Bundle Trust Board Meeting in Public Session 1 November 2022

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

1 Introduction, Welcome and Chair's Opening Remarks

Chair

2 Public Questions

Chair

3 Apologies for Absence

Chair

4 Declarations of Interest

Chair

5.1 Minutes of the meeting held on 4 October 2022

Chair

Item 5.1 Public Board Minutes October 2022V1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log October 2022.docx

6 Chief Executive Horizon Scan Including STP

Chief Executive

Item 6 CEO Trust Board report 011122.docx

7 Patient/Staff Story

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

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 October 2022v1.doc

Item 8.1 MNOG Papers for Trust Board.docx

Item 8.1 Appendix A - Midwifery Continuity of Carer letter_210922.pdf

Item 8.1 Appendix B - Q3 Report for MNOG Oct 22.docx

Item 8.1 Appendix C - Maternity Neonatal Safety Assurance Report for Oct 2022 MNOG.docx

Item 8.1 Appendix D - v1.3 Maternity Neonatal Safety Improvement Plan.pdf

Item 8.1 Appendix E - MatSIP Headline Report October MNOG 22 (003).docx

Item 8.1 Appendix F - ATAIN Quarterly Report for 2022-23 Q1 V0.2 Apr-Jun 22 FINAL.pdf

Item 8.1 Appendix G - ATAIN October 2022 Scorecard.pdf

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

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

Chair of People and Organisational Development Committee

Item 9.1 POD - Upward Report - October 2022.docx

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

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

Chair of Finance, Performance and Estates Committee

Item 10.1 FPEC Upward Report October 2022 v1.docx

10.2 Digital Strategy

Director of Finance and Digital

Item 10.2 2210 TB - Digital Strategy -Template.docx

Item 10.2 2210 TB - Digital Strategy 2022-25 v1.5.pdf

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 October 2022 Final.pdf

13 Risk and Assurance

13.1 Risk Management Report

Director of Nursing

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

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

13.2 Board Assurance Framework

Trust Secretary

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

Item 13.2 BAF 2022-2023 25.10.2022.xlsx

13.3 Audit Committee Upward Report

Chair of Audit Committee

Item 13.3 Audit Committee Upward Report Oct 22 v1.docx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 6 December 2022

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

United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 4 October 2022

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Dr Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Ms Dani Cecchini, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Mr Simon Evans, Chief Operating Officer
Mr Paul Matthew, Director of Finance and Digital
Mrs Rebecca Brown, Non-Executive Director
Mr Neil Herbert, Non-Executive Director
Dr Chris Gibson, Non-Executive Director

Non-Voting Members:
Mrs Sarah Buik, Associate Non-Executive Director
Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration
Mrs Vicki Wells, Associate Non-Executive Director

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mr Andrew Simpson, Deputy Medical Director
Dr Maria Prior, Healthwatch Representative
Ms Victoria Reynolds, Community Care Nurse Specialist – item 7

Apologies
Dr Colin Farquharson, Medical Director
Ms Claire Low, Director of People and Organisational Development

1647/22	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. Traditionally the meetings had been held in person however for the last 2 years, whilst observing regulations due to the Covid-19 pandemic these had been held virtually. The Trust Board had found that this format worked well for people, allowing open and convenient access, and therefore the decision had been taken to continue to hold the meetings in this format.

	The Chair thanked those who had provided feedback which had supported the decision taken. The Chair welcomed those members of the public who had joined the meeting virtually.
1648/22 1649/22 1650/22 1651/22	**Item 2 Public Questions** **Q1 from Jody Clark** **I have had some feedback from blue badge holders, parking at Grantham Hospital.** **The lines for some of the bays are difficult to see and if someone is parked close to a line, sometimes it puts the other car, on or over the line and they get fined for not parking between the lines of the parking bay.** **Can these please be re marked, so they are easier to see for the disabled patients please?** The Chief Operating Officer responded: This was an important aspect of making sure that people had access to services and a request had been made of the Estates Team to reline the areas which would be completed over the course of the next month. There would also be a review of other elements such as lighting to ensure these are visible. The Chief Operating Officer noted that if patients received a parking notice as a result of the scenario described that the Trust would be able to intervene and rescind the notice. This would be reasonable action if people had needed to park over the line if this was not seen or unclear. If found in this position it would be possible to appeal and the Trust would support this.
1652/22 1653/22	**Item 3 Apologies for Absence** Apologies were received from Dr Colin Farquharson, Medical Director and Ms Claire Low, Director of People and Organisational Development. The Chair welcomed Mr Andrew Simpson who was attending on behalf of the Medical Director.
1654/22	**Item 4 Declarations of Interest** There were no new declarations of interest.
1655/22	**Item 5.1 Minutes of the meeting held on 6 September 2022 for accuracy** The minutes of the meeting held on 6 September 2022 were agreed as a true and accurate record subject.

1656/22	**Item 5.2 Matters arising from the previous meeting/action log** 1914/22 – Action log – The Director of Nursing noted the work that had taken place across all of the endoscopy units which had been brought together over the past months. The work had now concluded, and the draft report written which would be presented to the People and Organisational Development Committee and Finance, Performance and Estates Committee in October with onward reporting to the Board in November.
1657/22	1265/22 – Integrated Improvement Plan – The Chair noted the update and would welcome sight of the data in due course.
1658/22	1635/22 – Risk Management Report – The Board noted that the Quality Governance Committee consider ambulance handovers and noted that the review would be available in November. There was a strong focus required by the Quality Governance Committee and as part of the Integrated Performance Report an update would be provided to the Board in relation to Urgent and Emergency Care pressures including ambulance handovers.
1659/22	1636/22 – Risk Management Report – It was noted that the Acute Services Review (ASR) update would be offered to the Finance, Performance and Estates Committee in October and upward to the Board in November.
1660/22	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board noting that the Chief Operating Officer would provide an update on system pressures and pressures within the Trust during the Integrated Performance Report item.
1661/22	It was noted that pressures were being experienced across the country and that this was not an issue just in Lincolnshire or the Trust. The detail of capacity in place for winter was being worked through, recognising the added complication of potential flu and Covid-19. Despite the return to normality in society Covid-19 was still present and a factor for the Trust as services were planned and provided.
1662/22	The Chief Executive noted that the Secretary of State for Health and Social Care had issued detailed of priorities and the plan for patients which was being referred to as the ABCD plan. This covered issues of ambulances, backlogs, care and Doctors and Dentists. This covered all parts of services with the detail being worked through to determine how this was best delivered.
1663/22	The Board noted that Dr Caroline Johnson, Member of Parliament for Sleaford and North Hykeham was now a Junior Minister in the Department of Health and Social Care, congratulations had been sent.
1664/22	The Chief Executive noted the position of the stroke implementation which had been referred to earlier in the meeting and advised that the Integrated Care Board (ICB) was now working through, with colleagues in the system, the implementation of the outcome of the consultation of the ASR. An implementation oversight group was now

