness, Validation, Process
	Reported medication incidents per 1000 occupied bed days	Safe	Our Patients	Medical Director	4	4.87	5.47	5.10	6.29		F		
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Our Patients	Medical Director	10%	18.40%	13.20%	15.20%	12.17%		F		
	Potential under reporting of patient safety incidents / Reported incidents (all harms) per 1,000 bed days	Safe	Our Patients	Medical Director	30	33.90	36.03	36.91	36.19		P	A	
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Our Patients	Medical Director	0	2	2	1	13		F		
	National Clinical audit participation rate	Effective	Our Patients	Medical Director	98%	92.60%	92.60%	94.10%	93.40%		F		
	7 day Services Clinical Standard 2 (all patients have a Consultant review within 14 hours of admission)	Effective	Our Patients	Medical Director	90%	Not Collected audit done twice a year			61.00%				
	7 day Services Clinical Standard 8 (ongoing review)	Effective	Our Patients	Medical Director	90%	Not Collected audit done twice a year			83.00%				
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Our Patients	Medical Director	95%	97.60%	97.43%	97.89%	97.21%		P	A	
	eDD issued	Effective	Our Patients	Medical Director	95%	92.2%	93.30%	93.40%	92.30%		F	A	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Nov-19	Dec-19	Jan-19	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	Our People	Director of HR & OD	95%	90.31%	90.39%	91.10%	91.21%		F		
	Number of Vacancies	Well-Led	Our People	Director of HR & OD	12%	14.73%	14.92%	14.54%	14.76%		F	A	
	Sickness Absence	Well-Led	Our People	Director of HR & OD	4.5%	4.86%	4.95%	4.99%	4.85%		F	H	
	Staff Turnover	Well-Led	Our People	Director of HR & OD	12%	11.51%	11.47%	11.38%	11.03%		P		
	Staff Appraisals	Well-Led	Our People	Director of HR & OD	90%	72.73%	71.95%	73.07%	73.77%		F		
True North	KPI	CQC Domain	2021 Objective	Responsible Director	£'000	£'000	£'000	£'000	£'000	£'000			
Sustainable Services	Surplus / Deficit	Well-Led	Our Services	Director of Finance & Digital	-£791	-£6,439	£3,897	-£4,076	-£32,390	-£29,040	F	A	
	Income	Well-Led	Our Services	Director of Finance & Digital	£42,991	£40,265	£49,338	£43,570	£431,346	£417,785	P	A	
	Expenditure	Well-Led	Our Services	Director of Finance & Digital	-£43,782	-£46,704	-£45,441	-£47,646	-£463,736	-£446,825	F		
	Efficiency Delivery	Well-Led	Our Services	Director of Finance & Digital	£2,827	£2,313	£1,526	£1,897	£13,713	£19,237	F		
	Capital Delivery Program	Well-Led	Our Services	Director of Finance & Digital	£3,956	£1,246	£1,623	£1,784	£18,849	£20,681	F		
	Agency Spend	Well-Led	Our Services	Director of Finance & Digital	-£1,997	-£3,628	-£3,466	-£3,136	-£37,429	-£25,607	F	A	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Nov-19	Dec-19	Jan-19	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Friends & Family Test Inpatient (Response Rate)	Caring	Our Patients	Director of HR & OD	26%	28.76%	25.29%		28.36%		F	A	
	Friends & Family Test Inpatient (Recommend)	Caring	Our Patients	Director of HR & OD	97%	86.72%	88.24%		88.64%		F		
	Friends & Family Test Emergency Care (Response Rate)	Caring	Our Patients	Director of HR & OD	19%	25.91%	25.08%		24.91%		P		
	Friends & Family Test Emergency Care (Recommend)	Caring	Our Patients	Director of HR & OD	87%	80.72%	83.41%		81.38%		F		
	Friends & Family Test Maternity (Response Rate)	Caring	Our Patients	Director of HR & OD	23%	24.46%	32.20%		19.09%		P		
	Friends & Family Test Maternity (Recommend)	Caring	Our Patients	Director of HR & OD	97%	94.51%	100.00%		98.77%		P		
	Friends & Family Test Outpatients (Response Rate)	Caring	Our Patients	Director of HR & OD	14%	11.48%	11.25%		11.02%		F	A	
	Friends & Family Test Outpatients (Recommend)	Caring	Our Patients	Director of HR & OD	94%	93.24%	93.77%		93.30%		F		
	Mixed Sex Accommodation breaches	Caring	Our Patients	Director of Nursing	0	0	0	0	0		P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	No of Complaints received	Caring	Our Patients	Director of HR & OD	70	72	64		570		P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	No of Pals	Caring	Our Patients	Director of HR & OD		492	414		4283				Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Our Patients	Chief Operating Officer	0%	1.48%	1.29%	0.66%	2.25%		F	L	
	Duty of Candour compliance - Verbal	Safe	Our Patients	Medical Director	100%	88.00%	100.00%		94.89%		P	A	
	Duty of Candour compliance - Written	Responsive	Our Patients	Medical Director	100%	54.00%	95.00%		85.78%		F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Nov-19	Dec-19	Jan-19	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Zero Waiting	4hrs or less in A&E Dept	Responsive	Our Services	Chief Operating Officer	82.0%	62.04%	64.71%	67.00%	67.43%	77.01%	F		
	12+ Trolley waits	Responsive	Our Services	Chief Operating Officer	0	11	0	0	11	0	P		
	%Triage Achieved under 15 mins	Responsive	Our Services	Chief Operating Officer	87.0%	78.58%	75.75%	84.70%	79.42%	80.55%	F		
	52 Week Waiters	Responsive	Our Services	Chief Operating Officer	0	0	0		8	0	P		
	18 week incompletes	Responsive	Our Services	Chief Operating Officer	83.8%	83.52%	82.75%		83.23%	83.83%	F	B	
	Waiting List Size	Responsive	Our Services	Chief Operating Officer	37,061	38,922	38,219		n/a	n/a	F		
	62 day classic	Responsive	Our Services	Chief Operating Officer	85.4%	65.70%	63.30%		69.83%	80.33%	F		
	2 week wait suspect	Responsive	Our Services	Chief Operating Officer	93.0%	78.04%	80.70%		80.90%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Our Services	Chief Operating Officer	93.0%	6.15%	5.90%		54.54%	93.00%	F	L	
	31 day first treatment	Responsive	Our Services	Chief Operating Officer	96.0%	97.04%	96.20%		96.76%	96.00%	P		
	31 day subsequent drug treatments	Responsive	Our Services	Chief Operating Officer	98.0%	100.00%	99.00%		98.90%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Our Services	Chief Operating Officer	94.0%	96.88%	81.80%		92.25%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Our Services	Chief Operating Officer	94.0%	100.00%	99.10%		95.59%	94.00%	P		
	62 day screening	Responsive	Our Services	Chief Operating Officer	90.0%	83.33%	81.10%		83.11%	90.00%	F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Nov-19	Dec-19	Jan-19	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Zero Waiting	62 day consultant upgrade	Responsive	Our Services	Chief Operating Officer	85.0%	77.52%	69.40%		81.27%	85.00%	F		
	diagnostics achieved	Responsive	Our Services	Chief Operating Officer	98.4%	96.55%	94.13%	95.35%	95.88%	98.15%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Chief Operating Officer	0.8%	2.54%	2.40%		2.18%	0.80%	F	B	
	Not treated within 28 days. (Breach)	Responsive	Our Services	Chief Operating Officer	5%	4.55%	11.28%		5.39%	5.00%	F		
	#NOF 48 hrs	Responsive	Our Services	Chief Operating Officer	90%	91.55%	92.31%	88.14%	90.52%	90%	F		
	#NOF 36 hrs	Responsive	Our Services	Chief Operating Officer	TBC	83.10%	85.90%	83.05%	83.41%				
	EMAS Conveyances to ULHT	Responsive	Our Services	Chief Operating Officer	4,974	5,754	5,329	5,170	5,195	4,741	F	A	
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Chief Operating Officer	0	996	1067	857	736	0	F		
	104+ Day Waiters	Responsive	Our Services	Chief Operating Officer	5	16	15	19	157	50	F		
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Chief Operating Officer	2.80	2.36	3.05	2.26	2.62	2.80	P		
	Average LoS - Non Elective	Effective	Our Services	Chief Operating Officer	4.50	4.52	4.51	4.88	4.42	4.5	F		
	Delayed Transfers of Care	Effective	Our Services	Chief Operating Officer	3.5%	2.95%	2.55%		2.96%	3.5%	P		
	Partial Booking Waiting List	Effective	Our Services	Chief Operating Officer	4,524	10,793	10,949	11,064	9,895	4,524	F	A	
	Outpatients seen within 15 minutes of appointment	Effective	Our Services	Chief Operating Officer	60.3%	34.0%	34.1%	35.4%	34.98%	48.88%	F	A	
	% discharged within 24hrs of PDD	Effective	Our Services	Chief Operating Officer	45.0%	39.6%	36.9%	40.9%	49.03%	45.00%	F		

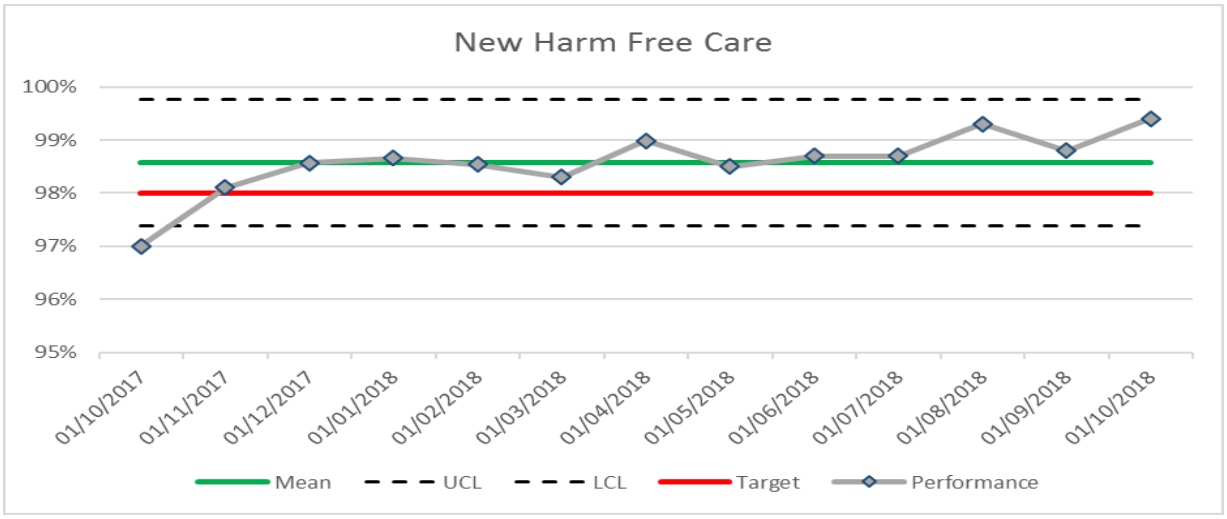
STATISTICAL PROCESS CONTROL CHARTS

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:



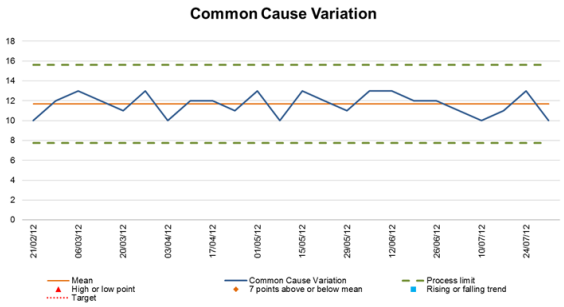
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

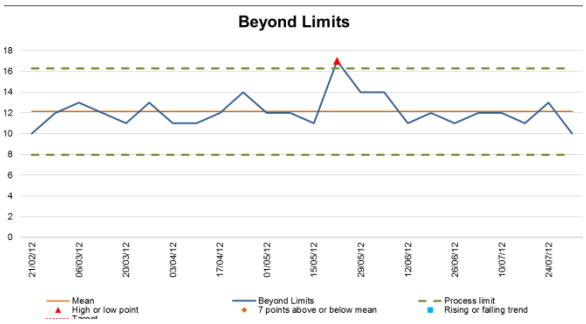
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful 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

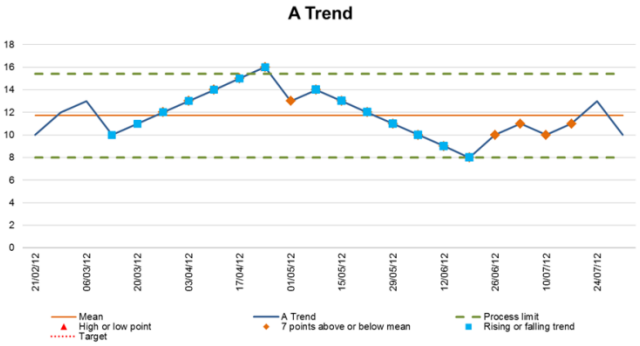


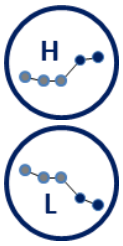
Extreme Values



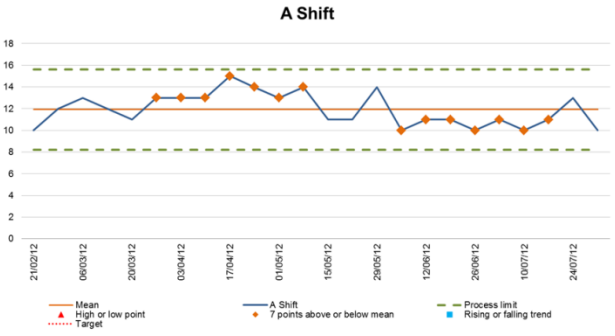
There is no Icon for this scenario.

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 data points have met or exceeded the target.

Where a target has been missed consistently

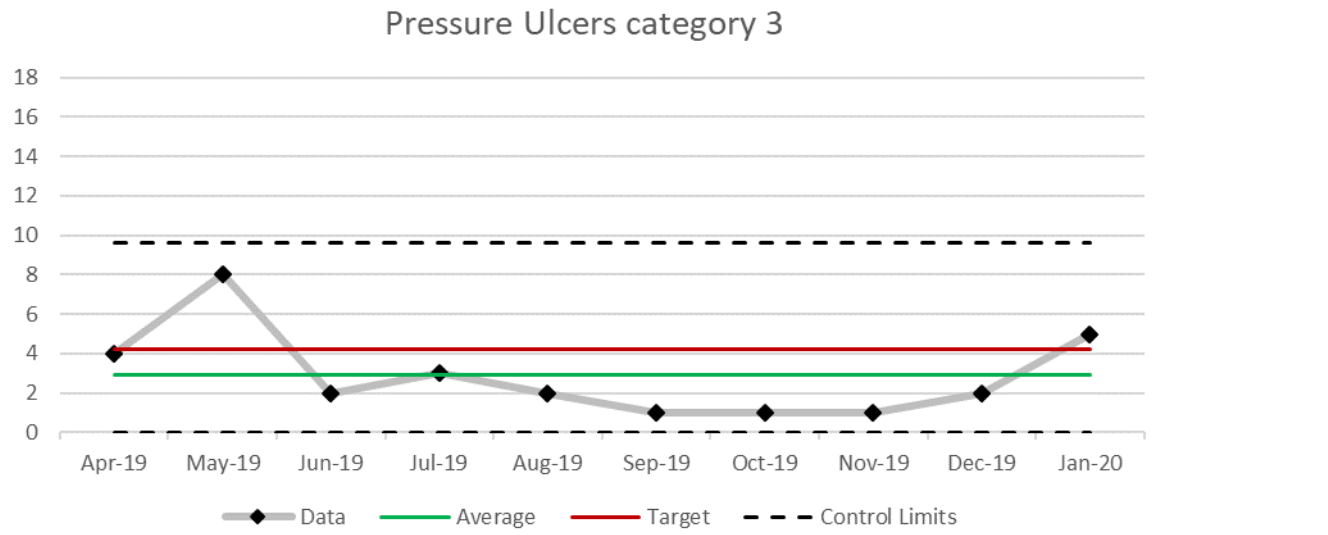
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

HARM FREE CARE – PRESSURE ULCERS CATEGORY 3

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



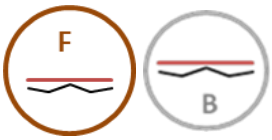
Narrative not provided by the team

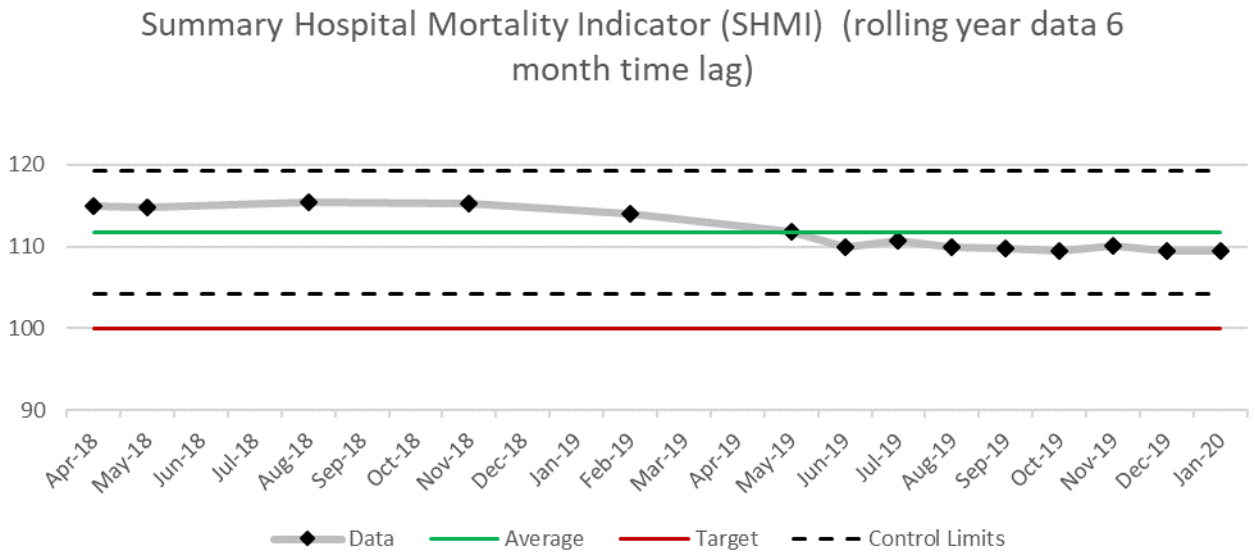
HARM FREE CARE - MORTALITY

Executive Lead: Medical Director

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

SHMI (September 2018 – August 2019) is 109.5 and is in band 2 within expected limits which is a slight decrease from the previous reporting period. SHMI includes both death in-hospital and within 30 days of discharge. SHMI'S current in-hospital SHMI is 94.86. ULHT's post discharge crude average is 1.64%. Both Grantham (average 2.45%) and Pilgrim (average 1.83%) have a significantly higher post discharge crude than Lincoln (average 1.40%).

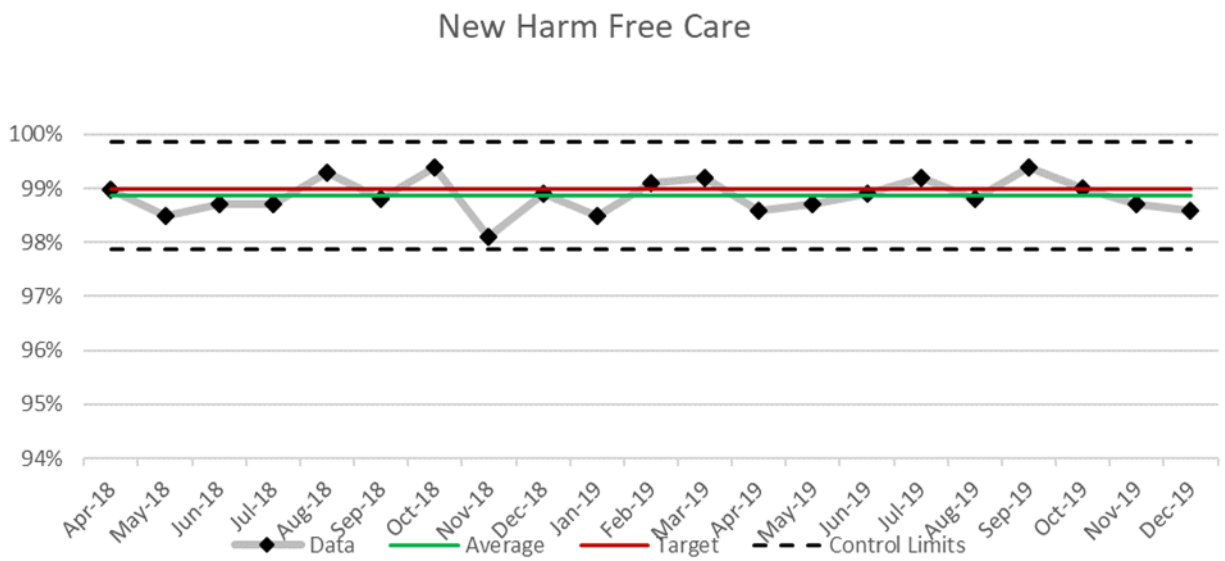
Alerts: There are currently no alerting diagnosis groups within SHMI.

HARM FREE CARE – NEW HARM FREE CARE

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

New Harm Free Care for the Trust for December 2019 is 98.6% compared to the national average of 97.8% and a Trust benchmark of 90%. The Trust has been above the national average since November 2017. 906 patients were audited in December and there were 4 patients with new pressure ulcers, 6 with falls with harm, 0 new CAUTI and 2 new VTE's.

Actions in place to recover:

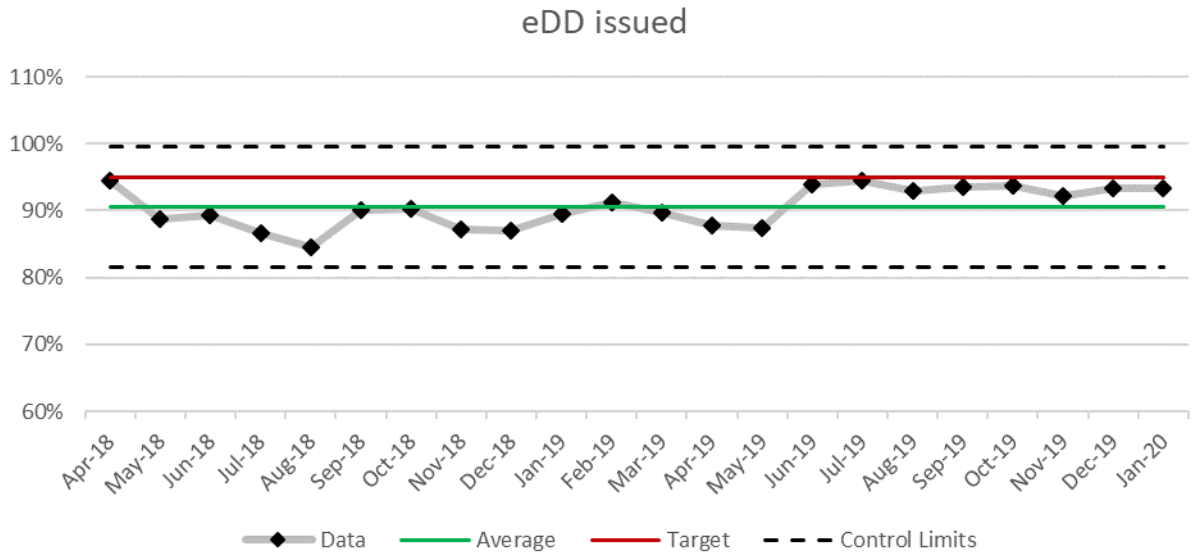
The Deputy Chief Nurse chairs the Harm Free Care group which encompasses falls, pressure ulcers and CAUTI's. The Trust also has a Thrombosis group chaired by the Consultant in acute medicine care.

HARM FREE CARE – eDD ISSUED

Executive Lead: Medical Director

CQC Domain: Effective

2021 Objective: Our Patients



Challenges/Successes

The Trust sent 93.4% of eDDs within 24 hours for January 2020, however 96.2% have been sent as of the 6th February. The eDD has been modified to incorporate mandatory anticoagulant information as this has been identified as an area of concern by the GPs. Feedback from the GPs has been very positive since this introduction.

Actions in place to recover:

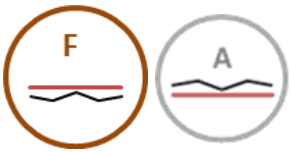
A modified paediatric template has been sent to the paediatric team to review. A monthly dashboard has been developed and distributed monthly to all clinicians and managers.

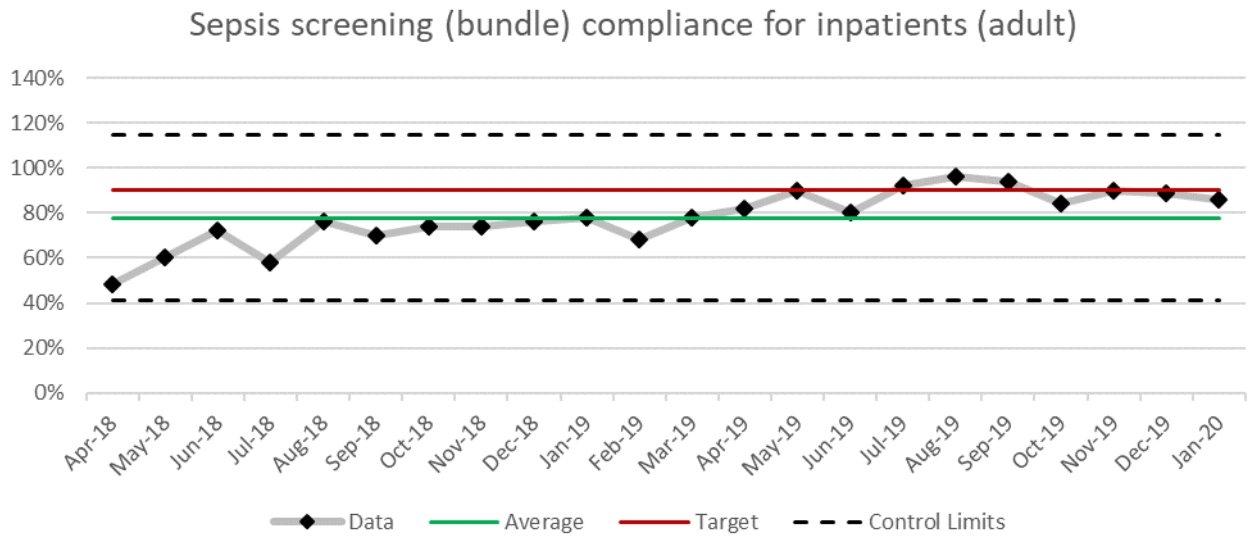
HARM FREE CARE – SEPSIS SCREENING

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

The sepsis screening results for adult inpatients remain static at 85.8% introduction of sepsis train the trainers will commence in the next financial year incorporated in the deteriorating patient ambassador role.

Actions in place to recover:

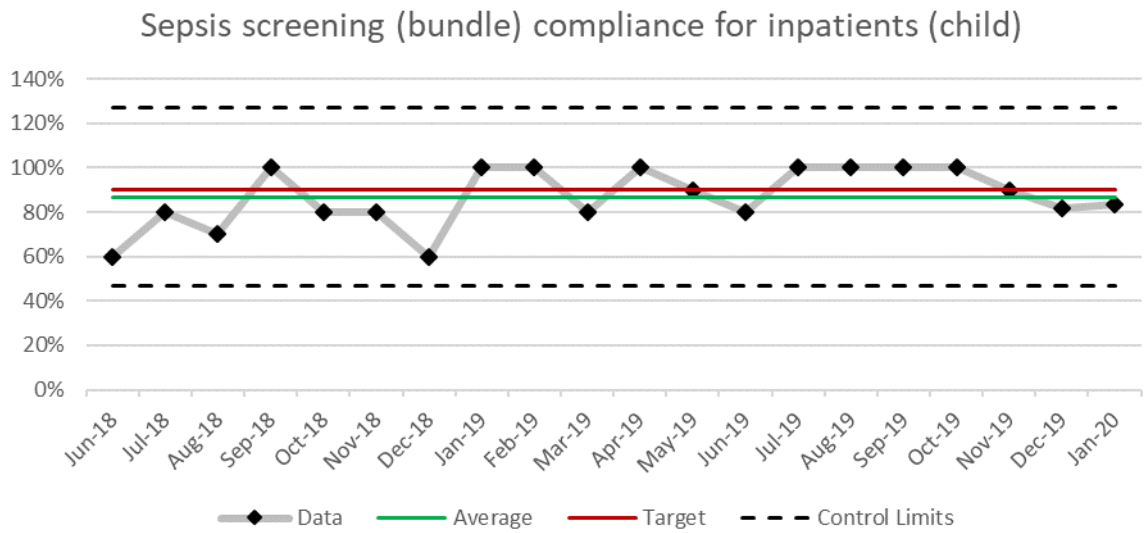
Individual areas/ hot spots are having bespoke training arranged and delivered by competent member of staff and sepsis practitioners. Sharing lessons and themes continues in the inpatient areas through harm review process at ward level.

HARM FREE CARE – SEPSIS SCREENING Continued

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

Sepsis screening for inpatient children has improved marginally to 83.5%.

Actions in place to recover:

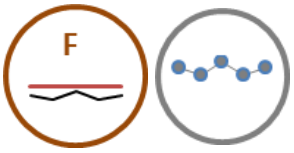
An unsure option has been piloted on the under 5s sepsis tool as demonstrated on the Great Ormond Street sepsis tool- this was approved as a pilot in the paediatric governance meetings, this allows this clinician to monitor and investigate the child's condition closely prior to making the decision to cannulate the child and treat unnecessarily with intravenous antibiotics. Unsure option use will be monitored.

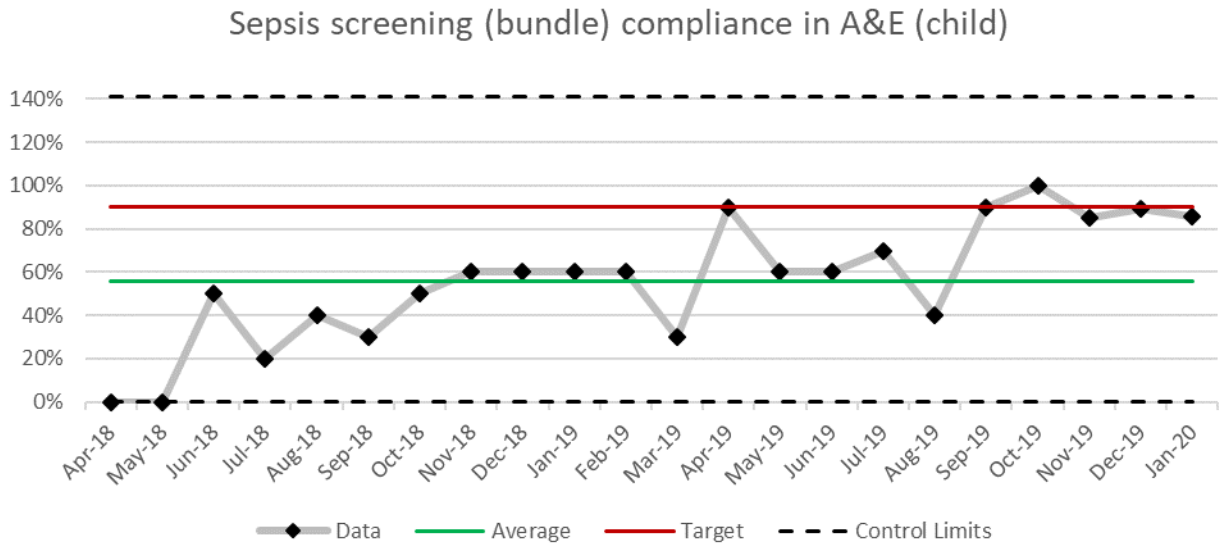
HARM FREE CARE – SEPSIS SCREENING continued

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

Sepsis screening compliance for children in A&E remains static at 85.5% falling short of the 90% target. Harm reviews gathered on a daily basic and collated on a weekly basis. No harm has come to any of the children requiring sepsis screens that didn't receive them.

Actions in place to recover:

An unsure option has been piloted on the under 5s sepsis tool as demonstrated on the Great Ormond Street sepsis tool- this was approved as a pilot in the paediatric governance meetings, this allows this clinician to monitor and investigate the child's condition closely prior to making the decision to cannulate the child and treat unnecessarily with intravenous antibiotics. Unsure option use will be monitored.

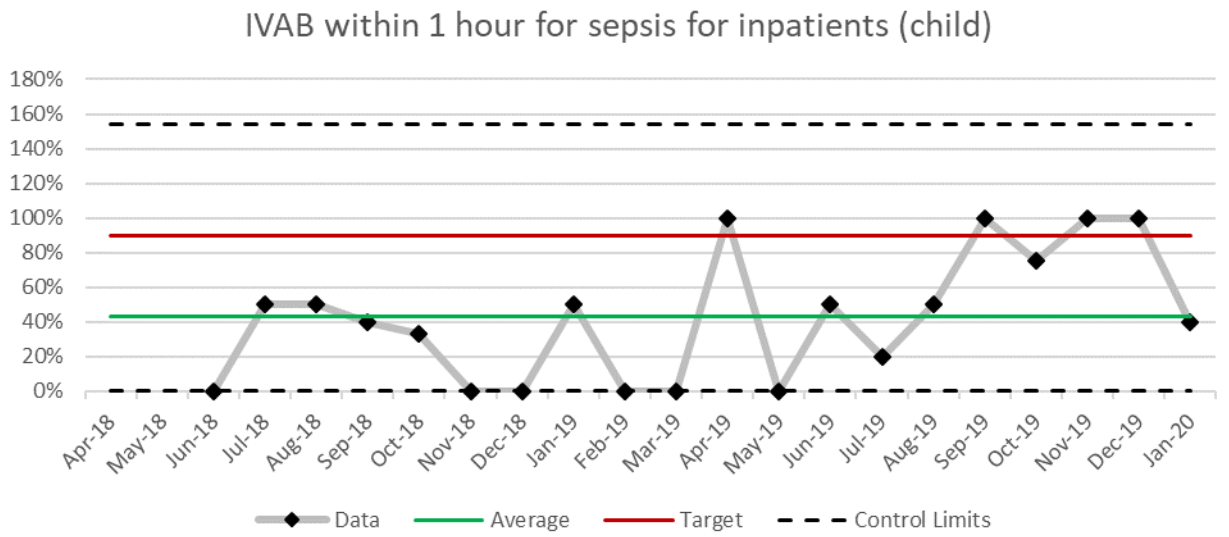
Sepsis practitioners continue to attend A&E safety huddles when able to discuss sepsis for both adults and children, compliance results collected weekly and results shared locally with the teams.

HARM FREE CARE – IVAB WITHIN 1 HOUR FOR SEPSIS

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

Administering intravenous antibiotics in children has declined in January falling short of the 90% target with the result sitting at 40% equating to 2 of 5 patients, harm reviews are being conducted by ward manager to investigate this decline further.

Actions in place to recover:

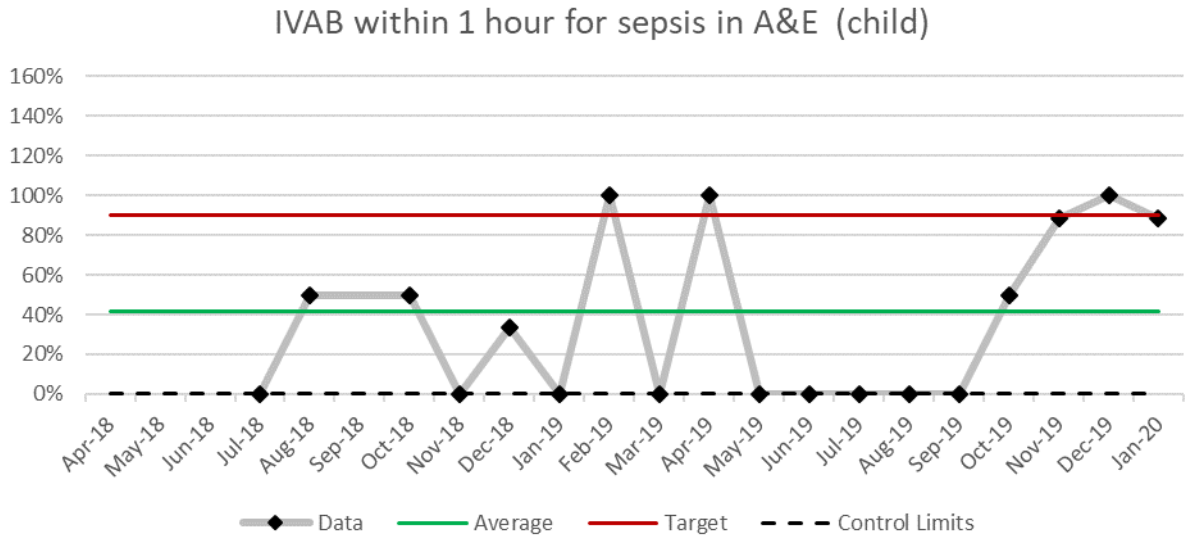
An unsure option has been piloted on the under 5s sepsis tool as demonstrated on the Great Ormond Street sepsis tool- this was approved as a pilot in the paediatric governance meetings, this allows this clinician to monitor and investigate the child's condition closely prior to making the decision to cannulate the child and treat unnecessarily with intravenous antibiotics. Unsure option use will be monitored.

HARM FREE CARE – IVAB WITHIN 1 HOUR FOR SEPSIS continued

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

Administering intravenous antibiotics in children has declined in January falling short of the 90% target with the result sitting at 88.8% equating to 8 of 9 patients- the 1 patient that had a delay in intravenous antibiotics was due to the Dr wishing to await blood reports prior to giving antibiotics.

Actions in place to recover:

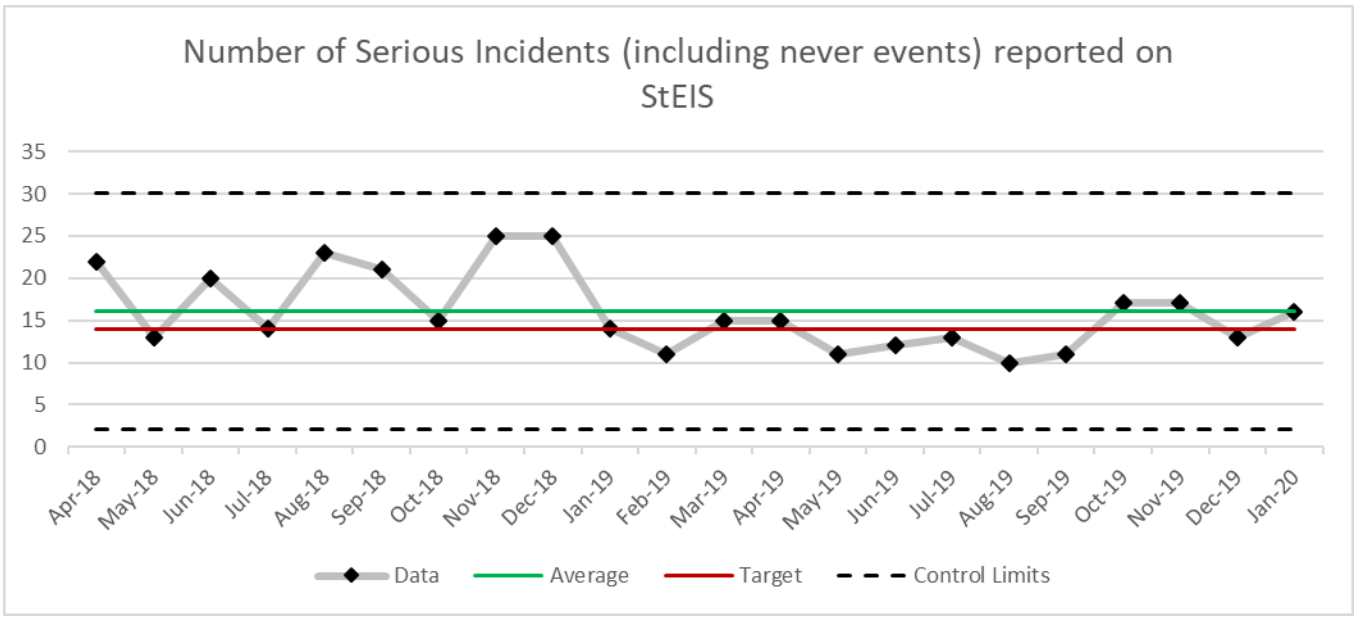
Sepsis practitioners continue to attend A&E safety huddles when able to discuss sepsis for both adults and children, compliance results collected weekly and results shared locally with the teams.

HARM FREE CARE – NUMBER OF SERIOUS INCIDENTS ON StEIS

Executive Lead: Medical Director

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

- The Trust declared 16 Serious Incidents in January 2020, compared with an average of 17 per month for 2019/20
- 5 of those incidents actually occurred in January
- 63.9% of Serious Incidents declared so far this year occurred within Medicine Division

Actions in place to recover

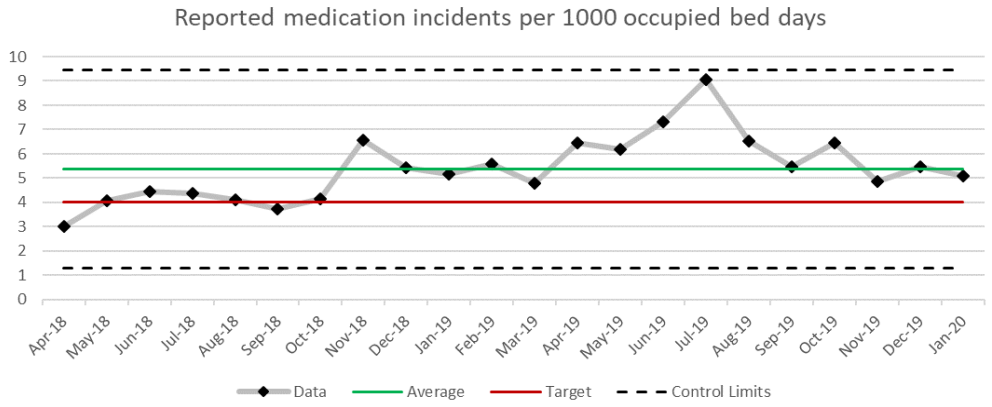
- A temporary Serious Incident Review Team continues to be in place to coordinate and support the majority of Serious Incident investigations
- A comprehensive review of Never Events and their related Action Plans has taken place and additional process improvements have been identified to strengthen action management processes

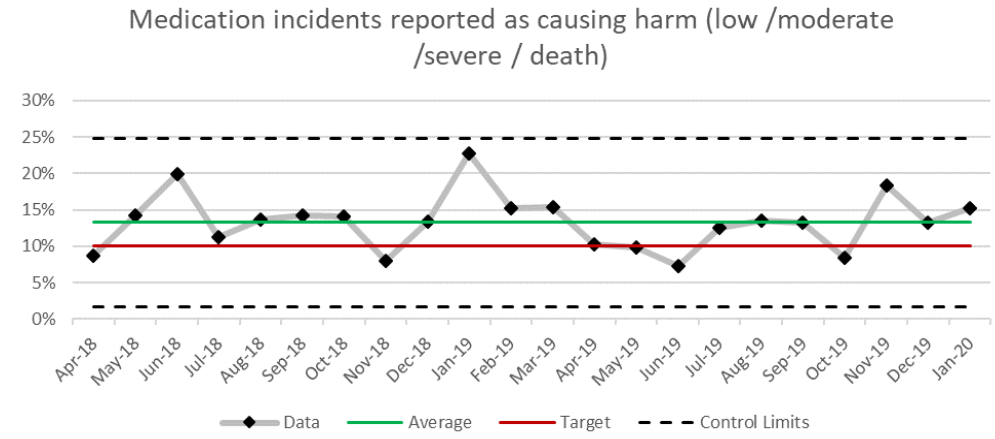
HARM FREE CARE – MEDICATION INCIDENTS

Executive Lead: Medical Director

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

The harm rate from January 2019 to January 2020 shows a downward trend despite the number of incidents being reported increasing.

Actions in place to recover

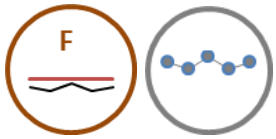
Encourage staff to report all harm classifications of medication related incidents.
The speciality Pharmacists are to support CBU in reducing harm from incidents through governance meetings.

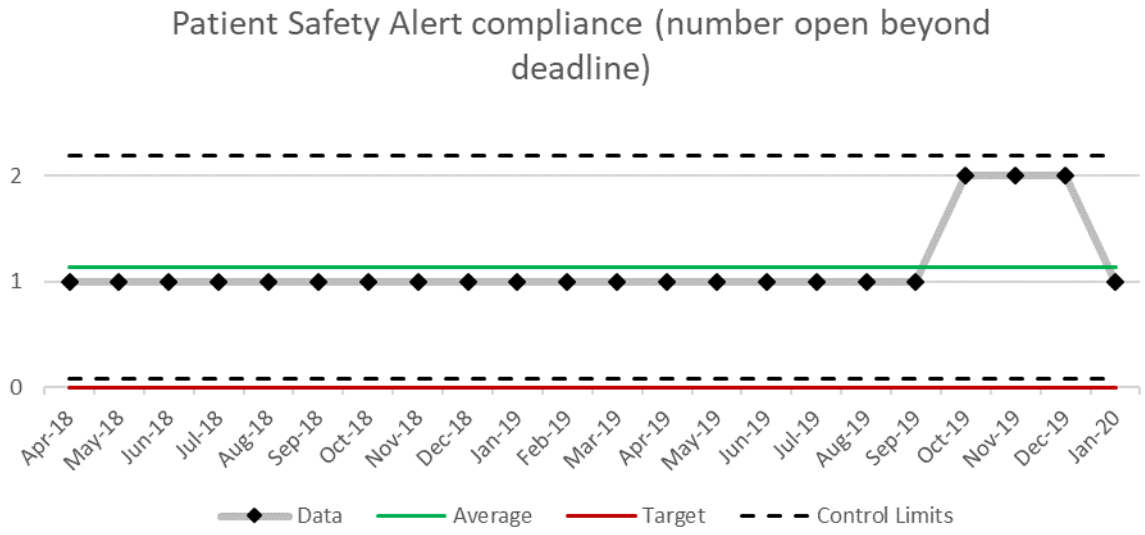
HARM FREE CARE – PATIENT SAFETY ALERT COMPLIANCE

Executive Lead: Medical Director

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

- There was 1 Central Alerting System (CAS) alert overdue its deadline at the end of January 2020:
  - Estates & Facilities Alert - Anti-barricade devices (due February 2018)

Actions in place to recover:

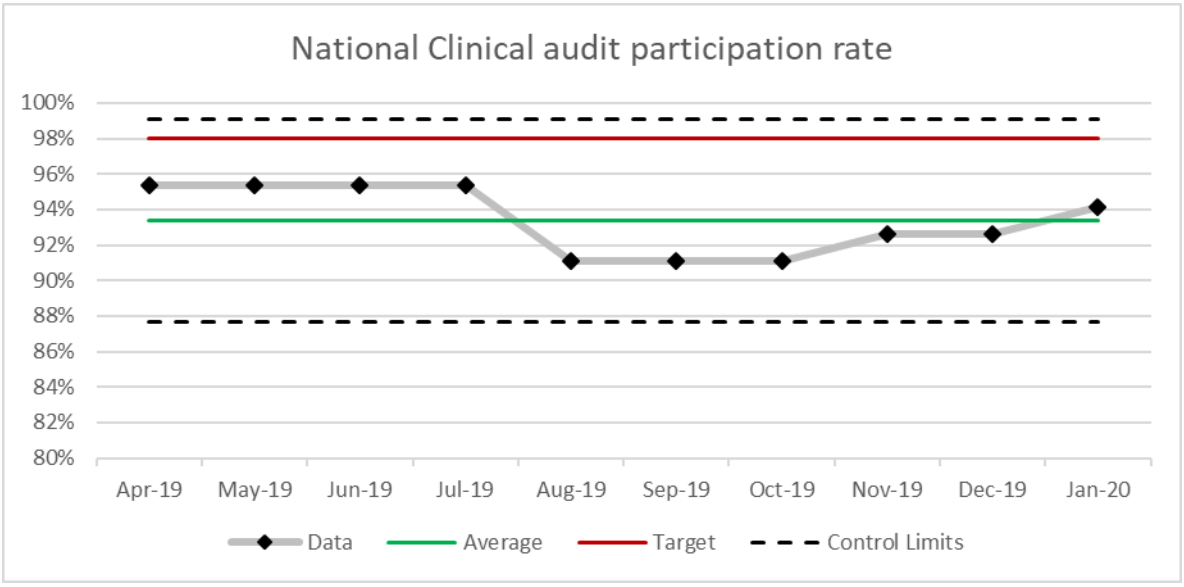
- A programme of work has been taking place to address the requirements of the Estates & Facilities Alert and is nearing completion
- Work at Grantham & District Hospital is now complete

HARM FREE CARE – NATIONAL CLINICAL AUDIT

Executive Lead: Medical Director

CQC Domain: Effective

2021 Objective: Our Patients



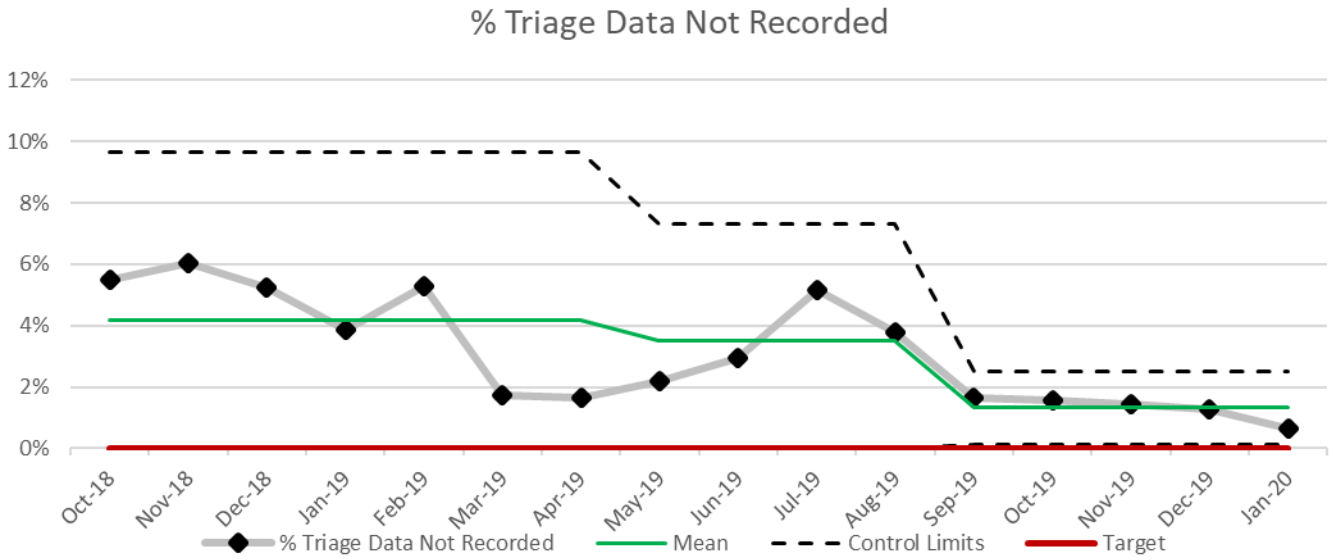
- The % participation National Clinical Audit rate has improved to 94.1% for the month of January 2020 compared to a target of >98% the following are not compliant with data submissions;
- The National Ophthalmology Audit has been a challenge to secure funding to support the technology required by the Clinicians to complete this audit, business case was not approved escalated to General Manager and Clinical Lead
    - Latest update is that the medisight electronic patient software was planned to be up and running at the end of January 2020 awaiting update
    - Data to be uploaded to NOD
    - Participation will be reported as No for the 19/20 Quality Account as retrospective data will not be available on Medisight
- The National Oesophageal Gastric Cancer Audit (NOGCA)
    - Latest update from the Cancer Centre Manager 23/12/2019 is that the position has changed from “nil” to 80 submissions
    - Robust process to be put into place with the Clinical Team escalated to the Clinical Directors for both Surgery and Medicine to discuss a plan to ensure compliance with data submissions
    - Please note full audit participation is confirmed via case ascertainment (that is number of expected cases and the number submitted for the audit period) for some national audits which are listed in the Quality Account we will not have confirmation fully participated from the national leads until the end of March 2020

VALUING PATIENTS TIME – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

2021 Objective: Our Patients



Challenges/Successes

January continued to demonstrate the monthly improvement. Compliance is now 99.34% against a target of 100%. This equates to adverse variance of 0.66%

Achievement against this metric remains dependent upon having a fully trained and compliant staffing rota as well as the individual compliance of staff.

