Bundle Trust Board Meeting in Public Session 7 December 2021

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

1	Introduction, Welcome and Chair's Opening Remarks *Chair*
2	Public Questions *Chair*
3	Apologies for Absence *Chair*
4	Declarations of Interest *Chair*
5.1	Minutes of the meeting held on 2 November 2021 *Chair* Item 5.1 Public Board Minutes November 2021v1.docx
5.2	Matters arising from the previous meeting/action log *Chair* Item 5.2 Public Action log November 2021.docx
6	Chief Executive Horizon Scan *Chief Executive* Item 6 Chief Executive's Report, 071221.docx
6.1	CQC Core Service and Well-Led Inspection *Director of Nursing/Deputy Chief Executive* Item 6.1 CQC Update - December 2021 v1.0 - Public Board.docx Item 6.1 Appendix 1 - Core Service verbal feedback letter.pdf Item 6.1 Appendix 2 - Well Led verbal feedback letter.pdf
7	Patient/Staff Story *Director of Nursing* *Please be aware that sometimes our patient and staff stories can deal with very difficult subjects, which may affect you personally. If you are concerned about this the Trust Secretary can advise you of the subject to be discussed at the start of the meeting.*
7.1	BREAK
8	Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
8.1	Assurance and Risk Report from the Quality Governance Committee *Chair of Quality Governance Committee* Item 8.1 QGC Upward report November 2021v1.doc
9	Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
9.1	Assurance and Risk Report from the People and Organisational Development Committee *Chair of People and Organisational Development Committee* Item 9.1 POD - Upward Report - November 2021.docx
10	Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate
10.1	Assurance and Risk Report from the Finance, Performance and Estates Committee *Chair of Finance, Performance and Estates Committee* Item 10.1 FPEC Upward Report November 2021v1.docx
10.2	Urology Service Engagement Output update *Chief Operating Officer* Item 10.2 FINAL 2122 ULHT Urology Reconfiguration of services update.docx
11	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing

12 Integrated Performance Report

Director of Finance and Digital

Item 12 IPR Trust Board - Front page.docx

Item 12 IPR Trust Board November 2021 v2.pdf

13 Risk and Assurance

13.1 Risk Management Report

Director of Nursing

Item 13.1 Trust Board - Strategic Risk Report - December 2021.docx

13.2 Board Assurance Framework

Trust Secretary

Item 13.2 BAF 2021-22 Front Cover December 2021.docx

Item 13.2 BAF 2021-2022 v29.11.21.xlsx

14 Any Other Notified Items of Urgent Business

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

EXCLUSION OF THE PUBLIC
In accordance with Standing Order 3:1 and Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960: To resolve that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Minutes of the Trust Board Meeting

Held on 2 November 2021

Via MS Teams Live Stream

Present

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

Non-Voting Members:
Mrs Alison Dickinson, Associate Non-Executive Director

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Cathy Geddes, Improvement Director, NHSE/I

Apologies
Dr Maria Prior, Healthwatch Representative

1751/21	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. In line with guidance on Covid-19 the Board continue to hold meetings open to the public through the use of MS Teams live. In line with policy, papers had been published on the Trust website a week ahead of the meeting and the public able to submit questions in the usual manner. The Chair highlighted that although national Covid-19 restrictions were lifted on the 19 July 2021 the NHS continued to operate under the advice of NHS England in regard to Infection Prevention Control measures including the requirement to follow social distancing rules, impacting on the ability to revert to Board meetings in the pre pandemic format. The Trust Board would continue to follow national advice and operate in accordance with procedures that had been implemented during the pandemic.
1752/21	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Jody Clark**

	I want to firstly thank everyone for continuing to care for patients during such difficult times. I understand that winter pressures and increasing covid cases are putting enormous pressure on our NHS services. **Can I just ask if Grantham Hospital is in any escalation plans? Do you have any additional capacity available here?** The Chief Operating Officer responded: As pressure builds up across the Trust, and both regionally and nationally, in respect of Covid-19 there is progressively more use of surge and escalation plans. Grantham Hospital is part of this however there were two important roles for the escalation these being urgent care and emergency medicine capacity, this was a relatively limited number of increase. Grantham Hospital also contributes to a larger part in the escalation and surge plans that sees time protect for surgery. There is an ability to learn from the excellent work carried out in wave 1 and 2 of Covid-19 to protect this capacity for patients, primarily with cancer. This allows the Trust to continue to operate on patients with Grantham playing a key part in the ability to respond over the winter and escalation period.
1753/21	**Q2 from Chris Sharman** **In response to a recent Freedom of Information (FOI) request, the Trust has acknowledged that, as at 17 June 2021, it had 512 overdue FOI requests, the oldest dating from 9 January 2020.** **My question is in three parts;** **1. Is this failure to comply with the Freedom of Information Act, and the reputational risk attached thereto, included in the Trust's Strategic Risk Register (agenda item 13.1)?** **2. Does the Trust Board have overview of this situation, and does it receive regular updates on performance in this area?** **3. What plans are in place to address this significant backlog?** The Director of Finance and Digital responded: The Trusts Risk Register details risk associated with all areas of Information Governance and includes responses to Subject Access Requests and Freedom of Information (FOI) request. The risk is being addressed through the implementation of an improvement plan in this area and a piece of work which is currently ongoing regarding capability and capacity within the organisation for this function. The governance route for reporting is via the Information Governance Group with regular reporting taking place in respect of FOI performance. The Information Governance Group upwardly reports to the Finance, Performance and Estates Committee on a bimonthly basis and in turn the Committee provides information to the Trust Board. The Director of Finance and Digital stated that it was important to note the large number of people involved within the organisation in dealing with FOIs in order to obtain and provide the information. Clearly the Trust had been responding, over the past year, to the pandemic which has meant many of the staff have been responding as frontline staff and other redeployed to the Trust's response.

	However, the Trust recognises that the performance is not where it would want to be and so has been working with the Information Commissioners Officer with an improvement and action plan put in place. This was paused due to the impact of the pandemic and the Trust are now putting this back in place to ensure performance was improved to a suitable level.
1754/21	**Q3 from Vi King** **Please can I ask what the uptake is with theatre Lists at Grantham with regarding capacity.** **Re the Public consultation that Grantham hospital will become a centre of excellence for elective orthopaedic. What will happen if the public want their orthopaedic surgery done at the hospital which is closer to them, will they have that choice?** The Chief Operating Officer responded: The uptake of lists at Grantham Hospital has been improving, albeit there had been some difficulties with elective capacity, particularly over the half term period as teams took well deserved and quite urgently needed rest. There had been a focus on maintaining urgent care support noting that the lists had reduced during the half term period to 26 lists in a week of the 50 available. Whilst it was disappointing to have reduced the lists these were now back to 38 lists running over the course of the next two weeks and continues to improve. One of the 5 theatres was temporary with the Trust planning to replace this and add a further theatre where possible. Discussion was underway with NHS England and Improvement in order to do this on a more permanent basis. The use and development of theatres runs alongside a productivity scheme where the Trust were attempting to see more patients on a list. Regarding Orthopaedics, this had been the reason that the Trust had enacted the pilot in order to reduce the number of patients cancelled due to other services impacting on the elective orthopaedics. The pilot demonstrated up to a 90% reduction in cancellations and offered a change in the ability to be able to offer important surgery in a more rapid way than when offered across all sites. This combined with the Get It Right First Time work had enable the Trust to identify an area, ring fenced for elective orthopaedic surgery, that had been held up as national exemplar of best practice and was in line with having a centre of excellence. Whilst the Acute Services Review process was run by Lincolnshire Clinical Commissioning Group the Trust would encourage patients and the public to feedback about the experiences and what they would like to see. This would then factor in to any future permanent decision of service configuration going forward.
1755/21	**Item 3 Apologies for Absence** Apologies for absence were received from Dr Maria Prior, Healthwatch Representative
1756/21	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared and declarations had been updated on the Trust website as required.

1757/21	**Item 5.1 Minutes of the meeting held on 5 October 2021 for accuracy** The minutes of the meeting held on 5 October 2021 were agreed as a true and accurate.
1758/21	**Item 5.2 Matters arising from the previous meeting/action log** The Chair noted that most items on the log were dealt with or included within the forward agendas however action 579/21 in relation to triangulating data between staff survey and quality measures remained outstanding. It was noted that a position statement would be offered at the December 2021 Trust Board meeting.
1759/21	**Item 6 Chief Executive Horizon Scan including STP** The Chief Executive presented the report to the Board noting the continued pressure on the NHS and system including the Trust, noting that this was highlighted through the media, including access to face to face GP appointments.
1760/21	The Trust was incredibly busy with high occupancy levels and crowding in the Accident and Emergency departments with difficulties in being able to safely discharge medically optimised patients.
1761/21	It was noted that ambulance handovers continued to be an issue with the Trust trying to allow the ambulance service to get back on the road to respond to urgent cases appearing in the community. There was a lot of work underway to address the issues being faced.
1762/21	The vaccination programmes continued with a major focus of the system on the Covid-19 vaccinations for 12-15 year olds. There had been considerable national media focus along with the booster programme with vaccinations continuing for staff. The hospital hubs continued to vaccinate Trust staff and other healthcare staff alongside issuing the flu vaccinations.
1763/21	The Chief Executive advised that there had not been an appointment made to the Chair designate of the Integrated Care Board (ICB) and as such, Mrs Baylis, Trust Chair had agreed to continue to chair in the interim. The outcome of the interview process for the Chief Executive Officer designate of the ICB was awaited.
1764/21	Other key aspects in relation to the Integrated Care System (ICS) was the Provider Collaborative, there was a strong view that providers would create delay with the transformation of service change, particularly the integration of services. There was a provider collaborative in Lincolnshire, the Lincolnshire Health Care Collaborative (LHCC) which was about all providers, not just statutory NHS Trusts. This would allow a view across all sectors and pathways and whilst this was in its infancy there was an advert out for a Managing Director in order to offer day to day direction.
1765/21	The system improvement plan continued with the System Improvement Director assisting with the work in the system. There were 3 areas of focus set out in the report detailing the work conducted with clinical and support colleagues in relation to phase 1 of the system improvement plan. There was a national review of the overall recovery support programme which both the Trust and system were part of, a meeting was scheduled to take place on 15 November.

1766/21	In respect of Trust issues the Chief Executive advised that the Trust had achieved the month 6, H1, financial plan of a £1.8m surplus. This continued the good work undertaken by the Trust and the success of achieving the financial plan at the end of the financial year in both March 2020 and 2021. This did not minimise the underlying financial issues but demonstrates the Trusts ability to meet the plans, effort would now turn to H2 deliverability.
1767/21	The Chief Executive noted that the Director of Finance and Digital was currently caretaking the People and Organisational Development Directorate with thanks being offered for taking this on alongside existing responsibilities. Considerable leadership and direction had already been offered alongside decision making authority. The Trust remained out to advert through a recruitment agency for the Director position with interviews planned for the 3 December. It was hoped that the Trust would appoint substantively.
1768/21	An appointment had been made to the secondment for the Director of Improvement and Integration, the person selected was outside of the Lincolnshire system meaning that it was not possible for the Trust to make an announcement until the process had concluded.
1769/21	The Chief Executive noted that the Trust was currently being inspected by the Care Quality Commission in respect of a core service inspection. The well-led review would be conducted week commencing 8 November for 3 days. The draft report for all aspects of the inspection would be available early in the new year.
1770/21	The Board was advised of the virtual staff award ceremony that would take place on 3 November. The inaugural Leading Together Forum had taken place online across 2 cohorts, whilst this would have ideally been held in person it was not possible due to Covid-19.
1771/21	There was renewed commitment from the leaderships of the organisation as to how, as part of the cultural and leadership programme, there was a need to change behaviours and leaderships culture within the organisation. The Trust Board: • **Noted the report and significant assurance provided**
1772/21	**Item 7 Patient Story** The Director of Nursing presented the patient story to the Board advising that the story detailed the experience of a young patient with severe autism and sensory processing disorder. The story offered a fantastic example of how innovation and technology supported the patient's experience.
1773/21	The Board watched the video presentation that detailed the innovation undertaken during Covid-19 utilising 3D printing to produce over 2000 oxygen connectors and restrictors for the use of CPAPs for Covid-19 compromised patients.
1774/21	The Board noted that the Trust had reached out to the local community, working with the University of Lincoln and children from local schools, who had 3D printers at home to deliver the demand for T-pieces during the pandemic. This had not only delivered cost efficiencies but had been an innovations within MHRA guidance.
1775/21	The video presentation offered information regarding the 3D printing of an ultrasound probe in order to support the patient with severe and sensory processing disorder. Jack Simons, Clinical Engineer and Elizabeth Scrivener, Chief Cardiac Physiologist, worked together to provide the patient with excellent care using personal experiences to produce a replica probe

	to support desensitisation for the patient. This had supported the patient's ongoing treatment meaning that this was more bearable for both the patient and the parents.
1776/21	The Chair offered thanks for the video noting that the staff involved had been unable to join the meeting however recognised the fantastic example of innovation and patient centred care that had been demonstrated to the Board.
1778/21	This was not just in respect of the patient subject but also the innovation during Covid-19, congratulations were offered to the staff involved in the technology advancements.
1779/21	Dr Gibson noted the positive work between the healthcare scientists and the direct clinical impact this had had. The low cost customised care was noted with Dr Gibson suggesting that this be considered each time a patient presented with particular needs. Dr Gibson asked if the Trust were taking advantage of modern education and training programmes in relation to healthcare science that was designed to bring people in with innovative skills and direct clinical care capabilities.
1780/21	The Director of Nursing echoed the thanks to the staff for sharing the story and thanked the students, Isaac, Joseph and Stephen who demonstrated the coming together of the community during Covid-19 to support the Trust. There was a desire for this work to be continued and the Trust were working with education organisations collectively across healthcare to bring technology in the digital age in to the NHS.
1781/21	The Director of Nursing noted the research and personal experience that had been applied to the solution offered to the patient for desensitisation and noted that there would likely be other staff with personal experiences that could support with simple ideas that would have a maximum benefit for patients.
1782/21	The Chief Operating Officer noted that the Trust were bringing in new members of the team and were tying in with other innovation and education facilities. It was noted that the clinical engineering team was going from strength to strength, having expanded and would continue to do so and would include modern apprenticeships and trainee roles. This was an exciting opportunity to bring in energetic and enthusiastic members to the team.
1783/21	Mrs Libiszewski asked if quality standards regarding medical devices was reported to the Finance, Performance and Estates Committee. A response would be offered outside of the meeting once clarity had been sought.
1784/21	Mrs Dickinson noted the innovation that had taken place and suggested that this should be shared more widely and consideration given to putting this forward for an NHS England Innovation Award.
1785/21	The Chair noted the footnote within the presentation thanking the Director of Finance and Digital for supporting the investment to the 3D printer and supporting colleagues in their endeavours to improve patient care. The Trust Board: • **Received the staff story**

	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
1786/21	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Deputy Chair of the Quality Governance Committee, Dr Gibson provided the assurances received by the Committee at the 19 October Meeting.
1787/21	The Committee received the Infection Prevention and Control Group upward report noting the progress towards compliance with the requirements of the hygiene code however noted some environmental issues due to the estates which would prevent full compliance. A specific area of concern was ventilation for which a task and finish group had been established and was progressing issues to be resolved. It was noted that further investment was likely to be required.
1788/21	The Patient Safety Group report noted positive progress of the Aortic Dissection Task and Finish Group which had been established due to a number of incidents. The Committee commended the support from Think Aorta and a patient's relative that would ensure progress took in to account the needs of patients.
1789/21	The Committee noted the issue raised in relation to paediatric radiology and that action to address this would be included within the general radiology provision however it was noted that there was a shortage of specialists in the country.
1790/21	The Committee commended the thoroughness and details of the reports received from the Maternity and Neonatal Oversight Group noting the ongoing issue with the maternity IT system. Action was being taken through a consortium of affected Trusts.
1791/21	Recent guidelines from the National Institute for Health and Care Excellence (NICE) had been received in respect of induction of labour for women which had seen an upward trend in the number of women undergoing induction. The NICE guideline reflected this however there would be changes made to practice as a result of the impact of the guidelines on service provision.
1792/21	The Committee noted the imminent implementation of an artificial intelligence (AI) solution to help prioritise patients of the waiting list, reported through the Clinical Harm Oversight Group. Assistance would be provided from the AI in order to address the backlog and to direct resources appropriately it would not however work in the absence of clinicians but would provide guidance.
1793/21	The Committee received the national inpatient survey results that had been reviewed by the Patient Experience Group noting disappointment with the results. A key area related to discharge in terms of information provided and the ability of the Trust to discharge patients to relevant care settings.
1794/21	The Committee received the first report from the Lincolnshire wide Quality Committee that had been established by the ICS and had cross representation including members of the Quality Governance Committee. It was noted that this had been established to avoid duplication of work.
1795/21	The performance dashboard was received the Committee noted the HSMR trend had now been restored after data interruption, this was seeing a downward, favourable trend.
1796/21	Duty of candour was raised as a concern due to the continuous adverse trend in performance over the past few months. The Committee were advised of the actions in train to address this.

1797/21	The Committee noted the unannounced Care Quality Commission inspection that took place in October and the initial feedback that had been received. The Committee looked forward to receiving the full report in due course.
1798/21	The Chair was encouraged to note the positive Infection, Prevention and Control report, specifically the 5 star hygiene rating of the production restaurant at Pilgrim Hospital.
1799/21	The Chair was pleased to hear that the system Quality Committee had been established and extend thanks to colleagues for the contributions being made, particularly Mrs Libiszewski who had taken this forward in challenging circumstances. The Trust Board: • **Received the assurance report**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1800/21	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker provided the assurances received by the Committee at the 13 October Meeting noting that this was the first meeting of the Committee since July 2021.
1801/21	Professor Baker noted that the meeting was positive and extended thanks to Senior Executives, who, despite the pressures prioritised attendance at the Committee.
1802/21	The Committee spent a considerable amount of time discussing the sub-group structure that reported to the Committee and established a detailed work programme to ensure that the sub-groups would be able to report appropriately.
1803/21	Assurances received by the Committee for objective 2a were in relation to the establishment review for which the Committee commended the paper to the Board and would be discussed on the agenda. The paper highlighted the need for an increase in the establishment with the Committee noting the cost increase that would be seen as a result. It was however noted that some of the positions were currently being filled by bank and agency staff.
1804/21	The Committee noted the paper on safer staffing and the challenges of the Trust to meet the Care Hours Per Patient Day and fill rates however detailed mitigations were in place to ensure patient safety was not compromised.
1805/21	The Committee received updates in respect of objective 2b from the Culture and Leadership Programme, Equality, Diversity and Inclusion and the wellbeing evaluation. The Committee, whilst grateful for the updates, spent some time detailing what would be required as a Committee in order to receive appropriate assurances. The Committee looked forward to further updates providing assurance on these areas at future meetings.
1806/21	A report was received from the Guardian of Safe Working with the Committee noting the concerns reported. Discussion took place on the action to be taken that would involve the Medical Director and again the Committee looked forward to received further reports on the actions being taken and how concerns were being addressed.

1807/21	An update was received from the University Hospitals Group and the Research and Innovation Governance Group (RIGG) meetings. A report and business case was received from the RIGG meeting that the Committee noted would dovetail with the application and progression of the teaching status and relationship building with the University of Lincoln.
1808/21	The Committee did not receive assurance in respect of the Workforce Race Equality Standards and the Workforce Disability Equality Standards and held discussion regarding the action plan and what needed to take place in order to offer assurance to the Board. Significant improvement and movement would be required and was expected to be reported to future meetings. This would ensure that the Board, through the Board Assurance Framework would receive appropriate assurance ratings and assurances on the issue of People and Organisational Development.
1809/21	Professor Baker noted that much of the work required was in progress and needed to take place noting that this was a crucial step being taken in order to garner future assurance required by the Board.
1810/21	The Chair noted the positive and clear articulation of the expectations that were offered to the Committee from Professor Baker.
1811/21	The Chief Executive noted that it was useful for this to have been set out by Professor Baker including the clarity between an update and assurance. The agenda for People and Organisational Development was large and therefore the focus on assuring of progress, improvement and delivery was needed.
1812/21	It was noted that this would be taken forward in the interim by the Director of People and Organisational Development and would then be passed to the substantive Director once appointed. The focus on assurance would support both the current and incoming Directors.
1813/21	The Chair was pleased to note that the Committee had received the establishment review that would be received by the Board. There was clarity provided through the update on where assurances were and were not received however it was assuring to note that the Quality Cell was in place at that there was no increase in harm, incidents or deaths as a result of staffing. The Trust Board: • **Received the report noting the limited assurance**
1814/21	**Item 9.2 Establishment Review** The Director of Nursing presented the report to the Board noting that this had been received by both the People and Organisational Development Committee and Finance, Performance and Estates Committee.
1815/21	The paper outlined very detailed work that was evidence based and utilised a methodology of objectivity that stood up to scrutiny in undertaking a nursing and midwifery establishment review. This was required to be undertaken by all Directors of Nursing on an annual basis.
1816/21	Overall the report offered detail on the areas where this had been undertaken and it was hoped that endoscopy and emergency department reviews would be presented to the Board in December. This had not been reported currently due to additional work being required.
1817/21	The establishment review lead to an overall increase of the establishment to just over 83 whole time equivalents (WTE) of both registered nurses (RNs), healthcare support workers

	(HCSW) and midwives across the whole organisation. This would equate to just over £2.7m full year effect.
1818/21	The Director of Nursing advised that the Trust had been successful in a bid for Ockenden funding for just over 5WTE midwives and full year funding of just under £250k, this would reduce the overall requirement to just over 78WTE and £2.5m.
1819/21	The Board was advised that within the additional funding for RNs and HCSWs this would predominantly be HCSW with just under 60WTE and 25WTE of RNs. It was noted that the requirement for RNs would not only be those on level 1 of the Nursing and Midwifery Council register but new and emerging roles. This would include nursing associates and trainees. Within the establishment review a new 3 year and emerging role workforce plan had been built in.
1820/21	This would further enhance the establishments as the Trust was aware of the difficulties of recruiting to the registered element of the workforce. It was noted that the Trust had no difficulty recruiting to HCSWs and as such there were no concerns in the increase in establishment for those roles.
1821/21	The Director of Nursing advised that the report presented to the Committees had offered financial analysis to August however this had been further reviewed ahead of the Board paper being discussed and now offered this to September.
1822/21	The current run rate impact of agency spend for RNs along with bank staff was known and there had been increases in both activity and capacity, therefore the Trust needed to care for patients as a result of the pandemic and those patients, who did not have Covid-19, were presenting with more complex and acute illnesses.
1823/21	The Director of Nursing noted that if the establishment review was approved this would be actioned in November with a part year funding impact of just over £1m. In the long term this would provide a revised level of funding for the nursing establishment to recruit to and see a reduction in agency costs. The Trust were keen to break the cycle of agency usage however it was noted that since the last establishment review there had been a shift in need that, in part, could not have been anticipated meaning that the Trust were unable to over recruit due to established and budgeted workforce establishments.
1824/21	The approval of the review would see planned recruitment to posts and would commence the cycle of the break of agency usage. Through the Performance Review Meetings trajectories would be offered in line with the establishment review.
1825/21	The Director of Finance and Digital noted that the discussion held by the Finance, Performance and Estates Committee resulted in the need for clarity on some items which had been updated within the paper. Further clarity was required however on the profiling of the impact and link to trajectories in order to understand the absolute impact of this on the H2 financial plan and in to the next year.
1826/21	As a result of this a further clarification paper would be offered to the November Finance, Performance and Estates Committee.
1827/21	Assurance was sought regarding the move from registered practitioners to associates and the potential impact on the quality of care along with what approach was being taken to ensure establishment reviews were completed for other professions.
1828/21	The Director of Nursing noted that there was a level of assurance that could be offered in the move to associates noting that the Trust had a number of trainee and nursing associates

	within the current establishment who offered a good level of support to staff nurses, deputy and ward leaders. These roles were built in to the career escalator from apprentice up to director level.
1829/21	The review had demonstrated the need to expand the level of enhanced provision and the Board were reminded of the national vacancy position which was in the region of 45k nursing vacancies. This remained and demonstrated the need to consider alternative roles to attract staff.
1830/21	The Director of Nursing noted that work was underway to expand the establishment review to other professions noting the Medical Directors intention to replicate this across the medical workforce. Through the Director of People and Organisational Development there would be collaborative working in order to lead this for clinical priority work areas and support services to have a triangulated view of the workforce and workforce plan.
1831/21	Dr Gibson asked if there would be a benefits realisation assessment of the investment that would demonstrate the reduction in agency costs.
1832/21	The Director of Finance and Digital stated that this would take place and with trajectories in place this would allow this to be worked through. This was about getting the establishment right with the right level of acuity and setting a target for substantive recruitment. There was a need for an absolute plan for delivery with clear metrics and appropriate governance that would enable the impact to be measured.
1833/21	This would be a key part of the move to financial sustainability, driving quality and safety forward through having a substantive workforce that was better than having in place a transient agency workforce that was in place in some areas.
1834/21	The Chief Executive noted the system improvement plan of home first and care closer to home with less reliance on hospital services and sought assurance that increasing the establishment and staffing could take in to effect changes within the system around a different model.
1835/21	The Director of Nursing noted that this was discussed at the People and Organisational Development Committee noting that the Trust was working through how the transition would take place from having safe hospitals now to one of care closer to home. As the move took place to care close to home this would be about the shift of individuals, skills and experiences to deliver care outside of the hospital setting.
1836/21	It was likely that across the Lincolnshire system the volume of the workforce to transition and deliver safe care would be required. There was confidence that the Trust's part of the integrated system would be to offer fluidity of the workforce to move the care closer to home and support system providers to achieve this. There was a current pressing need to address the establishment of the Trust and then work through the transition.
1837/21	The Chief Executive noted the need to manage the transition and was supportive of the proposal noting that it was right to plan ahead being mindful that the location of care may change the number of people required.
1838/21	The Chair noted that it was helpful to understand that the review was evidence based with objectivity. It was clear that the strategic approach of the paper was to progress the workforce regardless of the setting in which care would be delivered and there was a clear alternative approach to recruitment and the opportunity to grow our own.

1839/21	A robust approach would need to be taken to fund the establishment that had been clearly articulated to the Board with trajectories being seen to fit this in to the overall budgetary establishment and offer benefits realisation.
1840/21	There had been good levels of assurance offered and the Trust Board was asked to approve the review and subsequent investment in order to commence the planned recruitment and break the cycle of agency use.
1841/21	The Chair noted that the Finance, Performance and Estates Committee were asked to receive a further paper to be assured of and understand the financial position, trajectories and ongoing monitoring of how this would integrate in to an overall budgetary position. **Action – Director of Finance and Digital, 25 November 2021** The Trust Board: • **Received the report noting the moderate assurance** • **Approved the Establishment Review and subsequent investment**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1842/21	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Mr Woodward provided the assurances received by the Committee at the 21 October 2021.
1843/21	The Committee received the estates statutory compliance report noting the assurances received through this on a number of areas, the improvement in assurance was noted from the position in prior months.
1844/21	The Committee discussed ventilation and the work required in the area and noted that a key issues for the Committee was the Estates Strategy that was due to be received by the Committee in November.
1845/21	The finance report noted the delivery of the H1 figures in line with plan with the Committee recognising the work that had been put in by the Executive Team and organisation to deliver a challenging plan in very difficult circumstances.
1846/21	The Committee considered the challenges in relation to Cost Improvement Plans and the need for this to be addressed during the second half with further work being carried out. The capital position was also considered in detail by the Committee due to the importance of addressing a number of strategic issues for the Trust.
1847/21	The Committee noted the level of grip and control that had further developed from the previous meeting not only within the report received by the Committee but through the buy in and improvement from staff delivery. The Capital Delivery Group was working well in respect of delivery requirements.
1848/21	The Board was advised that not all of the original planned capital would be spent by the end of March 2022 however mitigations had been considered in detail with clinical staff and prioritised to ensure any spend to replace delayed spend added value to the organisation.

1849/21	The Committee received the establishment review and spent some time discussing the detail noting that the further clarification requested had been presented by the Director of Finance and Digital.
1850/21	Mr Woodward noted the operational performance and continued issues within urgent care and the implications of 12 hour trolley waits and ambulance handover. It was noted there was a need for ongoing and increased support from the system. Discussion was also held in relation to cancer and planed care performance.
1851/21	The Committee received the new format of the Integrated Improvement Plan report which offered further assurance with an expectation of further developments being received at the November Committee. It was expected that this would offer the ability to challenge and hold responsible people to account in more detail.
1852/21	The Chair noted the positive progress in relation to the estate report and congratulated the Family Health Division on the achievement of a 20% reduction in agency use. The Board was encouraged by the strengthened reporting being received by the Committee and the assurance being offered on the capital programme. The good news regarding the release of the funding for the medical school given that the Trust had carried the risk on this was noted by the Board.
1853/21	The Chair asked what more could be done to support with regard to patient notes given the delay in the implementation of the electronic health record.
1854/21	Mrs Dunnett asked what actions were being taken in both the Trust and across the system to address issues of discharging patients.
1855/21	The Chief Operating Officer responded to Mrs Dunnett's question noting that the Trust remained focused on those actions that the Trust was able to take including the use of Same Day Emergency Care (SDEC) units and providing a many access points to ambulances to directly bring patients to teams as needed, as opposed to using the emergency departments.
1856/21	The early impact of these actions was positive and had significantly increased patients to other areas, in particular Lincoln Medicine SDEC unit which was now seeing typically double the number of patients through the unit, being discharged the same day.
1857/21	This was positive however it was not just internal Trust actions that were required as delays were being experienced at the end of pathways. The system had appointed a new Director of Flow who was making headway in benchmarking and considering types of services outside of the hospital. Work was underway with Lincolnshire Community Health Services NHS Trust and other community providers to consider pathways such as those who required domiciliary care but did not require a nursing home bed.
1858/21	There were green shoots from the work being undertaken and the Chief Operating Officer looked forward to seeing a sizeable amount of capacity coming online over the winter period that would form part of the winter plan.
1859/21	The Director of Finance and Digital offered a response to the question regarding the electronic health record noting that the outline business case had been approved some months ago and had been submitted to the regional team. This was progressing through a similar process to that of the Pilgrim emergency department outline business case.
1860/21	Due to the timing and movement in the digital world consideration was not being given to the possibility of a system wide solution to provide a Lincolnshire Electronic Patient Record rather than a single Trust system. There was also a desire to split data from software programmes

	to allow the Trust to own the data and have the ability to replace software more easily over time.
1861/21	The system Chief Information Officer was engaged in discussion along with the regional digital lead. The Board was advised of the impending visit from the National Chief Information Officer, NHS X where it was hoped discussions could be held to progress activity.
1862/21	The Director of Finance and Digital noted that it was hoped that the revised Digital Strategy would be presented to the November or December Finance, Performance and Estates Committee.
1863/21	The Chair hoped there would be an understanding from NHS X of the business critical nature of the Trust securing an electronic patient record and any support would be gratefully received.
1864/21	The Chair noted that there were no escalations from the Committee to the Board but noted the update requested from the People and Organisational Development Committee on the culture and leadership programme in order to understand how this would inform conversations regarding cost improvements. The Trust Board: • **Received the assurance report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1865/21	No items
1866/21	**Item 12 Integrated Performance Report** The Director of Finance and Digital presented the report to the Board noting that relevant items for attention of the Board had been raised through the Committee upward reports.
1867/21	Dr Gibson noted that the Quality Governance Committee had not discussed the medicines issues due to the timing of reports to the Committee and drew the attention of the Board to page 15 of the report that demonstrated a steady adverse trend of medication incidents causing harm. Dr Gibson noted that this was a concern of the Quality Governance Committee and this would be considered at the November meeting once a report had been received from the Medicine Quality Group.
1868/21	The Chair noted the national attention in relation to ambulance handovers that had been a concern for some time noting that the Trust was taking numerous actions to alleviate the issue and sought an update from the Chief Operating Officer.
1869/21	The Chief Operating Officer noted that nationally there was concern relating to the experience of ambulance services at hospitals across the country, this was noted both within the NHS and through wider media concerns.
1870/21	It was noted that the Trust was amongst once of the poorest performing Trusts for turnaround times with the Trust Board being aware of the physical constraints in the Emergency Departments. This supported the business case that was in place and the work towards a substantial increase in the Pilgrim Emergency Department. This would provide capacity to handover more patients.

1871/21	An intensive response was in place with the Trust working through a 12 week cycle with NHS England and holding daily ambulance handover cells in order to create a cadence of improvement. The Trust had started to make some improvement, particularly at Lincoln, putting in place discharge and increasing the number of places ambulances could handover in order to stop the bottle neck being seen at the Emergency Department.
1872/21	It was noted that the Finance, Performance and Estates Committee had received a performance report detailing the levels of occupancy within the hospitals being at an all-time high with over 100% of capacity being used on a regular basis. A system response was required to reduce the number of delays in care outside of hospital.
1873/21	Internally the Trust were increasing handover points directly to improve the number of people who did not require an overnight stay and as a system there was a need to try to reduce the number of delays in discharge. This would increase the flow required and create space within departments.
1874/21	There were quality concerns regarding ambulance handover delays with a lot of work having being conducted over the past 18 months, in particular working with the Care Quality Commission from a regulatory perspective and information of the improvements made. A robust response was operated in respect of delays and when necessary teams would review patients in ambulances to offer timely assessments and escalate care needs in a rapid way.
1875/21	The Chair noted the response which also offered a response to Mrs Dunnett's question in relation to the actions in place regarding the discharge of patients.
1876/21	The Chair stated that if there was a need for further action to be taken by members of the Board this should be raised at the appropriate times. The risk being faced was recognised by the Board along with the mitigations in place that continued to be taken. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk, Governance and Assurance
1877/21	**Item 13.1 Risk Management Report** The Director of Nursing presented the report to the Board noting that this was the monthly report on strategic risks and that demonstrated a reduction from the previous month in overdue risks to 52%. This was in part being addressed through the ongoing roll out of the risk register reconfiguration.
1878/21	The Director of Nursing noted the 4 highest strategic risks that continued to be related to Covid-19 and the potential impact on patients, staff and visitors and the continued provision of a full range of clinical services. It was noted that the delta variant of Covid-19 was driving a level of uncertainty and continuing level of risk.
1879/21	It was noted that the report included a review of the risk of Non-Invasive Ventilation (NIV) conducted by the Quality Governance Committee via the Patient Safety Group. A NIV pathway project group had been established with regular reporting in place to the Patient Safety Group. It was anticipated that the issue regarding NIV provision would begin to be addressed through this route with the Committee retaining oversight.
1880/21	The strategic risks within the report received regular review through the Gold Command structure on a daily basis.

1881/21	Mrs Dickinson sought confirmation that harm reviews were conducted for patient awaiting elective surgery.
1882/21	The Chief Operating Officer advised that not all patients awaiting elective surgery would have a harm review conducted, these were carried out on a risk basis dependent on the time waiting. The Trust were looking to implement an artificial intelligence solution that would support risk stratification.
1883/21	There were 10 events that would trigger a clinical harm and there were incorporated in to both urgent and planned care but focused on standards set nationally. These would indicate patients at increased risk of harm, used alongside best practice systems and templates. For those patients that required clinical harm reviews these were being provide, for those on waiting lists but not indicated, risk stratification was being undertaken in order to bring patients in in order of clinical dependency. In some cases this was overriding waiting times and was reported through to Quality Governance Committee and upwardly through the governance route. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
1884/21	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the report to the Board noting that this had been considered by all Board Committees during October including the Audit Committee that had received the report for oversight and to confirm that the systems and processes were operating as expected.
1885/21	The Trust Secretary noted that there had been no changes to the RAG ratings however the upward reports from both the People and Organisational Development Committee and Audit Committee had demonstrated the ask for a full review of objectives 2a, 2b and 2c. Further scrutiny would be offered to those elements identified ahead of the next Committee meetings and the Trust Board.
1886/21	The Director of People and Organisational Development reiterated the point raised in respect of the workforce objectives noting that there would be a focus as described and indicating that there was a BAF level risk within workforce that would be seen through the Committee in November.
1887/21	The Chair noted the update stating that there was an expectation that there would be a more detailed level of issues regarding People and Organisational Development directorate that would need to be reflected within the BAF. The Trust Board: • **Received the report and noted the limited assurance**
1888/21	**Item 13.3 Upward Report from Audit and Risk Committee** The Chair of the Audit and Risk Committee, Mrs Dunnett presented the report to the Board from the meeting held on 11 October 2021.
1889/21	The Committee received a progress report from the Internal Auditors noting the progress on the Internal Audit plan for quarter 2 which was slower than anticipated due to operational and

	capacity issues being faced by the Trust. It was noted however that Internal Audit were confident of the ability to be able to deliver the plan for 2021/22 within the current financial year however the Committee were seeking further assurance from Executive Directors of the Trusts' ability to support delivery.
1890/21	Mrs Dunnett advised that 2 Internal Audit reported had been received, both offering partial assurance ratings, in relation to the Care Quality Commission and Equality, Diversity and Inclusion audits. Both reports were with the respective Committees to follow through on the recommendations made.
1891/21	An update was received by the Committee from the Chief Operating Officer and Director of Estates and Facilities in respect of the action plan in place to address significant weaknesses highlighted by the Internal Audit report in relation to Estates received earlier in the year.
1892/21	The Committee were encouraged with the progress being made in respect of the actions plan however given the seriousness of the issues raised the Committee would continue to monitor this at each meeting.
1893/21	Mrs Dunnett noted the follow up report received on recommendations made by Internal Audit and the concern that had been raised regarding the implementation of these. The Committee were keen to see greater grip, particularly in relation to workforce and medicines management, with these being a focus of the Committee.
1894/21	Discussion was held in relation to the finance ledger system with an implementation date of 1 December 2021. The Audit Committee would oversee assurance on the implementation with Internal and External Audit reviewing progress over the coming months. The Committee had been pleased to note that this was a system finance ledger that would support the move towards the Integrated Care System and a further step to Lincolnshire wide working.
1895/21	Mrs Dunnett noted the short report received from External Audit which reflected the timing of the audit cycle with the planning to commence for the 2021/22 work, this would be a focus of the January 2022 Committee.
1896/21	A full report was received from the Counter Fraud Team with the Committee encouraged by the results of the counter fraud survey. A good response had been received from staff with a 10% increase on responses from the previous years. This was recognised as a high response rate compared to other Trust's that the Counter Fraud Team work with.
1897/21	The Committee noted the good awareness of fraud in general however an action place was in place to ensure further improvement. This would in part be introduced to the organisation as part of the week long fraud awareness week.
1898/21	There were a number of areas within fraud where the Trust was seeking to strengthen controls in place with a key areas being the establishment of the fraud champion role. This had been taken on by the Trust Secretary and further national guidance was awaited.
1899/21	The fraud risk assessment would be aligned to the risk management reconfiguration and the Audit Committee noted the clear outcome metrics being received for counter fraud.
1900/21	The Committee received the Quarter 2 Compliance reported from the Trust Secretary and was pleased to report to the Board improvements across a number of areas including losses reported in respect of overpayments in pharmacy services. Improvements had also been seen in respect of waivers.

1901/21	The Committee were keen to see further promotion within the Trust of the new standards of conduct and gifts and hospitality.
1902/21	The regular update on risk management was received and progress was being made in respect of the reconfiguration of the risk register and was a recommendation previously made by Internal Audit.
1903/21	Mrs Dunnett noted the strengthening in terms of training and the work ongoing with divisions and oversight through the governance framework that was in place. Policy management, a year 2 Integrated Improvement Plan project, had shown much improved progress reflecting the additional resource that had been committed. Fortnightly reporting was in place to the Executive Leadership Team and the new document management system was being put in place. Assurance would continue to be sought as the project continued throughout the course of the financial year.
1904/21	The Board Assurance Framework was reviewed and comments had been offered to the Board. The Committee undertook the overarching role in relation to the control environment and as previously noted an in-depth review of objectives 2a and 2b had been requested.
1905/21	The Committee requested that objective 2c was updated to reflect the progress reports received by the Committee. The Trust Board: • **Received the report noting the moderate assurance**
1906/21	**Item 14 Any Other Notified Items of Urgent Business** No items
1907/21	The next scheduled meeting will be held on Tuesday 7 December 2021, arrangements to be confirmed taking account of national guidance

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

David Woodward								X	A	A	X	X	X
Philip Baker										X	X	X	X
Colin Farquharson										X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
4 February 2020	077/20	Assurance and Risk Report Quality Governance Committee	Review of TOM and governance to be presented to the Board	Chief Operating Officer	~~02/11/2021~~ 01/02/2022	Further work commissioned. Report now expected at January Audit Committee
6 April 2021	579/21	Staff survey	Consideration to be given to triangulation of data between staff survey results and quality measures	Int Dir of P&OD	~~01/06/2021~~ 01/02/2022	Work in progress. Paper to be brought to Trust Board in February
6 April 2021	596/21	Smoke Free Policy	Post implementation review following relaunch to be presented to the Board	Int Dir of P&OD	~~02/11/2021~~ 01/02/2022	Review commenced. Paper to be brought to Trust Board in February
6 July 2021	994/21	Patient Story	Invitation to Dr Sakthivel and Jody Blow to present and update on the progress of communication training following story at the Board	Trust Secretary	07/12/2021	
6 July 2021	1141/21	Urology Pathway Update	Refreshed site strategies to be presented to the Board	Dir of Imp & Integration	~~05/10/2021~~ 02/11/2021	Private Board agenda. Complete
3 August 2021	1286/21	Assurance and Risk Report People and Organisational Development Committee	Establishment review to be presented back to Committee and Trust Board.	Int Dir People & OD	~~07/09/2021~~ 02/11/2021	Agenda Item Complete

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

3 August 2021	1301/21	Equality Diversity and Inclusion Annual Report	Equality, Diversity & Inclusion Lead would engage with the People and Organisation and Developmental Team and HR colleagues to provide further detail on the impact of EU Exit on the Trusts European Workforce.	Int Dir of POD	02/11/2021	To be picked up in POD Committee – Complete
3 August 2021	1360/21	Urology Service Engagement Output	An update paper on the Urology Service Engagement output to be reported to Board in three Months.	Int Dir of Imp & Integration	~~02/11/2021~~ 07/12/2021	Engagement commenced on 9 August. Three months data not collected until early November. Defer to December Board Agenda Item
5 October 2021	1618/21	Chief Executive Horizon Scan	Congratulatory letter to be sent to the newly appointed Chief Executive of Lincolnshire Community Health Services NHS Trust	Trust Secretary	02/11/2021	Complete
2 November 2021	1841/21	Establishment Review	Finance, Performance and Estates Committee to receive further paper offering financial position and trajectories	Director of Finance and Digital	25/11/2021	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*7 December 2021*
Item Number	*Item number 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to operate under significant demand pressure. This is not unique to Lincolnshire, but it is still a significant concern with winter approaching and a new strain of COVID emerging. The focus remains on ensuring that patients are treated safely, in the right place at the right time. Key pieces of work underway relate to reducing ambulance handover delays, a home-first approach to discharging medically optimised patients from the acute hospital sector, protecting where possible the elective care capacity, ensuring safe staffing levels and looking after staff.

b) The COVID vaccination programme is continuing. At the time of writing there are proposals emerging to change the COVID booster eligibility to all over 18s, reduce the time period between second doses and the booster dose to 3 months, giving 12-15 year olds a second dose 12 weeks after the first dose and offering the severely immuno-compromised a fourth dose. Further details are awaited on how this will be operationalised across the NHS.

c) The Government has announced that front-line NHS staff will need to be fully vaccinated against COVID by 1st April 2022. This is subject to Parliamentary approval and will make being vaccinated a condition of deployment in organisations undertaking CQC regulated activities. The requirement will relate to two doses of the COVID vaccine, not the booster or the flu vaccine. Further guidance is awaited relating to exemptions, which categories of staff will be covered by the requirement and how the new requirements will be enforced in terms of staff deployment.

d) A number of Trades Unions have confirmed that they are balloting their members on potential industrial action relating to the Government's 3% NHS pay rise in 2021/22. The outcome of the ballots is not yet known and neither is the form that any industrial action may take. Business Continuity Plans will be amended/enacted to mitigate as far as practicable any service implications of industrial action.

e) John Turner has been confirmed as the Chief Executive (Designate) of the NHS Lincolnshire Integrated Care Board (ICB) which is due to come into existence in April 2022. John is currently the NHS Lincolnshire CCG CEO and the Executive Lead for the ICS. An appointment has yet to be made to the Chair position of the ICB.

Trust Overview

a) At Month 7 the Trust reported an in-month deficit of £0.7m, with a year to date surplus of £1.1m. This is in line with plan.

b) The CQC conducted a Well-Led inspection of the Trust between 9th-11th November. The initial CQC feedback letters from this and the earlier core services inspection in October are included elsewhere in the agenda. The formal report from the CQC is not expected until early 2022. Overall there has been significant progress since the last inspection in the middle of 2019.

c) The Trust has agreed the metrics that will form the basis for the Trust to exit the national Recovery Support Programme and SOF Level 4. The plan is to

exit in 2022. The timing will be influenced by the CQC report referred to above. The metrics cover there being evidence of a stable Board with the capacity and capability to deliver the required improvements; and agreement between Regulators that there is evidence of significant progress and confidence in the Trust leadership team to continue with the improvement trajectory, taking into account external review reports.

d) A positive discussion has been held with the Capital Delivery Team of the DHSC in connection with the Full Business Case (FBC) for the new Emergency Department at Pilgrim Hospital. There is a shared commitment to work together to ensure that the FBC progresses through the national approval process such that the new build can be completed in 2024 as planned.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board – Public*
Date of Meeting	*07 December 2021*
Item Number	*Item 6.1*
Update on CQC Core Service and Well-Led Inspection	
Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Kathryn Helley, Deputy Director of Clinical Governance* *Jeremy Daws, Head of Compliance*
Report previously considered at	*Not Applicable*

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

Risk Assessment	*Link to strategic risks:-* *4405; 4083; 4175; 3688; 3951; 4156; 3503; 4041; 4081; 4145; 4300; 4476*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*Through governance process of IIP.*
Equality Impact Assessment	*Through governance process of IIP.*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	*The Board is asked to:-* • *note the update provided* • *note the formal feedback received from the CQC in appendix 1 and appendix 2* • *note the action being taken in response, detailed in appendix 3.*

Executive Summary

During the months of October and November 2021, the Trust received an unannounced core-service inspection followed by an announced Well-Led inspection. A brief overview of the visits are as follows:

Unannounced inspection: During the 5 – 8 October 2021 the CQC undertook an unannounced, focussed inspection of the Trust's following core services:

- Urgent and emergency care
- Medicine
- Children and Young People
- Maternity Services.

Well-Led inspection: During the 9 – 11 November the CQC undertook an announced Well-Led inspection, hosted on the Lincoln site.