	in place and there had been no legal challenges to the decision of the Clinical Commissioning Group (CCG) meaning that the ICB could progress. It was likely this would be regularly reported to the Board as progress was made.
1665/22	The Board noted that the system remained in the recovery support programme and therefore was required to have a System Improvement Director (SID). The current SID, Keith Spencer, was approaching the end of the contract in place and as such the system was advertising for a new SID. This had progressed to the shortlisting stage with 12 good applicants and confidence that the system would be able to appoint a replacement.
1666/22	The Chief Executive advised that the first Integrated Care Partnership (ICP) meeting had recently taken place with Board members reminded of the 3 key parts of the Integrated Care System (ICS). These being the ICB, ICP and Provider Collaborative which in Lincolnshire was the Lincolnshire Health and Care Collaborative (LHCC). All parts of the system were now in place and further updates would be expected from the ICP and progress was made.
1667/22	The Quarterly System Review Meeting had taken place and the Chief Executive noted that there had been positive engagement with NHS Midland. It was noted that there was work to be undertaken in respect of the ABCD plan, Urgent and Emergency Care, elective care, cancer and the financial position with the underlying enables around the workforce and digital being discussed.
1668/22	The Chief Executive offered an update in respect of Trust issues noting that the financial position would be discussed as part of the Finance, Performance and Estates Committee upward report.
1669/22	In respect of Covid-19 there had been a return to as near normal as possible which had been highlighted by the Trust returning visiting arrangements to pre-Covid-19 levels. It was hoped that this would be well received by people who wished to visit loved ones and accompany people attending appointments.
1670/22	The Trust had striven to keep people safe and would continue to do so through infection prevention and control measures around hand cleanliness and mask wearing in clinical areas.
1671/22	The Trust restaurants had now reopened to the public and the Trust continued to work to update and improve arrangements around the cafes and shops which were now under the direct management of United Lincolnshire Hospitals NHS Trust. The Trust was looking to extend the range of services and hours of operation.
1672/22	The Chief Executive noted the absence due to ill health of the Medical Director noting that responsibility was being covered between Mr Paul Dunning and Mr Andrew Simpson with Mr Dunning taking the title of Medical Director until at least the 31 December 2022.
1673/22	Thanks were offered to both for stepping in at short notice to cover the position and it was noted that they would be supported by the new Deputy Medical Director, Ciro Rinaldi.

1674/22	The Chief Executive also announced that Claire Low would be stepping up to the position of Director of People and Organisational Development until further notice. This would see the Director of Finance and Digital step away from the role with the Chief Executive offering thanks and admiration for having carried out the role, in addition to substantive duties, for the past year.
1675/22	The Chief Executive was pleased to advise that the annual staff awards were due to take place in the coming week and was looking forward to seeing colleagues in person to celebrate the great work they did.
1676/22	Dr Gibson noted the C element in the ABCD plan which referred to £500m of funding to support discharge from hospitals and asked if it was known yet how this would be used locally.
1677/22	The Chief Executive noted that care covered both discharge and workforce in the care sector. The exact amount coming to Lincolnshire was not yet known but welcomed the importance of the focus on discharge and flow. Further detail, once known, would be presented to the Board.
1678/22	It was noted that whilst the support was welcomed the key constraint was often the workforce availability.
1679/22	The Chair offered congratulations to both Claire Low and Ciro Rinaldi on their recent appointments and also noted that a letter of thanks would be sent to Keith Spencer for the work undertaken whilst in the role as SID. **Action: Chair, 1 November 2022**
1680/22	The Chair also thanked the Director of Finance and Digital for stepping into the vacancy of the Director of People and Organisational Development. The directorate was in a much-improved position than when this was taken over due to the resilience shown. The Trust Board: • **Received the report and significant assurance provided**
1681/22	**Item 7 Patient Story** The Director of Nursing introduced the patient story and welcomed Victoria Reynolds, Community Care Nurse Specialist (CCNS) to the meeting.
1682/22	A letter of thanks had been sent to the Director of Nursing by the Community Care Nurse Specialist for a Multi-Disciplinary Team meeting. This had allowed a married couple, both end of life, with the efforts of various teams, to reunite at the Butterfly Hospice with one patient having been on the Stroke Ward and the other on ward 5a at Pilgrim.
1683/22	The Director of Nursing noted the timing of the meeting as the following week was hospice week for which an awareness campaign would be run.

1684/22	The Trust Board watched the video which detailed the work of the CCNS within the Trust to support an end-of-life couple to share their last days together in their preferred place of the care.
1685/22	The Chair thanked the CCNS for the story noting that this had been heart-warming although the circumstances were sad. On behalf of the Board the Chair thanked the CCNS and teams for making the couple's last days as they had wanted despite the efforts required to achieve this. There was clear personal resilience of the CCNS with the story also demonstrating how the values held which lined up with those of the Trust.
1686/22	Professor Baker noted that end of life care did not often receive the attention and resource it should and was pleased to have received the story which focused on an important component of care that the Trust and healthcare system offered.
1687/22	Mrs Wells noted that the story demonstrated fantastic teamwork across different organisations and asked if there was an opportunity to share stories, similar to the one offered, with staff across the Trust during October and beyond.
1688/22	The Director of Nursing thanked the CCNS for the story noting the powerful and key role in advocating for patients but also for importantly coordinating other healthcare professionals to deliver care to patients.
1689/22	The Director of Nursing advised that a patient and staff story library had been created and the Trust would continue to collect these and enable access by any team. Promotion of the story presented was being developed in readiness for national hospice week which would commence with the Director of Nursing blog.
1690/22	The Director of Improvement and Integration noted that the Trust Leadership Team were now receiving an item under the outstanding care, personally delivered heading and as part of that stories would be presented to offer examples of where staff had gone above and beyond.
1691/22	Mrs Buik asked what training and support was in place for staff to support recognition of end of life.
1692/22	The CCNS noted that education was an area in which support was required noting that the role was part of St Barnabas Hospice but based in Pilgrim Hospital alongside adult social care. The CCNS attended the wards to education doctors and nurses in recognising the early signs of palliative needs.
1693/22	There was a need to recognise the earlier stages of end of life and the main role for the CCNS was to recognise those patients entering the last year of life and to promote advance care planning and wishes of the patient which could then avert a crisis towards end of life.
1694/22	Whilst there was support in place for palliative care the focus on education and recognition of early palliative care was needed in order to ensure opportunities for patients were not missed including access to palliative support. Education was in