The role of the Pre Hospital Practitioner is currently under review to ensure the correct competencies are in place. The use of a triage coordinator role ensures that this important process is delivered consistently and a greater compliance has been demonstrated and sustained.

High levels of agency usage and temporary non-substantive staff continue to be in place in the Emergency Departments, but these staff are familiar to the departments are deemed competent to both practice and support.

Actions in place to recover:

The actions against this metric are repetitive but still valid.

The Urgent and Emergency Care Lead Nurse (Secondment) ensures increased compliance and maintenance against this target and improvements continue to be realised.

The Divisional UEC Operational Lead continually feeds back performance to the clinical teams and addresses non-adherence to process and seeks rectification measures.

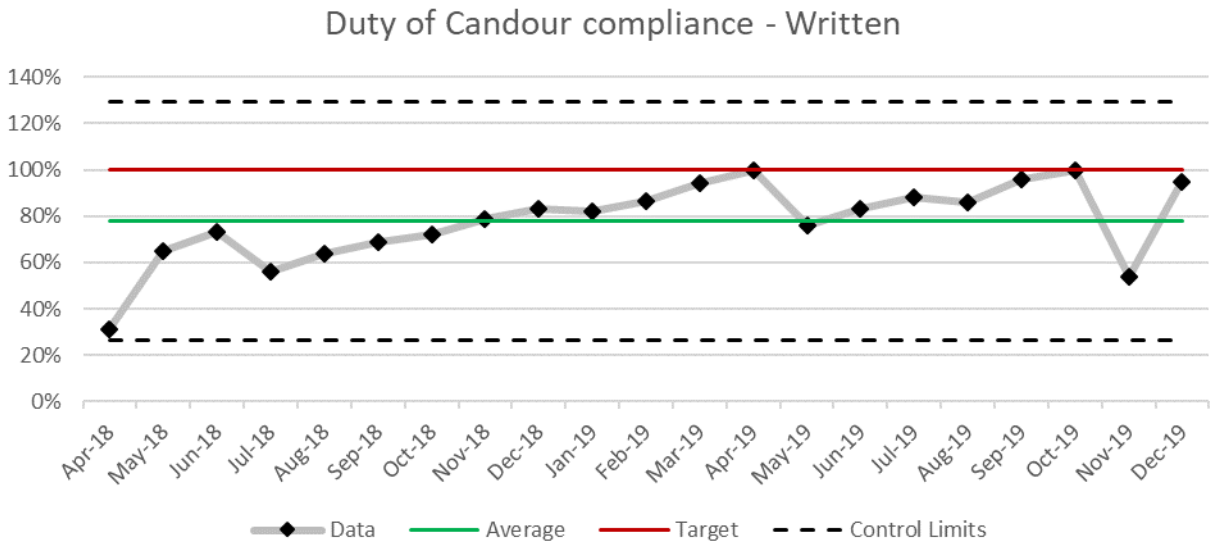
Triage time is a key patient safety performance indicator and will continue to be monitored and challenged at the 3 x daily through the Capacity and Performance Meetings.

VALUING PATIENTS TIME – DUTY OF CANDOUR

Executive Lead: Medical Director

CQC Domain: Caring/Responsive

2021 Objective: Our Patients



Challenges/Successes

- Duty of Candour 'Written follow-up' compliance in December 2019 was 95% (1 non-compliant incident)
- This incident occurred within Family Health Division and written follow-up has now been provided

Actions in place to recover:

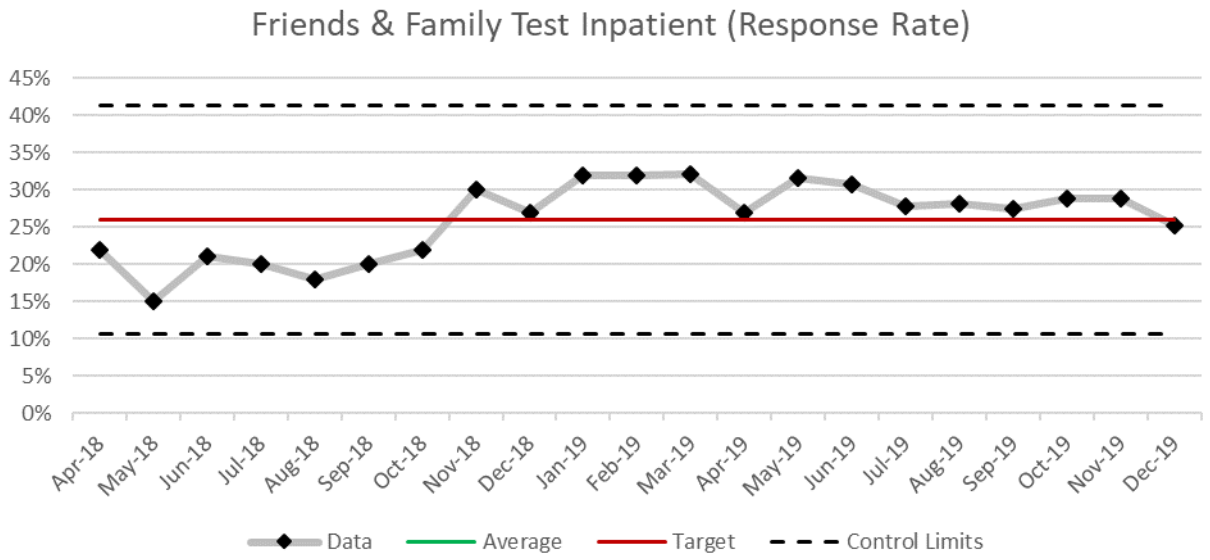
- Family Health Division had previously achieved 100% compliance with Duty of Candour for every month of the financial year
- The corporate Risk & Incident team are now providing additional support to the process for completion of written follow-up letters, where required

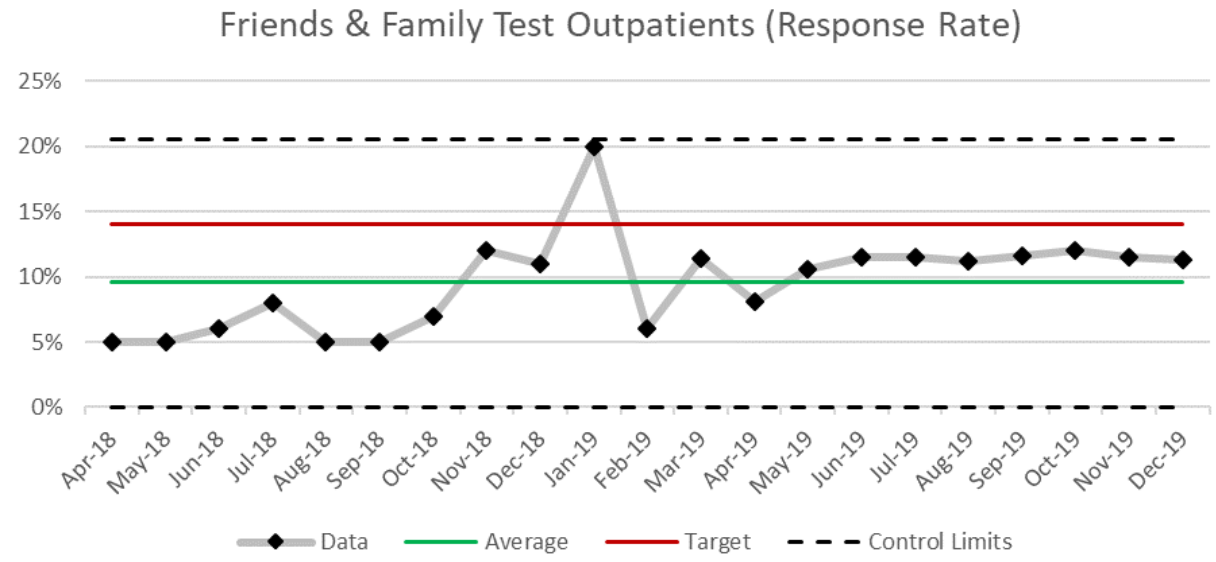
VALUING PATIENTS TIME – FRIENDS AND FAMILY RESPONSE RATES

Executive Lead: Director of HR & OD

CQC Domain: Caring

2021 Objective: Our Patients



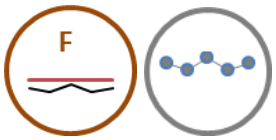


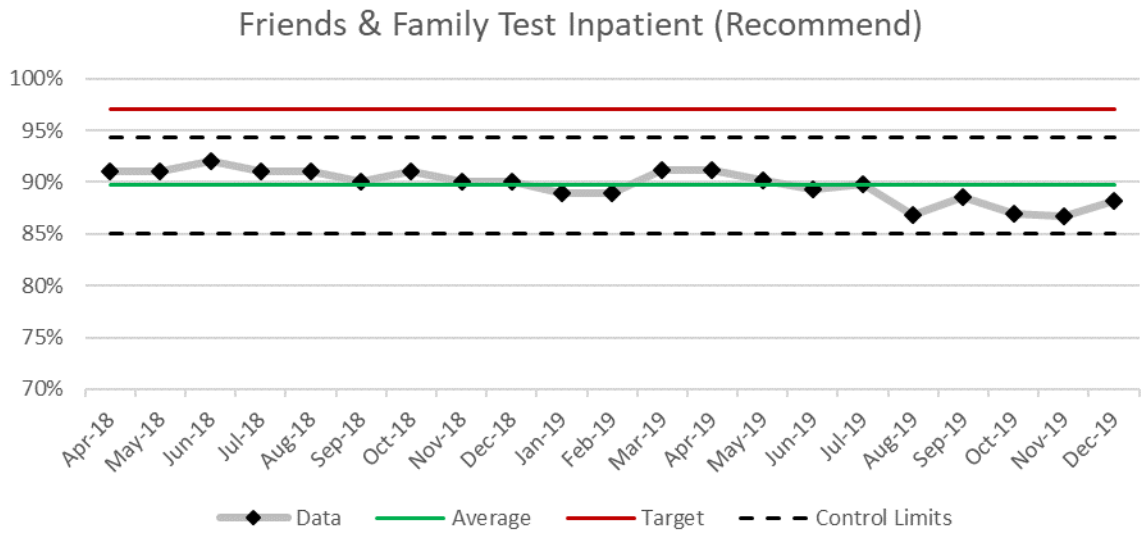
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

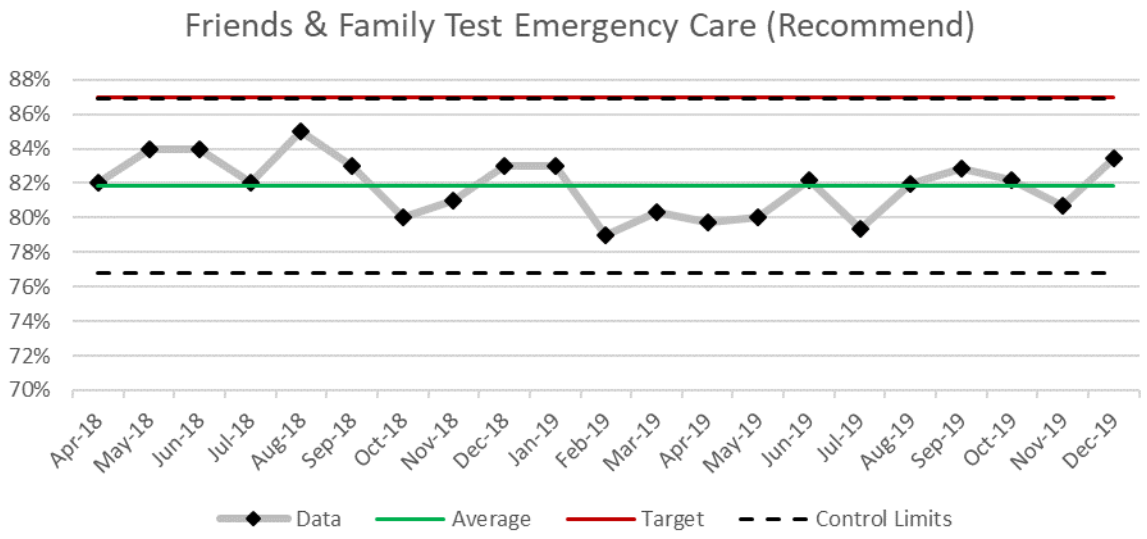
Executive Lead: Director of HR & OD

CQC Domain: Caring

2021 Objective: Our Patients





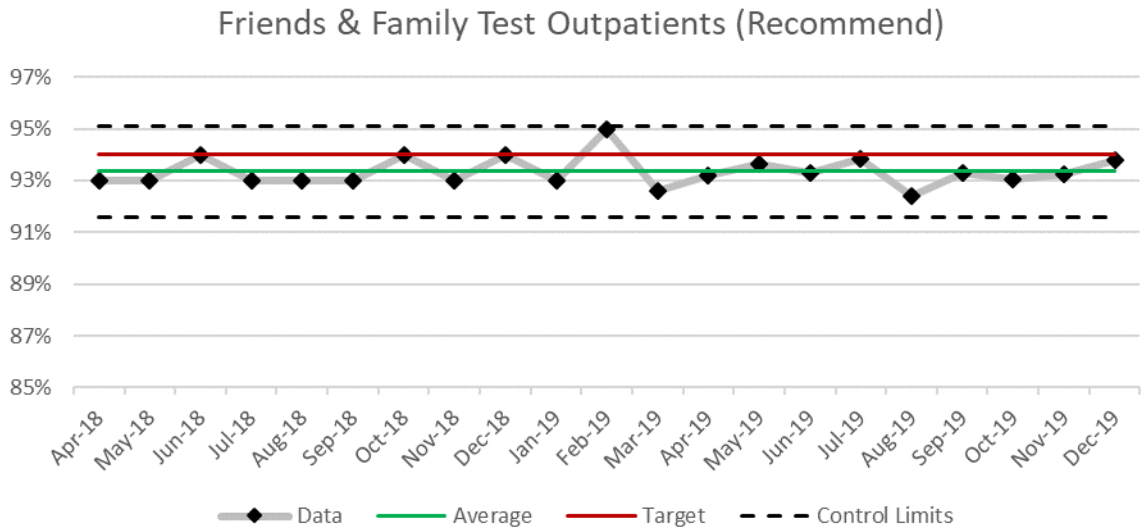


VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

Executive Lead: Director of HR & OD

CQC Domain: Caring

2021 Objective: Our Patients



Challenges/Successes

- Overall 92% of patients would recommend and 5% of patients would not recommend. Based on 6,823 ratings and 5,391 comments with 75% of comments received being positive, 6% neutral and 19% negative.
- Inpatients % FFT recommends has seen a continual drop for the last 8 months and a continual 8 month rise in the % non-recommend.
- Emergency care improved by 2% in %recommends and a 1% decrease in % non-recommend
- Other nationally reports FFT streams remain static

Actions in place to recover:

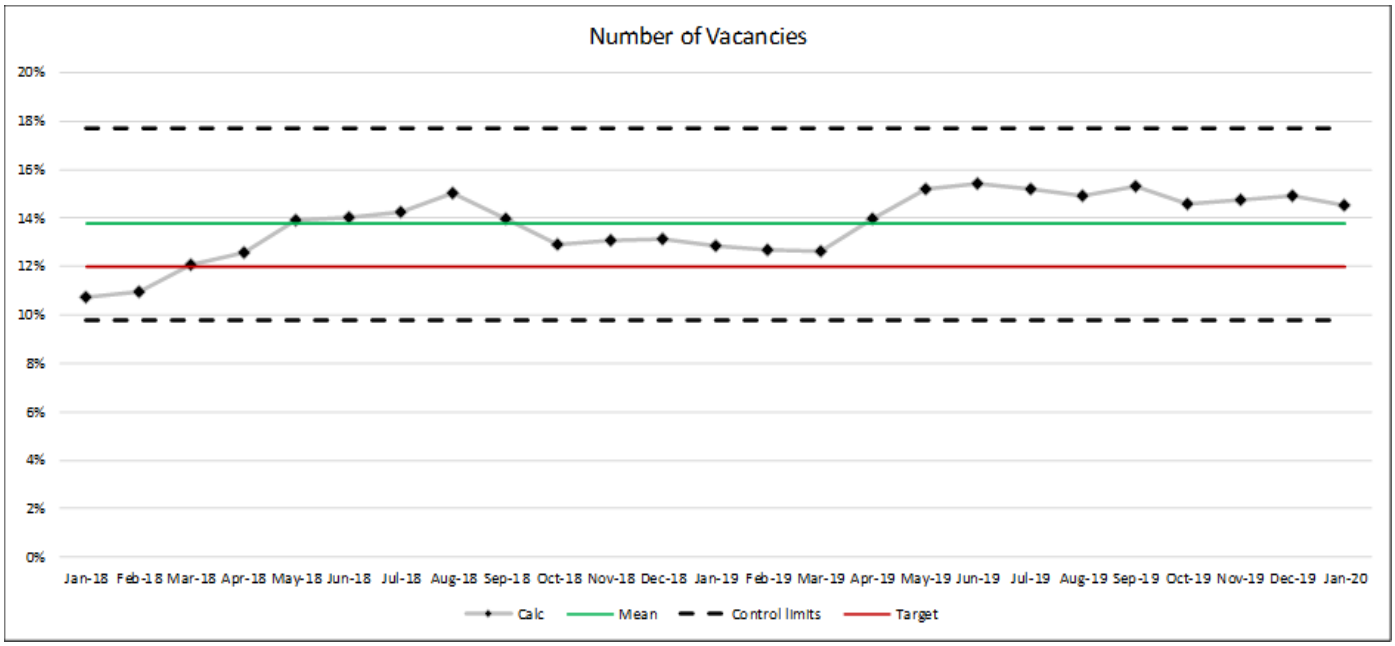
- On-going discussions with Divisions around the future of the Patient Experience Group from April 2020 and the mechanism by which we can be confident that action is being taken to address the issues identified
- Interim dates for PXG have been agreed and circulated for Q4
- 3rd annual Patient Experience Conference was well attended in December with the focus being on empathy, civility, compassion and communication

MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Director of HR & OD

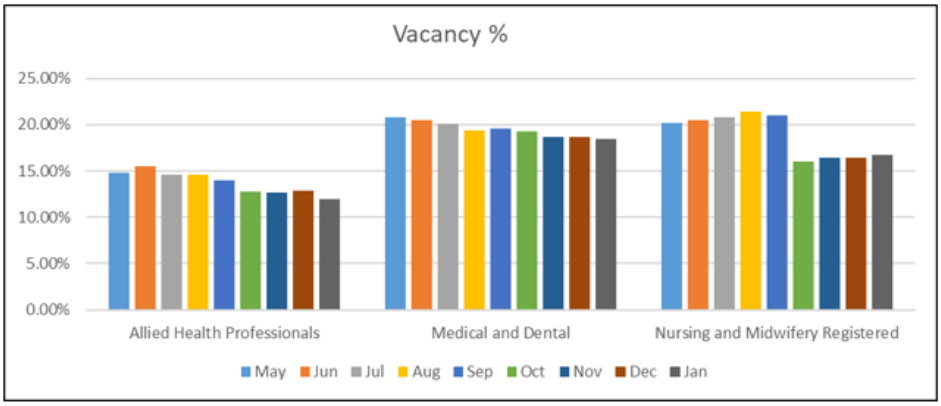
CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

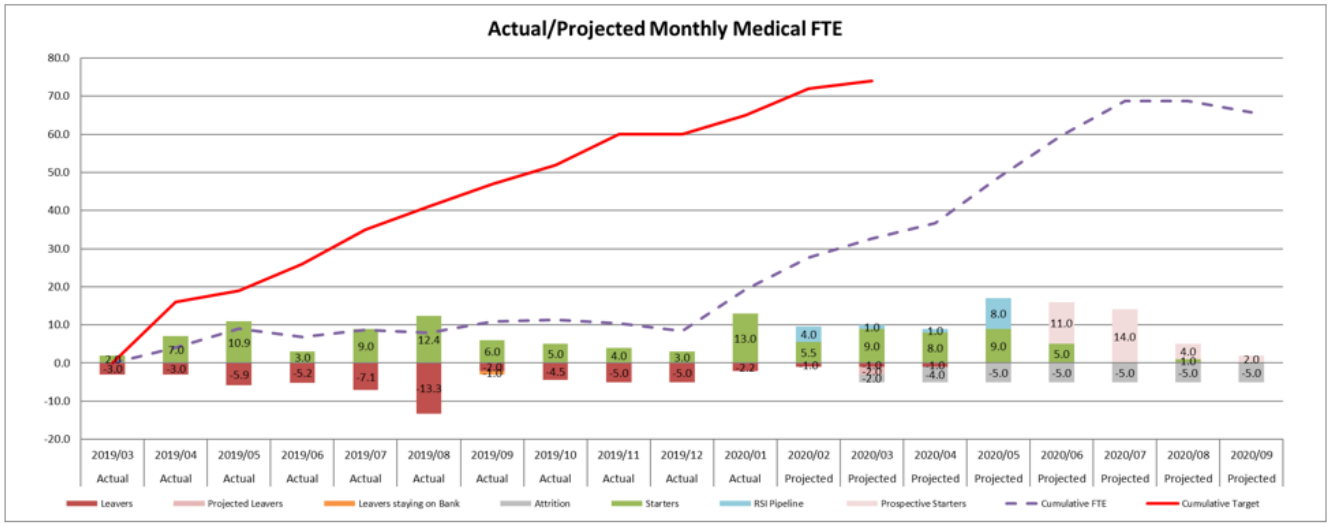
Whole Trust vacancy rate improved to a nine month low in January 20, despite being artificially inflated by the impact of continued scrutiny on the filling of all non-clinical posts. Improvement in the vacancy rates for the three priority groups continues to be consolidated despite higher than regional median levels of turnover.



Staff Group	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Allied Health Professionals	14.80%	15.48%	14.61%	14.60%	13.94%	12.76%	12.68%	12.82%	12.00%
Medical and Dental	20.80%	20.45%	20.04%	19.38%	19.60%	19.24%	18.64%	18.62%	18.43%
Nursing and Midwifery Registered	20.19%	20.46%	20.80%	21.37%	21.04%	16.06%	16.40%	16.40%	16.74%

Actions in place to recover

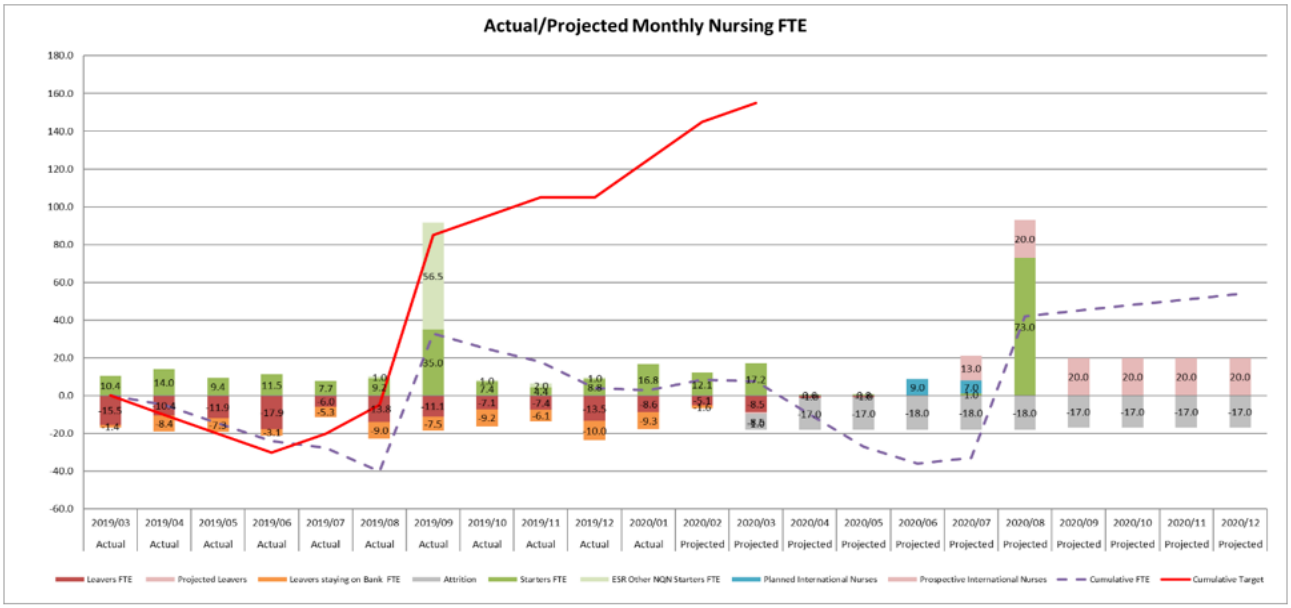
Medical and Dental



Continued strong pipeline into Q4
Divisions continue to use the 'plan for ever post' approach to all vacant posts and there is greater triangulation with associated agency costs (about 75% of all consultant and SAS vacancies are actively being progressed).
High number of AACs planned for Q4
International strategic partnership fully mobilised, Divisional engagement events and MAC presentation.
Recruitment plan being developed for DiT August rotational gaps
Increased focus on medical engagement to reduce turnover.

Risks
Historic Agency (RSI) pipeline at risk
Investment in ED medical staffing will impact vacancy rate.
Domestic success relatively low but required for residency test (potential delay)
Divisional timely processing of leavers

Nursing and AHPs



International recruitment through strategic partner in progress.
Fully engaged with HEE GLP programme
First International nursing cohorts planned for March
International radiographers planned for Q4
AHP recruitment campaigns

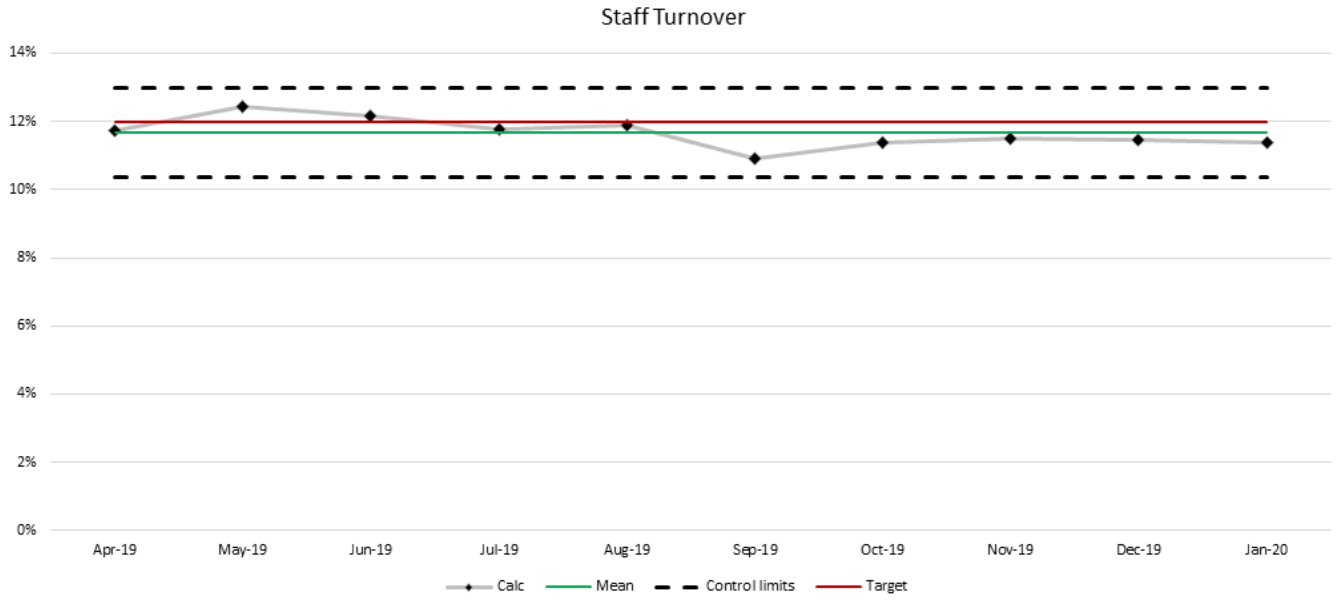
Risks
Period of higher ‘risk of retirement’ numbers.
Attrition of international recruits from offer to start
OSCE capability for paediatric nursing

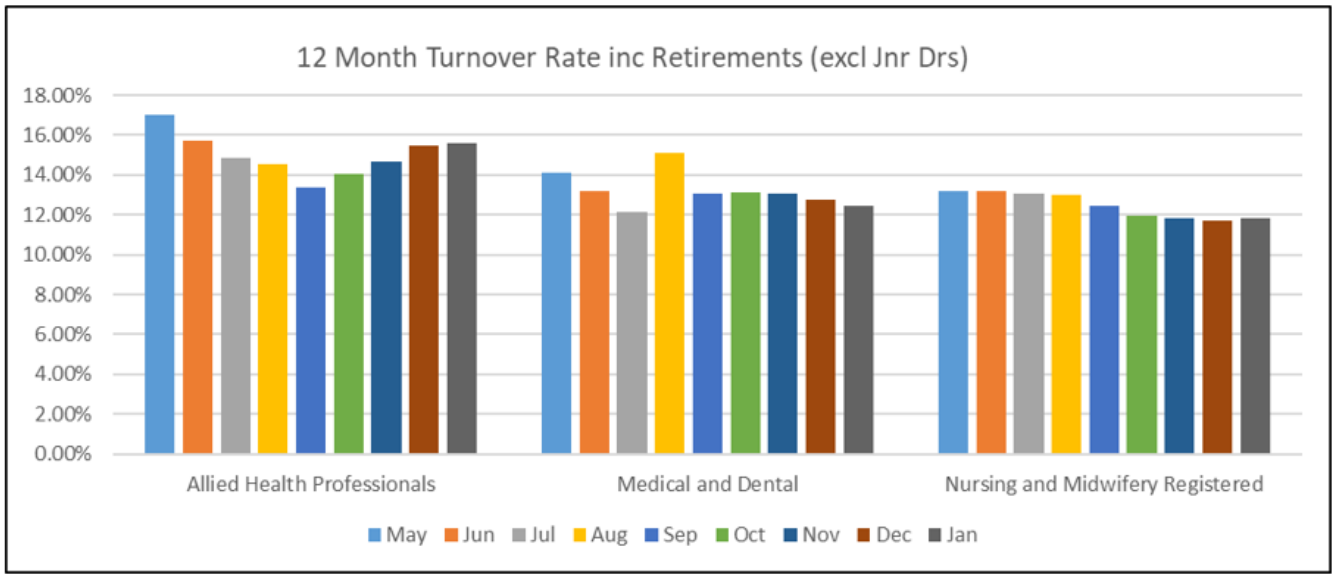
MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People





Staff Group	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Allied Health Professionals	16.99%	15.73%	14.84%	14.53%	13.36%	14.02%	14.69%	15.46%	15.60%
Medical and Dental	14.09%	13.21%	12.16%	15.10%	13.07%	13.11%	13.04%	12.78%	12.46%
Nursing and Midwifery Registered	13.21%	13.19%	13.05%	12.99%	12.43%	11.96%	11.81%	11.70%	11.82%

Challenges/Successes

Longer-term trends for Turnover remain positive, AHP rate has increased consecutively for the last four months, the denominator for AHPs is significantly lower than the other two groups but headcount of leavers in last 4 months is 14 (5 diagnostics and 9 therapies) the majority leaving other NHS organisations. All the rates remain above national and regional benchmarks slowing the improvement in vacancy rate from recruitment.

Actions in place to recover

Exit interviews: The exit interview process is providing us with some useful data. Work is ongoing on improving the response rate of exit surveys. We intend to focus particular attention on why people leave the Trust after a short time period.

Flexible Retirement - Retire and Return: The Retire and Return scheme is an initiative that looks at retiring staff and roles that they can come back to – the new role could be in the same ward/clinic or could be a completely different area. The process was designed and implemented in **April 2019** and sits within the nursing Clinical Education team. A tracker is used to monitor progress as well as report impact on periodic turnover data.

Work underway to identify AHP specific projects and initiatives to reduce AHP turnover.

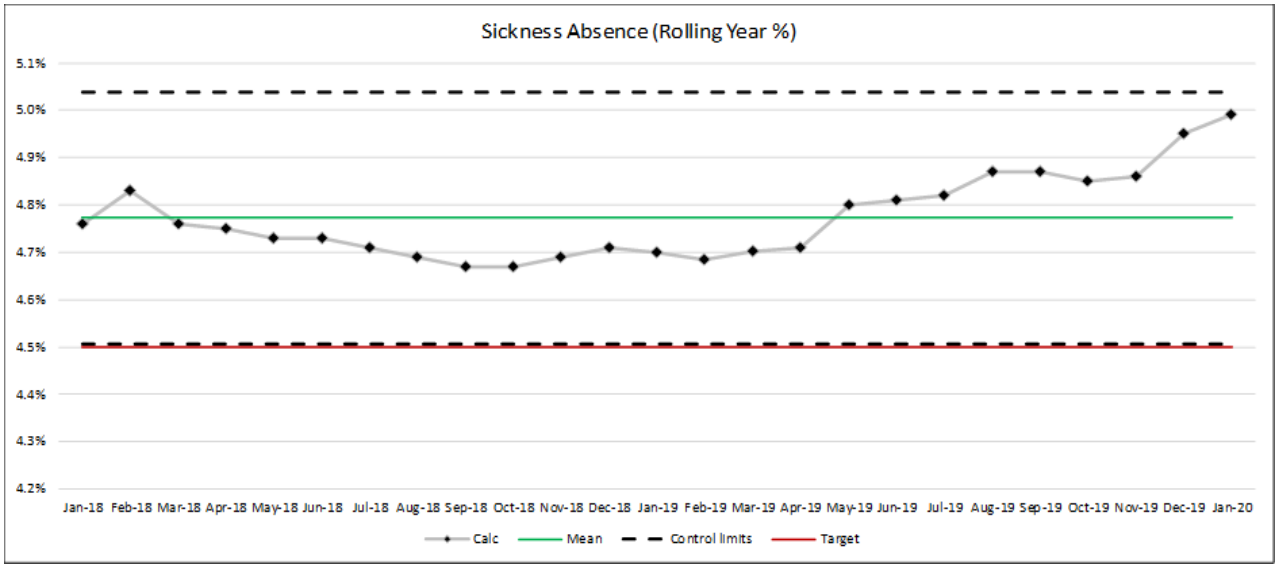
Retention initiatives will link directly with divisional NSS plans rolled out in the coming months.

MODERN AND PROGRESSIVE WORKFORCE – SICKNESS ABSENCE

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

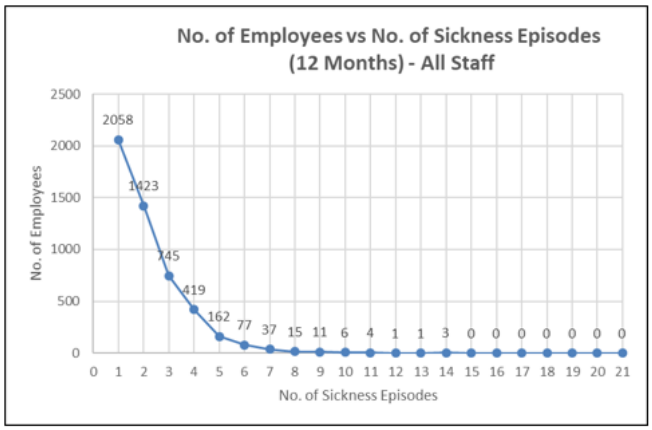
Whilst the rounded figure for the 12 month rolling average remains at 4.9%. The trend is a matter of real concern.

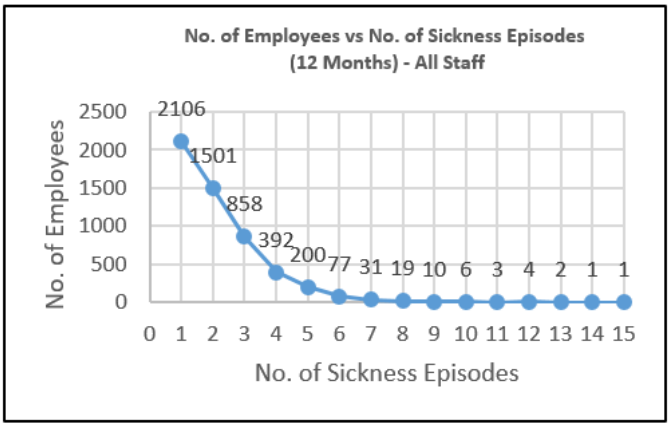
The top five reasons for sickness absence are:

Absence Reason	Headcount	FTE Days Lost	Abs Estimated Cost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	804	28,341.22	£2,353,505.52	24.5
S98 Other known causes - not elsewhere classified	1028	17,695.42	£1,535,636.22	15.3
S12 Other musculoskeletal problems	463	10,183.93	£809,509.30	8.8
S25 Gastrointestinal problems	2104	9,320.06	£746,757.54	8.0
S28 Injury, fracture	349	8,497.14	£740,150.11	7.3

Absence cases	Medicine	Surgery	Family Health	CSS	Corporate	Facilities	Total
Long Term +28 days	23	33	16	36	18	36	162
5 or more episodes in 12 Months	124	71	25	53	17	42	332

The number of staff with more than 5 occasions in the last 12 months is unchanged.





The number of staff with absence exceeding 28 days has significantly increased from the last report from 131 to 162 with an increase in average length of absence.

Actions in place to recover

ER Advisors continue to carry out ad-hoc training with their divisional managers around managing attendance and promoting the roll out of the Empactis portal and it's benefits.

ER Advisors attended a session on the new attendance management portal (Empactis) gaining knowledge and understanding of processing individual absence within the new system and the importance of real time reporting of non-attendance at work.

Absence Management training package has now been completed and awaiting roll out dates, these will be confirmed during February.

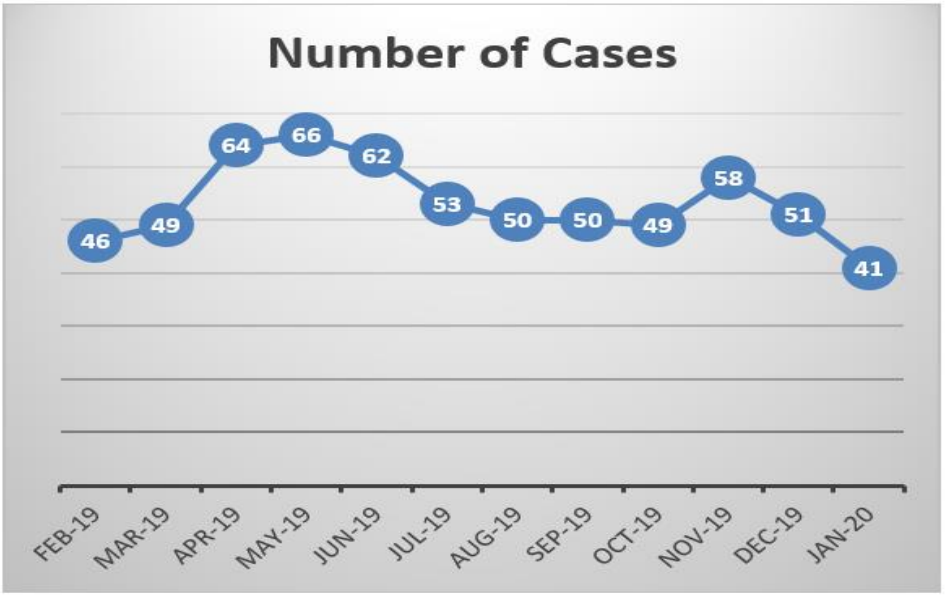
ER managers are now meeting weekly with ER advisors to discuss all sickness cases within the divisions to improve/ reduce absence rates as well as gaining a real focus on the case management. ER Advisers are working on robust plans including discussion on actions taken to date.

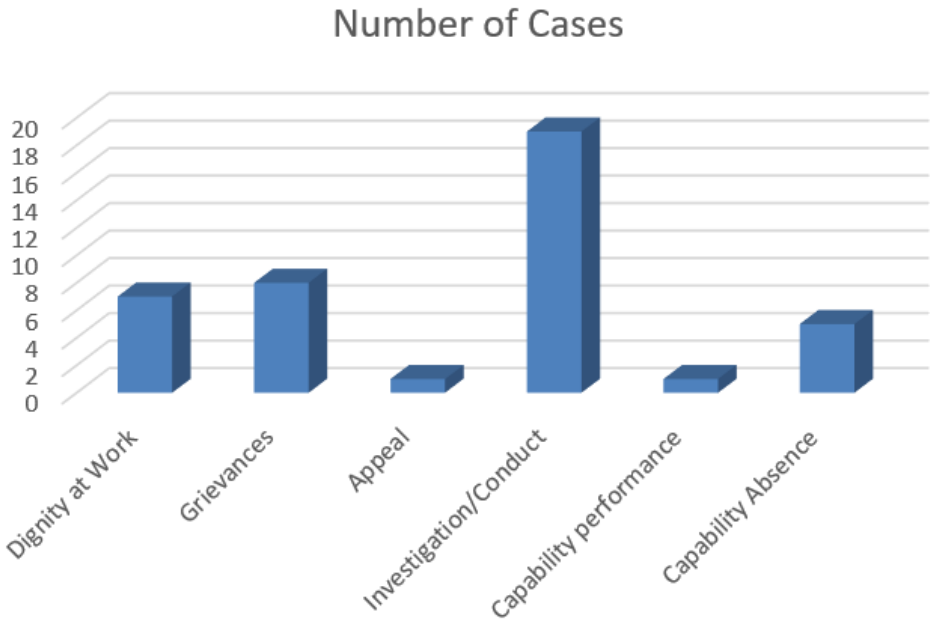
MODERN AND PROGRESSIVE WORKFORCE – Employee Relations

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People





Employee Relations Cases:

There are 41 open cases in January compared with 51 cases in December. The breakdown of case by type (i.e. policy type) is shown in the second table.

We have reduced the amount of capability cases in this month's IPR as they are not in a formal process, only those entering a formal HR process will be reported going forward.

Action has taken place over the last month to ensure timely completion of cases, as such the total number of cases have reduced from 50 to 41.

Actions in place to recover

Training packages have been completed in relation to investigations, disciplinary and capability management and are awaiting roll out dates, these will be confirmed during February.

ER managers are meeting with the ER advisors on weekly basis to discuss all ER and sickness casework and any actions to proactively resolve and identify blockages.

Head of HR Operations has arranged weekly/ fortnightly meetings with divisional manages to discuss ER cases in their respective divisions and agree actions to be taken to resolve and reduce delays.

Following a review of capability performance/ ill health cases moving forward the ER team will only log these cases when they proceed to the hearing stage within the policy. As a consequence there has been reduction of 2 cases and this month there is only 1 case to report.

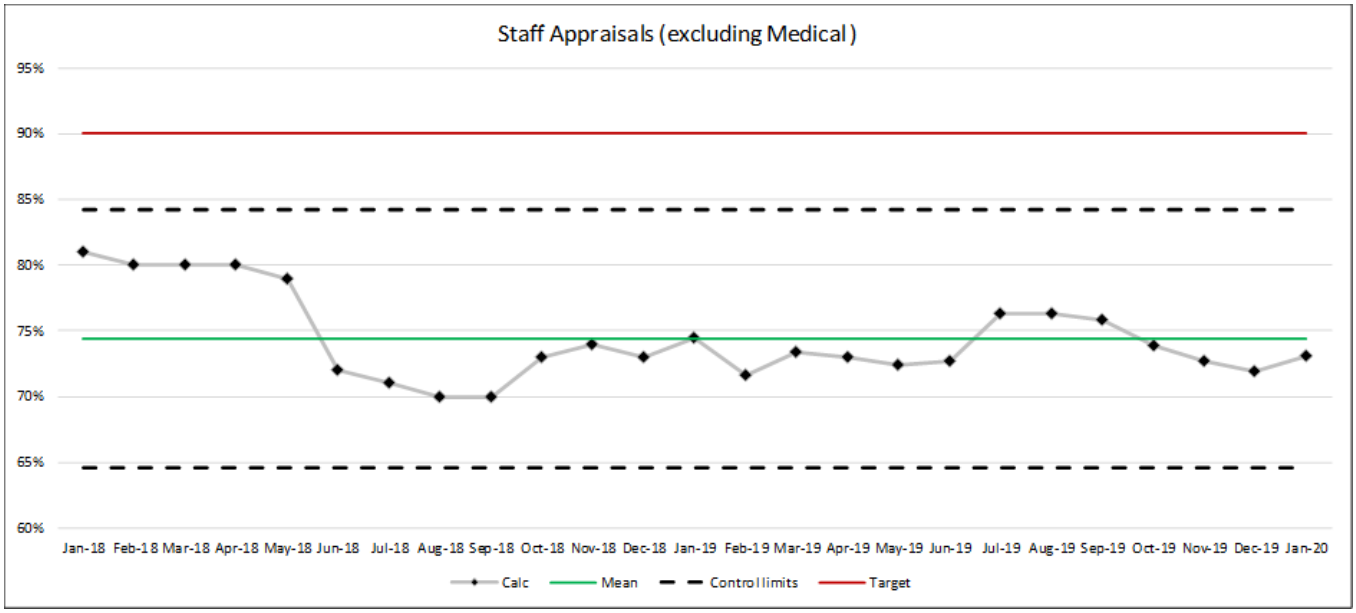
A 2 day course for new investigators has just taken place which mirrors and advises the MHPS process.

MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People



Actions in place to recover

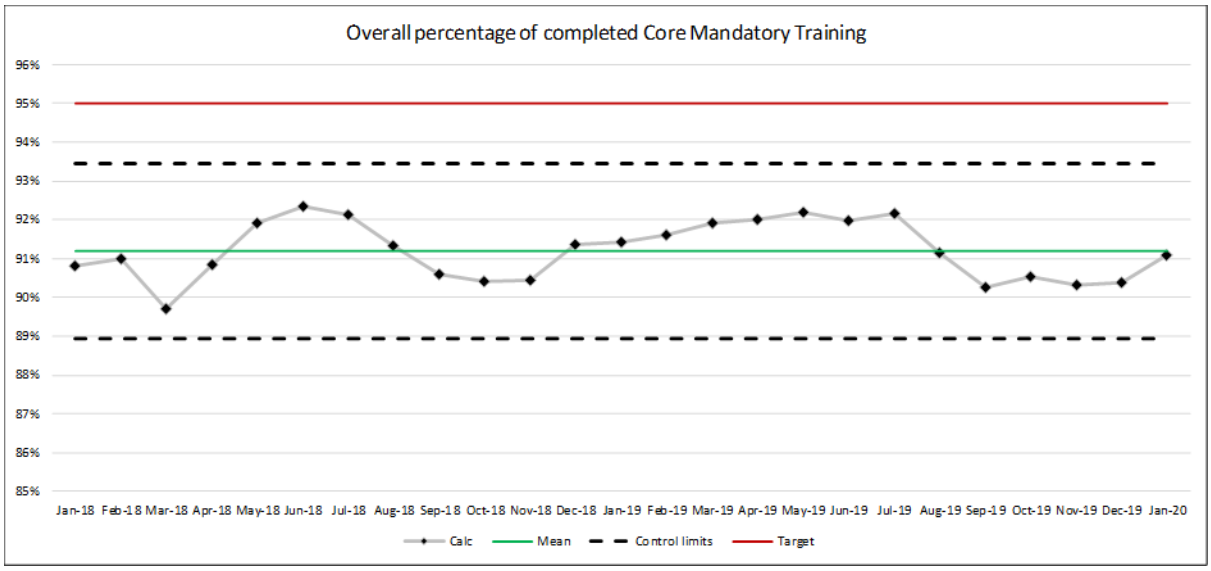
- Appraisee and appraiser training widely available across all sites
- Improved management information to Divisions for targeting action
- SHRBPs working with Divisional teams to improve position
- Work underway to improve perceived value of the process

MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Compliance rate for Core Learning is showing a consistent pattern of over 90% compliance. Data from Lincolnshire Partnership Foundation Trust (LPFT) and Lincolnshire Community Health Services (LCHS) show that their compliance rates are in the same overall range.

Actions in place to recover

Discussions are ongoing within the STP to consider the possible benefits of sharing approaches to Core Learning with other Trusts in the Lincolnshire Healthcare community and the potential of this to increase Core Learning compliance even further. In addition, HR Business Partners and specialist trainers such as those in the Resuscitation Department are working actively with senior managers to continue to improve compliance.

New starters are now able to complete some of their Core Learning before commencing with the Trust. Although this is not likely to affect overall compliance rates, it does enable the new starters to commence working effectively and safely at an earlier stage than before.

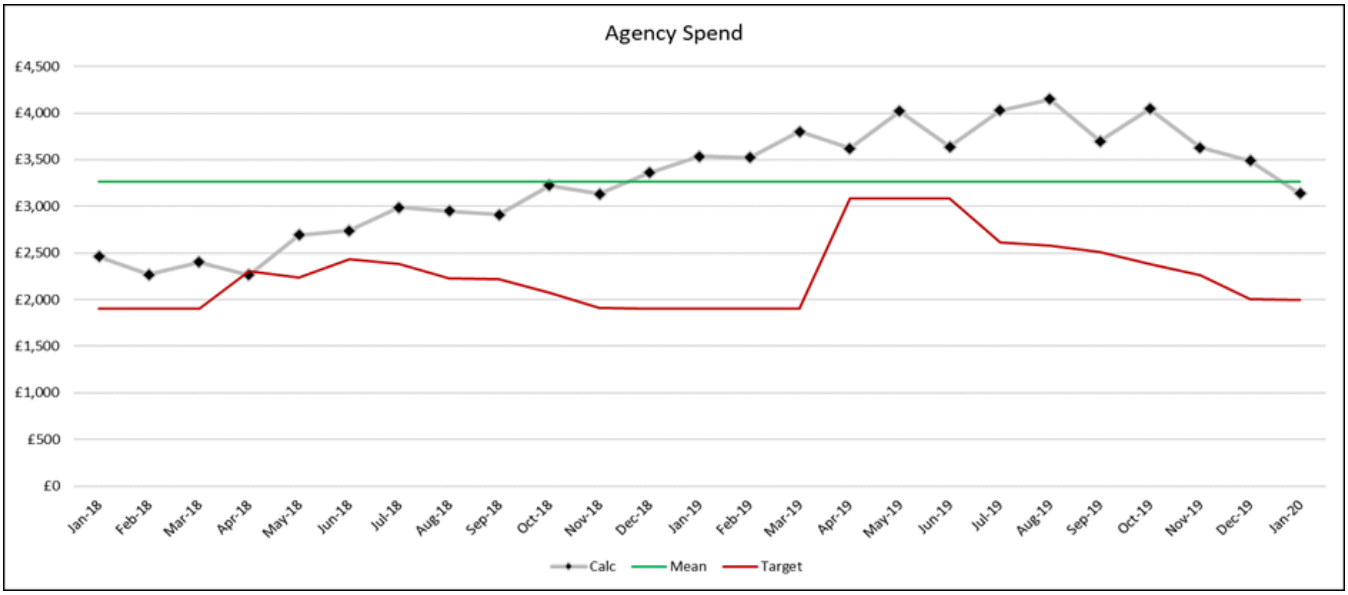
Following a recent audit report, we will be reviewing the content of Core Learning and the way in which it is managed.

SUSTAINABLE SERVICES – AGENCY SPEND

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People

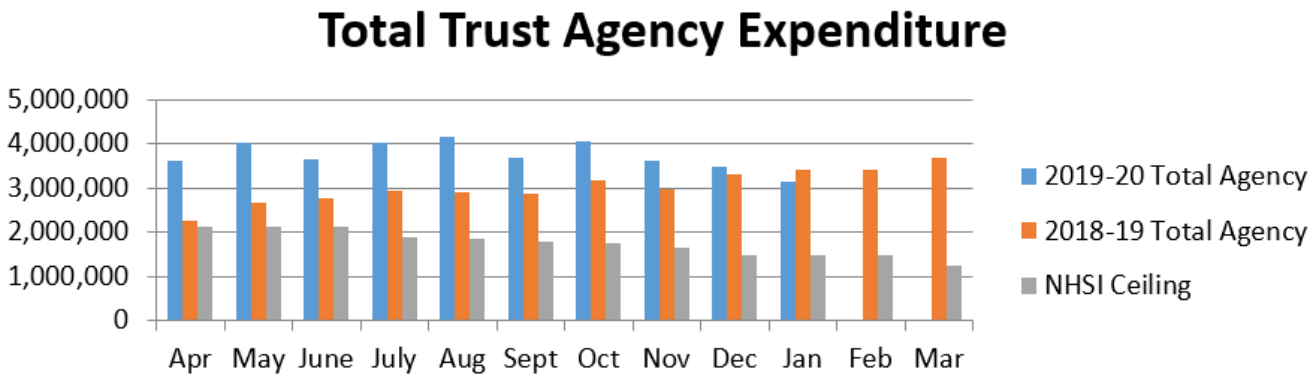


Challenges/Successes

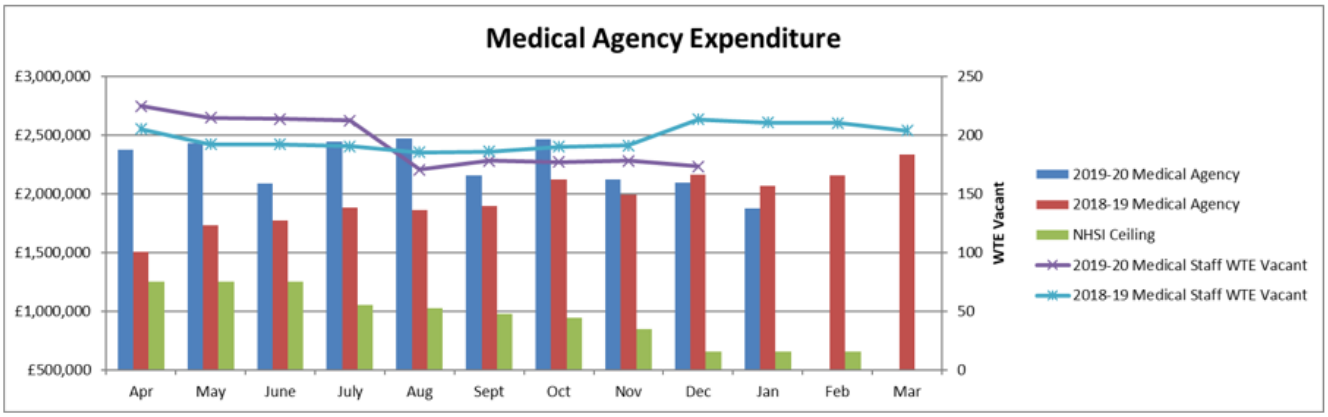
In January (M10), Year to Date (YTD) planned pay increased to 5.5% adverse to plan with the value increasing from £13.5M to £15.9M. This is because total pay run rate increased by £0.3M and the planned pay costs were planned to reduce in month 10.

The positive variance of actual income against planned income continues (+3.25% in January (M10)) and partly accounts for the variance in pay with the remainder resulting from higher premium cost of agency staffing (to cover vacant clinical pots and addition resource required for higher than planned activity) and under delivery of workforce CIP, in particular reduction in medical staffing capacity.

The monthly run rate for total agency spend reduced further (-£350K) from Month 9 to Month 10 to £3.14M, and is the lowest monthly spend since April 19, however agency spend now exceeds that planned by 46.2% due to planned agency savings in Month 10.

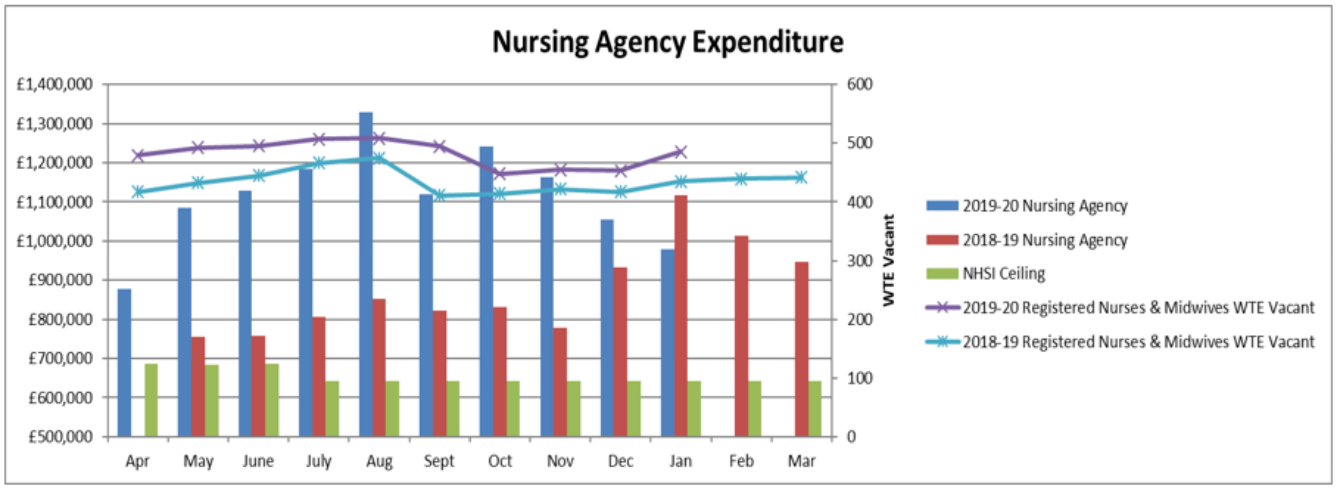


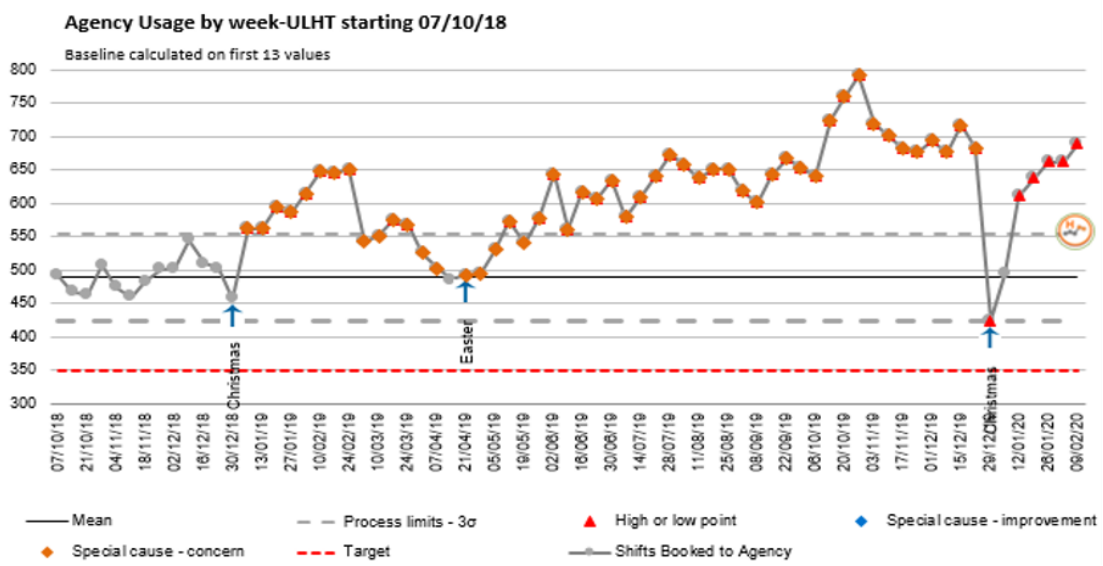
Overall temporary medical staffing costs reduced in December with reductions in both medical agency demand and spend (The DE efficiency was up further 94.7%). Medical agency spend was below comparable monthly spend for 2018/19 again for the second month in a row. The reduction was largely due to continued reduced demand in Surgery division. Demand in Medicine Division increased.



Nursing Agency Costs

Reported Nursing Agency costs decreased in January due to technical adjustments only with actual activity, fill rates and cost increases including off-framework use.





Scientific, AHP and other agency costs were down in January at £281K.

Actions in place to recover

Agency spend continues to be driven by actual demand being higher than planned activity, high vacancy rates and, in some cases, a lack of grip and control over spend. The primary action to reduce agency costs is to still to reduce vacancy rates through substantive recruitment (See Vacancy Rates Section), however urgent action is also being taken to ensure the necessary controls are in place, as follows:

- Divisions to review all temporary staff spend volume and values – bank, additional hours / sessions and agency
- Improving productivity and reviewing performance and access to allow cost removal e.g. OP clinics, theatres, turnaround times
- Challenging and deferring as appropriate to the 1st April all non-clinical recruitment.
- Ending all non-clinical temporary staff where their Return on Investment (in relation to cost reduction) is smaller than their cost to the Trust.
- Systematic review of all pay elements.
- The Trust will join the South Yorkshire Collaborative Medical Staffing Bank and launch the associated Bank App
- Maintain tier 3.5 framework nurse agency volumes to further reduce reliance on off frame work agency use;
- Longer term temporary nursing staffing plans in place to avoid higher premiums of shorter lead time requests.
- Suite of short education sessions for Band 7 Ward Managers completed.
- Rostering Policy revision and practice review.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Expenditure Summary 2019/20

2019/20	Current Month 10			Year to Date			Plan		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	42,991	43,572	581	417,785	431,346	13,561	501,616	519,758	18,142
Expenditure	(43,782)	(47,647)	(3,865)	(446,825)	(463,736)	(16,911)	(533,922)	(552,154)	(18,232)
EBITDA	(791)	(4,075)	(3,284)	(29,040)	(32,390)	(3,350)	(32,306)	(32,396)	(90)
Net Finance costs	(812)	(824)	(12)	(7,498)	(7,501)	(3)	(9,106)	(9,097)	9
Surplus/(Deficit)	(1,603)	(4,899)	(3,296)	(36,538)	(39,891)	(3,353)	(41,412)	(41,493)	(81)
Technical adjustments	1	19	18	11	117	106	14	120	106
Surplus/(Deficit)	(1,602)	(4,880)	(3,278)	(36,527)	(39,774)	(3,247)	(41,398)	(41,373)	25
EBITDA % Income	(1.8%)	(9.4%)	(7.5%)	(7.0%)	(7.5%)	(0.6%)	(6.4%)	(6.2%)	0.2%
CIPs	2,827	1,897	(930)	19,237	13,713	(5,524)	25,610	20,549	(5,061)

YTD financial performance is £39.8m deficit, or £3.2m adverse to plan.

Excluding the £0.4m adverse movement to plan in relation to Passthrough, Income YTD is £13.9m favourable to plan including in line with plan £22.4m of PSF, FRF and MRET. However, the Income position includes £16.7m of transitional support from commissioners.

Excluding the £0.4m favourable movement to plan in relation to Passthrough, Expenditure YTD is £17.3m adverse to plan: Pay is £15.9m adverse to plan and Non-Pay is £1.3m adverse to plan. The YTD pay position includes £1.0m of non-recurrent technical FEP, without which Pay would be £16.9m adverse to plan. The adverse pay movement YTD is driven by higher than planned expenditure on temporary staffing: while substantive pay is £0.7m adverse to plan, bank pay is £3.4m adverse to plan and agency pay is £11.8m adverse to plan. The pay position is driven by lower than planned FEP savings delivery in relation to workforce schemes and temporary staffing pressures in relation to Medical and Nursing Staffing.

Excluding the £0.4m favourable variance in relation to Passthrough, Non Pay is £1.3m adverse to plan. However, the Non Pay position includes £1.5m of non-recurrent technical savings delivery, without which Non Pay would be £2.8m adverse to plan. Some variation to plan would be expected given the slower than planned savings delivery and higher than planned levels of Non Elective volumes. The majority of the movement to plan, though, is in relation to the level of non-clinical expenditure. This includes higher than planned expenditure in a number of areas e.g. ongoing support costs in relation to FSM, dual running for Community COIN (for which there is an offset within Income) and additional building & engineering costs in Estates. Non Pay expenditure is being reviewed to ensure that any expenditure which may be capitalised is treated accordingly and that Non Pay expenditure in general is minimised.

Overall, CIP savings of £13.7m have been delivered YTD or £5.5m less than savings of £19.2m planned YTD. Excluding non-recurrent technical savings delivery of £2.5m, CIP savings delivery is £8.1m adverse to plan YTD.

The forecast excluding PSF, FRF and MRET is a deficit of £70.3m in line with plan.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE RUN RATE

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led **2021 Objective:** Our Services

Income & Expenditure Run Rate 2019/20

2019/20	By Month / Quarter				In Month			Year to date			Full Year		
	Actual Qtr 1 £'000	Actual Qtr 2 £'000	Actual Qtr 3 £'000	Actual M10 £'000	Plan January £'000	Actuals January £'000	Variance January £'000	Plan January £'000	Actuals January £'000	Variance January £'000	Plan Full Year £'000	Forecast Full Year £'000	Variance Full Year £'000
Income													
Clinical income	96,836	105,371	103,908	32,675	32,763	32,679	(84)	325,674	338,790	13,116	389,070	406,471	17,401
Pass through income	11,962	12,428	12,924	4,592	4,232	4,592	360	42,263	41,906	(357)	50,710	50,710	0
Total Patient related income	**108,798**	**117,799**	**116,832**	**37,267**	**36,995**	**37,271**	**276**	**367,937**	**380,696**	**12,759**	**439,780**	**457,181**	**17,401**
PSF, FRF and MRET funding	4,705	5,968	8,497	3,250	3,252	3,250	(2)	22,420	22,420	0	28,928	28,928	0
Other Income	8,078	8,307	8,794	3,051	2,744	3,051	307	27,428	28,230	802	32,908	33,649	741
Total Other operating income	**12,783**	**14,275**	**17,291**	**6,301**	**5,996**	**6,301**	**305**	**49,848**	**50,650**	**802**	**61,836**	**62,577**	**741**
Total Income	**121,581**	**132,074**	**134,123**	**43,568**	**42,991**	**43,572**	**581**	**417,785**	**431,346**	**13,561**	**501,616**	**519,758**	**18,142**
Expenditure													
Pay	(89,930)	(92,308)	(90,815)	(30,260)	(27,847)	(30,257)	(2,410)	(287,389)	(303,313)	(15,924)	(342,620)	(362,267)	(19,647)
Pass through non pay	(11,962)	(12,428)	(12,924)	(4,592)	(4,232)	(4,592)	(360)	(42,263)	(41,906)	357	(50,710)	(50,710)	0
Other Non pay	(34,701)	(35,253)	(35,769)	(12,794)	(11,703)	(12,798)	(1,095)	(117,173)	(118,517)	(1,344)	(140,592)	(139,177)	1,415
Total Expenditure	**(136,593)**	**(139,989)**	**(139,508)**	**(47,646)**	**(43,782)**	**(47,647)**	**(3,865)**	**(446,825)**	**(463,736)**	**(16,911)**	**(533,922)**	**(552,154)**	**(18,232)**
Interest receivable	39	31	35	20	3	19	16	30	125	95	36	138	102
Finance costs	(2,069)	(2,290)	(2,448)	(844)	(815)	(844)	(29)	(7,528)	(7,651)	(123)	(9,142)	(9,260)	(118)
Profit on disposal of assets	12	8	5	0	0	1	1	0	25	25	0	25	25
I&E - Deficit	**(17,030)**	**(10,166)**	**(7,793)**	**(4,902)**	**(1,603)**	**(4,899)**	**(3,296)**	**(36,538)**	**(39,891)**	**(3,353)**	**(41,412)**	**(41,493)**	**(81)**
Impairments/Revaluations Adjustment	0	0	0	0	0	0	0	0	0	0	0	0	0
Donated/Govern't grant Asset Adjustment	58	57	(17)	19	1	19	18	11	117	106	14	120	106
Adjusted Surplus/(Deficit)	**(16,972)**	**(10,109)**	**(7,810)**	**(4,883)**	**(1,602)**	**(4,880)**	**(3,278)**	**(36,527)**	**(39,774)**	**(3,247)**	**(41,398)**	**(41,373)**	**25**
Adjusted Surplus/(Deficit) ex PSF, FRF & MRET	**(21,677)**	**(16,077)**	**(16,307)**	**(8,133)**	**(4,854)**	**(8,130)**	**(3,276)**	**(58,947)**	**(62,194)**	**(3,247)**	**(70,326)**	**(70,301)**	**25**
Total Trust (including passthrough)													
Adjustments to derive underlying deficit													
FSM Loan Interest	2,030	2,259	2,413	824	812	824	12	7,498	7,526	28	9,106	9,122	16
External Support	1,221	540	343	47	0	47	47	1,900	2,151	251	1,900	2,242	342
Profit on Disposals	(12)	(8)	(5)	0	0	0	0	0	(25)	(25)	0	(25)	(25)
Technical Adjustments	(1,581)	(950)	0	0	0	0	0	0	(2,531)	(2,531)	(500)	(2,531)	(2,031)
Transitional Support	0	(5,900)	(10,800)	0	0	0	0	0	(16,700)	(16,700)	0	(16,700)	(16,700)
Underlying Surplus/(Deficit)	**(20,019)**	**(20,136)**	**(24,356)**	**(7,262)**	**(4,042)**	**(7,259)**	**(3,217)**	**(49,549)**	**(71,773)**	**(22,224)**	**(59,820)**	**(78,193)**	**(18,373)**

As at the end of January, the Trust position is a deficit of £39.8m or £3.2m adverse to plan.

The adverse movement to plan YTD in Expenditure of £16.9m has been partly offset by a favourable movement in Income of £13.6m; the favourable movement in Income includes transitional support of £16.7m.

Securing £16.7m of transitional support from commissioners has enabled the Trust to mitigate the adverse Expenditure movement to plan at the end of the third quarter, and in doing so avoid the loss of PSF, FRF and MRET funding of £19.2m.

The in-month position includes £3.3m of PSF, FRF and MRET funding, of which the PSF and FRF funding of £2.9m would be lost if the Trust does not deliver its planned deficit of £70.3m.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

NHS Patient Care Income & Activity 2019/20

2019/20 Clinical Income Summary: YTD Month 010

	Activity: In-Month				Income: In-Month				Activity: Year-To-Date				Income: Year-To-Date			
	2018/19	2019/20			2018/19	2019/20			2018/19	2019/20			2018/19	2019/20		
	Actual January Activity	Plan January Activity	Actual January Activity	Variance January Activity	Actual January £'000	Plan January £'000	Actual January £'000	Variance January £'000	Actual January Activity	Plan January Activity	Actual January Activity	Variance January Activity	Actual January £'000	Plan January £'000	Actual January £'000	Variance January £'000
Activity:																
Accident & Emergency	12,157	12,206	11,921	(285)	1,803	2,074	2,097	24	124,337	120,477	124,040	3,563	18,072	20,467	21,437	970
Daycases	5,850	5,627	5,328	(299)	3,111	2,998	2,744	(254)	54,624	54,492	53,731	(761)	28,563	29,042	28,886	(156)
Elective Spells	628	807	659	(148)	1,802	2,227	1,876	(351)	7,302	7,819	7,177	(642)	19,158	21,578	21,075	(502)
Non Elective Spells	6,269	5,995	6,267	272	12,481	11,128	14,274	3,146	59,690	60,199	62,807	2,608	109,097	112,258	133,964	21,706
Elective Excess Bed Days	55	117	64	(53)	13	32	17	(15)	1,219	1,172	1,093	(79)	302	318	296	(22)
Non Elective Excess Bed Days	939	1,645	1,783	138	227	431	301	(130)	14,076	16,447	11,803	(4,644)	3,395	4,310	2,974	(1,336)
Outpatient Firsts	25,031	25,693	24,588	(1,105)	3,298	3,681	3,432	(249)	244,833	248,848	241,919	(6,929)	32,606	35,653	34,554	(1,100)
Outpatient Follow Ups	34,132	33,356	33,753	396	2,873	3,094	3,084	(10)	322,352	322,960	313,523	(9,437)	27,305	29,956	29,090	(866)
Outpatient Non Face To Face	2,610	2,123	2,588	465	56	138	162	24	21,708	20,999	27,895	6,896	473	1,371	1,765	394
Outpatient Virtual	0	0	552	552	0	0	12	12	59	0	2,633	2,633	1	0	55	55
Outpatient Advice & Guidance	0	279	461	182	0	8	11	3	0	2,791	4,812	2,021	0	85	120	35
Critical Care	1,609	1,630	1,442	(189)	1,162	1,551	1,449	(103)	16,106	16,304	14,323	(1,982)	12,263	15,515	13,803	(1,712)
Maternity	1,047	1,028	947	(81)	980	895	882	(13)	10,098	10,275	9,543	(732)	8,632	8,950	8,855	(95)
Non PbR				0	3,986	3,111	3,301	190				0	38,433	31,009	31,576	567
Block	0	0	0	0	0	225	225	0	0	0	0	0	0	2,254	2,254	0
Non Recurrent Contract Variation	0	0	400	400	0	12	12	0	0	0	400	400	0	122	122	0
Shadow Monitoring	0	1,395	1,438	43	0	0	0	0	0	13,950	13,843	(107)	0	0	0	0
Repatriation						483	0	(483)						4,766	0	(4,766)
Backlog						54	83	29						516	833	318
Work in Progress:						0	(545)	(545)						0	(957)	(957)
Sub total without passthrough					**31,792**	**32,143**	**33,417**	**1,274**					**298,301**	**318,169**	**330,701**	**12,532**
CQUIN					647	369	384	15					6,083	3,647	3,794	147
Fines						0	(74)	(74)						0	(795)	(795)
Fines Reinvested						0	31	31						0	358	358
Bring Lincolnshire CCG Contract to Plan						0	(2,160)	(2,160)						0	(18,893)	(18,893)
APA (calculated at quarterly billing)						0	206	206						0	2,005	2,005
Prior Year								0							294	294
Maternity Prepayment								0								0
Total (Non Passthrough)					**32,438**	**32,512**	**31,802**	**(710)**					**304,384**	**321,815**	**317,463**	**(4,352)**
Non-recurrent Transitional Support						0	0	0						0	16,700	16,700
Central Funding / Winter						0	223	223						0	446	446
Total (Non Passthrough including transitional support)					**32,438**	**32,512**	**32,025**	**(487)**					**304,384**	**321,815**	**334,609**	**12,794**
Passthrough - Drugs					4,094	4,232	4,124	(108)					40,029	42,263	35,936	(6,327)
Passthrough - Clinical Supplies and Services						0	562	562						0	5,885	5,885
Passthrough - Prior Months Adjustment						0	(93)	(93)						0	85	85
Total (Inc Passthrough)					**36,532**	**36,744**	**36,618**	**(126)**					**344,414**	**364,078**	**376,515**	**12,437**

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Headline
Contract income year to date of £377m is £12m (3.4%) favourable to plan. Excluding c£0.4m adverse variance on pass-through, contract income year to date is £13m favourable to plan.

Key variances by POD below excluding pass-through
• Non Elective Spells are favourable to plan by £22m (19.3%) – Medicine accounts for £19m of the over-performance. Activity is above plan by 2,608 (4.3%) and the Trust has seen 3,117 more patients for the same time period in 2018/19.
• Outpatients are £1.5m adverse to plan - Medicine and Surgery account for 93% of the adverse movement to plan. Activity is 1,831 adverse to plan in 2019/20
• Critical Care is £1.7m adverse to plan – with this variance driven by Adult Critical Care. Activity is 1,982 adverse to plan in 2019/20 and 1,784 down on the same time period in 2018/19.
• A&E attendances are £1.0m favourable to plan. Activity in 2019/20 is above planned levels by 3,563 attendances, this is only 297 less than the same time period in 2018/19.

Key variances by Commissioner
• Lincolnshire CCGs are £2.0m favourable to plan excluding the revised c£16.1m non-recurrent transitional support funding and central/winter funding. This is driven by the NEL APA adjustment.
• Removal of Repatriation and unidentified backlog assumptions deteriorated the financial position by £4.4m offset by the increase in transitional support
• Non Lincolnshire commissioners are £1.3m adverse to plan driven by:
  o Fines of £437k, predominantly due to 2ww breast symptomatic and suspect cancer.
  o Screening is £336k adverse to plan, of which bowel scope is £294k, diabetic retinopathy is £190k, offset by a favourable variance of £147k in Breast Screening.

Risks
• Lincolnshire CCGs are querying the level of NEL financial over-performance for both volume (activity) and price (casemix). Specifically these queries are in relation to Frailty Unit, Discharge (from A&E) and Paediatric Assessment Unit.
• A&E over performance – the plan assumed a greater impact in relation to primary care streaming and commissioner demand management schemes than is currently being delivered.
• PLCV challenges – It has been identified that prior approval is not being received for all procedures currently and there is a risk in the year-to-date position of c£1.0m, in particular tonsillectomy's and hernias. This is not transacted through the current contract arrangements.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY RUN RATE

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

Income & Activity Run Rate - Activity 2019/20

2021 Objective: Our Services

	Activity Units: By Month / Quarter				In Month				Year to date			
Activity	Actual Qtr 1	Actual Qtr 2	Actual Qtr 3	Actual M10	Plan January Activity	Actual January Activity	Variance January Activity	% Variance	Plan January Activity	Actual January Activity	Variance January Activity	% Variance
Accident & Emergency	36,746	38,447	36,926	11,921	12,206	11,921	(285)	(2.3%)	120,477	124,040	3,563	3.0%
Daycases	16,353	16,024	16,026	5,328	5,627	5,328	(299)	(5.3%)	54,492	53,731	(761)	(1.4%)
Elective Spells	2,148	2,280	2,090	659	807	659	(148)	(18.3%)	7,819	7,177	(642)	(8.2%)
Non Elective Spells	18,550	19,040	18,950	6,267	5,995	6,267	272	4.5%	60,199	62,807	2,608	4.3%
Elective Excess Bed Days	264	377	388	64	117	64	(53)	(45.4%)	1,172	1,093	(79)	(6.7%)
Non Elective Excess Bed Days	3,393	3,443	3,184	1,783	1,645	1,783	138	8.4%	16,447	11,803	(4,644)	(28.2%)
Outpatient Firsts	72,284	73,363	71,684	24,588	25,693	24,588	(1,105)	(4.3%)	248,848	241,919	(6,929)	(2.8%)
Outpatient Follow Ups	93,273	94,198	92,300	33,753	33,356	33,753	396	1.2%	322,960	313,523	(9,437)	(2.9%)
Outpatient Non Face To Face	7,828	8,101	9,378	2,588	2,123	2,588	465	21.9%	20,999	27,895	6,896	32.8%
Outpatient Virtual	-	41	2,040	552	-	552	552	0.0%	-	2,633	2,633	0.0%
Outpatient Advice & Guidance	1,334	1,432	1,585	461	279	461	182	65.2%	2,791	4,812	2,021	72.4%

Activity run-rates are assumed for the key POD groups.

Whilst A&E actual activity is marginally lower for the first ten months of 2019/20 when compared to 2018/19 it is significantly above planned levels; this is primarily due to a change in plan in relation to assumed levels of increased activity transferring to Primary Care Streaming (i.e. a planned change between years).

A&E and Non-Elective activity levels are being raised formally with Lincolnshire CCGs given their impact upon the Trust's ability to manage flow and bed resources and their overall impact on the Trust's financial position. As a note of caution, CCGs are also querying back to ULHT the level of NEL activity and income recording that is currently being shown as they believe they are incorrect. Those discussions are continuing around Discharge Lounge, PAU and Frailty activity.

Non Elective activity is 4.3% up against plan YTD in relation to activity and c19.3% in relation to income. This Non Elective over performance is mainly within the Medicine Division and further details are being shared with the Division.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY RUN RATE £

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Activity Run Rate - £ 2019/20

	By Month / Quarter				In Month			Year to date		
	Actual Qtr 1 £'000	Actual Qtr 2 £'000	Actual Qtr 3 £'000	Actual M10 £'000	Plan January £'000	Actual January £'000	Variance January £'000	Plan January £'000	Actual January £'000	Variance January £'000
Accident & Emergency	6,267	6,627	6,445	2,097	2,074	2,097	24	20,467	21,437	970
Daycases	8,944	8,651	8,546	2,744	2,998	2,744	(254)	29,042	28,886	(156)
Elective Spells	6,340	6,574	6,285	1,876	2,227	1,876	(351)	21,578	21,075	(502)
Non Elective Spells	38,699	39,382	41,610	14,274	11,128	14,274	3,146	112,258	133,964	21,706
Elective Excess Bed Days	71	101	107	17	32	17	(15)	318	296	(22)
Non Elective Excess Bed Days	918	920	835	301	431	301	(130)	4,310	2,974	(1,336)
Outpatient Firsts	10,340	10,500	10,282	3,432	3,681	3,432	(249)	35,653	34,554	(1,100)
Outpatient Follow Ups	8,604	8,736	8,666	3,084	3,094	3,084	(10)	29,956	29,090	(866)
Outpatient Non Face To Face	504	523	576	162	138	162	24	1,371	1,765	394
Outpatient Virtual	0	1	43	12	0	12	12	0	55	55
Outpatient Advice & Guidance	33	35	40	11	8	11	3	85	120	35
Critical Care	4,155	4,012	4,187	1,449	1,551	1,449	(103)	15,515	13,803	(1,712)
Maternity	2,629	2,664	2,680	882	895	882	(13)	8,950	8,855	(95)
Non PbR	9,240	9,566	9,470	3,301	3,111	3,301	190	31,009	31,576	567
Block	676	676	676	225	225	225	0	2,254	2,254	0
Non Recurrent Contract Variation	37	37	37	12	12	12	0	122	122	0
Repatriation	0	0	0		483	0	(483)	4,766	0	(4,766)
Backlog	250	250	250	83	54	83	29	516	833	318
Work in Progress	(41)	(582)	210	(545)	0	(545)	(545)	0	(957)	(957)
Sub total without passthrough	**97,666**	**98,673**	**100,945**	**33,417**	**32,143**	**33,417**	**1,274**	**318,169**	**330,701**	**12,532**
CQUIN	1,143	1,138	1,129	384	369	384	15	3,647	3,794	147
Fines	(235)	(253)	(233)	(74)	0	(74)	(74)	0	(795)	(795)
Fines Reinvested	102	126	99	31	0	31	31	0	358	358
Bring Lincolnshire CCG Contract to Plan	(5,234)	(3,978)	(7,521)	(2,160)	0	(2,160)	(2,160)	0	(18,893)	(18,893)
APA (calculated at quarterly billing)	384	470	945	206	0	206	206	0	2,005	2,005
Prior Year	0	0	0	294	0	294	294	0	294	294
Total (Non Passthrough)	**93,825**	**96,177**	**95,365**	**32,096**	**32,512**	**32,096**	(416)	**321,815**	**317,463**	**(4,352)**
Non-recurrent Transitional Support	0	5,900	10,800	0	0	0	0	0	16,700	16,700
Central Funding / Winter	0	0	223	223	0	223	223	0	446	446
Total (Non Passthrough)	**93,825**	**102,077**	**106,388**	**32,319**	**32,512**	**32,319**	(193)	**321,815**	**334,609**	**12,794**
Passthrough - Drugs	10,512	10,515	10,785	4,124	4,232	4,124	(108)	42,263	35,936	(6,327)
Passthrough - Clinical Supplies and Services	1,718	1,841	1,765	562	0	562	562		5,885	5,885
Passthrough - Prior Months Adjustment	0	0	178	(93)	0	(93)	(93)		85	85
Total (Inc Passthrough)	**106,055**	**114,433**	**119,116**	**36,911**	**36,744**	**36,911**	**168**	**364,078**	**376,515**	**12,437**

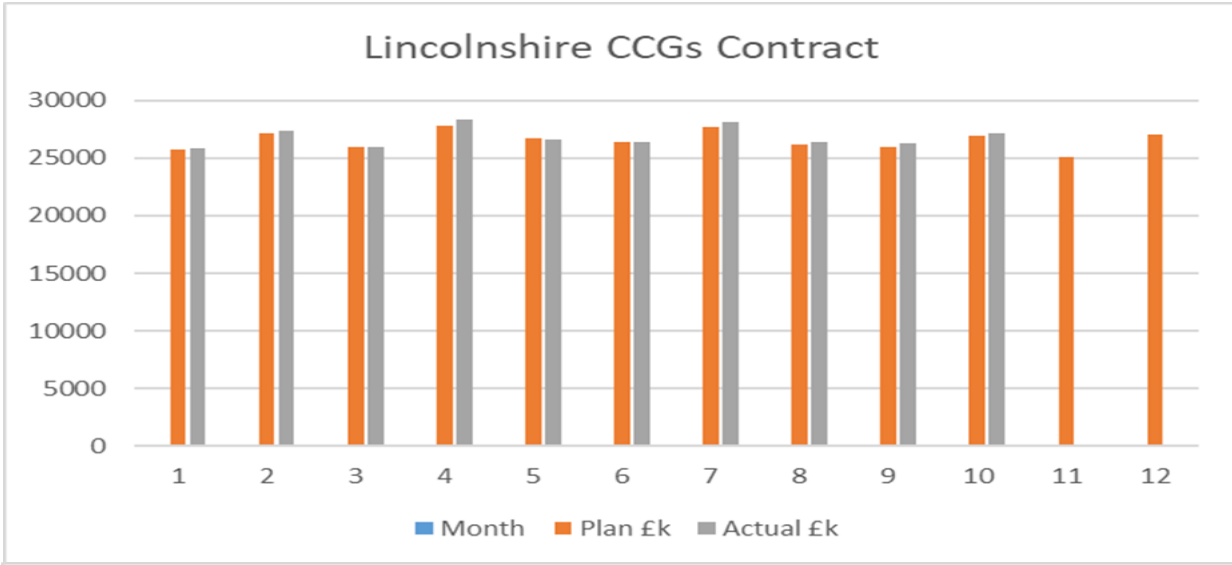
SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME 2019/20

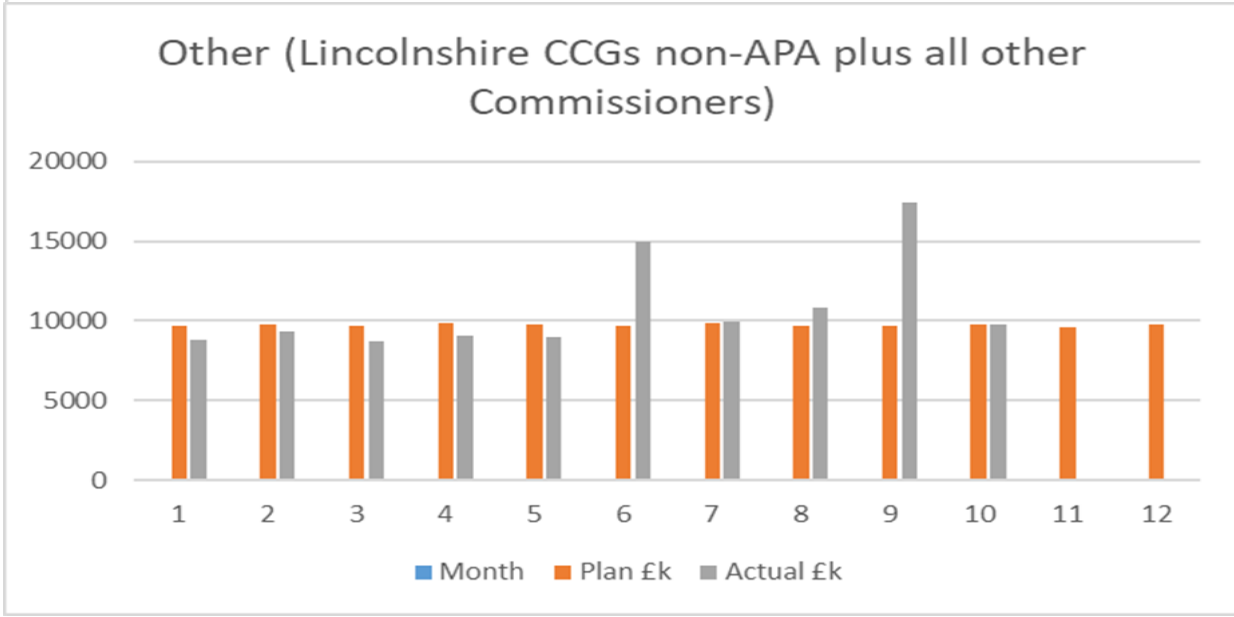
Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

NHS Patient Care Income 2019/20 - Lincolnshire CCGs and 'Other' performance





SUSTAINABLE SERVICES – PAY SUMMARY

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Pay Summary 2019/20

2019/20 Pay Summary: YTD Month 10	By Month / Quarter				Pay: In-Month				Pay: Year-To-Date			
Staff Groups	Actual Qtr 1 £'000	Actual Qtr 2 £'000	Actual Qtr 3 £'000	Actual M10 £'000	2018/19 Actual January £'000	2019/20 Plan January £'000	2019/20 Actual January £'000	Variance January £'000	2018/19 Actual January £'000	2019/20 Plan January £'000	2019/20 Actual January £'000	Variance January £'000
Substantive:												
Registered Nursing, Midwifery and Health visiting staff	21,589	21,389	21,423	7,225	7,077	7,191	7,225	(34)	69,630	72,068	71,626	442
Health Care Scientists and Scientific, Therapeutic and Technical staff	8,251	8,242	8,416	2,919	2,626	2,603	2,919	(316)	25,472	26,111	27,829	(1,718)
Support to clinical staff	14,800	14,881	14,820	5,058	4,698	4,780	5,058	(278)	46,144	47,995	49,559	(1,564)
Medical and Dental Staff	19,093	20,956	20,709	6,923	6,367	6,723	6,923	(200)	64,839	68,122	67,681	441
Non-Medical - Non-Clinical Staff	8,256	8,720	8,443	2,812	2,646	2,911	2,812	99	25,759	29,210	28,231	979
Apprentice levy	347	316	341	116	109	107	116	(9)	1,065	1,069	1,120	(51)
Capitalised staff	(45)	(261)	(367)	(88)	(60)	0	(88)	88	(552)	0	(761)	761
Total Substantive costs	**72,291**	**74,243**	**73,787**	**24,964**	**23,462**	**24,315**	**24,964**	**(649)**	**232,357**	**244,575**	**245,285**	**(710)**
Bank:												
Registered Nursing, Midwifery and Health visiting staff	1,523	1,526	1,523	562	489	471	562	(91)	4,621	4,716	5,134	(418)
Health Care Scientists and Scientific, Therapeutic and Technical staff	131	136	146	45	44	44	45	(1)	441	445	457	(12)
Support to clinical staff	1,144	1,272	1,079	381	382	371	381	(10)	3,703	3,715	3,876	(161)
Medical and Dental Staff	2,846	2,758	2,590	979	1,096	472	979	(507)	8,813	6,561	9,173	(2,612)
Non-Medical - Non-Clinical Staff	715	501	552	190	286	177	190	(13)	2,346	1,770	1,959	(189)
Total Bank costs	**6,358**	**6,194**	**5,890**	**2,157**	**2,297**	**1,535**	**2,157**	**(622)**	**19,924**	**17,207**	**20,598**	**(3,391)**
Agency:												
Registered Nursing, Midwifery and Health visiting staff	3,086	3,631	3,435	980	1,073	876	980	(104)	8,099	8,934	11,131	(2,197)
Health Care Scientists and Scientific, Therapeutic and Technical staff	500	484	331	85	136	131	85	46	1,270	1,331	1,401	(70)
Support to clinical staff	6	0	0	0	45	17	0	17	122	149	7	142
Medical and Dental Staff	6,901	7,075	6,684	1,876	2,067	902	1,876	(974)	18,992	13,583	22,536	(8,953)
Non-Medical - Non-Clinical Staff	787	682	689	196	215	71	196	(125)	1,313	1,610	2,354	(744)
Total Agency costs	**11,281**	**11,873**	**11,139**	**3,136**	**3,535**	**1,997**	**3,136**	**(1,139)**	**29,794**	**25,607**	**37,429**	**(11,822)**
Total Pay	**89,930**	**92,310**	**90,815**	**30,258**	**29,294**	**27,847**	**30,258**	**(2,411)**	**282,075**	**287,389**	**303,313**	**(15,924)**

Pay year to date is £15.9m adverse to plan [despite the release of £1.0m of non-recurrent technical savings in prior months] including an adverse movement to plan of £2.4m in January.

The adverse movement to plan in Pay is driven by the adverse movement of £15.2m on temporary staffing, of which £11.8m (78%) relates to Agency Pay.

Whilst the above table shows that Substantive Pay YTD is £0.7m adverse to plan, this includes £1.0m of one-off technical benefit. However, the YTD Substantive Pay position also includes £0.7m in relation to higher than planned cost of the Medical & Dental pay award, the impact of which on the Trust's I&E position was halved by additional external funding the Trust received. In terms of the underlying substantive pay position, whilst this was flat in the third quarter in comparison to the previous quarter, it rose in January by £0.4m, of which £0.1m was due to radiology Pay arrears and £0.2m was related to other pay increases across Nursing, STT and Other Support Staff.

The above table also shows that Medical & Dental Pay accounts for £11.1m (70%) and Nursing & Midwifery accounts for £2.2m (14%) of the overall adverse movement to plan. This movement is driven by spend on temporary staff. However, underlying temporary staffing spend is reducing: having increased from an average monthly spend in Q1 of £5.9m to £6.0m in Q2, spend on temporary staffing then fell to an average of £5.7m per month in Q3, and fell again to £5.3m in January. Of the reduction of £0.7m in average monthly spend on temporary staffing from £6.0m Q2 to £5.3m in January, £0.4m (58%) relates to Medical Staffing.

The Trust breached its Agency Ceiling for 2019/20 by the end of September and Agency Pay has YTD averaged £3.7m per month. However, expenditure of £3.1m in January is the lowest monthly spend since December 2018 when the Trust spent £3.5m. Whilst the higher than planned spend on Agency Pay is in part due to need to respond to safety concerns and the growth in Non-Elective activity, the scale of expenditure and trend in expenditure over a longer period is of great concern given the impact it will have upon the Trust’s ability to deliver the control total. Financial Recovery Plans have focussed heavily on the need to reduce expenditure on Agency Pay in the final quarter.

SUSTAINABLE SERVICES – NON PAY SUMMARY

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Non Pay Summary 2019/20

2019/20 Non Pay Summary: YTD Month 10

	By Month / Quarter				Non Pay: In-Month				Non Pay: Year-To-Date			
Non Pay	Actual Qtr 1 £'000	Actual Qtr 2 £'000	Actual Qtr 3 £'000	Actual M10 £'000	2018/19 Actual January £'000	Plan January £'000	2019/20 Actual January £'000	Variance January £'000	2018/19 Actual January £'000	Plan January £'000	2019/20 Actual January £'000	Variance January £'000
Transport*	469	500	1,084	283	174	170	283	(113)	1,370	1,697	2,336	(639)
Clinical Supplies & Services	13,487	14,041	14,211	5,004	4,858	4,509	5,004	(496)	47,072	45,151	46,744	(1,593)
Clinical Supplies & Services - Pass through	1,497	1,950	1,877	562	493	672	562	111	4,524	6,663	5,885	778
Drugs	2,410	2,228	2,717	1,070	715	1,106	1,070	35	9,242	11,050	8,426	2,624
Drugs Pass through	10,465	10,478	11,048	4,031	3,602	3,560	4,031	(470)	35,506	35,600	36,021	(421)
Establishment Expenditure*	1,606	2,051	986	298	507	527	298	229	5,318	5,279	4,941	338
General Supplies & Services*	2,841	2,335	1,799	672	1,047	589	673	(84)	10,377	5,989	7,647	(1,658)
Other*	898	720	1,520	685	481	328	685	(357)	2,377	3,263	3,823	(560)
Premises & Fixed Plant*	4,524	4,913	5,675	1,984	1,687	1,634	1,985	(351)	14,849	16,335	17,096	(761)
Clinical Negligence	5,222	5,223	4,553	1,741	1,775	1,740	1,741	(1)	17,741	17,409	16,739	670
Capital charges	3,244	3,242	3,221	1,057	908	1,100	1,058	42	6,223	11,000	10,764	236
Total Non Pay	**46,663**	**47,681**	**48,691**	**17,387**	**16,247**	**15,935**	**17,390**	**(1,455)**	**154,599**	**159,436**	**160,422**	**(986)**

Non Pay expenditure of £160.4m is £986k (0.62%) adverse to plan.