Following both visits, the Trust received verbal feedback which was followed up by a formal letter confirming the feedback. The letters are attached in full as appendices to this public Board paper:

Appendix 1: Formal feedback following the Core Service inspection;
Appendix 2: Formal feedback following the Well-Led inspection.

In response to this initial feedback from the CQC, the Trust have implemented a plan of action to focus on key themes identified.

The Trust is now awaiting the full report detailing all findings from the inspection process, it is anticipated that this will be received during January 2022. On receipt, the Trust will review the action plan to ensure this covers all findings from the visits and will monitor progress against improvement activities with assurance reporting to the Trust Board and nominated sub-committee structure.

By email

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Mr. Andrew Morgan Chief Executive Officer
United Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
Lincolnshire
LN2 5QY

Date: 11 October 2021

CQC Reference Number: INS2-11012116741

Dear Mr Morgan

Re: CQC Core Service inspection of United Lincolnshire Hospitals NHS Trust

Following your feedback meeting with Michelle Dunna and Anna Kerrigan on 6 and 8 October 2021, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meetings.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 6 and 8 October 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

Pilgrim Hospital

<u>Children and young persons</u>

- Children and young people were cared for in a safe way.
- Medical staff felt well supported and described a good experience.
- All staff described good educational opportunities

- Staff told us they were proud of the improvements made within the service.

However:

- There was no dedicated pharmacy service which meant staff were often taken away from clinical duties to sort discharge medicines.
- Staff were anxious about being moved to work in adult areas.
- Staff described a poor experience when working in the emergency department but did acknowledge work had been done to address this.
- Staff described delays in in moving children from the emergency department to the ward.

Maternity

- Good MDT working.
- Strong leadership of the service.
- A positive culture.
- No concerns with staffing.
- Good governance processes in relation to management and learning from incidents and risk management.

Medical

- All patients were cared for in a safe way.
- The inspection team recognised significant improvements in the service specifically, diabetes management, MCA and DoLS, falls and non-invasive ventilation.
- Generally, staff morale was good especially on Ward 6B and Bostonion and staff were happy to work at the Trust.
- Patient feedback was mostly positive.

However:

- There appeared to be no oversight, in terms of leadership, of the discharge lounge which impacted on a good patient experience.
- Staff morale on Ward 6A was poor however, this was not seen to impact on patient care.

Urgent and emergency care

- All patients were cared for in a safe way.
- The inspection team recognised significant improvements in the care of the deteriorating patient including the recognition and treatment of sepsis.
- Improvements had been made in areas of the department dedicated to the care of children and young people including resus.
- The inspection team saw a good pathway for children and young people.
- All staff were described as caring and doing their best for patients despite an extremely busy environment and patient feedback was positive.
- Where concerns were identified for example, an unlocked medicine cupboard staff responded quickly and appropriately.

However:

- Oversight of flow out of the emergency department did not appear to be given sufficient priority. Some staff felt ‘left to get on with it’ when the department was full.
- Specialties did not appear proactive in ‘pulling’ patients from the department.

- The inspection team expressed concern that where a patient had to remain on an ambulance due to capacity in the department, ED staff would not physically have sight of the patient for a minimum of 60 minutes when the first comfort round was due. They did, however, acknowledge that observations would be carried out and escalated appropriately.

Pharmacy
- The pharmacy team recognised significant improvement in medicines management since our last inspection.
- The MOCH pilot in elderly care was seen as a particular area of good practice.

However:
- The prescription chart within the emergency department lacked scope to add medicines administered outside of the department. I.e. during conveyance or whilst waiting on the ambulance. This meant there was a risk patients could receive more medicines than required.
- Prescribing within the emergency department tended to be for 'immediate' medicines with no mechanism in place to prompt staff to prescribe a patient's regular medicine.

Lincoln County Hospital

Children and young persons
- We saw good MDT working.
- Staff were caring and we observed some good examples of care delivery in the neonatal Unit.
- Staff described good executive oversight of Children and young persons and said it felt better than previously.

However:
- At times, there was no evidence to suggest interpreting service were used when required and we saw two occasions where a relative was used.
- There was no dedicated breast feeding/milk kitchen available.

Maternity
- Comprehensive risk assessments were carried throughout a lady's pregnancy.
- We saw good MDT working.
- We saw areas of good practice. For example, mechanical induction of labour.
- We saw evidence of learning from incidents.
- At the time of our inspection, mums and babies were safe.

However:
- We were concerned midwifery staff were not appropriately trained to recover women post C-Section. However, we have since received information giving assurance that staff are appropriately trained.
- We were not assured staff reported all incidents appropriately.
- The physical environment was in poor condition although we appreciate estates have been on site addressing our issues.
- On two separate occasions we found medicines which were not secure.
- Not all staff appeared engaged, morale was mixed, and we found an inconsistent safety culture with not all staff happy to challenge.

- The temperature of the treatment room was not monitored despite feeling warm. We were concerned that medicines may not be stored at the correct temperature. In addition, there was not restricted access to this room.

Medical

- Staff were patient focused.
- We saw good MDT working with staff describing how supportive they were of each other.
- Patients were safe and appeared well cared for.
- Patient information boards in the ward areas enabled staff to clearly identify where the sickest patient was.
- We saw good record keeping.
- We were told about projects in place to reduce falls and saw positive outcomes on the wards.

However:

- On MEAU there was only one shower for 26 patients (previously 50 patients). This shower was not working. Whilst MEAU was a 'short stay' area, one patient had been on the ward for 14 days. In addition, the area was mixed sex.
- We saw three patients across two wards who were self-medicating with no documented risk assessment in place.
- We saw loose tablets in the clinical area on two wards. On one occasion there were approximately 25 sleeves of unsecure tablets.

Urgent and emergency care

- Local leadership was strong.
- Staff demonstrated a willingness to embrace change and improve.
- Patients were well cared for and patient feedback was overwhelmingly positive.
- We saw good learning from incidents. For example, diabetes.

However:

- We felt there was a lack of ownership of the paediatric area and did not feel there was one individual taking the lead.
- We saw some inconsistencies with record keeping especially in relation to risk assessments for falls and mental health.
- The medicines room door was open for the entirety of the inspection.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater at NHSEI.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC

Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Sarah Dunnett

Sarah Dunnett

Head of Hospitals Inspection

c.c. Elaine Baylis, Chair

Dale Bywater, Midlands Regional Director NHSEI

Jonathon Davies, CQC regional communications manager

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

Mr. Andrew Morgan Chief Executive Officer
United Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
Lincolnshire
LN2 5QY

Date: 12 November 2021

CQC Reference Number: INS2-11012116741

Dear Mr Morgan

Re: CQC Well Led inspection of United Lincolnshire Hospitals NHS Trust

Following your feedback meeting with Sarah Dunnett, Michelle Dunna, Caroline Bell and Garry Marsh on 11 November 2021, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 11 November 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

W1. There is the leadership capacity and capability to deliver high quality, sustainable care.

- There is a strong, cohesive leadership team.
- There is a strong board development programme.

W2. There is a clear vision and credible strategy to deliver high-quality sustainable care to people and robust plans to deliver.

- There was bold decision making of the board that underpinned a well-planned and understood strategy.

W3. There is a culture of high-quality, sustainable care.

- Without exception the patient is now at the heart of this organisation.
- The organisation's approach to changing the culture is supported by credible plans and a palpable energy within the board.
- The work that has already started needs to continue at pace to ensure the requirements of duty of candour are met.

W4. There are clear responsibilities, roles and systems of accountability to support good governance and management at board level.

- However, there are inconsistencies in its application at some levels of leadership across the organisation of which, the trust has plans in place to address.

W5. There are clear and effective processes for managing risks, issues and performance.

- The trust should continue to ensure they are using timely data to gain assurance and continue their described work on the integrated performance report.
- The trust should continue to review and manage the work required to improve medicines management across the organisation.

W6. Appropriate and accurate information is being effectively processed challenged and acted on.

W7. People who use services, the public, staff and external partners are engaged and involved to support high-quality sustainable services.

- There are positive and collaborative relationships with stakeholders and providers across the Lincolnshire system.
- There is executive presence across all sites, engaging with staff at all levels.

W8. There are robust systems and processes for learning, continuous improvement and innovation.

- Quality improvement is embedded across the organisation and we have heard of some good examples where the quality and safety of patient care has improved.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater at NHSEI.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

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If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Sarah Dunnett

Sarah Dunnett

Head of Hospitals Inspection

c.c. Elaine Baylis, Chair

Dale Bywater, Midlands Regional Director NHSEI

Jonathon Davies, CQC regional communications manager

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	23 November 2021
Chairperson:	Liz Libiszewski, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives.
	Assurance in respect of SO 1a Issue: Deliver harm free care **Clinical Harm Oversight Group Upward Report** The Committee received the report noting the substantial increase in the number of harm review triggers, this would also be seen in the next reporting period. The Committee were pleased to note that the dataset was now being utilised with the artificial intelligence system with the synthesis and trajectory being available in the near future. **Executive/Non-Executive Visits** The Committee received the update noting the difficulties faced due to the pandemic and operational pressures. The Committee noted the need to ensure the data was triangulated with other sources and for any concerns or issues to be escalated and addressed. **Patient Safety Group Upward Report** The Committee received the report noting the reduction in HSMR and that the palliative care coding review was now underway. Positive indicators had also been offered from the deteriorating patient group within the report. **Infection Prevention and Control (IPC) Group Chairs Report** The Committee received the Chairs report noting that the meeting had been stood down due to operational pressures. The Committee noted the risk assessment to reduce the isolation from national guidance from 14 to 10 days with a PCR swab at 9 days. This would be a repeat of action taken at the height of the pandemic in order to support operational pressures.

	The Committee noted that a view on the approach had been taken from both eternal agencies and CCG colleagues and endorsed the decision taken. **High Profile Cases** The Committee received the report noting the content. **Serious Incident Summary Report** The Committee received the report noting the number of SIs and actions being taken. The Committee noted that publication of the patient safety framework would support the Trust in respect of external reviews. This was not yet available. **Complaints, Legal Claims and Inquests, Incidents and Patient Advice and Liaison Services (CLIPS) Report** The Committee received the second quarterly report noting that there were no new themes emerging and these remained as communications and discharge. It was noted that the triangulation was helpful across multiple domains and that this would strengthen as the report continued to develop and drive specific areas of focus. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the report noting that the Ockenden evidence was being resubmitted to ensure accuracy in some domains. The formal outcome of the commissioned thematic review was awaited however this had not currently identified any new findings. The final report would be received by the group in November. The Committee noted the bi-annual staffing report that had been presented to the group with positive conversation held in relation those colleagues who were leading in to or within the demographic of retirement age. This would support the Trust to achieve the right balance of student midwives. The Committee noted that Clinical Negligence Scheme for Trusts (CNST) had been achieved however again noted the concern regarding the IT system and the achievement particularly for year 4 of the schemes and safety actions 2 and 6. The Committee noted the update offered from the NED Maternity Safety Champion whereby discussion noted by the Committee was confirmed as an accurate reflection of feedback being received from the service.

	Safeguarding Group Upward Report The Committee received the report noting the improvements being seen by the group including improved attendance and atmosphere from those in attendance. The Committee were pleased to note the proactive approach to inviting the Chair of the Adult Safeguarding Board to the meeting and the positive feedback that had been received. The Committee noted that training remained a concern however this was a similar position across the region. The Committee were advised of the increase in Section 85 and the number of young people presenting with eating disorders or disordered eating and mental health issues. It was noted that there was a lack of specialist support across the county. **Medicines Quality Group Upward Report** The Committee received the report noting the issue raised in relation to NICE TAs had been resolved with a process approved and now in place. The Committee raised concern that the roadmap had not been received and that actions linking to both internal audit and the Care Quality Commission reports were not sighted which had been due for completion in August. The Committee noted that assurance had not been received through the group or the Integrated Improvement Plan and requested that the Executive Directors work to address the concerns raised and provide assurance.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report noting the intention to develop reporting to the Committee and the utilisation of SPC charts and core themes from data. It was noted that there were a large number of national surveys which were currently not clear to read across, an overarching plan would be put in place to support actions required. The Committee noted the involvement of the Group in respect of mental wellbeing alongside harm reviews that were taking place. Various communication system were being developed and tested however it was noted that this was a system decision to progress and was not being mandated nationally. **Patient Experience Quarterly Report** The Committee received the quarterly report noting the imminent

	expansion to the team which would offer further capacity to support teams and services to deliver patient experience work. The Committee noted there were a number of internal audit actions there was passed due date however further information was due to be sent to the auditors. It was noted that when agreeing internal audit actions there was a need to ensure these were deliverable and risk based. The Committee noted the intention to review and refresh the patient experience risk. **Complaints Quarterly Report** The Committee received the report for quarter 2 noting that this outlined the number of complaints in the quarter which had again increased however these were not yet at pre-Covid-19 levels. The report offered themes and trends from complaints that had been received with the Committee noting the triangulation of data within the CLIPs report. The Committee highlighted the overdue complaints however were advised this was primarily due to the operational pressures being seen, it was hoped improvement would be seen in quarter 3.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the progress that was being made by the group including improved attendance. The Committee noted the escalation of record keeping made by the Group where clinical audit had demonstrated that there were quality and construct issues of records. The Committee noted the positive position in relation to the NICE Technology Appraisals noting this was an improved position for the Trust. **Clinical Audit Report** The Committee received the report noting the work that had taken place with the divisions in order to agree a structured clinical audit programme along with the developments offered in the report. The Committee noted the Trust was an outlier for some national audits and was advised that there was an alert process in place for the Trust to review and resubmit audit information if identified as an outlier. Action plans were put in place to address outliers that were not resolved when data quality errors were rectified.

	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the report noting the continued improvement in relation to the Executive Scorecard and the mapping of indicators to monthly measures. The Committee noted the continued issues relating to medicines management and duty of candour noting the need to have traction on the issues to be clear on improvements. The Committee noted the positive reporting of pressure ulcers, infection control and never events. **PRM Upward Report** The Committee were pleased to note the continued improvement in reporting however noted disappointment that an issue challenged and addressed during the meeting had been translated in to the report. The Committee noted cultural issues discussing if these impacted on patient safety noting that a review may be required to ensure no issues were missed. **Integrated Improvement Plan** The Committee received the report noting there were some items related to the patient safety agenda where there had been some slippage. The Committee noted that the report did not clearly demonstrate the progress of projects at a glance and concern was noted that demonstrated an improvement in medicines management where there was a risk that this would not be delivered in year 2. Concern was raised that the report did not clearly identify responsible leaders for projects meaning that it was unclear who held accountability. It was noted that this was being reviewed. **CQC Update** The Committee received the letter that had been offered to the Trust following the Well Led inspection and the action plan following the core inspection with many areas already actioned. **Ionising Radiation (Medical Exposure) Regulations Update** The Committee received the report noting the content and positive progress that had been made. A final report is anticipated towards the end of this calendar year. **Board Assurance Framework** The Committee considered the detail of the report along with the reports received during the meeting and the discussion held noting that objectives 1b and 1c could be rated as amber from red. Objective 1a was considered and remained rated amber.

Issues where assurance remains outstanding for escalation to the Board	The Committee wished to alert the Board to the ongoing concerns relating to the Medicines Quality Group and the lack of assurance due to the roadmap not having been received by the Committee
Items referred to other Committees for Assurance	The Committee referred the quality of patient records to the Finance, Performance and Estates Committee.
Committee Review of corporate risk register	The Committee noted the risk register and the position of the reconfiguration
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12 month period

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	16th November 2021
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2021/22 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **NHS National Staff Survey** The Committee received the update noting the headline position that was presented and the response rate of just over 40% being advised this was just under the average acute trust response rate. The full results would be released under embargo in February 2022 with publication in March 2022. The Committee noted the actions that were proposed in order to continue to progress staff engagement across the Trust. The Committee noted that any actions determined as a result of the staff survey should be incorporated in to the Integrated Improvement Plan and the broader work underway within the Trust including the inpatient surveys. **Safer Staffing** The Committee received the report noting the intention to develop the report to a dashboard format. The Committee noted the significant challenges that had been experienced during October and the staffing requirements to support this. There were mitigations in place to support the response and to monitor staffing and quality of care during these periods of pressure. The Committee noted the improvements in fill rates over the past 3 months noting these had been up to 90%. The reporting detailed increases and decreases that were small figures noting the need for statistical rigour to be applied to ensure the response to changes was appropriate.

Assurance in respect of SO 2b
Issue: Making ULHT the best place to work

Progress Report: Trust's EDI Service
The Committee received the update noting that feedback on the cultural intelligence programme had been positive along with the reverse mentoring scheme that had been launched.

The Committee noted the priorities and future ambitions that were presented recognising that in the absence of the EDI reporting group assurance was not received. It was noted that the next meeting of the group had been arranged with the update provided to the Committee offered an outline of the work plan for the group. This would also need to include links to the wellbeing work in place.

WRES/WDES Action Plans – Lack of Assurance/Update
The Committee received the update noting that need to ensure that timescales were included within the action plan and that these were defined in order for the Committee to hold people to account.

Guardian of Safe Working Quarter 2 Report and Annual Report
The Committee received the quarter 2 report along with the annual report for information noting the content.

The Committee noted that the Junior Doctor forum had not been held regularly due to operational pressures and meetings being stood down. It was noted however in the absence of meetings concerns continued to be raised and dialogue with Junior Doctors retained.

Bullying and Harassment
The Committee were pleased to note the update and the meetings that had taken place to address concerns of bullying and harassment that had been raised with the Guardian of Safe Working.

The Committee noted the recommendation for reporting to be offered on a 6 monthly basis that included thematic review of concerns raised and detail of action taken.

Freedom to Speak Up Quarterly Report
The Committee received the report noting the comprehensive action plan that was in place that, along with the support from NHSE/I, was demonstrating the benefit of having a full time Guardian in post.

Upward report from Culture and Leadership Programme
The Committee received the report noting the content and expressing the need for assurance to be provided through the report as this was not currently being reported.

Assurance in respect of SO 4b
Issue: To become a University Hospitals Teaching Trust

Upward Report from University Teaching Hospital meeting
The Committee received the report noting the 2 key priorities of the project being the funding for clinical academic posts and the achievement of the University Hospitals Association criteria.

The Committee noted the meeting that had been scheduled with the University to set a framework to progress. A further update would be received to the December Committee.

Upward Report from Research and Innovation Governance Group
The Committee received the report noting that this required development to offer assurance to the Committee in the expected format.

There was a need to address the frequency of reporting and the alignment of the meeting to the Committee to ensure appropriate reporting was in place.

The Committee noted the synergy between this and the University Hospitals work noting that work could be done to offer better alignment.

Assurance in respect of other areas:

Committee Performance Dashboard
The Committee were not in receipt of the performance dashboard noting the required developments in order for a meaningful report to be received by the Committee.

Work was underway to offer the first iteration of a report to the Committee in December in order to hold discussion about the content and further developments of the report.

Policies Position
The Committee received the report noting that this would in future be incorporated within the performance dashboard for the Committee to offer oversight of the policy position relevant to the Committee.

Integrated Improvement Plan
The Committee received the report noting the content.

Board Assurance Framework
The Committee received the report noting the updates that had been provided and held discussion regarding the assurance ratings.

The Committee agreed that the assurances ratings would for all objectives would be moved to red to reflect that assurances that were

	not yet being received by the Committee. It was however noted that this was not a deterioration rather a reflection of the current position with the Committee acknowledging the significant progress that was being made.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to advise the Board of the action being taken to address bullying and harassment concerns raised by Junior Doctors to the Guardian of Safe Working. The Committee would receive reports on a 6 monthly basis detailing concerns raised, themes and actions taking to address concerns.
Items referred to other Committees for Assurance	No items referred
Committee Review of corporate risk register	The committee received the risk register noting the current risks presented
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	No areas identified
Areas identified to visit in ward walk rounds	Department walk around currently suspended.

Attendance Summary for rolling 12 month period

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	25 November 2021
Chairperson:	David Woodward, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Strategy** The Committee received the first iteration of the estates strategy noting the external support that had been received to develop this. Due to the national context of HIP Bids the strategy focused on 2 years recognising that large programmes of work would not be undertaken ahead of HIP works. The strategy described the current context of the estate and offered a framework that would allow navigation of investment in to the right areas. The Committee noted the work that would be undertaken for 6 facet surveys to support the identification of required works and the level of urgency to be applied to these. The Committee noted that a further iteration would be developed following feedback and comments offered on the version presented to the Committee however were pleased to note the links to the IIP, clinical dimension and risk scoring. **Estates Statutory Compliance Report inc. Estates Group and H&S Committee upward reports** The Committee received the report noting the work being undertaken with regard to ventilation and the group that had been set up to address the areas of concern. It was noted that some immediate actions had been taken with the group focusing on sustainability and maintenance moving forward.

	Emergency Planning Group Upward Report The Committee received the report noting that the Trust remained substantially compliant of standard noting the recent testing of EPRR arrangements not only due to the pandemic but operational pressures. Concern was noted in relation to access to specialist areas and out of hours access however assurance was offered on the work undertaken to resolve issues that had arisen.
	Assurance in respect of SO 3b Efficient Use of Resources **H2 Financial Planning** The Committee received the H2 financial plan noting that block arrangements remained in place for H2 however with slight adjustments from H1. It was noted that the underlying principle remained. The Committee held discussion regarding the detail of the plan noting that from the total allocation for Lincolnshire, after allowing for the pay award, there was a true uplift of £2m on H1. The Committee approved submission of a breakeven plan for H2 noting the requirement to deliver £6m cost improvements for which £2.2m had been delivered in H1 leaving a £3.8m gap of delivery. This was included within the plan however due to the lack of assurance on schemes this presented a risk for the Trust. The Committee noted the £7.8m of restoration costs however a £0 assumption was included for elective recovery fund meaning that this would not impact on the plan. Assuming breakeven was achieved for H2 this would see a £1.8m surplus outturn for the full year. **Finance Report** The Committee noted the £681k deficit in month that had come as a result of a cash accounting basis against expenditure accrual. As this was a timing issue on the identification of the income number this would resolve in month 8 to a breakeven position in month and YTD £1.8m surplus. The Committee noted the income and overall YTD position remaining £4m favourable to plan when actual income for October was taken in to account. Elective recovery fund was reported as £4.2m adverse. The Committee noted the significant gap between actual activity and trading income with a discussion held in relation to the actual underlying deficit.

	The Committee noted that pay was adverse to plan due to the pay award noting that some of this would roll forward however adverse movement on pay was not expected going forward as this was planned in to H2. The Committee explored the increase in bank and agency spend noting that this was driven by both price and volume alongside the increase in open beds. The Committee considered the benefit of service line reporting in current times noting that this would be further explored to determine if this would add benefit to reporting. A baseline report would be offered to the Committee in January. **Capital Report** The Committee noted the continued progress in relation to capital noting that a number of actions were being taken in relation to the over commitment. The Committee noted that £12m of capital fund bids had been successful meaning that some items were deliverable such as the modular theatres. There were a number of projects that would deliver by the end of March 2022 with areas such as medical equipment that were easier to deliver in the timescales. The Committee noted concern in the ability to deliver projects requiring staff to deliver due to the volume of activity however it was noted that an alternative approach to delivery was being considered in order to utilise recourses effectively. The Committee asked the Director of Finance and Digital and the Chief Operating Officer to review the delegation to over commit, but not spend, of £2m to £5m and whether this gives sufficient flexibility to deliver the agreed capital outturn. **Establishment Review** The Committee received the financial position of the establishment review as requested by the Board noting that there would be a maximum of £330k pressure taking in to account availability of bank and agency staff. The run rate adjustment had been built in to the financial plan. Further work would be required in order to establish the profile and trajectories of recruitment however it was noted that with appointments being made in to the People and Organisational Directorate that an update could be offered in January 2022.
	Assurance in respect of SO 3c Enhanced data and digital capability Papers for objective 3c were deferred to the December Committee to allow and in-depth review of this important area.

	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report noting that discussions had been held since the last Committee with regard to the content and structure of the report. It was noted that the report would evolve over the coming month in order to provide further assurance to the Committee. Work was underway to ensure alignment of the IIP with the integrated performance report which should be seen by the Committee in December. The divisions were being engaged in respect of reviewing documentation and record keeping in order to develop reporting templates for use with the highlight reports. The Committee welcomed the approach and development that was being proposed noting that this was year 2 of the process with the Trust having come a long way. The developments would help to address an assurance gap with the report received in December being key to seeing what this would look like in practice. Key linkages would be to the IPR, dependencies and critical paths. **Development Session** The Committee undertook a development session to discuss what had worked well and next stages of assurance. Committee members reflected on the improvements that had been made specifically in respect of the quality of reports and assurances offered to the Committee. The Committee noted those areas to be continued and heard the views of the Committee Chair on the areas of the next stages of assurance. **Operational Performance against National Standards** **Urgent Care** The Committee received the report which was taken as read however noted the current performance in respect of 12 hour trolley waits and ambulance handover delays. The Committee noted that some actions taken had been successful however there were waves of exit blocks from the organisation. Discussions were taking place across the system to work to resolve issues. **Cancer Performance** The Committee noted the continued deterioration in the breast cancer 2 week wait position that had been alerted to the Committee in October with a deep dive undertaken to review the position.

	It was noted that the Trust had put in place actions to increase capacity however the capacity ceiling had been reached. The 62 day back log was noted which was being driven by the lack of capacity for surgery that required HDU or critical care intervention. A plan for recovery was in place. **Planned Care** The Committee received the report noting that the dataset was being run through the artificial intelligence system that would support clinical prioritisation of patients on the waiting list. **Committee Performance Dashboard** The Committee noted the continued improvement in the quality and useability of the executive scorecard and parameters listed each month that could be related to the baseline or targets. **Performance Review Meeting Upward report** The Committee received the report noting the content **Board Assurance Framework** The Committee undertook a detailed discussion regarding the content of the Board Assurance Framework and the reports presented to the Committee and considered each of the objectives assurances ratings relevant to the Committee. The Committee agreed to move objectives 3a and 3b from red to amber ratings based on the level of controls in place and assurances being provided to the Committee. Objectives 3c and 4a would remain as reported.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risks presented
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
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	D	J	F	M	A	M	J	J	A	S	O	N
Gill Ponder, Non-Exec Director	X	X	X	X	X							
David Woodward, Non-Exec Director						O	X	X	X	X	X	X
Geoff Hayward, Non-Exec Director	A	X	X	X	A	X	X	A				
Chris Gibson, Non-Exec Director	X	X	X	X	X	X	X	X	X	A	X	X
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	C	X	X	D	X	X	X	X	X	X	X	X
Director of Improvement & Integration	C	C	C	X	X	X	X	X	A			

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*ULHT Trust Board*
Date of Meeting	*7th December 2021*
Item Number	*Item 10.2*
Trustwide Urology Reconfiguration of services update	
Accountable Director	*Simon Evans, Chief Operating Officer and Paul Matthew, Director of Finance and Digital*
Presented by	*Simon Evans, Chief Operating Officer Mr Andrew Simpson, Consultant Urologist and Deputy Medical Director, Clinical Effectiveness*
Author(s)	*Chloe Scruton, General Manager*
Report previously considered at	

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

Risk Assessment	*Clinical Risk Analysis completed to inform QIA, along with Benefits Analysis.*
Financial Impact Assessment	*Financial Impact - £300k savings pa as a result of agency use reduction*
Quality Impact Assessment	*Approved by QIA Panel on 17th November 21. Overall risk score of 12.*
Equality Impact Assessment	*EIA forms part of the new QIA model*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations	• *Assurance to Trust Board as to the current successes of the Urology Reconfiguration (this represents a 3-month follow paper from the August 2021 Trust Board meeting)*

Executive Summary

In August 2021 a briefing paper titled 'ULHT Urology Reconfiguration of Services proposal' was presented by the Deputy Chief Executive and Executive Director of Improvement and Integration, to the ULHT Trust Board following which, approval was given to implement the new model of care. There was also a request for a 3-month review to ensure benefits were being realised and the project was delivering the expected outcomes.

Under the current reconfigured model, Pilgrim hospital continues to see emergency urology patients, but if the patient needs admission or surgery they are transferred to Lincoln County Hospital if they are medically stable to do so. Where patients are too unstable for transfer, they are admitted to Pilgrim Hospital ICU, the Urology Consultant on-call will travel to Pilgrim Hospital site as required to assess and support with the management of the patient.

The previous model of care was fragile and unsustainable due to the on-call challenges (specifically, consultants being on call and also having elective surgery commitments at the same time) This reconfigured model has enabled us to ensure that we have a stable and sustainable urology service for the future, increasing our capacity to perform planned surgery without disruption, avoiding on the day cancellation due to surgeon non availability; as well as better meeting the needs of our emergency cases through prompt access to specialist opinion enabling us see and treat more people in a timely manner.

An interim GIRFT (Getting it Right First Time) review of the service took place on 23rd July 21, attended by three GIRFT clinical leads. The team offered uniform support for the new model.

Expected benefits of the model and its wider impact are being monitored; however, it is difficult to draw conclusions given the limited amount of data available. As expected, the medical agency doctor spend has reduced and it is anticipated that this trend will continue. Other metrics have been impacted by the significant urgent and emergency care pressures that the trust has experienced in recent months. The team intends to continue to monitor the data to determine any trends over a longer time period.

Benefits Realised to Date

Since go-live of the new service on the 9th August 2021, the following benefits have been noted. There is a more detailed view of the benefits presented throughout the document. The table below provides the main headlines.

IIP Pillar	Benefit Theme	Progress to Date	Current Status
Patients	Deliver the change	Service now reconfigured following formal patient consultation. Service go-live 9th August 2021.	
Patients	Admissions	Total number of non-elective admissions downward trend since go-live. Ongoing monitoring of this metric in place.	

Patients	Voice of the Patient	Mechanism in place to capture feedback specifically on the reconfiguration. Overall, positive themes emerging from the feedback	
People	Staff engagement	Robust baselining of engagement taken pre-go live and also 3 months' post go live. Opportunities exist to improve engagement. Action plan to be created based on the latest feedback.	
People	Staff vacancy rate	Medical vacancy rate now at 0 (compared to 28% before the reconfiguration.)	
Service	Financial performance	The total investment into the service is £700k pa. Medical agency spend reduced to zero. To date, the overall pay savings reported amount to £9.4k, and this is expected to increase to up to £140k in this financial year now that medical agency has fully ceased.	
Partners	Collaboration with GIRFT	Endorsement of changes via the GIRFT clinical leads	

A number of stakeholder experts have been involved throughout implementation of the new model, they are:

GIRFT (Get it Right First Time)
Patient Experience panel
KPMG
EMAS – East Midlands Ambulance Service
CCG colleagues – Clinical Commissioning Group
ULHT staff – United Lincolnshire Hospital Trust

1. Purpose

The purpose of this briefing paper is to provide the Trust Board with an update of the reconfiguration of services within Urology at United Lincolnshire Hospitals NHS Trust. The previous proposal paper titled 'ULHT Urology Reconfiguration of Services proposal' was submitted to the ULHT Trust Board in August 2021 following which, approval was given to implement the proposed model with a 3-month review required to ensure benefits were being realised.

The approved reconfigured model enabled Lincoln County Hospital to receive all emergency urology admissions seven days per week. The aim was to ensure that the other sites are better organised to manage the majority of elective procedures, thereby reducing elective cancellations, increasing capacity and supporting the recovery of services post-COVID 19. Essentially, this approach planned to level the demand across the sites, creating enhanced patient choice and reducing patient wait times, while better meeting the needs of our emergency cases.

Support for other services at Pilgrim Hospital has been maintained by the daily presence of a "duty urologist" of specialty doctor grade or above to review and manage in-house referrals as well as access to the Urology Single Point of Contact (USPOC) 24 hours a day. Post operative care for CBU patients at the Grantham site has been further strengthened by the appointment of core trainees who work closely with the operating consultant and ward nursing teams.

2. Case for Change

Historically ULHT had struggled with delivering the optimal mix of capability, capacity and resources across its hospital sites. Services tended to be delivered across all sites, however the rurality of Lincolnshire means that the distance between the sites and poor transport infrastructure limits opportunities for scale and networked ways of working. Over recent years ULHT has experienced pressure on elective beds due to a high volume of unplanned admissions.

Alongside this, prior to the reconfiguration, high medical vacancies existed across ULHT in the urology (elective and non-elective) service (c.28% of medical posts vacant).

Data analysed between 2017 - 2020 inclusive shows that on average, 5 urology procedures are cancelled every day (c.1,900 annually). For the procedures that were cancelled by the hospital (i.e. not by the patient), around 25% were cancelled on the day and 10% due to lack of beds. Cancellation of surgery at any time leads to poor patient experience and satisfaction, and additional pressure on the waiting list. Being cancelled on the day of surgery is extremely distressing for patients and their families. The new NHS Long Term Plan published on 7 January 2019 fully supports the split of elective and non-elective work onto different sites to drive improvements, and recognises that managing complex, urgent care on a separate dedicated site allows improved emergency assessment and better access to specialist care, so patients have better access to the right expertise at the right time.

On the basis of recommendations arising from the Urology Getting It Right First Time (GIRFT) visit, Urology was selected for a major reconfiguration supported by the Integrated Improvement Directorate (IID) Delivery Team and KPMG, with strong executive sponsorship.

The GIRFT programme's national report into urology services, published in 2018, makes a number of important recommendations around the delivery of emergency urological care. These include providing consultant delivered emergency care by reducing elective commitments when on call,

reviewing workloads to ensure on-call arrangements are sustainable, and focusing available resources to ensure high-quality emergency care is available seven days a week. Most NHS organisations ensure that Consultants are not on-call when delivering elective commitments to ensure prompt response to emergency care.

The current reconfigured model for urology services at ULHT was developed following an options appraisal with GIRFT clinical lead, Mr Simon Harrison and supports the delivery of these recommendations. Support has been provided by the regional GIRFT implementation team throughout the project, through weekly meetings with the project team, and the current reconfigured model was presented to the GIRFT clinical leads on 23rd July 2021. The team offered uniform support for the model.

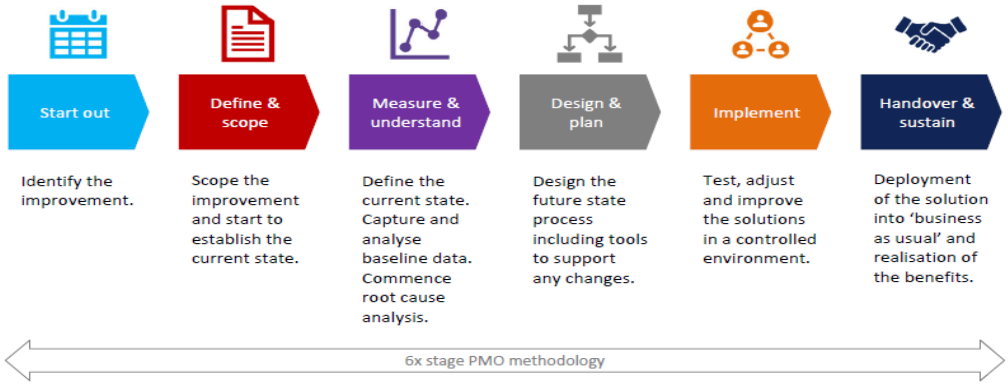
The key features of the reconfiguration include:

- Focus for acute urology at a single site emphasising increased same day care, acute lists and clinics
- Maintenance of diagnostic and outpatient activity across sites
- Increased non-complex elective procedures at Grantham and Pilgrim, with a focus on day case and short stay work but including specialist stone procedures.
- Retaining some complex major procedures at LCH
- Single urology team with expanded consultant and SAS (middle tier) colleagues and a new tier of acute care practitioners

Additionally, the project outcomes link directly to the Trust's 5 year Integrated Improvement Plan. At high level, the alignment to each of the strategy themes is as follows:

Patients	• Complaints, SI's and DATIX • Average length of stay (emergency) • Cancelled procedures • Cancer Performance (28d) • Variation in cost per patient (PLICS) • Procurement costs
People	• Staff engagement and medical vacancy rates
Service	• Financial performance • Agency costs • Service stability
Partners	• Collaboration with GIRFT – best practice alignment and delivery of GIRFT recommendations.

Delivery of the urology reconfiguration has been managed using the existing 6x stage project methodology with additional elements added to align with the Outstanding Care Improvement System (OCIS).

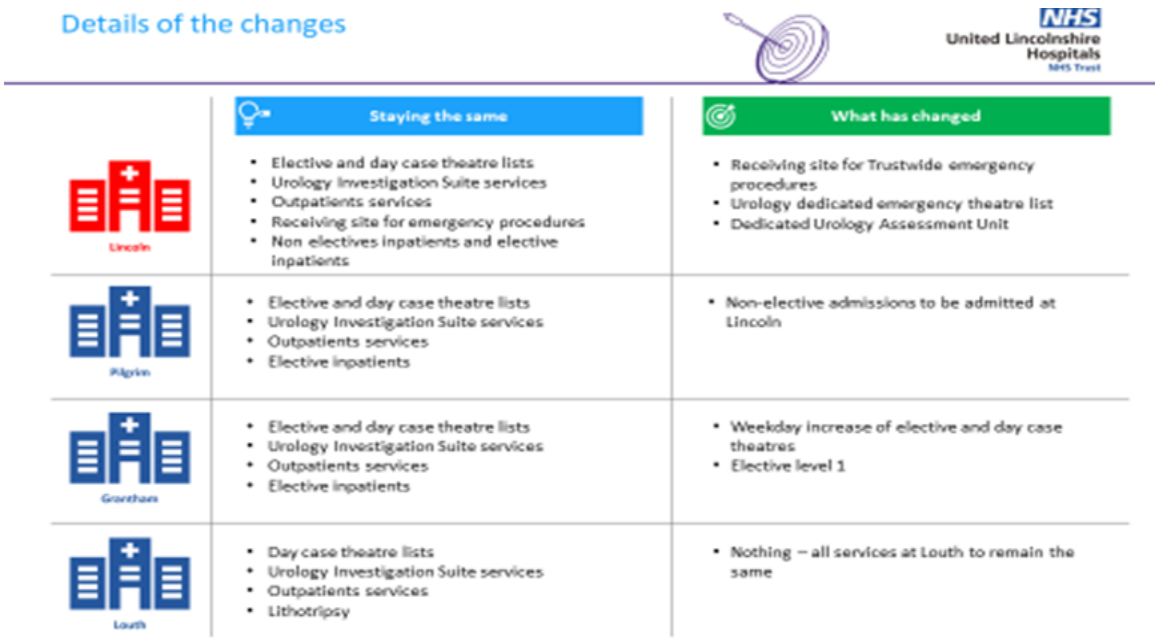


3. Background

One of the benefits of the current reconfigured model is to create a separation of duty, so that our consultants are either on-call or scheduled to perform planned care. Critically, they are not required to fulfil both duties at the same time, thus eliminating the risk around planned care being cancelled at short notice due to emergency pressures e.g. a consultant currently could previously have been on-call and delivering elective planned commitments at the same time.

In order to successfully implement this rota, we looked at the location of urology surgery provision across the county. The agreement was for Lincoln to become the primary receiving site for all non-elective activity. All sites continue to provide elective activity. The rationale behind this configuration was to:

- Stabilise elective activity – reduce disruption and cancelled procedures
- Provide a more robust clinical rota covering both sites, with the on-call consultant focused at Lincoln
- Improve patient access to emergency care and treatment
- Reduce on the day cancellations



4. Key Benefits

In the original evaluation of the new reconfigured model, it was recommended that the trust adopts a reporting dashboard to track delivery of the key expected benefits, monitor desirable/undesirable impacts and drive performance improvements in terms of quality, safety, patient experience and use of resources. These criteria were fully defined in the original Project Charter for the reconfiguration. This dashboard has now been created, therefore, performance against the KPI's is regularly monitored and performance against these are highlighted below in 'Benefits Matrix'. The dashboard aligns with the 'scorecard principle' adopted by the wider Outstanding Care Improvement System (OCIS).

	Expected Benefit Areas
Services	Medical agency spend reduction Procurement cost opportunities Reduction in service deficit against budget Sustainable financial service Urology assessment unit Improved flow from the Emergency Department
People	Improved engagement Training opportunity for SAS & ACP tier Reduced admin burden to manage rota and resource
Patients	Complaints, SIs and DATIX reductions Average length of stay reduction Direct access model for cancer pathway Continuity and consistency of care Increase in proportion of patients discharged from assessment unit Improved flow from ED Reduced waiting list and pathway times for cancer and RTT Reduced cancellations on the day Reduction in non-elective admissions and overall bed usage
Partner	Alignment of solution with GIRFT recommendations and best practice guidance Increased support of Primary Care Work with system to provide best care for Lincolnshire patients

5. Benefits Matrix

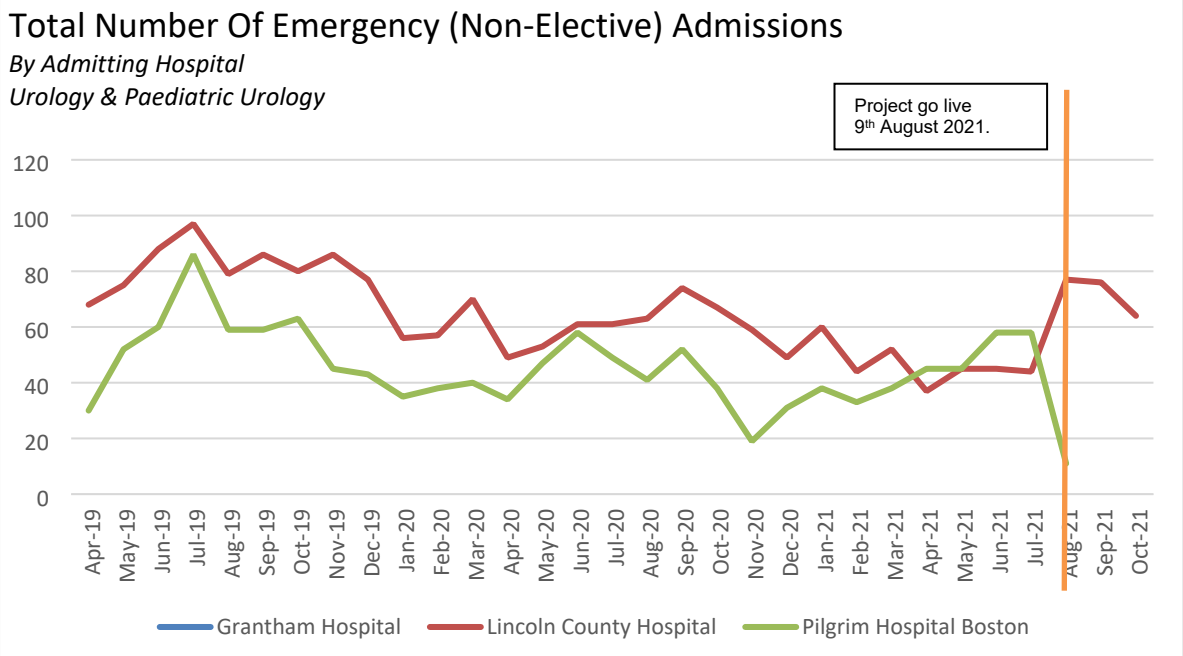
A comprehensive benefits matrix has been captured to support the reconfiguration. The key benefits are highlighted above in section 4. Below is a summary of the benefits matrix that will be used to manage and track the benefits of the reconfiguration.