	place with link nurses on the wards and it was recognised that, due to the focus of staff, nurses were more likely to recognise palliative needs earlier than doctors.
1695/22	The Chair noted the need to increase awareness and ensure support was in place regarding education noting that this would be considered by the Executive Directors.
1696/22	The CCNS noted that the main point to highlight to the Board was the early recognition of palliative care noting that if recognised in the journey early enough then patients were less agitated. End of life care could only be done right once, and the culture of the nation remained that people did not talk about dying.
1697/22	Holding discussions could result in better outcomes for patients and possibly prevent hospital admissions that may not be wanted. Listening to patients was a key element in understanding preferred place of care there were however challenges with packages of care and funding however listening and taking advice from one another would make a difference and impact the patient journey.
1698/22	The story presented demonstrated what could be achieved through collaborative working and the CCNS was proud of everyone involved in achieving the wishes of the patients.
1699/22	The Chair thanked the CCNS recognising the passion that was being demonstrated and noted that there was clear advocacy on behalf of the patients. The Trust Board: • **Received the patient story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
1700/22	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair of the Quality Governance Committee, Dr Gibson provided the assurances received by the Committee at the 29 September 2022 meeting.
1701/22	Dr Gibson noted that the Committee had welcomed Mr Simpson to the Committee as the Medical Director representative.
1702/22	The Committee had noted ambulance handovers which were reviewed through the Clinical Harm Oversight Group and a key part of the work of the Committee. Some time had been spent looking at the harm review process undertaken in the Trust which required clinical input.
1703/22	It was noted that there was a need to strike a balance over the essential nature of these against the level of clinical input required and therefore the Committee received recommendations from the group to alert the process. The Committee accepted all but one of the recommendations which required further work.
1704/22	An update was received in relation to patient safety alerts with the Committee reflecting that the Trust dealt promptly with Central Alerting System (CAS) notices

	with only 3 open notices. Field Safety Notices (FSN) had previously been more of a challenge to the Trust which related to items of equipment which could require actions. There was now a single database and the number of open FSNs had reduced, it was anticipated this reduction would continue.
1705/22	Dr Gibson noted the Patient Safety Incident Response Framework (PSIRF) noting that this was an important issue for the Trust and would be introduced nationally to replace the 2015 Serious Incident Framework. The Trust had received early indication of the this with the Committee viewing a video.
1706/22	PSIRF would focus on process, systems and learning lessons with an anticipation of a 12-month process to put this in place. The Committee agreed to receive formal quarterly reporting which would be presented through the upward report to the Board and would include information for the implementation.
1707/22	The Committee received the Infection Prevention and Control (IPC) group upward report noting the significant progress that had been made in relation to the Covid-19 Board Assurance Framework (BAF). With the lifting of visiting restrictions, it was intended that the Covid-19 BAF would cease but that the central IPC BAF would continue. This demonstrated the progress that had been made in managing the pandemic.
1708/22	Dr Gibson advised the Board that the Committee had received the Medicines Management Annual report noting that the Chief Pharmacist had attended the Committee to present the report. The Committee noted the key achievements of the establishment of the aseptic unit, delivery of 1.5m Covid-19 vaccination doses across Lincolnshire and the 7-day service to the Intensive Care Unit. The Committee looked forward to future developments.
1709/22	The Committee received the safeguarding report noting the introduction of the 'Oliver McGown' training for learning disabilities and autism. This would be statutory training introduced for all healthcare staff at tier 1 and tier 2 and would be a significant training programme to be delivered.
1710/22	Dr Gibson noted the comprehensive report from the Maternity and Neonatal Oversight Group and supporting documents which had been received. The Committee noted some continued concern regarding compliance with the Clinical Negligence Scheme for Trusts (CNST) standards within maternity due to software limitations.
1711/22	The Committee noted thanks to Mrs Dunnett who had now left the Trust for carrying out the role of Non-Executive Director, Maternity and Neonatal Safety Champion.
1712/22	Dr Gibson advised the Board of the recent success at the Patient Experience Network National Awards where members of the Trust had won a first prize for the patient experience dashboard and second prize for the Trust Patient Panel.
1713/22	The Committee received the Care Quality Commission (CQC) Action Plan and noted the biggest step change in achieving must do actions in any month to date noting the positive improvements and continued traction.

1714/22	The Director of Nursing advised the Board that the Trust was currently above trajectory for C-Difficile infections which was inline with the national position however noted that this did not detract from the work being undertaken. Reviews were being conducted on a case-by-case basis to understand where there may deficiencies in the Trust.
1715/22	Mrs Brown would be chairing the Committee from October and noted to the Board the limited assurance on medicines management however noted the confidence of the Medical Director's office and Director of Nursing to achieve a step change in this area.
1716/22	Mrs Brown noted the walk around of the maternity units at both Pilgrim and Lincoln Hospitals that had been conducted and offered additional assurance to the Board that there were dedicated teams who were focused on issues which required addressing. It was noted that those issues primarily focused on estates and IT.
1717/22	The Board was advised of the work being undertaken around staffing and how the Trust was attracting new midwives when this was not being seen nationally, this was a positive position for the Trust and the teams.
1718/22	Mrs Brown also advised of the visit undertaken to the neonatal area and how the Committee had received an update on the national peer review that had been undertaken which recognised the work of the neonatal team. The team had come from a position of challenge to a place of good practice which would be shared nationally.
1719/22	The Chair thanked Mrs Brown for the additional assurance offered to the Board noting that the visits undertaken had confirmed the reports which were being received.
1720/22	Continued scrutiny of clinal harm reviews was welcomed with the recognition of the need to reflect clinicians' times whilst carrying out the right actions. A level of assurance continued to be presented to the Board during a difficult time and it was pleasing to note there was a level of focus with a refined process.
1721/22	The Chair noted the issues regarding the Covid-19 BAF and the closure of this with a transfer of remaining actions to the Trust IPC BAF.
1722/22	It was noted that an update to the Board had previously been provided in respect of PSIRF in order to familiarise the Board however the Chair noted the new members of the Board and felt that it would be useful to consider this again. **Action – Director of Nursing, 1 November 2022**
1723/22	The Chair congratulated the Patient Experience Team members, Martin Staddon and Jennie Negus, on their success at the national awards.
1724/22	The Chair thanked Dr Gibson for holding the position of the chair for the Committee and was appreciative of the focus given to this in challenging operational