Excluding favourable variance on Pass-through, Non Pay is £1.3m (1.15%) adverse to plan. However, the Non Pay position includes £1.5m of non-recurrent technical savings delivery, without which Non Pay would be £2.8m (2.42%) adverse to plan.

Some variation to plan would be expected in Non Pay given the slower than planned savings delivery and higher than planned levels of Non Elective volumes. The majority of the movement to plan, though, is in relation to the level of non-clinical expenditure i.e. the spend is higher in relation to Establishment Expenditure, General Supplies & Services and Premises & Fixed Plant. This adverse movement to plan includes higher than planned expenditure in a number of areas i.e. ongoing support costs in relation to FSM, dual running for Community COIN (for which there is an offset within Income) and additional building & engineering costs in Estates.

Excluding Pass-through, overall Non Pay expenditure in January was £1.4m higher than in December. This in part reflects the fact that in December the Trust received a one off credit £669k in relation to Clinical Negligence - as a result of the Trust successfully delivering all ten actions required as part of the 2019/20 maternity incentive scheme - as well increased expenditure on a number of lines. The other expenditure increases include £252k in relation to training [which in the main was offset by additional income], an increase of £202k in overall Estates Non Pay, and smaller movements over a range of other expenditure lines.

Non Pay expenditure is being reviewed to ensure that any expenditure which may be capitalised is treated accordingly and that Non Pay expenditure in general and FSM support costs in particular are minimised.

SUSTAINABLE SERVICES – COST IMPROVEMENT PROGRAMME (CIP) SUMMARY

Executive Lead:

Director of Finance & Digital

CQC Domain:

Well-Led

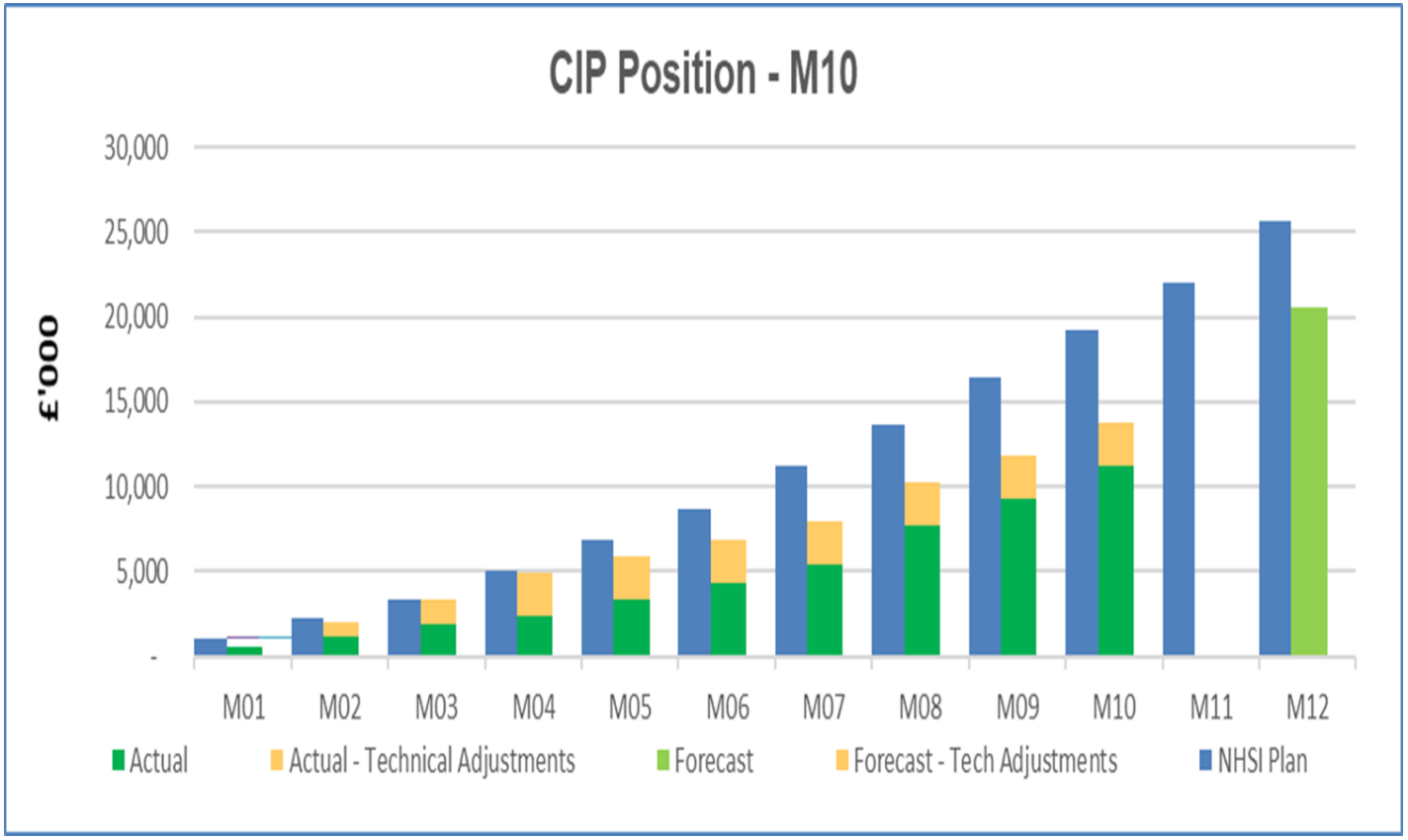
2021 Objective:

Our Services

M010	In Month: 2019/20			YTD: 2019/20			
	Plan January £'000	Actual January £'000	Variance January £'000	Plan January £'000	Actual January £'000	Variance January £'000	RAG
CIP	2,827	1,897	(930)	19,237	13,713	(5,524)	

Finance Position

YTD ACTUAL	£'000	FORECAST	£'000
Recurrent	9,788	Recurrent	16,094
Non Recurrent	3,925	Non Recurrent	4,455
TOTAL	**13,713**	**TOTAL**	**20,549**



The financial plan for 2019/20 includes an efficiency programme to deliver £25.61m of savings; this includes £250k of planned non-recurrent savings in relation to the sale of the original front entrance of Grantham Hospital.

CIP savings delivery of £1,897k is reported in January; compared to planned CIP savings delivery of £2,827k, savings delivery in January is £930k adverse to plan.

YTD CIP savings delivery of £13,713k to the end of December is £5,524k (29%) adverse to planned CIP savings delivery of £19,237k.

However, the YTD CIP position is supported by delivery of £2,531k of non-recurrent Technical CIP savings. This non-recurrent CIP savings delivery comprises of £1,022k of Technical Savings in relation to Pay, £1,493k in relation to Non Pay and £16k in relation to Income.

Excluding Technical CIP delivery, the YTD CIP position is £8,055k (42%) adverse to plan.

The delivery of non-recurrent Technical CIP savings have mitigated some of the continued underperformance in relation to Theatres, Outpatients, Procurement, Workforce programmes and Divisional Transactional schemes.

SUSTAINABLE SERVICES – STATEMENT OF FINANCIAL POSITION

	Year end		Year to date			Monthly Actual 2019/20				Forecast Outturn		
	Plan	Actual	Plan	Actual	Variance	Actual	Actual	Actual	Actual	Actual	Plan	Variance
	31 March 2019			31 January 2020		Qtr 1	Qtr 2	Qtr 3	31-Jan		31 March 2020	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non-current assets												
Intangible assets	5,488	6,341	4,699	4,922	(223)	5,907	5,484	5,062	4,922	4,639	4,637	2
Property, plant and equipment: **on-SoFP** IFRIC 12 assets	22,495	27,654	27,020	27,307	(287)	27,550	27,446	27,342	27,307	27,238	26,954	284
Property, plant and equipment: other	213,599	181,095	220,978	191,017	29,961	184,058	187,899	190,117	191,017	201,253	224,849	(23,596)
Trade and other receivables: due from non-NHS/DHSC group bodies	1,828	1,560	1,600	1,499	101	1,537	1,561	1,517	1,499	1,500	1,600	(100)
Total non-current assets	**243,410**	**216,650**	**254,297**	**224,745**	**29,552**	**219,052**	**222,390**	**224,038**	**224,745**	**234,630**	**258,040**	**(23,410)**
Current assets												
Inventories	6,799	7,440	7,350	7,495	(145)	7,317	7,484	7,657	7,495	7,500	7,350	150
Trade and other receivables: due from NHS and DHSC group bodies	17,664	15,203	20,947	37,119	(16,172)	16,170	25,931	40,248	37,119	26,845	26,845	0
Trade and other receivables: Due from non-NHS/DHSC group bodies	4,848	6,833	7,927	7,984	(57)	15,803	15,671	9,694	7,984	7,912	7,912	0
Assets held for sale and assets in disposal groups	0	660	2,000	660	1,340	660	660	660	660	660	510	150
Cash and cash equivalents: GBS/NLF	6,143	7,376	990	2,779	(1,789)	1,206	3,423	3,875	2,779	5,345	4,214	1,131
Cash and cash equivalents: commercial / in hand / other	10	10	10	10	0	10	10	10	10	10	10	0
Total current assets	**35,464**	**37,522**	**39,224**	**56,047**	**(16,823)**	**41,166**	**53,179**	**62,144**	**56,047**	**48,272**	**46,841**	**1,431**
Current liabilities												
Trade and other payables: capital	(4,723)	(10,791)	(5,234)	(5,693)	459	(7,990)	(6,831)	(5,955)	(5,693)	(10,613)	(4,466)	(6,147)
Trade and other payables: non-capital	(38,039)	(40,622)	(36,111)	(42,954)	6,843	(47,043)	(41,788)	(46,494)	(42,954)	(34,375)	(41,096)	6,721
Borrowings	(77,359)	(114,339)	(173,722)	(184,976)	11,254	(124,423)	(122,404)	(179,269)	(184,976)	(179,379)	(197,289)	17,910
Provisions	(735)	(608)	(565)	(629)	64	(608)	(608)	(672)	(629)	(629)	(565)	(64)
Other liabilities: deferred income	(2,707)	(2,869)	(1,200)	(1,685)	485	(1,110)	(1,871)	(2,832)	(1,685)	(1,200)	(1,200)	0
Other liabilities: other	(503)	(503)	(503)	(503)	0	(503)	(503)	(503)	(503)	(503)	(503)	0
Total current liabilities	**(124,066)**	**(169,732)**	**(217,335)**	**(236,440)**	**19,105**	**(181,677)**	**(174,005)**	**(235,725)**	**(236,440)**	**(226,699)**	**(245,119)**	**18,420**
Net Current liabilities	**(88,602)**	**(132,210)**	**(178,111)**	**(180,393)**	**2,282**	**(140,511)**	**(120,826)**	**(173,581)**	**(180,393)**	**(178,427)**	**(198,278)**	**19,851**
Total assets less current liabilities	**154,808**	**84,440**	**76,186**	**44,352**	**31,834**	**78,541**	**101,564**	**50,457**	**44,352**	**56,203**	**59,762**	**(3,559)**
Non-current liabilities												
Borrowings	(228,888)	(188,196)	(192,009)	(187,102)	(4,907)	(199,326)	(232,940)	(189,102)	(187,102)	(195,069)	(178,440)	(16,629)
Provisions	(2,911)	(2,863)	(2,832)	(2,833)	1	(2,989)	(2,689)	(2,829)	(2,833)	(2,762)	(2,782)	20
Other liabilities: other	(13,081)	(13,081)	(12,661)	(12,662)	1	(12,956)	(12,830)	(12,704)	(12,662)	(12,578)	(12,578)	0
Total non-current liabilities	**(244,880)**	**(204,140)**	**(207,502)**	**(202,597)**	**(4,905)**	**(215,271)**	**(248,459)**	**(204,635)**	**(202,597)**	**(210,409)**	**(193,800)**	**(16,609)**
Total net assets employed	**(90,072)**	**(119,700)**	**(131,316)**	**(158,245)**	**26,929**	**(136,730)**	**(146,895)**	**(154,178)**	**(158,245)**	**(154,206)**	**(134,038)**	**(20,168)**
Financed by												
Public dividend capital	257,563	260,042	263,166	261,388	1,778	260,042	260,042	260,555	261,388	267,029	265,318	1,711
Revaluation reserve	34,455	32,159	35,071	31,406	3,665	31,933	31,707	31,481	31,406	31,255	34,951	(3,696)
Other reserves	190	190	190	190	0	190	190	190	190	190	190	0
Income and expenditure reserve	(382,280)	(412,091)	(429,743)	(451,229)	21,486	(428,895)	(438,834)	(446,404)	(451,229)	(452,680)	(434,497)	(18,183)
Total taxpayers' and others' equity	**(90,072)**	**(119,700)**	**(131,316)**	**(158,245)**	**26,929**	**(136,730)**	**(146,895)**	**(154,178)**	**(158,245)**	**(154,206)**	**(134,038)**	**(20,168)**

BORROWINGS	Year end		Year to date			Monthly Actual 2019/20				Forecast Outturn		
Current	31 March 2019		31 January 2020			Qtr 1	Qtr 2	Qtr 3	31-Jan-20	31 March 2020		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Borrowings: DHSC capital loans	2,429	1,889	2,634	2,719	(85)	1,828	2,701	2,719	2,719	2,606	2,636	(30)
Borrowings: DHSC working capital / revenue support loans	74,930	112,450	168,337	180,085	(11,748)	120,859	117,357	174,085	180,085	174,084	191,521	(17,437)
Accrued interest on DHSC loans	0		2,289	2,172	117	1,736	2,346	2,465	2,172	2,449	2,670	(221)
Borrowings: other (non-DHSC)	0	0	462	0	462	0	0	0	0	240	462	(222)
Total current borrowings	**77,359**	**114,339**	**173,722**	**184,976**	**(11,254)**	**124,423**	**122,404**	**179,269**	**184,976**	**179,379**	**197,289**	**(17,910)**
Non-current												
Borrowings: DHSC capital loans	33,343	24,283	33,025	33,833	(808)	25,005	34,179	33,833	33,833	32,914	32,746	168
Borrowings: DHSC working capital / revenue support loans	195,545	163,913	155,746	153,269	2,477	174,321	198,761	155,269	153,269	160,913	142,687	18,226
Borrowings: other (non-DHSC)	0	0	3,238	0	3,238	0	0	0	0	1,242	3,007	(1,765)
Total non-current borrowings	**228,888**	**188,196**	**192,009**	**187,102**	**4,907**	**199,326**	**232,940**	**189,102**	**187,102**	**195,069**	**178,440**	**16,629**

The Year to date and forecast balance sheets are broadly in line with plan with the following main exceptions:

- Property plant and equipment: the 2019/20 plan was constructed prior to the results of the 31 March 2019 revaluation being completed. This resulted in an increase in asset valuation of circa £32m; the offset to this can be seen within the revaluation and Income & Expenditure Reserves.

- Borrowings: the split between debt due to be repaid within and after one year was incorrect at plan. In total however this is accurate.

- Trade / NHS Receivables: the levels at 31 January (£45.1m) are significantly increased against plan (£28.9m) due to high levels of NHS Accrued income versus plan. The balance of £45.1m broadly breaks down into outstanding invoices awaiting payment (NHS £6.4m, Non-NHS £1.4m), CRU (£1.4m), net PSF / FRF / MRET monies awaited (£10.5m), Prepayments (£5.6m), NHS Accrued Contract Income (£18.1m), Other NHS Accrued Income (£0.6m) and other receivables (£1.1m).

- Trade Payables - these are currently operating at levels above plan reflecting the level of cash resources available.

The forecast balance sheet assumes that the control total of £41.5m is achieved and the full PSF / FRF are awarded.

SUSTAINABLE SERVICES – CASH REPORT

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

Cash Report 2019/20 Month 10

2021 Objective: Our Services

Year to date:
The cash balance of £2.8m at 31 January reflects a number of factors, of which the most significant are:
- the reduction in capital creditors from the year end high of £10.8m to £5.7m;
- the operating deficit (£32.4m) being £3.3m adverse to plan.
- drawdown of Revenue loans (£59.0m) being higher than plan (£49.7m)
- an increase in NHS receivables of £25.0m since March to £37.1m at 31 January 2020 (reflecting an increase in accrued income due from the Lincolnshire CCGs); offset in part the level of Payables has fallen by £2.8m to £48.6m.

Simplistically therefore payments / cash have been managed through a mix of delays in the capital programme / capital creditors, increased borrowing and by flexing payments as necessary to manage within the cash resources available.
Whilst there has been an impact on the ability to pay suppliers within the 30 day target, the careful management of cash has meant that there has been no negative impact upon supplies and therefore the services provided by the Trust.

Borrowing:
Revenue and capital cash loans drawn between April - January 2020 equate to £59.0m / £11.7m respectively; taking the total revenue and capital borrowings (excluding accrued interest) at 31 January to £369.9m. As a consequence borrowing costs for 2019/20 are anticipated to be £9.3m in I&E terms, and in cash terms £8.8m.

Total borrowings since February 2018 against the Fire Safety Capital Scheme are £38.2m. The original business case agreed with NHSI set external support at £39.9m. NHSI have requested the business case be refreshed before signing off the final £1.7m.
Close monitoring of the cash position must continue to ensure sufficient borrowing is put in place where required.

Forecast:
The cash forecast is broadly in line with plan. The capital creditors are forecast to increase to £10.5m by March 2020 which allows the Trust to continue to meet revenue creditor obligations.
Revenue receivables will remain high into 2020/21 with DHSC not expected to process Q4 PSF / FRF payments until the new financial year.
The cash forecast assumes capital borrowing of £11.7m and revenue borrowing in 2019/20 at £60.6m (£41.4m: 2019/20 deficit support; plus £9.6m 2018/19 deficit support, £0.8m working capital support and £8.8m PSF and FRF).

SUSTAINABLE SERVICES – CASH REPORT continued

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

	In Month Actual January			Year to date January			Year End Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating Surplus	(791)	(4,076)	(3,285)	(29,040)	(32,390)	(3,350)	(32,306)	(32,396)	(90)
Depreciation	1,100	1,057	(43)	11,000	10,763	(237)	13,200	13,200	0
Other Non Cash I&E Items	(18)	0	18	(179)	(75)	104	(214)	(120)	94
Movement in Working Capital	2,615	289	(2,326)	(14,230)	(22,332)	(8,102)	(13,680)	(21,141)	(7,461)
Provisions	(50)	(39)	11	(31)	(18)	13	(81)	(80)	1
Cashflow from Operations	**2,856**	**(2,769)**	(5,625)	**(32,480)**	**(44,052)**	(11,572)	**(33,081)**	**(40,537)**	(7,456)
Interest received	3	20	17	30	125	95	36	138	102
Capital Expenditure	(3,554)	(2,045)	1,509	(31,621)	(23,947)	7,674	(38,312)	(31,302)	7,010
Cash receipt from asset sales	0	1	1	150	30	(120)	150	29	(121)
Cash from / (used in) investing activities	**(3,551)**	**(2,024)**	**1,527**	**(31,441)**	**(23,792)**	**7,649**	**(38,126)**	**(31,135)**	**6,991**
PDC Received	1,075	833	(242)	3,124	1,346	(1,778)	5,276	6,987	1,711
PDC Repaid	0	0	0	0	0	0	0	0	0
Dividends Paid	0	0	0	0	0	0	0	0	0
Interest on Loans, PFI and leases	(1,120)	(1,136)	(16)	(7,227)	(7,432)	(205)	(8,486)	(8,774)	(288)
Capital element of leases	0	0	0	0	0	0	0	0	0
Drawdown on debt - Revenue	0	4,000	4,000	49,684	58,954	9,270	59,809	60,598	789
Drawdown on debt - Capital	740	0	(740)	14,760	11,700	(3,060)	15,400	13,182	(2,218)
Repayment of debt	0	0	0	(1,573)	(1,321)	252	(2,721)	(2,352)	369
Cashflow from financing	**695**	**3,697**	**3,002**	**58,768**	**63,247**	**4,479**	**69,278**	**69,641**	**363**
Net Cash Inflow / (Outflow)	**0**	**(1,096)**	**(1,096)**	**(5,153)**	**(4,597)**	**556**	**(1,929)**	**(2,031)**	**(102)**
Opening cash balance	1,000	3,885	2,885	6,153	7,386	1,233	6,153	7,386	1,233
Closing Cash balance	**1,000**	**2,789**	**1,789**	**1,000**	**2,789**	**1,789**	**4,224**	**5,355**	**1,131**

SUSTAINABLE SERVICES – CAPITAL REPORT 2019/20 Month 10

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

The Trust has capital resources of c£31.1m for 2019/20 including ring-fenced funding e.g. Fire, LED Lighting, Fluoroscopy and e-HR. A further £0.7m is also accessible re: e-HR.

The year-to-date spend incurred amounts to c£18.8m against a planned spend of c£20.7m. All internally funded scheme leads have been written to or met face to face (w/c 9th February) to understand the forecast position to 31st March 2020. Based on current information received there is a need to look at revising the capital programme to ensure other key schemes can be supported where slippage is identified. An assessment on the potential impact into 2020/21 needs to take place where schemes are delayed due to the limited discretionary Trust funds available. Externally funded schemes have varying levels of forecasted spend against plan and are summarised below. ULHT are in contact with NHSI/HSLI to inform of these changes and look at methods of deferral into 2020/21.

Year-to-date spend analysis as follows:

Facilities; Minimal spend at M10 of £697k. Majority of spend incurred links to Anti-barricading improvements, £187k and roof improvements, £186k. 2nd IT room at Pilgrim, £72k. Lincoln Heating where CQC had raised an issue following an incident with a patient, £28k. Pilgrim Kitchen Floor, £27k. Corridor Flooring, £21k. Endoscopy, £16k. Regular meetings are taking place to ensure planned spend levels are accurate, and risks identified early. A revised forecast for all schemes has recently been completed for further review.

Fire; Costs incurred at the end of January amounted to c£12.6m. Fire Works package 1 at LCH is £3.6m, package 2 is £2.5m, Emergency Lighting at LCH is £0.7m. Package 1 at Pilgrim amounts to £1.6m. Work continues with the QS to ensure robust mechanisms are in place for capturing financial information and projections. Cash flow forecasts are also being managed.

Medical Devices; Spend year-to-date is £1.1m. Limited movement in month however progression of future purchases has been made. The previous equipment replaced this year has been; Radiology Ultrasound machine £66k, Theatre Tables £177k, Surgical Diathermy £114k, Theatre lights £123k, YAG Laser £42k, Field Analyser £38k, Ultrasound Scanner £22k and Dental Chair £11k and Pilgrim Fluoroscopy Room £469k. Due to the levels of emergency equipment replacement required there has been further reprioritisation of allocations involving Divisions - this has removed the £100k allocation for phaco-emulsifiers and enabled the Field Analyser, YAG Laser and Ultrasound for LCH A&E to be purchased instead.

IT; Spend to date of £1.7m. Key spend areas are as follows - E-Health-record costs of £465k, Windows 7 to 10 £406k, E-prescribing £209k, Cyber Security £196k, PC replacement £94k, Wifi spend linked to HSLI deferred monies amounting to £74k and Digital Dictation £138k. Revised forecasts continue to be progressed.

External Funding update

Work continues to progress regarding the £21.3k allocated for Pilgrim A&E and UTC. Business case being updated currently involving key stakeholders across Lincolnshire to ensure robust plans are assessed and options appraised and discussions taking place within NHSE/I around timescales for delivery as initial feedback has been they are too optimistic. Further to this funding support of £824k is due for 2 x CT Scanners & £953k for an MRI scanner in 19/20.

SUSTAINABLE SERVICES – CAPITAL REPORT continued

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Year to date	Plan	Actual	Variance
	£'000	£'000	£'000
Capital Balance	**20,681**	**18,849**	1,832

Year End Forecast	Plan	Actual	Variance
	£'000	£'000	£'000
Capital Balance	**31,124**	**31,124**	**0**

Year to date	Plan	Actual	Variance
	£'000	**£'000**	**£'000**
Medical Equipment replacement	1,638	1,086	552
Estates - Fire	11,666	12,556	(890)
ICT	2,083	1,708	375
Estates - Backlog	2,754	697	2,057
Service developments	2,540	2,802	(262)
Total	**20,681**	**18,849**	1,832

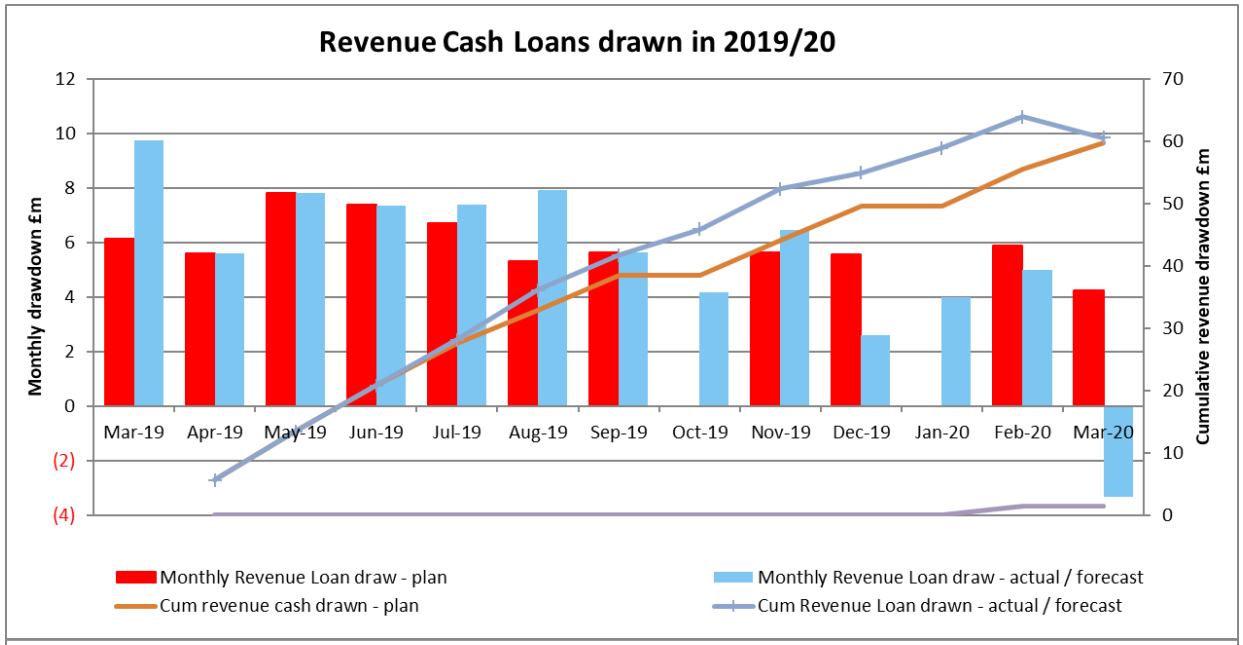
Year End Forecast	Plan	Actual	Variance
	£'000	**£'000**	**£'000**
Medical Equipment replacement	3,045	3,045	**0**
Estates - Fire	14,770	14,770	**0**
ICT	3,685	3,685	**0**
Estates - Backlog	2,129	2,129	**0**
Service developments	7,495	7,495	**0**
Total	**31,124**	**31,124**	**0**

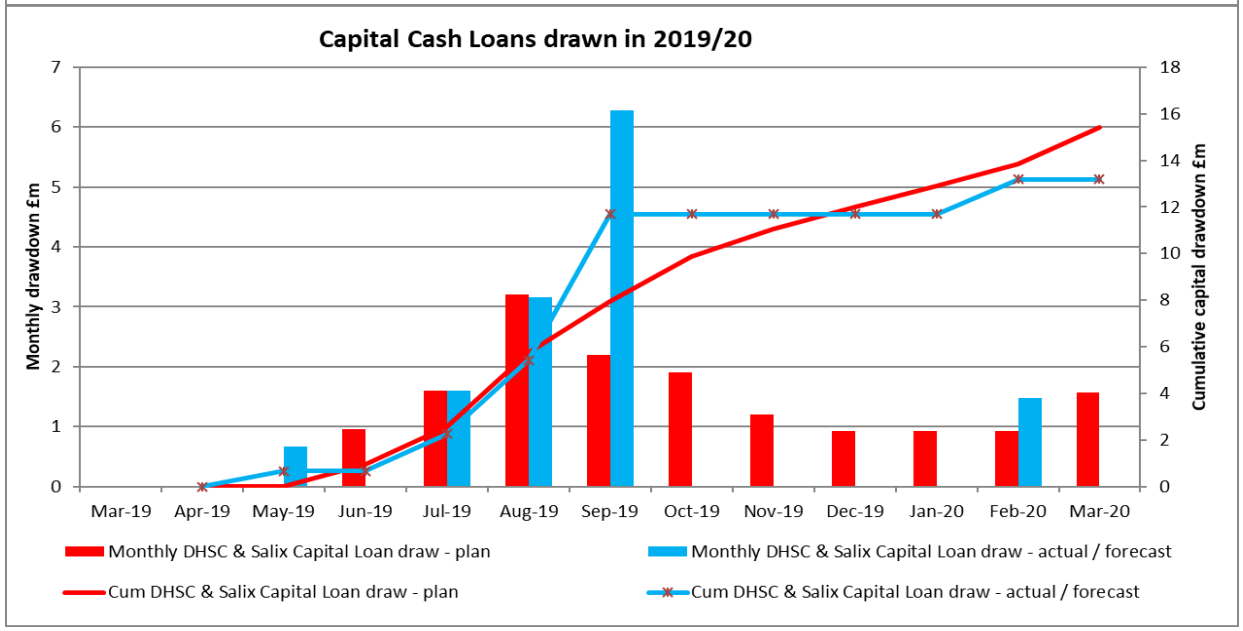
SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services





SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Borrowing
The Trust has drawn cash loans of £70.7m during the ten months to January 2020, this is split £59.0m revenue support and £11.7m capital (Forecast 73.8m : Revenue: £60.6m, Capital: £13.2m). This includes £9.6m deficit support relating to 2018/19.

Revenue
The forecast deficit for 2019-20 is £41.4m in line with the financial plan. Revenue borrowings are planned to be £60.6m (Deficit support 19/20: £41.4m, 18/19: £9.6m, working capital support £0.8m and PSF / FRF: £8.8m).
The impact of I&E pressures upon the Trust ability to pay suppliers has been largely mitigated by capital cash, available due to the high level of capital creditors brought forward from 2018/19. Although 2018/19 creditors have now been largely cleared, a large portion of the 2019/20 capital programme will not be completed until the final months of the year (with cash payments of £10.6m not expected until early 2020/21); this offers a degree of ongoing temporary support to meet any cash shortfall associated with the revenue position.
The Trust borrowing agreed by NHSI for January was £4.0m - within the limits authorised by the Trust Board.
February borrowing has been agreed by NHSI at £5.0m; in line with that authorised by the Board.

Discussions have taken place regarding the exact timing of elements of income from the four Lincolnshire CCGs. Payments were received in January with further substantial receipt expected during February although the precise timing and value are subject to final agreement.
Receipt of this income should mean the Trust will not need further borrowing in March. However to mitigate against any further risks the Board was requested to delegate authority to the Director of Finance to submit a further working capital cash request of up to £4.0m should this be required.

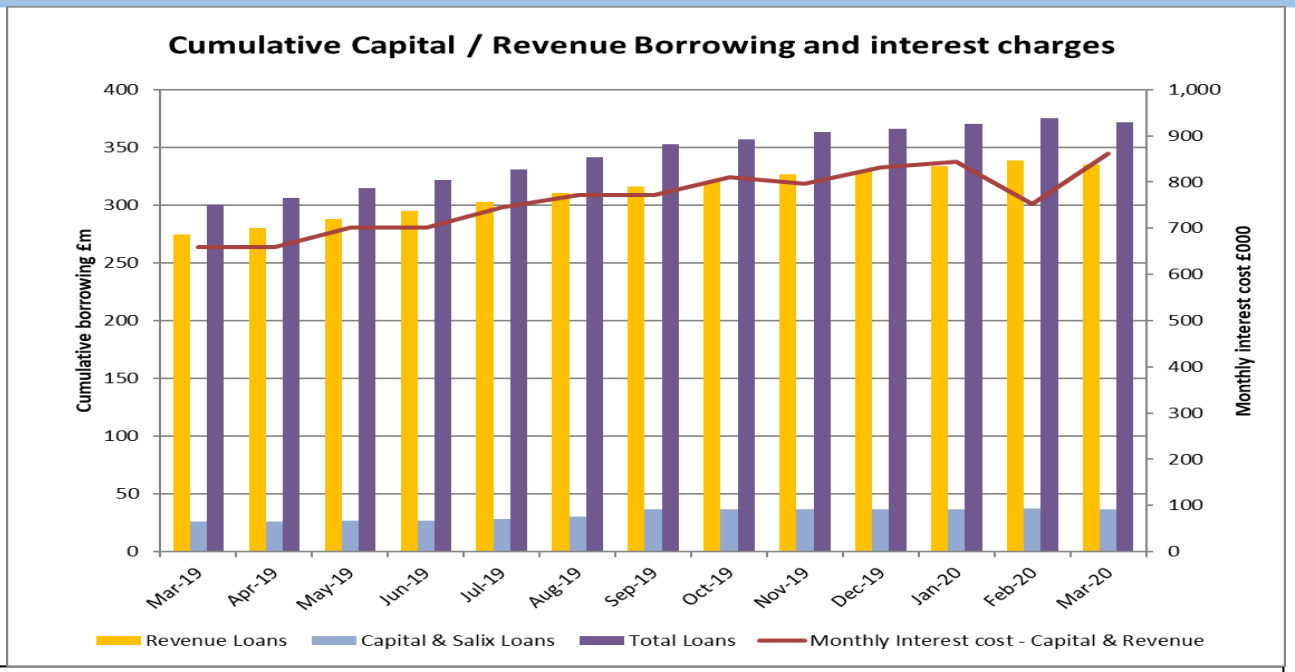
Capital Borrowing
A series of capital loans totalling £38.2m were agreed with DHSC in relation to the Fire Safety Capital scheme. Against this £26.5m was drawn prior to 2019/20 and a further £11.7m subsequently drawn in 2019/20. The balance of £1.7m is subject to a refresh of the original business case and once approved will be drawn in 2020/21.
A further loan of £4.0m funded through the SALIX Energy Efficiency Loan Scheme has been agreed. £1.5m is expected to now be drawn during February 2020 with the balance to be drawn in 2020/21.

SUSTAINABLE SERVICES – CUMULATIVE BORROWING

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services



Borrowings and Interest

At 31 January 2020 total 'repayable' borrowings (excluding accrued interest) were £369.9m, capital (£36.6m) and revenue (£333.3m).
Existing loans are held at a variety of interest rates, Capital 1.1% (£8.6m) & 1.37% (£28.0m), Revenue 1.5% (£155.3m), 3.5% (£134.6m) & 6.0% (£43.4m).

In early November the Trust received notification from DHSC that a series of loans with original repayment dates between November 2018 and March 2019 have been extended into 2020/21. The original interest rates remain unchanged.

Interest costs for 2019/20 are £9.2m (Revenue £8.8m / Capital £0.4m).
Changes in accounting standards from 2018/19 have meant that any accrued interest (January 20 - £2.2m) is now reported as part of overall borrowings on the Statement of Financial Position.

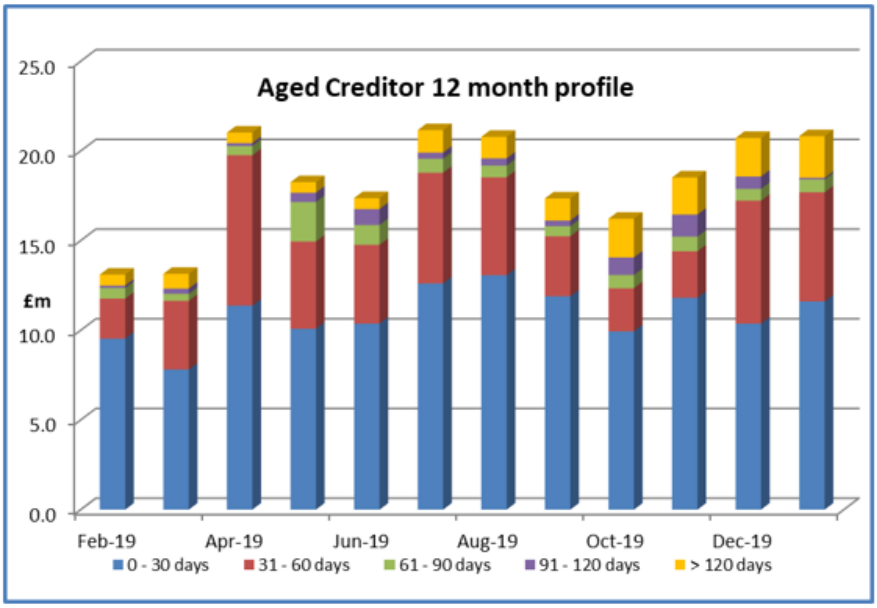
Future borrowings are anticipated to be at 1.37% for capital.
Guidance issued as part of the 2020/21 planning submission indicates that existing revenue borrowings will be converted to PDC, with future deficit financing flowing through the Financial Recovery Fund rather than loans. Further details are awaited, but at present it appears unlikely that additional revenue borrowing will be required from April 2020.

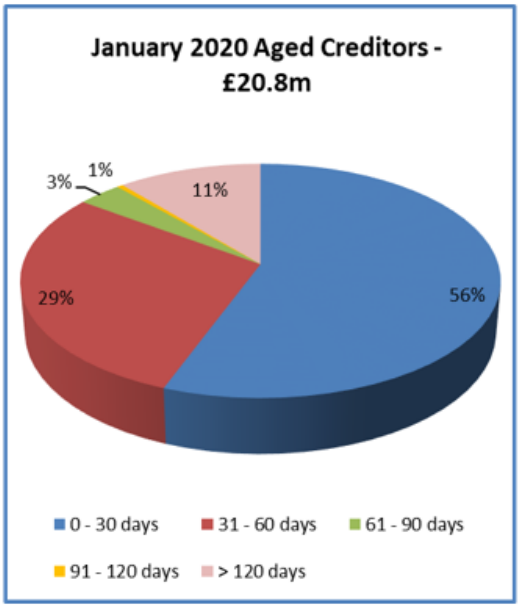
SUSTAINABLE SERVICES – CREDITOR PAYMENTS

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services





Creditors
Total Creditors were £20.8m at 31 January 2020, of which; £9.2m were over 30 days (£2.4m > 90 days).
Focusing further upon those invoices over 30 days; £4.9m had been authorised and was ready to pay at 31 January, a further £2.5m (59%) relates to ten suppliers where there are specific queries and which the payments team are actively working to resolve with the supplier and purchasing departments. The remaining £4.3m is spread across 342 suppliers and circa 1,262 invoices.

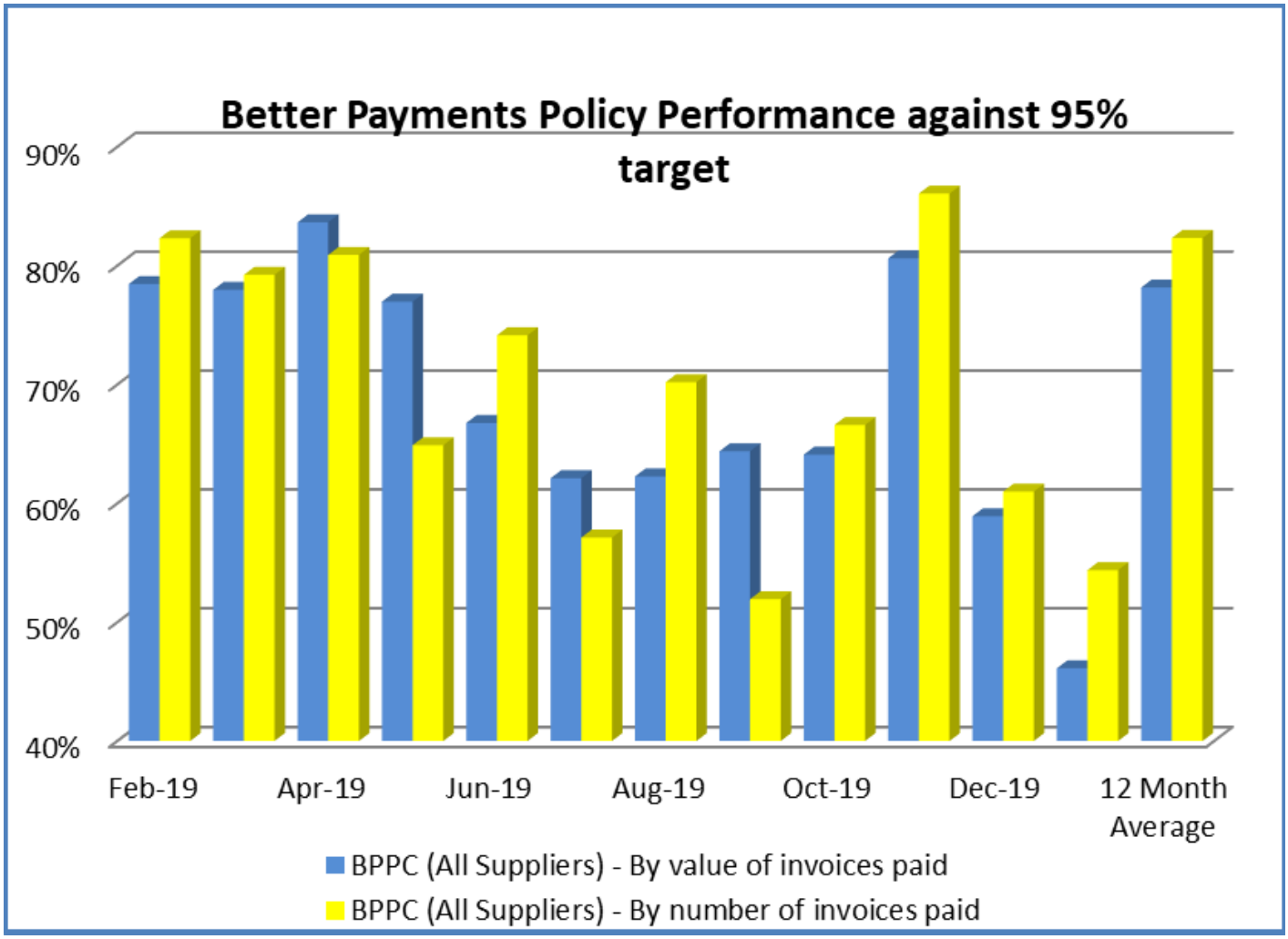
Performance
Performance against BPPC has declined from 2018/19 levels, principally due to the cash position of the Trust. It has been necessary to carefully manage outgoings often at the expense of BPPC to ensure sufficient reserves have been maintained to cover month end payroll costs and other potential unforeseen 'urgent' payments. The BPPC and Creditor profiles covering the previous 12 months illustrate the increase in Creditors and decline in BPPC since April.

SUSTAINABLE SERVICES – BETTER PAYMENTS

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services



BPPC

The Better Payment Practice Code (BPPC) requires the Trust to aim to pay all valid invoices by the due date or within 30 days (whichever is the latter).

The 12 month rolling and January 2020 performance are shown in the following table.

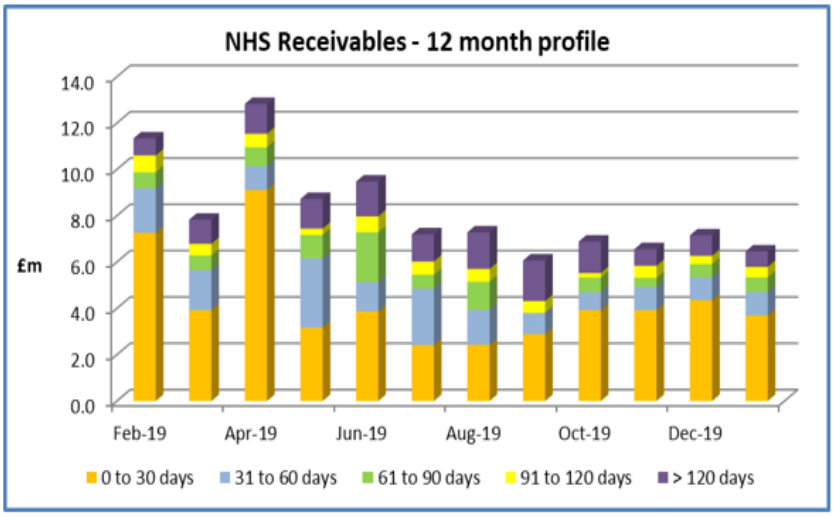
	NHS		Non-NHS	
	By volume Number	By Value £000s	By volume Number	By Value £000s
Total bills paid in the year	2068	36,372	99,084	162,823
Total bills paid within target	1170	25,612	65,559	101,898
% of bills paid within target YTD	**56.58%**	**70.42%**	**66.17%**	**62.58%**
% of bills paid within January 2020	**43.01%**	**33.02%**	**54.60%**	**51.23%**

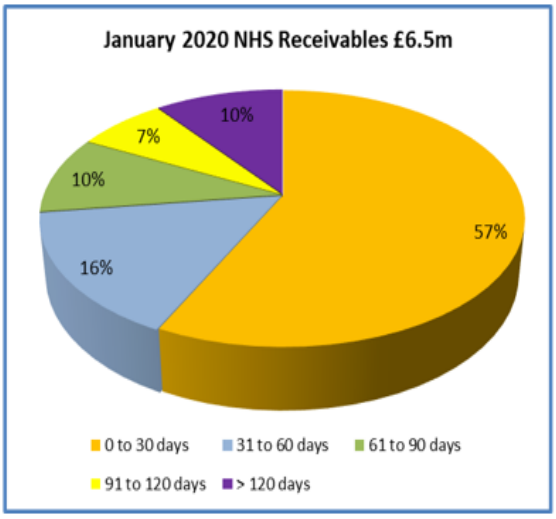
SUSTAINABLE SERVICES – NHS RECEIVABLES

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services





	Totals outstanding debt £'000						
	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
CCGs - Lincolnshire	2,191	203	133	3	283	2,813	286
CCGs - Other	249	8	87	40	117	501	157
Trusts - Lincolnshire	659	314	33	21	13	1,040	34
Trusts - Other	529	368	291	382	92	1,662	474
Other NHS	65	119	84	11	162	441	173
Total	**3,693**	**1,012**	**628**	**457**	**667**	**6,457**	**1,124**

The tables above show the level of NHS debt over the last 12 months alongside the aged split at 31 January 2020.
Overall levels of debt have remained steady having hit the lowest point since early 2018/19 in September. Much of this can be attributed to the 'without prejudice' agreement between ULHT and the four Lincolnshire CCGs, LPFT and LCHS to make invoice payments 'on account' to assist ULH cash liquidity.

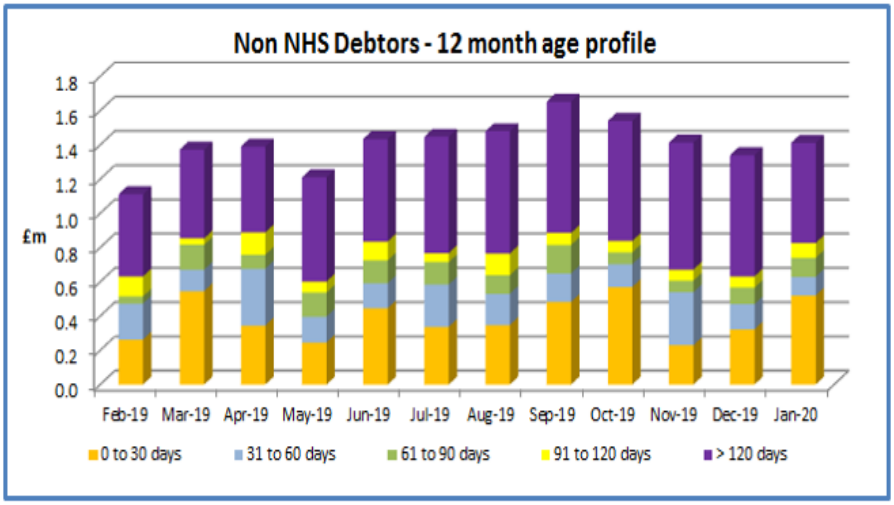
The principal area of concern at present is the level of debt outstanding with Nottingham University Hospitals (£1.0m), the majority of which is over 30 days. This account has been escalated and agreement received to clear a substantial portion in February.