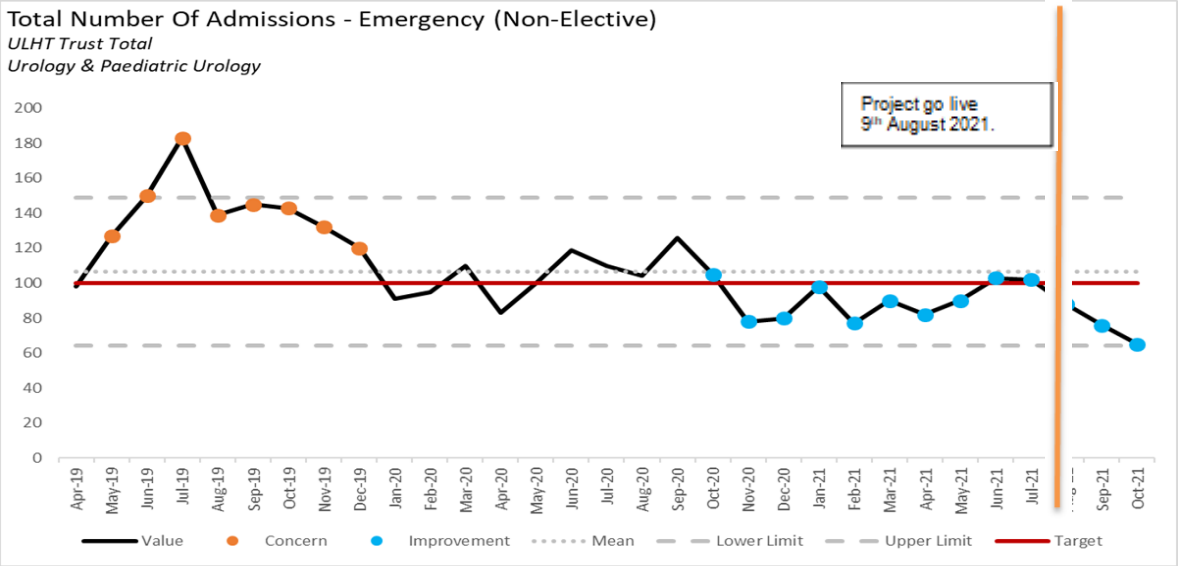
Benefit	Baseline	Opportunity statement	Current performance – NOV 2021	Current status	Quality	Operations	Workforce	Finance	GIRFT	Model Hospital	Benefit Realisation Period from go-live (May-21)
Medical agency spend	£100k / month	• c£300k annually • Reduce to zero by Sept-21	£0 spend on medical agency spend. All spend removed from early November 2021			X	X	X			Phase 1
Average length of stay	3 days	• Root cause understanding of ALoS metrics. Seeking to reduce non-elective admissions and overall bed usage • Increase in proportion of patients discharged from assessment units	Average length of stay remains the same but this is impacted by increased numbers of patients needing packages of care in order to be discharged.		X	X			X	X	Phase 2
Cancelled procedures	13% of EL and DC cases cancelled on same day.	• Reduction in cancelled operations. Target to be established once root cause and analysis completed. • 2019 baseline used – cancelled by the hospital (not patient)	August 13 September 24 October 13. Increase owing to level 4 pressure		X	X	X		X		Phase 2
Cancer performance (28d)	46%	• Direct access pathway model to reduce pathway duration • Improvement in 28d national standard performance • Standardise process • Focus on bladder and kidney pathway	50% Delay in implementing rapid diagnostic pathways due to governance sign off Issues owing to level 4 pressure		X	X					Phase 2
Indirect and PLICS data variation	Various	• Over the data, the total costs for all codes is £13.98m against an income of £11.10m yielding a delta of £2.88m • 80% of the loss (£2.3m) is attributed to 18 unique HRG codes (this accounts for 51% of the total volume of procedures)	Ongoing work being undertaken. Deep drive into areas of the specialty being undertaken which has identified potential for cost reduction per patient.		X	X	X	X	X	X	Phase 2
Procurement costs	£843k annual non pay costs.	• Note: £561k of the total non-pay costs relate to clinical supplies & services • At least £93k identify to date (urethroscope)	Delays in endourology procurement due to staffing issues with Procurement team		X			X			Phase 2

Benefit	Baseline	Opportunity statement	Current performance – NOV 2021	Current status	Quality	Operations	Workforce	Finance	GIRFT	Model Hospital	Benefit Realisation Period
Waiting list	December 2020	• 18 week RTT for ULHT is 60.8% (847 patients over 18 weeks) • Target to be identified following further investigation	• 18 week for RTT 64.44% (889 patients over 18 weeks Position expected to be higher but impact seen from level 4 escalations		X	X		X			Phase 2
Staff engagement	TBC	• Pulse survey issued Jan-21 to establish baseline. • Engagement plan to be developed to support outcomes	• Pulse Survey • Survey to be repeated in March 2022 owing to low responses			X	X		X		Phase 1
On-call provision	GIRFT	• Hot / cold site configuration will address the key concerns from GIRFT about reducing elective commitments for on-call consultants.	• Consultants no longer have elective commitments when undertaking on call		X	X	X	X	X		Phase 1
Emergency care provision	GIRFT	• Ensure high-quality emergency care is available 7-days a week • Explore options as part of a Urology Area Network (UAN)	• Emergency care is delivered on a 3 tier on call system 24/7 • Working in alliance with Leicester		X	X			X		Phase 2
Data integrity	GIRFT	• Review data collection • Improve coding accuracy • Increase income through accurate coding • Staffing costs per WAU	• This is ongoing with the support of Coding and Urology Clinical Leads		X	X	X	X	X	X	Phase 2

Non-elective performance -

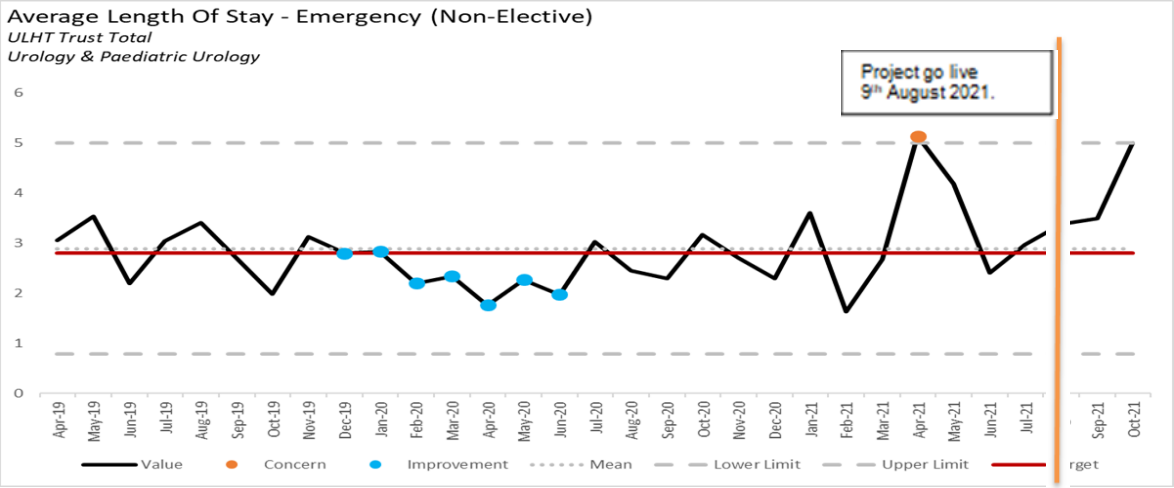
There was concern prior to the re-configuration that non-elective admissions would increase. The reconfigured service went live on the 9th August 2021. As you will see from the graphs below, admissions increased at Lincoln County once the reconfiguration commenced but are now significantly lower than what they were Trust-wide pre re-configuration. This trend will continue to be monitored through the scorecard.





Average length of stay non-elective –

Average length of stay on the Urology non-elective pathway has increased, as have all other specialties within ULHT. However, once the Urology patients can all be placed on one ward (level 4 escalation permitting) the specialty is confident this will improve as we can then implement criteria-led discharge.



6. Quality Impact Assessment

The clinical risk analysis has directly fed into the Quality Impact Assessment. The QIA was signed off by the Trust's QIA Panel on 12th July 2021. A further update QIA and scorecard was presented on 17th November 2021 which received full support and final sign off. The QIA received high praise from the panel and commented that the level of detail and due diligence that has gone into the document is outstanding.

7. Patient feedback

In order to capture patient experience information post go-live, the Project Team set up a Patient Experience Survey for Urology patients. This has been disseminated throughout the service for patients fit to sit and for inpatients. Staff have been encouraged to support patients with providing feedback through this forum. To date, as at 9/11/21, uptake has been 3 responses (1 response from a patient who travelled from Pilgrim Hospital, Boston). It is work in progress given the current climate and winter pressures. Feedback shown below –

"The service was excellent; every stage of the procedure was explained thoroughly before proceeding"

"The Urologist I saw today, I have seen before, very polite and knowledgeable"

"The two paramedics on the ambulance were as efficient and attentive as the staff in the hospital.

The staff in the hospital are magnificent under the conditions they work under, short staffed etc"

Although patient survey responses have been low, no negative feedback via PALS or formal complaints have been raised.

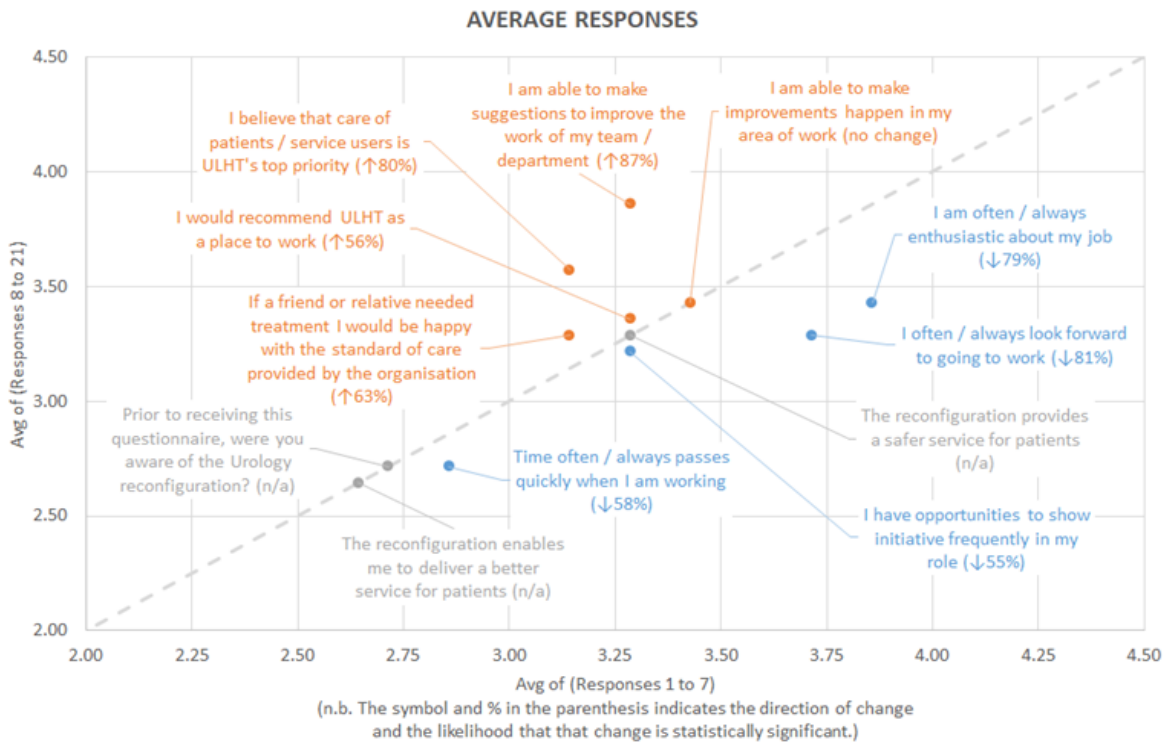
8. Public/patient engagement

Prior to implementing the reconfiguration, we consulted with Lincolnshire patients over a 12-week period. This involved formal communications about the changes, focus group meetings with patients, clinicians and service leadership for patients to share their views about the proposed changes and to directly influence the reconfiguration model.

Positive Feedback	Concerns	Mitigation
Staff: complementary about current staff, see the change as a vehicle to improved recruitment and specialists. Resource usage: general feeling that reconfiguration will positively improve access to resources / service. Patient experience: support for the separation of elective and planned activity. Feel this would result in a reduction in cancellations of elective activity. Support a reduction in elective waiting times. Patients happy to travel for expert care. Activity: welcome increased elective activity at Pilgrim, Grantham and Louth hospitals	Travel & transport: concern about delays in treatment due to emergency transport to another hospital site. concerns about how Boston-area patients would get back home after discharge from Lincoln hospital. Impact on other providers: EMAS ability to cope with demand. Patient safety: concern about risks connected with not receiving emergency care as quickly. Concerns about services being moved away from Pilgrim-disadvantaging population of Boston and the East Coast	Hospital transport on discharge will be provided for qualifying patients; for other patients, solutions including taxi provision will be explored on an ad hoc basis. EMAS are in full support of the proposal; modelling suggests the impact will be one additional transfer for admission per day The additional tier of on call provides enhanced access to specialist opinion through the SPOC. The provision of elective, diagnostic and specialist services at PHB will increase.

9. Staff engagement

Staff were consulted via a questionnaire at the commencement of the project in order to obtain a baseline set of information in relation to staff satisfaction. The questionnaire has now been repeated post go-live in order to identify improvement or otherwise. Approx. 50 staff were consulted with and the response rate has been low. Analysis shown below.



(n.b. The symbol and % in the parenthesis indicates the direction of change and the likelihood that that change is statistically significant.)

For each question it's possible to compare our score from our first set of surveys (responses 1 to 7) to our score from our second set of surveys (responses 8 to 21), and say (mathematically) whether that score has remained the same, gone up, or gone down.

The responses shown in orange show an increase in positive responses to the questions, those in grey show a remaining consensus and those in blue show an increase in negative response.

The arrow and % at the end of the scatter chart points labels tell us first the direction of travel (the arrow; the text "no change", an up-arrow, or a down-arrow) and how confident (the % calculated using a statistical test) we can be that the arrow is a true assessment of any change, rather than being simply due to random variation.

It is clear from the responses above that there is more work to be undertaken on improving 'morale' of our workforce, however, a higher sample of response would enable us to pin point any high levels of concern.

We plan to undertake a further survey in March 2022 and the in meantime are working with Organisational Development on improving team morale.

10. Finance

Prior to implementation there was a high reliance on agency medics. The investment into this service and improvements to the model of working was expected to improve recruitment and retention of staff. This included:

• Investment of 7.00 WTE Advanced Clinical Practitioners (ACP), who form part of the first on-call and reduce reliance on agency locums.

• Drive on substantive recruitment of Medical staff, including an investment of budget from within the CBU to fund a 10th consultant post.

• Introduction of Core Trainees working across Urology and Orthopaedics at Grantham site, funded from within the CBU.

The total investment into the service is £700k pa. Spend on medical agency was £780k in 19/20 and £1,153k in 20/21.

	Current Establishment			Future Establishment	
Cost Category	WTE	Cost 19/20 £k	Cost 20/21 £k	WTE	Cost £k
Consultants	8.00	2,143	2,313	10.00	1,682
SAS	8.80	948	992	8.00	878
Specialist Trainee	1.00	119	99	1.00	81
Junior Drs	7.00	325	358	8.00	373
ACPs	-	-	-	6.00	470
Total	24.80	3,535	3,762	33.00	3,484

Table showing current vs future costs of the medical workforce plus the ACPs. The future cost represents the model fully established with post-holders at 'top of scale' and without any premium costs from agency or extra duties.

As a result of these investments and the subsequent elimination of agency the specialty is expected to achieve a cost improvement of c£300k (FYE).

As at October 2021, all posts are either filled or have a plan in place for a new staff member to join, and as such the agency has ceased as planned in early November. The 21/22 medical agency spend year to date is £300k.

To date, the overall pay savings reported amount to £9.4k, and this is expected to increase to up to £140k in this financial year now that medical agency has fully ceased.

The overall capacity and activity will stay the same with the reconfiguration. However, there is a potential income opportunity for reduced cancellations. Of approximately 500 cancelled operations per year, 17% were due to bed availability or unplanned surgeon absence. The reconfiguration could mitigate cancellations for these reasons and therefore there is an opportunity worth around £120k, using an average elective tariff. The expected benefit has not yet been quantified and thus far no benefit realised in relation to reduced cancellations.

Work continues on deep dives into cost variations using patient level cost information, with Finance working with the CBU to identify opportunities for cost savings.

11. Key risks/issues

There are a number of potential issues to the continued success of the programme identified. These are listed below –

Issues *(An Issue has already occurred)*

Description	Date Raised	Status	Owner	High Level Actions	Scoring	Impact	Latest Reviewed
Retention of Middle Grade Doctors	21/10/2021	Open	Chloe Scruton	Working ongoing with HR to develop an individual development and training structure for each Middle Grade Doctor. Ongoing regular meetings with SAS doctors	2 (Low)	The impact is: We may not be able to fulfil the obligations of the rota in its' entirety and may have to utilise agency staff De-stabilisation of service.	04/11/2021
Compliance with the new service model by clinical staff – **all** urology patients being directed to LCH, without prior USPOC contact and agreement	19/08/21	Open	Chloe Scruton	Completion of SOP to incorporate roles and responsibilities model – this will then become and official Trust document and communicated accordingly and will ensure absolute clarity in terms of all aspects of the service model for non-elective walk-ins at non-receiving sites (SOP in final draft for CBU to verify and sign off) Good feedback from staff saying the service is much better. Keeping under review.	2 (Low)	The impact is: The flow of the patient pathway, and therefore the patient experience, may be compromised if the correct process is not followed, causing potential delay and inconvenience to our patients. Additional pressure on LCH to accommodate non-urgent urology patients, sent in by Pilgrim, that should be seen and treated as usual within A&E.	04/11/2021
Establishment of Urology/Trauma Assessment Hub (UTAH) – delayed partly owing to the stand down of CRIG halting progression	16/09/21	Open	Chloe Scruton	Target was to open the UTAH during October 2021. SAU is being used as an interim measure. The business side of the report has been completed and this is now sat with nursing to complete their part. The stand down of CRIG has halted progress. Continuation of use of SAU will need to continue.	2 (Low)	The establishment of the UTAH is essential to ensuring improved patient flow and timely treatment in the right location. The status quo of using SAU will need to be maintained.	04/11/2021

				Action: seek acknowledgement from Project Sponsor of the delay with regard to this element of the reconfiguration and to potentially identify a solution to aid progression as quickly as possible Update: Excessive ambulance handover delays have highlighted the need to escalate the establishment of UTAH as part of the solution to remedy some relief on A&E. All money has been approved for estates. Nursing to addressed at CRIG early November. Potential start Jan 2022.			

12. <u>Next Steps –</u>

To ensure performance recovers and remains on track, the Urology department along with Information Services have implemented a dedicated dashboard (contained within the QIA in section 6) tracking key expected benefits. The aim is that this dashboard can be reviewed in real time to assess performance and give the CBU triumvirate team the ability to identify issues and rectify. Currently rectification of performance going off track does not happen until the end of month by which point, performance is already adversely affected. Additionally, a thorough lesson learned exercise has been carried out by the project team to ensure knowledge transfer is shared across the Trust.

- Implementation of Urology and Trauma & Orthopaedics Hub
- Recovery of Urology elective RTT and cancer KPI's in order to achieve target performance. Using C2-AI to ensure patients are treated in clinical priority order to optimise patient outcomes
- Ensure improved efforts to gain regular patient and staff feedback
- Present the current model, success and challenges at the Urology GIRFT gateway review in early 2022
- Implement criteria led discharge

13. <u>Recommendations –</u>

Based on the improvements made within the Urology Trust-wide service following implementation of the new reconfigured model, we request Trust Board support in continuing to deliver the current and expected benefits of this model.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	7th December 2021
Item Number	Item 12
Integrated Performance Report for October 2021	
Accountable Director	Paul Matthew, Director of Finance & Digital
Presented by	Paul Matthew, Director of Finance & Digital
Author(s)	Sharon Parker, Performance Manager
Report previously considered at	N/A

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

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

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

Executive Summary

Quality

Pressure Ulcers

There was a further reduction in category 2 PU at 34 (target of 28.3 month) in October 2021. There are a number of continuing themes currently being observed relating to category 2 pressure ulcers relating to devices, delay in pressure relieving equipment and documentation. During November there is a four-week plan within the Focus on Fundamentals programme to raise the profile of skin integrity in line with International Stop the Pressure Day. There will be a focus on sharing learning from previous incidents, this will include device related damage and categorisation of pressure ulcers.

Medication incidents reported as causing harm

The number of reported incidents causing harm for the month of October has decreased to 17.7% nearly double the national average of 10.8%. Actions to recover are cited below.

SHMI

The Trust is currently at 111.98 for SHMI against targets of 100. SHMI has increased during the COVID-19 pandemic. The Trust are currently in discussion with the system partners in rolling out the ME service for community deaths and learning can be generated for deaths within 30 days alongside a peer review by NHSEI for structured judgement reviews.

Participation in National Clinical Audits

The Trust is participating in 97% of all relevant national clinical audits. The Trust has now registered for the IBD audit which will make us 100% compliant and data collection was due to commence in October 2021 however problems have occurred with IBD logins due to a national upgrade.

eDD

The Trust achieved 88.7% with sending eDDs within 24 hours for October 2021 against a target of 95% with 94.6% being sent anytime within the month of October.

Sepsis compliance – based on September data

Screening / IVAB ED / inpatient child - Screening compliance for paediatrics in ED was 78% and inpatients at 85%, with the administration of IVAB for paediatrics in ED at 83% in September. Clinical Harm reviews continue and actions to recover can be seen below.

Duty of Candour (DoC)

Verbal compliance for September is at 61% against a 100% target and 39% for written. DoC training has been sourced from an external provide and is being delivered throughout November2021. The Risk team are currently reviewing compliance and supporting the Divisions on a daily basis.

Operational Performance

The Covid 3rd wave has seen an increase demand in terms of hospitalisation with numbers of inpatients ranging from 55 patients to 88 patients. At the time of writing this executive summary, the Trust has 81 positive inpatients, of which 12 patients are requiring Intensive Care interventions. The impact of the 3rd wave on staff absences remains significant due to the increased prevalence of positive cases within our population. Lincolnshire has had at times the highest sickness rate in the Midlands. This has impacted on the delivery of both urgent and planned care pathways.

This report covers October's performance, and it should be noted that as the demands of Wave 3 have increased, the Trust moved back to a *Manage* phase whilst acknowledging the absolute need to combine the recovery and restoration of services. Guidance in how performance and recovery is approached is defined by national requirements as set out in NHS England's 2021/22 Priorities and Operational Planning Guidance. This guidance which moves away from a focus on statutory access standards will have direct impact on performance, specifically RTT. Additionally, new Emergency and Planned Care Standards which are now being implemented, monitored, and reported going forwards.

A & E and Ambulance Performance

Whilst the summary below pertains to October data and performance, the proposed new Urgent Care Constitutional Standards have now been adopted to run in shadow form and performance against these will be described in the supplementary Urgent Care FPEC paper. Amendments to the Urgent Care IPR dashboard have been made for October but these will be refined further as more data becomes available.

4-hour performance for October improved against September's performance of 62.13% being reported at 64.04. %. The Trust's performance has been below the agreed trajectory consistently for 12 months.
There were 173 12-hr trolley wait, reported via the agreed process. Sub-optimal discharges to meet emergency demand remains as the main route cause. (As described in the Trust Risk Register entry 4175)

Performance against the 15 min triage target in October demonstrated an improvement of 2.91% compared with September. 85.51% in October verses 82.60% in September.

Ambulance conveyances for October were 4211, up by 0.93% against September. There were 733 >59minute handover delays recorded in October, a decrease of 190 from September. Delays experienced at LCH and PHB are attributed to increased levels of overcrowding in EDs and managing the low, medium and high-risk IPC pathways. October demonstrated an overall decrease of >120mins handover delays compared with September, 386 in October compared to 465 in September, representing a 20.59% improvement, however, >4hrs handover delays increased, 107 in October compared to 94 in September. This represents a 12.15% increase.

Length of Stay

Non-Elective Length of Stay remains of concern and is a major contributor to overcrowding in EDs and the subsequent impact on ambulance handover. The average bed occupancy for October, excluding Grantham District Hospital was 93%. Multi agency discharge meetings continue to take place twice daily. All patients on pathways 1, 2 and 3 are reviewed, with a noted increase in discharge of medically optimised patients across the entire week (7days). Pathway 1 capacity (Domiciliary care) has decreased in availability and is a large contributor to increased LoS. All delays of greater than 24hours are escalated within the System. Elective Length of Stay has increased slightly in October to 2.37 days (September reported 2.30 days). This is mainly due to a higher level of complex patients accessing surgical pathways that require a reduced post-operative care period in intensive care.

Referral to Treatment

It is important to view and read this in the context of the current National Covid Restore Agenda, and the move away from a focus on constitutional standards to the expectation of clinical urgency; a clinical risk-based patient selection process as opposed to selection based upon the longest waits. Within this context it is unlikely that there will be complete improvement to statutory RTT performance for some time.

September demonstrated a decreased performance of 1.24% to 55.61%. The Trust reported 1451 incomplete 52-week breaches for September end of month compared to 1093 in August. The Trust still remains in a strong position when compared to other regional providers.

The Cancer/Elective Cell continue to meet weekly, with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation cell to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 40+, 52+ and 78+ week patients on the 18-week RTT PTL. As of 7th November, the Trust has 8 patients waiting longer than 104weeks. This has been identified as a patient choice issue.

Waiting Lists

Overall waiting list size has increased in September to 52,368 compared to 50, 804 in August. The end of October position is at 54,371. Work continues between OPD and the CBUs regarding the returning to a standard 'polling' approach as part of our restoration plans.

A recovery plan for ASIs has been developed and including a recovery trajectory. October demonstrated a reduction (567). As of 7th November, ASI numbers have increased to 663 and remains in line with the trajectory. The trajectory is 550.

As at 31st October 2021, the Trust reported 16,328 over 26 week waits and 5,847 over 40week waits. The longest waiting patients continue to be tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

DM01

DM01 for October 2021 demonstrated 66.23% compliance against a target of 99.00%. Echocardiography tests are the majority of the poor performance in diagnostic waiting time and have a considerable backlog due to a lack of capacity having not recovered to previous levels of activity and having not identified any external or independent sector support. The Trust has engaged with external management consultancy specialist in productivity in diagnostics to support recovery in this domain.

Cancelled Ops

This indicator has not been reported for three months due to data validation issues with teams redeployed to support the response to surges in urgent care.

This indicator has not been met since July 2021. The compliance target for this indicator s 0.8%. October demonstrated a 2.83% compliance. A negative variation of 2.03%

October demonstrated a slight improvement.

The tolerance level for re-booking late notice cancellation of operations is zero. October experienced 34 breaches against this standard. A review of the effectiveness of the 642 theatre scheduling meetings is now in train, however with variations in ICU capacity as a response to internal and external pressures (mutual aid) it is likely that performance is unlikely to substantially improve until the Trust moves out of wave 3.

Cancer

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

The current compliance trajectory is 85.40%. Trust compliance against this agreed trajectory is 63.33%. A negative variance of 22.07%

40% of the 14-day breach performance was attributed to the Breast Service in respect of the One-stop appointments. A demand verses capacity gap exists and has been previously articulated. This also applies to the Symptomatic Breast service.

The impact of COVID-19 on the delivery of the cancer pathways remains evident for 31 day and 62-day standards.

62 Day pathway backlogs are reducing – 392 as of 2nd November 2021.

Workforce

Mandatory Training – The trend for the completion of Core mandatory training continues to decrease in compliance again in October. The continuation in the pressures to the Trust due to high increases in patient activity, staffing pressures (including staff absences) as well as Covid absences has impacted on staff ability to undertake the training. The team are continuing to support the Trusts with concerns and issues that are escalated in the undertaking of core learning activity. New systems are being used to update the current training packages and review platforms for the storage and collation of uptake and performance data.

Sickness Absence – Sickness has continued to rise again October, there is still an attribution from the changes in government guidance regarding the wearing of facemasks. This is correlated against the increases in school and care home Covid outbreaks. There is also an increase in the 'usual' seasonal ailments and infections that may be attributed to the wearing of facemasks that has reduced immunity. The effect on our staffs wellbeing continues to increase as we move into winter and Christmas period. A review of the Attendance Management System is going to be arranged to see if there needs to be any changes or lessons learnt.

Staff Appraisals - The AfC appraisal rate continues to be lower than expected. Implementation of a new system – WorkPal and ongoing operational pressures have meant that staff do not get the time needed to spend on appraisal discussions. With the stand down of non-essential training, WorkPAL engagement sessions have been poorly attended. The need for having an appraisal cycle will be raised and discussed in the new year so that there is an organisation wide focus on appraisals for 3 months of the year only as compared to the current year round focus on appraisals.

Staff Turnover - Over the past few months, we have seen an increasing trend for turnover. Operational pressures, staffing challenges and Covid has meant that an increasing proportion of staff are looking for other avenues outside the Trust. While the Trust has launched the flexible working initiative, we are yet to see a reduction in turnover amongst people who cite this as a reason for leaving. One of the key requests coming up in the last month has been the need for face to face exit interviews (as compared to the survey version we currently have) with someone in HR/OD.

Finance

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

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

At the time of writing this report, the national financial planning process for H2 is not yet complete, and the Lincolnshire system has not submitted its financial plan for H2. The Month 7 position is therefore based upon the plan being equal to actual, and the Trust has delivered a deficit of £0.7m in the month of October and surplus YTD of £1.1m (in line with plan). The current month deficit of £0.7m is based upon block income from Lincolnshire CCG in line with the cash payment received; once the Lincolnshire system has agreed its financial plan, any difference between the block payment made in October and the final block amount agreed will be posted to I&E.

The capital programme for 2021/22 currently stands at £36.1m for the full year; actual capital expenditure of £8.7m has been incurred YTD against a submitted plan YTD of £17.2m.

The month end cash balance is £49.4m which is a reduction of £4.6m against cash at 31 March 2021.

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

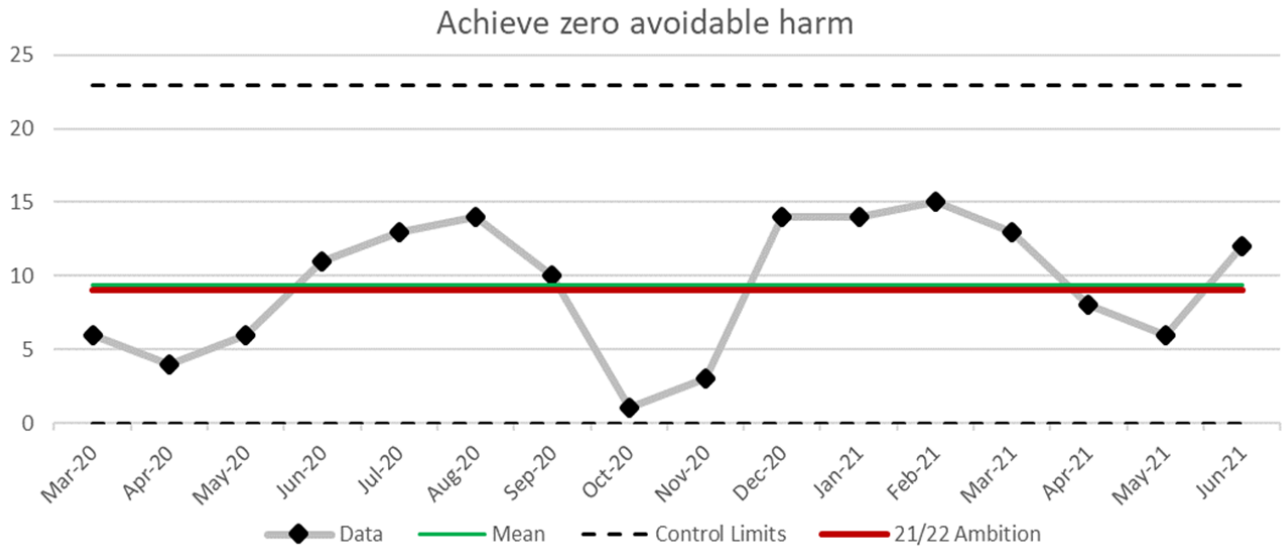
Statistical Process Control Charts

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

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

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

An example chart is below:



Statistical Process Control Charts

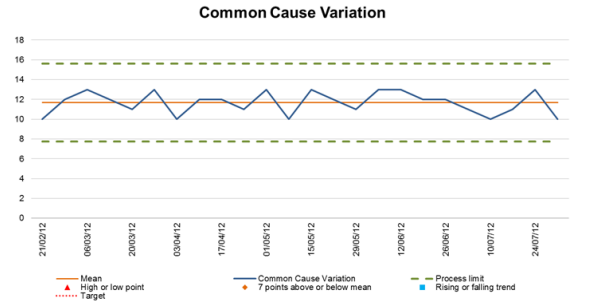
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

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

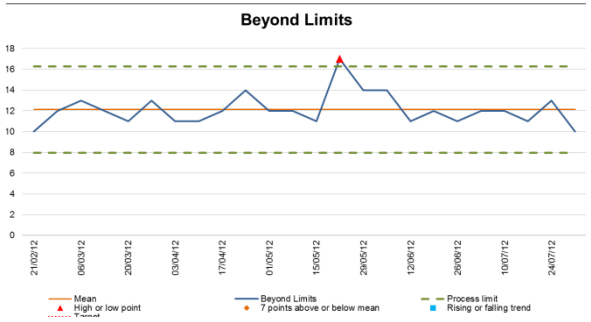
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



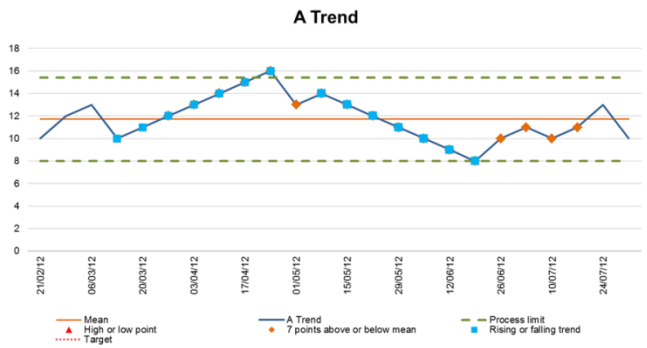
Extreme Values

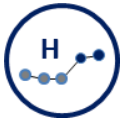
There is no Icon for this scenario.



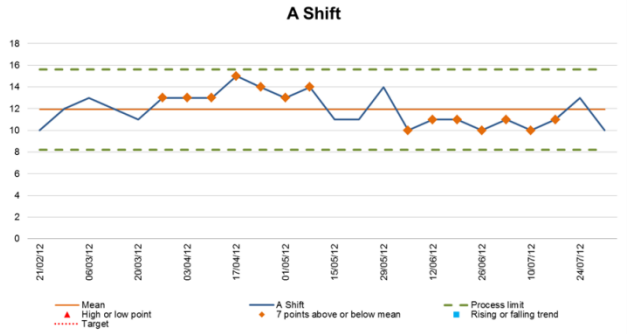
Statistical Process Control Charts

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

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

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EXECUTIVE SCORECARD

Strategic Goal	Domain	Measure ID	Measure	Measure Definition	Baseline	21/22 Ambition	£'000	2021/2022 Aug	Sep	Oct	Latest month pass/fail to ambition	Trend variation
Strategic Metrics	Patients	1	Top 25% for acute Trusts for 'Overall' Inpatient experience	Monthly Inpatient Friends and Family Test results, which are a proxy for annual inpatient experience survey.	4th Quartile	3rd Quartile		4th Quartile (87.43%) (108 of 120)	4th Quartile (87.83%) (104 of 120)	tbc (87.00%) tbc		
	Patients	2	Achieve zero avoidable harm	Serious incidents (including Never Events) of harm - Moderate, severe and death.	15	9		9	12	10		
	Patients	3	Top 25% for SHMI	Summary Hospital-level Mortality Indicator	4th Quartile	4th Quartile		4th Quartile (112.88) (111th of 123)	4th Quartile (111.83) (112th of 123)	4th Quartile (111.98) (113th of 123)		
	People	4	Top 25% for acute Trusts across all 10 themes in the staff survey	In year monitoring via staff survey on staff morale and leadership.		+10% improvement						
	Partners	26	Deliver 62 day combined cancer standard (77%)	Patients that start a first treatment for cancer within two months (62 days) of an urgent GP referral, including NHS cancer screening services.	69.20%	77%		63.10%	62.50%			
	Partners	27	Total wait in Emergency Department over 12 hours (<1% of patients)	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	3.60%	<1%		11.45%	15.77%	14.52%		
	Partners	28	Urgent Treatment (P2) treatment turnaround time is less than 4 weeks	Waiting time from receiving patient referral until treatment is given.	6.7	<4 weeks		5.8	8.1	7.3		
	Partners	29	Deliver Outpatient activity through non-face to face	Increase volume of Outpatients activity for pre-booked telephone and web-based sessions, between consultant and patient	45.28%	>25%		31.77%	32.12%	32.12%		
	Services	9	Deliver a breakeven revenue position	Financial status - Revenue monthly variance to plan		Breakeven	£'000	£1.00	£0.00	£0.00		
	Services	10	Deliver £200m capital plan	Financial status - Capital monthly actual shown cumulatively	£15m	£39m	£'000	£5,700.60	£7,342.40	£8,736.90		
Local Projects	Patients	11	No. of medication errors causing harm is <10%	Medication incidents reported as causing harm (low /moderate /severe / death), as a percentage of total medication incidents.	20%	13%		23.85%	26.80%	17.71%		
	Patients	12	Reduce no. of patient fall incidents. (Last 3 month Average)	Number of Falls reported (including no harm)	200	159 (-20.5%)		145.3	155.7	155.7		
	People	13	% of staff saying proud to work for ULHT	Staff survey on morale and leadership		+10% improvement						
	Partners	14	First non elective admission by 10am	Daily situation reporting before 10am, on unplanned admissions of patients for specific General and Acute wards.	48%	60%		56.57%	59.93%	61.24%		
	Services	15	Reduce agency spend by 25%	Reduction in hospital recruiting to posts as temporary cover (non permanent salaried positions). Agency - cumulative actuals	£44m	£33m (-25%)	£'000	£18,515	£22,148	£26,193		
Watch Metrics	Patients	16	Reduce complaints around discharge by 50%	Where patient has been discharged from hospital but is unsatisfied in the way the discharge was handled	n/a							
	Patients	17	Reduce complaints about the experience in A&E by 50%	Patient experience complaints about treatment of A&E	n/a							
	Patients	18	Time to screening and treatment for sepsis (1 hour)	Number of sepsis incidents reported - % of 8 metrics passing to 90%	37.5% (3/8)	62.5% (5/8)		37.5% (3/8)	62.5% (5/8)			
	Patients	19	Reduce incidence of pressure ulcers	Number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable	58 pcm	45 pcm		48	39	39		
	People	20	% of staff that feel trusted and valued	Staff survey on morale and leadership								
	People	21	No. of managers trained in coaching skills	Staff survey on morale and leadership								
	Partners	22	Increase the proportion of patients seen by a decision maker within one hour	Patient arrival to the time seeing a A&E doctor, within 1 hour.	50%			52.22%	44.95%	50.71%		
	Partners	23	Reduction in the new to follow up ratio	Reduction in the number of follow up outpatient activities undertaken.	1:2.28			1:1.59	1:1.58	1:1.52		
	Partners	24	First OPA within 4 weeks	Number of outpatients seen within 4 weeks of their referral to hospital. Includes external referrals only (from GP, Dentist, Optician) for all urgency types (2WW, Urgent, Routine) to consultant led services (non-telephone).	51%			47.67%	51.91%	49.45%		
	Services	25	Improve CIP performance to a minimum of 4% by 2021/22	Improving the financial performance through proactive monitoring of Cost Improvement Plan (CIP) - monthly variance to CIP plan (H1 £6.412m)	£11.1m	£15.4m	£'000	-£809.00	£550.00	£53.00		

(Grey means data unavailable, red is missing)

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

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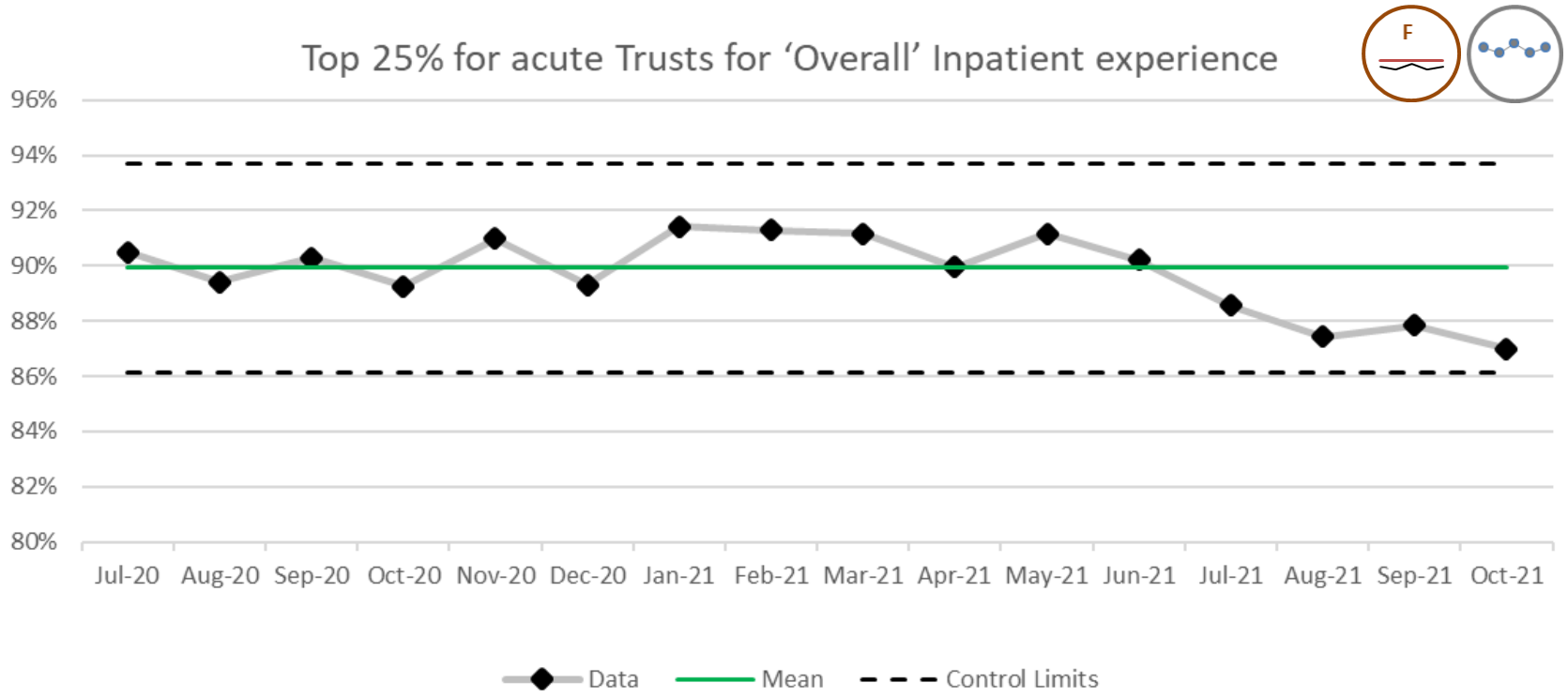

Oct-21
87% ranking tbc
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
3rd Quartile
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

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

What the chart tells us:
We are currently at 87% for October.

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

- Waiting times
- Communication
- Staff

These themes mirror those seen within other data sources including PALs and complaints.
Conversely the positive feedback in 'would-recommend' relates to:

- Staff
- Staff attitude

Actions:

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

Mitigations:
Links made with OD to include a patient story in induction.

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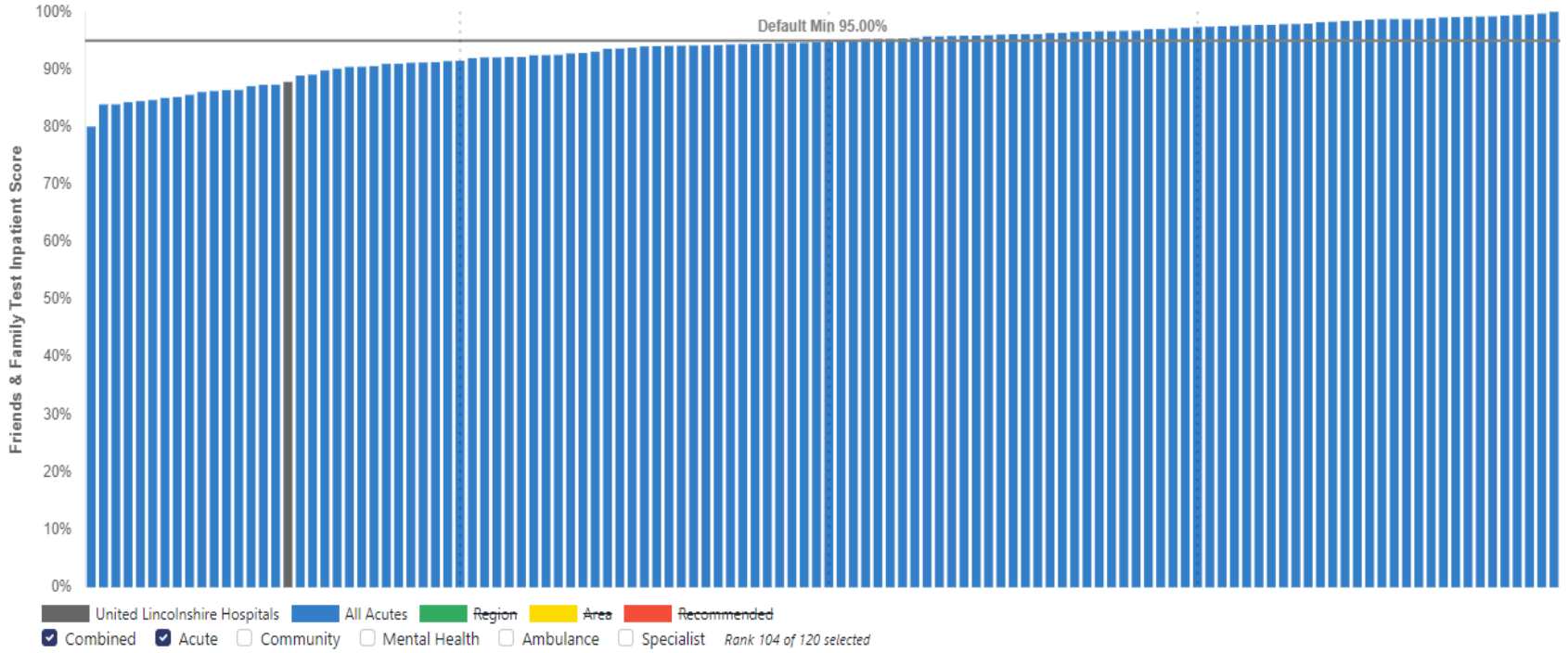
Public View extract September 2021



Sep-21
4th Quartile (87.83%) (104th out of 120)
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
3rd Quartile
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

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

What the chart tells us:
The latest reported month in Public view September 2021 shows we are 104th out of 120 Trusts, in the 4th quartile against a 21/22 ambition to be in the 3rd quartile.
Rankings are now just Acute Trusts rather than all, excluding specialised.