	circumstances however there had been a confidence in the level of scrutiny being given. • **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
1725/22	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker provided the assurances received by the Committee at the 13 September 2022 meeting.
1726/22	Professor Baker echoed thanks to the Director of Finance and Digital for the work achieved in leading the People and Organisational Development Directorate.
1727/22	Professor Baker noted the establishment of the sub-groups which reported to the Committee with reports received from the Workforce, Strategy and Organisational Development Group, Equality and Diversity Group, which had reviewed the Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) action plans.
1728/22	Reports were also received from the Culture and Leadership Group, who were undertaking work in respect of organisational values and behaviours, and the University Teaching Hospital Steering Group. The increased focus on development of rural healthcare strategy was noted.
1729/22	The Committee had moved to a process whereby the sub-groups were considering issues in detail and highlighting key elements for greater focus which had taken a number of months to establish and embed.
1730/22	Professor Baker noted progress against the CQC action plan, and the Committee had received an update from the Guardian of Safe Working. The Guardian had raised concerns, which were highlighted to the Board, from Junior Doctors in relation to culture and behaviours. The Committee had emphasised the seriousness with which the concerns taken, and this had been discussed with the Medical Director and team to understand how this would be addressed.
1731/22	It was noted that the Committee would continue to scrutinise the programme made against the concerns raised which would take some time to resolve. The Committee also noted the issue of hot food provision outside of regular working hours. The issues highlighted were not new to the Committee however the need for focus was noted.
1732/22	The Committee had considered the position of the strategic objective RAG ratings with Professor Baker advising the Board that these had previously been red rated.

1733/22	Professor Baker highlighted to the Committee the consideration to move objective 2a to amber from red to reflect the increased controls being developed. Progress was being made against other areas and it was hoped that progress would be seen by the end of the year.
1734/22	The Chair reflected that the upward report was one of the best received from the Committee and the sub-groups reporting into the Committee was offering a greater level of assurance than previously received.
1735/22	Thanks were offered to the Director of Finance and Digital, Professor Baker and the Director of People and Organisational Development for the work undertaken to move the Committee to a position where reporting was of this nature.
1736/22	It was pleasing to see the update to the Board Assurance Framework for objective 2a which reflected the work undertaken with the Trust staff.
1737/22	The Chair acknowledged the escalation from the Committee regarding Junior Doctors and the report from the Guardian of Safe Working and sought comment from the Deputy Medical Director.
1738/22	The Deputy Medical Director noted that this was a known issue, and it was hoped that the new Clinical Director appointment in the Surgery Division and the Speciality Lead for Orthopaedics, along with support and input from the Junior Doctors Project Manager should support and offer assurance on the concerns being addressed.
1739/22	It was noted that Health Education East Midlands had now reduced the frequency of monitoring to bi-monthly whilst the Trust worked through actions which would provide assurance moving forward.
1740/22	The Chair noted the update, recognising that this was being managed from an operational and medical management perspective. There was a level of oversight and assurance in place through the Committee with the Committee charged to continue to provide a level of scrutiny.
1741/22	An update to the next Board was requested to confirm the assurance on this and the matter being addressed. **Action: Deputy Medical Director – 1 November 2022** The Trust Board: • **Received the assurance report**
1742/22	**Item 9.2 Final Draft / ULHT Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) Action Plan 2022/23** The Director of Finance and Digital, in the absence of the Director of People and Organisational Development, presented the WRES and WDES action plans to the Board noting that these both had the same requirements.

1743/22	The action plans presented were for the 2022/23 year and required adoption and publication by 31 October. Both actions plans had been presented to the People and Organisational Development Committee and there was now a need to focus on the work required in the remaining part of the year.
1744/22	The Director of Finance and Digital advised that the plans had been informed by the previous year's NHS Staff Survey, regional and system priorities as well as ensuring alignment to the Lincolnshire People Plan to which this aligned to the 'belonging' element.
1745/22	The Trust was trying to move from being compliant to a place of good practice, as part of the journey to achieve outstanding.
1746/22	The Board noted that the plans had been ratified by the Equality Diversity and Inclusion Group and the People and Organisational Development Committee. There was a need to publish the action plans by the end of October and an update would be offered to the ICB team post approval. There would then be a move on the communications to the organisation in order to take the actions forward.
1747/22	Mrs Wells asked if the versions shared with the Board would be the published versions and if so, how accessible and clear would these be for all staff groups and individuals. Reference was also made to Freedom to Speak Up and if this should be better referenced.
1748/22	The Director of Finance and Digital noted that the Associate Director of Human Resources and Organisational Development would be asked to speak with the Freedom to Speak Up Guardian in order to increase the prevalence of this within the action plans.
1749/22	It was noted that the version of the action plans presented within the Board papers were the published format and that there was an importance on the communications regarding these. The action plans would be converted into something meaningful and accessible to the organisation in order to understand what needed to be done and how this would be taken forward.
1750/22	The Chief Executive noted, as the chair of the Equality, Diversity and Inclusion Group, that the messaging of how important this was to the Trust was important and whilst simplified plans were necessary there was a need for detailed plans as the official plans for the Trust.
1751/22	There would need to be an easier to read version for any stakeholders who required them and there was a need for considerable effort to close the loop on this as well to demonstrate that the Trust had done what it said it would do.
1752/22	Historically there had been a focus on the WRES rather than WDES and the Chief Executive commended the Trust for having both plans in place. The Director of Improvement and Integration was the Executive Champion for the MAPLE Network and would be reinforcing the message to focus on both visible and invisible disabilities.