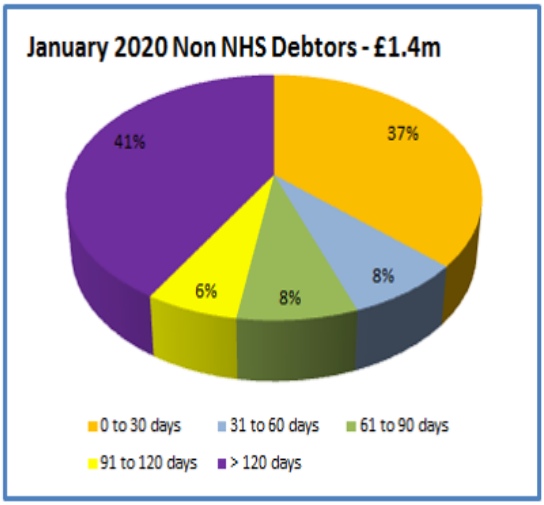
SUSTAINABLE SERVICES – NON NHS RECEIVABLES

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services





	Totals outstanding debt £'000						
Description	**0 - 30 days**	**31 - 60 days**	**61 - 90 days**	**91 - 120 days**	**120 + days**	**Grand Total**	**90+ days**
Overseas Visitors	6	3	11	13	65	**98**	78
Debt Collection - Overseas	0	0	0	0	93	**93**	93
NHS Non English	4	(2)	23	1	46	**73**	47
Misc	492	99	57	55	262	**965**	317
Salary Overpayments	17	8	19	15	42	**101**	56
Private Patients	0	0	0	0	0	-	0
Debt Collection - General	0	0	0	0	33	**34**	34
Agreed Installment Plans	0		1	2	45	**48**	47
Grand Total	**521**	**109**	**111**	**86**	**586**	**1,412**	**672**

The tables above show the level of Non-NHS debt over the last 12 months alongside the aged split at 31 January 2020.

The level of debt has increased £0.1m since last month and is £0.3m higher than this period last year. The position is driven by:
1. Overseas Debt - currently £0.2m over 90 days. Bad debt provision continues to be reviewed and CCG risk share is in place to fund 50% of any written off debt.
2. A dispute has arisen with one of the retailers on Trust Sites. This is being addressed through legal channels but accounts for £0.2m.
3. A further £0.1m is in dispute with St Barnabas and has been escalated to the contracting team to seek resolution / payment. A meeting was held between the two parties in month but further work remains to resolve.
The breakdown of debt across general category headings is shown opposite.

SUSTAINABLE SERVICES – EXTERNAL FINANCIAL LIMIT & CAPITAL RESOURCE LIMITS

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

External Financing Limit Target (EFL)	Initial EFL	Agreed & Notified amendments	Anticipated future amendments	Forecast EFL
	£000s	£000s	£000s	£000s
Anticipated EFL at Plan	**79,693**	**0**	**0**	**79,693**
April 19 Planned Cash movements	1,929			**1,929**
Capital element of Finance leases - repayments		0		**0**
2018/19 additional deficit financing		9,552		**9,552**
Interim revenue support loan: deficit financing		36,527	4,871	**41,398**
PSF temporary loan financing		12,070	(3,225)	**8,845**
Working Capital Loan		805	0	**805**
Fire safety - Loan		11,700	0	**11,700**
Fire safety loan repayments		(1,321)	(1,031)	**(2,352)**
Salix Loan Financing		1,200	282	**1,482**
Salix Loan repayment		0	0	**0**
PDC drawn 18/19 carried forward		102		**102**
PDC received: Medical School		0	0	**0**
PDC received: LED Lighting		1,439	0	**1,439**
PDC received: E- Health Records		977	0	**977**
PDC received: STP support LCHS / LPT		0	974	**974**
PDC received: Fluoroscopy			1,200	**1,200**
PDC received: Cyber Security			521	**521**
PDC received: CT / MRI			1,779	**1,779**
PDC received: Changing Places			97	**97**
Initial / Agreed changes / Anticipated changes / Forecast EFL	**1,929**	**73,051**	**5,468**	**80,448**

Performance against Capital Resource Limit (CRL) Target	Initial CRL	Agreed & Notified amendments	Anticipated future amendments	Forecast CRL
	£000s	£000s	£000s	£000s
Anticipated CRL at Plan	**31,155**	**0**	**0**	**31,155**
Planned Depreciation	13,200			**13,200**
Fire safety - Loan		11,700	0	**11,700**
Fire safety loan repayments	(2,490)		138	**(2,352)**
Salix Loan Financing		1,200	282	**1,482**
Salix Loan repayment	(231)	0	231	**0**
PDC drawn 18/19 carried forward		102		**102**
PDC received: Medical School		0	0	**0**
PDC received: LED Lighting		1,439	0	**1,439**
PDC received: E- Health Records		977	0	**977**
PDC received: STP support LCHS / LPT		0	974	**974**
PDC received: Fluoroscopy			1,200	**1,200**
PDC received: Cyber Security			521	**521**
PDC received: CT / MRI			1,779	**1,779**
PDC received: Changing Places			97	**97**
Initial / Agreed changes / Anticipated changes / Forecast CRL	**10,479**	**15,418**	**5,222**	**31,119**

Forecast Capital expenditure	**31,243**
Planned underspend re PDC schemes deferred into 2019/20	
Less Capital funded via Charitable Donations	**(120)**
Less Net book value of disposed assets	**(4)**
Charge against CRL	**31,119**
(Over) / Under shoot against CRL target	**0**

EFL

The Trust External Financing limit is set by the DHSC.

This is a cash limit on net external financing and it is one of the controls used by the DHSC to keep cash expenditure of the NHS as a whole within the level agreed by Parliament in the public expenditure control totals.

Trusts must not exceed the EFL target, which effectively determines how much more (or less) cash a Trust can spend over that which it generated from its activities.

This target translates in simple terms to the Trust holding a minimum cash balance at year end of £5.4m.

CRL

The Trust is allocated a CRL target based upon its planned internally generated resources - depreciation and asset sale proceeds plus agreed net additional developments funded by loans / PDC.

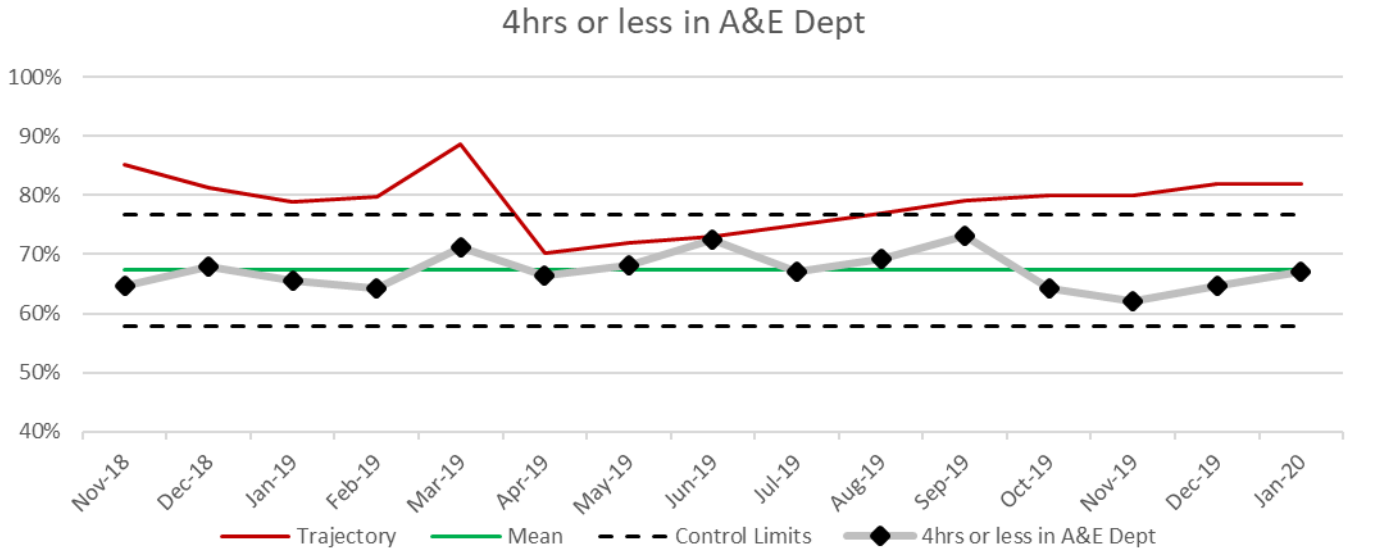
Trusts are not permitted to exceed the CRL.

ZERO WAITING – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- A&E overall outturn for January, Type 1 and primary care streaming delivered 67.00% against a trajectory of 82%, a variance of 15.00% against trajectory and 2.297% improvement compared with December.
- LCH performance for January was 63.25%, a slight deterioration on December. PHB performance was 62.75 for January, and improvement of 2.35%. GDH performance also improved from 92.4% to 95.27%. GDH performed above the national target. This is the first time since September 2019.
- Primary care streaming at Lincoln and Pilgrim are both above the ambition of 20% with Lincoln 32.6% and Pilgrim 31.2%. The implementation of the Urgent Treatment Centres in December continues to contribute significantly to this output.
- ED attendances for January were 16,432 including Streaming/UTC against 17,617 in December equating to a 6.73% decrease. ED attendances still continue to be above plan
- Emergency admissions in January reduced. The emergency admissions were 14.41% lower than experienced in December. Medical outliers across the sites decreased during this time.
- NEL LoS increased during the month at PHB and LCH but decreased at GDH but an overall increase to 4.88 days from 4.51 days has been experienced.
- Total ULHT bed occupancy for January continued to be in excess of 98%.

Actions in place to recover:

Some of the actions against this metric are repetitive but still valid.

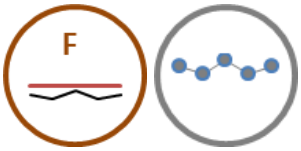
- Reduction of ambulance conveyances through alternative pathways targeting out of area first and increased use of the Clinical Assessment Service which as now been enhanced;
- Increased numbers of patients seen through primary care streaming/Urgent Care Centres; protecting the minors stream and focussing on delivering 4 hours through this stream. UTC numbers are now in access of 30%
- Long stay Tuesday and Wednesday at LCH and PHB to further reduce stranded patient numbers by re-focusing back to 21 day LOS as per ECIST recommendations is now realising both impact and reduction.
- Increased numbers of patients who are seen and treated through a Same Day Emergency Care (SDEC) pathway; Target is 20% of the Emergency Take is being realised.
- Red to Green roll out has been well received across the Trust. The second MADE event took place week commencing 6th January and some benefits were demonstrated with increased discharges. Additional challenge is in place against the 13 LCC funded schemes to reduce acute care LOS.

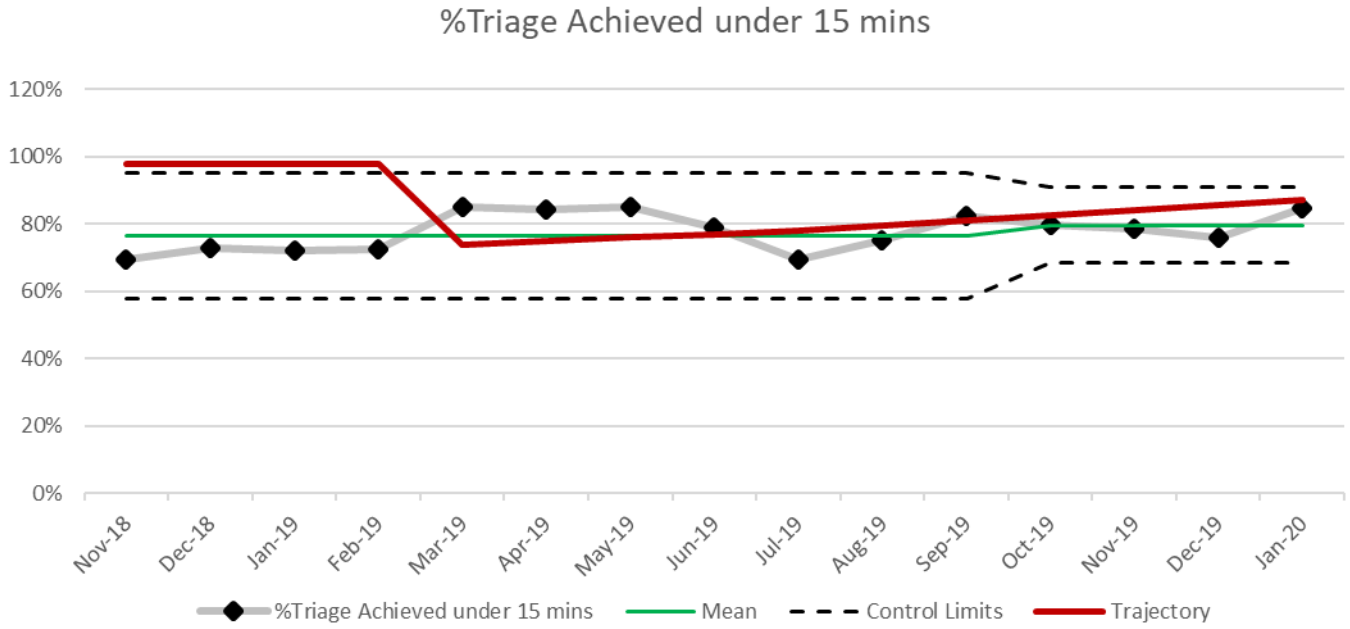
ZERO WAITING – %TRIAGE ACHIEVED UNDER 15 mins

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- January 2020 saw the first improvement in compliance since September 2019. January recorded an 84.70% compliance against the target of 87%. This was an 8.95% improvement on December (75.75%).
- The continued use of a triage coordinator role is ensuring that this important process is now being delivered consistently.

Actions in place to recover:

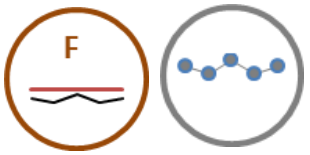
- Work continues at LCH and PHB, to ensure that the 2nd triage stream is in place and protected. As and when required
- Triage time is a key performance indicator in regards to patient safety and will continue to be scrutinised, monitored and challenged at all operational delivery levels 3 x daily through the Capacity and Performance Meetings and within the UEC programme.
- The report now available at individual patient level to identify where the standard has not been met still requires a nominated operational lead daily to highlight and address omissions and ensure actions in place to reduce situation reoccurrence.
- Increased visibility on rectification actions is required.

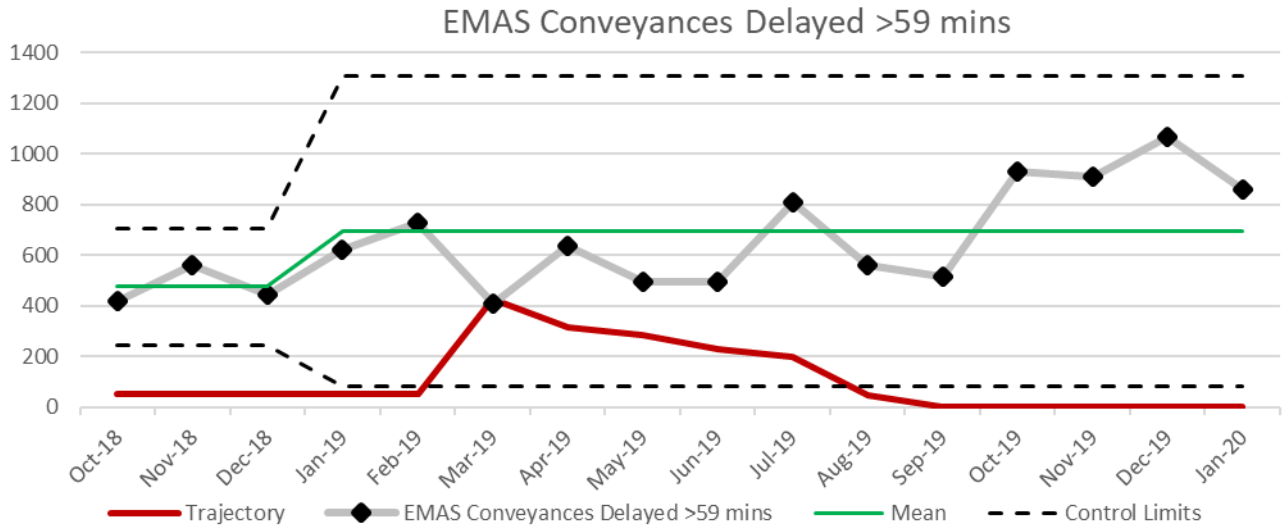
ZERO WAITING – AMBULANCE HANDOVER >59 Mins

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- Ambulance handover delays >60 and >120 minutes continue to be experienced but have experienced an overall reduction during January.
- 857 >59 minutes in January verses 1067 in December.
- This represents a 19.69% reduction during January. This should be seen against an in month decrease in conveyances of 3.9% but a 3.7% increase above agreed adjusted plan.
- LCH demonstrates the largest reduction. During January at LCH there were 436 >59 minute ambulance handovers compared with 669 in December an improvement of 233.
- Overall compliance with <59 minute handover across all 3 sites in January is above 80% - PHB, 80%, LCH, 84.39% and GDH, 99%.
- The Rapid Handover Protocol implemented during November continues to be enacted where safely appropriate to do so. Space continues to be a rate limiting factor.
- Whilst the Pre-Hospital Practitioner cover in place 24/7 at both PHB and LCH has been effective, the CQC raised concerns in regard to PHP Manchester Triage training status. This has resulted in the requirement for an additional registrant to 'supervise' and input Ambulance triage data. This has caused data input delays and will be seen in 'Triage <15 minutes % compliance' in February. We remained assured that our compliance against this crucial safety measure is robust.

Actions in place to recover

Some of the actions against this metric are repetitive but still valid.

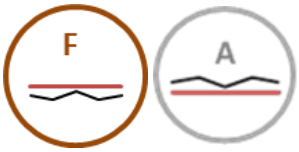
- Rapid Access and Treatment (RAT) models have been reviewed at both LCH and PHB hospital sites in particular the staffing models for RAT, competency and processing of patient. This is a key performance indicator within the Trust Capacity and Flow Meetings. The route cause for any delay is discussed and mitigation actions are formulated in response. These are now discussed in the Divisional UEC Governance Meeting.
- Site Duty Managers (SDMs) track and monitor every conveyance to ED greater than 15 minutes and record actions taken and report to the Deputy Chief Operating Officer, Urgent Care in hours and to the Silver Commander out of hours.
- The close working relationship between the DOM and Silver Commander (in and out of hours) continues to support appropriate conveyance and handover delays.
- Daily system calls are in place 7 days a week to review trends, activity spikes and predicted demand in order to inform the Emergency Department thus maximising readiness to receive.

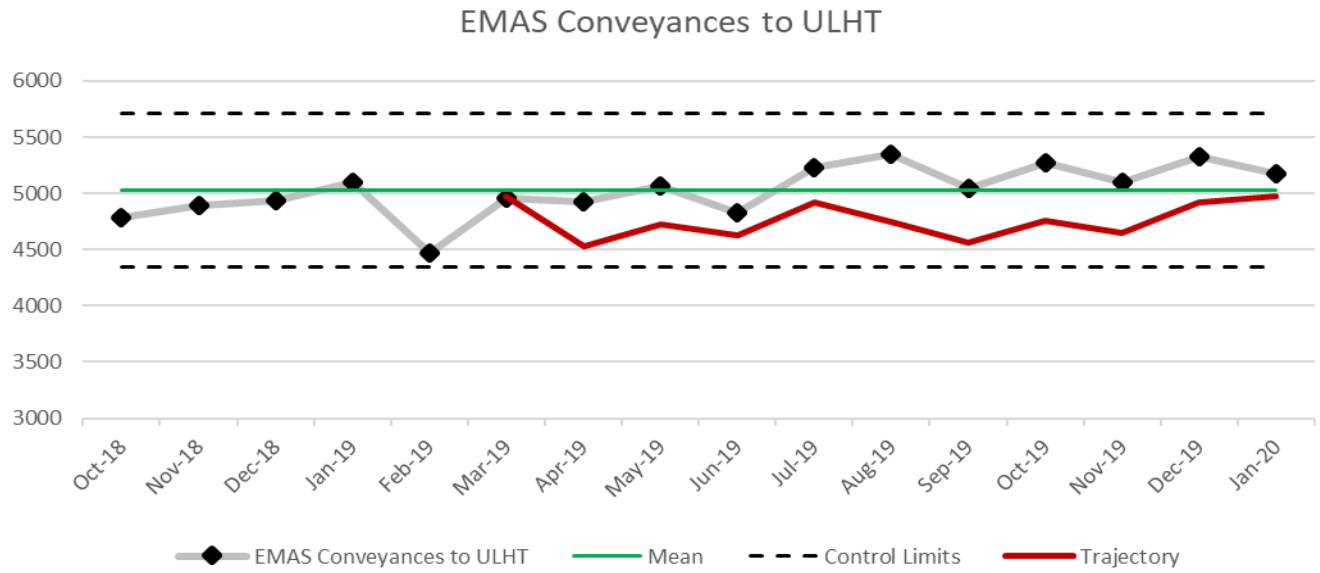
ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- January experienced a decrease in overall EMAS conveyances compared with December.
- During January there were 5170 conveyances compared to 5329 in December.
- 159 less than December but still 196 more than plan representing a 3.7% increase.
- Improvement work with system partners in applying a more intelligent demand response tool to support compliance with agreed handover recovery trajectory continues to be under increasing scrutiny, especially in light of the implementation of the Rapid Handover Protocol.
- The number of conveyances to the Trust is discussed daily on the Lincolnshire System Call and is also monitored through the Ambulance Handover Group.
- Non conveyances rates, as well as monitoring of alternative pathway usage is also reported but the latter continues to be below the expected benefit.

Actions in place to recover

Some of the actions against this metric are repetitive but still valid.

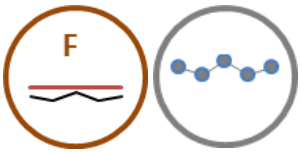
- This is a key metric within the Capacity and performance meetings held x 3 daily and has individual accountability to ensure delivery. This is overseen by the Deputy Chief Operating Officer, Urgent Care.
- Work remains ongoing with System Partners in applying a more intelligent demand response tool to support compliance with agreed handover recovery trajectory. This is a standard agenda item on the System Wide/Regulator Call conducted daily and the monthly Ambulance handover delay meeting chaired by NHSi
- ULHT Representative/Silver OOH and EMAS ROM / DOM control continue to apply a daily review of pressure on the departments, County wide profile against demand, destination of demand and attempts manage that demand. Daily intelligence shared routinely as to the forecast spikes in demand and this continues to be applied to the Emergency Departments response capability. This is co-ordinated by the Deputy Chief Operating Officer, Urgent Care and the Duty DOM
- Conveyance numbers continue to be monitored through the Ambulance Handover Group.
- Appropriate conveyance monitoring is in place within EMAS with oversight by Deputy Chief Operating Officer – Urgent Care and Daily System Call.
- EMAS currently undertaking spot audits against clinically appropriate conveyance and audit results reported to Ambulance Handover Group with escalation to SRG and UECDB.

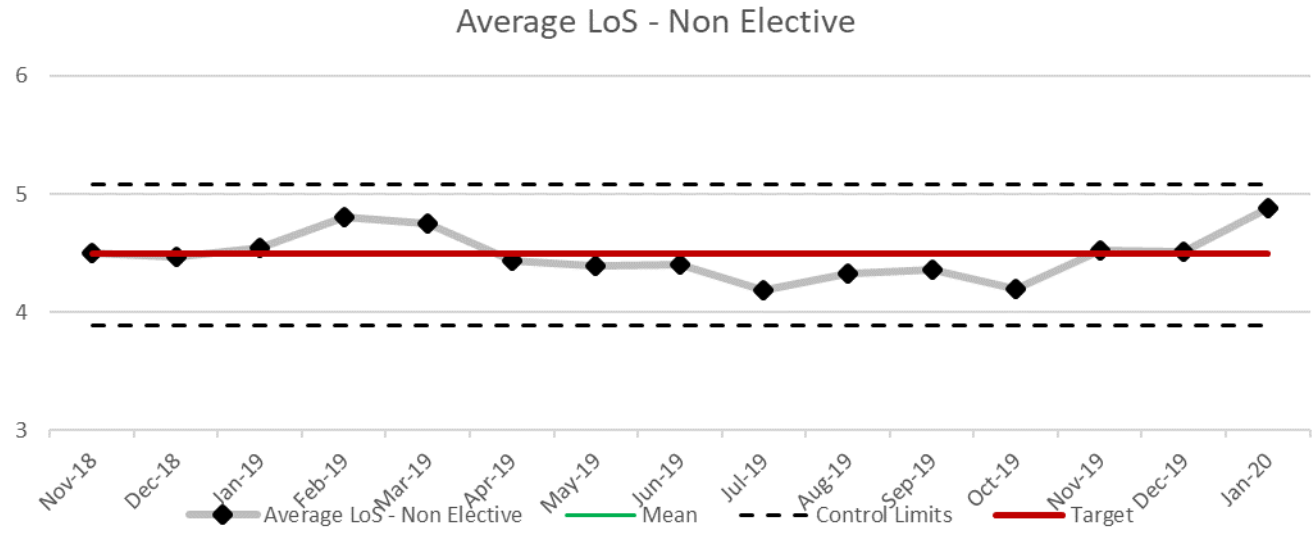
ZERO WAITING – AVERAGE LOS – NON ELECTIVE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- During January, there was a decrease in non-elective admissions by 474.
- In January there were a total of 3288 non-elective admissions compared with 3762 in December.
- January continues to demonstrate an above plan trend, and remains higher than 2018/19.
- There were 23 more non-elective discharges in January compared with December
- Average LOS for non-elective admissions has experienced its highest point for over 16 months with an ALOS of 4.88 days. This is only 0.12% lower than the upper control total of 5.00 days. The second highest point was experienced in February 2019 at 4.80 days.
- January non-elective length of stay at PHB was 4.69 compared with 4.26 in December and at LCH for January non-elective length of stay was 5.01 compared with 4.62 in December. GDH saw a 0.13% improvement in non-elective length of stay during January at 5.05 compared to 5.18 in December.

Actions in place to recover

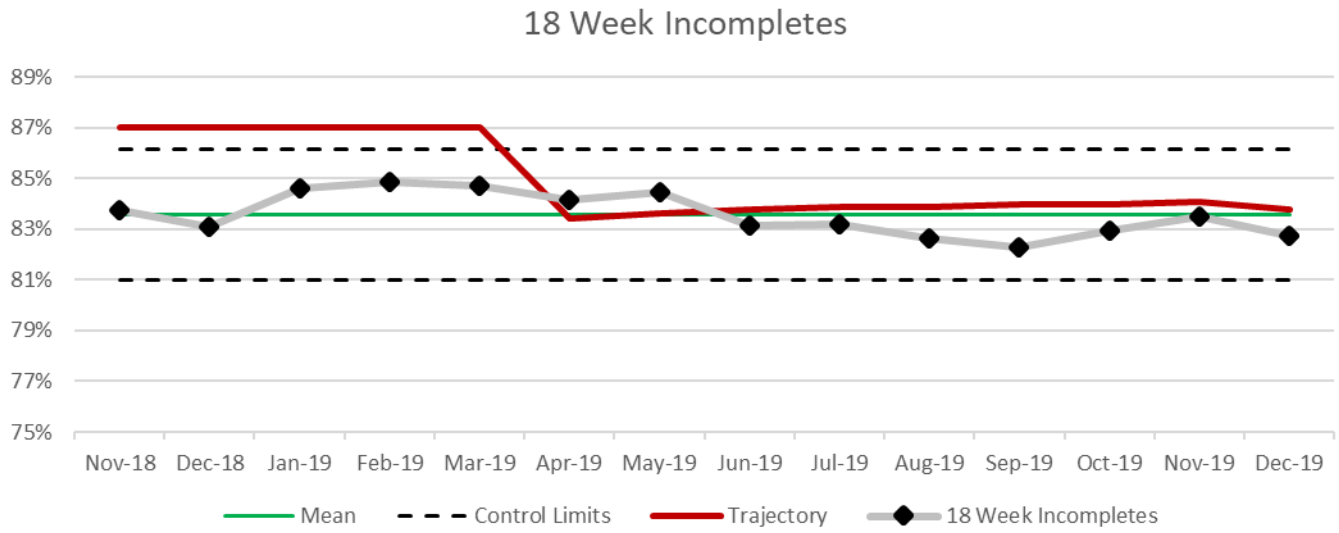
- Following a final review by ECIST, a re-focus on >21 days and not >11 days has been implemented with some success and focuses on understanding the granularity of why patients are delayed in hospital and specific actions needed to resolve.
- Criteria led discharge continues to be rolled out across the organisation but is problematic. Differing levels of engagement from medical staff needs to be addressed as does clear criteria led discharge pathway development.
- Greetwell ward (Swing Ward) continues to set the pace for criteria discharge and demonstrates consistent discharges daily. .
- A series of MADE events have been scheduled through to Easter with System Partners. The 2nd event took place week commencing 6th January 2020. The 3 event is due to take place week commencing 10th February 2020.

ZERO WAITING - RTT 18 WEEKS INCOMPLETES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

RTT performance is currently below trajectory and standard.

December saw RTT performance of 82.75%, 0.77% worse than November.

Endocrinology (64.06%) is the lowest performing specialty, from 69.88% last month (-5.82%). Neurology, the previous lowest performing specialty, has improved again this month with a 5.17% increase from 73.21% last month to 78.38% in December.

The five specialties with the highest number of 18 week breaches at the end of the month were:

- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 962 (Increased by 32)
- Gastroenterology - 766 (Increased by 118)
- Ent - 699 (Reduced by 4)
- General Surgery - 596 (Reduced by 16)
- Dermatology - 362 (Reduced by 32)

Actions in place to recover:

Continued focus in both Neurology and ENT has kept performance improving into December. However, General Surgery have capacity issues, particularly with pelvic floor/urodynamic patients due to a lack of specialist consultants. As detailed above, performance in Gastroenterology and Oral Maxillo Facial continue to decline. Agreement with NUH is for a cohort of admitted Maxillo Facial patient to be outsourced. A date is to be confirmed but is anticipated to commence February 2020.

Unfortunately T&O did not achieve their projected target to have achieved the18 week standard by end of December 2019, with the validated position finishing at 89.89%. The non-admitted figure was 92.25%, however due to winter pressures, giving bed capacity to Medicine Division and the Trust being on level 4 status meant that the admitted position fell to 80.78%. The division are focussed on achieving 92% in February 2020.

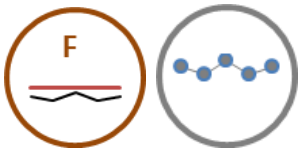
Following the IST recommendations from their visit to ULHT in November 2019, and subsequent report, an external team if validators commenced in the Trust on 4th February 2020. This will enable validation of the Data Quality exclusion pots, with the unconfirmed 52+ week pot being validated first.

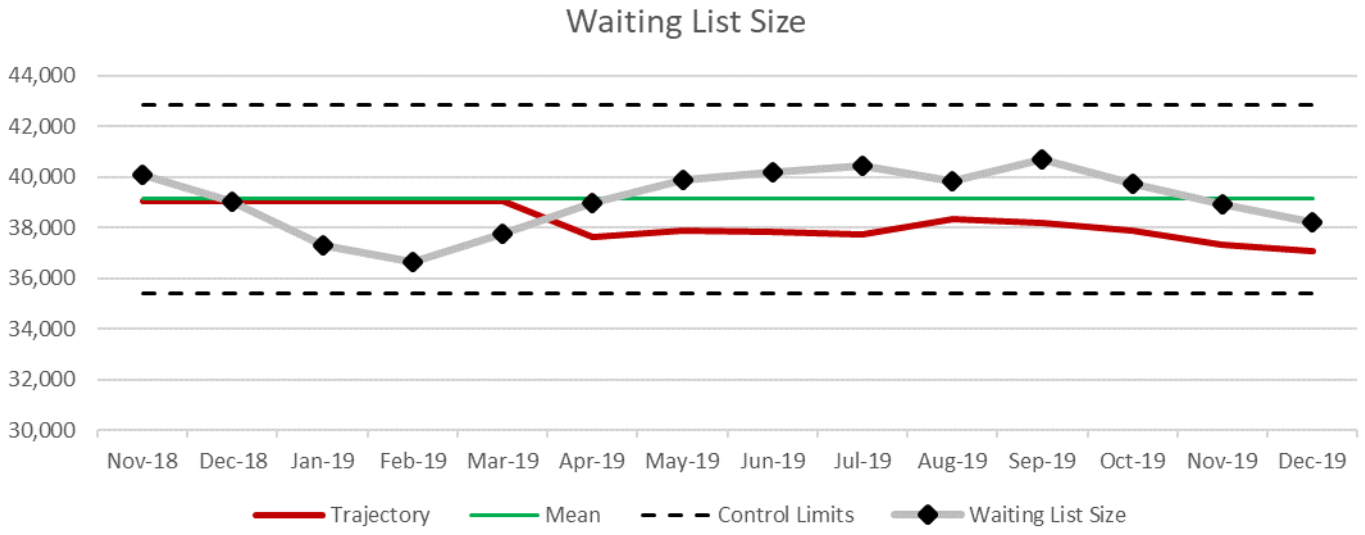
ZERO WAITING – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

December saw RTT performance of 82.75%, 0.77% worse than November.

Overall waiting list size has improved from November, with December total waiting list reducing by 703 to 38,219.The incompletes position for December is now approx. 813 less than it was in March 2018 (39,032).

The top five specialties showing an increase in total incomplete waiting list size from November are:

- Ophthalmology +241
- Gastroenterology +138
- Trauma & Orthopaedics +56
- ENT +48
- Rheumatology +28

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

- Neurology -277
- General Surgery -206
- Urology -161
- Dermatology -147
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery -123

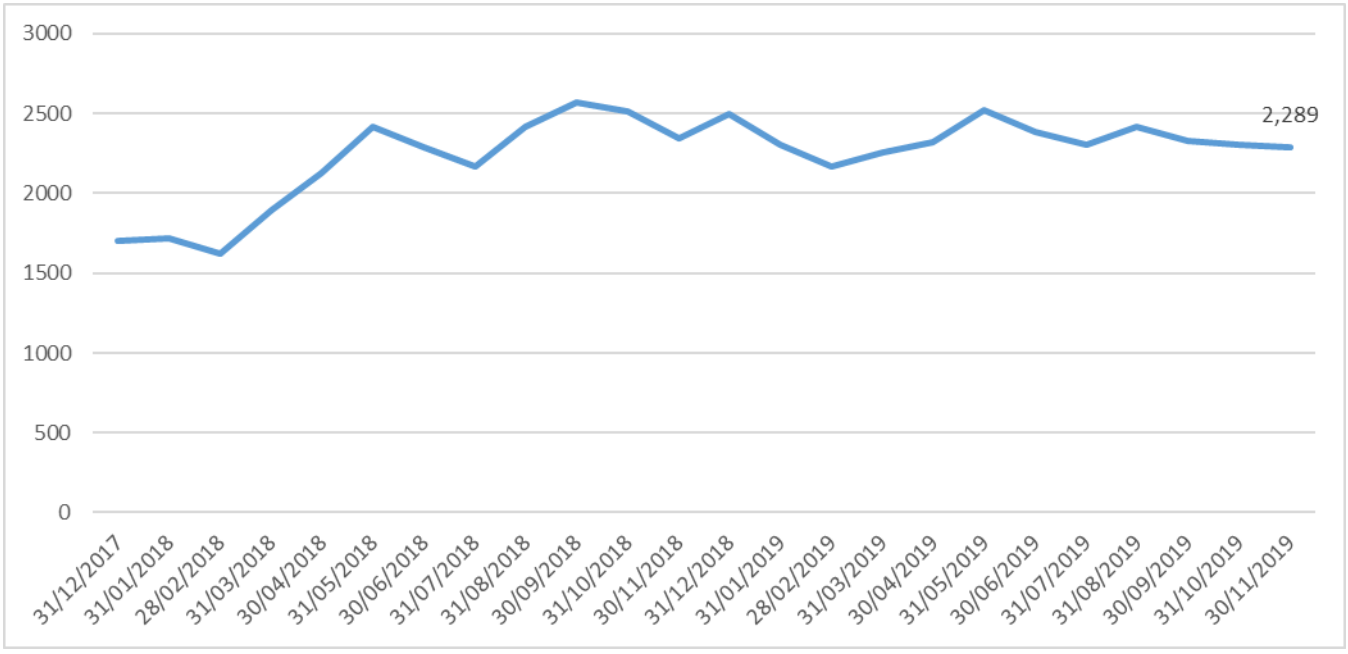
Actions in place to recover

Each service is continuing with their recovery plan, with focus on one of three main causes:

- Growth in referrals – with strategies to reduce this either internally through reduction in consultant to consultant, or external, working with CCG and the planned care improvement programme. This has approach proved very successful in Neurology.
- Mismatch of demand and capacity, or short term reduction in capacity through lack of workforce – with appropriate alternatives to attempting locums or existing models of staffing services which may have failed previously. For example the use of virtual clinics, nurse led clinics or non face to face and telephone clinics in key areas.
- Lack of appropriate validation and completion of administrative activities to remove from waiting list

- November to December saw an increase of patients waiting over 40 weeks, +79, with General Surgery (+22) showing the largest increase. Four specialties reduced their position compared to last month, with Rheumatology showing the best improvement of -2 patients from last month.
- The Trust are also working to reduce overall waiting times to 26 weeks. With monitoring/challenge of this target being tracked through the RTT Recovery and Delivery meeting.
  The chart below shows progress up to 31st December, with an increase of 210 patients from November. The largest increase was seen in Maxillo-Facial Surgery + Orthodontics + Oral Surgery, +59. The largest decrease of -61, being in Neurology.

Total Number of Incomplete Patient Pathways at 26 Weeks and Above for ULHT by Month

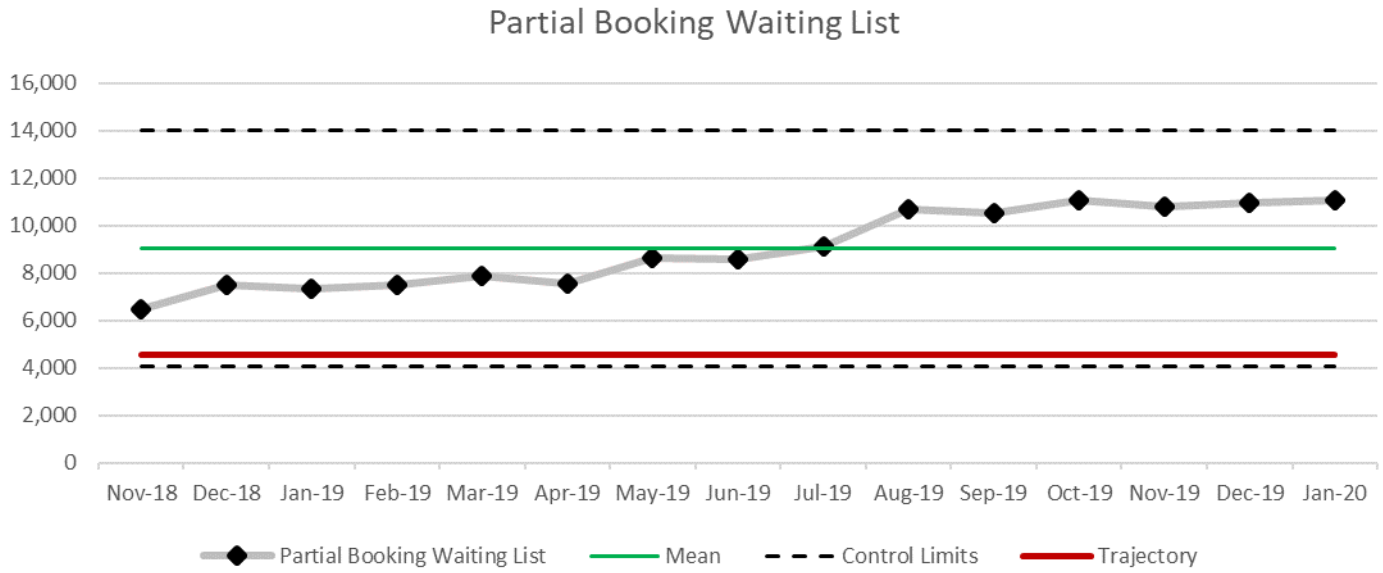


ZERO WAITING – PARTIAL BOOKING WAITING LIST

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes.

Ophthalmology have completed their review / validation of their waiting lists both administratively and clinically. Risk stratifying patients, discharging, removing, booking and leaving on the waiting list dependant on need.

The Trust is working with the CCG's with regards to the availability of funding to do further validation to the Trusts PBWL's.

The Outpatient management team is meeting regularly with the Divisions looking at ways to increase utilisation of core capacity without increasing cost.

Actions in place to recover:

The Trust is running 642 meetings to reduce cancellations with an increased level of authorisation. We are now using a different system to highlight slot utilisation and vacant slots to ensure we maximise slot capacity and discuss with the Clinical Business Units.

Outpatients will provide support for the Divisions to redesign, offering alternative patient pathways to reduce the number of patients on the PBWL. Clinical Forum took place for 5 specialities to review their services in partnership with the CCG's to look at alternative patient pathways to reduce the need for Outpatient clinical follow up appointments. The detail is currently being worked up to deliver the pathways and the subsequent improvements.

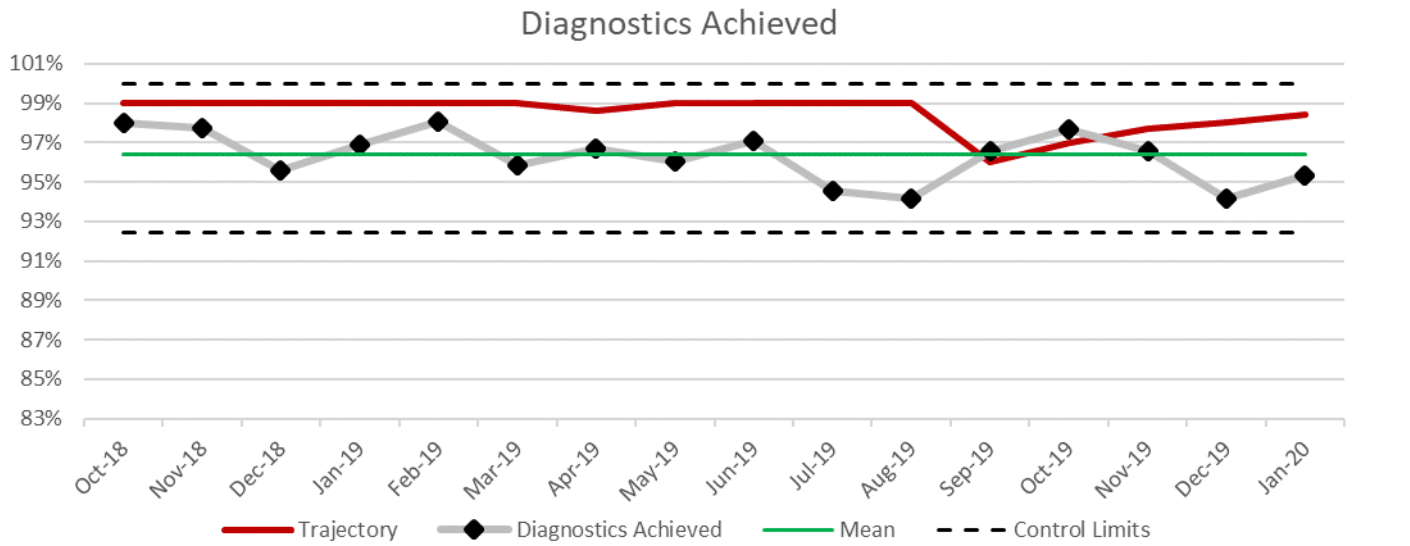
A further 2 specialities have been identified to follow a similar review process.

ZERO WAITING – DIAGNOSTICS ACHIEVED

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes:

January return
95.35%

- Cardiology. 41cardiac echoes and 30 cardiac TOES.
- Urology. 51 month end breaches over UIS and Endoscopy .
- Urodynamics 73 month end breaches.
- Neurophysiology. 75 month in breaches.

Actions in place to recover:

- Cardiology of predicting 0 cardiac echoes month end breaches for February, at the moment they are predicting 29 TOES. Cardiology have been asked to produce a recovery plan to be at 98% for February a 99% for January.

- Urology are looking to use CRIS as a booking system in the future this will allow for future forecasting of month end breaches. Additional clinics have been added to try and reduce the backlog, the backlog has been worked out by looking at the previous month end backlog growth and predicting with additional clinics 25 month end breaches for February.

- Urodynamics of forecasting 58 month then breaches for February. Additional capacity within gynaecology and urology has been asked for to support the service. the machine is currently broken and we are looking for an alternative machine or outsourcing capacity to deal with the backlog while we wait for the machine part to arrive.

- Neurophysiology of forecasting 0 month then breaches for February this is based on no machines breaking or staff sickness.

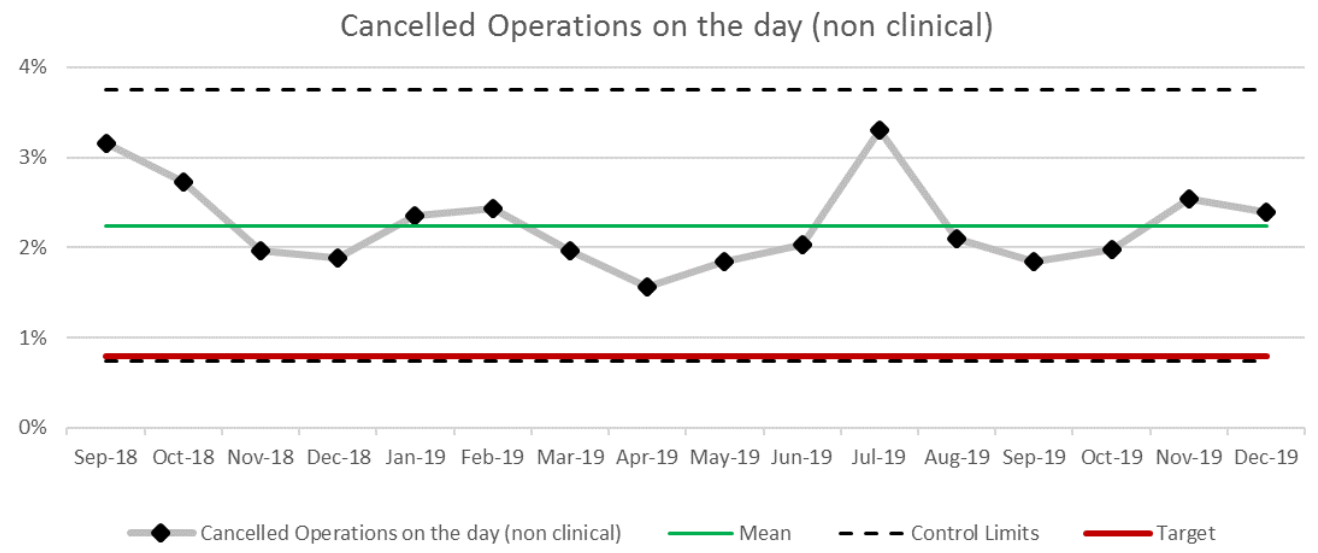
ZERO WAITING – CANCELLED OPS

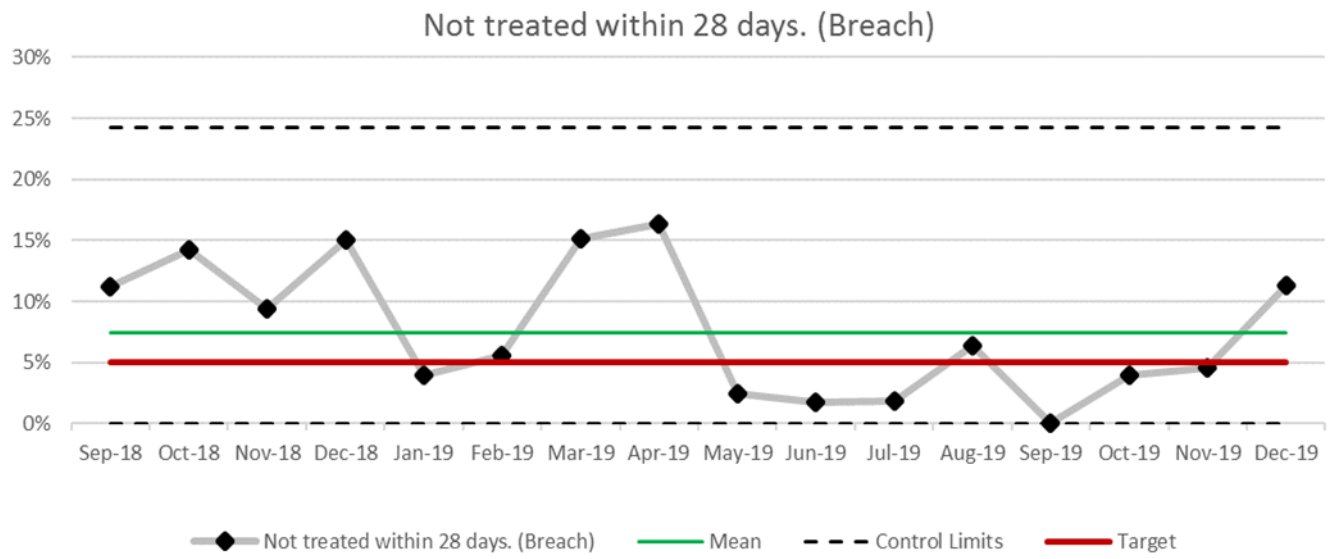
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services

January validated Cancelled Ops not received yet





Based Un-validated Cancelled Ops figures

Challenges/Successes

We are demonstrating a downward trend in cancellations on the day for non-clinical reasons, in January 2020 we achieved a 27% improvement compared to January 2019. The numbers of cancellations on the day for non-clinical reasons are at the lowest in January 2020 since April 2019.