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

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

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

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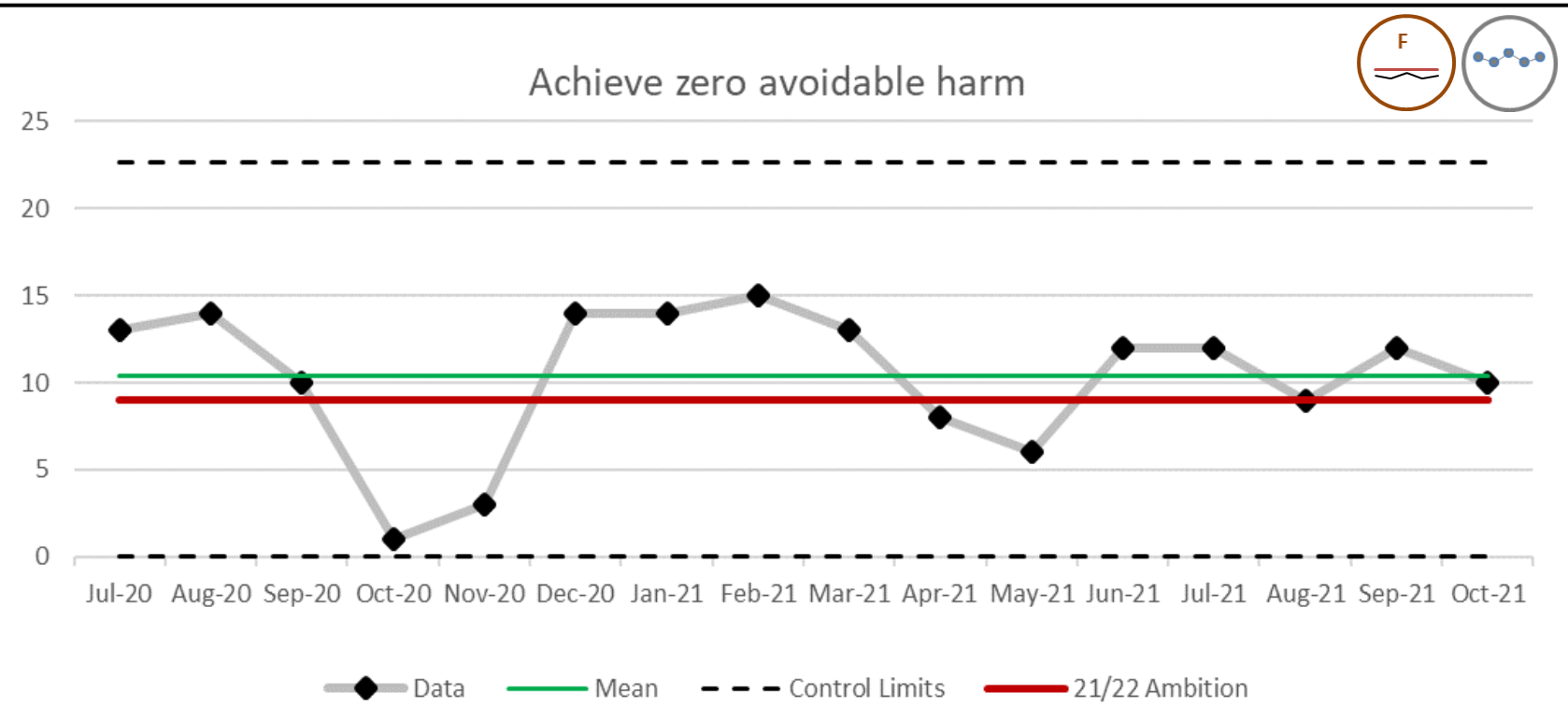

Oct-21
10
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
9
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

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

What the chart tells us:

Issues:

Actions:

Mitigations:

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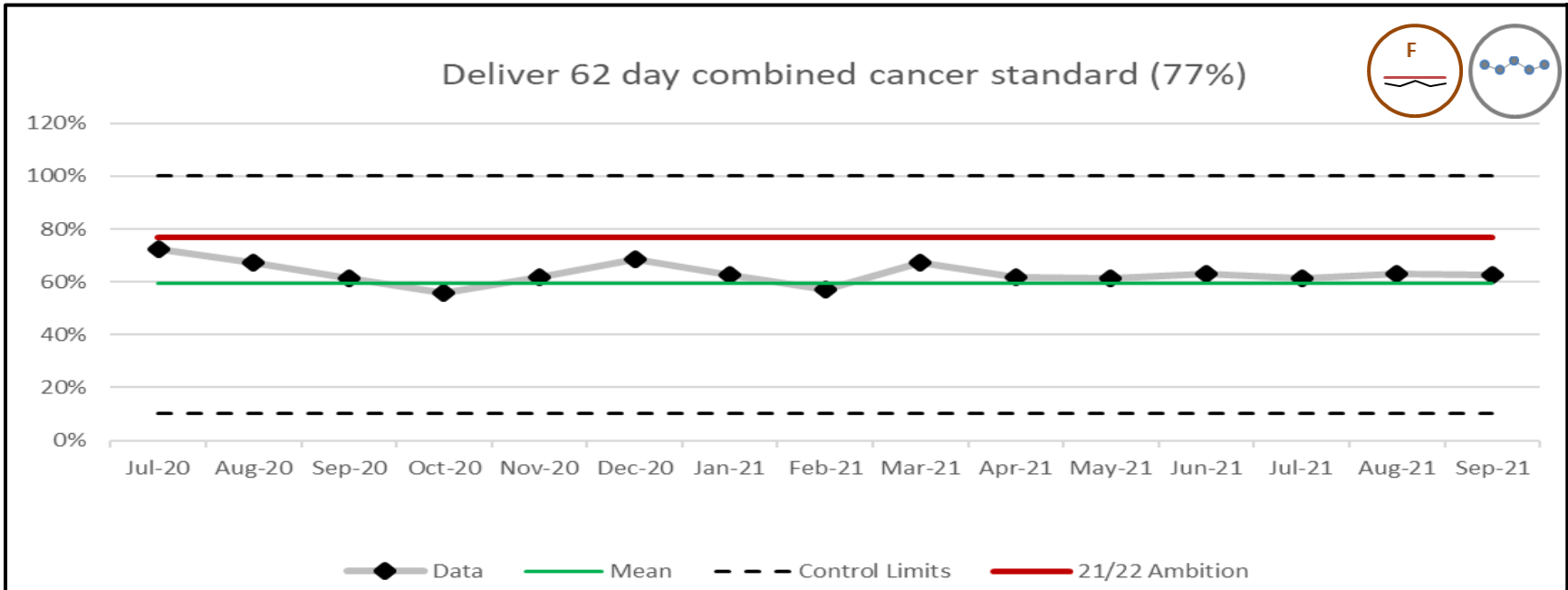
NHS United Lincolnshire Hospitals NHS Trust



Sep-21
62.5%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
77%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 62.5% against a 77% target.

Issues:

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period). This is continuing to reduce.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, and Head & Neck.
Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently, there are 4 Locum Oncologist posts out to advert.
Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI and Lung CBU's to support clinical engagement. Following this model, funding has also been identified a navigator in the Head & Neck CBU whilst a second navigator post within the Colorectal and Urology CBUs have recruited and recently commenced in post – these posts will be key to securing and facilitating regular and consistent Clinical Review sessions with the Consultant teams in order to prevent delays in the pathway.
Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.
Negotiations to outsource some activity to The Park BMI have been underway, but this has been a challenging process so far and is not going to be an option for colorectal surgery, the area currently greatest in demand. However, the potential for robotic radical prostatectomies to be redirected to The Park BMI is currently being explored in order to reduce the backlog of patients awaiting these procedures.

Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns. Two Colorectal Nurse Practitioners have recently commenced in post to support capacity and colorectal pathway flow. A review of the internal Gynaecology pathways is underway and Colposcopy and PMB capacity issues and throughput are being addressed with a new locum and nurse hysteroscopist commencing in post imminently.

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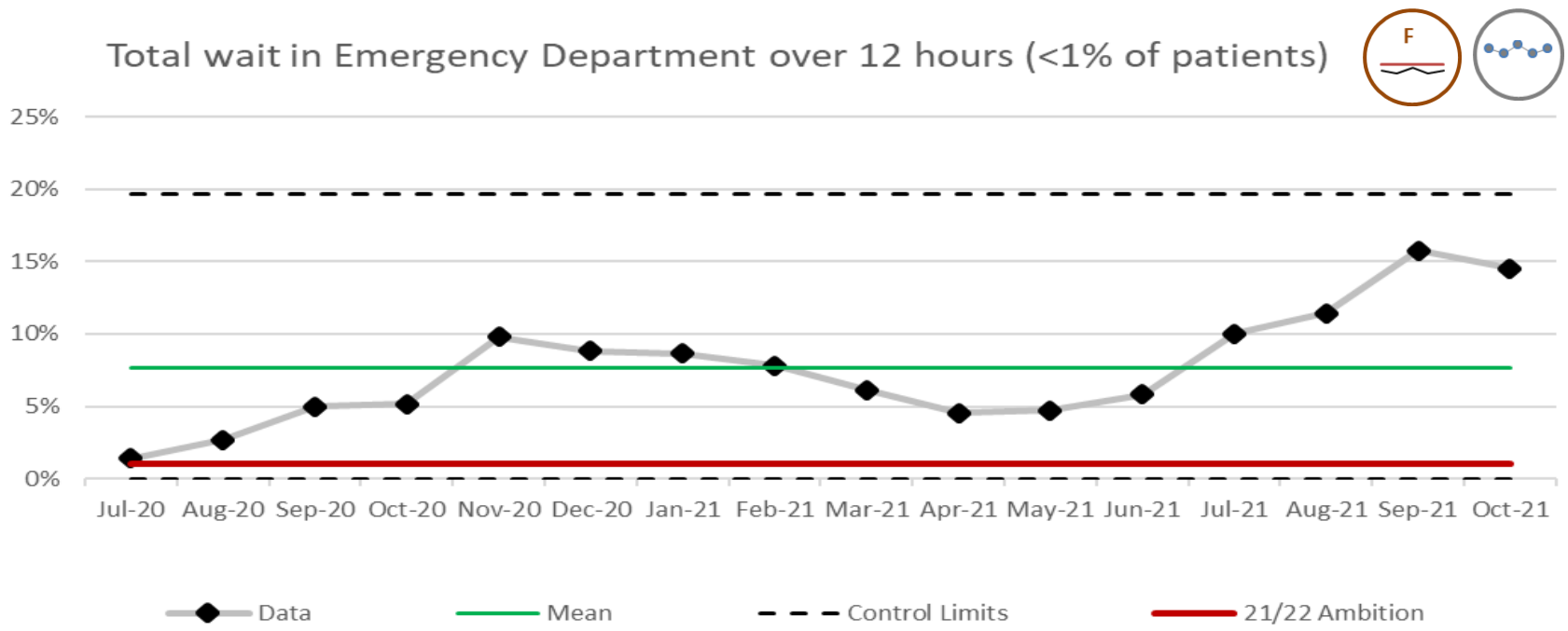


Oct-21
14.52%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
<1%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

October experienced a decrease in the numbers of patients with an aggregated time of arrival greater than 12 hours.14.52% (1422)
of all patients attending the Emergency Department against an agreed target of <1%.

Issues:

The main factor continues to be because of exit block due to inadequate discharges to meet the demand although a slightly improved discharge profile was demonstrated.
Increased number patient experiencing an elongated LOS due to requiring non acute admission but requiring access to an alternative health care setting such transitional care, community hospital and Adult Social Care.
However, a weeklong system wide 'MADE' event focusing on pathway 1, 2 and 3, saw increased discharges during this event.
Delays in time to first assessment contribute to the clear formulation pf a treatment plan, especially out of hours.
Onward specialist centre care can also cause delay.

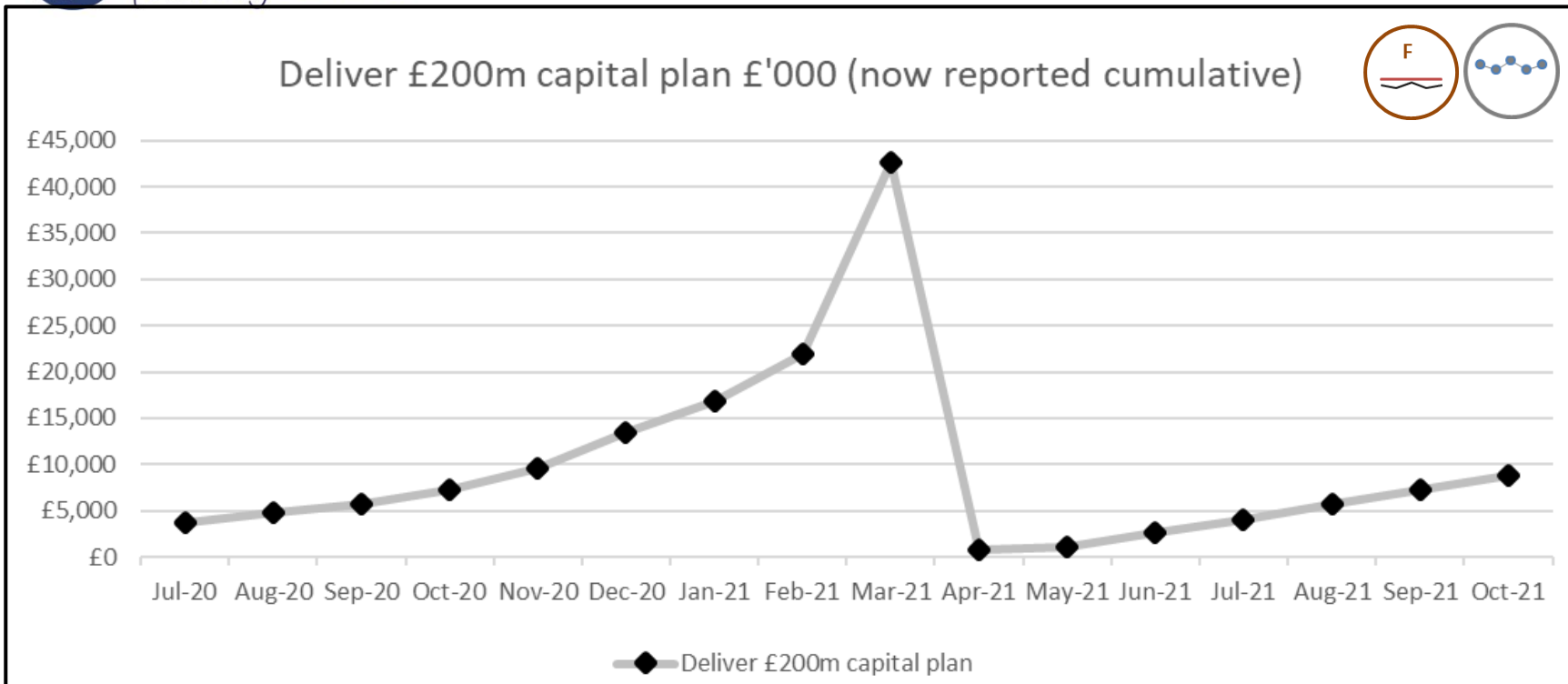
Actions:

These actions are repetitive but remain relevant.
Reduce the burden on the Emergency Department through maximising discharges in the morning to create flow and reduce exit block.
Use of alternative pathways such as the UTC, CAS, SDEC, FAU and SAU.
Direct access via EMAS to Community and transitional care facilities established and now in place to SDEC, FAU and SAU.
The use of the Trust agreed ExIT procedure as part of the Full Capacity Protocol which allow each ward (agreed list) to support the care of an extra patient above their current bed base.

Mitigations:

EMAS have enacted a targeted admission avoidance process.
The Discharge Lounge at LCH and PHB continue to operate a 24/7 service provision to release the burden placed on the Emergency Department at in terms of patients awaiting AIR/CIR and transport home.
Increased CAS and 111 support especially out of hours has been further enhanced.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation. Although the ability to board patients is becoming more problematic and agreement to formally review via the Quality Cell in place.

Quality | Operational Performance | Workforce | Finance



Oct-21
£8,736.90
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£39 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

Background:
The Trust has a revised capital programme to deliver of £36.1m, following external allocation of £1.5m of Shared Care funding.

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

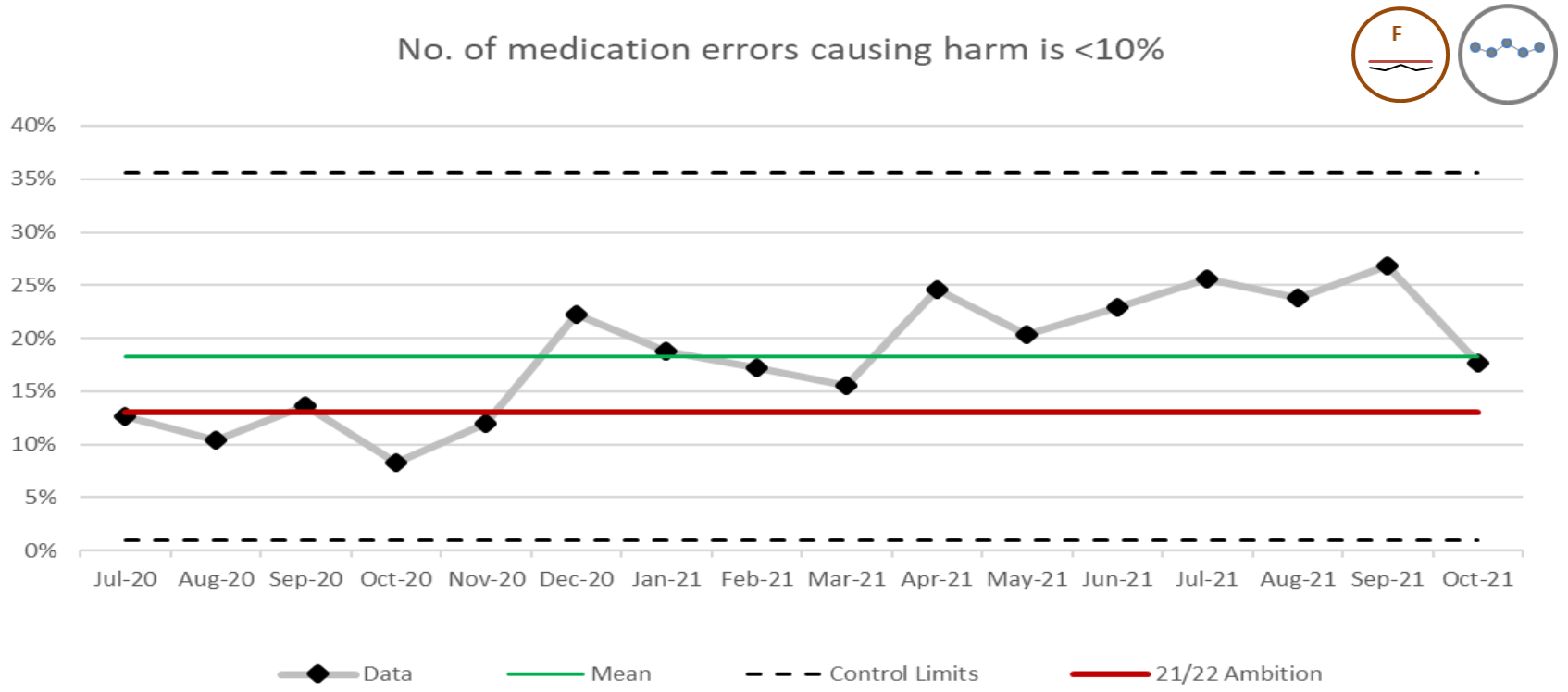
Issues:
The Trust has a large capital programme to deliver in 2021/22, and delivery of the programme is at greater risk if the actual expenditure profile is heavily weighted in the final two quarters.
As at the end of October, expenditure YTD of £8.7m is £8.5m behind NHSE&I plan, requiring expenditure of £27.4m in the remainder of 2021/22 to deliver the programme in full.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Oct-21
17.71%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
13%
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

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

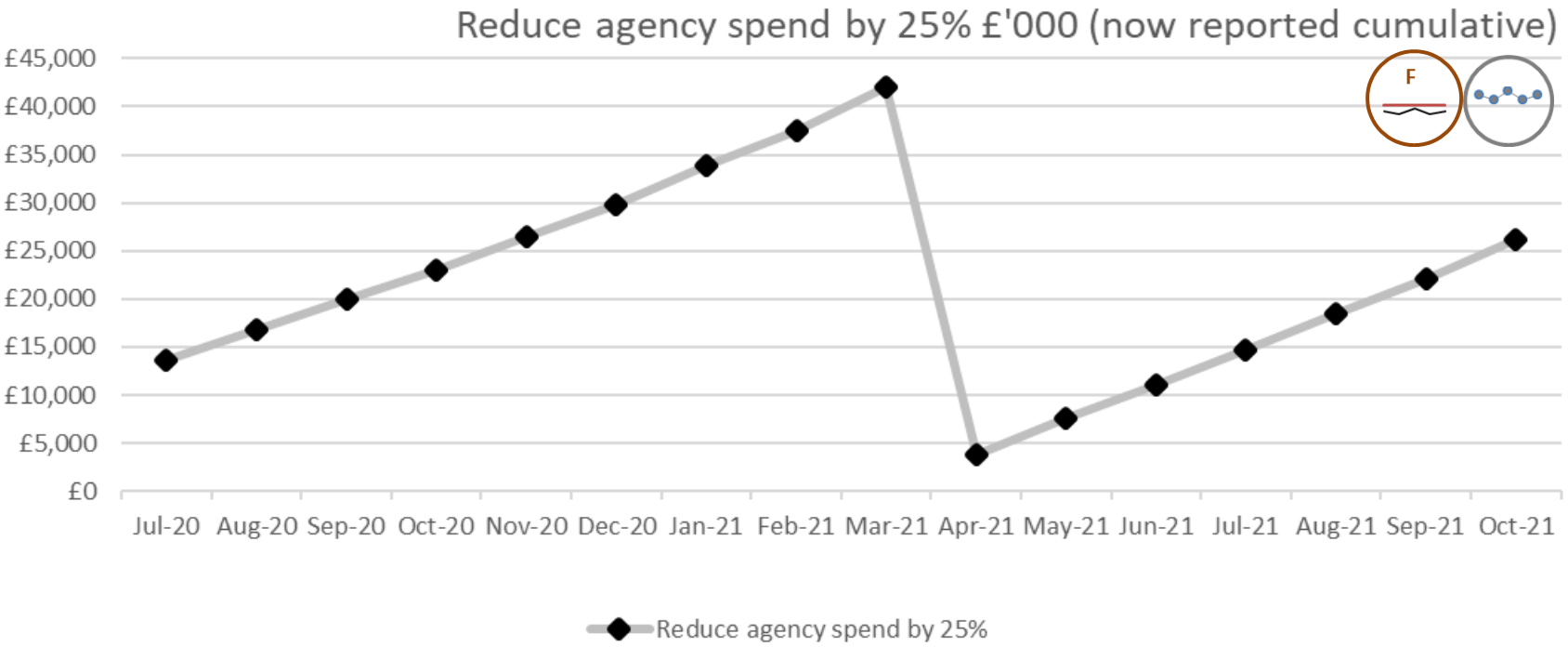
What the chart tells us:
In the month of October, the number of incidents reported was 175. The number of incidents causing some level of harm (low /moderate /severe / death) is 17.7, nearly double the national average of 10.8

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

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

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

Quality | Operational Performance | Workforce | Finance



Oct-21
£26,193.00
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£33 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

Background:
Aim to reduce agency spend by 25% or £11m from £44m in 2019/20 to £33m in 2021/22; the Trust has an Agency Ceiling of £21m.

What the chart tells us:
Agency spend in 2021/22 is around the mean; whereas to achieve the 25% reduction it requires to be lower at an average of £2.75m per month.

Issues:
The Trust has traditionally spent most on Medical and Dental Agency than on any other staff category. However, a continued focus upon a Plan for Every Post has meant that Medical and Dental is £0.4m favourable to the IIP plan.

Increased Agency spend on Nursing and Midwifery & Housekeeping, though, has driven total Agency spend YTD £6.5m above plan.

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

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

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

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

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Aug-21	Sep-21	Oct-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	3	8	2	31	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.07	0.01	0.00	0.05		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.13	0.14	0.03	0.12		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	0			5	P	
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.07	0.14	0.00	0.06	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	0	2	5	P	B
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	1	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	3	4	3	31	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	95.20%	95.93%	94.89%	96.12%	F	
	Never Events	Safe	Patients	Director of Nursing	0	1	0	0	2	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	4.33	5.37	5.76	5.13	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	23.8%	26.8%	17.7%	23.10%	F	A

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Aug-21	Sep-21	Oct-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	None issued	100%	100%	73.40%	P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	104.62	103.41		110.97	F	H
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	112.88	111.83	111.98	111.79	F	H
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	97.00%	97.00%	97.00%	96.14%	F	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	87.70%	84.00%	88.70%	89.56%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	87.25%	92.0%		90.13%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	95.58%	85.0%		87.81%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	86.66%	98.0%		93.24%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	57.00%	100.0%		88.67%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	92.17%	92.4%		92.50%	P	A
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	86.35%	78.0%		85.47%	F	A
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.30%	95.4%		94.74%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	50.00%	83.0%		70.08%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	2.86	3.26	3.25	3.05	P	B
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	75.00%	61.00%		60.67%	F	B
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	50.00%	39.00%		37.67%	F	B

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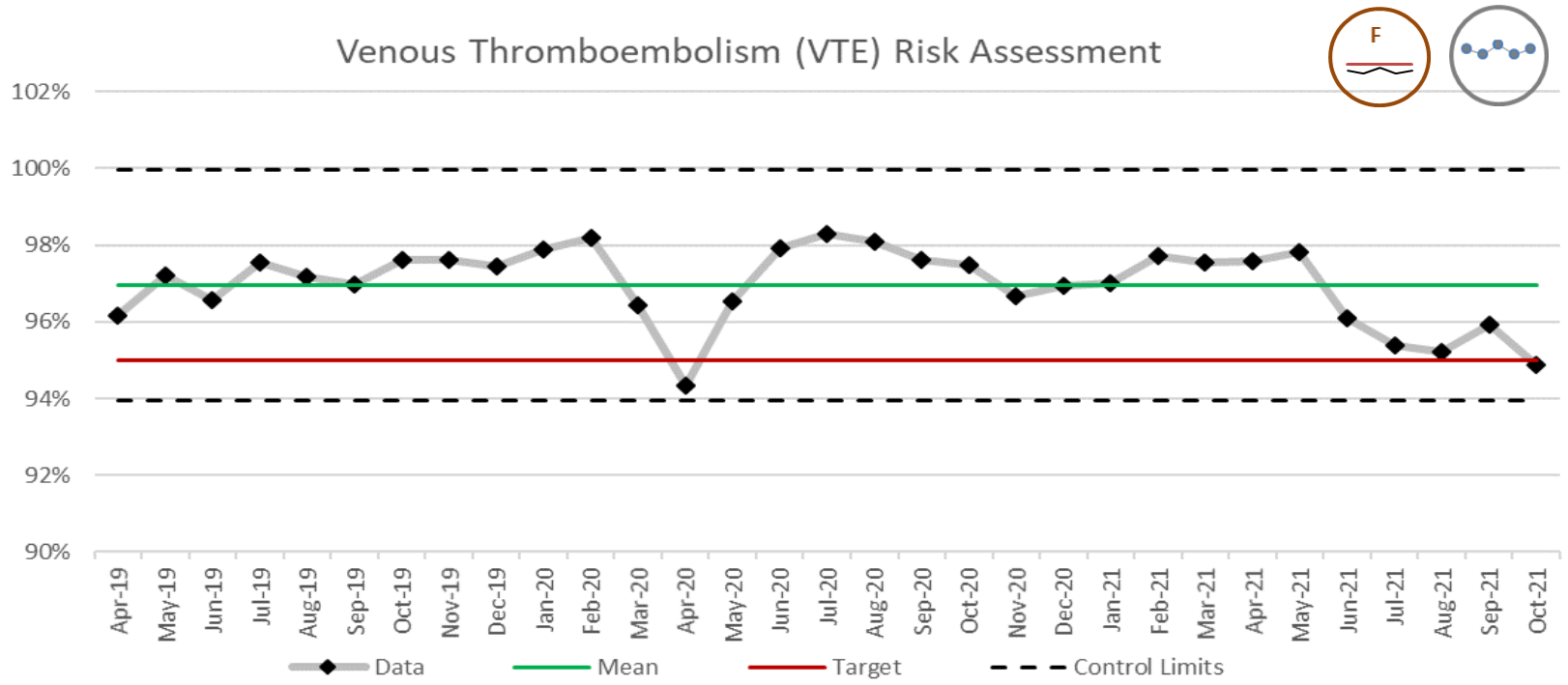

Oct-21
94.89%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is failing the target
Executive Lead
Medical Director

Background:
VTE risk assessment to assess need for thromboprophylaxis to reduce risk of DVT / PE should be undertaken in 95% or more of patient.

What the chart tells us:
VTE risk assessment performance is just below 95% target, currently at 94.9%.

Issues:
As previously discussed via the VTE and Anti-Coagulation Safety Group.

Actions:
Actions to be proposed, implemented and monitored through the Trust's VTE and Anti-Coagulation Safety Group Meeting, which in turns reports via Deteriorating Patients Group and Patient Safety Group.

Mitigations:
As discussed via the VTE and Anti-Coagulation Safety Group.

Quality | Operational Performance | Workforce | Finance

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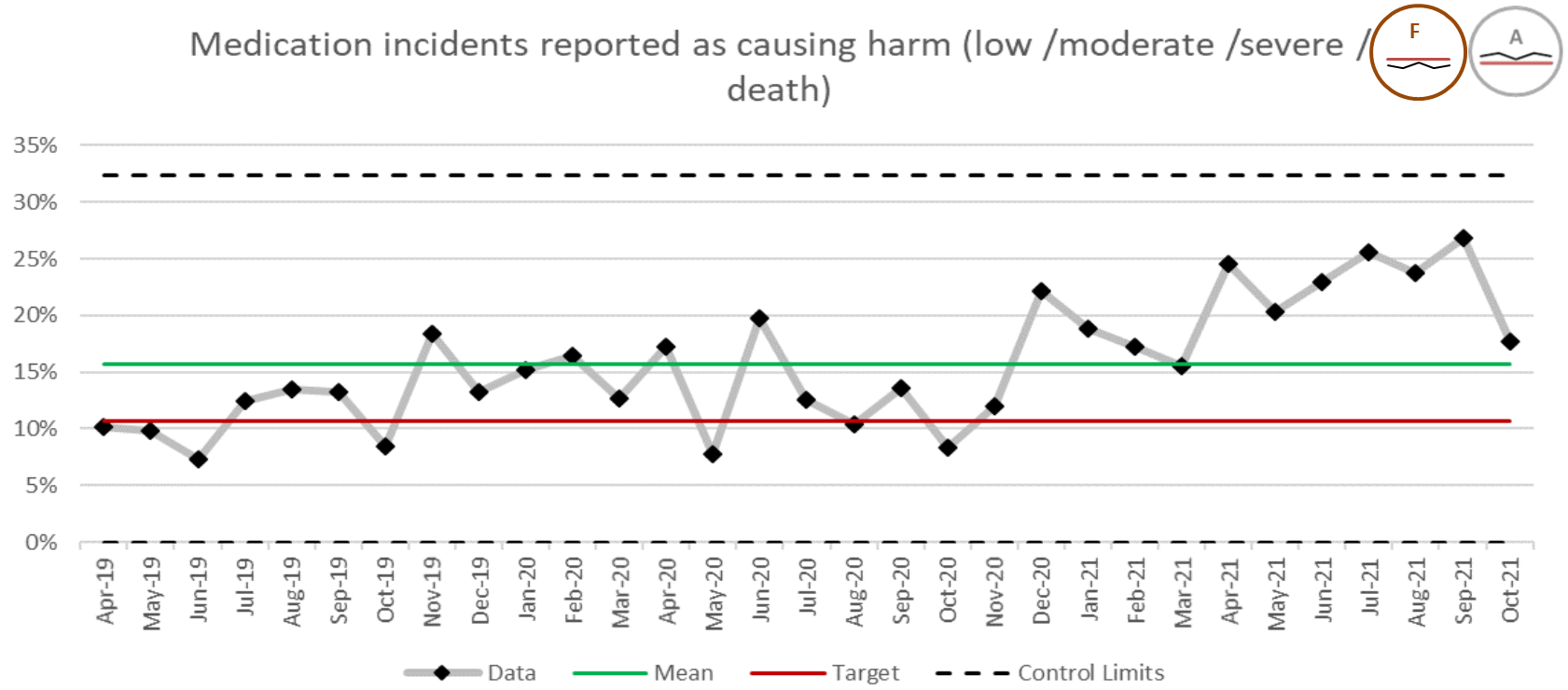

Oct-21
17.7%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
10.7%
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of October, the number of incidents reported was 175. The percentage number of incidents causing some level of harm (low /moderate /severe / death) is 17.7, nearly double the national average of 10.8, but has improved to lowest value since March 2021

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

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

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

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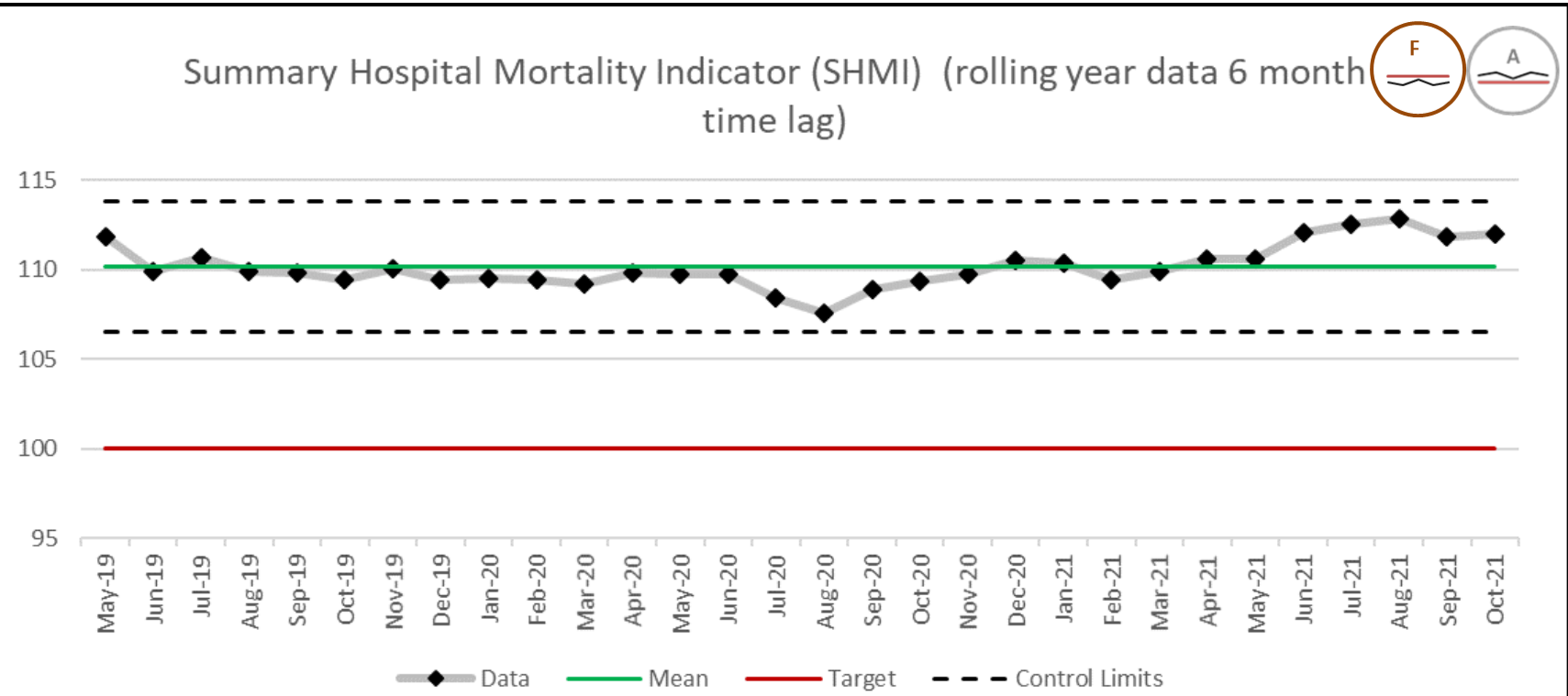


Oct-21
111.98
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
The Trust's SHMI has increased during the COVID-19 pandemic but there is a trend towards reduction i.e. improvement.

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

The higher SHMI is at least partially driven by out of hospital (OOH) 30 day post-discharge deaths in patients with multiple comorbidities and approaching end of life (EOL).

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

The Trust are currently in discussion with the system partners in rolling out the ME service for community deaths, as well as inappropriate admission prevention for e.g. palliative patients.

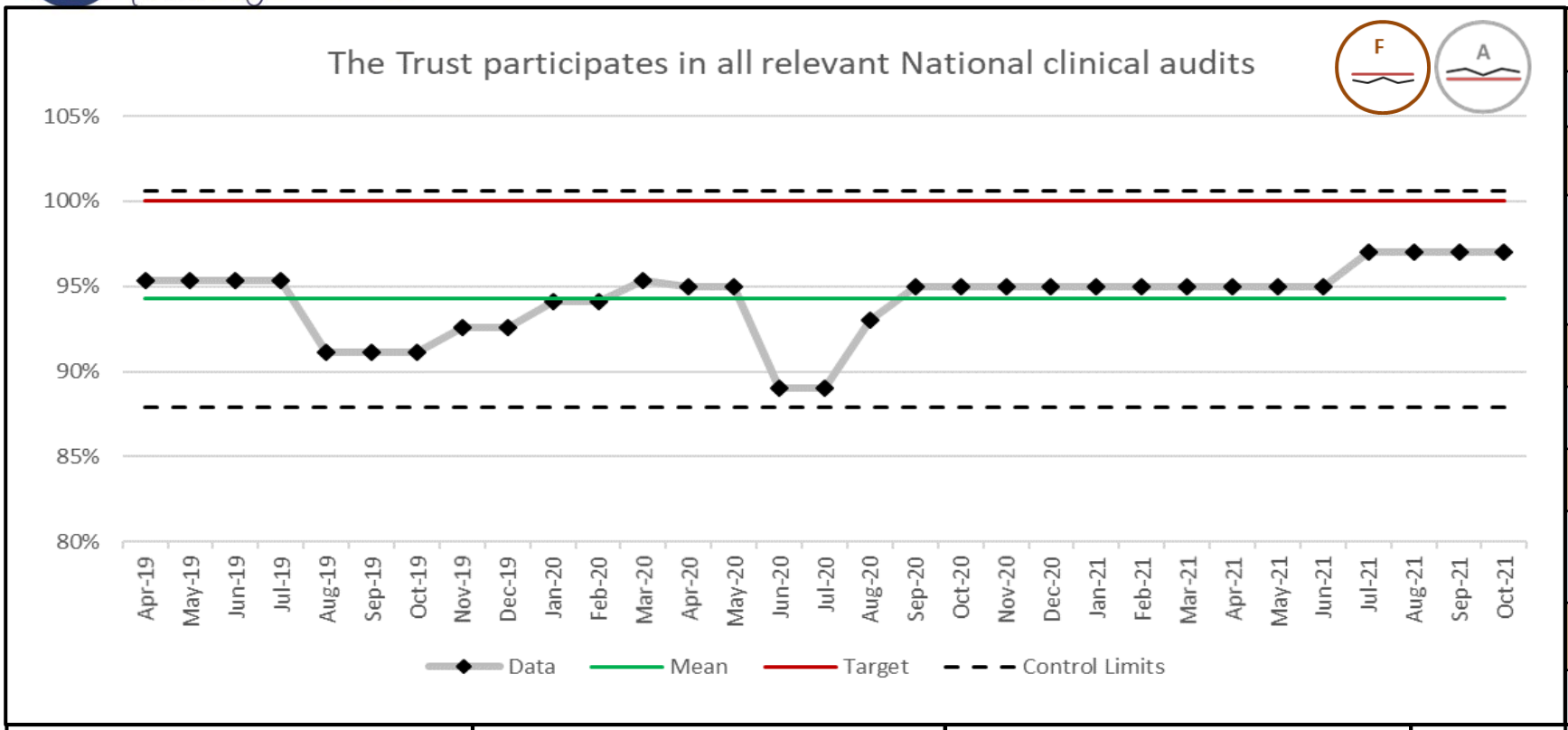
Mitigations:
All deaths are reviewed by the Medical Examiner and any deaths were issues are identified are escalated for a structured judgement review or rapid review.

Medical Examiner Officers have started within the Trust.

NHSI/E are completing a peer review on our structured judgement reviews.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Oct-21
97%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100%
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
This is measured by the % participation in relevant National Clinical Audits.

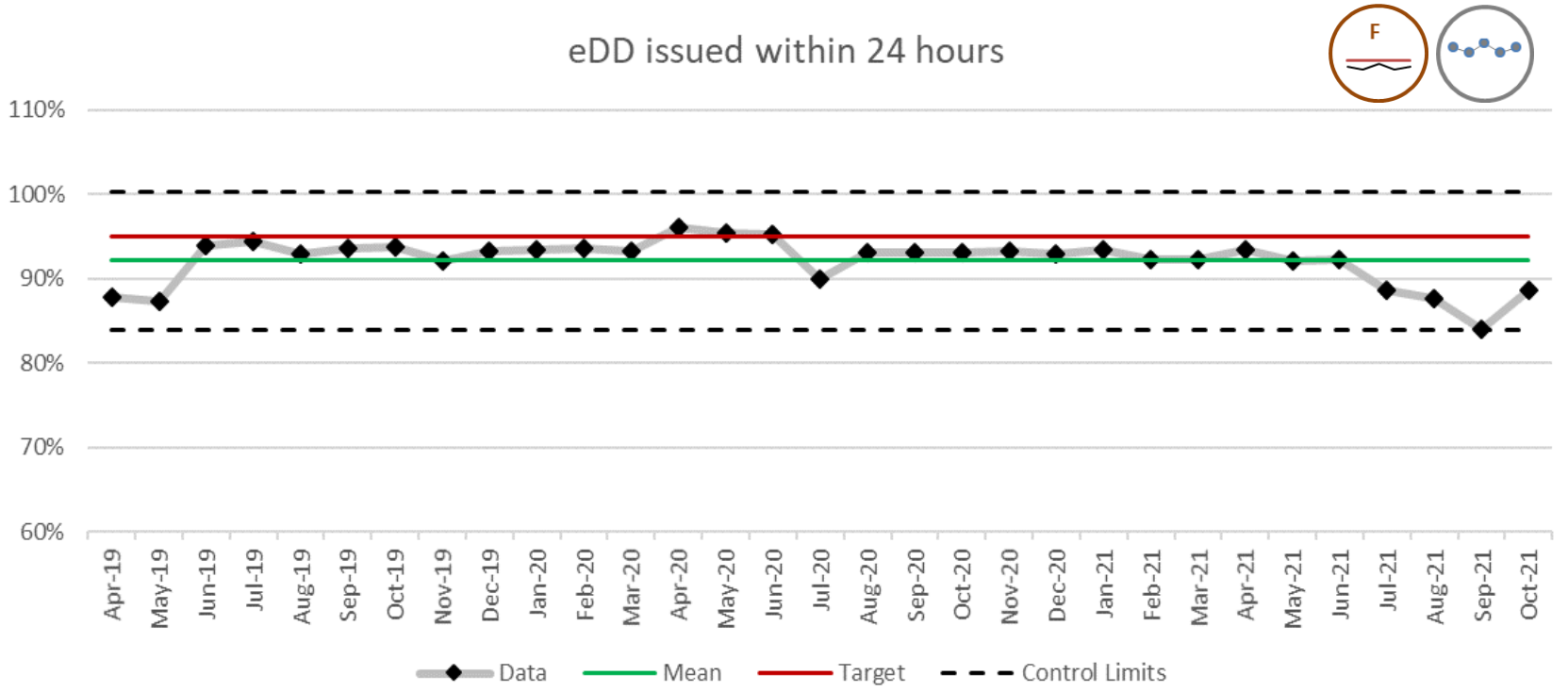
What the chart tells us:
Participation remains at 97% for the month of October 2021.

Issues:
Suboptimal participation in the IBD Audit.

Actions:
Monitored by the Clinical Effectiveness Group.

Mitigations:
IBD participation delay with issuing the IBD team logins and access to the web tool due to a national upgrade.

Quality | Operational Performance | Workforce | Finance



Oct-21
88.70%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
The metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
The Trust is not achieving the 95% target, for October the Trust achieved 88.7%. The Trust achieved 94.6% for eDDs sent anytime within the month of October.

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

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

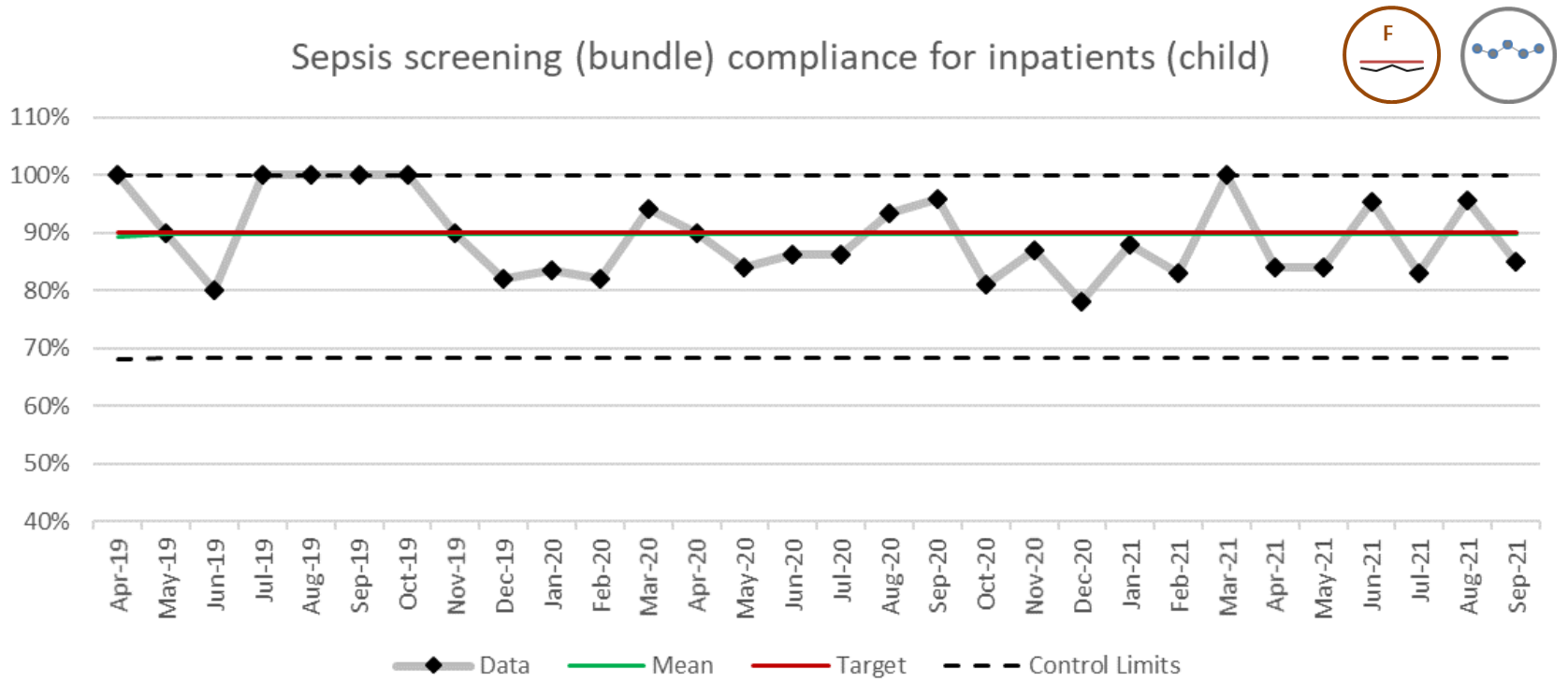
Actions:
A dashboard has been developed to highlight ward and consultant compliance.

Mitigations:
Streamlined eDD for paediatrics being developed.