1753/22 1754/22 1755/22	The Director of Improvement and Integration noted that the MAPLE Network was already implementing some of the actions from the WDES action plan and noted that people were joining the forums to enact key recommendations. The Chair noted that the report was straightforward for both WRES and WDES and was an improvement on past action plans. This was now about the implementation ad impact on the organisation. The action plans were presented to the Trust Board for formal sign off and offered a moderate level of assurance. The Chair noted that the actions plans had been ratified by the People and Organisational Development Committee with the issue of communications noted to ensure the plans were meaningful to people. The Trust Board: • **Received the WRES and WDES action plans noting the moderate assurance** • **Approved the WRES and WDES action plan**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1756/22 1757/22 1758/22 1759/22 1760/22 1761/22	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini provided the assurances received by the Committee at the 22 September 2022 meeting. Ms Cecchini noted that the Committee continued to receive limited assurance in respect of Estates due to the continued challenges and it was noted that progress on capital was focused on during finance discussions. The Board was advised of the escalation from the Fire Safety Group regarding the ability for the organisation to properly undertaken assessments of dire safety due to the challenges around assess verification. An update to the October Committee had been requested as the Committee wished to fully understand the position. Ms Cecchini advised that the Premises Assurance Model had been submitted to NHS England following independent review and the 6-facet survey was due to be received as a future meeting. It was noted however that there had been a poor response to the initial tender. Full Patient- Led Assessments of the Care Environment (PLACE) were now taking place through September and October and the Committee received assurance on the progress of the Low Surface Temperature works. Ms Cecchini advised the Board of the month 5 finance position which had been reported a £9.1 deficit which demonstrated a continued deterioration. The Committee understood the position noting the slippage on the Cost Improvement

	Programme (CIP), inability to take Covid-19 costs out and effecting the planned closure of beds.
1762/22	There was an expectation of £17m of CIP delivery compared to a target of £33m with the Committee being advised of the work being undertaken on the pipeline of CIP schemes, many of which now required work to support absolute delivery.
1763/22	Ms Cecchini noted that the Committee had requested a quantified risk and mitigation schedule in order to understand, from now, how the breakeven position would be achieved. This would support an understanding of the sense of deliverability of the position.
1764/22	The Committee noted that the finance team had coped admirably during the outage of the ledger and there was positive assurance on how the position had been reported during this period.
1765/22	The Capital Delivery Group upward report had offered moderate assurance on the delivery of the capital programme with slippage noted in some areas. It was possible that consideration may need to be given to reprioritisation of the programme given current challenges that were now arising following the initial sign off of the plan.
1766/22	Ms Cecchini advised the Board that the Procurement Strategy had been received which demonstrated the system wide approach being taken to procurement with the Committee requesting an understanding of the tope 20 contracts in the workplan in order to be sighted and assured on contracts being retendered in appropriate timescales.
1767/22	The Committee discussed operational performance noting the continued deterioration against the metrics with limited assurance being offered. Concern was noted in relation to the colorectal cancer backlog which was understood to be a national challenge. Good progress was however noted in relation to breast services and the success of the mastalgia pathway.
1768/22	A verbal update had been received in relation to the Winter Plan which the Board would receive an update on as part of the agenda.
1769/22	Ms Cecchini advised the Board that the Committee had used the Integrated Improvement Plan executive scorecard to gain a sense of delivery noting the limited assurance offered. It was noted that all but one indicator was rated green with 2 yet to be finalised. The green indicator related to the IPC BAF. Further work was required in order to understand how a better view of success of the programme in year would be achieved.
1770/22	The Improvement Steering Group upward report demonstrated maturing of the group and progress was being seen toward assurance being provides on larger programmes of work.
1771/22	The Chair noted the size of the agenda and the need to focus on how agendas were managed at future meetings. The comment regarding fire safety was a concern given the historic actions taken by the Trust.

1773/22	The Chief Operating Officer advised that this reflected that fire remained on the risk register as a level 20 for some time and whilst substantial progress had been made it was known that some progress of exploratory activity could identify issues.
1774/22	The Trust had a strong relationship with Lincolnshire Fire and Rescue (LFR) with a transparent approach in place, including LFR sitting on the Fire Safety Group and supporting prioritisation of next steps. It was reasonable that the issue had been escalated to the Committee and was in line with the parameters set as part of the response to the fire enforcement notices. Updates would continue to be offered to the Finance, Performance and Estates Committee to ensure the issues remained sighted.
1775/22	The Chair was pleased to note the progress on the Low Surface Temperature works which demonstrated that the Trust was a learning organisation from a serious incident.
1776/22	An update regarding finance would be welcomed to better understand the position and efficiencies.
1777/22	It was pleasing to note that PLACE assessments were fully underway, and it was hoped that the improvements made since the last assessments were conducted would be reflected in the scores. 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
1778/22	**Item 11.1 Nuclear Medicine** The Chief Operating Officer presented the Nuclear Medicine consultation to the Board noting the substantial amount of work that had gone into the presentation and proposal put forward to the Board.
1779/22	The Chief Operating Officer advised the Board that Nuclear Medicine was a small, specialised service and as such posed challenges on a number of fronts. The report described that the configuration of the service had remained largely unchanged since the Trust conception and prior to 2006, both in terms of the provision of service but also the equipment used.
1780/22	Both the equipment and staff within the service were highly specialised and required substantial investment and a procurement decision around the use of the specialist devices but also substantial lead times for training and developing the necessary specialist scientific professionals who lead the important diagnostics.
1781/22	As a result of this the Trust was in a position where the future of the service required consideration to ensure this was sustainable and maintained high standards of both equipment and staffing which were significant features to consider.