The TACC Transformation Oversight Committee has reviewed work streams to support the reduction in cancelled operations for non-clinical reasons.

Work streams and objectives

Pre-operative assessment

- To standardise pre-operative processes and procedures across ULHT.
- To pre assess sufficient patients to meet waiting list targets.
- To increase numbers of same day pre assessments being completed.
- To ensure pre-operative assessments being completed based on clinical need.

Booking and Scheduling

- To centralise waiting list teams into the TACC CBU.
- To co-locate waiting list staff to work collaboratively.
- To streamline effective and efficient booking processes.
- To implement KPI's and proactively manage.
- To ensure all lists are fully booked.
- To implement pooled lists where appropriate.

Clinical Planning

- To review the 642 process and management.
- To ensure "golden patient" is consistently identified on each list daily.
- To reduce cross site movement of equipment / cost.

Workforce optimisation

- To ensure transparency of theatre start and finish times.
- To optimise flexible working arrangements across the trust.
- To ensure effective leadership is in place across the trust.

Issues

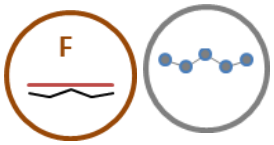
Improvement and sustainability of this metric is dependent on multiple factors, therefore the Trust Wide theatre services has been identified as an area for improvement via the Quality and Safety Programme of improvements. An ongoing challenge continues to be the high vacancy factors within our theatre departments as well as the pressure on bed availability.

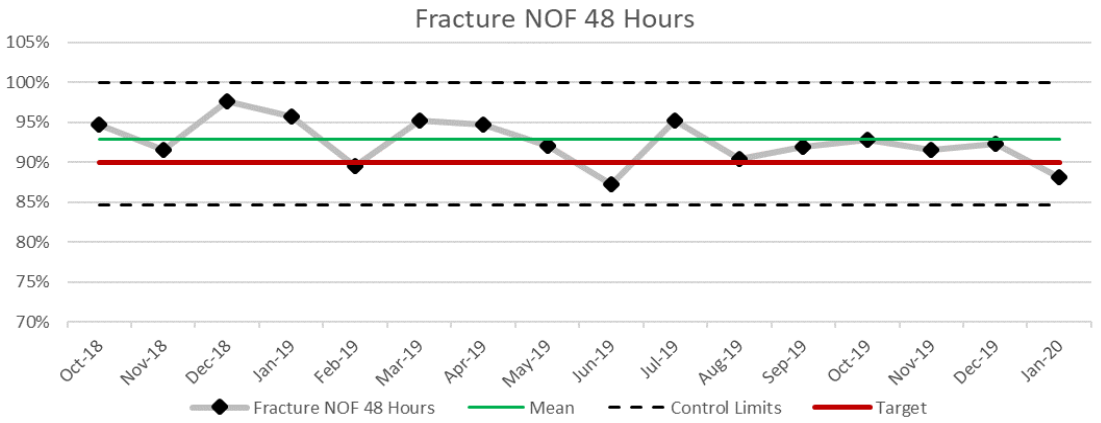
ZERO WAITING – FRACTURE NECK OF FEMUR BPT

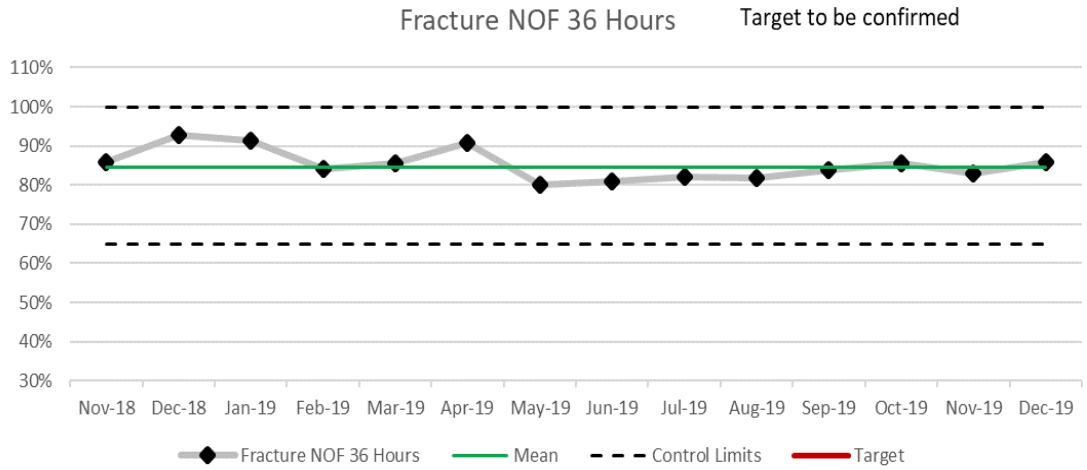
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services







Challenges/Successes

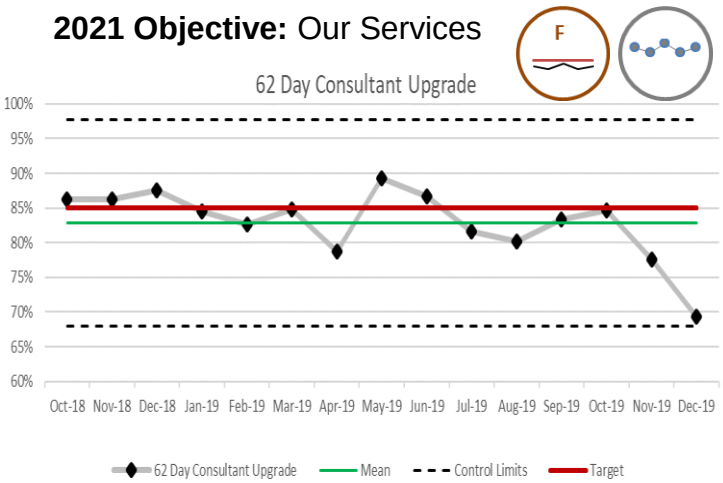
Actions in Place to Recover

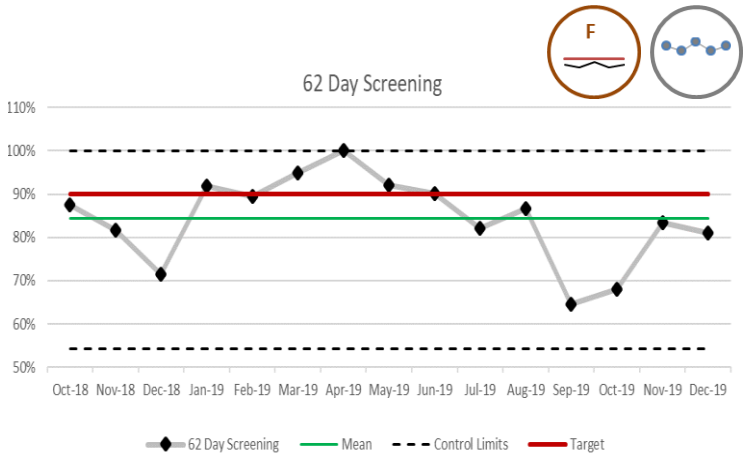
ZERO WAITING – CANCER 62 DAY

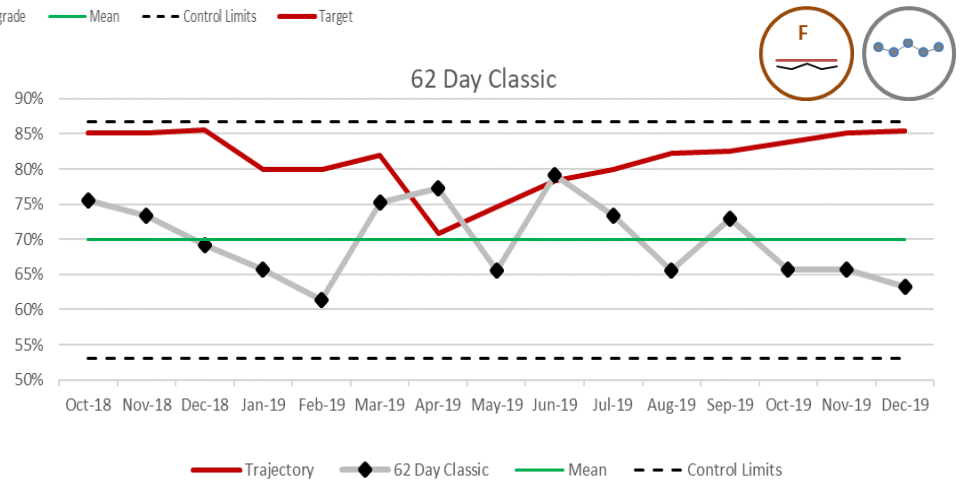
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services







Challenges/Successes

The 62 Day Classic standard under-performed against the trajectory of 86.6%, with only Gynaecology performing against their agreed trajectory.

Early indications are that our January 62 Day Classic performance will be similar to December's, with anticipated performance being circa 63% (trajectory 82.8%).

Actions in place to recover:

The Cancer Improvement team continue to move forward the high impact actions with the support of the Divisions and the STP.

The Trust forecast demonstrates a need to manage the 62 Day standard to ensure that we achieve the national standard and improve sustainability. In order to support this the high impact actions are being scoped to facilitate improvements across 5 speciality areas to improve 62 day performance and patient experience.

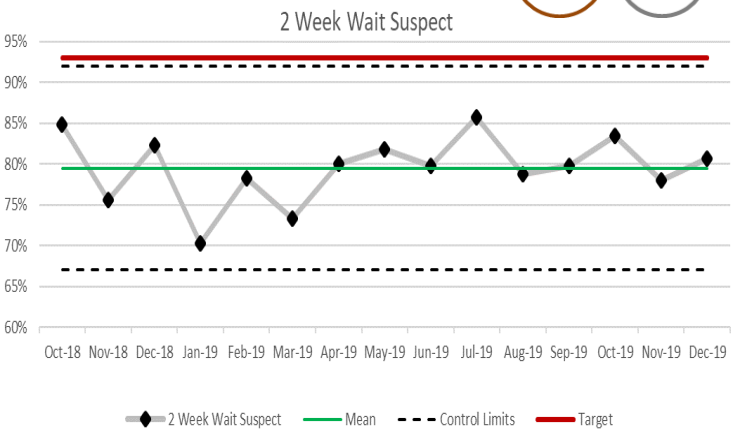
If delivery of all the actions were achieved, this would have the potential to typically improve the trust performance from circa 65% to approx. 78%, an improvement of 15%.

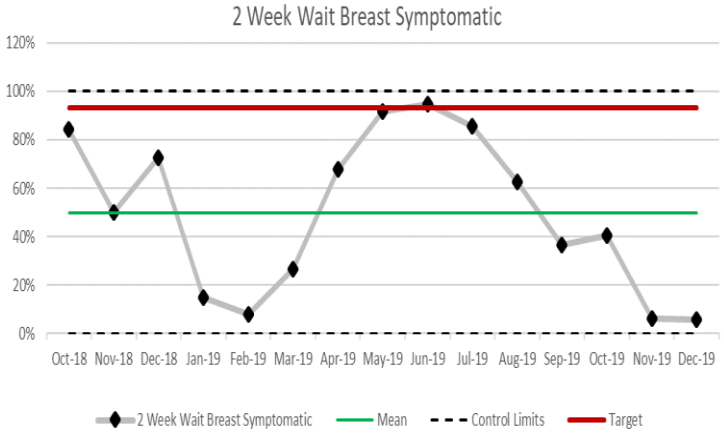
ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Six tumour sites met the 14 Day standard in December (Brain, Haematology, Lung, Sarcoma, Skin and Upper GI) and two narrowly missed (Gynaecology and Head & Neck)January's forecast tumour site performance is as below:

7 Day internal target = 80%	Total	< 7 Day Prfmnce %
Brain/CNS	16	68.8
Breast	293	1.4
Breast Symptomatic	164	0.6
Colorectal	447	30.2
Gynaecology	178	29.2
Haematology	24	62.5
Head & Neck	210	58.6
Lung	54	57.4
Sarcoma	15	73.3
Skin	341	84.2
Upper GI	177	39.0
Urology	297	48.2
Totals (excl Breast Sympto)	2052	42.9

Breast: Since August 2019 there have been substantial capacity issues for both Suspect and Symptomatic Breast patients, with a continually deteriorating position to date. This has resulted in nearly 94% of Symptomatic patients failing the 14 Day standard in December.

Actions in place to recover:

The Trust has set an internal target of 80% patents to be seen within 7 days of GP referral. As an organisation, from January 2020, we will continue to report the 14 Day performance externally however internally we will only be using the 7 Day performance as the measured metric to support us in preparation to deliver the 28 Day Faster Diagnosis Standard from April 2020. All tumour sites, excluding Gynaecology, have committed to deliver this standard.

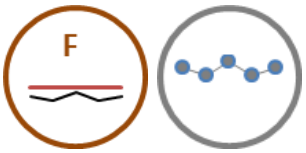
For the Breast Service, a high level pan-Division capacity review meeting is scheduled and weekly operational planning meetings are in place. The Trust's Clinical Service Review process is underway in the breast service (concludes mid-March) looking at service efficiency and models of care. The expectation was that all patients were to be booked within 14 days by beginning of February, with this position sustained going forward, but has proven challenging to accomplish, critical issue being the loss of one locum consultant Breast Radiologist and a second locum potentially at risk.

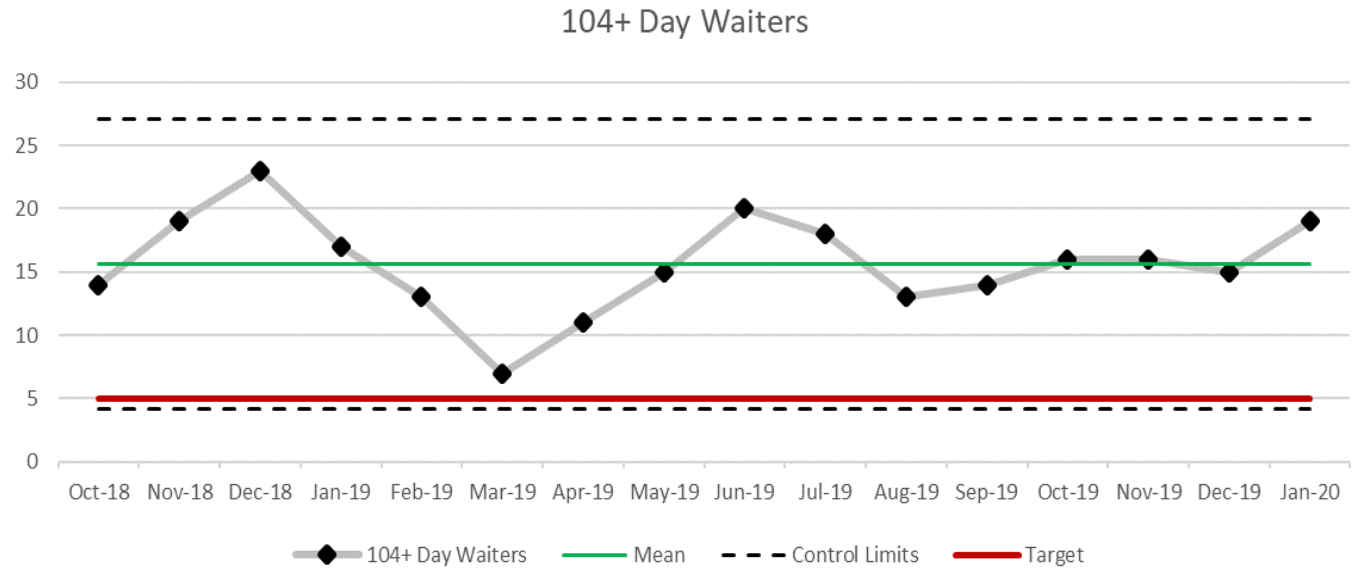
ZERO WAITING – 104+ DAY WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

The 104+ Day backlog having risen, due to an increase in backlog figures, has stabilised at 18 patients. This is above the target of 10 patients and maintaining this level against a background of high backlog numbers will be challenging.

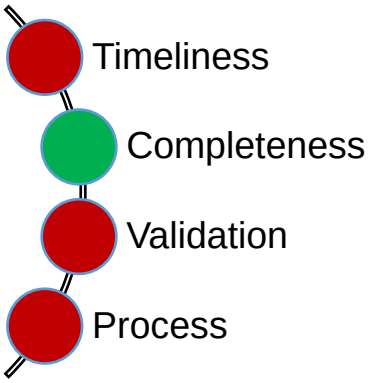
Actions in place to recover:

Focus is being placed on reducing the 62+ Day backlog and thereby minimise the numbers approaching the 104 day mark.

A daily report is issued to the Divisions, highlighting the volumes in their areas with the report allowing immediate drill-down to patient-level detail. The 104+ patients are first to be discussed during the twice weekly Trust-wide Cancer Call, chaired by the CSS Divisional Managing Director.

APPENDIX A – KITEMARK

Reviewed:
1st April 2018
Data available at: Specialty level



Domain	Sufficient	Insufficient
Timeliness	Where data is available daily for an indicator, up-to-date data can be produced, reviewed and reported upon the next day. Where data is only available monthly, up-to-date data can be produced, reviewed and reported upon within one month. Where the data is only available quarterly, up-to-date data can be produced, reviewed and reported upon within three months.	Where data is available daily for an indicator, there is a data lag of more than one day. Where data is only available monthly, there is a data lag of more than one month. Where data is only available quarterly, there is a data lag of more than one quarter.
Completeness	Fewer than 3% blank or invalid fields in expected data set. This standard applies unless a different standard is explicitly stated for a KPI within commissioner contracts or through national requirements.	More than 3% blank or invalid fields in expected data set
Validation	The Trust has agreed upon procedures in place for the validation of data for the KPI. A sufficient amount of the data, proportionate to the risk, has been validated to ensure data is: - Accurate - In compliance with relevant rules and definitions for the KPI	Either: - No validation has taken place; or - An insufficient amount of data has been validated as determined by the KPI owner, or - Validation has found that the KPI is not accurate or does not comply with relevant rules and definitions
Process	There is a documented process to detail the following core information: - The numerator and denominator of the indicator - The process for data capture - The process for validation and data cleansing - Performance monitoring	There is no documented process. The process is fragmented/inconsistent across the services

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Medical Director
Date:	March 2020

Title:	**Strategic Risk Report**

Responsible Director: Dr Neill Hepburn, Medical Director

Author: Paul White, Risk Manager

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

- Review the management of corporate risks within the Trust and the extent of risk exposure at this time
- Evaluate the effectiveness of the Trust's risk management processes

The Report is provided to the Committee for:

Decision		Discussion	✓
Assurance		Information	✓

Summary/Key Points:

- 39 out of 78 strategic risks recorded on Datix are currently rated as Very high or High (50% of the total; up from 46% last month)
- The highest rated strategic risks remain the same as reported in previous months: financial sustainability; workforce capacity, capability and morale; emergency demand; and the vulnerability of aseptic pharmacy services
- The risks of an outbreak of infectious disease (due to coronavirus); and non-compliance with patient safety regulations (due to the number of Never Events) have increased this month
- A new High risk in relation to safe management of emergency demand has been added
- Of the 192 risks recorded on divisional business unit risk registers, 56 (28%) are currently rated as Very high or High
- 2 operational risks are rated Very high (20) - Diagnostics CBU due to the age and condition of a substantial amount of diagnostic equipment; Specialty Medicine CBU due to the potential for delayed commencement of Non-Invasive Ventilation (NIV)

Recommendations
That the Trust Board considers the content of the report and advises if any further action is required.

Strategic Risk Register Significant strategic risks to Trust objectives are referenced within the Board Assurance Framework (BAF).	**Performance KPIs year to date** Performance in reviewing risks in accordance with the Risk Management Policy is reported regularly to the Audit Committee.
Assurance Implications This report enables the Trust Board to review the effectiveness of risk management processes so that it can be assured regarding current risk control strategies and the extent of risk exposure at this time.	
Patient and Public Involvement (PPI) Implications The effectiveness of the Trust's risk and corporate governance arrangements is reported through the Annual Governance Statement (AGS) and is included in the opinion of both internal and external audit. As such, it may influence the degree of confidence that patients and members of the public have in the Trust.	
Equality Impact The Trust's Risk Management Policy has been assessed for equality impact and no issues were identified.	
Information exempt from Disclosure – No	
Requirement for further review? No	

1. Purpose of the Report

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

- Review the management of corporate risks within the Trust and the extent of risk exposure at this time
- Evaluate the effectiveness of the Trust's risk management processes

2. Recommendations

2.1 That the Trust Board considers the content of the report and advises if any further action is required.

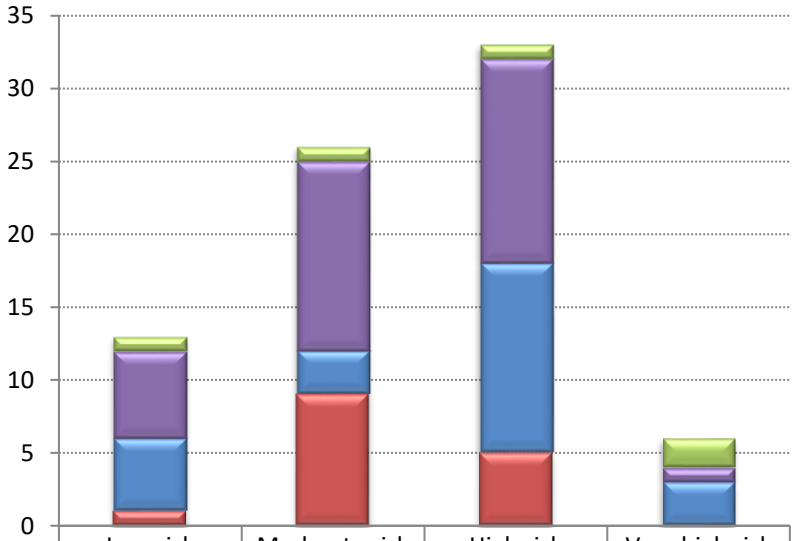
3. Reasons for Recommendations

3.1 The Trust Board has overall accountability for the management of risk within the organisation.

4. Summary of Key Points

Strategic Risk Profile

4.1 **Chart 1** shows the number of strategic risks by risk type and current (residual) risk rating:



	Low risk	Moderate risk	High risk	Very high risk
Finances	1	1	1	2
Reputation / compliance	6	13	14	1
Service disruption	5	3	13	3
Harm (physical or psychological)	1	9	5	0

4.2 **Table 1** shows a summary of the full Strategic Risk Register:

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4382	Delivery of the Financial Recovery Programme	Corporate	Finances	20	Very high risk
4383	Substantial unplanned expenditure or financial penalties	Corporate	Finances	20	Very high risk
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Clinical Support Services	Service disruption	20	Very high risk
4083	Workforce engagement, morale & productivity	Corporate	Reputation / compliance	20	Very high risk
4362	Workforce capacity & capability (recruitment, retention & skills)	Corporate	Service disruption	20	Very high risk
4175	Capacity to manage emergency demand	Medicine	Service disruption	20	Very high risk
4480	Safe management of emergency demand	Medicine	Harm (physical or psychological)	16	High risk
3688	Quality of the hospital environment	Corporate	Reputation / compliance	16	High risk
3520	Compliance with fire safety regulations & standards	Corporate	Reputation / compliance	16	High risk
3951	Compliance with regulations & standards for aseptic pharmacy services	Clinical Support Services	Reputation / compliance	16	High risk
4156	Safe management of medicines	Clinical Support Services	Harm (physical or psychological)	16	High risk
4384	Substantial unplanned income reduction or missed opportunities	Corporate	Finances	16	High risk
3690	Compliance with water safety regulations & standards	Corporate	Reputation / compliance	16	High risk
4437	Critical failure of the water supply	Corporate	Service disruption	16	High risk
4044	Compliance with information governance regulations & standards	Corporate	Reputation / compliance	16	High risk
4144	Uncontrolled outbreak of serious infectious disease	Corporate	Service disruption	16	High risk
4480	Safe management of emergency demand	Medicine	Harm (physical or psychological)	16	High risk
4497	Contamination of aseptic products	Clinical Support Services	Harm (physical or psychological)	15	High risk
4043	Compliance with patient safety regulations & standards	Corporate	Reputation / compliance	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
3689	Compliance with asbestos management regulations & standards	Corporate	Reputation / compliance	12	High risk
3720	Critical failure of the electrical infrastructure	Corporate	Service disruption	12	High risk
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Family Health	Service disruption	12	High risk
3722	Energy performance and sustainability	Corporate	Finances	12	High risk
4081	Quality of patient experience	Corporate	Reputation / compliance	12	High risk
4082	Workforce planning process	Corporate	Service disruption	12	High risk
4142	Safe delivery of patient care	Corporate	Harm (physical or psychological)	12	High risk
4145	Compliance with safeguarding regulations & standards	Corporate	Reputation / compliance	12	High risk
4146	Effectiveness of safeguarding practice	Corporate	Harm (physical or psychological)	12	High risk
4157	Compliance with medicines management regulations & standards	Clinical Support Services	Reputation / compliance	12	High risk
4176	Management of demand for planned care	Corporate	Service disruption	12	High risk
4300	Availability of medical devices & equipment	Corporate	Service disruption	12	High risk
4179	Major cyber security attack	Corporate	Service disruption	12	High risk
4385	Compliance with financial regulations, standards & contractual obligations	Corporate	Reputation / compliance	12	High risk
4368	Management of demand for outpatient appointments	Clinical Support Services	Service disruption	12	High risk
4481	Availability of patient information	Clinical Support Services	Service disruption	12	High risk
4406	Critical failure of the medicines supply chain	Clinical Support Services	Service disruption	12	High risk
4423	Working in partnership with the wider system	Corporate	Service disruption	12	High risk
4476	Compliance with clinical effectiveness regulations & standards	Corporate	Reputation / compliance	12	High risk
4467	Impact of a 'no deal' EU Exit scenario	Corporate	Service disruption	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4177	Critical ICT infrastructure failure	Corporate	Service disruption	8	Moderate risk
4182	Compliance with ICT regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4363	Compliance with HR regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4180	Reduction in data quality	Corporate	Reputation / compliance	8	Moderate risk
4181	Significant breach of confidentiality	Corporate	Reputation / compliance	8	Moderate risk
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Corporate	Reputation / compliance	8	Moderate risk
4352	Public consultation & engagement	Corporate	Reputation / compliance	8	Moderate risk
4353	Safe use of medical devices & equipment	Corporate	Harm (physical or psychological)	8	Moderate risk
4138	Patient mortality rates	Corporate	Reputation / compliance	8	Moderate risk
4141	Compliance with infection prevention & control regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4003	Major security incident	Corporate	Harm (physical or psychological)	8	Moderate risk
3687	Delivery of an Estates Strategy aligned to clinical services	Corporate	Service disruption	8	Moderate risk
3721	Critical failure of the mechanical infrastructure	Corporate	Service disruption	8	Moderate risk
4389	Compliance with corporate governance regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos	Corporate	Harm (physical or psychological)	8	Moderate risk
4398	Compliance with environmental and energy management regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4399	Compliance with health & safety regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4400	Safety of working practices	Corporate	Harm (physical or psychological)	8	Moderate risk
4401	Safety of the hospital environment	Corporate	Harm (physical or psychological)	8	Moderate risk
4402	Compliance with regulations and standards for mechanical infrastructure	Corporate	Reputation / compliance	8	Moderate risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4403	Compliance with electrical safety regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4404	Major fire safety incident	Corporate	Harm (physical or psychological)	8	Moderate risk
4528	Minor fire safety incident	Corporate	Harm (physical or psychological)	8	Moderate risk
4424	Delivery of planned improvements to quality & safety of patient care	Corporate	Reputation / compliance	8	Moderate risk
4483	Safe use of radiation	Clinical Support Services	Harm (physical or psychological)	8	Moderate risk
4486	Clinical outcomes for patients	Corporate	Harm (physical or psychological)	8	Moderate risk
4502	Compliance with regulations & standards for medical device management	Corporate	Reputation / compliance	8	Moderate risk
4526	Internal corporate communications	Corporate	Reputation / compliance	8	Moderate risk
4514	Hospital @ Night management	Corporate	Service disruption	4	Low risk
4469	Compliance with blood safety & quality regulations & standards	Clinical Support Services	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products	Clinical Support Services	Harm (physical or psychological)	4	Low risk
4438	Severe weather or climatic event	Corporate	Service disruption	4	Low risk
4439	Industrial action	Corporate	Service disruption	4	Low risk
4440	Compliance with emergency planning regulations & standards	Corporate	Reputation / compliance	4	Low risk
4441	Compliance with radiation protection regulations & standards	Clinical Support Services	Reputation / compliance	4	Low risk
4386	Critical failure of a contracted service	Corporate	Service disruption	4	Low risk
4387	Critical supply chain failure	Corporate	Service disruption	4	Low risk
4388	Compliance with procurement regulations & standards	Corporate	Reputation / compliance	4	Low risk
4277	Adverse media or social media coverage	Corporate	Reputation / compliance	4	Low risk
4061	Financial loss due to fraud	Corporate	Finances	4	Low risk

4.3 39 out of 78 strategic risks recorded on Datix are currently rated as Very high or High (50% of the total).

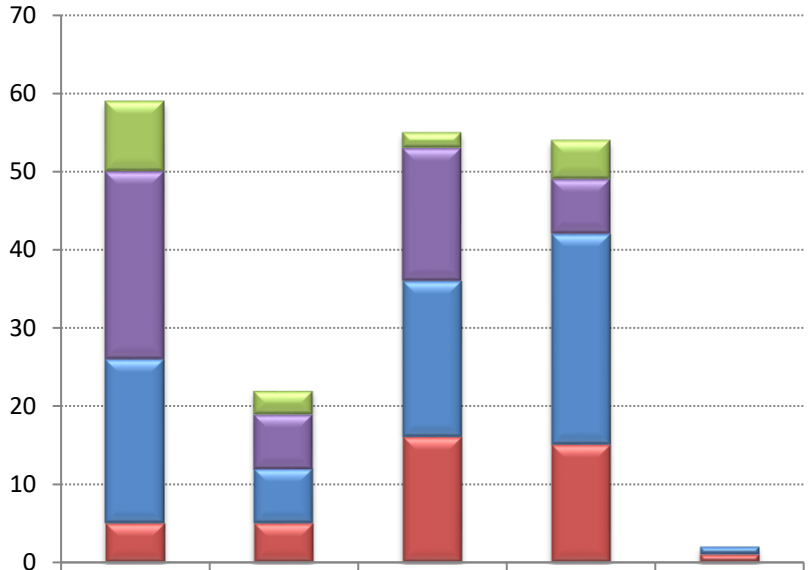
4.4 Since the last report (February 2020) there has been no change to any of the 6 Very high risks on the Strategic Risk Register. The following changes have been made to High risks:

- The risk of an outbreak of infectious disease has been increased from Moderate (8) to High (16) due to the threat from coronavirus; the Trust is following national and regional guidance
- The patient harm risk in relation to levels of emergency demand has been added as a new strategic risk, due to patient safety concerns regarding overcrowding in A&E at Lincoln County and Pilgrim hospitals; further analysis of this risk is required to understand other associated aspects of patient safety
- The risk concerning patient safety standards and regulations has increased from Moderate (8) to High (12) due to the number of Never Events the Trust has declared so far this financial year
- Risks associated with management of the Partial Booking Waiting list (PBWL) have been raised, with specific concerns already identified in Ophthalmology; ENT; and Oral/Maxillo-facial; further analysis is required this month to evaluate these risks and update the risk register accordingly

4.5 A report showing details of all risks recorded on the Strategic Risk Register with a current (residual) risk rating of High or Very high (a score of 12 or more) along with planned mitigating actions is included as **Appendix I**.

Operational Risk Profile

4.6 **Chart 2** shows the number of operational (divisional business unit) risks by current (residual) risk rating:



	Very low risk	Low risk	Moderate risk	High risk	Very high risk
Finances	9	3	2	5	0
Reputation / compliance	24	7	17	7	0
Service disruption	21	7	20	27	1
Harm (physical or psychological)	5	5	16	15	1

4.7 Of the 192 risks recorded on divisional business unit risk registers, 56 (28%) are currently rated as Very high or High. 2 operational risks are rated Very high (20):

- Diagnostics CBU due to the age and condition of a substantial amount of diagnostic equipment;
- Specialty Medicine CBU due to the potential for delayed commencement of Non-Invasive Ventilation (NIV)

4.8 A summary of those operational risks with a current rating of Very high or High risk is included as **Appendix II**.

Risk management process

4.9 Each strategic risk has an Executive lead, with overall responsibility for its management; and a Risk lead responsible for reviewing and updating the risk register. The majority are also assigned to a lead group for regular scrutiny. All are aligned with the appropriate assurance committee of the Trust Board.

4.10 Risks are defined according to the type of consequence that would be experienced should they materialise, with a severity scale of 1 to 5 using the following definitions:

- Harm (physical or psychological) – this may be to patients (as a result of issues with care); to members of staff, or to visitors (arising from health & safety issues) and covers a range from minor injuries through to multiple fatalities

- Service disruption – which ranges from the implementation of local business continuity plans up to critical and major incidents
- Reputation / compliance – which covers the potential for individual complaints up to a fundamental loss of confidence amongst commissioners; regulators; and the government (many risks of this nature relate to compliance with national standards, regulations and contractual obligations)
- Finances – which is based on the budgetary impact, from minimal cost increases to jeopardising financial sustainability

4.11 The Risk Scoring Guide, which is used to assess all risks recorded on the Trust's strategic and operational risk registers, is attached for reference as **Appendix III**.

4.12 Operational risk registers are also in place for every Clinical Business Unit (CBU) and corporate department. A flow chart summarising the risk management process is attached as **Appendix IV**.

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
Executive lead: Evans, Simon												
4175	**Capacity to manage emergency demand** If the volume of emergency demand significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.	ULHT operational demand management policies & procedures. Operational performance management framework & regular reporting / monitoring at divisional and corporate levels. Monthly performance report to Trust Board. Urgent and Emergency Care Board (UECB) delivery plan. Lincolnshire Sustainability & Transformation Partnership (STP) and Plan. Horizon scanning processes.	20	Finance, Performance & Estates Committee		8	• Comprehensive and effective triage • Improve time to RAT • Reduce ambulance handover delay • Improve time to 1st assessment • Effective GP Streaming • Improve non-admitted pathway compliance • Delivery of an ambulatory care model • Implementation of frailty model • Reconfiguration • Redesign the site management and bed meeting model • SAFER implementation • Effective discharge by 10:00 • Reduce number of stranded and super stranded patients • Implementation of Red to Green • Implementation of Full Capacity Protocol (FCP) • Implementation of criteria led discharge • Rapid handover Protocol	Operations	High risk (12-16)	Continued interrogation against workstream progress through the urgent and emergency care workstream (ULHT). Continued scrutiny of delivery against agreed actions against all 7 workstreams (now including hospital at night). A completely revised approach to winter planning and system resilience needs to be commissioned to be undertaken including governance and assurance against delivery. Revise scope, internal professional standards and SOP for capacity meetings Capacity meeting template designed to be action and performance related Written and revised clinical operational flow policy Escalation levels reviewed and aligned to OPAL levels Individual role- based action cards revised and clear expectation set on actions at each escalation level Review of outlier SOP	31/03/2020	*The UEC improvement programme has undertaken an internal review of process, key stakeholders and original milestones where off track clear rectification plans are now in place *Recovery and rectification is led by the UEC improvement programme lead (Sarah Hall) *A system wide resilience review has also been commissioned and completed *System Resilience Group (SRG) is the vehicle by which assurance will be given for example the 13 government funded schemes for LCC *Partnership working with the system and a more intuitive winter plan (ULHT) will support a more proactive response and delivery to system need *The system has matured over the last 12 months and confidence exists to challenge each part of our system *The risk remains as highlighted to Trust Board (ULHT) and UCB that the volume of emergency demand continues to pose a significant threat to delivery *Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super stranded patients *Further mitigation exists within the Lincoln site reconfiguration to minimise the impact of the projected circa -120 bed deficit trust wide
4480	**Safe management of emergency demand** If the Trust is unable to safely manage demand for emergency care; Caused by fundamental issues with the design or application of patient pathways, the availability of sufficient staffing capacity, inadequate medical equipment or lack of clinical space; It could result in incidents of significant harm affecting multiple patients.	Emergency Department patient pathway management processes, performance information and management framework. Medicine Division Clinical Cabinet & CBU / specialty governance arrangements. ED clinical policies, procedures, guidelines, pathways & supporting documentation. Clinical governance arrangements at corporate level - Quality & Safety Oversight Group (QSOG) / Patient Safety Group (PSG). Trust Board / Quality Governance Committee strategic oversight. Urgent & Emergency Care CBU staff recruitment, induction, mandatory training, registration & re-validation processes. Risk & incident management policies & procedures / Datix system. Quality & safety improvement planning process & plans. Defined safe staffing levels. Ward accreditation programme & data monitoring / review processes.	16	Quality Governance Committee		4	Combination of capacity issues, lack of ward bed availability and demand levels at Lincoln ED can create over-crowding which increases the likelihood of significant patient harm.	Accident & Emergency	High risk (12-16)	LCH reconfiguration project. Emergency medical floor plan to be developed for ED.	31/03/2021	
							Space and layout within ED at PHB is not adequate to meet the level of demand, which can result in over-crowding that increases the likelihood of significant patient harm.	Accident & Emergency	High risk (12-16)	Review & redevelopment of PHB Emergency Department (Govt funding identified).	31/03/2021	
3520	**Compliance with fire safety regulations & standards** If the Trust is found to be systemically non-compliant with fire safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Fire Safety Group. Fire Policy. Estates risk governance & compliance monitoring process. Health & Safety Committee & site-based H&S committees. Personal Emergency Evacuation Plans (PEEPs). Incident reporting and investigation proces & system (Datix). Planned Preventative Maintenance (PPM) / testing. Fire Risk Assessments. Fire safety training (Core Learning, annual) Capital investment planning & implementation processes.	16	Finance, Performance & Estates Committee	Fire Safety Group	4	The Fire Alarm System at LCH requires additional new work to ensure continued compliance with current standards. The Maternity Wing has a partially compliant alarm system in need of upgrading to current standards (Any works to the Fire alarm system within the Maternity Wing are constrained by the presence of asbestos. This applies to maintenance works and any upgrade works). Detection Zones plans are also referenced as a reason for the inadequate Fire Detection System under Article 13(1) (a) & 13 (2) of the Fire Enforcement noticed served 14th June 2017. Following the installation of the additional fire compartmentation within the east wing roof voids and corridors a review of the fire alarm system is required to ensure compliance.	Estates	High risk (12-16)	The Fire Alarm System at LCH is maintained by a specialist contractor and directly employed labour force. The system in some areas has been upgraded as part of services developments e.g. HDU & ICU and as part of previously funded upgrade. Programme of refurbishment and re-provision on a phased basis to install a 'loop' for the site and linking in modern equipment is underway.	31/03/2020	Phases 1, 2 and 3 complete. Phases 4 is underway and as part of these works; and to improve auditability and compliance with DDA, additional sounders and beakers are being installed. Phase 5 (Mat Wing) The Fire Alarm systems on 1st and 6th floor have been replaced, works are currently on-going to replace the Fire Alarm system within all lift lobby areas and within the 3rd floor ward area.

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
							Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection of patient and staff areas in accordance with statutory standards. See Fire Strategy surveys for areas affected. As referenced under article 8 in the Fire Enforcement Notices. Numerous sets of fire doors in poor condition due to wear and tear and damage where the fire resisting qualities have been reduced or negated.	Estates	High risk (12-16)	Fire Strategy Plans and surveys identify where compartmentation is required. Fire compartmentation works costs are detailed within the capital plan. Fire Doors will be addressed as part of the Fire Action Plan from the enforcement notices received for Lincoln and Pilgrim. Fire Doors requiring replacement to be replaced with new certified fire doors. PPM inspections and ad hoc repairs to fire doors in response to serious damage, etc.	31/03/2020	The work packages for the remedial works are taking place subject to availability of sufficient capital funding.
							Adherence to fire safety policy, procedures, strategic approach to active and passive fire safety measures and evacuation strategy. Adherence to Fire Safety training arrangements which include recording, analysis of training needs, personal development systems in place for all staff inclusive of permanent, temporary, agency and or bank staff. 1. Staff failing to attend Fire Safety Training in accordance with policy, procedures and Training needs analysis. 2. No testing of emergency procedures via evacuation drills. 3. Fire safety training to be provided in accordance with role, seniority or professional discipline within the fire emergency plan. 4. Undertaking and Recording of Personal Emergency Evacuation Plans for Less able bodied and disabled staff. 5. Staff being allowed to continue within role against HTM guidance that states: 'should not be permitted to continue their duties with a gap in their record of training longer than twice the interval identified in the training needs analysis' which is two years within ULH. 6. Non identification of staff by managers to attend core modules when undertaking annual PDR.	Estates	High risk (12-16)	Specific actions in relation to fire safety training & evacuation: 1. staff identified and managers informed to ensure staff attend 2. Evacuation drills to be implemented and tested. 3. New Fire safety training packages being introduced. 4. persons requiring PEEP and procedures tested during evacuation drills. 5. discussions with HR to identify an appropriate procedure to identify and inform staff outside of compliance dates, with managers cc into correspondence to ensure urgent attendance. 6. Fire safety trainer to discuss with ESR team about information required for PDR and H & S team for reporting against core modules to ensure compliance.	31/03/2020	New mandatory staff fire safety awareness module introduced.
3688	**Quality of the hospital environment** If the Trust is unable to maintain a hospital environment and facilities that meet the expectations of patients, staff and visitors and the requirements of services across all of its sites; Caused by the condition of the estate and facilities and issues with maintenance and development; It could result in widespread dissatisfaction which leads to significant, long term damage to the reputation of the Trust and may lead to commissioner or regulatory intervention.	Estates Infrastructure and Environment Committee (EIEC). Patient Experience Committee. NHS Premises Assurance Model (PAM) Patient-led Assessment of the Care Environment (PLACE) survey & response plans. Robust defect reporting system which prioritises critical issues within available resources. Cleanliness audit system that integrates with the Estates helpdesk. Estates capital investment process and programme.	16	Finance, Performance & Estates Committee	Patient Environment Group	8	Reduced standards if painting & decorating of clinical areas on all sites are not completed. (Identified through PLACE annual inspection).	Estates	High risk (12-16)	Require a programme to improve standard of hospital environments, via painting & decorating of clinical areas.	31/03/2020	Funding and resource to be allocated.
							Floor Coverings across the Trust - Many areas are 45 years old, looks tired and is damaged in areas. Frequently fails environment and PLACE audits. Sub Floor is also damaged in some cases. High risk areas include Maternity at Lincoln, Tower Block at Grantham, Theatre Corridors at Pilgrim.	Estates	High risk (12-16)	Ad hoc repairs to flooring carried out across the Trust. Funding required for comprehensive programme.	31/03/2020	
							LCH & GDH: Lack of resources to carry out external decoration. High level areas in the East Wing are difficult and costly to access due to requirement to erect scaffolding. Deterioration of paint finish to wooden windows and door fascias and soffits leaving timber exposed to weather. Will lead to deterioration of timber window frames and their failure with associated costs. Physical appearance very poor. Fails annually on PLACE scores.	Estates	Moderate risk (8-10)	Repairs to external decoration at LCH & GDH undertaken based on available labour, accessibility. Monitor the situation and carry out ad hoc repairs where situation dictates. Funding required for a rolling programme of external decoration, window replacement and facias.	31/03/2020	
							LCH: Patient bed space curtain track systems within patient areas are obsolete; sufficient hooks to hang the curtains satisfactorily are not available; not all curtain tracking is ligature safe; inadequately hung curtains can affect patient dignity as reported on PLACE.	Estates	Moderate risk (8-10)	Existing curtain hooks at LCH are "spaced out" to increased distances to allow curtains to hang. Funding required to replace the obsolete curtain rail systems.	31/03/2020	
3690	**Compliance with water safety regulations & standards** If the Trust is found to be systemically non-compliant with water safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Trust Water Safety Group. Oversight by Infection Prevention & Control Committee (monthly report submitted by the AE). Water safety policies, procedures & training. Duty Holder, Responsible person, Site Deputy responsible persons and competent persons in place. Appointed Authorising Engineer (Water). Chlorine Dioxide Injection water treatment. Planned maintenance regime in place including	16	Finance, Performance & Estates Committee	Water Safety Group	4	Unable to comply fully with ACOP and Trust Policies for legionella monitoring due to competing priorities.	Estates	Moderate risk (8-10)	Appoint additional staff or contractor in lieu of staff to carry out work. Further actions required (subject to funding): water systems drawings are required for all sites (CAD); review and issue a Trustwide tender document for the monitoring work; to appoint a responsible person; to form a Trustwide Legionella group to consist of Facilities, Infection Prevention and Control Consultant and Nurses (sub group of Infection Prevention and Control Committee?)	31/03/2020	Legionella monitoring carried out by direct labour as far as possible with competing priorities.

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
		written scheme of works. Site based Risk Assessments informing the Water Safety Group Management process. Water sampling, temperature monitoring and flushing undertaken; remedial actions taken in response to positive samples.					13 waste disposal units do not incorporate a 'Type A Air Gap' on the water supply inlet and therefore as they are classed as 'CAT 5 Fluid' they do not comply with the 'Water Regulations' which is a statutory regulation.	Estates	High risk (12-16)	The non-compliant units to be replaced with those which comply with the Water Regulations. Obtain costs for the supply and installation of compliant units and prepare a business case for replacement.	31/03/2020	A 'Double Check' valve has been fitted to waste disposal units to non-compliant provide a higher level of protection after discussion with Anglian Water's 'Regulations Inspector' as an 'interim measure'.
							Lack of compliance with ACOP L8 and HTM standards in respect of water schematics for the hot and cold water systems could impact on the Trust's ability to demonstrate compliance with statutory standards and potentially place service users at risk of poor water safety.	Estates	High risk (12-16)	Water flushing as per agreed IP&C Standard Operating Procedure. Surveys undertaken at Lincoln County, Pilgrim Hospital and at Grantham surveys are on-going.	31/03/2020	Funding required for replacement TMVs, sinks and hand basins. Schematics produced by surveyors have not been quality assessed and have not been stitched into Estates and Facilities master CAD models. Some funding has been identified from Facilities CIP.
							Although routine checks are undertaken, the water tanks at LCH do not comply with the Water Regulations	Estates	Moderate risk (8-10)	Replacement of non-compliant water tanks at LCH.	31/03/2020	Capital funding required.
							Trustwide Water Systems - Chlorine Dioxide Dosing System. Scotmas inform that some of the monitors are now obsolete and require replacing. BMS is now linked to Lincoln.	Estates	Moderate risk (8-10)	Specification tender for the renewal of maintenance contract. Costs are to be obtained for Pilgrim and Grantham. If it fails, Scotmas will set new controllers.	31/03/2020	In December 2017 Scotmas were the only supplier to bid on this tender.
							The Trust may not comply with drinking water guidelines and HTM04-01 at Pilgrim Hospital, because of Chlorine Dioxide dosing impurities due to lack of available maintenance.	Estates	Moderate risk (8-10)	Completion of new water main. Automatic monitors in place. Capital investment required to mitigate this risk.	31/03/2020	Delayed completion of new water main which is required before we can gain access to complete the work required.
							The Water Safety Statutory Improvement Programme (directed by site risk assessments) may not complete on time; ongoing upgrade to sanitary ware, WHB's, Showers etc. to comply with ACOP L8 and HTMs.	Estates	Moderate risk (8-10)	Completion of the Water Safety Statutory Improvement Programme. Stringent Water sampling and flushing programs in place.	31/03/2020	Funding required to complete the programme.
4437	**Critical failure of the water supply** If there is a critical failure of the water supply to one or more of the Trust's hospital sites; Caused by the age and condition of water pipes, or a major incident which damages the infrastructure; It could result in significant, prolonged disruption to multiple services throughout the site, impacting on the experience and care of a large number of patients and the productivity of a large number of staff.	Estates Investment & Environment Group oversight. Water Safety Group operational governance. Capital & revenue prioritisation & investment procedures. Planned Preventative Maintenance (PPM) programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Appointed Authorising Engineer (Water). Emergency & business continuity plans for infrastructure failure / evacuation / relocation.	16	Finance, Performance & Estates Committee	Water Safety Group	4	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.	Estates	High risk (12-16)	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	31/03/2020	Scheme of work and design currently being produced.
3689	**Compliance with asbestos management regulations & standards** If the Trust is found to be systemically non-compliant with asbestos management regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Estates Infrastructure and Environment Committee (EIEC). Trust Asbestos Core Working Group. Asbestos Awareness training for managers and operatives (Estates staff and contractors). Specialist contractor appointed to advise Trust on specific Asbestos management issues across sites. Site Survey data available on Micad. Third Party Contractor induction for both capital schemes and day to day maintenance. Annual Facefit training for specialist PPE equipment. Occupational Health reviews, lung function test. Specialist surveys prior to making any physical change to built-in environment. Air monitoring of specific areas to give assurance that controls in place are adequate. Risk Prioritised Estates Capital Programme. Restricted access where known asbestos containing materials (ACMs) exist (permit to work system).	12	Finance, Performance & Estates Committee	Asbestos Management Group	4	Asbestos Management Plan still to be fully developed.	Estates	High risk (12-16)	Complete development & begin implementation of Asbestos Management Plan.	31/03/2020	Asbestos Management Plan in place and works being undertaken as part of the on-going capital investment programme.
							Availability of sufficient capital funding to remove Asbestos; or other higher risk competing priorities depleting capital resources.	Estates	High risk (12-16)	Involvement with Trust Capital prioritisation process to make case for Estates backlog maintenance to cover costs associated with the Asbestos Management Plan.	31/03/2020	Included in Asbestos Management Plan.
							Appointed Person not yet in place; Asbestos Management Structure to be agreed.	Estates	Moderate risk (8-10)	Agree Appointed Person & structure for Asbestos management.	31/03/2020	Included in Asbestos Management Plan.
							Continuity of contractors appointment requires resourcing and managing; verification of contractors training required.	Estates	High risk (12-16)	Review of asbestos contractors appointment & verification of training.	31/03/2020	Included in Asbestos Management Plan.
							No Access areas still to be surveyed for asbestos.	Estates	Moderate risk (8-10)	Asbestos re-Inspection Programme to be completed (including 'no access' areas.	31/03/2020	Included in Asbestos Management Plan.
							Potentially inaccurate survey data due to restricted access to areas.	Estates	Moderate risk (8-10)	Periodic review of site survey data to ensure current and up to date; Micad to go live with the Asbestos Module.	31/03/2020	Included in Asbestos Management Plan.
3720	**Critical failure of the electrical infrastructure** If the Trust experiences a critical failure of its electrical infrastructure; Caused by issues with the age and condition of	Estates Infrastructure and Environment Committee (EIEC). Estates Strategy. Estates capital investment programme.	12	Finance, Performance & Estates Committee	Electrical Safety Group	4	Potential for Electrical Infrastructure Breakdowns at LCH due to poor condition of distribution systems.	Estates	High risk (12-16)	Regular Inspection & Essential repairs are carried out as necessary. Funding required to upgrade Infrastructure.	31/03/2020	Estimated cost £50k +vat.