The responsibility of eDD will be with Medical Records Group as from next month.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
85%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The current compliance is at 85%

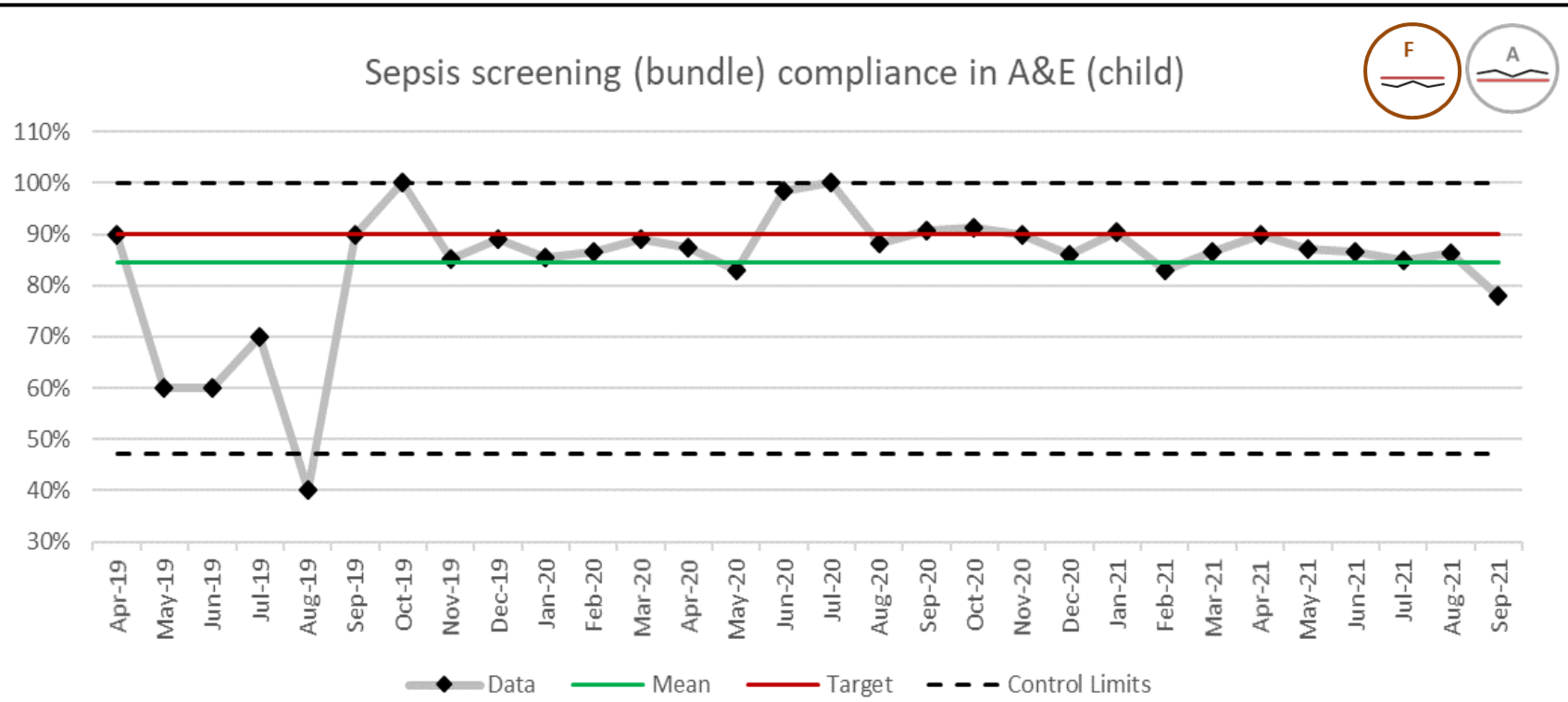
Issues:
There was a split of delayed screens between Agency/bank and substantive staff.
The wards have increased numbers of patients and acuity due to the predicted respiratory surge, therefore the majority of missed/delayed screens are non-infection. IR1s have been completed for 2 that were infections.

Actions:
Paediatric Simulation training is taking place in clinical areas with a focus on sepsis, not only identifying the patient but also completing the bundles.
There is a similar focus in the PILS course, Sepsis is discussed for all scenarios.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
78%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance in ED is 78.0% which is below the 90% target.

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

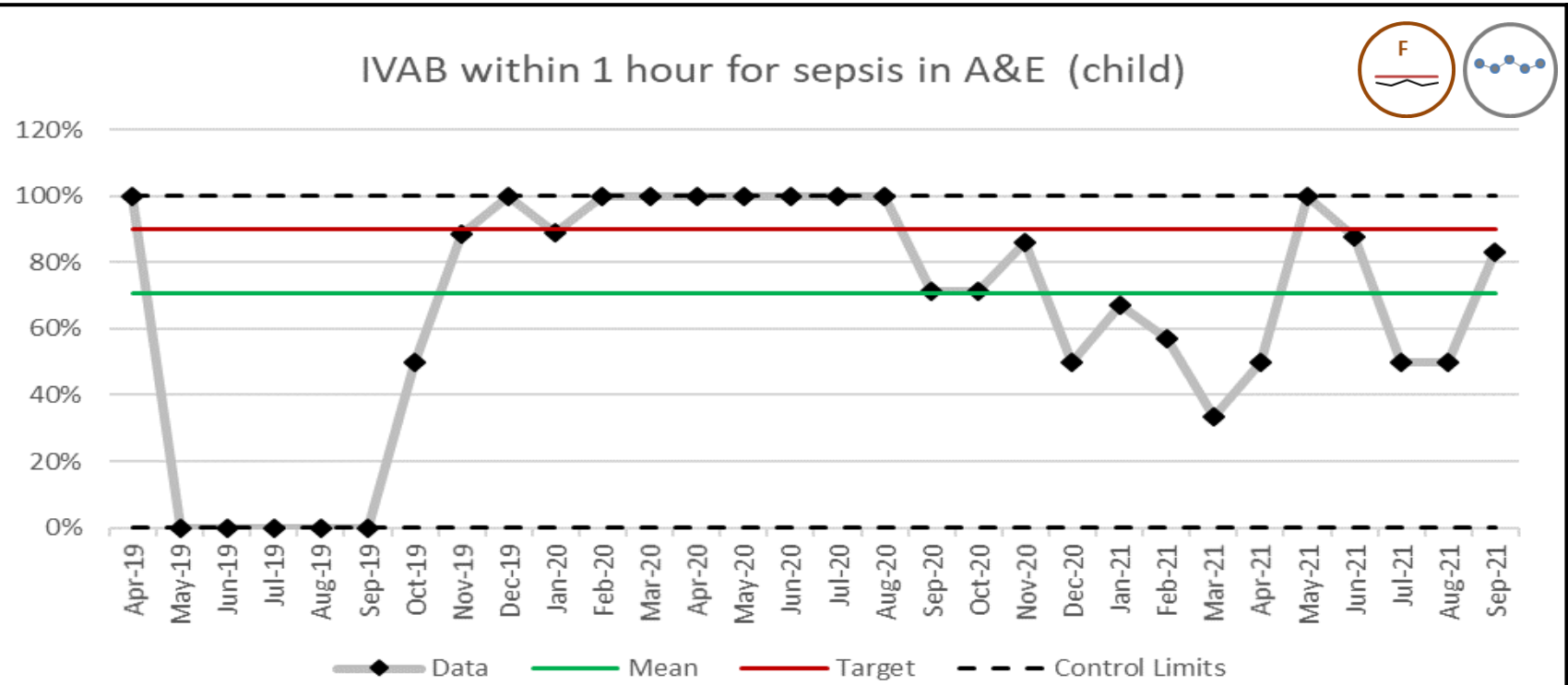
Actions:
Sepsis Practitioners are currently doing regular walk rounds in the department and offering any assistance if needed. Harm reviews are being carried out for all delayed / missed screens and ED staff are involved in carrying these out. Sepsis Practitioner will attend morning huddles and ED meetings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

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
83%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

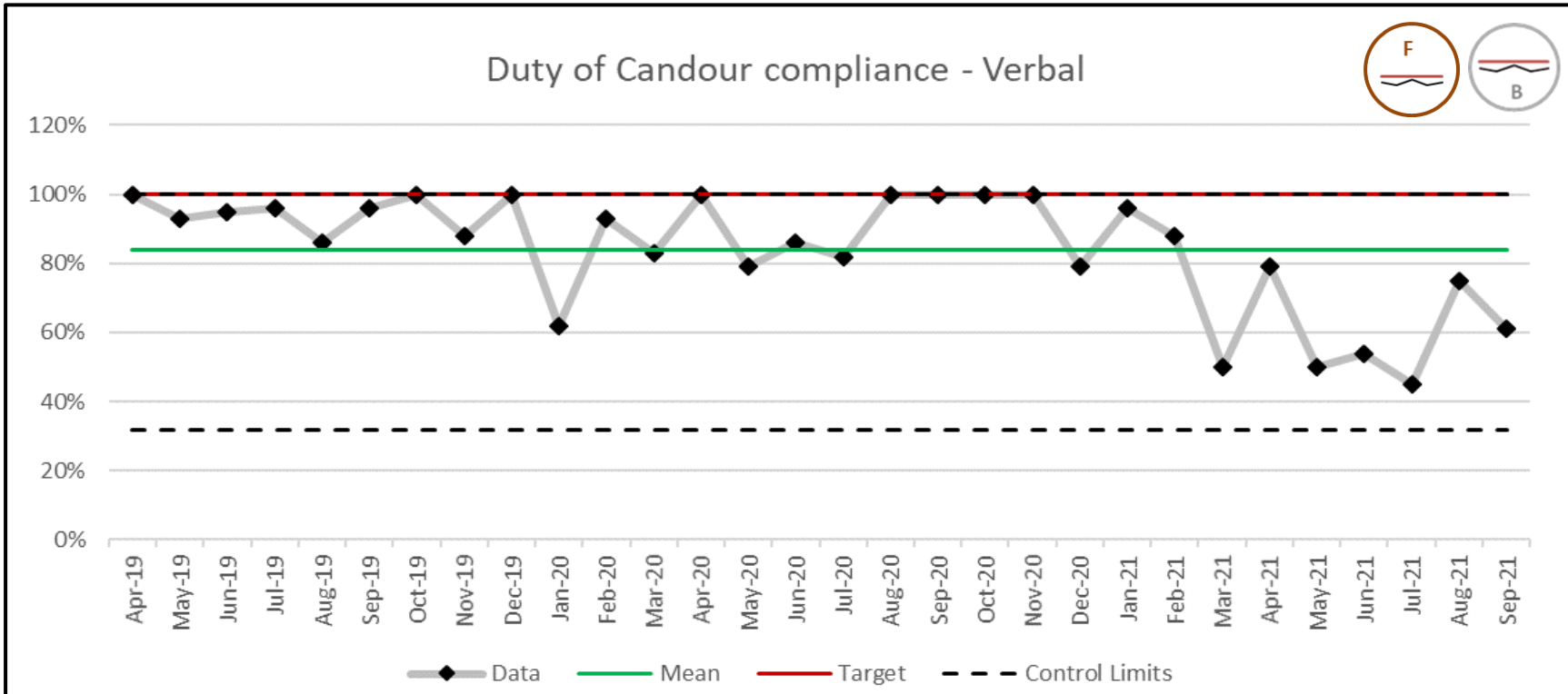
Background:
IVAB within 1 hour for sepsis in A&E (child)

What the chart tells us:
The compliance in ED this month for IVAB is 83.00%, 5 out of 6 children received antibiotics within 1 hour.

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

Actions:
Harm reviews are being completed for all children who have delayed antibiotics.
Children are being moved out of the department and to wards as quickly as possible- but this sometimes means antibiotics are not given until being on the ward. Staffing in the ED is currently being looked at in order to support the Paediatric Nurse on duty. Ward staff will support when able.

Mitigations:
Discussed at ongoing weekly Sepsis meeting. If ED need assistance with looking after children within the department they are phoning the paediatric wards. Wards are offering help if possible.
The paediatric Sepsis Practitioner is also attending ED regularly to offer support and training.
Data is being pulled every other day in order to detect issues as quickly as possible and try to resolve. This is being replicated on all 3 sites.



Sep-21
61%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
Verbal compliance for September is at 61% against a 100% target.

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

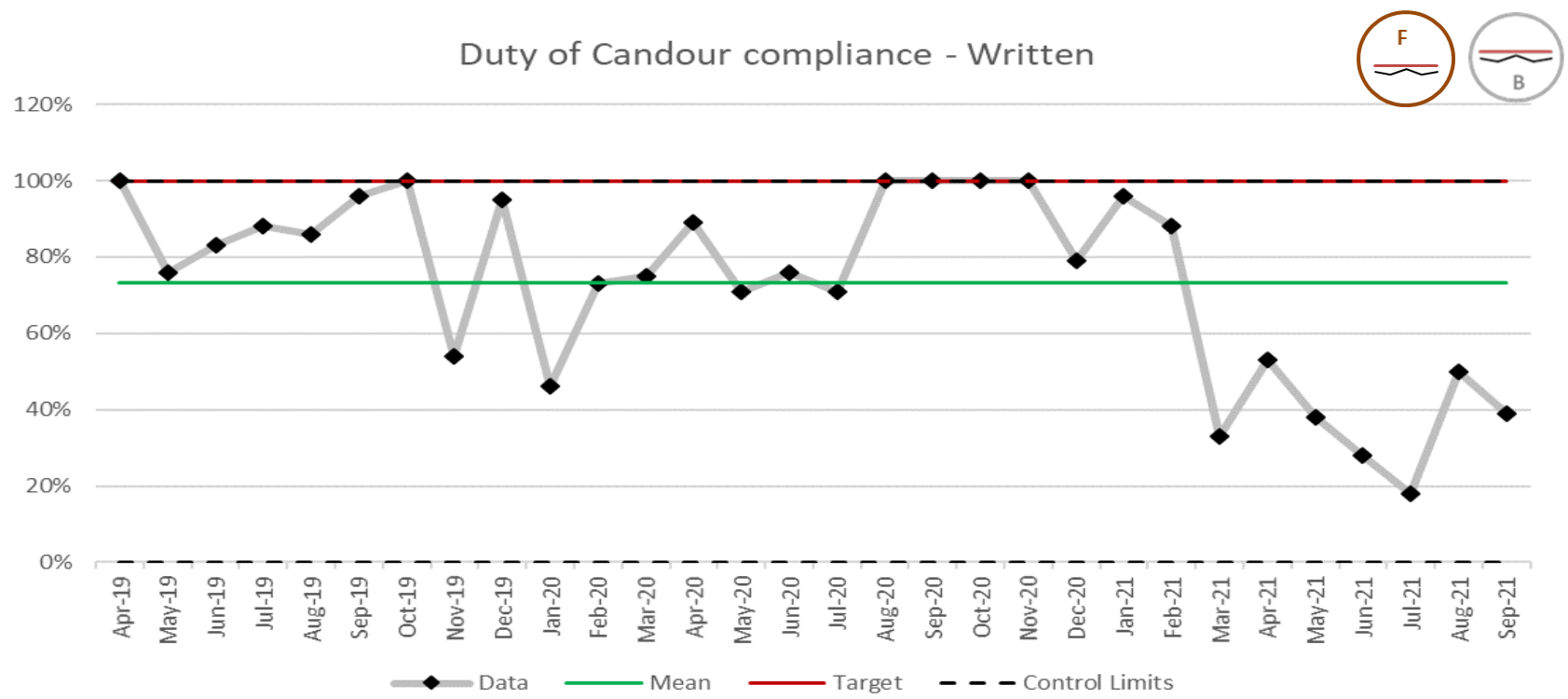
A lack of understanding of the purpose of the Duty of Candour

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

DoC training has now commenced being provided by external provider to increase number of trained individuals.

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

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



Sep-21
39%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
Verbal compliance for September 2021 is at 39% against a 100% target.

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

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Aug-21	Sep-21	Oct-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.46%	0.56%	0.08%	0.36%				

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Aug-21	Sep-21	Oct-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	66.96%	62.13%	64.04%	67.94%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	12	71	173	269	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	87.98%	82.60%	85.51%	86.45%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	1093	1451		6509	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	56.85%	55.61%		58.38%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	50,804	52,368		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	64.69%	63.33%		62.91%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	78.70%	70.41%		78.36%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	12.74%	15.24%		11.98%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	89.36%	90.10%		91.46%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	100.00%	99.27%		99.59%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	75.00%	59.18%		76.24%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	95.70%	92.81%		96.19%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	63.49%	75.00%		72.30%	90.00%			

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Aug-21	Sep-21	Oct-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	79.07%	66.88%		76.94%	85.00%			
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	66.00%	66.75%	66.23%	67.95%	99.00%			
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	2.51%	2.87%	2.83%	2.06%	0.80%			
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	8	23	34	103	0			
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	94.81%	88.46%	92.00%	90.58%	90%			
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	74.03%	73.08%	72.00%	75.94%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,381	4,172	4,211	4,492	4,657			
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	629	923	733	528	0			
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	67	77	103	433	70			
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.81	2.30	2.37	2.71	2.80			
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.70	4.72	4.83	4.49	4.5			
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	16,098	16,634	16,739	15,792	4,524			
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	43.0%	43.4%	46.5%	42.86%	70.00%			
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	39.4%	38.7%	44.4%	41.05%	45.00%			

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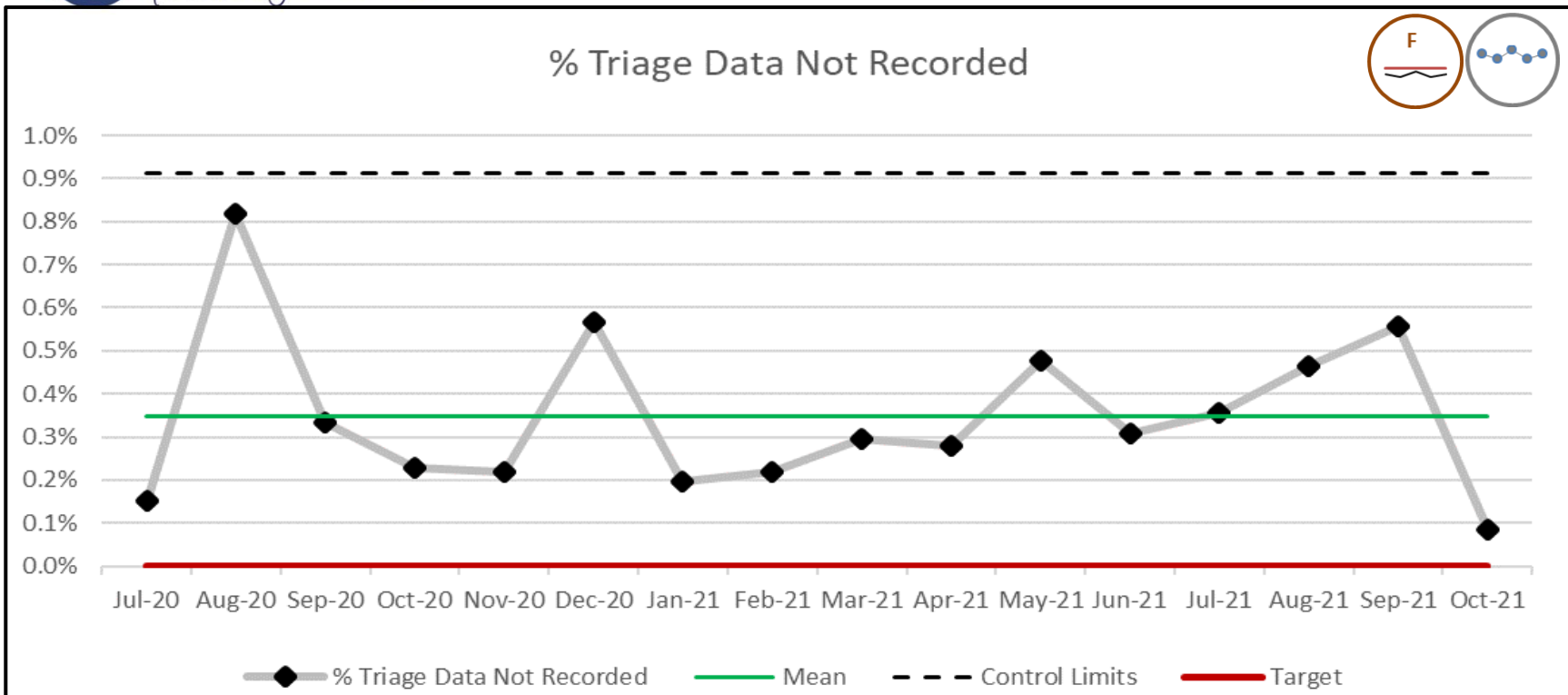

Oct-21
0.08%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%.
October reported 0.08% data not recorded verses 0.56% in September October demonstrated a 0.44% positive variation compared with September.
This metric is below target.

Issues:

- Timely inputting of data.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP).
- Staffing gaps and skill mix issues
- Increased demand is still cited as a causation factor.

Actions:

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

Mitigations:

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

OUTSTANDING CARE personally DELIVERED

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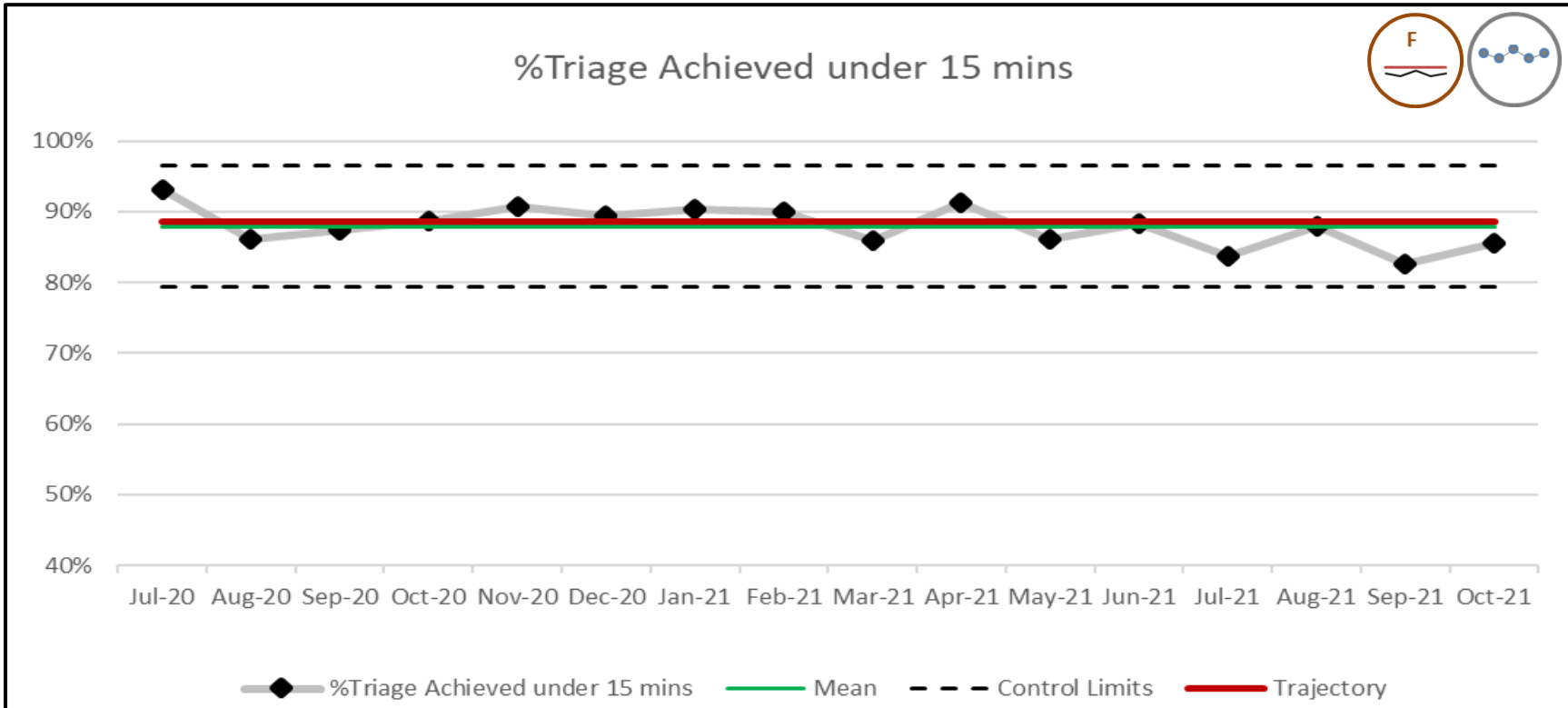

Oct-21
85.51%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of triage achieved under 15 minutes.

What the chart tells us:

The compliance against this target is 88.50%.
October outturn was 85.51% which is 2.99% below the agreed target.
October demonstrated an improvement of 2.91% o compared with September.

Issues:

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

Actions:

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

Mitigations:

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

OUTSTANDING CARE personally DELIVERED

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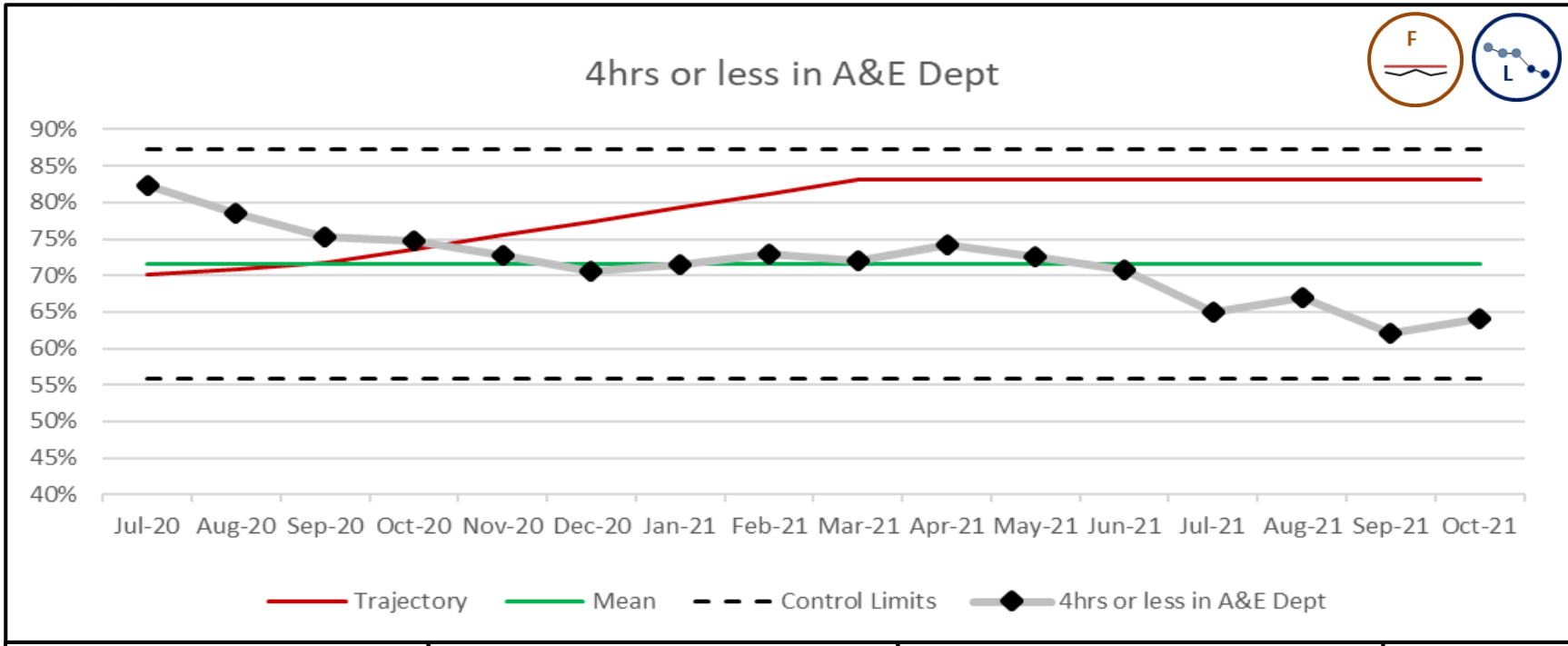


Oct-21
64.04%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

The national 4-hour standard is set at 95%. The agreed trajectory for compliance for ULHT is set at 83.12%.

What the chart tells us:

The current 4-hour transit target performance for September was 64.21% which is 18.91% below the agreed target.
October out turned at 64.04% compared to 62.13% in September.
A 1.91% positive variance compared to September.

Issues:

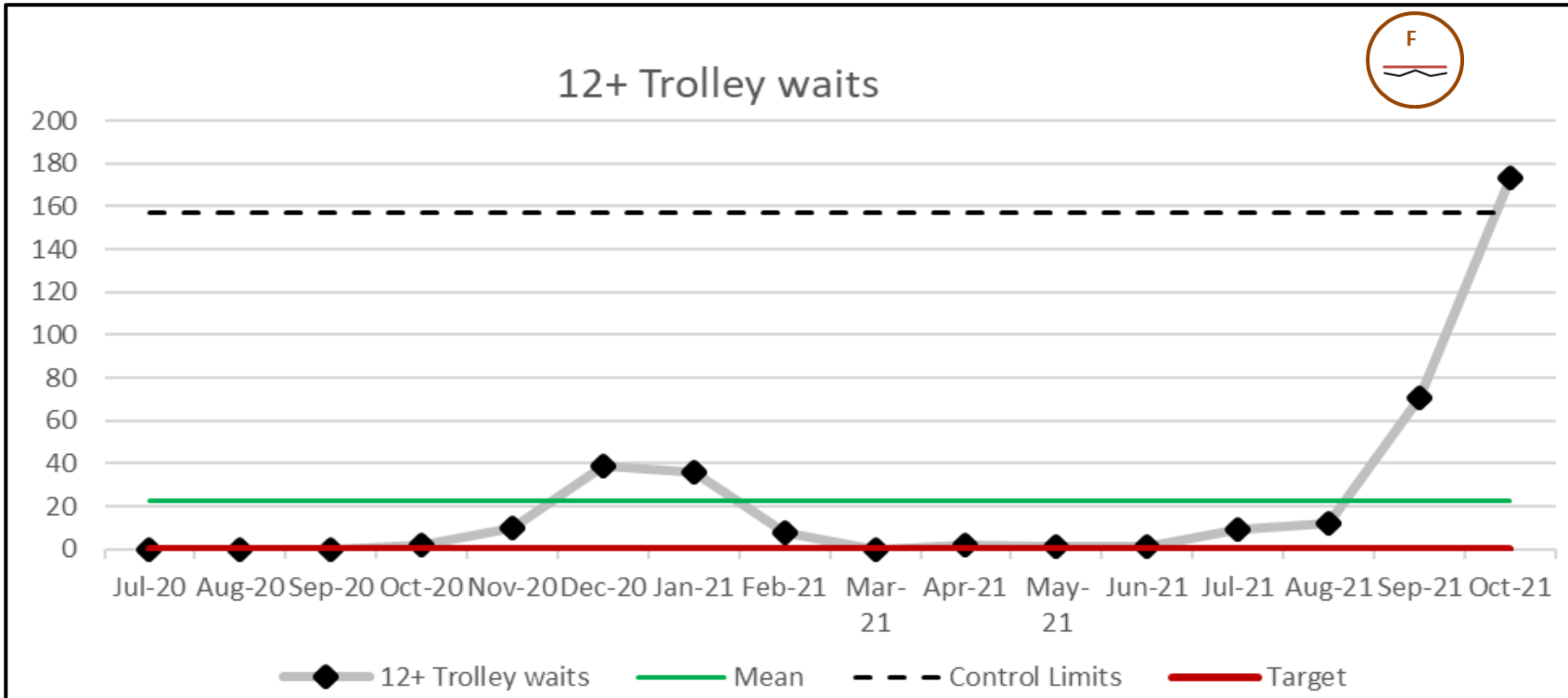
The Emergency Departments saw an 3.59% increase in attendances in October 2021 (646 patients) compared to September 2021.
18,032 combined attendances (ED and UTC) in October compared to 17,386 combined attendances in September.
A comparison to October 2019 denotes an increase of 15.92%.
Of the 18,032 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 11,963 and type 3 accounted for 6,069. This is an increase on type 1 and type 3 attendances is across all 3 acute sites.
Inadequate discharges to meet the admission demand remains an issue.
Ongoing medical and nursing gaps that were not Emergency Department specific.

Actions:

Reducing the burden placed upon the Emergency Departments further will be though the continued development of Same Day Emergency Care (SDEC) Services
Direct EMAS conveyance to SDEC services has commenced.
Maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients.
A twice daily report is sent to all Divisions.
Twice daily System calls are in place to maximise pathway 1, 2, and 3 patients. This is led by the Lead Nurse for Discharge in partnership with System Partners. All delays >24hrs post optimisation are escalated for resolution.

Mitigations:

The mitigations are repetitive but still relevant.
EMAS have enacted a targeted admission avoidance process.
The Discharge Lounge at LCH and PHB continue operating a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and also transport home.
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.



Oct-21
173
Variance Type
Metric is currently experiencing Special Cause Variation – outside the control limits
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

There is a zero tolerance for greater than 12-hour trolley waits. These events are reported locally, regionally and nationally.

What the chart tells us:

October experienced 173 12-hour trolley wait breaches. This equates to 1.44% of all type 1 attendances for October.

Issues:

Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or failure to transfer. The 12hr trolleys were anticipated against flow predictions.
October has experienced an increase in incidental positive covid cases, which as restricted the use of several inpatients beds, impacting further on flow.
To prevent nosocomial transmission, the use of boarding areas has been problematic.

Actions:

Every reported 12hr trolley wait is subject to an immediate clinical review to ascertain whether it is deemed a 'true' 12hr trolley wait breach and is signed off by the Clinical Lead for ED.
The Trust continues to work closely with national regulators in reviewing and reporting these breaches. A timeline for the 12 trolley waits with the greatest total time in ED is submitted to NHSe/i at 11am the next day by the Deputy Chief Operating Officer. A daily review of all potential 12hr trolley waits is in place.
System Partners and Regulators remain actively engaged and offer practical support in situational escalations.
Expectation of securing10 discharges by 10am and 35% of all discharges before midday. All confirmed discharges must go to the discharge lounges unless a clinical exception is agreed.
Daily review of all IPC issues affecting capacity and restricted beds is now in place.

Mitigations:

All potential DTA risks are escalated at 8hrs to the Day Time Silver Commander/ On Call Manager and rectification plans are agreed with the UEC CBU.
A System agreement is remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support. This has demonstrated a positive impact
A Criteria to Admit Lead is being established ensuring all decisions to admit have to be approved by the EPIC (Emergency Physician In Charge) with the relevant On Call Team.

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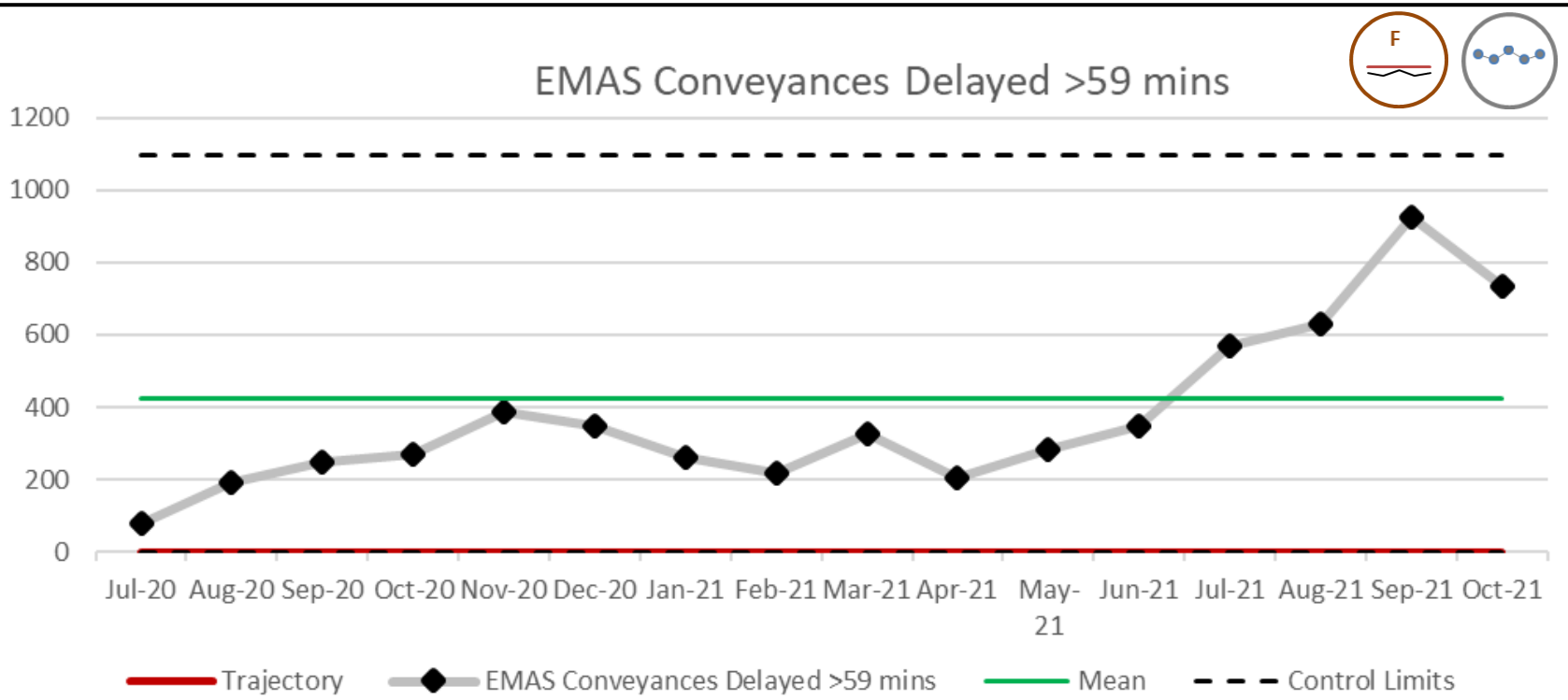


Oct-21
733
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

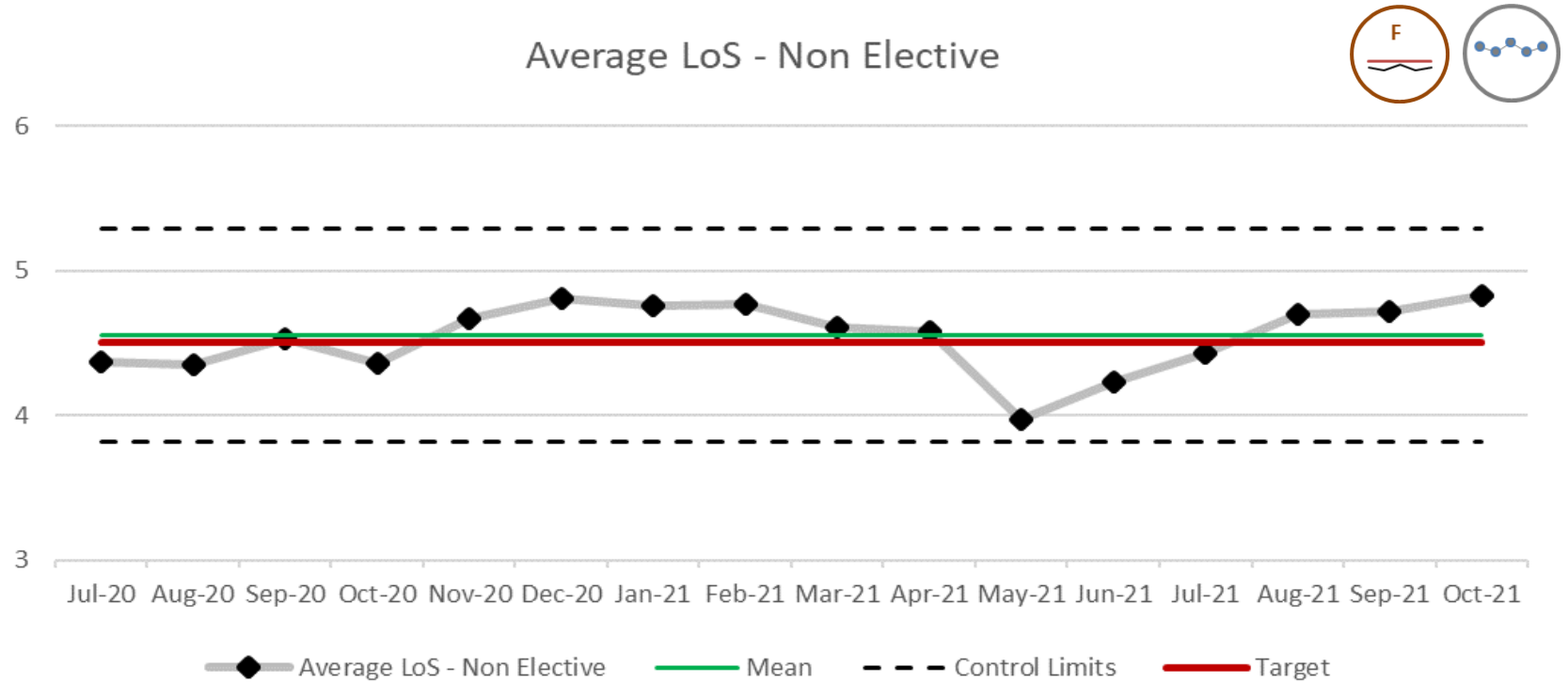
Background:
Delays in offloading patients following a conveyance has a known impact on the ability of EMAS to respond to outstanding calls. Any delays greater than 59 minutes is reportable to the CCG. There is local and national Ambulance handover delay escalation protocol.

What the chart tells us:
October demonstrated a reduction in greater than 59 minutes' handover delays. 733 in October compared to 923 in September. This represents a 20.59% decrease.
What the chart does not tell us is the slight decrease of >2hrs in October 2021 (386 in October vs 465 in September) and the overall increase in >4hr delays (107 in October vs 94 in September).

Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
Poor flow and discharges continue to result in the emergency departments being unable to de-escalate due to an increase number of patients waiting for admission.
A more detailed account of >59-minute handover delays are featured in the UEC FPEC report.

Actions:
All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager and the in hours Operational Silver Commander to secure a resolution and plans to resolve are feedback to the DOM
Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
The rapid handover protocol is currently being reviewed and agreed designated escalation areas are being identified to assist in reducing delays in handover.

Mitigations:
Early intelligence of increasing EMAS demand has allowed for planning and preparedness to receive and escalate.
Contact points throughout the day and night with the Clinical Site Manager and Silver Commander to appreciate EMAS on scene and calls waiting by district and potential conveyance by site.



Oct-21
4.83
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for Non-Elective inpatients.

What the chart tells us:

The agreed target is 4.5 days verses the actual of 4.83 days in October.
This is an increase of 0.11 days compared with September.
This is a 0.33 variance against the agreed target.

Issues:

Increasing numbers of stranded (228) and super stranded (73) patients.
PCR turnaround delays impacting on the discharge of pathway 1, 2 and 3 patients due to equipment failure.
Increasing length of stay of all pathways 1-3 The most significant increase in volume of bed days is Pathway 1 Domiciliary care.
Reluctance of Care Homes to admit at the weekends
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers leading to delays in senior reviews.
Increased number of positive covid cases requiring a longer length of stay.

Actions:

Focused discharge profile through right to reside data.
Cancellation of elective activity and SPA time to allow for daily consultant review of all patients.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Use of rapid PCRs to ensure no delay once social care plans are secured.
Maximise use of all community and transitional care beds.

Mitigations:

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

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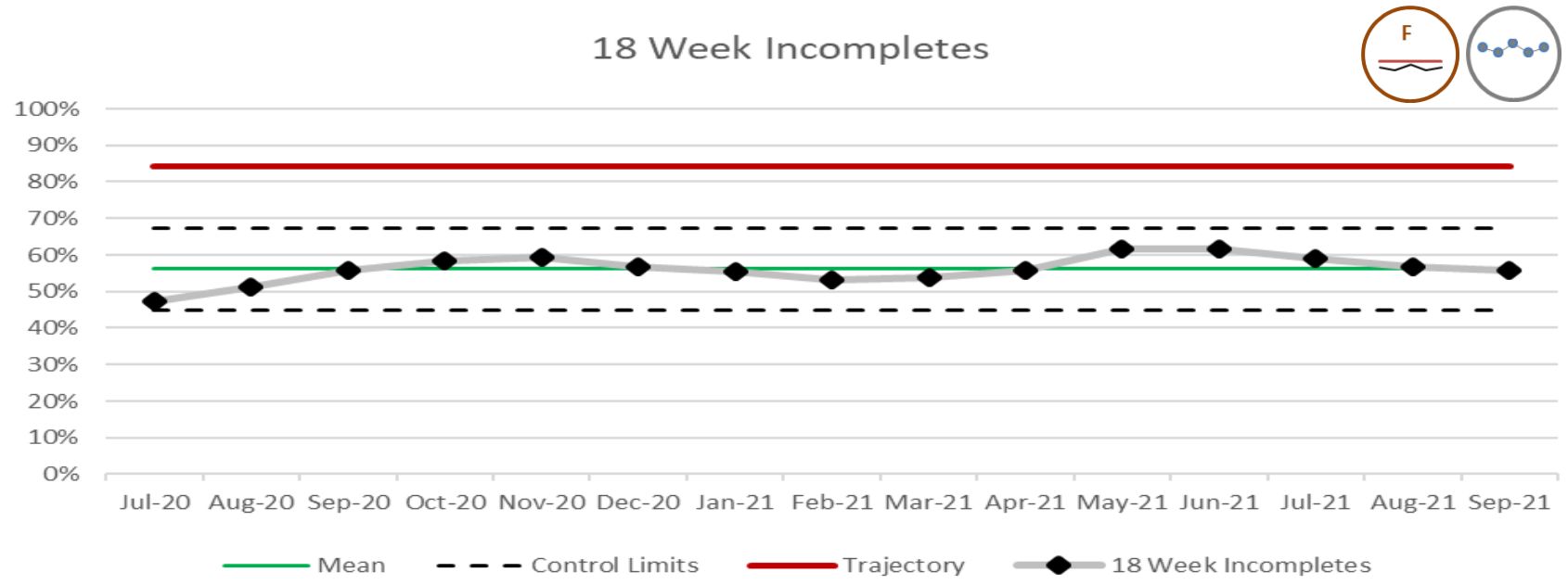

Sep-21
55.61%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background
Percentage of patients on an incomplete pathway waiting less than 18 weeks.

What the chart tells us:
There is significant backlog of patients on incomplete pathways. September saw RTT performance of 55.61% against a 92% target, which is 1.24% down on August.

Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:

- ENT – 3673 (increased by 194)
- Ophthalmology – 2517 (reduced by 214)
- Dermatology – 2448 (Increased by 245)
- Gynaecology – 2083 (Increased by 136)
- Gastroenterology 1808 (Increased by 228)

Actions:
Planned routine elective work remains challenging, with available capacity being focussed on cancer, patients classified as being P2 and longest waiting patients.

Mitigations:
Patient pathways are tracked and discussed at the weekly PTL meeting. Patients are also assessed for their suitability to be transferred to private sector organisations and offered this choice for treatment.