1782/22	The Chief Operating Officer advised that the equipment was now past the expected life span and a decision to replace was required. This would be a substantial exercise, but consideration would also be required with regard to sustainable staffing and ensuring an attractive service for new staff to join. This would require suitable provision and range of services at each site.
1783/22	A review and considerations of a number of options had been undertaken resulting in the case presenting a 2-site option and single site option. A 3-site option, continuing as currently configured had been ruled out on the basis that there would not be sufficient activity to run the service on three sites and therefore the 2-site and single site options were developed.
1784/22	The Board noted the important of the decision which had been subjected to a full business case approach and the process had been described and scrutinised within the report. The green book treasury approach had been utilised to evaluate the decision with options subject to testing, including a health economics test, both value and impact on patients and expectations and value of healthcare.
1785/22	A consultation process had been undertaken with patients and wider stakeholders with substantial feedback received from stakeholders and the public. As part of this process the Trust had articulated the 2 options which had been worked up in full detail and presented.
1786/22	The Chief Operating Officer noted that the feedback from the consultation process supported the 2-site option and in order to consider how the Trust would sustain the service going forward a safe and sustainable model of staffing was considered throughout. Time was taken through the consultation to consider sustainability in the future given that national provision of training and development of scientific specialist roles had reduced over recent years. New starters were not coming through leaving many vacancies across the country.
1787/22	It was noted that it had been helpful to make comparisons to the national and regional review of the Positron Emission Tomography (PET) scanning service, which was commissioned and provided by regional NHS England colleagues. This had resulted in the service being centralised at Lincoln and recognised that there was not sufficient activity to provide the service at all hospital locations in the country.
1788/22	The Chief Operating Officer noted that as the options were considered, provision at early stages, had been made as part of the Pilgrim Emergency Department build, which would require the service to move as part of the developments. A location had been identified along with provision for financial outlay if the Trust continued to pursue the 2-site option or maintained the 3-site option.
1789/22	When evaluating the overall system of health economics, the cost of re-providing equipment had been excluded, however this had been considered in the overall financial value of the service and cost of running across all sites as part of the full financial model and business case process.

1790/22	The Chief Operating Officer advised the Board that the case presented recommended a single site option, counter to feedback as part of the consultation, where the desire was to maintain a second site. This had been determined through the scoring of the case which indicated the single site scored the highest in the options appraisal. This also recognised that since beginning the case there had been further staff leave the service and others expected to retire and leave by the end of the year.
1791/22	This would place the service in a position where there would be concerns of the safety of the service at Pilgrim but also the safety of the whole service. It would also be difficult to recruit to the posts as the Trust was unable to run a full range of services as existing staff tried to cover more sites.
1792/22	The Chief Operating Officer recommend to the Trust Board the single site option based on the evaluation of the options appraisal, recognising the fragility of the service and sustainability of staff in the future.
1793/22	The Chair noted the comprehensive paper which had been put forward and set out well the position, fully recognising the case for change and the outcome of the consultation. This was not just a public consultation but had included clinicians and key stakeholders. The financial and economic section of the paper was strong however it was noted that the workforce was the single critical factor.
1794/22	The Chief Executive noted a preference for the 2-site option and noted that the delay in the presentation to the Board had been due to the desire to test to destruction the ability to deliver a 2-site option. A clear explanation was requested as to why the 2-site option was not deliverable to have a service both safe and sustainable.
1795/22	The Chief Operating Officer noted that there would be 2 major risks should the 2-site option be pursued, these being the ability to set up and run the service from the outset and the risk of losing 1 site in addition to some elements of the service on the other site.
1796/22	Possible recruits to the service were keen to understand the impact of both the case and the future of the service and what range of tests would be offered at different locations, running the 2-site model would highly likely see a failure of one or more elements in quick succession.
1797/22	Mrs Brown noted the thorough case that was presented and noted concern regarding the recommendations stating that the 2-site option offered an easier option for patients to travel but agreed with the decision as this would offer a safe, good quality service for Lincolnshire.
1798/22	Mrs Brown asked how this would be communicated to stakeholders, if approved, particularly to those within the council where concern had been raised.
1799/22	The Chief Operating Officer noted that the next stage, subject to the decision being taken, would be to share more widely with stakeholder groups and work through some of the questions that had been raised. It was anticipated that delivery would take weeks to months in order to understand how the service would operate.

1800/22	Temporary measures would need to be taken ahead of the final configuration due to the works at the Pilgrim Emergency Department however there would be a broad communications exercise. Whilst the numbers of patients were small, 3-5 a day, there would be an impact on the patient group and time would need to be spent with existing and potential patients to advise this was being done to provide a high-quality service.
1801/22	Dr Gibson commented, based on professional experience, that the service was in need of significant investment for both equipment and staffing in order to develop and reach modern standards. Fragility in the system was being seen due to staffing difficulties nationally however essentially the service needed a significant change in order to secure the future.
1802/22	Dr Gibson noted that the question of travel and health inequalities had been raised however noted that this was mitigated by the nature of nuclear medicine which was essentially a one-off service and was almost entirely an outpatient service. This meant that transport issues would be easier to address.
1803/22	Dr Gibson noted the need for appropriate investment and support to develop the service along with a view to identify university links. There was a need to consider mitigation of transport issues in conjunction with system partners.
1804/22	The sentinel biopsy service at Pilgrim for breast surgery would need to be maintained and this had been referenced within the report but was a key element. Dr Gibson strongly support the recommendation with the caveats described.
1805/22	The Chief Operating Officer noted the need for maintenance of the breast service which had been a clear point of discussion throughout the process, to ensure other services were not materially affected.
1806/22	Patients were already accessing the service at Lincoln from the East Coast however there would be continued monitoring to ensure health inequalities were not impacted as part of the high-quality service, cancer services and diagnostics into the future.
1807/22	The Director of Nursing offered reassurance of the Quality Impact Assessment process and panel which had included the Medical Director. There had been a detailed debate by the panel as part of the consultation process and the Director of Nursing supported the option being recommended.
1808/22	The Chair noted, when considering the case, the Board had previously tried to run services which had been fragile, and this had not always been the best approach in terms of patient experience. Provision of high-quality, safe care and a good working environment for staff was required. It was fully recognised that this had started with a genuine intent to take the public consultation and preference for a 2 site option forward however things had moved on resulting in a different outcome.
1809/22	The Chair drew the attention of the Board to the consultation and recommendations on pages 47 and 48 of the paper which summarised the justification of the