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
	essential equipment and the availability of resources required to maintain it; It could result in significant disruption to multiple services across directorates, impacting on productivity and the experience of a large number of patients.	Estates revenue investment programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Planned Preventative Maintenance (PPM) / testing. Emergency & business continuity plans for infrastructure failure / evacuation / relocation. Authorising engineers for water, ventilation and medical gas pipeline systems appointed. Statutory insurance inspections carried out by the Trusts appointed insurance company. Compliance monitoring - NHS PAM / MiCAD systems. Compliance monitoring of 3rd party premises.					Electrical Infrastructure at Pilgrim Hospital is in poor condition and needs significant investment to eliminate backlog maintenance, reduce maintenance costs, maintain capacity of the estate to deliver clinical activity.	Estates	High risk (12-16)	Regular inspection & urgent repairs as required. Identify backlog maintenance funding and capital funding. Allocate funding through the Facilities Capital allocations.	31/03/2020	
							Potential for failure of Electrical Infrastructure at GDH resulting in service interruption, fire and closure of clinical services. The site has an aging electrical infrastructure and some of the switchgear is obsolete and in need of replacing. It does not comply with current IET wiring regulations (BS7671). Area affected are:- Tower Block. Rayrole room. Main Switchgear fed from Transformer no 3 (back of Theatres). Main Switchroom outside of ward 6 including Ward 6 Distribution boards. Various Distribution are obsolete and we unable to obtain spare parts for. A&E Endoscopy X-ray Department Theatres Tower Block Out-Patients Medical Physic Pharmacy Rehabilitation	Estates	High risk (12-16)	Capital investment required to upgrade electrical infrastructure at GDH.	31/03/2020	Capital funding applied for.
4176	**Management of demand for planned care** If demand for planned care (elective, outpatient and diagnostic services) significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.	Divisional capacity management processes. Corporate assurance processes including weekly PTL & fortnightly recovery & delivery meetings. Specialty recovery plans. System-wide planned care group driving reduced referrals into secondary care. Annual capacity & demand planning process. Productive services work-streams including: outpatients; theatres; endoscopy.	12	Finance, Performance & Estates Committee		4	Too much inappropriate activity defaults to ULHT. Sustainability of a number of specialties due to workforce constraints. Availability of physical assets & resources (e.g. diagnostic equipment; outpatient space; inpatient beds). ASR / STP not agreed / progressing at required pace (left shift of activity).	Operations	High risk (12-16)	System-wide planned care group setting up referral facilitation service & 100 day improvement programme, amongst other projects. Local mitigations in place including locum workforce; recruitment & retention premium; altering the model of working. Capital plan for estate development, space utilisation and medical equipment.	31/03/2020	Progression of 2021 Strategy. Engagement in local Acute Services Review (ASR) & Sustainability & Transformation Partnership (STP). Appointment of a Deputy Director of Operations for Planned Care is currently in progress.
4368	**Management of demand for outpatient appointments** If the Trust's Outpatient Services are unable consistently to manage the level of demand for appointments; Caused by issues with the design or application of demand management systems and processes; It could result in a significant reduction in the quality and continuity of outpatient services across multiple directorates and failure to achieve NHS constitutional standards, affecting a large number of patients.	Governance & performance management arrangements. Outpatient Improvement Group. Clinical policies, guidelines and pathways. Staff recruitment, induction & training policies & programmes. Access management policies, guidelines & staff training. Medway patient administration system. Self-assessment & performance management processes for national requirements. Patient Tracking List (PTL) validation & management processes. Approval policy for clinic cancellation with less than 6 weeks notice (Deputy Director level). Weekly PTL meetings. Incident reporting and management systems and processes (Datix).	12	Finance, Performance & Estates Committee		4	Potential for failure to meet national targets of 52 weeks for clinic waiting times due to patients not appearing on PTL & Business Units occasionally lacking visibility of long waiting patients.	Operations	High risk (12-16)	Information Support team to develop further reports to minimise number of patients not been visible in PTL.	31/03/2020	Requested further information from performance team to understand discussions at PTL meetings. Information are producing an extra report for all 40week+ patients regardless of RTT status for validation, also further DQ checks have been completed on specific cohorts of patients to improve DQ.
							Capacity to record e-outcomes onto Medway in a timely manner; Consultants not taking ownership of completing e-outcomes. May lead to Missing Outcomes not being completed & consequent delayed treatment.	Operations	Moderate risk (8-10)	Short term solution to offer overtime to reduce the number of patients outstanding in the report to within 48hours. Business case to be investigated and written to allow e-outcomes to update Medway with the outcomes.	31/03/2020	Missing Outcomes transposing of outcomes is currently about 10 days behind on LCH site. Overtime being offered to reduce timeframes. All other sites being completed within 2 working days. Increase in number of outcomes not being completed by clinicians, this is being highlighted to DMD's for action. Business case for API links agreed by CRIG, delays in implementation occurring due to upgrades by 3rd parties need to happen first. Further update due 01/10/2019.
							Capacity gaps within individual specialities, and with outpatients from a staffing / estates perspective increase the potential for appointment delays due to issues with the management of overdue new referrals; Appointment Slot Issues (ASIs); and the Partial Booking Waiting List (PBWL) for management of Overdue follow-ups.	Operations	High risk (12-16)	Clinical Directorates to provide trajectories for recovery plans - monitored at fortnightly RTT Recovery and Delivery Groups. Detailed plans at speciality level. C&A manually drawing down referrals from ASI list.	31/03/2020	CBU Recovery plans submitted to the performance team and they are tracking performance against trajectory. Performance being monitored at Delivering Productive Services Group.
							Overdue new appointments may be incorrectly added / unvalidated on the Open Referrals worklist . The New Booking team identify 'other' new patient referrals added to the Open Referral worklist by other parties in BU's. As the New Booking Team did not make the entry they are unable to validate the referral.	Operations	High risk (12-16)	The Trust was required to be fully compliant with an electronic booking system with a target set by NHSI of June 2018.	31/03/2020	The Trust is fully compliant with the NHSI requirement to be receiving GP requests to first consultant led appointment by eRS. It is those referrals that do not fit the specific criteria of the NHSI scheme that could lead to un-validated patients on the open referral worklist. Further work required with information support and the booking team to ensure all patients are identified and validated.

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
3503	**Sustainable paediatric services at Pilgrim Hospital, Boston** If the Trust is unable to maintain the full range of paediatric services at Pilgrim Hospital, Boston; Caused by issues with the recruitment or retention of sufficient numbers of staff with the required skills and experience; it could result in extended, unplanned closure of the service or significant elements of it, impacting on the care and experience of a large number of patients and on the provision of interdependent services across the region.	Workforce planning systems & processes. Workforce management information. Recruitment framework & associated policies, training & guidance. Rota management systems & processes. Bank, locum & agency temporary staffing arrangements. Operational governance arrangements for paediatric services. Project Manager appointed to coordinate review & development of future service model.	12	Quality Governance Committee		4	Issues with recruiting and retaining sufficient numbers of middle grade doctors to safely maintain paediatric services at PHB.	Paediatric Medicine	High risk (12-16)	Interim paediatrics service model in place; dependent upon locum staffing and therefore vulnerable and not cost effective or sustainable.	30/03/2020	
							Concerns about limited supervisory resource for trainee doctors at PHB could result in withdrawal of trainees by HEE.	Paediatric Medicine	High risk (12-16)	Interim arrangements in place to provide sufficient supervision in order to maintain supply of trainee doctors. Sustainable position is dependent upon agreement and resourcing of long-term service model.	31/03/2020	
							Long term service model not yet agreed; until this is agreed and in place the service remains vulnerable to staffing and demand management issues. Current demand is lower than expected (for reasons unknown).	Paediatric Medicine	High risk (12-16)	Development of sustainable long-term model for paediatrics at PHB, through the STP.	31/03/2020	
4467	**Impact of a 'no deal' EU Exit scenario** If the UK leaves the European Union without a deal in place; Caused by failure to agree terms; It could result in prolonged, widespread disruption to the health and social care sector that has a significant adverse impact on the continuity of services provided by the Trust.	COO appointed as Senior Responsible Office (SRO) for EU Exit preparations. UK Government guidance on: - the regulation of medicines; medical devices; and clinical trials - ensuring blood and blood products are safe - quality and safety of organs; tissues; and cells UK Government contingency plans for continued supply of: - medical devices and clinical consumables - medicines (6 weeks supply), including prioritised freight capacity and arrangements for air freight of medicines with short shelf-lives NHS Supply Chain systems & processes ULHT Business Continuity Policy & service-specific contingency plans ULHT EU Exit Planning Group: - local risk assessment, covering: potential demand increase; supply of medicines, medical devices & clinical consumables; supply of non-clinical goods & services; EU workforce; reciprocal healthcare; research & clinical trials; data sharing & security.	12	Finance, Performance & Estates Committee	EU Exit Contingency Planning Group	4	The supply of medicines & vaccines may be disrupted in the event of a 'no deal' EU Exit.	Pharmacy	High risk (12-16)	Completion of all required actions in respect of medicines and vaccines, as detailed in the national EU Exit guidance. Specific instruction not to stockpile medicines or to prescribe extra medicines.	31/03/2020	Current Pharmacy stock holding of around 27 days. Local protocol for management of short supply medicines. Most significant residual risk concerns high-cost drugs that cannot readily be switched to an alternative. Supply chain heavily reliant on national arrangements. MoU in place to support transfer of medicines between providers if needed.
							The supply of medical devices & clinical consumables may be disrupted in the event of a 'no deal' EU Exit. Some parts for diagnostic machines used in Radiology & Cardiology (Cath Lab imaging systems; MRI compatible monitors – two out of support monitors, two MRIs) are obtained from Germany, which may lead to delays in fulfilling orders. There are BC plans in place, including back-up machines and some spare parts held, but not all possibilities can be covered. Availability of single-use consumable accessories for medical devices that are used constantly across the trust is also of concern.	Finance	Moderate risk (8-10)	Completion of all actions in respect of medical devices & clinical consumables, as detailed in the national EU Exit guidance.	31/03/2020	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments. Concern that we do not have assurance about plans to manage the traffic impact of Immingham being opened up to increase port capacity – to be escalated through SCG to the Dept of Transport/Highways Agency.
							The supply of non-clinical goods and services may be disrupted in the event of a 'no deal' EU Exit. There are some concerns regarding the supply of food, as 30% comes from the EU and import delays would affect perishable goods.	Finance	Low risk (4-6)	Completion of all required actions in respect of non-clinical goods and services, as detailed in the national EU Exit guidance. The DHSC has issued updated guidance on supply of food, advising a common sense approach in the event of short-term shortages.	31/03/2020	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments.
							The supply of workforce may be disrupted in the event of a 'no deal' EU Exit. Concern emerging that under a 'no deal' scenario a DBS check for a European national maybe subject to a long delay.	Human Resources	Moderate risk (8-10)	Completion of all required actions in respect of the workforce, as detailed in the national EU Exit guidance.	31/03/2020	General message regarding settlement scheme & registration sent out. Approx 300 affected staff. Concern that DBS check for a European national maybe subject to a long delay. Memorandum of Understanding has been agreed for staff sharing within Lincolnshire.
							Existing arrangements in relation to reciprocal healthcare may be disrupted in the event of a 'no deal' EU Exit.	Finance	Low risk (4-6)	Completion of all required actions in respect of reciprocal healthcare, as detailed in the national EU Exit guidance.	31/03/2020	Concern over staffing capacity to deal with a potential increase in overseas visitor screening and billing/payment processing.
							Existing arrangements in relation to Research & Clinical Trials may be disrupted in the event of a 'no deal' EU Exit.	Research and Development	Low risk (4-6)	Completion of all required actions in respect of Research & Clinical Trials, as detailed in the national EU Exit guidance.	31/03/2020	All sponsors are UK-based and actively working to ensure continuity of drug supply. ULHT is not a sponsor for any of the 38 current trials. Some trial drugs come from the EU. Current trials to be risk assessed against threat from a 'no deal' scenario.
							Existing arrangements for data sharing, processing & access may be disrupted in the event of a 'no deal' EU Exit.	Information & Communications Technology	Moderate risk (8-10)	Completion of all required actions in respect of data sharing, processing & access, as detailed in the national EU Exit guidance. Instruction to follow advice from The Department for Digital, Culture, Media and Sport and the ICO and to complete the annual Data Security and Protection Toolkit assessment as early as possible.	31/03/2020	Local risk assessment carried out did not identify any significant data sharing implications.
							Existing arrangements for the recording of costs may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Finance	Low risk (4-6)	Completion of all required actions in respect of finance (recording of costs), as detailed in the national EU Exit guidance.	31/03/2020	Processes in place to record costs associated with Brexit planning. Agreed to include all related costs, included opportunity costs (staff time).

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
							Existing arrangements for communications may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Communications & Engagement	Moderate risk (8-10)	Completion of all required actions in respect of communications, as detailed in the national EU Exit guidance.	31/03/2020	Use of traditional and social media channels to provide up to date information to staff and patients; managed in conjunction with Local Health Resilience Partnership (LHRP) communications teams and into the Local Resilience Forum (LRF).
Executive lead: Hepburn, Dr Neill												
4405	**Critical infrastructure failure disrupting aseptic pharmacy services** If there is a critical failure of the infrastructure that supports aseptic pharmacy services within the Trust; Caused by issues with the age and condition of the facilities and the impact of managing increasing levels of demand; It could result in unplanned suspension of services which would have a significant and prolonged impact on a large number of patients, services, and other service providers.	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Estates & Facilities Planned Preventative Maintenance programme & responsive repairs process. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates). Business continuity plans for ASU require patients to be treated outside of the Trust in the event of service disruption.	20	Quality Governance Committee	Medicines Optimisation & Safety Group	4	The Pilgrim ASU facility is18 years old, is operating at capacity and the availability of external supplies is both erratic and inconsistent. In addition, cancer care in the Trust is increasing by 10% annually and demand for aseptic preparations is predicted to outstrip current levels of availability by the end of 2020.	Pharmacy	Very high risk (20-25)	Development of a sustainable infrastructure plan for aseptic pharmacy services.	31/12/2020	Full Business Case being prepared for Trust Board in October 2019, containing proposals for a new aseptic unit; preferred option is a joint venture partnership through the STP.
							Repeated incidents of water leaks into one of the PHB aseptic rooms (tray washing room) from an upstairs toilet. If this happens and water reaches the main clean room it could result in closure of the aseptic unit for recommissioning and therefore inability to provide an aseptic service for the Trust for several months.	Pharmacy	Very high risk (20-25)	With Estates, to identify the reasons for the ongoing leaks and provide a permanent resolution to the problem; if a permanent resolution is not possible, to explore a way to identify the leaks at an early stage to minimise the risks (detection alarms are in other areas of the aseptic unit, so can this be applied to all other areas). To arrange cultures and chemical assay of the water. To request an assessment from Bernie Sanders, East Midlands Regional Quality Assurance to advise on continuation of production.	31/10/2019	Temporary closure of the aseptic unit at PHB - implementing BCP until assurance is received that the contamination is safely managed.
3951	**Compliance with regulations & standards for aseptic pharmacy services** If the Trust is found by a regulator to be systemically non-compliance with regulations & standards for aseptic pharmacy services; Caused by fundamental issues with the design or application of local policies and procedures, or the quality of the facility; It could result in regulatory intervention that forces immediate closure of the facility and suspension of services, impacting on a large number of patients, services and other service providers.	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	16	Quality Governance Committee		4	Pilgrim Hospital ASU does not comply with national and EU standards: • the Air Handling Unit is aging, • air changes are below the recommended levels for the clean rooms, • risk of leak from water pipes located above the unit. Leaks have occurred in the past, • there is limited capacity for the preparation of TPNs. Only one positive pressure isolator and no room space for the addition of a second isolator, • there are inadequate workflows of materials, finished products, personnel and waste due to current layout of the unit.	Pharmacy	High risk (12-16)	Proposals for a sustainable aseptic services facility to support compliance with QAAPS requirements.	31/12/2020	Business Case in development, to be presented to Trust Board in October 2019.
							Aseptic preparation services must have adequate resources to ensure compliance with the defined national standards as described in Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic preparation time has increased due to changes in aseptic services standards (addition of an extra disinfection stage and use of a sporicidal agent with an increased contact disinfection time).	Pharmacy	High risk (12-16)	Additional staffing capacity with appropriate skill mix required to provide a service that complies with QAAPS standards. CSS Division to identify resources for additional staff required.	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity.
4156	**Safe management of medicines** If there are multiple, widespread failings in the safe management of medicines across the Trust; Caused by issues with the design or application of medicines safety policies and procedures; It could result in multiple incidents of significant, avoidable harm to patients in the care of one or more directorates.	Medicine safety policies & procedures. Medicine management governance arrangements (including audit & performance monitoring). Medicine safety training & education programmes. Pharmacy support and advice service. Pharmacy facilities & specialist equipment. Incident reporting and investigation systems & processes (Datix).	16	Quality Governance Committee	Medicines Optimisation & Safety Group	4	The Trust currently uses a manual prescribing process across all sites, which is vulnerable to human error that increases the potential for delayed or omitted dosages; moving of charts from wards; and medicines not being ordered as required.	Pharmacy	High risk (12-16)	Planned introduction of an electronic prescribing system across the Trust, to eliminate some of the risks associated with manual prescribing.	31/03/2020	
							Pharmacy is not sufficiently involved in the discharge process or medicines reconciliation, which increases the potential for communication failure with primary care leading to patients receiving the wrong continuation medication from their GPs.	Pharmacy	High risk (12-16)	Routine monitoring of compliance with electronic discharge (eDD) policy. Request for funding to support additional pharmacy resources for involvement in discharge medicine supply.	31/10/2019	extended date to allow for review of progress
							The Trust routinely stores medicines & IV fluids on wards in excess of 25 degrees (& in some areas above 30 degrees). This is worse in summer months. These drugs may not be safe or effective for use.	Pharmacy	High risk (12-16)	Introduction of electronic temperature monitoring systems for all drug storage areas to enable central monitoring. Capital investment required. Contingency - ward monitoring of temperatures & escalation of issues.	31/03/2020	
							Inappropriate storage of refrigerated medicinal products (fridges constantly going above 8 degrees) due to lack of fridge(s) space. Periods of time where storage requirements are compromised has the potential to affect the stability of the products and therefore could have impact on patient treatment.	Pharmacy	Very high risk (20-25)	Temperatures of refrigerated medicinal products to be monitored continuously. Additional fridges required in order to ensure appropriate storage and product quality and comply with standards. Business case to request additional funding for fridges completed and approved. Fridges being purchased.	31/10/2019	extended date to allow for review of progress

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
							Inadequate and unsecure storage and stock accountability of medical gas cylinders at all sites. Modifications required to meet standards and improve security.	Pharmacy	Moderate risk (8-10)	Risk regarding unsecure storage and stock accountability of medical gas cylinders at all sites to be assessed with local security management specialist; recommendations will include new lighting to storage buildings, surveillance cameras, effective alarm system and new doors to replace weak hinges and stronger locks.	31/03/2020	
							Screening, management and review mechanisms of patients requiring or in receipt of Intravenous Immunoglobulin (IVIg) is inadequate.	Pharmacy	Moderate risk (8-10)	Single staff reliance for local panels, 1x haematology consultant, 1x neurology consultant and 1x chief pharmacist only. Antimicrobial and High Cost Drugs Management Pharmacist undertaking administrative functions to ensure all referrals are screened and are done so in a timely manner. Shared care arrangements and prescribing accountabilities are unclear and need review.	31/03/2020	
4497	**Contamination of aseptic products** If the products supplied by the Trust's aseptic pharmacy services were to become contaminated; Caused by issues with hygiene standards at the production facility, or user error; It could result in significant harm and potentially the death of multiple patients.	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS) regulatory stndards. Aseptic pharmacy lead. QAAPS states that aseptic capacity should not exceed 80%. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	15	Quality Governance Committee		5	Due to the current state of the infrastructure in Lincoln, and the potential risk of contamination, the Lincoln Pharmacy ASU is not fit for purpose.	Pharmacy	High risk (12-16)	Closure of the Lincoln Pharmacy ASU to avoid the risk.	31/12/2020	Lincoln Pharmacy ASU has been closed.
							Most aseptic processes are operator dependant. This means that when overcapacity there is an increased risk of calculation errors or producing contaminated products. Whilst air pressure monitoring will highlight the risk of contamination it does not give information on the actual risk. Microbial plates take 2 weeks to provide results, therefore any potentially contaminated products cannot be identified until after they have been issued and administered to patients. This is because the aseptic unit operates under Section 10 exemption from the Medicines Act and is not licensed. There is therefore no batch manufacturing and no associated quality control of batch manufactured products which would otherwise enable microbiological and chemical stability testing to take place.	Pharmacy	High risk (12-16)	Additional staffing capacity with appropriate skill mix required to provide a safe service and achieve capacity levels of under 80%. CSS Division to identify resources for additional staff required.	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity. Frequent activation of BCP paces additional workload strain on staff, which further increases the associated risks. This is only sustainable for a short period of time.
							The current condition of the aseptic facility at Pilgrim Hospital is inadequate, which increases the risk of contamination: • the Air Handling Unit is aging, • air changes are below the recommended levels for the clean rooms, • risk of leak from water pipes located above the unit. Leaks have occurred in the past, • there is limited capacity for the preparation of TPNs. Only one positive pressure isolator and no room space for the addition of a second isolator, • there are inadequate workflows of materials, finished products, personnel and waste due to current layout of the unit.	Pharmacy	High risk (12-16)	Implementation of a sustainable and fit for purpose aseptic services facility at Pilgrim Hospital.	31/03/2020	Business Case in development, to be presented to Trust Board in October 2019.
4142	**Safe delivery of patient care** If there widespread instances throughout the Trust of patient care that does not meet essential safety requirements; Caused by fundamental issues with the consistent application of appropriate clinical policies, procedures, guidelines or pathways; It could result in multiple incidents causing significant harm to a large number of patients.	Clinical policies, procedures, guidelines, pathways & supporting documentation. Clinical governance arrangements at corporate level - Quality & Safety Oversight Group (QSOG) / Patient Safety Group (PSG) & sub-groups: - Harm Reduction Group - Radiation Protection Group - Deteriorating Patient Group - Medical Devices Group - Hospital Transfusion Group - Nutrition Group Divisional Clinical Cabinets & CBU / specialty governance arrangements. Clinical staff recruitment, induction, mandatory training, registration & re-validation processes. Risk & incident management policies & procedures / Datix system. Quality & safety improvement planning process & plans. Defined safe staffing levels. Ward accreditation programme & data monitoring / review processes (including Safety Thermometer). Quality Matron team and specialist nurses (Tissue Viability; Frailty; Sepsis).	12	Quality Governance Committee	Patient Safety Group	4	Inconsistent identification of & response to deteriorating patients, including sepsis screening & intervention.	Corporate Nursing	High risk (12-16)	Design & introduce updated policies and processes for the identification of & response to deteriorating patients. Monitor their effectiveness through improved incident reporting and tracking.	31/03/2020	Datix Dashboard set up to track incidents involving Failure to Escalate & Sepsis.
							Challenges to the safe & effective delivery of Non-Invasive Ventilation (NIV): 1. Treatment may not commence within 1 hour of decision to treat if NIV bed unavailable on the ward or if insufficient nurse capacity. 2. NIV may be the ceiling of care which would deem a patient not suitable for admission to an ICU bed; if a patient were then admitted to ICU it may be unsuitable for the patient and would be in breach of Critical Care Network agreed policies. 3. Supply of Bank and Agency staff with NIV competencies is limited and may involve use of Tier 4 agencies. 4. Recruitment of nurses with required skills to vacancies on Ward 7B (PHB). 5. Inconsistent adherence to the NIV Care Pathway.	Respiratory Medicine	High risk (12-16)	1. SOP to be developed for commencement of NIV in Emergency Departments. 2. Escalation Process for Ward Based NIV Capacity developed. 3. Capacity & demand being reviewed with the aim of increasing established, trained staff levels. 4. On-going competency training in place for all nurses. 5. NIV to review audit results and agree appropriate action.	31/03/2020	Action plan kept under regular review by the NIV Group, which meets quarterly.
							Inconsistent levels of compliance with the Trust's Local Safety Standards for Invasive Procedures (LocSSIPs), which increases the likelihood of a Never Event occurring both within and outside the Theatres environment. Evidence of possible under-reporting of near miss incidents.	Clinical Governance	High risk (12-16)	Trust-wide review of LocSSIPs policy & process, training and culture (including incident reporting practice).	31/03/2020	LocSSIPs review in progress.

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
							Development of the WebV system for handover has been delayed due to lack of dedicated project manager; potential adoption of the Nervecentre system is not possible until 2021. Presently there is no Trustwide handover IT system in place.	Information & Communications Technology	High risk (12-16)	Development of the WebV system for handover process Trustwide. Requires a business case for investment and project management with the supplier.	31/03/2020	Escalated to TMG, Regular updated provided to PSG.
							Inconsistent application of clinical pathways and guidelines for pneumonia, leading to increased mortality risk.	Clinical Governance	Moderate risk (8-10)	Pneumonia Task & Finish Group to oversee completion of CQUINS Action Plan.	31/03/2020	Business case in development for audit function.
							Operational decisions based on patient flow priorities may result in patients requiring specialist care being treated in areas where staff do not have the necessary specialist skills or equipment, which can increase the risk of incidents occurring that result in significant harm.	Clinical Governance	Moderate risk (8-10)	Trust-wide review of decision-making processes based on patient flow and safety.	30/09/2020	Risks identified through incident reports in areas including: Non-Invasive Ventilation (NIV); Diabetic Keto-Acidosis (DKA); Parenteral Nutrition (PN).
							Inconsistencies within the patient discharge process, including the timely completion of electronic Discharge Documents (eDDs).	Clinical Governance	Moderate risk (8-10)	Implementation of discharge process improvement plan.	30/09/2020	Review underway of discharge-related incidents reported via the CCGs Healthcare Professional Feedback (HPF) process.
							Asthma length of stay and readmission rates are among the worst in the country. Identified through 2019 GIRFT Review. At Lincoln County, MEAU is the highest risk area in the hospital after ED.	Respiratory Medicine	High risk (12-16)	Clinical service review team to analyse the data and develop a risk mitigation plan.	30/06/2020	In the immediate future (at Lincoln County), aiming to ensure ALL asthmatics are moved to Carton Coleby Ward. New Respiratory ACPs will also help with the asthma related issues (from January 2020).
							Pleural Disease – there is no set provision for these patients on any Trust site, and in order to deliver best practice there should be a minimum of 2 DCCs on each site dedicated to care of these patients.	Respiratory Medicine	Moderate risk (8-10)	Review of GIRFT data on management of pleural diseazse to enable an appropriate risk mitigation plan to be developed.	24/03/2020	Limited Respiratory resource is currently stretched over 3 sites. Recruitment efforts continue.
4157	**Compliance with medicines management regulations & standards** If the Trust is found to be systemically non-compliant with medicines management regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by regulators such as the Care Quality Commission (CQC), NHS Improvement and the Medicines and Healthcare products Regulatory Agency (MHRA) or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.	Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Mandatory medicines management training as part of Core Learning for clinical staff. Specialist advice & support from the Pharmacy team. Datix incident reporting & investigation processes. Root cause analysis of serious medications incidents. Pharmacy compliance monitoring / auditing.	12	Quality Governance Committee	Medicines Optimisation & Safety Group	4	The Trust currently uses a manual prescribing process across all sites, which is inefficient and presents challenges to auditing and compliance monitoring.	Pharmacy	High risk (12-16)	Planned introduction of an auditable electronic prescribing system across the Trust.	31/03/2020	
							Compliance with Falsified Medicines Directive (FMD) legislation (Directive 2011/62/EU) is mandatory from February 2019, aiming to provide assurance to patients that the medicines they are supplied are not counterfeit or 'Falsified Medicines' that might contain ingredients, including active ingredients, which are not of a pharmaceutical grade or incorrect strength or indeed may contain no active ingredient. Falsified medicines are considered a major threat to public health with seizures by regulators increasing annually across the globe. We do not currently have a plan in place to ensure that we will comply with this legislation, and be able to robustly provide the necessary assurance to patients.	Pharmacy	High risk (12-16)	The FMD legislation requires that a system be established to enable all pharmaceuticals to be tracked through the supply chain, from manufacturer, via wholesalers, to pharmacy and to end user, and will be facilitated through the use of 2D barcode scanning technology. The Trust will work regionally with wholesalers and pharmacy computer system providers. Funding for new equipment is likely to be needed.	31/10/2019	Deadline extended and review of progress to be undertaken
							Administration of medication by pharmacy technicians including oral, intravenous, NG and PEG - legislation, governance and training issues. The Medicines Regulations 2012 specified that parenteral products can be legally administered by persons acting under the instruction of a legally valid appropriate prescriber (as shown in Regulation 214). Pharmacy technicians could also adopt this role in clinical areas in the Trust. However, his practice has not been approved and accepted by the Trust and is not embedded into the Medicines Management policy.	Pharmacy	High risk (12-16)	To define the process for administration of medicines by pharmacy technicians and their supervision and training. To embed the process in the Medicines Management Policy.	30/06/2020	
							There is not full assurance that the new pharmacy technician roles and practices are acceptable in terms of professionally registered practice and that professional codes of practice are being correctly adhered to.	Pharmacy	High risk (12-16)	To establish the professional supervision and development of the new roles. To take advice from the General Pharmaceutical Council (GPhC) and NHSI to ensure the new roles are covered by the relevant professional codes of practice.	31/10/2019	Target date extended by one month to allow for review on progress
							recommendation from CQC that, where practicable, patients keep with them their regular medication and self administer whilst an inpatient	Pharmacy	Low risk (4-6)	suitable bedside lockers to be researched, to ensure the safety and security of medication Policy to be reviewed & updated when applicable to new products being used	31/01/2020	
4300	**Availability of medical devices & equipment** If the Trust's is unable to maintain the availability of essential medical devices and equipment; Caused by issues with capital and / or revenue planning, procurement and delivery processes or the availability of sufficient funding and resources; It could result in widespread disruption to clinical services across one or more divisions, reducing productivity and impacting on the experience of multiple patients	Capital and revenue planning processes. Procurement, delivery and contract management processes. Medical Devices Safety Group operational oversight. Medical device & equipment inventory. Clinical Engineering Services and Estates & Facilities equipment maintenance programmes & repairs capability. Business continuity / contingency plans for	12	Quality Governance Committee	Patient Safety Group	4	Trust-wide issues with the availability of suitable equipment (e.g. beds / trolleys; wheelchairs; weighing scales; blood pressure cuffs) and appropriate policies, procedures & pathways supported by training for the safe care of bariatric patients.	Corporate Nursing	High risk (12-16)	To review and update where necessary policies, procedures and relevant pathways to improve the safety of care for bariatric patients across existing policy areas, including: moving & handling policy; Theatres - procedures on trolleys / tables; observation policy (e.g. right size cuff to take blood pressure); A&E; outpatients.	31/03/2020	Working group set up, involving corporate nursing, health & safety & risk, to identify required improvements.

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
	multiple patients.	Business continuity / contingency plans for reduced availability of devices & equipment. Datix incident reporting & management processes for incidents involving medical devices.					Lack of a centralised database for all medical devices; some records are held locally.	Clinical Engineering	High risk (12-16)	To deliver a Trust centralised medical equipment management database(which includes asset register, re-active and proactive maintenance planning, service history, etc.)	30/11/2020	MDSG has agreed on MEMS as the centralised medical equipment management database. Divisional engagement is underway.
							Current contractual arrangements for bed frames and mattresses (with ARJO) have expired and continue on a 6 month rolling basis; the current contract model may not represent the best value for money. Bed management processes lack corporate oversight and effective control.	Facilities	High risk (12-16)	Appointment of a dedicated project manager to coordinate development of a revised bed / mattress operational model and contract review. Option to work collaboratively with LCHS and LPFT.	31/03/2020	BC developed and approved in principle by CRIG
							A substantial amount of aging medical and diagnostic equipment throughout the Trust is overdue for replacement and prone to failure, which would cause delays in patients pathways and in certain areas mean that the Trust is unable to provide services.	Clinical Engineering	High risk (12-16)	Implementation of a Managed Equipment Service (MES) approach would reduce the risk of the Trust having to close services or to stop carrying out procedures or diagnostic examinations.	31/03/2021	Equipment is under service contracts where possible and business cases are being put forward to the trust capital replacement programme but lack of capital funds is a mayor limitation.
4406	**Critical failure of the medicines supply chain** If the Trust experiences a critical failure in its medicines supply chain; Caused by issues with the business continuity arrangements of one or more major suppliers and a lack of resilience within the system; It could result in significant disruption to services throughout the Trust, impacting on productivity and the care and treatment of a large number of patients.	Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Medicines stock management arrangements. Medicines supplier business continuity arrangements.	12	Quality Governance Committee	Emergency Planning Group	4	The Trust currently uses a manual prescribing process across all sites, which is inefficient and increases the potential for medication not being ordered when needed.	Pharmacy	High risk (12-16)	Planned introduction of an electronic prescribing system across the Trust.	31/03/2020	
							Shortages of several brands of normal immunoglobulin. Gap in immunologist input for switching patients between brands.	Pharmacy	High risk (12-16)	Senior pharmacist and medical staff to manage switch between immunoglobulin brands with advice from the responsible consultant. Where patients are not looked after by any consultant following retirement of consultant Immunologist, the patients will remain on existing brand until Immunology cover is available.	31/10/2019	
							Frequency and duration of medication shortages are presenting an increasing problem, with associated risks to patient care. May mean increasing reliance on unlicensed import products. Management of shortages often involves procurement of more expensive alternatives. Identification of shortages is often at the point at which stocks are depleted – a more robust system would be desirable whereby we anticipate shortages.	Pharmacy	High risk (12-16)	Shortages of contract lines are reported centrally; shortages of non-contract lines rely on identification by Trust pharmacy staff. Where shortages are identified, aim to put in place an appropriate management plan, after liaison with relevant members of pharmacy staff or specialist clinicians.	31/10/2019	
							Due to a significant shortage of Varicella zoster immunoglobulin (VZIg), Public Health England (PHE) has centralised stock holding of this product within their unit at Collindale. Ordinarily the Trust holds stock of this product on site to facilitate timely, appropriate treatment of patients. Pregnant patients in the first 20 weeks of pregnancy, with negative VZ antibody, who are eligible for treatment may experience a delay – this may be a risk if they are presenting towards the end of the treatment window as the product needs to be given within 10 days of exposure.	Pharmacy	Very high risk (20-25)	Information regarding the restrictions to use of VZIg and also the process for obtaining stock have been shared with all pharmacy staff. Stock will routinely be supplied on the next working day to the pharmacy or GP surgery. Clarification has been sought from PHE regarding out of hours emergency access.	31/10/2019	
4476	**Compliance with clinical effectiveness regulations & standards** If the Trust is found to be systemically non-compliance with regulations and standards for clinical effectiveness; Caused by fundamental issues with the systems and processes used for managing clinical audits, policies, guidelines and best practice; It could result in a significant loss of confidence amongst a large number of patients as well as commissioners, regulators and the general public which may lead to regulatory action and sanctions.	Clinical governance arrangements in place at corporate level: Quality & Safety Oversight Group (QSOG) / Clinical Effectiveness Group. Clinical policies, guidelines and best practice management processes. National clinical audit programme management processes. Local clinical audit programme management processes.	12	Quality Governance Committee	Clinical Effectiveness Group	4	Infrastructure is in place for divisional management of clinical policies; guidelines; best practice and clinical audit. Issues with time allocation within job plans for divisional leads to deliver against requirements.	Clinical Governance	High risk (12-16)	Development & implementation of regular divisional reports to provide a comprehensive overview of clinical effectiveness.	31/03/2020	Report template in development.
							Oversight of clinical effectiveness is not current part of the divisional Performance Review Meeting (PRM) process.	Clinical Governance	Moderate risk (8-10)	Integration of routine oversight of clinical effectiveness as part of the divisional Performance Review Meeting (PRM) process through the introduction of appropriate KPIs.	31/03/2020	
							Insufficient staffing resources within the established Clinical Effectiveness central support team.	Clinical Governance	High risk (12-16)	Restructure of the Clinical Governance directorate to increase and redesign establishment to provide an appropriate level of support to divisions.	31/12/2019	New CG structure now established.
4043	**Compliance with patient safety regulations & standards** If the Trust is found to be systemically non-compliant with patient safety regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by the Care Quality Commission (CQC), NHS Improvement or local Clinical Commissioning	Clinical governance arrangements at corporate, directorate and specialty levels. Clinical governance policies & processes. Board Assurance Framework (BAF) & review process. CCG oversight & assurance arrangements. CQC liaison & inspection management arrangements. Management of clinical policies, guidelines and pathways.	12	Quality Governance Committee	Patient Safety Group	4	CQC Section 29a warning notice received following inspection in 2019, in respect of governance within Children & Young Persons services, giving the Trust 3 months to make identified improvements.		Moderate risk (8-10)	Delivery of improvement actions agreed to address issues raised in CQC Section 29a warning notice for Children & Young Persons services.	31/03/2020	Progress to be monitored through PSG.
							CQC Section 31 notices received in respect of emergency departments at Lincoln & Pilgrim.	Accident and Emergency	Moderate risk (8-10)	Delivery of improvement actions agreed to address issues raised in CQC Section 31 warning notices for emergency departments at Lincoln & Pilgrim.	31/03/2020	Progress to be monitored through PSG.

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
	Groups (CCGs) including warning or prohibition notices and financial penalties.	Ward assurance programme. Internal audit arrangements (360 Assurance). Datix incident reporting & risk management system & processes. Serious Incident (SI) management & governance processes, including dedicated central support team and investigator training. NHS Central Alerting System (CAS) management arrangements.					Statutory role of Guardians of Safe Working - to safeguard welfare and working conditions of doctors in training. Appointed by the Medical Director, independent of the management structure. At present there is very limited admin support, putting the Trust at risk with the BMA & NHSI & providing limited oversight and voice for junior doctors.	Clinical Strategy & Transformation	Moderate risk (8-10)	Plan to move to 1x Guardian of Safe Working, supported by 1x admin.	31/03/2020	Interim arrangements currently in place.
							The Trust declared 15 Never Event Serious Incidents between April 2018 – December 2019; this suggests that existing control measures regarding Never Events are not functioning effectively. Specific incidents covered the following Never Event types: o 7 wrong site surgery (4 out of theatre & 3 in theatre) o 2 wrong implant/prosthesis o 2 retained foreign object (1 in theatre and 1 out of theatre) o 2 mis- selection of high strength midazolam during conscious sedation o 1 misplaced naso or oro – gastric tube o 1 administration of medication by the wrong route	Clinical Governance	High risk (12-16)	Complete thematic analysis of recently reported Never Events, then develop and implement a comprehensive action plan to strengthen existing control measures and governance / monitoring arrangements.	30/09/2020	Analysis complete; report presented to QSOG.
4423	**Working in partnership with the wider healthcare system** If the Trust fails to work effectively in partnership with the wider healthcare system, including other healthcare providers and commissioners; Caused by issues with the planning process, the availability of sufficient resources or the effectiveness of partnership governance arrangements; It could result in significant disruption to the provision and sustainability of multiple services that has a long term impact on the experience and quality of care for a large number of patients.	Sustainability & Transformation Partnership (STP), including ULHT; LCHS' LPFT; & others. STP partnership governance arrangements. STP planning & delivery mechanisms. Lincolnshire Coordinating Board (including chairs of each partner organisation).	12	Finance, Performance & Estates Committee		4	Failure to work effectively in partnership may result in some ULHT services having demand that exceeds capacity; failure to work with other providers and CCGs may also result in the viability of ULHT services being jeopardised. Failure to progress on taking forward the Acute Services Review may result in some existing fragile services failing, or some services becoming fragile.		High risk (12-16)	Re-assessment of strategic risk and development of appropriate mitigations.	31/03/2020	Continued engagement with the STP delivery process through established governance arrangements.
Executive lead: Matthew, Paul												
4382	**Delivery of the Financial Recovery Programme** If the Trust becomes unable to delivery key elements of the Financial Recovery Plan within the current financial year; Caused by issues with the design or implementation of planned cost reduction initiatives; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Financial strategy. Financial recovery planning process. Financial Recovery Plan governance & monitoring arrangements. Directorate performance & accountability framework. Financial management information. Financial Special Measures (since September 2017). Financial Turnaround Group (FTG) oversight. Programme Management Office & dedicated Programme Manager.	20	Finance, Performance & Estates Committee	Financial Turnaround Group	8	Identified schemes for 2019/20 cover the level of efficiency required (£25.6m). If assumptions are inaccurate; or if there are capacity & capability issues with delivery; it may result in failure to deliver these schemes.	Finance	Very high risk (20-25)	Finance PMO team working with divisions to manage planned schemes and identify mitigating schemes. Additional external resource to be brought in to support delivery.	31/03/2020	
4383	**Substantial unplanned expenditure or financial penalties** If the Trust incurs substantial unplanned expenditure or financial penalties within the current financial year; Caused by issues with budget planning, budgetary controls, compliance with standards or unforeseen events; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Financial strategy. Annual budget setting process. Capital investment planning process. Capital investment programme delivery & monitoring arrangements. Monthly financial management & monitoring arrangements. Contract governance and monitoring arrangements. Directorate performance & accountability framework. Key financial controls.	20	Finance, Performance & Estates Committee	Financial Turnaround Group	8	Continued reliance upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services across the Trust, at substantially increased cost.	Finance	Very high risk (20-25)	Financial Recovery Plan schemes: recruitment improvement; medical job planning; agency cost reduction; workforce alignment.	31/03/2020	
							Interest rate may increase if the Trust deviates adversely from plan in the financial year. Non-delivery of plan would also mean the Trust won't have access to FRF; PSF; and MRET (valued at £29m).	Finance	Very high risk (20-25)	Delivery of the Financial Recovery Programme; maintaining grip & control on expenditure; use of PRM process to hold divisions to account and develop mitigating schemes where needed.	31/12/2018	

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
		~~key financial controls.~~ Financial management information.					As advised by NHS Digital this risk has been added to the corporate risk register as there is a considered risk that the Trust is at risk of being removed from the National Windows 10 licensing arrangement with a potential liability of up to £1.5m. NHSDigital will make a final decision in March 2020 depending on the overall state of the NHS estate in England. The recent announcement by Microsoft that they will continue to provide extended support for Windows 7 until January 2021 does not provide any reason to delay your migration to Windows 10. Currently licensed organisations have been granted free licensing on the basis of agreeing to fully utilise the Windows 10 licences provided. As per Clause 2.11 of your Service Agreement, licences may be revoked if they are not fully utilised. This decision will be taken in March 2020, the annual review point at which we must decide which organisations continue to be part of the national agreement with Microsoft. Any organisation who has licences revoked will also cease to qualify for the free extended support for Windows 7, since this free extended support is only available by being part of the NHS national agreement. Therefore by delaying Windows 10 local organisations will not only risk losing the free Windows 10 licences but will also need to pay for their own extended support for their Windows 7 estate. The cost of replacing free National licences and purchasing extended support is currently £205 per user (inc. VAT) x all users in your estate - £1m for an NHS organisation with 5,000 users. Please ensure that you calculate and include this risk on your corporate risk register if you are not planning to have completed your Windows 10	Information & Communications Technology	Moderate risk (8-10)	The Trust to continue to work closely with NHS Digital keeping them appraised of our situation. The ICT Department has a plan to continue the rollout of Windows 10 upgrading the devices that can be upgraded and by rolling out the correct version to the VDI environment, this will continue to increase the numbers of devices that are using the national licensing agreement. The ICT Department working with finance continue to explore ways and means of accessing external capital resource and this continues to be top priority pending any capital allocation to ICT in 19/20 and beyond.	31/03/2020	Risk has been discussed within ICT and with Paul Matthew, it has also been escalated as a system issue to the STP via IMTEG. Current capital position is unhelpful and unsupportive of a resolution. ICT working with Finance colleagues to explore options and review potential for emergency capital bids.
4384	**Substantial unplanned income reduction or missed opportunities** If the Trust experiences a substantial unplanned reduction in its income or missed opportunities to generate income within the current financial year; Caused by issues with financial planning, an unexpected reduction in demand or loss of market share; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Financial strategy. Contract governance and monitoring arrangements. Annual budget setting & monthly management process. Monthly financial management & monitoring arrangements. Key financial controls. Financial management information.	16	Finance, Performance & Estates Committee	Financial Turnaround Group	8	Clinical coding & data quality issues impacting on income.	Information Services	High risk (12-16)	Iqvia engaged to review Trust data on a monthly basis; strengthening of clinical coding practice.	31/03/2020	
							Operational ownership of income at directorate level.	Finance	High risk (12-16)	Strengthening of management of activity and income plans at speciality level through the divisional PRM process.	31/03/2020	
							Commissioners have a combined shortfall to contract of c£8m. This could result in a number of schemes that will impact the Trust.	Finance	High risk (12-16)	Agreed contractually that the impact of income reduction for these schemes will be on a net neutral basis for the Trust; monitored and managed through the Finance & Contracting Group.	31/03/2020	
							Activity levels increase above the plan where the Trust remains under tolerance, no additional income is received; where above tolerance only a percentage of tariff is received.	Finance	High risk (12-16)	Internal control via PRM process for monitoring and agreeing any necessary actions to manage demand; & via Finance & Contracting Group for the system to manage demand.	31/03/2020	
							Up to £8m at risk through non-delivery of backlog improvements and repatriated activity.	Finance	High risk (12-16)	System to develop robust plans and internal productivity gains to ensure there is sufficient capacity to deliver the activity; where the planned level of activity can't be achieved to secure income, the associated costs will need to be removed.	31/03/2020	
4044	**Compliance with information governance regulations & standards** If the Trust is found to be systemically non-complaint with information governance regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by the Information Commissioner's Office (ICO), including warning or enforcement notices and substantial financial penalties.	Information governance policies & procedures. Information governance guidance & mandatory training (core learning). Incident reporting and management systems and processes (Datix). Oversight by Information Governance Committee.	16	Finance, Performance & Estates Committee	Information Governance Group	4	Reduced ability to complete Subject Access Requests under the Data Protection Act due to the potential for personal information to be held on multiple IT systems and in paper records in ways that cannot be accurately traced; the majority of Trust IT systems do not enable retention timescales to be set and no systems enable records to be disposed of, and there is no process in place to review the retention of information held in paper health records, which results in personal information be retained for longer than is necessary.	Information Governance	Moderate risk (8-10)	Requires a strategic decision from the IGG regarding the Trust's approach to retention and disposal of records held electronically and in hard copy.	31/03/2020	Further discussion required.
							The Trust is required to complete the national Data Security & Protection Toolkit (DSPT) each year. Processes are in place to ensure this is completed. Where specific standards aren't met the Trust may be exposed to the risk of regulatory action by NHS Digital and potentially the ICO. At present the Trust is not able to evidence compliance with all of these standards.	Information Governance	Moderate risk (8-10)	Implementation of the Trust improvement plan for the DSPT, which has been approved by NHS Digital.	31/05/2020	Outstanding actions regarding contract management - confirmation required that suppliers have data security contract clauses in place if they handle personal data.
							Issues with achieving compliance with the Freedom of Information Act timescales, due to gaps in the Information Asset Register; lack of knowledge of how to apply exemptions; limited staffing capacity and absence of a suitable IT system.	Corporate Affairs	High risk (12-16)	Review of Freedom of Information Act management processes and capacity; introduction of regular compliance reporting to the IGG; investigation of possible IT solutions to support the management of FoI requests.	31/03/2020	Currently looking into potential IT solutions.