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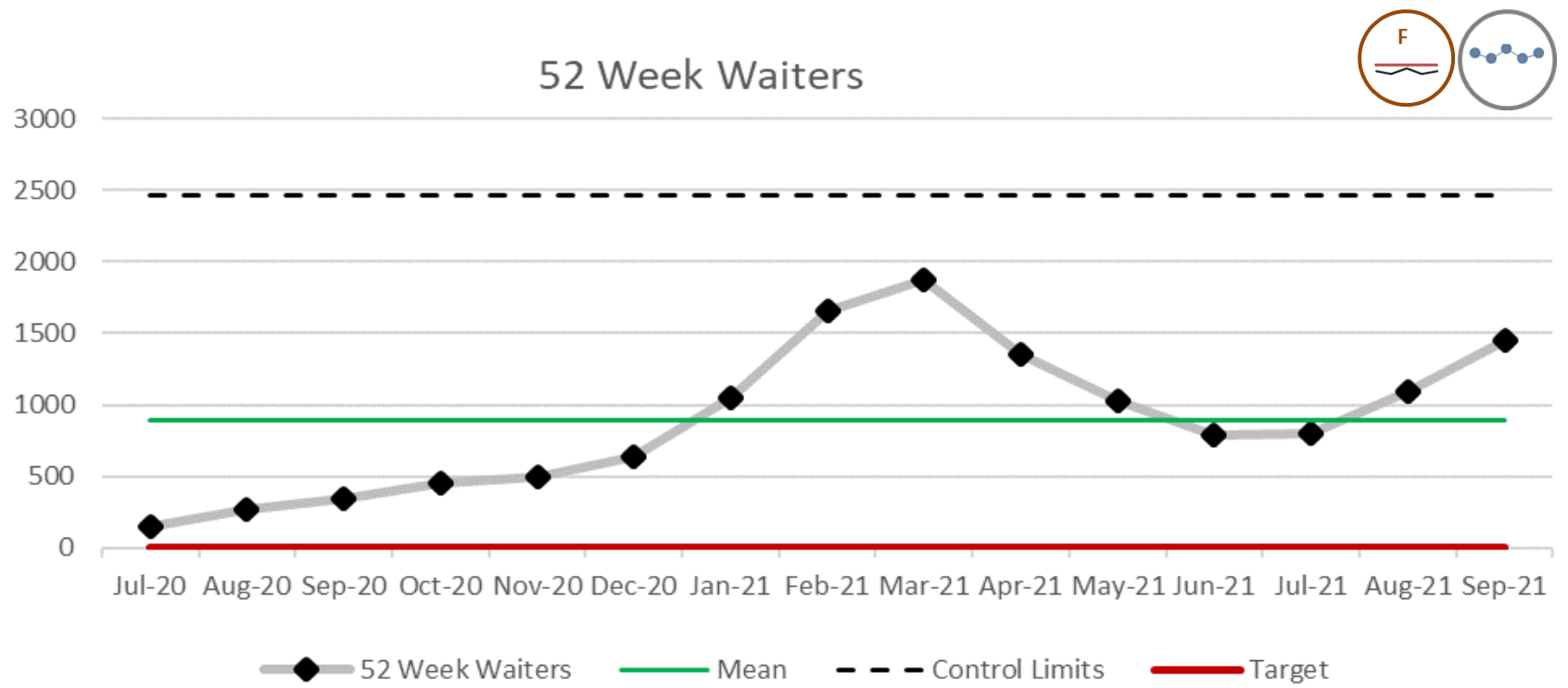

Sep-21
1451
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 1451 incomplete 52 week breaches for September. An increase of 358 from August. The number of 52 week breaches has been steadily reducing since March 2021 but has gone up considerably in August and September.

Issues:
The admitted position remains challenging. Wave 3, winter pressures and capacity challenges are impacting on service delivery, which will in turn, detrimentally effect the 52 week position.

Actions:
Admitted patients are individually graded and allocated a priority code. The longest waiting patients, irrespective of their P code status are treated alongside urgent and P2 patients. All patients waiting more than 52 weeks are required to have an RCA and harm review completed. The harm reviews are also discussed at the Clinical Harms Oversight Group, chaired by the COO.

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

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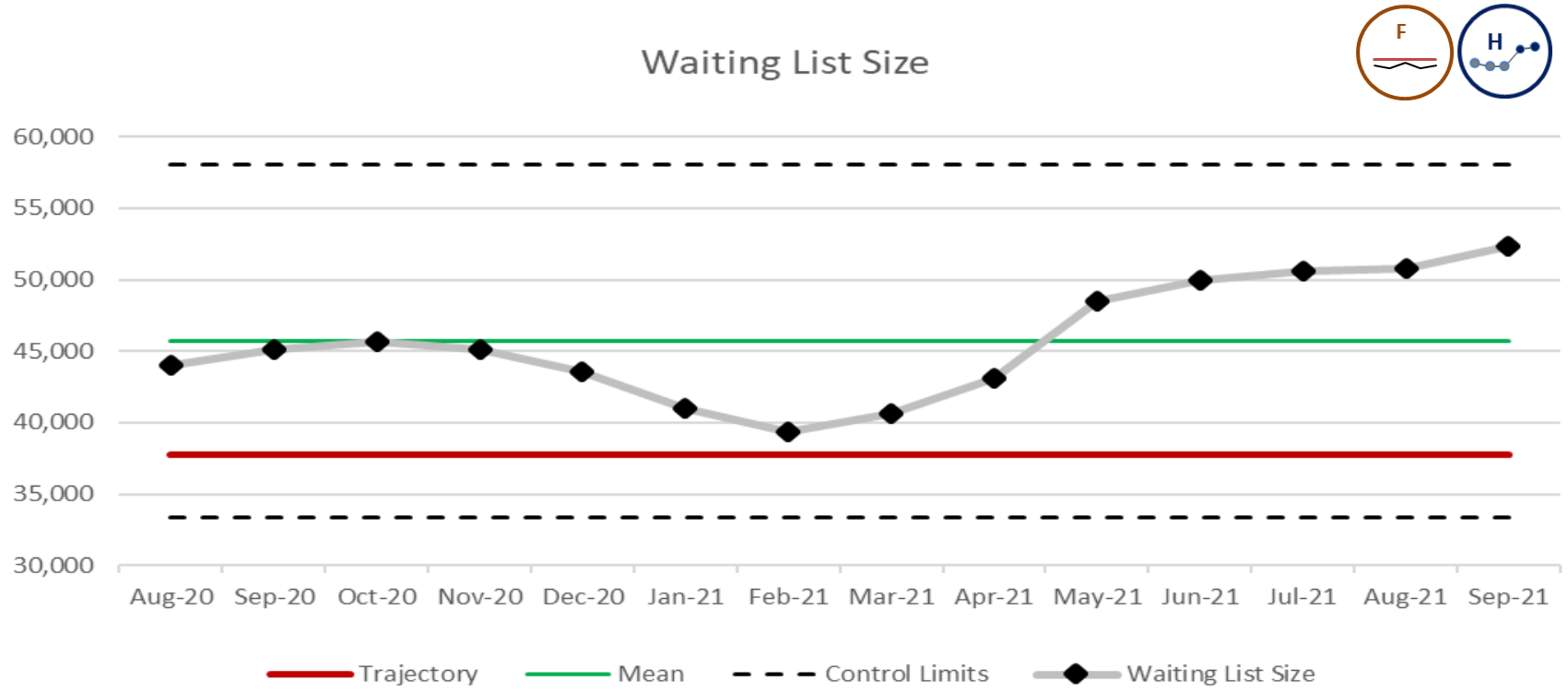


Sep-21
52,368
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has increased from August, with September showing an increase of 1564 to 52,368.
The incomplete position for September 2021 has increased by approximately 14,342 more than the reported pre pandemic size in January 2020.

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

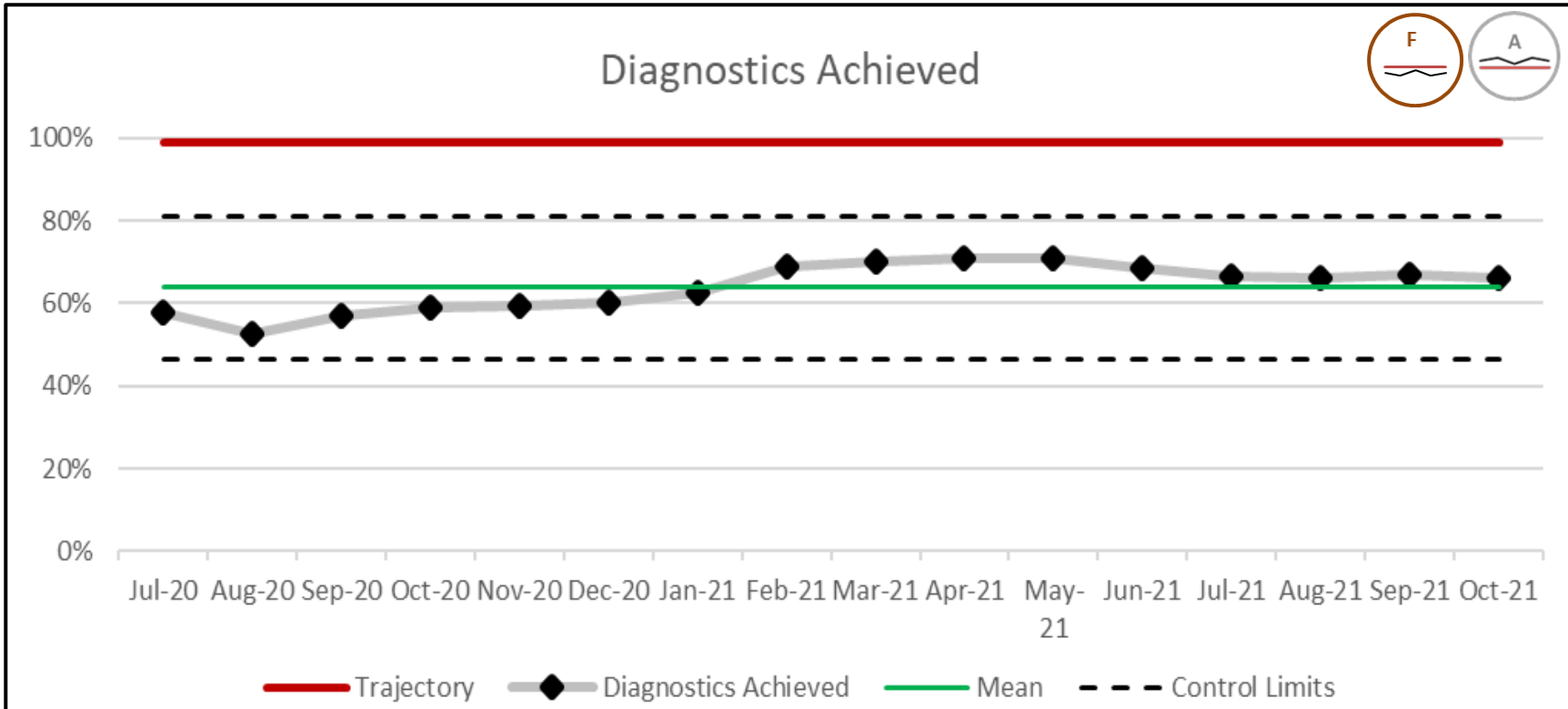
- Gastroenterology + 363
- Dermatology + 308
- Cardiology + 232
- ENT +183
- Nephrology + 150

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

- Ophthalmology – 481
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery – 105
- Colorectal Surgery - 45
- Respiratory Physiology - 31
- General Surgery - 25

The Trust reported 5,632 over 40 week waits; an increase of 443 from August. The numbers of patients waiting over 26 weeks increased by 1287.

Actions/Mitigations:
The longest waiting patients continue to be monitored and discussed at the weekly PTL meeting. Issues preventing booking of patients are also discussed in the RTT Recovery and Delivery meeting to help find solutions.



Oct-21
66.23%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
99%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

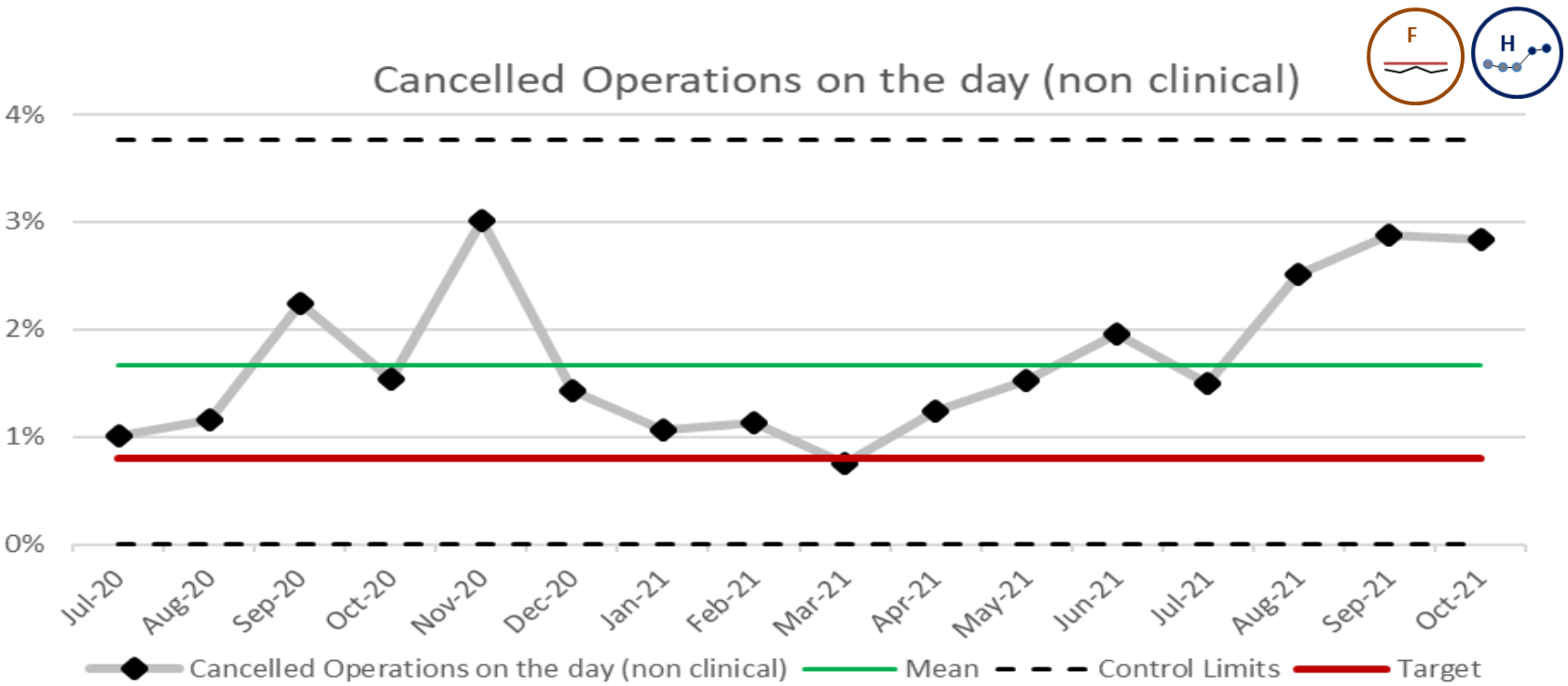
What the chart tells us:
We are currently at 66.23% for October 2021 against the 99.00% target.

Issues:

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

Actions:
Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes, additional US list are happening but not enough to deal with the additional 2000 scans.

Mitigations:
All waiting lists are being monitored and where 50% of the waiting list is over 6 weeks, we are being asked to complete a clinical validation for each patient and assign a D code to that patient. Going forward every new referral will have a D code assign to that patient. This will make sure all patients are seen in clinical urgency.



Oct-21
2.83%
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

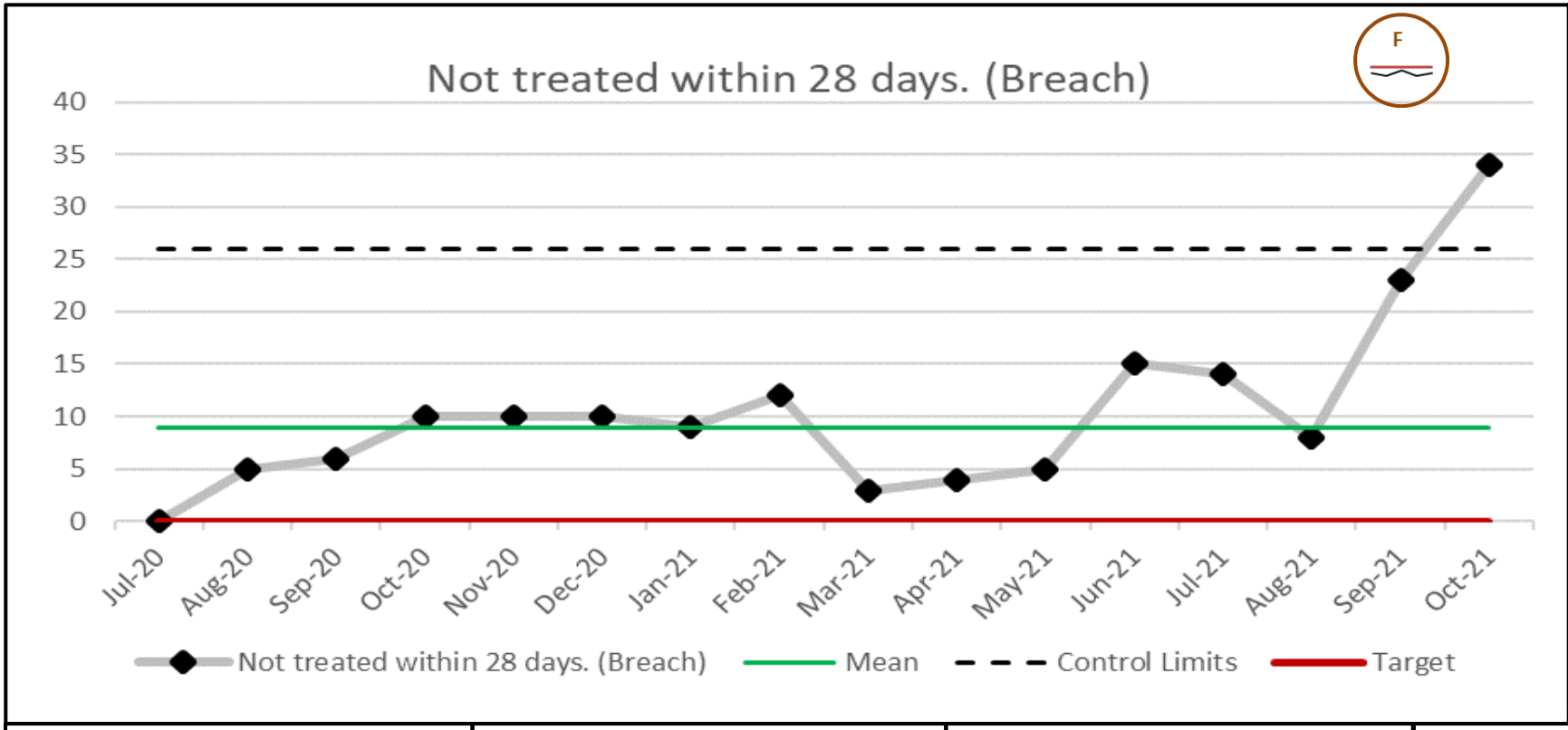
Background:
This shows the number of patients cancelled on the day due to non-clinical reasons.

What the chart tells us:
Levels of same day cancellations have increased from July and August to September substantially. The trajectory does look to be levelling off for October compared to the steep rise between July and August.

Issues:
Main reasons for same day non-clinical cancellations are: equipment not available, no bed, no Level 2 HDU bed, patient choice, administration issues, surgeon or anaesthetist unwell, no Theatre staff, lack of time (often linked to late starts).

Actions:
Regular meetings with TACC and the CBUs to discuss Theatre issues. Need to encourage CBU attendance.
642 process revitalised to ensure the lists identified are filled with the appropriate number of patients.
Have members of the Waiting List Management at the 642.
Review and action plan to reduce late starts, these lead to same day cancellations due to lack of time.

Mitigations:
Better attendance at meetings including more involvement from CBUs, Theatres (all sites) and SAL to address this and devise ways of prevention.
Staffing reviewed in advanced and redeployed from other sites.
642 process reviewed and updated ensure lists appropriately filled.
Ensured Waiting List Team understood the need to fill the lists completely.



Oct-21
34
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The number of breaches between September and October has risen to 34, above the control limit.

Issues:
The Waiting List Team (WLT) spent 25-30% of their time cancelling and moving patients due to: More urgent patients coming in, such as those with cancer, patients not accepting the alternative date, and not enough ICU Level 2 capacity.
Changing rotas to cover staffing has also impacted list availability 2 were cancelled for lack of Theatre Staff and 2 for lack of surgeon, all factors listed impact on breaches.

Actions:
Highlight these patients at the TACC CBU meetings include the WLT. If a surgeon or CBU wants to move such a patient, ensure they know it will cause a breach.
Pre-book ICU beds, reassess, consider a Level 1 bed, if Level 2 will lead to a breach
7-day working is in place, extra weekend lists would decrease breaches, need to be utilised.

Mitigations:
There is a plan to 'Freeze' lists at 7 days' pre-op, so no patient on that list can be moved unless their consultant specifically says so.
There is now a Level 1 Facility at Pilgrim and plans to extend Trust wide.
Regular meetings are starting to address these issues, need all stakeholders to attend.

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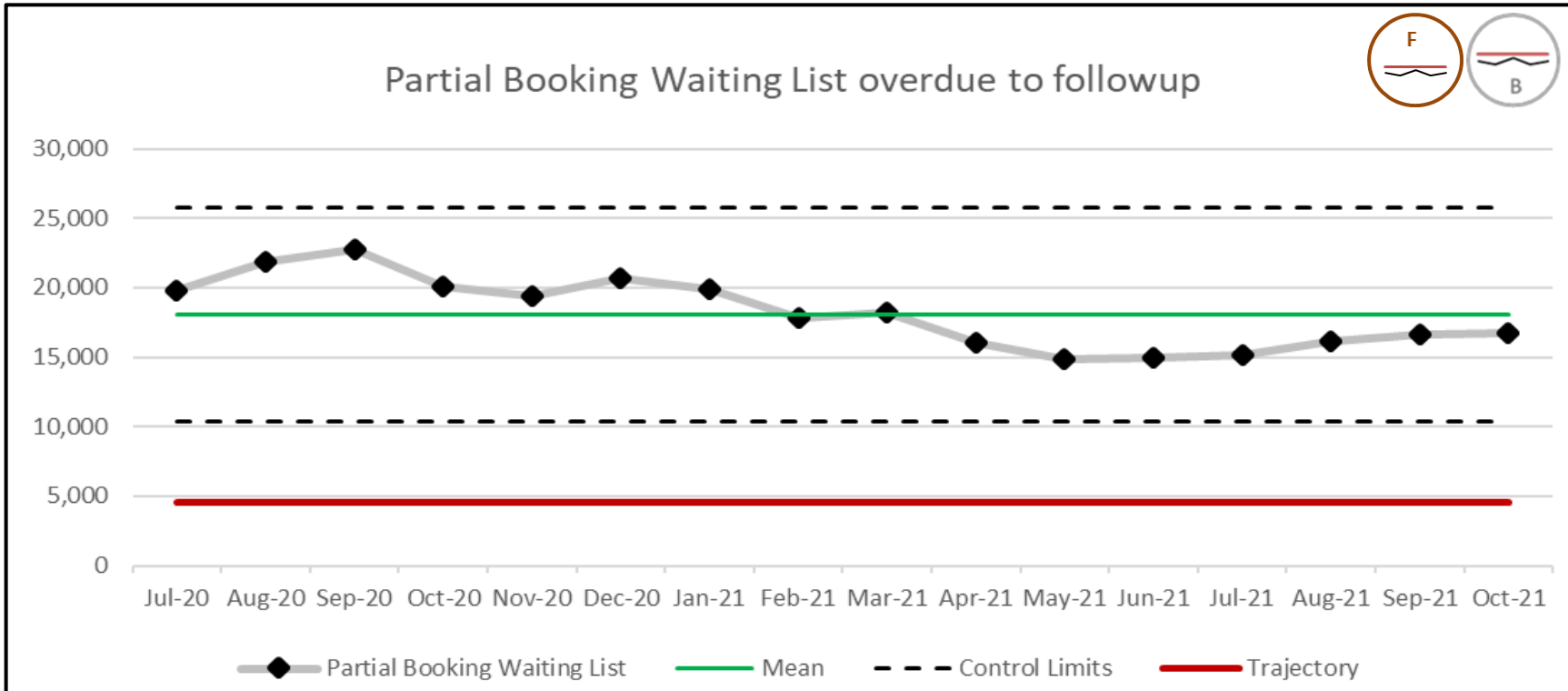
NHS United Lincolnshire Hospitals NHS Trust



Oct-21
16,739
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 16,739 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased.
Recovery work took place and reduced the number of patients overdue but this has started to increase on a slight upward trend since July 2021.

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

Actions:
Service recovery plans produced and updated regularly. Specialities are continuing with validation, clinical triage and exploring technological solutions. Clinical Harm Oversight Group are challenging the specialties around the risk of harm to patients overdue on PBWL.
642 / PBWL meeting in place to challenge capacity shortfalls but stepped down due to Level 4 actions.

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

OUTSTANDING CARE personally DELIVERED

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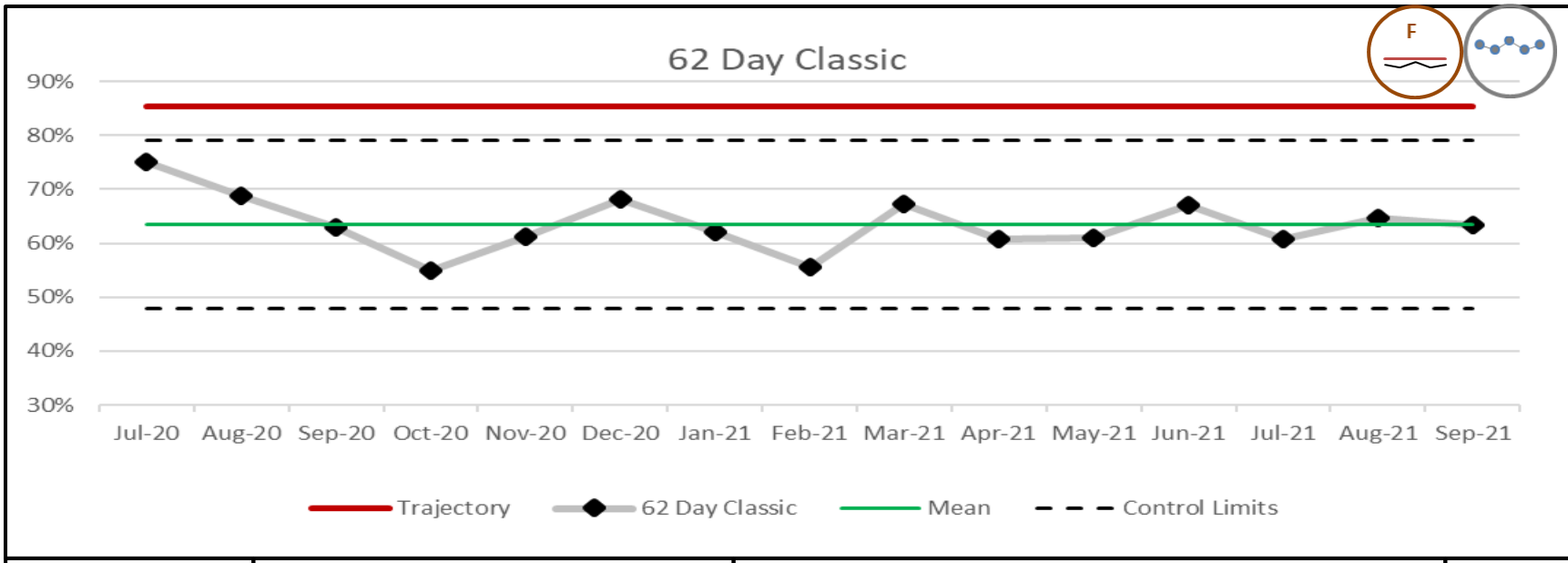


Sep-21
63.33%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 63.33% against an 85.4% target.

Issues:

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

Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, and Head & Neck.

Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently, there are 4 Locum Oncologist posts out to advert.

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

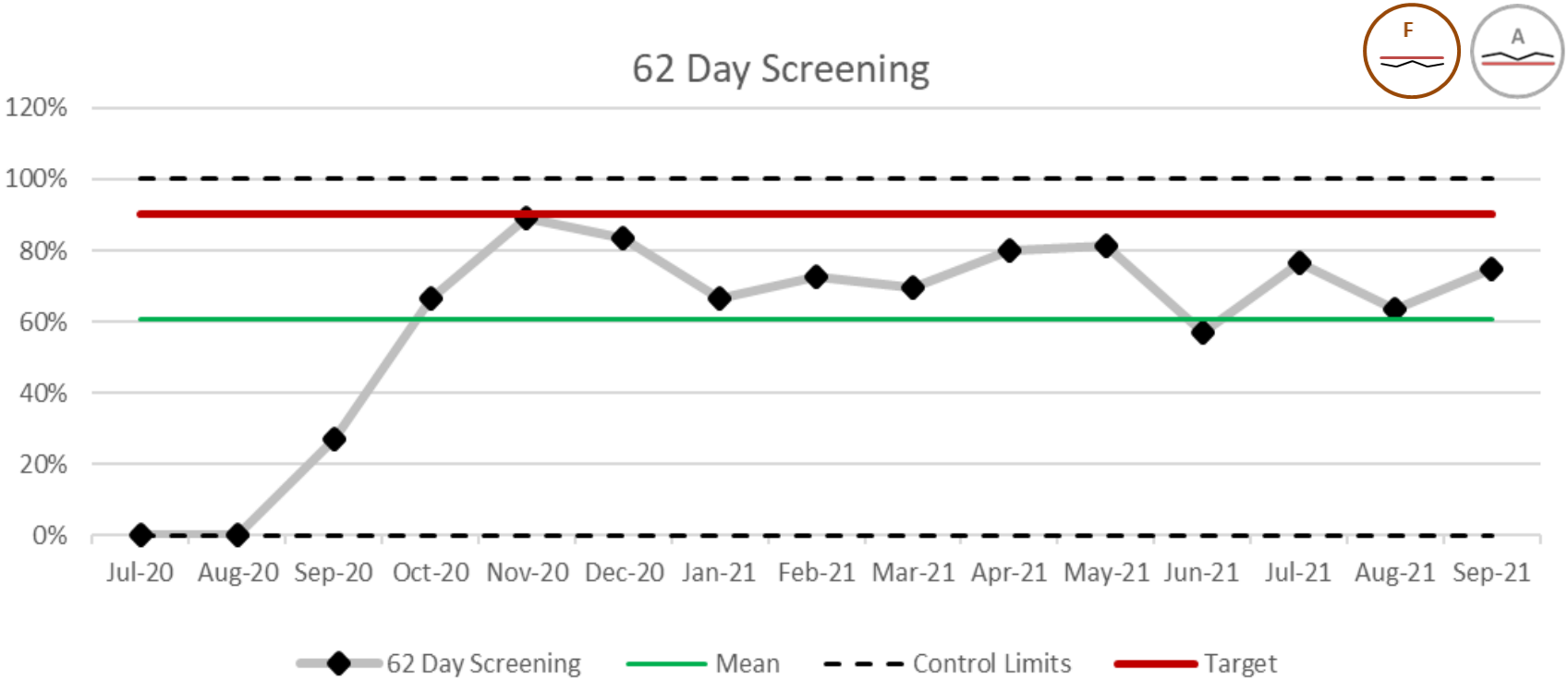
Following this model, funding has also been identified a navigator in the Head & Neck CBU whilst a second navigator post within the Colorectal and Urology CBUs have recruited and recently commenced in post – these posts will be key to securing and facilitating regular and consistent Clinical Review sessions with the Consultant teams in order to prevent delays in the pathway.

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

Negotiations to outsource some activity to The Park BMI have been underway, but this has been a challenging process so far and is not going to be an option for colorectal surgery, the area currently greatest in demand. However, the potential for robotic radical prostatectomies to be redirected to The Park BMI is currently being explored in order to reduce the backlog of patients awaiting these procedures.

Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns. Two Colorectal Nurse Practitioners have recently commenced in post to support capacity and colorectal pathway flow. A review of the internal Gynaecology pathways is underway and Colposcopy and PMB capacity issues and throughput are being addressed with a new locum and nurse hysteroscopist commencing in post imminently.



Sep-21
75%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

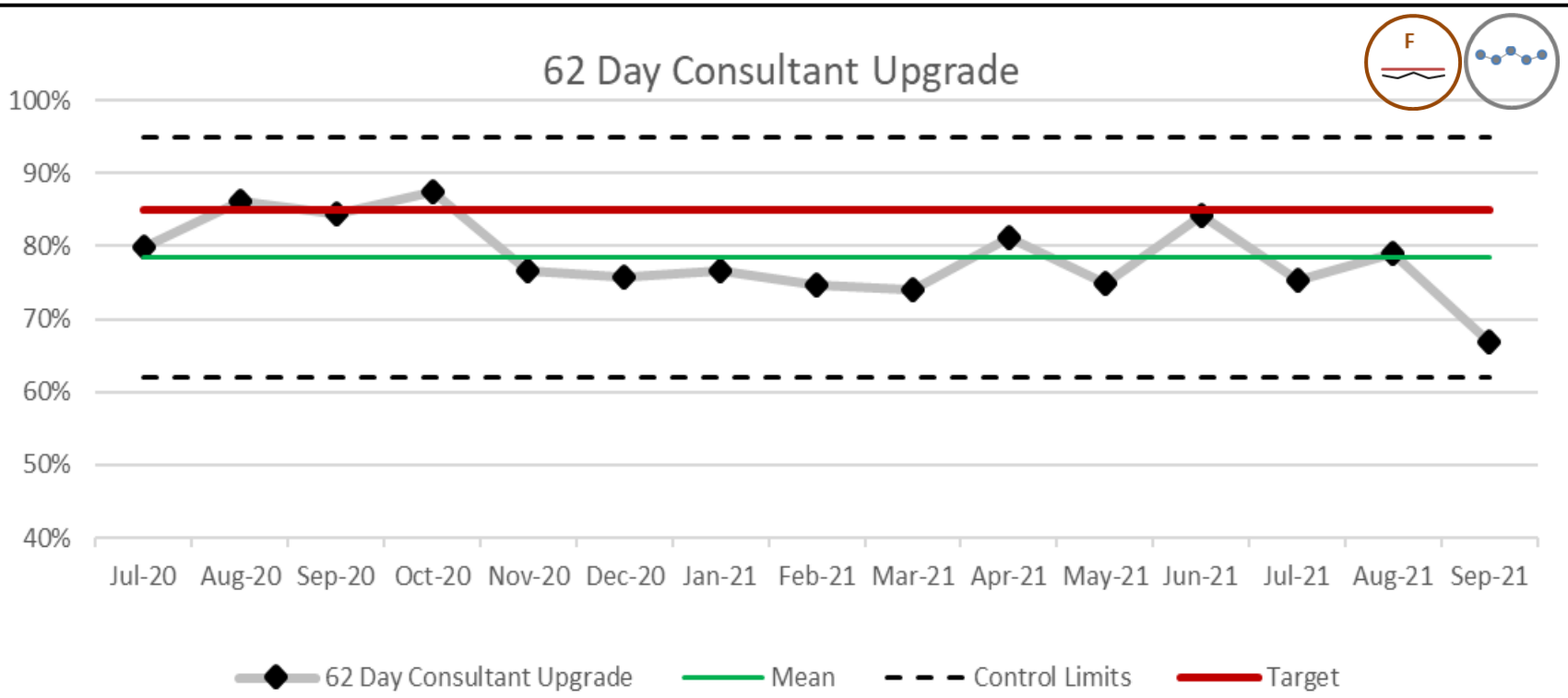
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 75% against a 90% target.

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

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

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



Sep-21
66.88%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days of a consultant's decision to upgrade their priority.

What the chart tells us:
We are currently at 66.88% against an 85% target.

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

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

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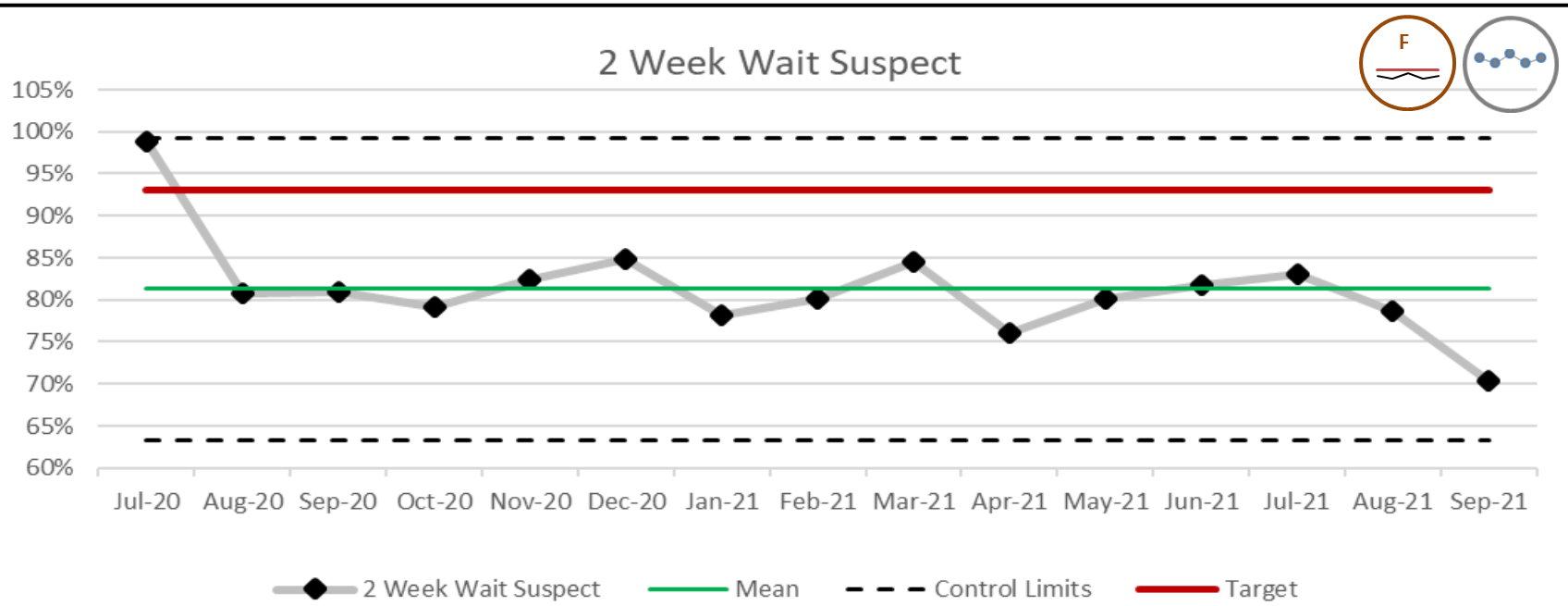

Sep-21
70.41%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 70.41% against a 93% target.

Issues:
The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 40% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Lung (25.2%), Gynaecology (52.0%), Urology (59.1%), Head & Neck (78.7%), Upper GI (79.6%), Colorectal (81.7%) and Haematology (84.6%). All other tumour sites achieved the standard. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.

Actions:
The Trust is actively seeking to implement RDC pathways for brain, haematuria, testicular and Upper GI by December 2021. A pathway review for gynaecology and a direct access ultrasound pathway has also been identified as a priority for 2022.. A scoping exercise is underway in respect of the bladder and testicular pathway – this includes a direct access pathway and haematuria one stop clinics. Clinical sign-off took place in June and is planned to be in place by the end of October. Recruitment of a new diagnostic ACP is underway to improve capacity in the Urology diagnostic clinics. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

Mitigations:
Further respiratory consultant posts will secure lung clinic capacity and support the pilot to appoint lung patients within 48 hours – 2 Lung Specialty Doctors are due to start by the end of November 2021 and a Lung Consultant is due to commence in post in January 2022. A comprehensive review of Breast Services is ongoing following the final report issued by NHSI support. Breast clinic capacity has now been restored to pre-COVID levels and additional clinics to clear the backlog are being sought and will continue to be until the backlog is cleared. A mastalgia pathway is being worked up with primary care and system partners which has the potential to reduce inbound referrals by circa 15%. Colposcopy and PMB capacity issues are being addressed with a new locum and nurse hysteroscopist commencing in post by the end of November 2021.

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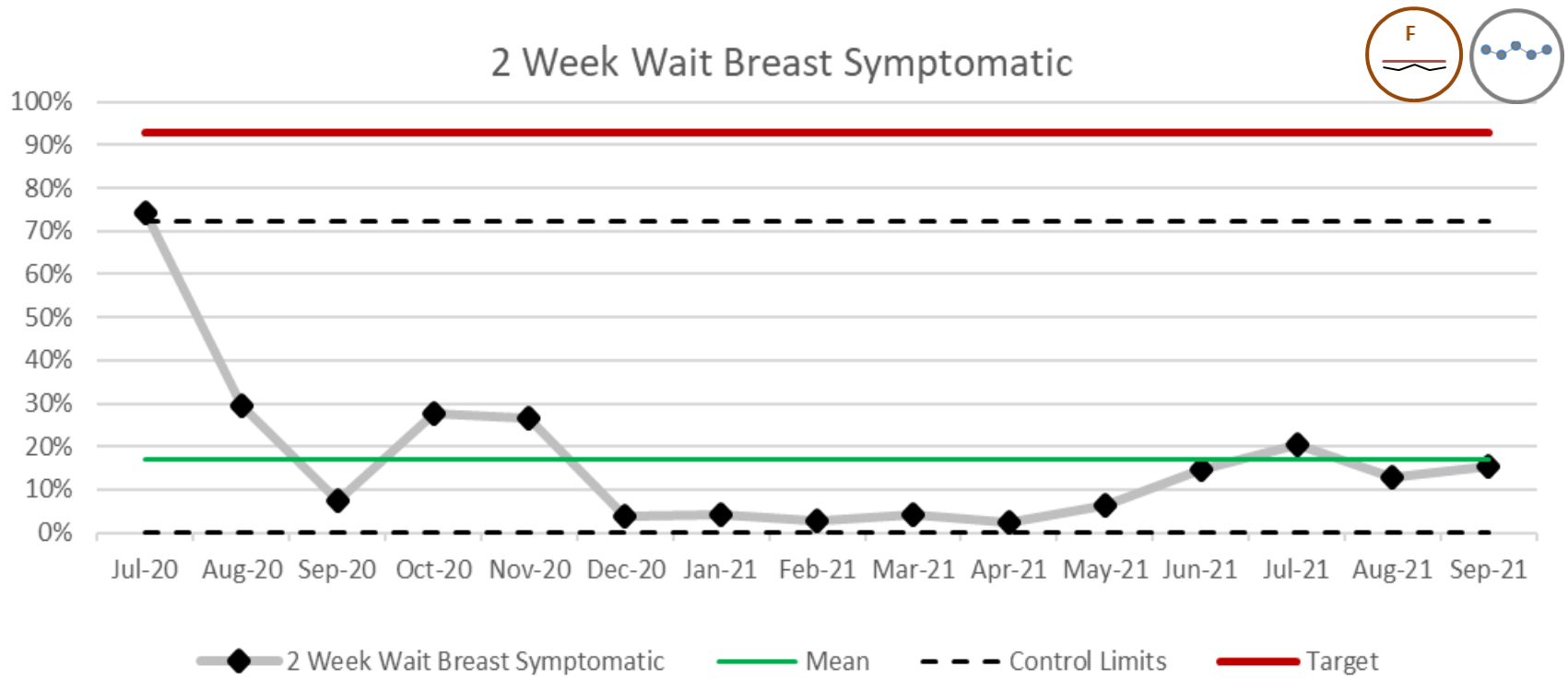


Sep-21
15.24%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

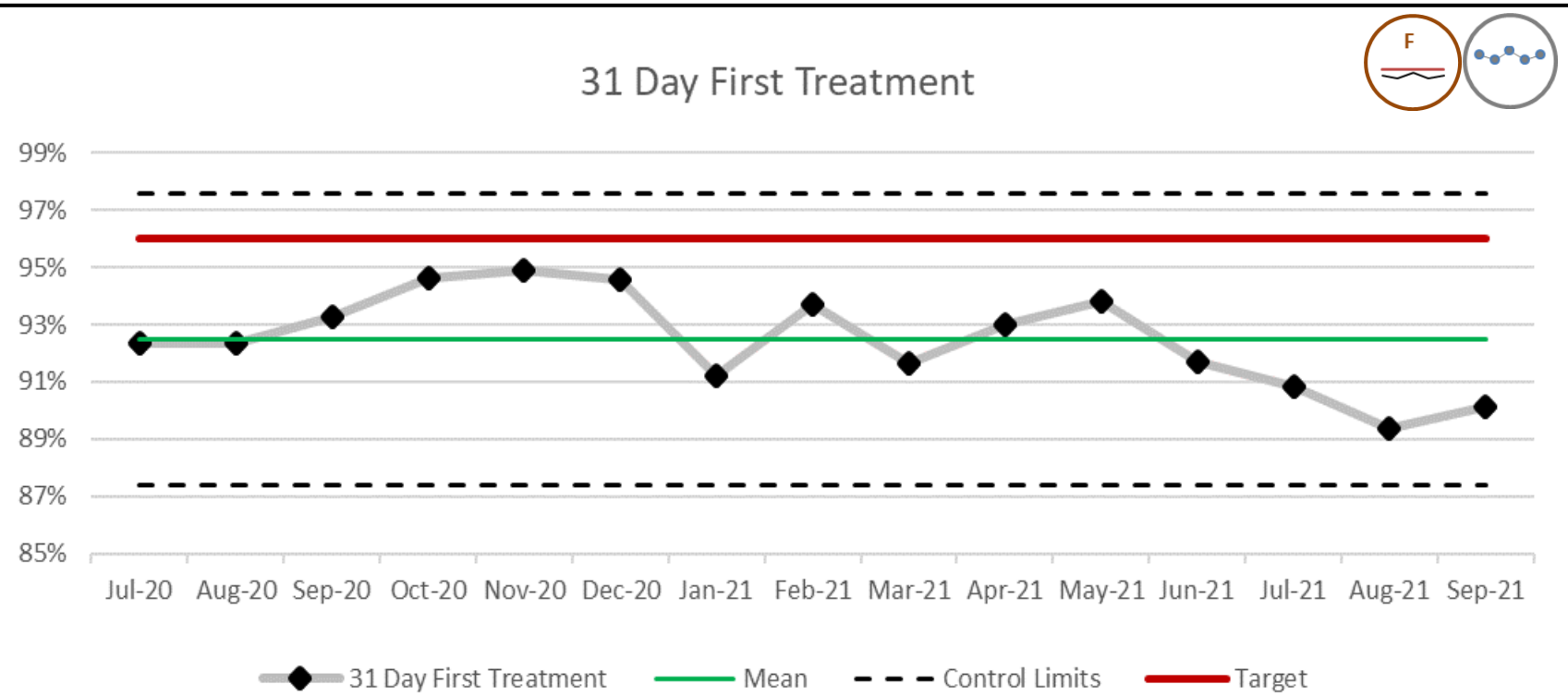
Background:
Percentage of patients urgently referred for breast symptoms (where cancer was not initially suspected) seen within two weeks of referral.