	recommendation presented. The Board had had an opportunity to ask questions and satisfactory responses had been offered by the Chief Operating Officer.
1810/22	The service was not sustainable and on that basis the Chair put to the Board approval of the recommendation presented. It was recognised that there would be some concerns from key stakeholders however the decision was being taken on the basis of safety and sustainability. The way to achieve this was to move to a single site model of care.
1811/22	Members of the Board approved the recommendations and the Chair noted the caveats offered by Dr Gibson.
1812/22	The Chair offered thanks to the team, in particular Laura White, Head of Nuclear Medicine, for the leadership and development of the process. The Trust Board: • **Received the report noting the moderate assurance** • **Approved the recommendation that the Trust support the move to a single site model of care**
1813/22	**Item 12 Integrated Performance Report** The Director of Finance and Digital presented the report to the Board noting that there was nothing further to add following the business that had been conducted by the Committees.
1814/22	The Chair noted the reference made by the Chief Executive regarding the operational pressures which were reflected in the performance report and sought a current view of the position from the Chief Operating Officer.
1815/22	The Chief Operating Officer noted the update offered through the Finance, Performance and Estates Committee upward report regarding cancer with good progress being seen in a number of areas. It was noted however that colorectal cancer services, like many other Trusts and systems, was under substantial pressure. This was contributed to by urgent care pressures and levels of bed occupancy which could restrict the ability to operate in a timely manner.
1816/22	It was noted that here had been progress made in recent weeks with outpatient waits reduced and the 2-week wait service, at the beginning of the cancer pathway, substantially improved and well within the specified time limit.
1817/22	The Chief Operating Officer noted the urgent care position which, as reported through the Integrated Performance Report (IPR) demonstrated a continued deteriorating position. This followed the national position and nationally in the past month the NHS did not achieve the 4-hour standard.
1818/22	The increase in pressures being faced continued into October with the Trust in the past days having faced the most challenging urgent and emergency care (UEC) conditions since pre-Covid-19. As a result, the Trust had moved into critical incident status in order to respond. This had seen increased numbers of patients waiting in

	emergency departments, handover delays and the inability to turn around ambulance crews swiftly. There was a known impact in the community for the ambulance service as a result.
1819/22	There had been a system response to the incident however it was noted that this was not necessarily demand driven but an increase in discharge issues. These were both for the Trust to resolve in being able to discharge patients quickly and effectively but also related to services and capacity within the community, both at home and in settings such as care homes and community beds.
1820/22	The Board noted that the system had schemes in place which would take effect over the coming weeks and months as preparations for winter continued. There was an assumption that the current challenges would be the same as those likely to be faced over winter. The Board would continue to be updated through the IPR and Finance, Performance and Estates Committee.
1821/22	The Chief Operating Officer would see to use the winter plan 6 key indicators, set by NHS England, to identify if the actions put in place were having an impact. The winter plan should be received at the Board in November which would offer mitigation for emergency care demand over the course of the winter.
1822/22	The Chair appreciated the situation noting that the Board needed to ensure that it was sighted and supporting the Chief Operating Officer and colleagues across the Trust in what was clearly a difficult situation.
1823/22	Mrs Brown sought to further understand the DM01 indicator for diagnostics and the current length of time patients were waiting and if there was mitigation in place for those patients waiting an extended length of time.
1824/22	Mrs Brown also noted the metric for fractured neck of femur and reflected on the significant deterioration of patients waiting over 48 hours and asked if there was a recovery plan in place.
1825/22	The Chief Operating Officer noted that there were different modalities in the DM01 diagnostics metric meaning that it was not always clear in presenting the position for some elements of the service which were performing extremely well. Some other services were performing substantially less than 6 weeks, but it should be noted that there was more than one stream of diagnostics with some patients receiving urgent and prompt access whilst others would go on to the waiting list. All of these patients would be contained with the DM01.
1826/22	The Chief Operating Officer noted that, through the Finance, Performance and Estates Committee, further detail of the DM01 would be provided as a deep dive into echocardiography was being undertaken with NHS England and would be reported to the November Committee. **Action: Chief Operating Officer, 24 November 2022**
1827/22	

1828/22	External consultancy support was in place recognising the staffing and capacity challenges which had been significant for the Trust. It was noted that it had not been possible to obtain mutual aid.
1829/22	Fractured neck of femur was a significant challenge on bed occupancy related to urgent care and the level of bed occupancy of the Trust. This meant that it was more difficult to take people into theatre and back out to the trauma ward where there was substantially higher activity than 2019.
1830/22	The Chief Operating Officer would provide an update through the Finance, Performance and Estates Committee in November along with an examination of the quality impact to determine if there was a need for this to be offered to the Quality Governance Committee. **Action: Chief Operating Officer, 24 November 2022**
1831/22	Mr Herbert noted the complex issues and activity in accident and emergency and asked what the Board should expect to see in terms of the trajectory for performance and when it was anticipated that an improvement would be seen.
1832/22	The Chief Operating Officer advised that there were clinical care quality standards within UEC and that strong indicators, developed over the past 2 years, would continue to be sustained. Those which should continue to be protected were the 60-minute standard for patients to be seen by a doctor or senior decision maker and the 12-hour trolley wait standard which was currently impacted due to bed occupancy and length of stay.
1833/22	The trajectory for the 12-hour trolley wait standard required delivery before the holiday season and work was underway with partners on this for a trajectory. Capacity would be in place to support discharges before Christmas in order that the Trust could be in the best position to protect services when the increase was seen in early January. The key element was to reduce the number of patients in beds that did not require hospital care in order to be able to focus on caring for patients who required acute care.
1834/22	The Chair offered thanks to all those leading on the work recognising that support was being sought where required in order to ensure that the Trust was as efficient and effective as possible.
1835/22	There was a need to continue to work with and push system partners to deliver in order to spread the risk across the system and ensure further pace and capacity out of hospital was in place to do this.
	The Board would discuss UEC and winter planning at the meeting in November. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance

1836/22	**Item 13.1 Risk Management Report** The Director of Nursing presented the monthly report to the Board noting that there were 9 quality and safety risk rated very high, a reduction of 1 since the previous month.
1837/22	The reduction related to the risk of potential for disruption to patient care if the high dose rate unit in radiotherapy was to fail. This had been verbally updated to the Board in September and the risk reduced as the replacement plans had now been approved.
1838/22	The very high risks remained around the recovery of planned care pathways which had just been discussed, availability of accurate patient and medicine information, documentation, potential for harm due to falls, processing echocardiograms and the ability to learn lessons from serious incidents. All of the risks detailed had been reviewed through the Quality Governance Committee.
1839/22	The Director of Nursing advised of 3 very high workforce risks which could impact on safety, these being recruitment and retention, culture and workforce and a new very high risk of the fragility of the stroke service. These risks had been reviewed by the People and Organisational Development Committee.
1840/22	The Board noted 3 risks relating to the Finance, Performance and Estates Committee including the potential for a major fire, compliance with fire safety standards assessed by Lincolnshire Fire and Rescue and the reliance on high-cost temporary clinical staff. These had all been reviewed and remained the same as the previous month.
1841/22	There were clear mitigations in place and a process of executive confirm and challenge continued to take place with all divisions and directorates to ensure a dynamic risk register.
1842/22	The appendices offered the strategic risks in full.
1843/22	The Chair noted that the risks were clearly articulated within the paper and invited members of the Board to confirm the risk register as presented represented the risks to which all Board members were alert to and that the content of the risk reduction plans remained relevant and meaningful. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the significant assurance**
1844/22	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the report to the Board noting that the Board Assurance Framework (BAF) had been considered by all Board Committees during September.