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
							The data protection / privacy impact assessment process is not consistently followed at the start of a system change project, therefore results may not be available to inform decision-making and system development. In the event of a future breach the Trust would be exposed to regulatory action.	Information Governance	Moderate risk (8-10)	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process.	31/03/2020	Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues.
							Reduced ability to complete Subject Access Requests under the Data Protection Act due to not having the technical tools to carry out a search of emails/ systems to identify personal information held.	Information & Communications Technology	High risk (12-16)	Implementation of Office 365 which will provide the necessary IT capability to enable search of emails.	31/03/2020	Discussed at September 2019 IGG.
4179	**Major cyber security attack** If the Trust is subject to a major cyber security attack that breaches its network defences; Caused by the exploitation of an existing vulnerability or the emergence of a new type of threat; It could result in loss prolonged, widespread loss of access to ICT systems throughout the Trust which disrupts multiple services and affects a large number of patients and staff.	ICT network security arrangements. Network performance monitoring. Cyber security alerts from NHS Digital (CareCerts) ICT hardware & software upgrade programme. NHS Data Security Protection Requirements (DSPR). Corporate and local business continuity plans for loss of access to ICT systems. Mandatory major incident training for all staff (part of Core Learning). Installation of Site based Firewalls with full Traffic inspection enabled.	12	Finance, Performance & Estates Committee	Information Governance Group	4	A structured framework approach to cyber security would provide more reliable assurance that existing measures are effective and support any necessary improvement work.	Information & Communications Technology	Moderate risk (8-10)	The Trust is working towards compliance with standards in the NHSD DSPT as updated in 2019	31/03/2020	The DPST was updated nationally to include the requirements of Cyber Essentials and other national requirement's. The Trust is working towards meeting this for march 2020 return.
							Availability of sufficient funds to support required hardware & software upgrades & deliver the digital strategy, with increasing scale of threat which may leave the network vulnerable to attack.	Information & Communications Technology	High risk (12-16)	Prioritisation of available capital and revenue resources to essential cyber security projects through the business case approval process.	31/03/2020	For financial year 19/20 no Trust capital has currently been provided to any Business as Usual schemes. Affecting the ability to continue in delivery schemes Move forward with in plan schemes Delays will affect the strategy as attack vectors and methods are constantly evolving
							Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested.	Information & Communications Technology	Moderate risk (8-10)	Digital business continuity & recovery plans to be updated & tested at STP level. ICT plan to engage an independent security consultant to advise on any further action required.	31/03/2020	The BCP and Disaster plan has been updated A test of the plan is scheduled for the 31st July 2019, to desktop test the current plan.
4385	**Compliance with financial regulations, standards & contractual obligations** If the Trust is found to be systemically non-compliant with financial regulations & standards & or is unable to meet its contractual payment obligations; Caused by issues with the design or application of financial and contract management policies and procedures, or the availability of sufficient cash to meet payment obligations; It could result in regulatory action and sanctions or legal action which damages the reputation of the Trust amongst key stakeholders and may lead to sustained adverse local and / or social media coverage.	Financial governance & compliance monitoring arrangements. Trust Board approval of borrowing. Scheme of delegation & authority limits. Financial management policies, procedures, systems & training. Working capital strategy; prioritisation of payroll & critical supplier payments and escalation through Trust Board to NHSI. Cash forecasting and reconciliation processes. Contingency fund balance. Self-assessment & management processes for statutory & regulatory requirements. Annual internal audit plan. External audit annual report.	12	Finance, Performance & Estates Committee	Financial Turnaround Group	4	The Trust has a financial deficit and is therefore not able to meet its statutory obligation to break even.	Finance	High risk (12-16)	In Financial Special Measures; agreed Financial Recovery Plan to return the Trust to a sustainable footing ove ther medium term.	31/03/2024	
Executive lead: Rayson, Martin												
4081	**Quality of patient experience** If multiple patients across a range of the Trust's services have a poor quality experience; Caused by issues with workforce culture or significant process inefficiencies and delays; It could result in widespread dissatisfaction and a high volume of complaints that leads to a loss of public, commissioner and regulator confidence.	Patient Experience Strategy and Workplan; Patient experience metrics and reporting (FFT, Care Opinion, PALS & Complaints, Healthwatch data, compliments); Patient Experience training (leadership development programmes).	12	Quality Governance Committee	Patient Experience Group	4	Staff engagement & ownership of patient experience feedback, staff morale and staff shortages; lack of pride or hope in working at ULHT translated as low energy and passion; communication features highly as a negative indicator within feedback; staff lacking awareness of the 'impact of self'; staff do not feel valued; workload and demand gives little time to provide the care to the standard aspired to leaving staff disappointed and dissatisfied.	Human Resources	High risk (12-16)	Deliver against Patient Experience workplan; provide service and divisional level patient experience reports that are useful, timely and meaningful, secure a FAB Experience champion in every directorate; promote & spread Academy of FAB NHS Stuff to highlight FAB patient experience quality projects and achievements - spreading celebration and enthusiasm to rebuild motivation and hope and passion; determine links between staff and patient experience and drill down to team level to support improvements and interventions; provide data that delivers confidence that this is what staff and patients are saying about their experience within that service - and then support that service to design and deliver improvements.	31/03/2020	Continued implementation of agreed strategy and work programme. To be reviewed at the end of the financial year.
Executive lead: Bagshaw, Victoria												

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
4144	**Uncontrolled outbreak of serious infectious disease** If there is an uncontrolled outbreak of serious infectious disease within the Trust; Caused by a fundamental failure within the design or application of infection prevention and control measures; It could result in closure of several areas of the estates leading to widespread disruption to multiple services affecting a large number of patients, staff and visitors across directorates.	Infection control policies, guidance, systems and supporting documentation. Infection Control Committee & sub-group governance structure (Decontamination Group; Water Safety Group). Mandatory infection control training as part of Core Learning. Specialist advice & support from the Infection Control team. Datix incident reporting & investigation processes. Root cause analysis of hospital acquired infections. Infection control compliance monitoring / auditing. Outsourced sterile services (Steris) contract management. Outsourced microbiology services (Pathlinks) contract management. Cognos IT system (hosted by Pathlinks) by which the IP&C team receives sample reports for infection in patients.	16	Quality Governance Committee	Infection Prevention & Control Group	4	Global spread of new type of coronavirus - Covid 19. Potential for local outbreak if infection is not promptly identified and appropriately contained.	Corporate Nursing	High risk (12-16)	NHS in Lincolnshire and Public Health England (PHE) to put in place measures to ensure the safety of all patients and NHS staff while also ensuring services are available to the public as normal. ULHT to implement actions as required in line with the national and regional plan.	30/09/2020	Local implementation of plans underway. Signage installed on all sites. Temporary use of HAZMAT tents outside all 3 A&E departments to use for triage. Risks associated with use of tents have been assessed and mitigated as far as possible. Planned replacement with customised portacabins (including bathroom facilities and telecoms) is in progress.
4145	**Compliance with safeguarding regulations & standards** There is a statutory requirement for the Trust to evidence it is compliant with safeguarding regulations and standards. If the Trust is found to be systemically non-compliant with safeguarding regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by the Care Quality Commission (CQC), NHS Improvement or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.	9/12/19 Review of Safeguarding group governance structure and membership in progress.Gap analysis commenced against local, regional and national guidance and statutory requirements being undertaken by Safeguarding Leads Adult and MCA, Children and young people. Safeguarding policies, guidance, systems and supporting documentation. Chaperone policy supported by guidance, posters and training. Mandatory safeguarding training (role-based) as part of Core Learning; accountability through performance reviews and Ward Accreditation. Safeguarding Group & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing.	12	Quality Governance Committee	Safeguarding Group	4	Inconsistent compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and Trust safeguarding policy requirements (e.g. Failure to recognise the need to assess capacity & make a DoLS application) picked up by regular audits.	Safeguarding	Moderate risk (8-10)	Increase visibility of the Safeguarding team who are providing advice, support and supervision to staff to bridge theory practice gap; Monthly audits to monitor progress which are reported through operational group and committee; Benchmarking data being explored.	29/02/2020	Lead professional for MCA reports that although MCA audits continue to show areas of concern they are showing a significant increase in knowledge and compliance. This is supported by CCG and CQC feedback. There remains some cases where there is clear evidence of lack of compliance with policy for example SI investigation. Monitoring will continue through audit and review of incidents, complaints and concerns. On this basis risk reduced to moderate. 9/12/19 Work being undertaken on the actions that will be required by the Trust to transition from existing DoLS legislation to new statutory requirements under Liberty Protection Safeguards.
							Not yet consistently achieving 90% compliance with safeguarding training requirements.	Safeguarding	Moderate risk (8-10)	Confirm that safeguarding training completion continues to be included in performance framework with compliance reviewed and managers held to account through operational performance management reviews; individual accountability to be managed through appraisal process.	29/02/2020	6/12/19 With the exception of Level 1 training compliance continues to fall short of the 90% trajectory. Discussions with Divisional Nurses/Matrons in relation to the hidden child agenda resulted in all Theatre staff and MaxFax staff (rather than a select cohort) receiving Level 3a training. Adding compliance to the records for such staff could account for the reduction in the Trust's overall Level 3a compliance. Additional bespoke training dates for this cohort of staff has been arranged.
							Capacity within the Safeguarding team affecting the ability to fulfil all statutory responsibilities of their roles (e.g. Domestic Homicide and Serious Case Reviews) and deliver proactive support to front-line staff.	Safeguarding	High risk (12-16)	Areas for more efficient working to be identified and improvements implemented; progress work to develop an integrated Safeguarding model for Lincolnshire that will deliver optimum benefits for Safeguarding across the county and ultimately deliver improved safeguarding outcomes for adults, children and young people in receipt of an holistic service: minimal duplication and gaps in provision (including transitions); greater innovation as future need is better anticipated; smooth patient hand-over and movement across organisational boundaries; urgent advice available via the Local Authority.	31/03/2020	9/12/19 Review of Safeguarding group governance structure and membership in progress.Gap analysis commenced against local, regional and national guidance and statutory requirements being undertaken by Safeguarding Leads Adult and MCA, Children and young people.
4146	**Effectiveness of safeguarding practice** If there is a significant,widespread deterioration in the effectiveness of safeguarding practice across the Trust with failure to facilitate person centred outcomes and focused responses to safeguarding for individuals who are vulnerable and at risk. Caused by fundamental issues with the design or application of local policies and protocols; It could result in multiple incidents of significant, avoidable harm affecting vulnerable people in the care of one or more directorates.	Safeguarding policies, guidance, systems and supporting documentation. Mandatory safeguarding training (role-based) as part of Core Learning. Safeguarding Group & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing. Learning Disability Mortality Review process (LeDeR). Safeguarding Statements of Intent (covering access to services by children, young people &	12	Quality Governance Committee	Safeguarding Group	4	Agitated patients may receive inappropriate sedation, restraint, chemical restraint or rapid tranquilisation; policies are now in place and training is in the process of being rolled out across the Trust. Audit of the use of chemical sedation is raising concerns that the Trust policy is not consistently being adhered to: choice of drug; dose; route of administration.	Safeguarding	High risk (12-16)	Develop & roll out clinical holding training for identified staff Trust-wide. Introduce debrief process. Identify trends and themes through incidents reported on Datix. Monitor training compliance rates. Introduce audit of 5 security incidents per month from September 2018. Review of chemical sedation pathway.	29/02/2020	9/12/19 Monthly chemical sedation audits continue to be undertaken by Safeguarding team and show improvements in compliance. A revised Rapid Tranquilisation Policy which incorporates new pathways developed to support staff is in the consultation stages prior to being submitted to CEG.Clinical Holding Training continues to be delivered and individuals identified as requiring training attendance is being monitored on a person by person basis by relevant managers. Matrons undertake review of cases where rapid tranquilisation has been administered

Strategic Very high High risks (February 2020)

ID	Title & description	Controls in place	Rating (current)	Lead assurance committee	Lead management group	Rating (acceptable)	Weakness/Gap in Control	Specialty	Action risk rating	Planned action	Action due date	Progress
		adults as well as modern slavery & human trafficking). Hospital IDVA's in place. Targeted audits by Safeguarding and Ward Accreditation about compliance.					The Trust has no agreed pathway for referring clinicians, both internal and external, for patients with significant learning disabilities and challenging behaviours and no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc. This can lead to sub-optimal care and delays in diagnosis or treatment.	Safeguarding	High risk (12-16)	Development of an appropriate pathway for patients with learning disabilities: Plans currently made on an individual basis however this results in delays; task and finish group to scope extent of issues and to progress pathway development.	29/02/2020	Draft pathway developed and under consultation. 9/12/19 A divisional response has been requested against each of the possible draft pathway considerations and that if they are not possible alternatives required.
							There is no mandatory, core learning or core learning plus formal training programme provision within the Trust for: 1. Mental Health - awareness; responsibilities in relation to administering the Mental Health Act, ligature risk 2. Learning disability - awareness, care in hospital and reasonable adjustments 3. Autism - - awareness, care in hospital and reasonable adjustments	Safeguarding	Moderate risk (8-10)	1. Liaise with training and development department to resubmit applications for core learning. 2. Liaise with clinical education department to determine numbers and reach of HEE funded programme. 3. Refresh training needs analysis to incorporate Autism developments. 4. Ensure reflected within MHLD&A Strategy and associated work-plan.	29/02/2020	Mental Health Awareness Core learning training developed and available from 1st July 2019. As of 25th July 2019 49.66% of required staff had completed it. Compliance and impact will be monitored through MHLDA group. Update reports received by Safeguarding Group.
							There is evidence from CCG visits,MARAC research and internal audit processes that Domestic Abuse (DA) Trust policy and guidelines are not being consistently followed and therefore victims of DA continue to be at risk of harm. This is a Trust wide issue but particularly relevant for ED. All deaths associated with DA are subject to a domestic homicide review which is Home office reportable and all high risk DA cases are referred to the local MARAC therefore lack of adherence to policy places the Trust at risk of adverse media, CQC,CCG and Home Office attention where death or serious harm occur to a person and ULHT did not follow the proper processes.	Safeguarding	High risk (12-16)	Domestic Abuse Policy in place. Hospital IDVAs now in place in Pilgrim and Lincoln EDs. Targeted audits by Safeguarding and Ward Accreditation undertaken about compliance. Internet support and guidance available. Safeguarding training covers DA ,staff complete DASH form during training. Safeguarding team attending huddles in ED. Escalated to Lead Nurse for ED. DA/DASH/MARAC mini teaches for the ED staff in both PHB and LCH. Trial of targeted supervision by SG team. Communications about DA processes and cases. Patient Safety Briefings. Ensure staff attendance at SG training in date.	30/06/2020	

Appendix II - Very high High Operational Risks (February 2020)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4301	Delayed patient diagnosis or treatment (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	20	Very high risk
4426	Availability of essential equipment & supplies (Diagnostics CBU)	Clinical Support Services	Service disruption	20	Very high risk
4305	Exceeding annual budget (Specialty Medicine CBU)	Medicine	Finances	16	High risk
4311	Access to essential areas of the estate (Specialty Medicine CBU)	Medicine	Service disruption	16	High risk
4331	Exceeding annual budget (Urgent & Emergency Care CBU)	Medicine	Finances	16	High risk
4392	Replacement of essential equipment to prevent service disruption (Estates & Facilities)	Corporate	Service disruption	16	High risk
4396	Exceeding annual budget (Estates & Facilities)	Corporate	Finances	15	High risk
4334	Access to essential areas of the estate (Urgent & Emergency Care CBU)	Medicine	Service disruption	15	High risk
4340	Workforce capacity & capability (Cancer Services CBU)	Clinical Support Services	Service disruption	15	High risk
4330	Workforce capacity & capability (Urgent & Emergency Care CBU)	Medicine	Service disruption	15	High risk
4328	Quality of patient experience (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	15	High risk
4320	Workforce capacity & capability (Cardiovascular CBU)	Medicine	Service disruption	15	High risk
4302	Workforce capacity & capability (Specialty Medicine CBU)	Medicine	Service disruption	15	High risk
4303	Safety & effectiveness of patient care (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	15	High risk
4170	Workforce capacity & capability (Pharmacy)	Clinical Support Services	Service disruption	15	High risk
4297	Workforce capacity & capability (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	15	High risk
4190	Safety & effectiveness of patient care (Surgery CBU)	Surgery	Harm (physical or psychological)	12	High risk
4191	Availability of essential equipment (Surgery CBU)	Surgery	Service disruption	12	High risk
4196	Workforce capacity & capability (Surgery CBU)	Surgery	Service disruption	12	High risk
4201	Compliance with regulations & standards (Surgery CBU)	Surgery	Reputation / compliance	12	High risk
4221	Access to essential areas of the estate (T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4262	Availability of essential equipment & supplies (T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4288	Availability of essential information (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	12	High risk
4115	Workforce capacity & capability (TACC CBU)	Surgery	Service disruption	12	High risk
4116	Availability of essential equipment & supplies (TACC CBU)	Surgery	Service disruption	12	High risk
4118	Safety & effectiveness of patient care (TACC CBU)	Surgery	Harm (physical or psychological)	12	High risk
4120	Delayed patient discharge or transfer of care (TACC CBU)	Surgery	Harm (physical or psychological)	12	High risk
4168	Availability of essential equipment & supplies (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4169	Availability of essential information (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4304	Health, safety & security of staff, patients and visitors (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk

Appendix II - Very high High Operational Risks (February 2020)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4315	Delayed patient diagnosis or treatment (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4317	Exceeding annual budget (Cardiovascular CBU)	Medicine	Finances	12	High risk
4318	Compliance with regulations & standards (Cardiovascular CBU)	Medicine	Reputation / compliance	12	High risk
4322	Safety & effectiveness of patient care (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4324	Access to essential areas of the estate (Cardiovascular CBU)	Medicine	Service disruption	12	High risk
4325	Availability of essential information (Cardiovascular CBU)	Medicine	Service disruption	12	High risk
4327	Delayed patient diagnosis or treatment (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4329	Safety & effectiveness of patient care (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4333	Delayed patient discharge or transfer of care (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4372	Compliance with regulations & standards (Outpatient Services)	Clinical Support Services	Reputation / compliance	12	High risk
4373	Availability of essential information (Outpatient Services)	Clinical Support Services	Service disruption	12	High risk
4391	Health, safety & security of staff, patients and visitors (Estates & Facilities)	Corporate	Harm (physical or psychological)	12	High risk
4408	Safety & effectiveness of patient care (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4409	Health, safety & security of staff, patients and visitors (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4412	Access to essential areas of the estate (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4415	Exceeding annual budget (Children & Young Persons CBU)	Family Health	Finances	12	High risk
4416	Delayed patient diagnosis or treatment (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4420	Workforce capacity & capability (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4425	Workforce capacity & capability (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4429	Availability of essential information (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4433	Compliance with regulations & standards (Diagnostics CBU)	Clinical Support Services	Reputation / compliance	12	High risk
4435	Access to essential areas of the estate (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4452	Compliance with regulations & standards (Women's Health & Breast Services CBU)	Family Health	Reputation / compliance	12	High risk
4460	Workforce capacity & capability (Women's Health & Breast Services CBU)	Family Health	Service disruption	12	High risk
4461	Safety & effectiveness of patient care (Women's Health & Breast Services CBU)	Family Health	Harm (physical or psychological)	12	High risk
4462	Health, safety & security of staff, patients and visitors (Women's Health & Breast Services CBU)	Family Health	Harm (physical or psychological)	12	High risk

NHS
United Lincolnshire Hospitals
NHS Trust

Risk Management Policy Appendix I: Risk Scoring Guide

To be used when assessing risks that are recorded on the Trust risk register (Datix).

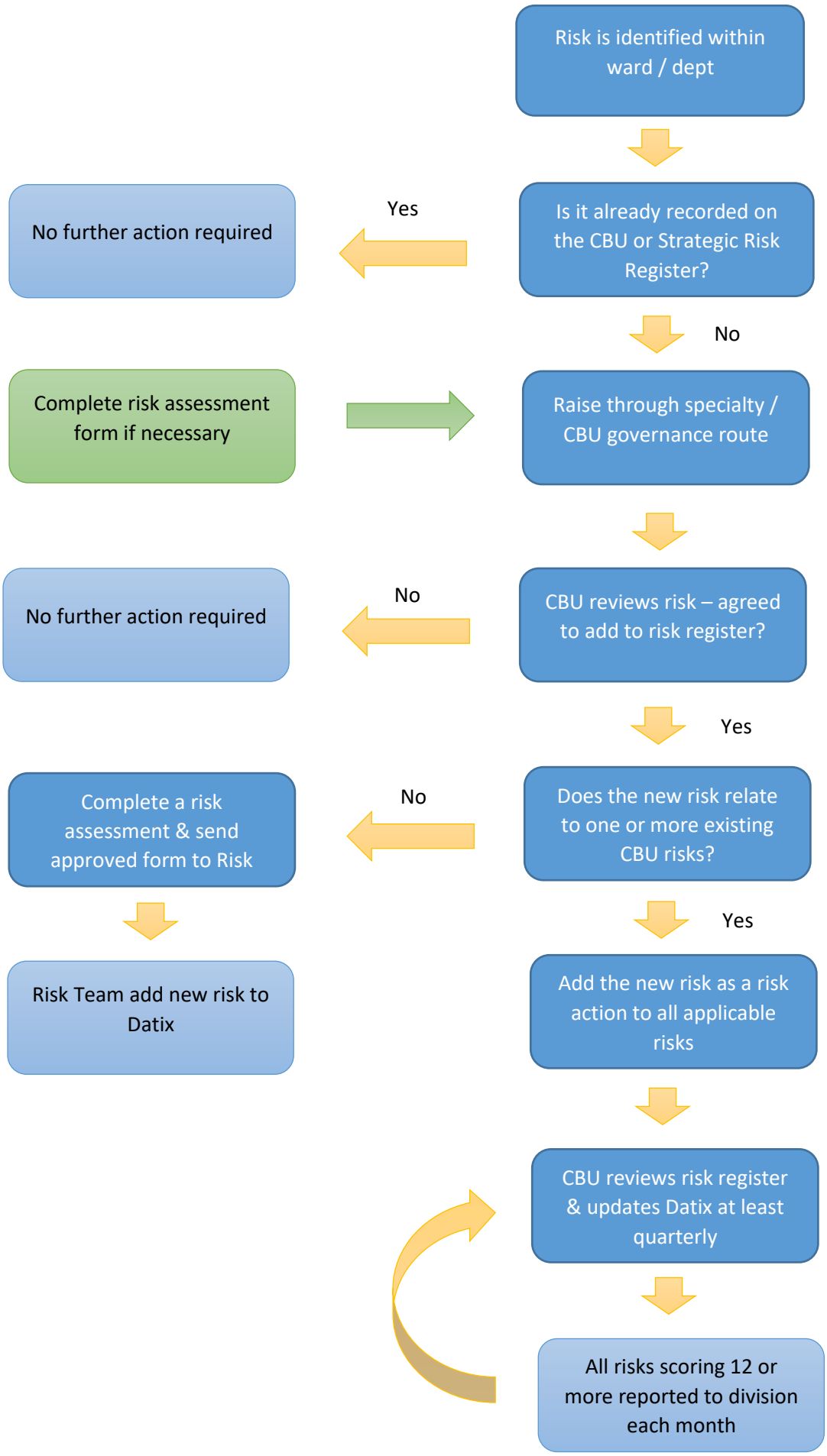
	Severity score & descriptor (with examples)				
Risk type	**1 Very low**	**2 Low**	**3 Medium**	**4 High**	**5 Very high**
Harm (physical or psychological)	Low level of harm affecting a small number of patients, staff or visitors within a single location.	Low level of harm affecting a large number of patients, staff or visitors within a single location.	Significant but not permanent harm affecting multiple patients, staff or visitors within a single business unit.	Significant long-term or permanent harm affecting multiple patients, staff or visitors within one or more business units.	Significant long-term or permanent harm affecting a large number of patients, staff or visitors throughout the Trust.
Service disruption	Manageable, temporary disruption to peripheral aspects of service provision affecting one or more services.	Noticeable, temporary disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more services.	Temporary, unplanned service closure affecting one or more services or significant disruption to efficiency & effectiveness across multiple services.	Extended, unplanned service closure affecting one or more services; prolonged disruption to services across multiple business units / sites.	Indefinite, unplanned general hospital or site closure.
Compliance & reputation	Limited impact on public, commissioner or regulator confidence. e.g.: Small number of individual complaints / concerns received.	Noticeable, short term reduction in public, commissioner and / or regulator confidence. e.g.: Recommendations for improvement for one or more services; concerns expressed in local / social media; multiple complaints received.	Significant, short term reduction in public, commissioner and / or regulator confidence. e.g.: Improvement / warning notice for one or more services; independent review; adverse local / social media coverage; multiple serious complaints received.	Significant, long-term reduction in public, commissioner and / or regulator confidence. e.g.: Special Measures; prohibition notice for one or more services; prosecution; sustained adverse national / social media coverage.	Fundamental loss of public, commissioner and / or regulator confidence. e.g.: Suspension of CQC Registration; Parliamentary intervention; vitriolic national / social media coverage.
Finances	Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget.	Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total.	Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation.

Likelihood score & descriptor (with examples)				
1 Extremely unlikely	**2 Quite unlikely**	**3 Reasonably likely**	**4 Quite likely**	**5 Extremely likely**
Unlikely to happen except in very rare circumstances. Less than 1 chance in 1,000 (< 0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1 chance in 100 & 1 in 10 (1- 10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1 chance in 10 & 1 in 2 (10 - 50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1 chance in 2 (>50% probability). Evidence of substantial threats with significant gaps in control.

Risk scoring matrix						
Severity	**5**	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	**2**	**3**	**4**	**5**
		Likelihood				

Risk rating	**Very low** (1-3)	**Low** (4-6)	**Moderate** (8-10)	**High** (12-16)	**Very high** (20-25)

Risk management process (January 2020)



United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Karen Willey, Deputy Trust Secretary
Date:	3rd March 2020
Essential Standards:	

Title:	Board Assurance Framework (BAF) 2019/20

Author/Responsible Director: Karen Willey, Deputy Trust Secretary/Jayne Warner, Trust Secretary

Purpose of the Report:

To present the 2019/20 Board Assurance Framework

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Information	X

Summary/Key Points:

The 2019/20 BAF has been presented to the Board Committees during February.

The BAF contains a number of updates including the identification of further controls against objective 1a, mortality metric, updates to the assurance gap and mitigation of objective 2a and additional identification of control gaps and mitigation within objective 2b.

Following review by the Finance, Performance and Estates Committee objective 2a has been rated as Amber.

There have been no changes to the RAG ratings during February.

Direction of Travel of Assurance Ratings:

RAG Rating	January 2020	February 2020	Direction
Red	7	6	↓

Amber	0	1	↑
Green	0	0	→

The BAF will continue to be updated through the Executive Directors before being presented to Committee meetings for discussion and further update where required, monthly updates will be received by the Trust Board.

Recommendations:

The Trust Board are asked to:

- Note the updates within the Board Assurance Framework and confirm the assurance ratings provided by the Committees
- Consider the identified gaps in assurance and advise/identify reports to be presented to the Board or Committees which would support the closure of the assurance gaps

Strategic Risk Register	**Performance KPIs year to date**
Links to the risk register are included within the BAF and will be updated as risks are identified	Appropriate KPIs relevant to the ambitions will be identified within the BAF

Resource Implications (eg Financial, HR) N/A

Assurance Implications Assurance on delivery of Trust ambitions is provided within the BAF

Patient and Public Involvement (PPI) Implications N/A

Equality Impact N/A

Information exempt from Disclosure No

Requirement for further review? Monthly review through Committees and Trust Board

United Lincolnshire Hospitals NHS Trust

Board Assurance Framework (BAF) 2019/20 - February 2020

Ambition	Board Committee	Enabling Strategy	
Our Patients: Providing consistently safe, responsive, high quality care	Quality Governance Committee	Quality Strategy	Research Strategy
Our Services: Providing efficient and financially sustainable services	Finance, Performance and Estates Committee	Financial Strategy Estates Strategy	Digital Strategy Environmental Strategy
Our People: Providing services by staff who demonstrate our values and behaviours	Workforce, OD and Transformation Committee	People Strategy Equality Diversity and Inclusion Strategy Communications and Engagement Strategy	
Our Partners: Providing seamless integrated care with our partners	Finance, Performance and Estates Committee		

Ref	Objective	Metric	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	**Providing consistently safe, responsive, high quality care**													
1a	Deliver harm free care	Mortality - HSMR within control limits	Medical Director	Coding incomplete/inaccurate Non delivery of the Trust Mortality Reduction Strategy Not working in Partnership across the health care system Inability to control/manage emergency demand	Corporate Risk ID 4138 - Mortality rates (Moderate)	CQC Safe	Dr Foster - investigations into Dr Foster alerts HSMR and SHMI National Benchmarking Reports National audits - secondary control ReSPECT Quality Account Priority 3 Learning from deaths and patient safety incidents Introduction of medical examiners Perinatal mortality review tool (PMRT)	Consistent delivery of ReSPECT Inability to control/manage emergency demand System wide partnership working: - preventing admission - provision of appropriate and timely discharge - reviewing deaths	Comprehensive ReSPECT roll out programme, system wide multi-professional education and audit Urgent Care Board Lincolnshire Mortality Learning Network	Triangulation of lessons learned, incidents, coroners, claims and complaints National audit reports Mortality Reduction Plan Regular reporting on learning from deaths. Reviews of alerting diagnosis/conditions, including independent reviews IPR Routine quarterly focussed assurance reports to Quality Governance Committee	System wide partnership reports	System wide mortality group System Improvement Board	Quality Governance Committee	R
		Harm Free Care - Safety Thermometer 99%	Director of Nursing	Unreliable or inaccurate data Failure to deliver against action plans in place for key harms Inconsistency in quality reporting from new Divisions.	Corporate Risk ID 4142 - Safety of patient care (Moderate)	CQC Safe	QSIP Plan Harm Free Action Plans in all areas Ward Accreditation Programme National benchmarking Integrated Performance Report Quality Strategy Patient Experience Plan Inclusion Strategy QSOG reports Quality Account priorities 1 ,2 &	Lack of capacity to deliver Inclusion of actions from CQC visit within QSIP plan Not available in all areas Data Quality Quality Strategy not approved Risk highlighted through QSOG of gaps in senior clinical leadership roles within the Divisions	Bi weekly meetings Harm Free care Steering Group QSIP Programme Patient experience annual plan as part of Quality Strategy Meeting to finalise metrics Infection Prevention and Control Group	Integrated Performance Report Patient Experience Dashboard and codesign of pathways with patients Quality and Safety Improvement Plan Clinical Audit Programme Ward Accreditation results Harm Free Care Group Medicines Management exception report Safeguarding exception report Infection Prevention	Quality Strategy not approved Harm Review data quality - Process has been significantly reviewed fits with committee work programme. To remain as gap for time being QSOG still in development New Trust Operating Model still embedding.	Director of Nursing and Medical Director to further develop Quality Strategy Identification of relevant groups ownership of Harm Review policy and process	Quality Governance Committee	

Ref	Objective	Metric	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
							4 Hygiene Code <u>Internal Audit:</u> Data quality of KPIs - Q4 Compliance with legislation - Q2	Lack of ability to rely on divisional governance Metric not finalised Sharing and learning not at desired level Implementation and/or delivery against existing guidance or safety recommendations (national and local) in relation surgical site safety leading to Never Events	Action plan being developed to address surgical site safety to reduce the number of Never Events reported. Sign off of action plan January 2020 at QGC	Control exception report Equality and Diversity Patient report Inclusion strategy	Patient Experience and links to Quality Strategy and how articulated in BAF			
1b	Valuing our patients' time	% patients seen at appointment time (within 15 minutes of appointment time)	Chief Operating Officer	Unreliable, incomplete or inaccurate data Insufficient clinic capacity resulting in overbooking Inappropriate clinic configuration providing duplicate appointment times Patients arriving late for their clinic appointment Poor engagement	Corporate risk ID 4368 - Outpatient demand (High)	CQC Responsive	Specialty Governance Data Quality Group Outpatient Improvement Programme Delivering Productive Services Group	Data Quality Insufficient outpatient capacity to meet current demand across a number of specialties Consistency of Specialty Governance process	Data Quality workstream Performance Review Meetings Outpatient improvement programme System approach to managing planned care demand Governance team supporting embed of specialty governance post TOM implementation	Monthly Productive Services Group FPEC	Impact of actions being taken via PRM and prodcutive services group not visible	Ensure reported through performance report to incorporate necessary narrative and impact from productive services group	Finance, Performance and Estates Committee	R

Ref	Objective	Metric	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
SO2	Providing efficient and financially sustainable services													
2a	Have 'zero waits' to access our services	% patients discharged within 24 hours of PDD	Chief Operating Officer	Unreliable or inaccurate data Poor engagement with setting PDD Internal systems not efficient to support timely discharge	Corporate risk ID 4176 - Planned care demand (High)	CQC Effective	Urgent and Emergency Care Improvement Programme - workstream 4, Ward Processes and 5, Discharge and Partnerships Daily review and overview by operational services Delivering Productive Services Group	Specialty Governance Data Quality Issues	Data Quality workstream PRMs probing gaps in speciality control and assigning actions to close	Urgent and Emergency Care Improvement Programme update IPR	Beginning of the year represented a process with an assurance gap	Current performance reported now accurately reflects the metric however, year to date reflects the previous gap from Q1	Finance, Performance and Estates Committee	A
2b	Ensure that our services are sustainable on a long-term basis i.e. here to stay	Delivery of Financial Plan £70.3m deficit	Director of Finance and Digital	Efficiency schemes do not cover extent of savings required - £25.6m Continued reliance on agency and locum staff to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure or financial penalties Failure to secure all income linked to coding or data quality issues Failure to secure contract income through backlog and repatriation schemes and inability to remove cost Activity exceeds contracted levels over and above repatriation and fails to secure all income due from commissioners	Corporate risk ID 4382 - Delivery of FRP (Very high) Corporate risk ID 4384 - Income reduction (High) Corporate risk ID 4383 - Unplanned expenditure (Very high)	CQC Well Led CQC Use of Resources	Financial Turnaround Group (FTG) oversight of FRP Vacancy control process Centralised agency team Financial Strategy and Annual Financial Plan Performance Management Framework Delivery of output of Clinical Service Review programme System wide savings plan <u>Internal Audit:</u> Finance efficiency programme - Q2 Performance Management and reporting - Q3 Education Funding - Q1	Reliance on temporary staff to maintain services, at increased cost Operational ownership and delivery of efficiency schemes Delivery of workforce cost reduction schemes Clinical coding & data quality issues Operational ownership of income at directorate level Lack of control over local demand reduction initiatives	Recruitment & retention initiatives to reduce reliance on temporary staff Income improvement plan for each directorate Divisional FRP meetings held fortnightly. Reporting by schemes into PRMs Divisional review of every post in the Trust Engagement with commissioners through system wide contract management framework Improved reporting in to divisions System savings plan and delivery group Performance review process refresh through new operating model	Monthly Finance Report to Trust Board including capital and contracting FSM meetings with NHSI Scrutiny and challenge through Finance, Performance and Estates Committee Internal Performance Review Meetings Internal Audit work reports IPR System Wide NHSE&I Performance and Escalation Meeting	Impact of recruitment and reduction in temporary staff Structures and systems in place however the Trust have a lack of control over expenditure Model Hospital Benchmarking CQC Use of resources	Report on recruitment and temporary staffing impact PRM Meeting outcomes, dashboard to be developed to be presented to Finance, Performance and Estates Committee Delivery of Financial Efficiency plans	Finance, Performance and Estates Committee	R

Ref	Objective	Metric	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
		% of services rated as 'delivering' *Note: 2019/20 is baseline year. % not in place, working through baseline in draft, scrutiny and road testing criteria and application, scheme of delivery and devolution* *Baseline analysis of how to manage classification of service performance - 3 levels*	Director of Finance and Digital	Lack of capacity to establish a robust programme of work Lack of focus and attention - not nationally required, externally driven - alternative pressures	None	CQC Use of Resources	TOM Operational Group TMG Delivery Proposal taken and agreed at TMG to set baseline 6 month shadow running <u>Internal Audit:</u> TOM Governance - Q4	Aligned to revision to national standards 20/21 Report on milestone plan Triumvirate Plan Signed off proposal at TMG	Tracking national developments Developing shadow running of national standards as they become clear Trust Operating Model Operational Group Debate on metrics across the CBUs/Divisions Project management plan with milestones being met	FPEC Updates TMG Updates	Process not in place currently, no plan and milestones	TOM Implementation to develop and agree service rating scheme for formal agreement at TMG	Finance, Performance and Estates Committee	
SO3	**Providing services by staff who demonstrate our values and behaviours**													
3a	Have a modern and progressive workforce	Vacancy fill rate	Director of People&OD	Inadequate workforce planning processes	Corporate risk ID 4362 - Workforce capacity & capability (Very high) Corporate risk ID 4082 - Workforce planning (High)		System workforce planning process - aligned with 5 year plan + internal workforce planning process, aligned to operational plan + Ward establishment reviews + Job planning for medical and other staff	Alignment of workforce plans to operational plans and intentions for the system + Job planning process not yet completed for 2019/20	LWAB Workforce Planning Group + Improved internal process, aligned to operational plans + Job planning process for 20/21 linked to demand/capacity planning	Completed workforce plans + completed job plans + output of ward establishment reviews	Effectiveness of job planning + Accuracy of establishment information	20/21 job planning process to begin in Autumn 2019 - regular monitoring reports on progress + Establishment review process	Workforce, OD and Transformation Committee	R
				Inability to recruit to areas of high vacancy - consultants, doctors and registered nurses in particular			Workforce Plan aligned to Financial Recovery Plan + Agreed approach to recruiting to key roles + Attraction strategy	Continued high vacancy rates for key clinical staff and no reduction in high agency spend	Recruitment partnership for medical and nursing recruitment + System attraction strategy + National campaigns for nursing and AHPS + Improvements to transactional recruitment process	Workforce IPR - vacancy data + KPIs relating to speed of recruitment process + Audit work	Availability of registered nurses + Appropriate targets for recruitment process, regularly reported	New recruitment partner for nursing recruitment + On-going review of recruitment process		
				Reliance on deanery positions to cover staffing gaps			Attraction of junior doctors + experience whist at ULHT (Guardian of Safe Working Practice role + GMC surveys)	Establishment of Guardian role across ULHT + poor survey results	Additional support being provided to the Guardian + Project to improve junior doctor experience	Regular report by Guardian to Committee + GMC survey results	Comprehensive Guardian's report not yet regularly provided to the Committee	Action being taken to improve support to the Guardian		
				Failure to embrace new roles			Workforce planning processes + Work of the Talent Academy around promotion of apprenticeships, new roles and new supply pipelines	Failure to fully to embrace new roles, such as Physician Associates	Additional funding to support new roles	Regular report on number of apprenticeships and activities of the Talent Academy	Pay back of ULHT apprenticeship levy	Maximisation of apprenticeship take-up in ULHT and transfer to primary care		
				Significant proportion of the workforce reaching retirement age			Succession planning + Initiatives such as "retire and return"	Succession planning not in place systematically	Talent management approach to ULHT being developed, within a system approach	Age profile of the workforce + Take up of schemes available	None			
				Attrition rate (overall and at particular sites and in specialties) is above the average			Retention plan - initiatives around flexible working, exit interviews, itchy feet interviews	Potential impact of Brexit	Communication and engagement by managers to EU staff	Workforce IPR - Turnover rate + numbers signing up to remain after Brexit	Report on EU staff remaining in the workplace	Progress reports on implementation of retention plans and take-up of initiatives		
				Failure to adequately equip our staff with the skills they need to fulfil their roles			Mandatory training programme + Development and delivery of the Education and Learning Strategy + Ability to access learning programmes + Potential of Medical School to refocus Trust on learning as an offer	Low completion rates of mandatory training + Education and Learning Strategy not yet driving investment + Progress in development of partnership with Medical School	Communications + Establishment of the Education and Learning Group + New appointment of Director of Education	Workforce IPR - training completion rates + Progress reports on Education & Learning Strategy and Medical School + Audit work	Regular reporting of progress not in place	Intention as part of IIP to monitor progress on delivery of plan and PI to cover access to learning and development		
				Sickness absence rates higher than in other Trusts			Attendance Policy + ER activity with managers to manage attendance + Health and Well-being activity	Sickness rates higher than others + Low NSS scores on health and well-being	Introduction of Empactis system and review of policy + Review of approach to health and well-being	Workforce IPR - Sickness data + Regular Health and Wellbeing updates + Audit work	Visibility to managers of sickness patterns and of appropriate management action not being taken	Empactis system will enable more detailed reporting		
				Lack of clarity over the future direction of the Trust and each individual's role in it			Review of Strategic Planning Framework to simplify + Communications Plan around new vision etc. + Individual Performance Management System (Appraisal)	Awareness of 2021 brand strong, but cannot translate into understanding of future direction and individual role in it	Review of framework + Review of internal communications plan	NSS Survey data + Internal Comms survey + Appraisal completion rates	Explore other ways we can regularly monitor awareness of key messages			

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
3b	Work as one team	Recommend as a place to work in staff survey 46% (↑ of 5%	Director of People&OD	Lack of trust in the senior leadership of the organisation - opportunity for staff voice to be heard)	Corporate risk ID 4083 Workforce engagement (High)		Role of Senior Leadership Forum and new Middle Manger Forum (both to be renamed) + TOM OD Plan to build capability + Work on visibility (staff feeling that they are heard) + Medical Engagement Work	Evidence from National Staff Survey (NSS) indicates a lack of trust, hope in the future and belief that things can improve + Low levels of medical engagement	Work to improve visibility - future of "big conversations" + review of Team Pilgrim/Louth etc. + Links to leadership work	NSS Survey data + other survey work	None		Workforce & OD Committee	R
				Leadership which is not compassionate and engaging			Leadership development programmes + Personal Responsibility Framework for managers + Appraisal for managers	Evidence from NSS indicates quality of leadership is not consistent + Attendance of the right people on the right programmes (with appropriate wrap-arounds to ensure impact)	Revisions to current leadership programme (e.g. adoption of coaching) + Review of Personal Responsibility Framework + Development programmes for Clinical Leads & General Managers	NSS Survey data + Attendance at leadership programmes	Explore other ways in which we can measure impact of leadership development	Work as part of the IIP to identify additional impact measures for work around leadership		
				Organisational culture which does not reflect the values of the Trust			Values and Staff Charter (Personal Responsibility Framework) - Staff Charter Workshops to embed values	Behaviours are not consistently good	Work on "civility" and "kindness"	NSS Survey data + ad-hoc surveys	Ability to assess progress between national staff survey data being available	Potential for a regular temperature check on behaviours to be developed		
		Recommend as a place to receive care in staff survey 53% (↑ of 5%)		Lack of fairness in the operation of ULHT workforce policies			Framework of ULHT Workforce policies under regular review + Freedom To Speak Up Guardian	Pressure on ER system + Lack of fair application of policies referenced in CQC report + Awareness of Freedom To Speak Up Guardian	Implementation of "Just Culture" approach to policies and ER work + Management Development + Freedom To Speak Up Champions	Workforce IPR - Regular data on ER activity + Freedom To Speak Up Guardian Reports	None			
				Lack of effective partnership with staffside			Recognition Agreement + EPF/JNF + Informal dialogue	Partnership with Staffside is broken	Revised Recognition Agreement with new meeting structure and facility time breakdown + Further relationship building work		Can measure progress on the recognition agreement, but no formal measure of the strength of our partnership	Explore need for a measure of health of partnership with staffside		
				Organisation does not fully embrace inclusiveness			Inclusion Strategy and regular reporting + Staff Networks	Issues around bullying and harassment + Workforce profile that demonstrates inclusivity	Talent management approach will embrace issues of diversity	WRES and WDES reporting + Gender Equality Data	None			
				Addressing issues around bullying and harassment in the ULHT workplace			Bullying and harassment project and initiatives that will follow	NSS data evidences a problem with bullying and harassment in the Trust	Complete project and implement actions agreed - initially 100 day projects	NSS Survey data	None			

United Lincolnshire Hospitals NHS Trust

Ref	Objective	Metric	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
SO4	**Providing seamless integrated care with our partners**													
4a	Make sure that the care given to our patients is seamless between ULHT and other service providers through better service integration	% reduction in face to face contacts in Outpatients 5% (Responsibility for the metric delivery sits with the Chief Operating Officer)	Chief Executive Officer	Lack of robust system plan Lack of/insufficient system capacity Poor engagement with primary/community care Demand Unaffordable Poor system working No single system plan	Corporate risk ID 4368 - Outpatient demand (High)	CQC Caring CQC Responsive CQC Well Led	1st line Activity monitoring Activity plan Contract Improvement project System plan delivery System Performance Report to SET STP/SET/LCB infrastructure ASR Single system plan ICC development programme 2nd line: ICS Development 3rd line: NHS ICS Maturity Index Internal Audit: STP Governance - Q2	ASR - capital limitation System delivery method not yet mature	ASR being refreshed for resubmission System wide SROs appointed and delivery framework being established	LCB Oversight SET CEO Updates at Board Healthy Conversation System wide partnership reports	No named ULHT individual for delivery of work stream	Allocation of responsibility and resource to ULHT individual for delivery of workstream Improving ULH document agreed through Remuneration Committee. Shared with organisation w/c 13 Jan creates new Directorate of Integration and Improvement Headed by Dir of Integration and Imp/Dep CEO	Finance, Performance and Estates Committee	R

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating

The BAF management process

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

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

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

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

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

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

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

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

United Lincolnshire Hospitals NHS Trust

TRUST BOARD FORWARD PLANNER

[2019/20]

	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Feb 20	Mar 20	Apr 20
Standing Items											
Chief Executive Horizon Scan	X	X	X	X	X	X	X	X	X	X	X
Patient/ Staff Story	X	X	X	X	X	X	X	X	X	X	X
Integrated Performance Report	X	X	X	X	X	X	X	X	X	X	X
Board Assurance Framework	X	X	X	X	X	X	X	X	X	X	X
Declaration of Interests	X	X	X	X	X	X	X	X	X	X	X
Governance											
Audit Committee Report	X	X		X			X		X		
Strategic Objectives for 2019/2020									X		
BAF Sign off for 2019/20	X									X	
Annual Accounts, Annual Report and AGS Sign Off	X										
Quality Account	X										
Corporate Risk Register	X	X	X	X	X	X	X	X	X	X	X
NHSI Board Observation Actions						X			X		
SO 1. Providing Consistently Safe, Responsive, High Quality Care											
Quality Governance Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X
Quality and Safety Improvement Plan	X	X	X	X	X	X	X	X	X	X	X
Safer Staffing Report		X					X				
Safeguarding Annual Report			X								
Annual Report from DIPC				X							
Innovation Update	X	X	X	X	X	X	X	X	X	X	X
SO 2 Providing Efficient and Financially Sustainable Services											

Finance, Performance and Estates Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X
Financial Plan and Budgets										X	
Clinical Strategy Update					X					X	
Operational Plan Update					X		X		X		
Emergency Planning Annual Self Assessment					X						
SO 3 Providing Services by Staff Who Demonstrate our Values and Behaviours											
Workforce, OD and Transformation Committee Assurance and Risk Report	X			X		X			X		X
Staff Survey Results											X
Freedom to Speak Up Report	X			X			X			X	
Report from Guardian of Safe Working		X			X					X	
Equality and Diversity Strategy		X									
5 Year Strategy	X			X			X		X		X
SO 4 Providing Seamless Integrated Care with our Partners											

United Lincolnshire Hospitals NHS Trust

Title:	Innovation Report

Author/Responsible Director: Anna Richards, Associate Director of Communications and Engagement/ Andrew Morgan, Chief Executive

Purpose of the Report: To update the Trust Board on innovative working across the Trust

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Information	X

Summary/Key Points:

The Trust has signed a new Energy Performance Contract to enable it to find innovative new ways to reduce carbon emissions, improve environmental performance and save money.

Recommendations:

For Trust Board to note the innovation report.

Strategic Risk Register	**Performance KPIs year to date**
Resource Implications (eg Financial, HR)	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact	
Information exempt from Disclosure	
Requirement for further review?	

Agenda Item 19

Lincolnshire's hospitals investing in reducing carbon emissions

United Lincolnshire Hospitals NHS Trust (ULHT) is embarking upon a trio of major energy-saving projects to improve sustainability and energy-efficiency across its hospital sites.

The Trust has recently signed a new Energy Performance Contract (EPC), finding innovative new ways to reduce carbon emissions, improve environmental performance and save money.

As part of its long-term Sustainable Development Management Plan, the Trust is introducing a new Combined Heat and Power (CHP) centre at Lincoln County Hospital. This will provide more efficient heating and hot water facilities for patients and staff at lower cost. The new centre is expected to be operational by mid-2020.

It will also be installing energy-efficient LED lighting across the main hospital sites, which will last longer than conventional lighting, saving up to 70% of energy and cost and creating a better environment for patients and staff.

Finally, the Trust is also planning to convert the main energy supply at Pilgrim Hospital, Boston to gas from oil. This will ensure there is a reliable, lower-carbon supply of energy to the site.

Together, the three projects are expected to save the Trust more than £1.2 million a year.

Estates and Facilities Associate Director of Strategic Business Planning, Claire Hall, said: "Sustainability, energy efficiency and carbon reduction are at the heart of our work. We want to make sure our hospitals meet modern standards and that we have a reliable, environmentally-friendly supply of energy for the benefit of our patients and staff.

"We have already made great strides in reducing our carbon footprint, having cut it by 13% between 2009 and 2015 – against a national average of 10%.

"By upgrading and investing in these new sustainable technologies, it's our ambition to reduce our carbon footprint by 28% by 2021."