What the chart tells us:
We are currently at 15.24% against a 93% target.

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

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

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



Sep-21
90.10%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

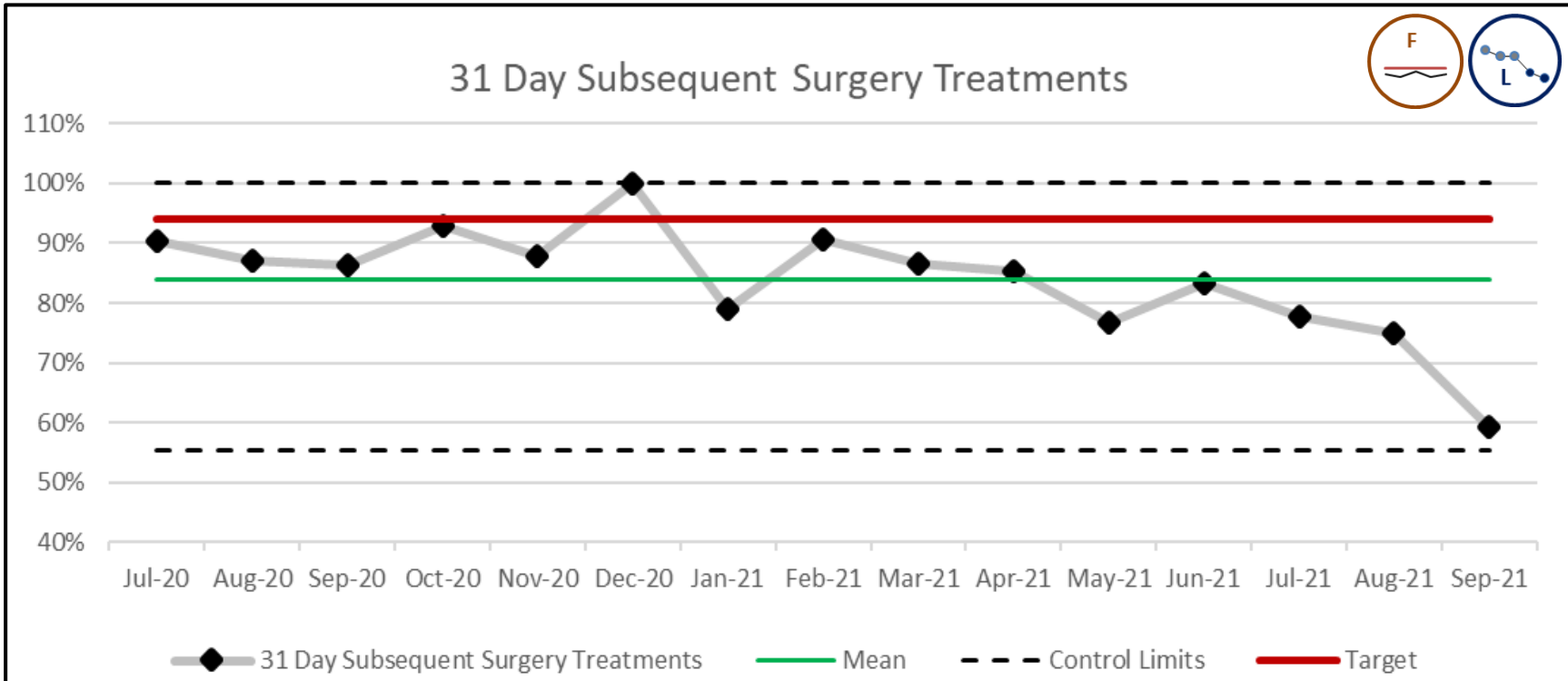
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 90.10% against a 96% target.

Issues:
The failure of the 31 Day standards was primarily due to the impact of COVID (the reduction in theatre capacity). Reduced theatre capacity across the Trust, all Specialties vying for additional sessions.

Actions:
Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently, there are 4 Locum Oncologist posts out to advert.

Mitigations:
A review of colorectal theatre list scheduling in order to better align with clinician availability continues, and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns. Negotiations to outsource some activity to The Park BMI have been underway, but this has been a challenging process so far and is not going to be an option for colorectal surgery, the area currently greatest in demand. However, the potential for robotic radical prostatectomies to be redirected to The Park BMI is currently being explored in order to reduce the backlog of patients awaiting these procedures.



Sep-21
59.18%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

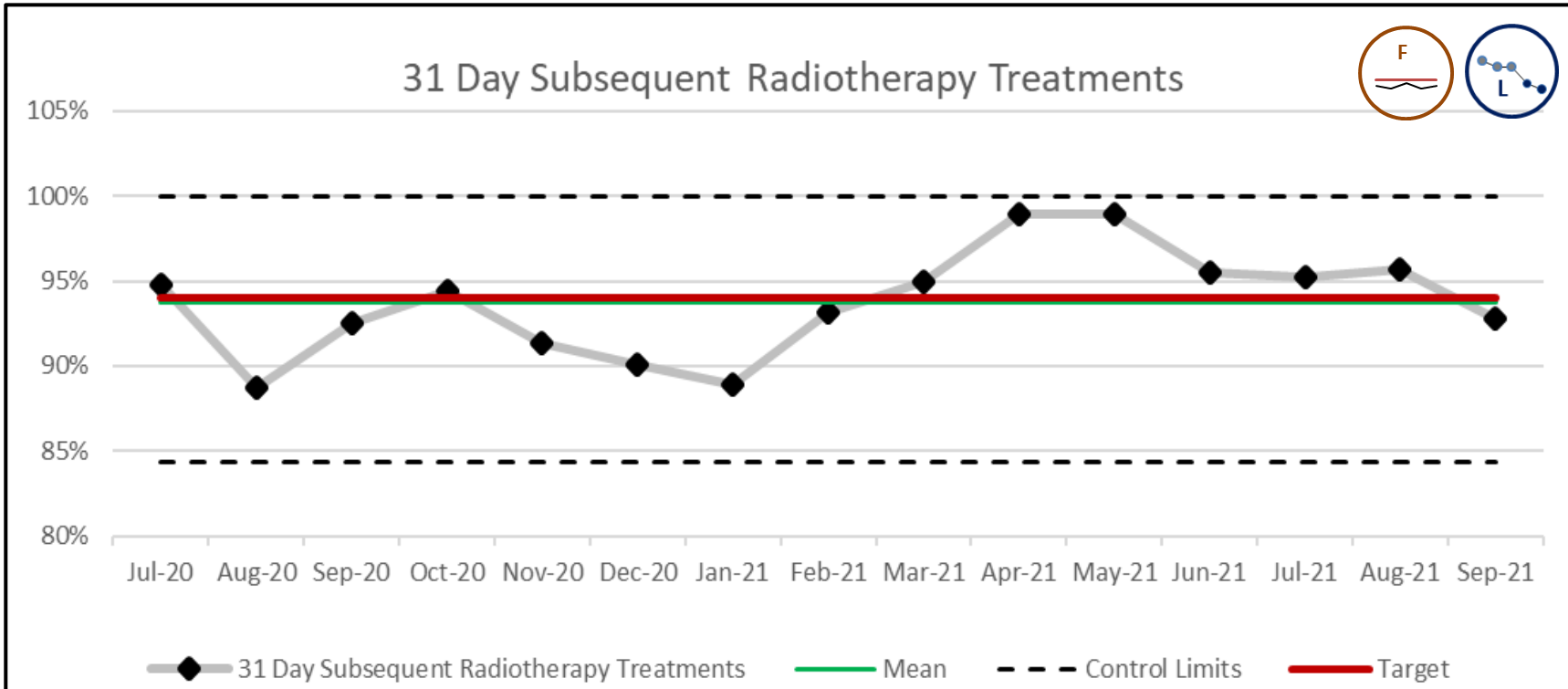
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was surgery.

What the chart tells us:
We are currently at 59.8% against a 94% target.

Issues:
The failure of the 31 Day standards was primarily due to the impact of COVID (the reduction in theatre capacity). For the subsequent standards the Trust was successful in the Drug standard, failing in the Surgery standard and narrowly missing the Radiotherapy standard. Reduced theatre capacity across the Trust, all Specialties vying for additional sessions.

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

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



Sep-21
92.81%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 92.81% against a 94% target.

Issues:
The failure of the 31 Day standards was primarily due to the impact of COVID (the reduction in theatre capacity). For the subsequent standards the Trust was successful in the Drug standard, failing in the Surgery standard and narrowly missing the Radiotherapy standard.

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

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

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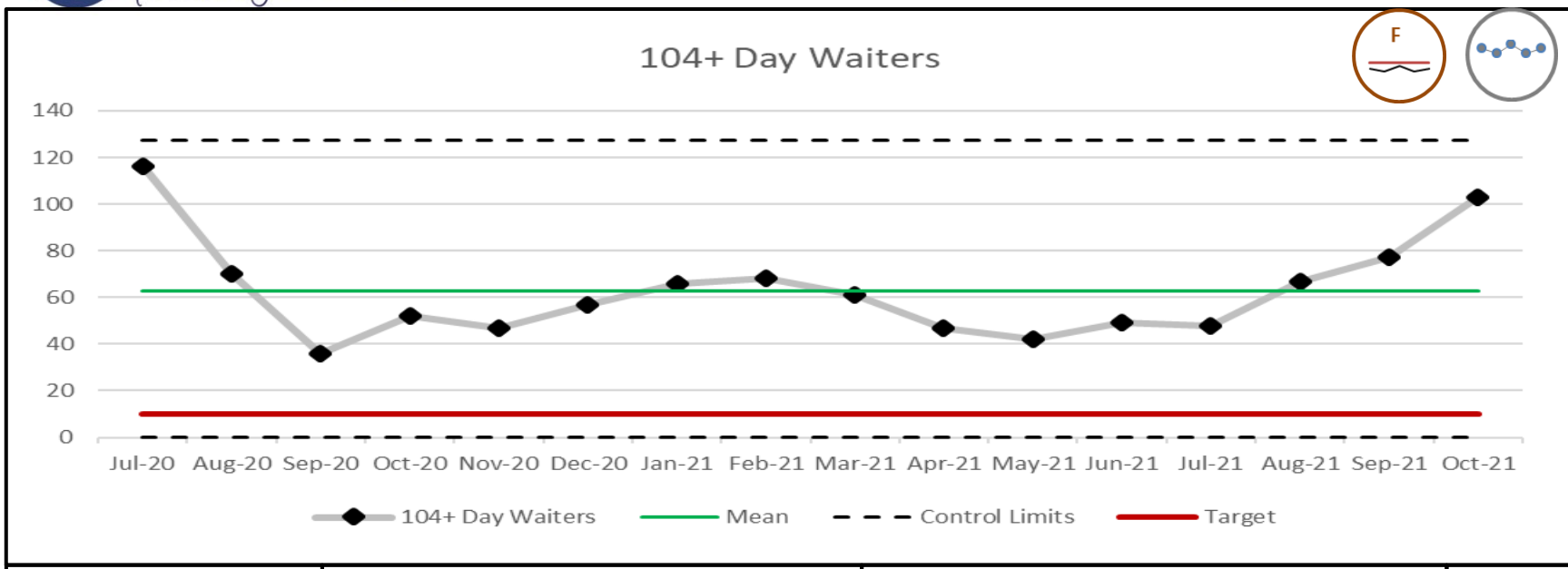

Oct-21
103
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Number of cancer patients waiting over 104 days.

What the chart tells us:

As of 11th of November, the 62 Day backlog is at 429 patients. The agreed target is <40. As of 11th of November the 104 Day backlog is at 109 patients. The agreed target is <10. The current position by tumour site is as follows:-
82 Colorectal
7 each Urology, Head & Neck and Lung
3 Upper GI
1 each Breast, Gynaecology and Haematology

Issues:

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period) – this is starting to improve.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.
Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.
Reduced theatre capacity across the Trust, all Specialties vying for additional sessions. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Head & Neck, Lung and Gynaecology. Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients. Approximately 11% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently, there are 4 Locum Oncologist posts out to advert. Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI and Lung CBU's to support clinical engagement. Following this model, funding has also been identified a navigator in the Head & Neck CBU whilst a second navigator post within the Colorectal and Urology CBUs have recruited and recently commenced in post – these posts will be key to securing and facilitating regular and consistent Clinical Review sessions with the Consultant teams in order to prevent delays in the pathway. Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts.

Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns. Negotiations to outsource some activity to The Park BMI have been underway, but this has been a challenging process so far and is not going to be an option for colorectal surgery, the area currently greatest in demand. However, the potential for robotic radical prostatectomies to be redirected to The Park BMI is currently being explored in order to reduce the backlog of patients awaiting these procedures.
Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Aug-21	Sep-21	Oct-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	90.39%	87.80%	87.25%	89.30%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	12.13%	11.93%	10.28%	10.76%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.09%	5.18%	5.31%	5.08%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	12.46%	13.04%	13.69%	12.14%		F		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	62.79%	56.84%	52.09%	66.17%		F		

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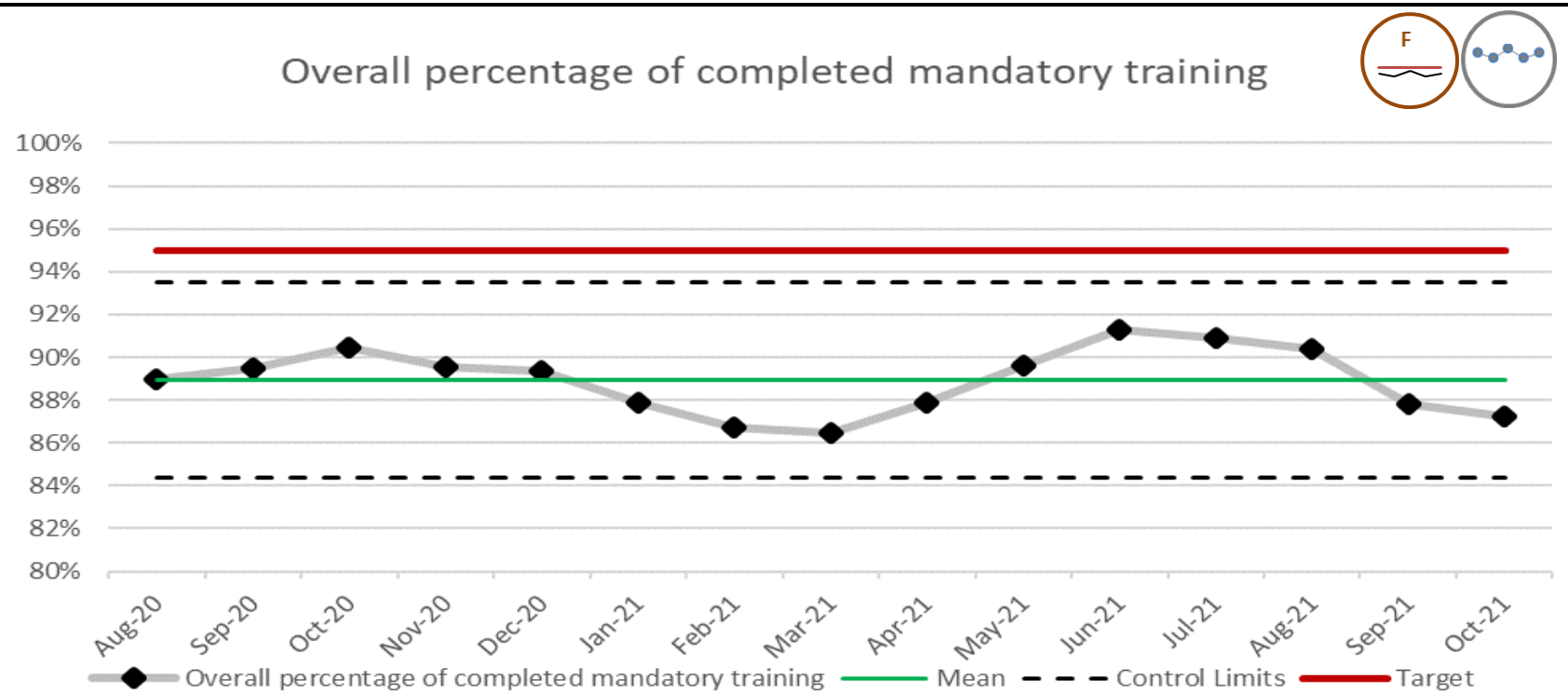

Oct-21
87.25%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Compliance with mandatory training is still high but continues to reduce due to staffing pressures, higher absence levels, an increase in patient activity and operational pressures.

Issues:
- Front line staffing continue to see increased difficulty in ensuring protected time due to current pandemic
- The continuation of increases absences also prevent staff to access their ESR which becomes overdue
- Training continues to be stood down when necessary.

Actions:
- The team continue to support the ongoing review, including looking at packages, software and platforms.

Mitigations:
See actions

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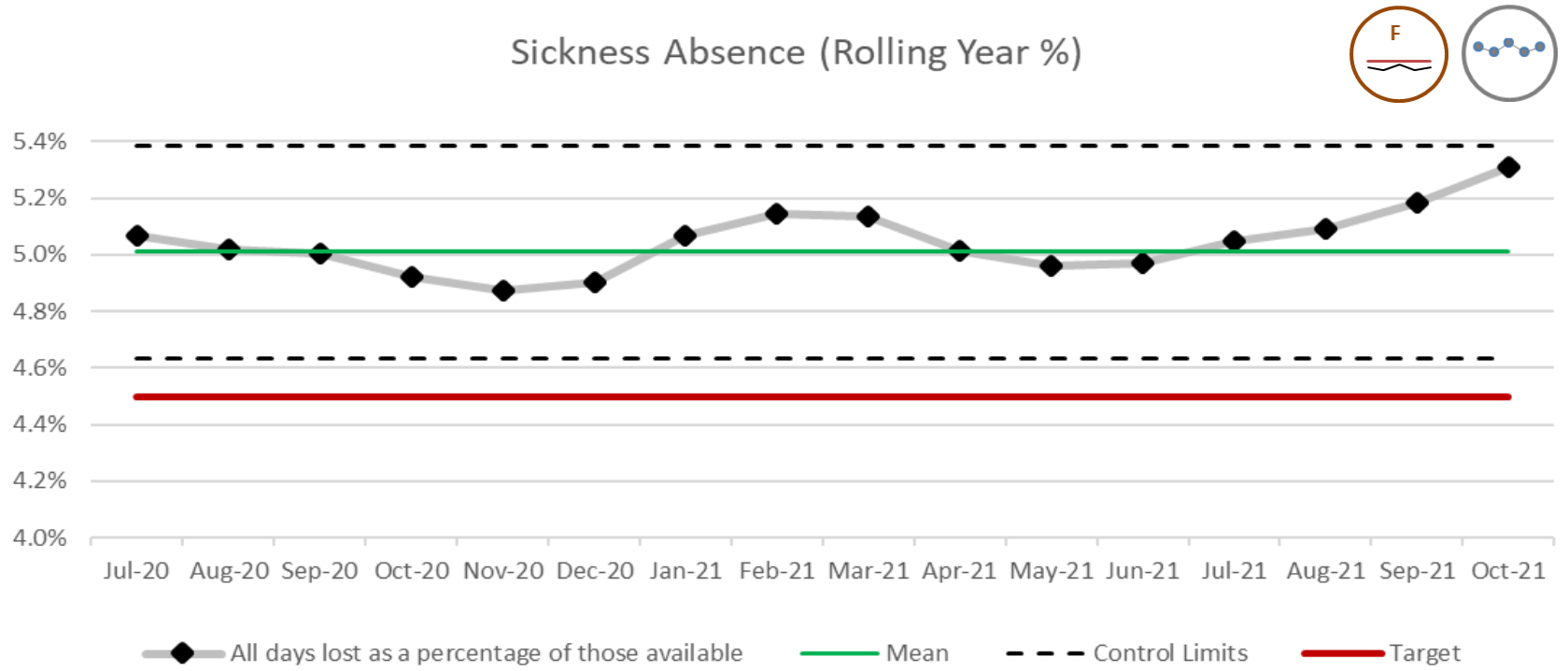

Oct-21
5.31%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The Chart shows us that sickness absence has increased to its highest level since June 2020.

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

Actions:
- The implementation of the risk assessment process means staff do not have to isolate for long periods when they can return to work safely.
- An enhanced wellbeing offer is being considered to support the increase in staff suffering with mental health issues attributed by the pandemic.

Mitigations:
See Actions.

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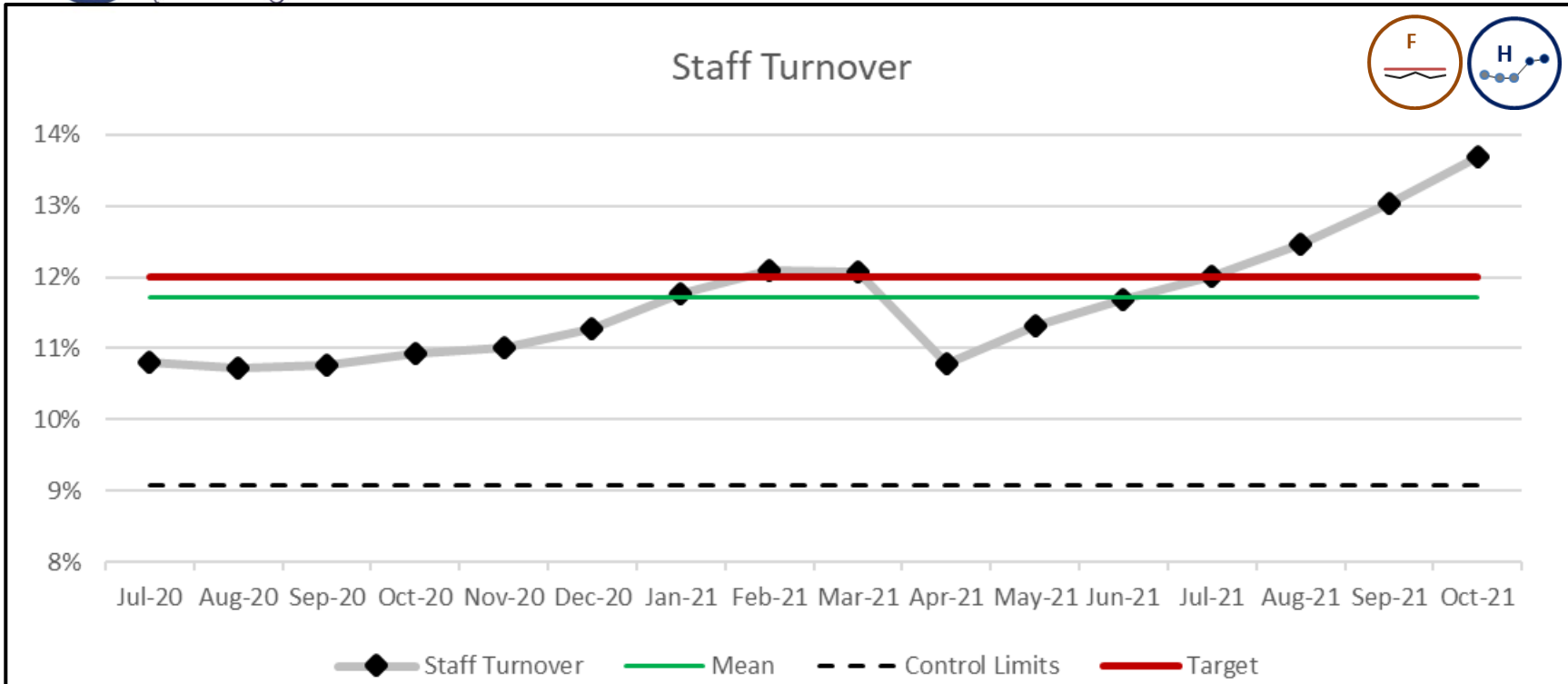

Oct-21
13.69%
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
12%
Target Achievement
Metric is failing to target
Executive Lead
Director of HR & OD

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

What the chart tells us:
As expected, turnover rates continue to steadily creep up. The pressures of working in an acute trust environment for the past 18 months is having an impact on people.

Issues:
Analysis of exit interview survey data shows (completion rate of 40%):

- 29% of leavers who completed the survey were 'unavoidable' leavers
- lack of development opportunities and flexible working continue to be the top 2 reasons.
- a third new category has come up in the last 2 months – workload issues.

Actions:
The flexible working policy is published in October. However, we continue to see staff leaving for lack of flexible working opportunities. This will be discussed and actioned through the Task & Finish group.

Mitigations:
See actions

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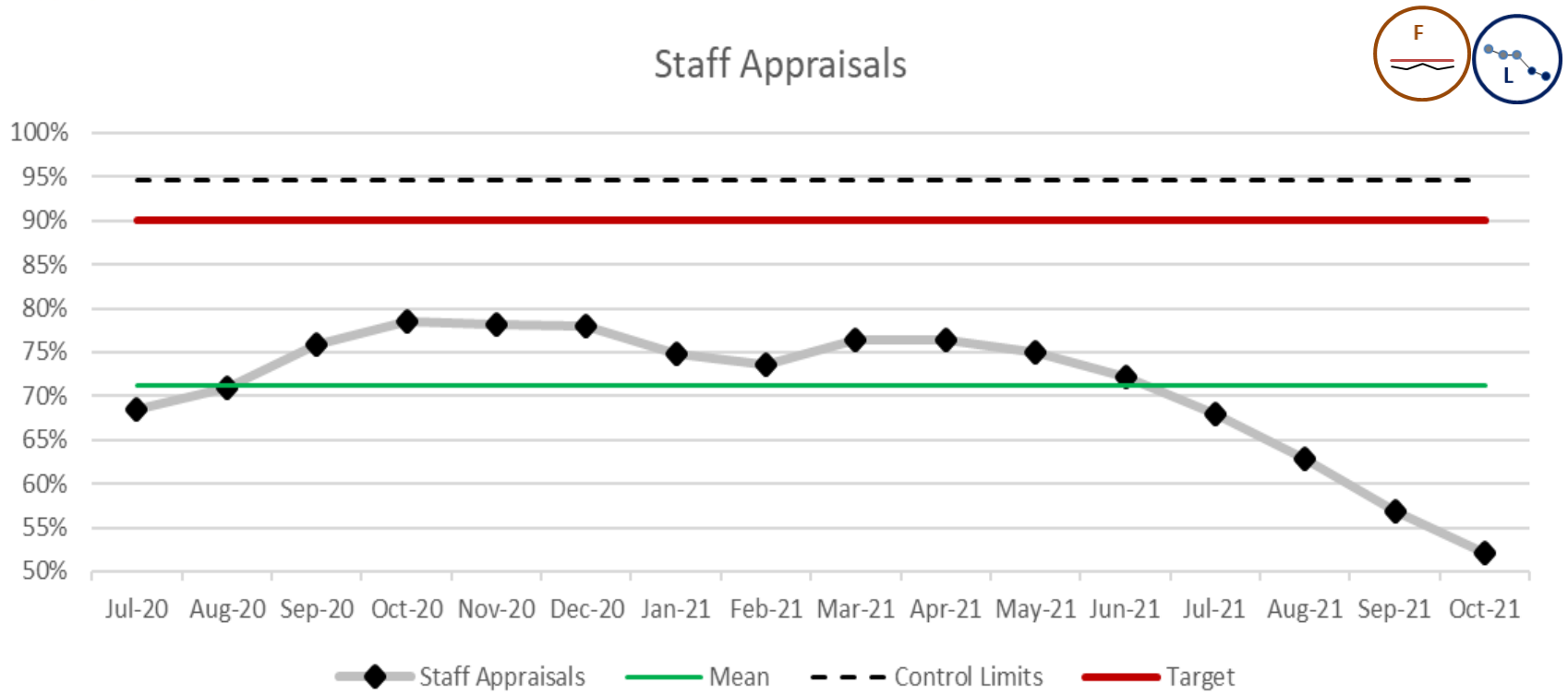

Oct-21
52.09%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 52.09%.

What the chart tells us:
The gap to achieve the target completion rate for appraisal is widening. While there is a systemic issue around completion of appraisals, operational pressures over the past few months have had a significant impact on the completion of appraisals.

Issues:
- Operational pressures is causing an impact on completion
- Decision taken to go ahead with pay progression even if appraisal is not completed.
- Engaging staff and working with them on a new system WorkPAL through the past few months has been difficult.

Actions:
- Appraisal completion to be focussed through the divisions regardless of operational pressures.

Mitigations:
- Trust to consider an appraisal cycle – 3 months of the year when everyone in the Trust completes appraisals. The appraisal training calendar can also be aligned to this cycle.

Financial Position Month 7 (2021/22)
Finance Report
5 Year Priority – Efficient Use of Resources

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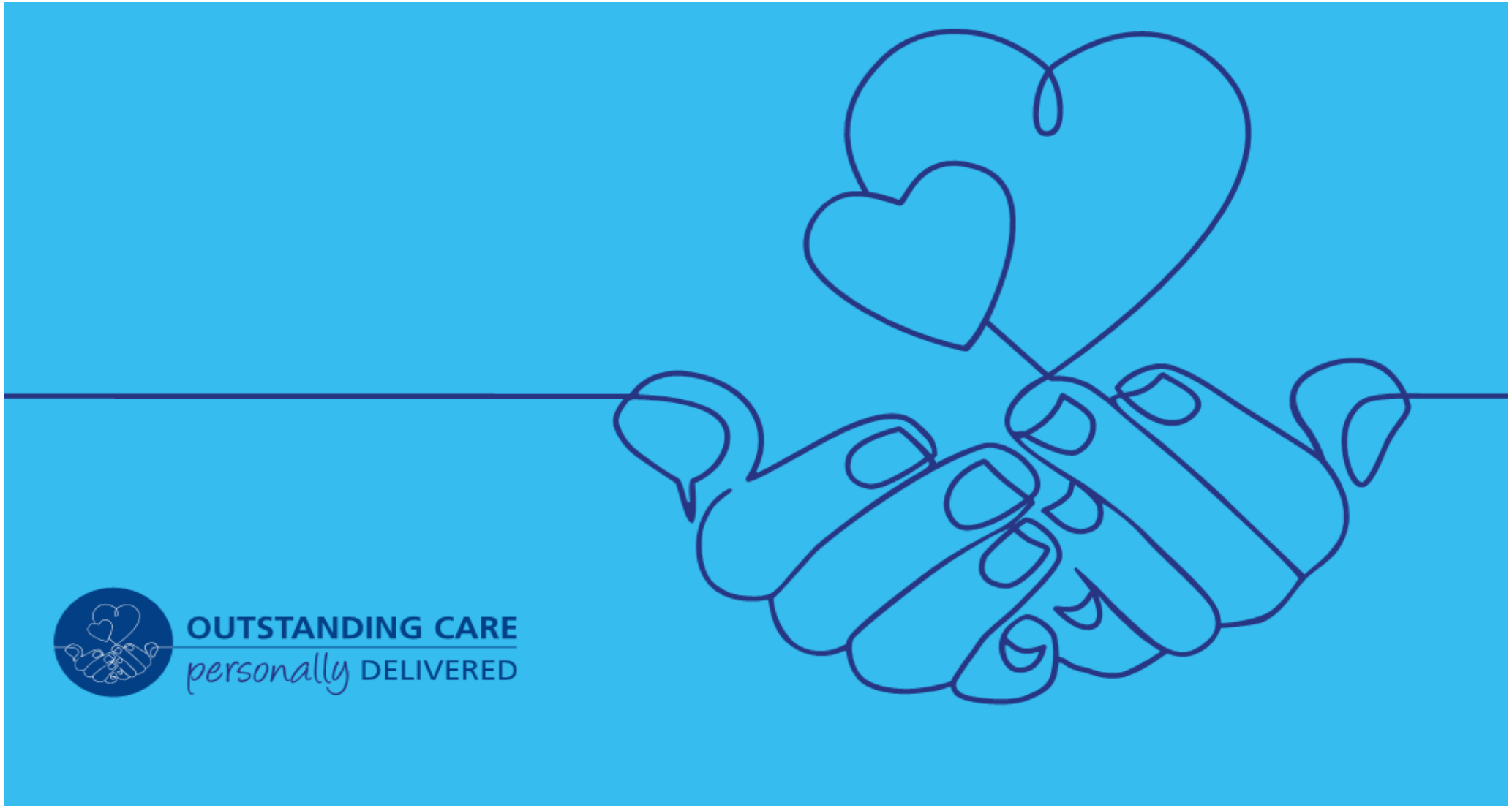
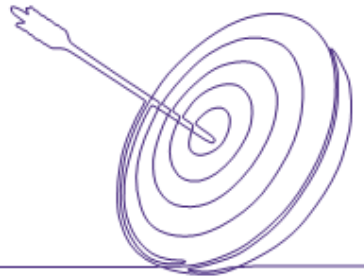


Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)

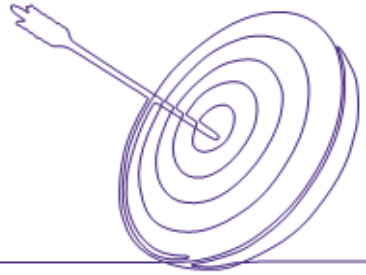


United Lincolnshire Hospitals NHS Trust

	Current Month			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	50,891	50,891	0	354,632	357,558	2,926
Other operating income	3,120	3,120	0	18,500	19,527	1,027
Employee expenses	(36,657)	(36,657)	0	(243,478)	(250,775)	(7,297)
Operating expenses excluding employee expenses	(17,471)	(17,471)	0	(124,201)	(121,261)	2,940
Net Finance Costs	(640)	(640)	0	(4,447)	(4,447)	(0)
Other gains/(losses) including disposal of assets	20	20	0	20	123	103
Surplus/(Deficit) For The Period/Year	(737)	(737)	0	1,027	725	(302)
Remove capital donations/grants I&E impact	56	56	0	92	394	302
Adjusted financial performance surplus/(deficit)	**(681)**	**(681)**	**0**	**1,119**	**1,119**	**0**

- The Trust delivered its planned £1.8m surplus in H1.
- At the time of writing, the national financial planning process for H2 is not yet complete, and the Lincolnshire system has not agreed nor submitted its financial plan for H2. **The reported current month position is therefore based upon the plan being equal to actual**. It is therefore not possible to include financial bridges for Month 7, but they will be included for Month 8.
- The above table shows that the Trust delivered a deficit of £0.7m in Month 7 and a surplus of £1.1m YTD. The current month position is based upon block income from Lincolnshire CCG in line with the cash payment received; once the Lincolnshire system has agreed its financial plan, any positive difference between the block payment made in October and the final amount agreed will be posted to I&E in month – with the expectation that this will improve the YTD position.

Finance Spotlight Report (Key areas of focus - Income)



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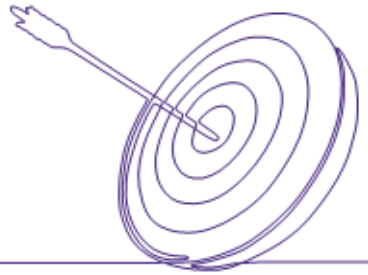
- Given the Income plan in October is based upon the actual income received, the overall YTD Income position remains £4.0m favourable to plan as at the end of H1:
  - **£4.2m adverse movement re ERF** – This movement reflects lower than planned achievement of ERF income in H1; the financial plan for H1 assumed ERF income of £7.6m and that £3.4m of this would be brokered to the CCG, but given the Trust only achieved £3.4m of ERF income this brokerage was not possible.
  - **£4.5m favourable movement re Pay award** - As per national guidance, the Trust accrued income in Month 6 from our Lead Commissioner to match the cost of the pay award paid for A4C and medical staff in September; the block payment received in October included the centre's estimate of the cost of the pay award.
  - **£2.6m favourable movement re other Patient Care Income** – This movement comprises £1.8m re pass through income, £0.4m one-off benefit re prior year pass through income, £0.3m re additional block funding allocations not known at the time of plan submission, and £0.1m over performance on other variable income streams such as CRU and Private Patients.
  - **£1.0m favourable movement re Other Operating Income** – made up of £0.4m of additional top up funding (in relation to Covid), and £0.6m in relation to variable income streams such as non patient care recharges, car parking income and catering income.
- Shadow monitoring of activity on a Tariff basis determined that actual activity of £34.4m was delivered in the current month.

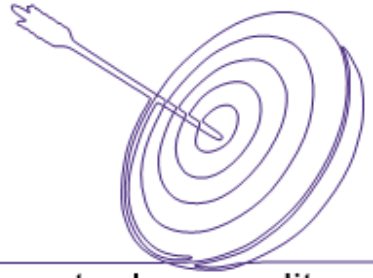
Finance Spotlight Report (Key areas of focus - Pay)



NHS
United Lincolnshire Hospitals
NHS Trust

- **Given the expenditure plan in October is based upon the actual expenditure incurred, the overall YTD Pay position remains £7.3m adverse to plan as at the end of H1**:
    - **£4.5m adverse movement re pay award** – As per national planning guidance, the H1 plan excluded the impact of the pay award for A4C and medical staff, such that the actual costs incurred in September of £4.5m gave rise to an adverse Pay movement of £4.5m in H1; as per national guidance, this adverse Pay movement was offset in the I&E position by an additional income accrual of £4.5m.
    - **£1.8m adverse movement re Pay CIP delivery** – Recurrent Pay savings delivery in H1 was £2.4m lower than planned, but non recurrent Pay savings of £0.6m reduced CIP slippage to £1.8m.
    - **£1.1m adverse movement re Restore and Covid** – The additional costs of Covid in H1 (including the cost of bank incentive rates) were £2.0m higher than planned; this pressure was mitigated in part by £0.9m lower than planned costs in relation to Restore.
    - **Other adverse movements have been offset within the position** – Other adverse movements of £1.0m have been mitigated by other upsides; these pressures include £0.6m re investment (beds), £0.2m re prior year commitments, and £0.2m re expenditure offset by top up funding e.g. Covid vaccination programme.
- **Excluding the pay award arrears paid in September, overall Pay in October was £1.0m higher than in September**; this increase included £0.1m re substantive Pay, £0.5m re Bank Pay & £0.4m re Agency Pay.
- The £0.5m increase in Bank Pay expenditure in October is driven by an increase of £0.4m on Nursing, Midwifery & Health Visitors, and £0.1m on Other Support Staff.
- The £0.4m increase in Agency Pay expenditure is driven by an increase of £0.2m on Housekeeping and £0.1m on Medical & Dental. Against the IIP priority to reduce Agency expenditure by 25% (or £11m) compared to 2019/20, the Trust's YTD Agency expenditure is £6.9m higher than the level required to meet this target.

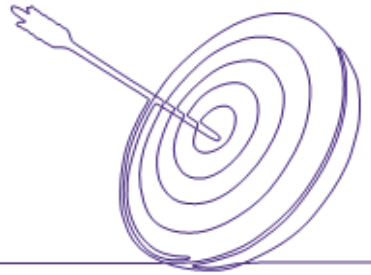
Finance Spotlight Report (Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

- Given the expenditure plan in October is based upon the actual expenditure incurred, the overall YTD Non Pay position remains £2.9m favourable to plan. However, actual expenditure is £0.8m higher than in September driven by a £1.2m reduction in technical savings & £0.5m increase in premises costs; pass through drugs expenditure reduced by £0.7m and general supplies and services reduced by £0.2m.
- In H1, while the Trust planned CIP savings of £6.4m and delivered £6.2m in relation to 2021/22 savings schemes, £5.2m of the savings made were non recurrent. The Trust's original plan required a further £9m of savings in H2, and against a plan in M7 of £1.5m the Trust delivered CIP savings of £0.4m.
- Capital funding levels for 2021/22 agreed through Trust Board & FPEC, showed a plan of c£33.7m; this increased to c£34.6m in M6 due to confirmation of Community Discharge Hub (CDH) funds of £0.9m.
- The capital plan submitted to NHSE/I has a year-to-date plan at M6 of c£14.9m. Spend incurred at M6 equated to c£7.3m, therefore schemes are behind plan by c£7.5m externally. A detailed capital forecast – agreed with all scheme leads - has created an 'Internal Plan' for monitoring purposes also and this shows that schemes are £0.9m behind plan. Please see separate capital report for details.
- The month end cash balance is £49.4m which is a reduction of £4.6m against cash at 31 March 2021.
- BPPC performance is 92% / 88% by value / volume of invoices paid for the seven months to October (appendix 5d). (In month performance 95%/ 88% by value / volume). Work has been undertaken and options identified for consideration to further improve performance. Drugs invoices received and processed through Pharmacy would appear to be the area where most significant improvement could be made – taking October alone, circa 50.3% of invoices passed through pharmacy, with performance in this area averaging 86% for the year to date. Options will be pursued through the Divisional FRM.

Finance Dashboard



United Lincolnshire Hospitals NHS Trust

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

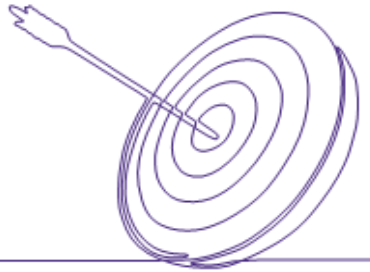
Clinical Services
People
Clinical Support Services
Corporate Services, Procurement, Estates and Facilities
Finance

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

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

Finance and use of resources rating	Full Year	Full Year	Full Year	Actual	Forecast
	31/03/2019	31/03/2020	31/03/2021	YTD OCT 2021	31/03/2022
Capital service cover metric	(10.40)	(1.73)	0.06	1.82	3.17
Capital service cover rating	4	4	4	2	1
Liquidity metric	(98.73)	(128.28)	3.71	3.61	2.63
Liquidity rating	4	4	1	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.30%	0.28%
I&E margin rating	4	4	2	2	2
Agency metric	77.00%	110.00%	113.00%	114.00%	114.00%
Agency rating	4	4	4	4	4
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.30%	0.00%
I&E margin: distance from financial plan - rating	4	1	n/a	1	1

Balance Sheet



United Lincolnshire Hospitals NHS Trust

	31 March 2021	31 October 2021	
		Plan	Actual
	£000	£000	£000
Intangible assets	4,600	3,541	3,513
Property, plant and equipment	247,119	256,612	248,233
Receivables	2,790	2,781	2,748
Total non-current assets	**254,509**	**262,934**	**254,494**
Inventories	6,510	6,728	6,839
Receivables	25,935	18,875	24,539
Cash and cash equivalents	54,042	36,771	49,431
Total current assets	**86,487**	**62,374**	**80,809**
Trade and other payables	(69,643)	(52,393)	(57,359)
Borrowings	(402)	(554)	(555)
Provisions	(2,056)	(2,178)	(2,206)
Other liabilities	(1,587)	(2,943)	(7,724)
Total current liabilities	**(73,688)**	**(58,068)**	**(67,844)**
Total assets less current liabilities	**267,308**	**267,240**	**267,459**
Borrowings	(3,624)	(4,231)	(3,471)
Provisions	(4,069)	(4,082)	(3,941)
Other liabilities	(12,075)	(11,781)	(11,782)
Total non-current liabilities	**(19,768)**	**(20,094)**	**(19,194)**
Total assets employed	**247,540**	**247,146**	**248,265**
Financed by			
Public dividend capital	677,570	677,570	677,570
Revaluation reserve	27,522	27,116	27,115
Other reserves	190	190	190
Income and expenditure reserve	(457,742)	(457,730)	(456,610)
Total taxpayers' equity	**247,540**	**247,146**	**248,265**

Note 1: The revised H1 financial plan submitted in May did not include a full monthly balance sheet and cashflow. The plan presented here, whilst not submitted, underpinned the actual submission.

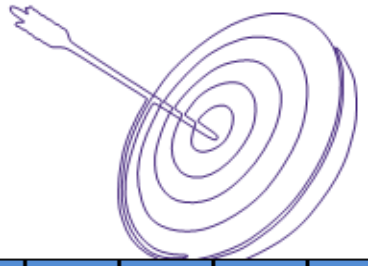
Note 2: Trade and other receivables continue to be supressed at pre-pandemic levels with the continuation of block contract payments now confirmed for the remainder of 2021/22. See Appendix 5a-b

Note 3: Cash balances remain significantly increased on 2019/20 levels. Whilst Trusts are no longer paid one month in advance, the continued block payment regime means cash balances remain high. Coupled with this the Trust received payments in March to cover future outgoings associated with accrued annual leave.

Note 4: Trade Payables (Appendix 5c) remain below pre-pandemic levels with the Trust continuing to pay suppliers well within the 30 day target. Staff related creditors are at higher levels than historically seen, with increases due to annual leave (£8.3m).
Capital creditors have dropped from March (£13.0m) and are now at £2.5m.
BPPC for October was 95% / 88% as measured by value / volume of invoices paid. See Appendix 5d

Note 5: The in month increase in 'Other Current Liabilities' of £4.2m is temporary, resulting from the early invoicing / deferral of Nov - Jan SIFT and Madel income.

Receipts & Payments – April 2021 - March 2022



NHS United Lincolnshire Hospitals NHS Trust

	Apr-21 £m	May-21 £m	Jun-21 £m	Jul-21 £m	Aug-21 £m	Sep-21 £m	Oct-21 £m	Nov-21 £m	Dec-21 £m	Jan-22 £m	Feb-22 £m	Mar-22 £m
Cash at Bank b'f	**54.0**	**50.5**	**53.1**	**44.0**	**47.8**	**52.4**	**46.2**	**49.4**	**47.3**	**41.6**	**42.2**	**46.5**
NHS England	6.4	6.5	6.5	8.0	6.8	8.3	7.8	6.5	6.5	6.5	6.5	6.5
Clinical commissioning groups	42.0	43.6	42.6	42.6	42.6	42.7	51.1	42.1	42.1	42.1	42.1	42.0
Other Patient related income	0.2	0.3	0.7	0.7	0.4	0.2	0.4	0.4	0.4	0.4	0.4	0.4
Patient related Income	**48.6**	**50.5**	**49.9**	**51.3**	**49.8**	**51.1**	**59.3**	**48.9**	**48.9**	**48.9**	**48.9**	**48.8**
Non-pat care services to other Govt bodies	1.1	0.8	1.2	(0.0)	0.8	0.2	0.3	1.0	1.0	1.0	1.0	1.0
Education & Training	8.4	-	0.1	4.4	0.0	0.1	0.0	1.4	1.4	1.4	1.4	1.4
Research & Development	0.0	0.0	0.2	0.2	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1
Pay Recharges	0.4	0.1	0.3	0.2	0.2	0.3	0.4	0.4	0.4	0.4	0.4	0.4
Leasing Income	0.0	0.2	0.3	0.1	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1
Other Income	0.4	0.6	0.6	0.3	5.1	0.4	0.5	0.7	0.7	0.7	0.7	0.7
Other Operating Income	**10.4**	**1.7**	**2.7**	**5.2**	**6.3**	**1.1**	**1.3**	**3.7**	**3.7**	**3.7**	**3.7**	**3.7**
Income Total	**59.0**	**52.2**	**52.5**	**56.5**	**56.1**	**52.2**	**60.6**	**52.6**	**52.6**	**52.6**	**52.6**	**52.5**
Payroll: Weekly / Monthly	(18.1)	(17.5)	(17.7)	(17.7)	(17.8)	(21.0)	(18.5)	(18.2)	(18.2)	(18.2)	(18.2)	(18.2)
Payroll: Tax / NI	(8.2)	(8.2)	(8.1)	(8.4)	(8.0)	(8.0)	(5.2)	(8.3)	(8.3)	(8.3)	(8.3)	(8.3)
Payroll: Pensions	(4.6)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)	(5.5)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)
Agency	(7.2)	(2.7)	(5.3)	(4.7)	(3.3)	(4.1)	(4.4)	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)
Non Pay: NHSLA	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	-	-
Non Pay Other	(17.4)	(10.8)	(21.8)	(15.1)	(16.4)	(13.4)	(20.4)	(16.5)	(16.5)	(16.5)	(16.4)	(16.4)
Non Pay - VAT Reclaim	1.3	-	0.8	1.5	3.0	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Operating Expenses Total	**(56.5)**	**(46.2)**	**(59.1)**	**(51.4)**	**(49.5)**	**(52.8)**	**(55.7)**	**(52.7)**	**(52.8)**	**(52.8)**	**(50.3)**	**(50.3)**
PDC dividends payable/refundable	-	-	-	-	-	(3.1)	-	-	-	-	-	(3.8)
Finance Costs Total	**-**	**-**	**-**	**-**	**-**	**(3.1)**	**-**	**-**	**-**	**-**	**-**	**(3.8)**
Revenue Cash movement in Month	**2.4**	**5.9**	**(6.5)**	**5.1**	**6.6**	**(3.7)**	**4.8**	**(0.1)**	**(0.1)**	**(0.1)**	**2.3**	**(1.6)**
Capital cash spent: Internally Funded	(5.9)	(3.2)	(2.5)	(1.1)	(1.0)	(2.0)	(0.2)	(0.7)	(0.1)	(0.2)	(0.3)	(0.9)
Capital cash spent: PDC Funded	(0.0)	(0.0)	(0.1)	(0.3)	(1.0)	(0.5)	(1.5)	(1.4)	(5.3)	(4.1)	(2.8)	(2.3)
Capital PDC received	-	-	-	-	-	-	-	-	-	5.0	5.0	9.2
Total External Financing & Capital	**(5.9)**	**(3.2)**	**(2.6)**	**(1.3)**	**(1.9)**	**(2.5)**	**(1.7)**	**(2.0)**	**(5.5)**	**0.7**	**1.9**	**6.1**
TOTAL CASH AT BANK c'f	**50.5**	**53.1**	**44.0**	**47.8**	**52.4**	**46.2**	**49.4**	**47.3**	**41.6**	**42.2**	**46.5**	**51.0**

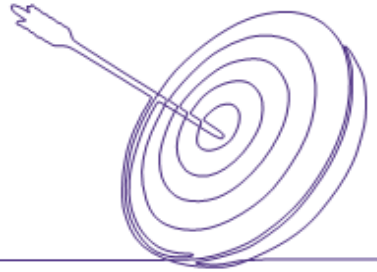
Note 1: Cash balances remain significantly increased on 2019/20 levels. Whilst Trusts are no longer paid one month in advance, the continued block payment regime means cash balances remain high. Coupled with this the Trust received payments in March to cover future outgoings associated with accrued annual leave.
Future projections assume a breakeven I&E position for the remainder of 2021/22.

Note 2: The cash position has remained relatively steady since March, the exceptions being a reduction in both capital creditors (£13.1m to £2.7m) and trade creditors (£16.5m to £9.3m). See Appendix 5c

Note 3: During October the Trust received payment of H1 ERF monies (£3.4m) and Pay Award funding (£4.5m) from CCGs.

Note 4: Taking into account the capital underspend from 2020/21, capital creditors and internally generated depreciation, £6.9m of the cash held relates to capital.

Cashflow reconciliation– April - Oct 2021



United Lincolnshire Hospitals NHS Trust

	Full Year 2020/21	31 October 2021	
		Plan	Actual
	£000	£000	£000
Operating surplus / (deficit)	8,778	4,062	5,049
Depreciation and amortisation	13,674	9,104	8,704
Impairments and reversals	3,121	-	-
Income recognised in respect of capital donations	(3,923)	(350)	-
Amortisation of PFI deferred credit	(503)	(294)	(293)
(Increase) / decrease in receivables and other assets	16,119	7,069	1,439
(Increase) / decrease in inventories	527	(218)	(329)
Increase/(decrease) in trade and other payables	16,987	(8,721)	(3,082)
Increase/(decrease) in other liabilities	(2,085)	1,356	6,137
Increase / (decrease) in provisions	1,556	164	50
Net cash flows from / (used in) operating activities	**54,251**	**12,171**	**17,675**
Interest received	12	-	-
Purchase of intangible assets	(1,245)	-	-
Purchase of property, plant and equipment	(39,483)	(26,367)	(19,297)
Proceeds from sales of property, plant and equipment	625	-	129
Net cash flows from / (used in) investing activities	(40,091)	(26,367)	(19,168)
Public dividend capital received	409,664	-	-
Loans from Department of Health and Social Care - repaid	(377,859)	-	-
Other loans received	2,544	760	-
Interest paid	(2,522)	-	(1)
PDC dividend (paid)/refunded	(5,662)	(3,836)	(3,117)
Net cash flows from / (used in) financing activities	26,165	(3,076)	(3,118)
Increase /(decrease) in cash and cash equivalents	**40,325**	**(17,271)**	**(4,611)**
Cash and cash equivalents at 1 April - brought forward	13,717	54,042	54,042
Cash and cash equivalents at period end	**54,042**	**36,771**	**49,431**

Note 1: The Cashflow reconciliation presents the same information as the preceding Receipts and Payments slide, but does so by analysing the various balance sheet classifications.

Note 2: Cash held at 31 October was £49.4m against a plan of £36.8m.

Note 3: The principle reason for the cash variance to plan of £12.7m is a shortfall of £7.1m against planned capital payments. This is linked to delays in the capital programme.

Note 4: The working capital position is in line with expectations with movements in payables / receivables broadly netting off. The exception to this being the increase in 'Other Liabilities' driven by the early invoicing and subsequent deferral of Nov 21 - Jan 22 Training Income (£4.2m)

Meeting	*Trust Board*
Date of Meeting	*7 December 2021*
Item Number	*Item 13.1*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Matt Hulley, Risk & Incident Manager*
Report previously considered at	*N/A*

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

Risk Assessment	*Multiple – please see report*
Financial Impact Assessment	*None*
Quality Impact Assessment	*None*
Equality Impact Assessment	*None*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	*Trust Board is invited to review the report and identify any areas of strategic risk requiring further action*

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks currently being managed within the Trust.
- Key risk indicators for all Very high risks (those rated 20-25) have been updated with available data, as evidence of the current extent of risk exposure
- The risk levels around timely provision of Non-Invasive Ventilation have been escalated due the disruption of the work surrounding the improvement plan. However, this risk is currently under review as part of the Risk Register reconfiguration work as the mitigation actions are now in place to reduce the risk rating from very high. The NIV group will be asked to review the risk at the next meeting and upwardly report to PSG on this particular matter.
- Of note 52% of all strategic risks are overdue their review. This is being addressed as part of the ongoing roll out and review of the Risk Register reconfiguration.
- In addition to the scheduled review, risks are also discussed at the Gold meetings and relevant cells daily during this ongoing period of increased pressure.

Purpose

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

- Review the management of significant strategic risks.
- Evaluate the effectiveness of the Trust's risk management processes.

1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. They are comprised of two distinct layers, which are defined in the Trust's current Risk Management Strategy as:

- Strategic risk register – used to manage significant risks to the achievement of Trust-wide or multi-divisional objectives.
- Operational risk registers – used to manage significant risks to the objectives of divisional business units and their departments or specialties.

1.2 This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). A summary of the full strategic risk register is also provided for reference. Of note 52% of all strategic risks are now overdue their review date. This is being addressed as part of the ongoing roll out and review of the Risk Register reconfiguration.

1.3 In addition to the scheduled review, risks are also discussed at the Gold meetings and relevant cells daily during this period of increased pressure

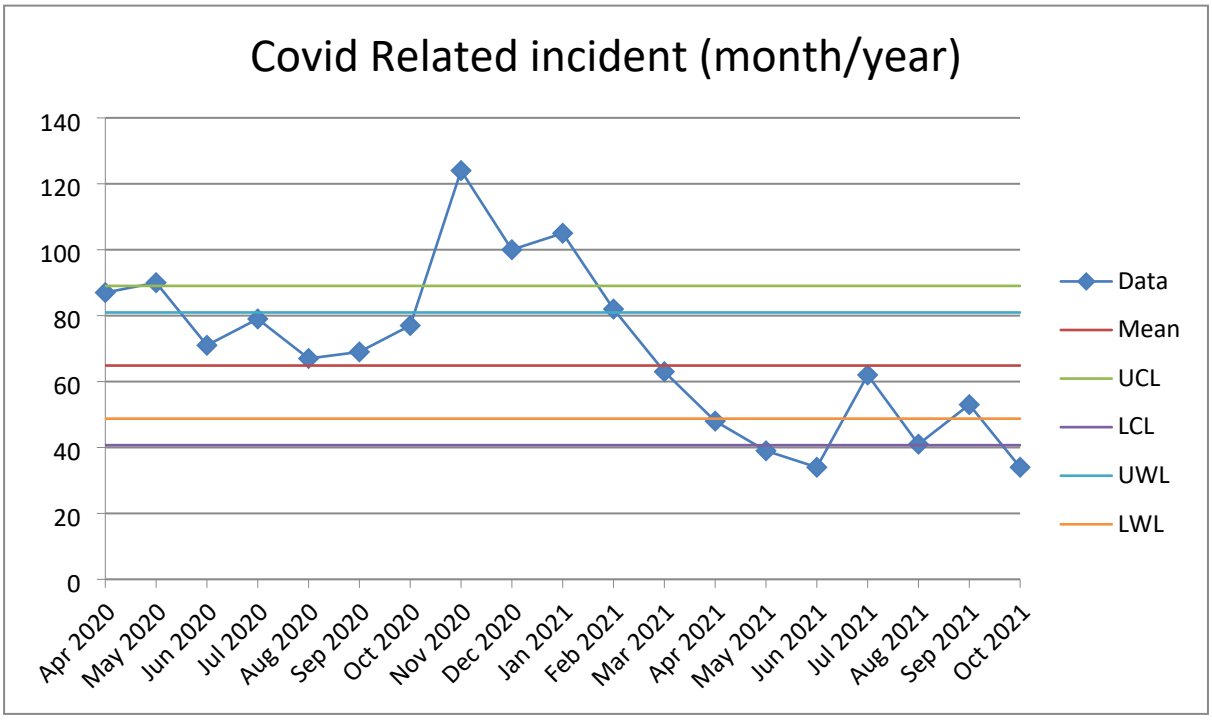
2. Strategic Risk Profile

2.1 There are 2 strategic quality & safety risks with a current rating of Very high risk:

Risk title (ID)	Local impact of the global coronavirus (Covid-19) pandemic (4558)		
Current risk rating	Very high (25)	**Risk lead**	Natalie Vaughan
Lead group	Infection Prevention & Control Group		

Key Risk Indicators (KRIs):

- Total number of Covid-19 inpatient admissions – as of 5th November 2021 there had been 3,768 Covid-19 inpatient cases within ULHT; this is an increase of 113 since the 22 October.
- Number of current inpatient admissions due to Covid-19 – 37 at Lincoln and 41 at Pilgrim as of 5th November 2021; an increase from 28 inpatients at the 22 October2021.
- Patient deaths due to Covid-19 – total of 928 as of 5th November 2021 compared with 916 as of 22 October2021.
- Covid-related incidents – between March 2020 and October 2021 there were 1325 incidents that cited the pandemic response as a factor.



Gaps in control & mitigating actions:

- ULHT continues to manage demand and resources in line with the national pandemic strategy.
- The trust has taken the decision to move patient visiting to a risk based system according to Salus principles all visiting to across all sites from 11th August in an attempt to protect staff and patients
- Incentives have been implemented to tackle staffing short falls in clinical areas with non-clinical staff now being redeployed to support clinical areas, as well as non-clinical work being reviewed to prioritise clinical care.
- Essential information to all staff continues and is provided through the ULHT Bulletin

Risk title (ID)	Timely provision of Non-Invasive Ventilation (NIV) (4041)		
Current risk rating	Very high (20)	**Risk lead**	Donna Gibbins
Lead group	Patient Safety Group		

Key Risk Indicators (KRIs):

- Completion of the NIV Pathway project as part of the Respiratory Improvement Plan
- Incidents involving NIV related care are now being addressed by the ULH NIV Group
- Findings from this group will be fed back into the risk register as assurance and reported in this risk report going forward.

Gaps in control & mitigating actions:

- Evidence of ongoing incidents and concerns around the recognition of Type 2 Respiratory Failure, which then impacts onto the timely commencement of NIV therapy in accordance with national standards.

This risk is currently under review as part of the Risk Register reconfiguration work as the mitigation actions are now in place to reduce the risk rating from very high. The NIV group will be asked to review the risk at the next meeting in December alongside incident reporting and upwardly report to PSG on this particular matter.

2.2 There is 1 strategic finance, performance or estates risk with a current rating of Very high risk:

Risk title (ID)	Capacity to manage emergency demand (4175)		
Current risk rating	Very high (25)	**Risk lead**	Simon Evans
Lead group	Trust Gold Recovery and Restoration Meetings. Emergency Care Clinical Standards Forum. Divisional Performance Review Meetings (PRMs)		

Key Risk Indicators (KRIs):

- The A&E 12hour Trolley wait standard continues to be breached This standard often does not fully describe the overall levels of overcrowding in Emergency Departments that occurs when this standard is breached.
- Over the same period July 7th to date the Trust has escalated its emergency status to Level 4 the highest level of response on a number of occasions. This also includes enacting the Critical Incident STANDBY emergency preparedness response as a result of loss of safe access to emergency department services through overcrowding.
- A&E waiting times against the constitutional standard – 4-hour performance for October was 64.04%, an improvement on the previous monthmonth by 1.91%. The Trust is consistently failing this target.
- Ambulance conveyances delayed by over 59 minutes for October were 733. A decrease of 190 compared to last month.

KPI	In Month Target	August	September	October	YTD	Last month Pass/Fail	Trend Variation
A&E waiting times	83.12%	66.96%	62.13%	64.04%	67.94%		
Ambulance Conveyances Delayed >59 minutes	0	629	923	733	528		

Gaps in control & mitigating actions:

- The trust has met with NHSEi regional executive team to review gaps and mitigations on two occasions the latest 19th July 2021.
- It is recognised that across the region the combination of pressure to recover backlogs, increased urgent care admissions above expected levels, increased Covid presentations (although below Wave 1 and 2) coupled with workforce availability issues have created a particularly challenging environment for acute trusts to operate safely in.
- Improvement measures and the U&EC improvement plan whilst will help alleviate some pressures currently do not fully address the combined issues of demand vs capacity and workforce availability.
- In Wave 1 and Wave 2 of the Covid-19 response the Trust identified a Risk Score of 25 for Covid-19 pandemic impact. Although many of the elements of this risk are the same as those described in the Covid-19 score 25 risk, this risk Capacity to manage emergency demand (4175) more accurately describes the main risk the Trust is experiencing.
- Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super-stranded patients
- Lincoln site reconfiguration plans & business case for investment on Pilgrim site (with government funding)

- The U&EC improvement programme has undertaken an internal review of process, key stakeholders and original milestones where off track clear rectification plans are now in place
- Partnership working within the system will support a more proactive response and delivery to system need. U&EC Partnership Board currently leads the system response to the risk described.
- Harm reviews are being carried out for all patients affected by waiting more than 12 hours in A&E following a decision to admit and ambulance handover delays of more than 2 hours

2.3 There is 1 strategic people & organisational development risks with a current rating of Very high risk:

Risk title (ID)	Workforce engagement, morale & productivity (4083)		
Current risk rating	Very high (20)	**Executive lead**	Paul Matthew, Director of Finance
Lead group	Workforce Strategy Group		

KPI	In Month Target (%)	Jul 21 (%)	Aug 21 (%)	Sept (%)	Oct (%)	YTD (%)	Last month Pass/Fail	Trend Variation
Staff Appraisal Rates	90	67.95	62.79	56.84	52.09	70.86		

- People Pulse survey results – almost 900 staff completed the first survey (in July 2020), a response rate of around 12%; 85% of staff felt informed (+0.6 vs NHS overall); 63% felt confident in local leaders (equal to NHS overall); 61% felt supported (-5.7 vs NHS overall); 59% felt they had a good work-life balance (-2.5 vs NHS overall).
- NHS National Staff Survey (NSS) results – some improvement in results of 2019 staff survey across two thirds of the questions, still below average for acute trusts; less than 50% of staff would recommend ULHT as a place to work; the Trust's score for the bullying & harassment theme in the NSS stayed relatively unchanged in 2019 at 7.6 against a national average of 7.9.

Gaps in control and mitigating actions:

- Work on morale continues to be part of the Integrated Improvement Plan, individual performance management/appraisal e-learning programme the new WorkPal online appraisal system, have been implemented.
- New approaches to interacting with staff during Covid response; feedback has been positive and was reflected in results from the NHS Pulse Survey

2.5 A summary of all current strategic risks is included as **Appendix 1**.

3. Conclusions & recommendations

3.1 The highest priority risks at present continue to relate to the Capacity to manage emergency demand and the Covid-19 pandemic due tothe potential impact on patients; staff; visitors and the continued provision of a full range of clinical services. There remains considerable uncertainty as to the future course of the pandemic and the risk posed to the Trust.

3.2 The Trust Board is invited to review the report and advise of any further action required at this time to improve the management of strategic risks or to strengthen the Trust's risk management framework.

Appendix 1 - Summary of all risks recorded on the Strategic Risk Register:

ID	Title	Clinical Business Unit	Risk Type	Rating (current)	Risk level (current)	Review date
4175	Capacity to manage emergency demand	Urgent & Emergency Care CBU	Service disruption	25	Very high risk	13/09/2021
4558	Local impact of the global coronavirus (Covid-19) pandemic	Operations	Harm (physical or psychological)	25	Very high risk	31/12/2021
4041	Timely provision of Non-Invasive Ventilation (NIV)	Specialty Medicine CBU	Harm (physical or psychological)	20	Very high risk	30/06/2021
4083	Workforce engagement, morale & productivity	Human Resources & Organisation Development	Reputation / compliance	20	Very high risk	30/06/2021
4403	Compliance with electrical safety regulations & standards	Estates & Facilities	Reputation / compliance	16	High risk	31/03/2021
4404	Major fire safety incident	Estates & Facilities	Harm (physical or psychological)	16	High risk	31/12/2021
4480	Safe management of emergency demand	Urgent & Emergency Care CBU	Harm (physical or psychological)	16	High risk	31/12/2020
4383	Substantial unplanned expenditure or financial penalties	Finance & Digital	Finance	16	High risk	31/12/2021
4300	Availability of medical devices & equipment	Medical Directorate	Medical equipment	16	High risk	31/12/2021
4156	Safe management of medicines	Pharmacy CBU	Harm (physical or psychological)	16	High risk	30/09/2021
4144	Uncontrolled outbreak of serious infectious disease	Nursing Directorate	Patient safety (physical or psychological harm)	16	High risk	31/12/2021
4142	Delivery of harm free nursing care	Nursing Directorate	Patient safety (physical or psychological harm)	16	High risk	31/12/2021
4044	Compliance with information governance regulations & standards	Corporate Services	Reputation / compliance	16	High risk	30/06/2021
3690	Compliance with water safety regulations & standards	Estates & Facilities	Reputation / compliance	16	High risk	31/03/2021
3720	Critical failure of the electrical infrastructure	Estates & Facilities	Service disruption	16	High risk	31/12/2021
3688	Quality of the hospital environment	Estates & Facilities	Reputation / compliance	16	High risk	31/03/2021
4003	Major security incident	Estates & Facilities	Harm (physical or psychological)	16	High risk	31/03/2022

4593	Lincoln Mortuary Building	Path Links (Pathology)	Service disruption	16	High risk	16/06/2021
4556	Safe management of demand for outpatient appointments	Outpatients CBU	Harm (physical or psychological)	12	High risk	31/12/2021
4581	Heating (Trust Wide)	Estates & Facilities	Harm (physical or psychological)	12	High risk	31/03/2021
3520	Compliance with fire safety regulations & standards	Estates & Facilities	Reputation / compliance	12	High risk	31/12/2021
4081	Quality of patient experience	Nursing Directorate	Patient experience	12	High risk	31/12/2021
4082	Workforce planning process	Human Resources & Organisation Development	Service disruption	12	High risk	31/03/2021
3689	Compliance with asbestos management regulations & standards	Estates & Facilities	Reputation / compliance	12	High risk	31/03/2021
4043	Compliance with clinical governance regulations & standards	Nursing Directorate	Regulatory compliance & standards (including performance targets)	12	High risk	31/12/2021
4145	Compliance with safeguarding regulations & standards	Nursing Directorate	Regulatory compliance & standards (including performance targets)	12	High risk	31/03/2021
4146	Effectiveness of safeguarding practice	Nursing Directorate	Patient safety (physical or psychological harm)	12	High risk	31/03/2021
4157	Compliance with medicines management regulations & standards	Pharmacy CBU	Reputation / compliance	12	High risk	30/06/2021
4181	Significant breach of confidentiality	Corporate Services	Reputation / compliance	12	High risk	31/12/2020
4179	Major cyber security attack	Finance & Digital	Information Governance: Data confidentiality & integrity	12	High risk	31/12/2021
4176	Management of demand for planned care		Service disruption	12	High risk	31/12/2020
4362	Workforce capacity & capability (recruitment, retention & skills)	Human Resources & Organisation Development	Service disruption	12	High risk	30/06/2021
4481	Availability & integrity of patient information	Finance & Digital	Service disruption	12	High risk	31/01/2022
4401	Safety of the hospital environment	Estates & Facilities	Harm (physical or psychological)	12	High risk	31/03/2021

4402	Compliance with regulations and standards for mechanical infrastructure	Estates & Facilities	Reputation / compliance	12	High risk	31/03/2021
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Pharmacy CBU	Service disruption	12	High risk	30/09/2021
4406	Critical failure of the medicines supply chain	Pharmacy CBU	Service disruption	12	High risk	31/12/2021
4423	Working in partnership with the wider healthcare system	Improvement & Integration Directorate	Service disruption	12	High risk	31/12/2020
4437	Critical failure of the water supply	Estates & Facilities	Service disruption	12	High risk	31/12/2021
4497	Contamination of aseptic products	Pharmacy CBU	Harm (physical or psychological)	10	Moderate risk	30/06/2021
4384	Substantial unplanned income reduction or missed opportunities	Finance & Digital	Finance	8	Moderate risk	31/12/2021
4441	Compliance with radiation protection regulations & standards	Diagnostics CBU	Reputation / compliance	8	Moderate risk	31/03/2022
4389	Compliance with corporate governance regulations & standards	Chief Executive	Reputation / compliance	8	Moderate risk	31/12/2020
4397	Exposure to asbestos	Estates & Facilities	Harm (physical or psychological)	8	Moderate risk	31/03/2021
4398	Compliance with environmental and energy management regulations & standards	Estates & Facilities	Reputation / compliance	8	Moderate risk	31/03/2021
4399	Compliance with health & safety regulations & standards	Estates & Facilities	Reputation / compliance	8	Moderate risk	30/09/2021
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Human Resources & Organisation Development	Reputation / compliance	8	Moderate risk	31/03/2021
4352	Public consultation & engagement	Chief Executive	Reputation / compliance	8	Moderate risk	31/12/2020
4353	Safe use of medical devices & equipment	Medical Directorate	Patient safety (physical or psychological harm)	8	Moderate risk	31/12/2021
4363	Compliance with HR regulations & standards	Human Resources & Organisation Development	Reputation / compliance	8	Moderate risk	31/03/2021
4368	Efficient and effective management of demand for outpatient appointments	Outpatients CBU	Reputation / compliance	8	Moderate risk	30/09/2021

4382	Delivery of the Financial Recovery Programme	Finance & Digital	Finance	8	Moderate risk	31/12/2020
4182	Compliance with ICT regulations & standards	Finance & Digital	Reputation / compliance	8	Moderate risk	20/12/2021
4177	Critical ICT infrastructure failure	Finance & Digital	Service disruption	8	Moderate risk	31/12/2021
4180	Reduction in data quality	Finance & Digital	Reputation / compliance	8	Moderate risk	31/12/2020
4138	Patient mortality rates	Medical Directorate	Reputation / compliance	8	Moderate risk	31/12/2021
4141	Compliance with infection prevention & control regulations & standards	Nursing Directorate	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2021
4143	Nursing profession staffing levels	Nursing Directorate	Workforce (including capacity & capability, engagement & morale, health & well-being etc.)	8	Moderate risk	31/12/2021
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Children & Young Persons CBU	Patient safety (physical or psychological harm)	8	Moderate risk	01/11/2021
3687	Implementation of an Estates Strategy aligned to clinical services	Estates & Facilities	Service disruption	8	Moderate risk	31/03/2021
3721	Critical failure of the mechanical infrastructure	Estates & Facilities	Service disruption	8	Moderate risk	31/12/2021
3722	Energy performance and sustainability	Estates & Facilities	Finance	8	Moderate risk	31/03/2021
3951	Compliance with regulations & standards for aseptic pharmacy services	Pharmacy CBU	Reputation / compliance	8	Moderate risk	30/09/2021
4579	Delivery of the new Medical Education Centre	Improvement & Integration Directorate	Reputation / compliance	8	Moderate risk	31/12/2020
4486	Clinical outcomes for patients	Medical Directorate	Harm (physical or psychological)	8	Moderate risk	31/12/2021
4502	Compliance with regulations & standards for medical device management	Medical Directorate	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2021
4526	Internal corporate communications	Chief Executive	Reputation / compliance	8	Moderate risk	31/12/2020

4528	Minor fire safety incident	Estates & Facilities	Harm (physical or psychological)	8	Moderate risk	31/12/2021
4553	Failure to appropriately manage land and property	Estates & Facilities	Finance	8	Moderate risk	31/03/2021
4400	Safety of working practices	Estates & Facilities	Harm (physical or psychological)	6	Low risk	30/09/2021
4061	Financial loss due to fraud	Finance & Digital	Finance	4	Low risk	31/12/2021
4277	Adverse media or social media coverage	Chief Executive	Reputation / compliance	4	Low risk	31/12/2020
4385	Compliance with financial regulations, standards & contractual obligations	Finance & Digital	Reputation / compliance	4	Low risk	31/12/2021
4386	Critical failure of a contracted service	Finance & Digital	Service disruption	4	Low risk	31/12/2021
4387	Critical supply chain failure	Finance & Digital	Service disruption	4	Low risk	31/12/2021
4388	Compliance with procurement regulations & standards	Finance & Digital	Reputation / compliance	4	Low risk	31/12/2020
4438	Severe weather or climatic event	Corporate Services	Service disruption	4	Low risk	31/12/2021
4439	Industrial action	Corporate Services	Service disruption	4	Low risk	31/12/2021
4440	Compliance with emergency planning regulations & standards	Corporate Services	Reputation / compliance	4	Low risk	31/12/2021
4469	Compliance with blood safety & quality regulations & standards	Cancer Services CBU	Regulatory compliance & standards (including performance targets)	4	Low risk	31/12/2021
4482	Safe use of blood and blood products	Cancer Services CBU	Patient safety (physical or psychological harm)	4	Low risk	31/12/2021
4483	Safe use of radiation (Trust-wide)	Diagnostics CBU	Harm (physical or psychological)	4	Low risk	31/03/2022
4567	Working Safely during the COVID -19 pandemic (HM Government Guidance)	Estates & Facilities	Reputation / compliance	4	Low risk	05/01/2022

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7 December 2021*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2021/22	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

Risk Assessment	*Objectives within BAF referenced to Risk Register*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure*

Executive Summary

The relevant objectives of the 2021/22 BAF were presented to all Committees during November and the Board are asked to note the updates provided within the BAF.

The Board are asked to note and consider the changes made to the assurance ratings by all Committees during November.

As a result of the considerations of the People and Organisational Development Committee the assurance ratings for objective 2a has been changed to being rated red from amber. This reflects the current position of the Committee and the developments underway to improve the provision of controls and assurance to the Committee and upwardly to the Board.

The Quality Governance Committee, upon receipt of further assurances, undertook a review of objectives 1b and 1c resulting in these being rated amber from red as there were clear controls in place offering an improved level of assurance to the Committee.

The Finance, Performance and Estates Committee, having also received further assurances, undertook a review of the objectives noting that objective 3a and 3b were now considered to have effective controls in place to enable these to be rated as amber.

The changes made to the assurance ratings through the Committees have been detailed in the table below.

The following assurance ratings have been identified:

Objective		**Rating at start of 2021/20**	**Previous month (October)**	**Assurance Rating (November)**
1a	Deliver harm free care	**R**	**A**	**A**
1b	Improve patient experience	**R**	**R**	**A**
1c	Improve clinical outcomes	**R**	**R**	**A**
2a	A modern and progressive workforce	**A**	**A**	**R**
2b	Making ULHT the best place to work	**R**	**R**	**R**
2c	Well led services	**A**	**A**	**A**
3a	A modern, clean and fit for purpose environment	**R**	**R**	**A**

3b	Efficient use of resources	G	R	A
3c	Enhanced data and digital capability	A	A	A
4a	Establish new evidence based models of care	R	A	A
4b	To become a University Hospitals Teaching Trust	R	R	R

Board Assurance Framework (BAF) 2021/22 - November 2021

Strategic Objective	Board Committee
Patients: To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities	Quality Governance Committee
People: To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT	People and Organisational Development Committee
Services: To ensure that **services** are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee
Partners: To implement integrated models of care with our **partners** to improve Lincolnshire's health and well-being	Trust Board

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Group, lead & plan in place to support the delivery of an improved patient safety culture (PSG)	Human Factors training delayed due to Covid-19 Definition of Safety Culture Ambition Operational pressures have meant that meetings have not taken place.	External Safety Culture company engaged to deliver focus groups at all levels through the organisation and support development of safety culture ambition Online Human Factors training to commence December 2021 Bite size lunchtime teaching sessions - open offer to all staff Project lead continues to review project and complete highlight reports as appropriate.	Safety Culture Surveys Action plans from focus groups and Pascal survey findings Update reports to the Patient Safety Group and upwardly reported to QGC	Due to operational pressures culture surveys have not been taking place.	Where possible, safety conversations have been taking place with staff. "Safe to Say" Campaign focus groups have been contiuing		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	Operational pressures have meant that QGC meeting has been reduced.	All papers have been considered and discussed by exception. Assurances provided to QGC include feedback from gold and relevant cells as outlined below.	Upward reports from QGC sub-groups 6 month review of sub-group function				
						Effective sub-group structure and reporting to QGC in place	Due to operational pressures, not all sub-groups have met and others have had a reduced agenda.	All papers have either been discussed by exception or a chair/vice chaire upward report completed following review of the papers.	Sub-Group upward reports to QGC				
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamimnation-related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1a	Deliver Harm Free Care	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). Infection Prevention and Control BAF in place and reviewed monthly (IPCG)	Non-compliance with some aspects of the Hygiene Code.	Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC. IPC policies to be updated / developed / written in line with the timetable. •Recruited into Estates and Facilities/Decontamination Lead post commenced in post July 2021 • Good progress with achieving and sustaining standards of environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve compliance with new National Standards of Cleanliness directive. Task and Finish Group feeds into IPCG. Good progress • Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.	Quality Governance Committee	A
						Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) (PSG) reporting in to monthly mortality group and upwardly to PSG	Gaps in the number of structured judgement reviews undertaken Impact of Covid-19 on coding triangles	Training has been delivered to approximately 40 members of staff to undertake SJR's. Bespoke training and support offered from the Moratality team to the Divisons.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback	Due to national issues, Dr Foster data has not been available.	Local data sources are used where possible.		
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG)	Clinical harm review processes not all documented & aligned with incident reporting	Task and finish group in place to agree required changes to harm review processes and documentation Appointment of a Clinical Harm and Mortality Manager	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports	PSG currently do not receive assurance reports from the Divisions as their governance process reports to their PRM			
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust although progress is being made within CSS, Family Health and Surgery Divisions. Operational pressures is impacting on delivery in medicine.	Working Group set up and meeting as per the ToR, divisional representation; quarterly reporting to PSG Additional support provided to medicine from the Safety Culture Team.	Audit of compliance	Audit of compliance not currently in place	Review will occur through the Task & Finish group and reported upwards to PSG		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
			Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19			Medication safety Group in operation (Reduce medication errors) (Improving the safety of medicines management) (Review of Pharmacy model and service) (PSG)	Lack of e-prescribing leading to increase in patient safety incidents	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes	Upward Report of the: Medicines Quality Group	Medicines Quality Group have not been receiving reports regarding progress with the medicines roadmap.			
						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme.	Recent increase in incidents. Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations to be progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training will occur through MNOG.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						Appropriate policies and procedures in place to ensure medical device safety (PSG)	Lack of assurance regarding staff training on the medical devices	Implementation of a central database of medical device user training records					
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. (Ensuring early detection and treatment of deteriorating patients) (PSG)	Number of incidents occurring regarding lack of recognition of the deteriorating patient Maturity of some of the sub-groups of DPG not yet realised Observation policy has now been reviewed and is out for approval.	Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA Observation policy ready to go to next NMAAF	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas				
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	New funding needed to continue restraint training delivery. Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months. Further work has taken place with LPFT to consider a joint approach to training - awaiting options paper from LPFT	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting from Mental Health/ Learning Disability and Autism Oversight Group	NO active Restraint training available within the trust	Paper to CRIG (End November) regarding funding for new Restraint training proposal Datix being monitorred by safeguarding team to ensute review of any restraint incidents		
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate.	Gap in current policy identified meaning that not all responses from divisions are received / recorded.	Task and Finish Group set up to review processes and improve compliance. This has led to improvement in compliance, however further work still required. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team (CG)	Training provision for Divisional Clinical Governance Leads No formal job description of roles and responsibilities for Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads Draft role description for a Clinical Governance Lead developed for consultation.	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity Meeting stood down due to operational pressures.	The group meets monthly, has developed a work reporting plan Papers reviewed and Chair's report provided. Any risks to quality and safety are discussed at the relevant cell meeting, eg, quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.	Upward reports to QGC monthly and responds to feedback Review of ToR in July 2021 Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Divisional assurance reports to PEG providing limited assurance; further work needed to improve this. Will be monitored through PEG.	Head of Pt Experience revising divisional assurance report template and have discussions with divisional clinical leads re: requirements for the reports. Template approved through PEG Nov 21	Quality Governance Committee	R
						Patient Experience & Carer plan 2019-2023	Number of objectives in the plan paused due to Covid Pandemic; this means the plan need a full review.	Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level. Patient & Carers Experience Plan to be reviewed by end Sept 21 and present to Oct PEG	Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports.	Limited assurance until the plan is reviewed.	Plan is being reviewed with a draft final date of end of January 22.		
						Quality Accreditation and assurance programme which includes section on patient experience.	Lack of alignment of findings in accreditation data to patient experience plans. Ward / Dept review visits paused due to operational pressures	Head of pt experience to have access to accreditation data. Deep dives into areas of concern as identified in quality meetings and accreditation reports. Update reports to PEG and QGC as required. Matrons audits continue to take place. Any risks to quality and safety identified are discussed at the quality cell and issues escalated to gold as appropriate.	Reports to PEG and upwardly to QGC	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year. Pt Experience team to have sight of hotspots / concerns and can inreach to provide support.		
						Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging Sensory Loss group upwardly reports to Patient Panel.	Upward reports and minutes to the Patient Experience Group IIP reporting to Support & Challenge group.	Diversity of patient engagement and involvement.	CCG colleagues exploring development of a Health Inequalities cell to combine efforts in reaching out. Experts by Experience to be championed by Cancer Board. Breast Mastalgia expert patient group to be developed for pathway design.		
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information	Inconsistency in applying end of life visiting exceptions.	Swan resource boxes distributed to all areas Wedding boxes created for a number of key wards and within Chaplaincy services. Exceptions guidance re-issued. Monitor through complaints & PALs.	Report to PEG through cmplaints & PALs reports; upward reports from Visiting Review working group.	Visiting experience section within complaints & PALs reports.	Complaints/PALs reports to include visiting concerns; divisional assurance reports to include visiting related issues.		

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						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports not being received by PEG	Head of Pt Experience to discuss with EDI lead to agree a way forward.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic;	PLACE Lite continues & reports to PEG.		
1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Getting it Right First Time Programme in place with upward reports to CEG and QGC (CEG) Agreement in place recommencement of the of the GIRFT Programme		Quarterly reports to Clinical Effectiveness Group GIRFT project Manager in post	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feeback to divisions			Quality Governance Committee	R
						Clinical Effectiveness Group as a sub group of QGC and meets monthly (CEG)		September papers reviewed and upward report produced for QGC by the chair/vice chair. Any risks to quality and safety are discussed at the relevant cell meeting, eg, quality cell and issues escalated to gold as appropriate. Quality Impact Assessments	Effective upward reporting to QGC	None	None		
						Clinical Audit Group in place and meets monthly (CEG) with quarterly reports to QGC	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate		
						National and Local Audit programme in place and agreed (CEG) - signed off by QGC Improved reporting to CEG regarding outcomes from clinical audit			Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports	None	None		
						Process for monitoring the implementation of NICE guidance and national publications in place (CEG) and upwardly reported through QGC			Reports on compliance with NICE / Tas demonstrating improved compliance.	None	None		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)			Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to no reporting during COVID-19	National reports to be presented at Governance Meetings once produced		

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						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.					

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SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
2a	A modern and progressive workforce	Director of People and Organisational Development	Vacancy rates rises Turnover increases Sickness absence rises Under-investment in education & learning Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce	4362	CQC Safe CQC Responsive CQC Effective	NHS people plan & system people plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future	Awaiting sign off of system people plan		Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year			People and Organisational Development Committee	R
						Workforce planning and workforce plans	Overall vacancy rate declining but increasing for clinical roles.	IIP Project - Embed robust workforce planning and development of new roles	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division.	Some areas remain hard to fill and therefore difficult to fully mitigate risk. Challenges in obtaining meaningful information from Trac, due to Recruitment team capacity issues.	Regular reviews take place with Divisions through workforce analyses and a plan for every post; alternatives and workforce mix are considered and where national workforce shortages identified then focus is on overseas recruitment.		
						Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up Performance Dashboard developed offering accurate and timely information to all appropriate managers and staff				
						Focus on retention of staff - creating positive working environments	IIP project on hold	IIP Projects - appraisal, mandatory training, talent management National Talent Management Framework launched, Lincs system identified as pilot site for launch	Modern Employer targets Rates of appraisal/mandatory training compliance	Appraisal and training compliance levels not at expected level			
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff	Staff survey feedback				
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates	Various reports (Sitrep, Gold,STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	The reports are run daily and any abnormalities are considered in the context of the national and regional position. The pandemic and the critical incidents the Trust is in has impacted on usual trends. AMS data is reviewed regularly and reported into Divisions on accuracy. Data currently for absence is inline with national reporting.		

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						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation	IIP projects in early stage of delivery	IIP projects - education and learning Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year				
						NHS People Plan & System People Plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future	Awaiting sign off of system people plan Delivery of IIP projects in early stage of delivery	People Plan - in draft System EDI Strategy underway 5 pillar -leads confirmed (ULHT joint lead for Health and Wellbeing / Lead for leadership and lifelong learning)					
						Trust values & staff charter - Resetting our Culture & Leadership programme	Poor staff survey results in 2020 (although in pulse survey more positive)	Creation of Leading Together Forum Delivery Plan and actions to be confirmed further to results of Leadership Survey	Culture and Leadership Programme Group upward report	Report not offering assurance to Committee	Improved function of group and reporting to be in place for November report		

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work			People and Organisational Development Committee	R
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT)		Continue to implement new leadership programme e.g training on well-being conversations	Pulse surveys - " Have your say" Number of staff attending leadership courses		Proposal to be shared with ELT (Dec'21): gradual introduction of L&M activities NB. L&M apprenticeship on going		
						Perception of fairness and equity in the way staff are treated	EDI Group not functioning	IIP Project - Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation EDI Group to be reinstated	WRES/ WDES Data Internal Audit - Equality, Diversity and Inclusion EDI Group reporting	WRES/WDES Action plan insufficient to address concerns EDI Group not functioning	Currently developing WRES and WDES action plans and internal audit to deliver the first actions for the 31.12.21 WRES/WDES and Internal Audit actions being monitored through Committee		
						Staff networks	Some staff networks stronger than others	Continued work to embed the networks and provide them with effective support	Protect our staff from bullying, violence and harassment - measure through National Staff Survey				
						Demonstrate that we care and are concerned about staff health and wellbeing		Embed programme focused on staff wellbeing	Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan Engagement with System Wellbeing Hub System wide HWB Strategy underway Number of Schwartz rounds completed (once implemented)				
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian		Junior doctor forum	Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee				

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2c	Well led services	Chief Executive	Current risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes	Training delayed due to Covid-19	Corporate support offer made to divisions	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	A

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						Shared Decision making framework	Councils suspended due to Covid-19		Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6	Feedback tools to review progress/success		
						Implementing a robust policy management system		Review of document management processes New document management system - SharePoint Single process for polices	Numbers of in date policies	Movement on policies still not fast enough	Clinical and Corporate Policies and Guidelines now managed through single process by Trust Secretary Report to Audit Committee quarterly Report to ELT fortnightly		
						Ensure system alignment with improvement activity							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Interim case for £9.6M of CIR continues in to 2021/22. Will reflect priority areas in the Estates Stategy Capital Delivery Group has oversight of the delivery of key capital schemes.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee	Infrastructure case has tackled £9.6M of the overall £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP Delivery of 2021/22 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance.		
						Delivering environmental improvements in line with Estates Strategy	No approved Estates Strategy	Estates improvement forum and improvement team monitor progress through and has restarted now Covid has become endemic. Products of strategy	Compliance report and IIP Update		Update Compliance and IIP report detailing Estates Strategy delivery progress		
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID		PLACE assessments	PLACE Assessments have been reduced to PLACE/light in lieu of access and staffing restrictions during Covid.			

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID		MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not. The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill. Review of 6 Facet Surveys will commnece as part of HIP Bid (Referral in Estates Strategy)	Finance, Performance and Estates Committee	A
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	Health and Safety Committee has not run effectively for periods 20/21 without being quorate	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Offficer/Director of Estates and Facitilies. Upward reporting to Finance, Performace and Estates Committee	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report				
						Delivering £6.4m CIP programme in H1 21/22 and estimated full Year 21/22 CIP value of £15.4m.	Operational ownership and delivery of efficiency schemes	Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21. Request to all Divisions to provide detailed CIP recovery plans.	Delivery of revised CIP Achievement of both ULHT and STP financial Plan	Model Hospital Benchmarking/Reporting - paused due to COVID - reinstated from May 21 (update brought to FPEC in May)	Gaps are being reviewed monthly with Divisions through FRMs		
						Delivering financial plan aligned to the Trust and Lincolnshire STP financial plan / forecast for 2021/22	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		
			Efficiency schemes do not cover extent of savings required. Continued reliance on agency and locum staff and use of			Reduce agency spend by 25% from the 19/20 baseline as per IIP priority	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team	Delivery of the IIP 25% agency reduction target.	Granular detailed plan for every post plans.	Through the Medical and Nursing Workforce Transformation Groups and through FRMs upward into FPEC		

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3b	Efficient use of our resources	Director of Finance and Digital	and locum staff and use of enhanced bank rates to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure (as a result of unforeseen events and operational pressures in H2) National requirements and Trust response to Restoration and Recovery and third COVID wave.	4382 4383 4384	CQC Well Led CQC Use of Resources	Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q2	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust from Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources is part of the Trust 21/22 IIP	Finance, Performance and Estates Committee	A
						Implementing the CQC Use of Resources Report recommendations	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust from Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources Trust scoring is part of the Trust 21/22 IIP and performance is reported through PMO upward reports.		
						Working with system partners to deliver the Lincolnshire financial plan for H1 and H2 21/22.	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1 and H2	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		
						Detailed workforce and activity modelling aligned to resource requirements to support Trust and System Restoration.	Impact of Wave 3 and increasing acuity of NEL patients creating bed and staffing resource pressures to deliver restoration plan.	Trust Restoration plan and through Restoration and Recovery daily Trust meetings. Lincolnshire STP activity plan Lincolnshire STP collective management of restoration of planned care activity	Reporting against the Trust and System Restoration plan and national Trajectories.				
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182 4481	CQC Responsive	Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal	Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible. .	Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces. EMAS, GPs, mental health, community, social care and care homes data now also available within the Care Portal.	Finance, Performance and Estates Committee	A
						Commence implementation of the electronic health record	Roll-out IT equipment to enable agile user base Redeployment of staff as a result of Trust response to Covid-19.	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of 20/21 e HR plan		EPR OBC to be approved by NHSE/I OBC requirments being worked thorugh with NHSE/I		
						Undertake review of business intelligence platform to better support decision making			Delivering improved information and reports Implement a refreshed IPR	IPR refresh being completed in July 2021 for June 2021 reporting.	Steady implementation of PowerBI through specific bespoke dashboards and requests.		

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						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case under development						
						Improve end user utilisation of electronic systems	Business case for additional staff under development						
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion.		
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence August 2021	Reports -ELT / TLT -Committees -Board -System -Region	Impact of specialty changes	New performance framework will address and the upward report regarding IIP	Finance, Performance and Estates Committee	**A**
						Improvement programmes for cancer, outpatients and urgent care in progress	Recovery post COVID and risk of further waves Urgent Care Transformation team not yet established	Outpatient Improvement Group Cancer Improvement Board Urgent and Emergency Care Board.	Improvement against strategic metrics % of patients in Emergency Department >12 hrs (Total Time) Delivery against 62 day combined standard Urgent Treatment (P2) turnaround time Deliver outpatient activity non face to face		Reporting via FPEC		
						Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans.	Engagement exercise required to seek further views regarding the proposed revised model	CYP Group re-established	Board report July 2021				
						Urology Transformational change programme	Engagement exercise required to seek further views regarding the proposed revised model	Urology steering group in place reporting through IIP	Board report July 2021				
						Pre op Assessment Modernisation							

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating

The BAF management process

The Trust Board has assigned each strategic objective of the 2021 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