1845/22	The Board was advised that the Finance, Performance and Estates Committee had considered the framework during development sessions in September where assurance from the reporting groups was considered.
1846/22	The Trust Secretary highlighted the recommendation from the People and Organisational Development Committee to move objective 2a – A modern and progressive workforce, from red to amber.
1847/22	The Chair congratulated colleagues of the Committee on the movement noting that the Committee was now receiving reports offering higher levels of assurance which had enabled the movement of the rating.
1848/22	At this point in the year the BAF was at the expected position with the Chair noting further work would be required before the year end but that consideration of the 2023/24 would soon commence.
1849/22	Progress towards the current BAF would continue and further discussion would take place in due course about the coming year and the content of the BAF. The Trust Board: • **Received the report noting the moderate assurance**
1850/22	**Item 14 Any Other Notified Items of Urgent Business** The Chair took the opportunity to congratulate the Director of Nursing on reaching 35 years' service with the NHS in September 2022 noting the achievement and thanking the Director of Nursing for the dedication, commitment and ongoing leadership not only to the NHS but to the Trust.
1851/22	The Chair offered thanks for the expertise that had been brought to the Trust noting the benefit from the leadership and experience offered.
1852/22	The next scheduled meeting will be held on Tuesday 1 November 2022, arrangements to be confirmed taking account of national guidance.

Voting Members	**7 Sept 2021**	**5 Oct 2021**	**2 Nov 2021**	**7 Dec 2021**	**1 Feb 2022**	**1 Mar 2022**	**5 Apr 2022**	**3 May 2022**	**7 June 2022**	**5 July 2022**	**2 Aug 2022**	**6 Sept 2022**	**4 Oct 2022**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	A	X	A	X	X	A	X	X	X	X	X	X
Sarah Dunnett	X	X	X	X	X	X	A	X	A	X	A	A	
Elizabeth Libiszewski	X	X	X	X									
Paul Matthew	X	X	X	X	X	A	X	X	X	X	A	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	A	A	X	X	X
Mark Brassington													

Simon Evans	X	X	X	X	X	X	X	X	X	X	A	X	X
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X	X
David Woodward	X	X	X	X									
Philip Baker	X	X	X	X	X	X	X	X	X	X	X	X	X
Colin Farquharson	X	X	X	X	X	X	X	X	X	X	X	A	A
Gail Shadlock					X	X	X	X	X	X			
Dani Cecchini					X	X	X	X	X	X	X	X	X
Rebecca Brown												X	X
Neil Herbert												X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
7 December 2021	1914/21	Action Log	Establishment reviews for endoscopy and ED would be received once considered at Committee in Jan/Feb 2022 Endoscopy review to be received in July	Director of Nursing	~~01/03/2022~~ ~~05/07/2022~~ ~~02/08/2022~~ ~~04/10/2022~~ 01/11/2022	Agenda Item
5 July 2022	1265/22	Integrated Performance Report	Board to review performance report through IPR ahead of the winter pressures, with focus to be afforded to the scorecard performance and position of a range of metrics.	Trust Secretary	~~06/09/2022~~ ~~04/10/2022~~ 01/11/2022	To be considered in private Board session before being offered to public Board as part of the winter plan in October Deferred to November
6 September 2022	1635/22	Risk Management Report	Detailed reporting of ambulance handover delays and patient harm to be considered to Quality Governance Committee	Chief Operating Officer	01/11/2022	Agenda item for October QGC
6 September 2022	1636/22	Risk Management Report	ASR Stroke service implementation update to be offered to the Board	Director of Improvement and Integration	~~04/10/2022~~ 01/11/2022	To be received by Finance, Performance and Estates Committee in October, to Board in November

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

4 October 2022	1679/22	Chief Executive Horizon Scan	Chair to write to System Improvement Director to offer thanks for the work undertaken whilst with the system	Chair	01/11/2022	Complete
4 October 2022	1722/22	Assurance and Risk Report Quality Governance Committee	PSIRF update to be offered to the Board	Director of Nursing	01/11/2022	October Board Development Session
4 October 2022	1741/22	Assurance and Risk Report People and Organisational Development Committee	Update to be provided to the Board to offer assurance on progress of Junior Doctor concerns raised by the Guardian of Safe Working	Deputy Medical Director	01/11/2022	
4 October 2022	1826/22	Integrated Performance Report	Echocardiography deep dive to be reported to Finance, Performance and Estates Committee	Chief Operating Officer	24/11/2022	
4 October 2022	1829/22	Integrated Performance Report	Fractured Neck of Femur update to be reported to Finance, Performance and Estates Committee and consideration to be given to quality impact and possible reporting to Quality Governance Committee	Chief Operating Officer	24/11/2022	

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*1 November 2022*
Item Number	*Item number 6*

Chief Executive's Report

Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	
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 our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish collaborative models of care with our partners	
4b Becoming a university hospitals teaching trust	
4c Successful delivery of the Acute Services Review	

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to be under significant operational pressure. The winter plan is being assurance tested to ensure that it meets the needs of the system. Additional national guidance has been received relating to the need to further expand winter plans to build in additional resilience. This additional national guidance covers topics such as better support for people in the community; maximising bed capacity and supporting ambulance services; ensuring timely discharge from hospital; continuing to support elective activity; infection prevention and control measures; staff vaccinations; oversight and incident management arrangements.
b) All parts of the local NHS system have been undergoing Emergency Preparedness, Resilience and Response (EPRR) core standards assurance testing. This is being conducted by colleagues from NHSE. The standards that are expected from organisations have recently been tightened and extended. The outcome will be reported to the Board in due course.
c) The report of the independent investigation into maternity and neonatal services in East Kent has been published. The report makes for harrowing reading. The report identifies four areas for action. The NHS could be much better at identifying poorly performing units, at giving care with compassion and kindness, at teamworking with a common purpose and at responding to challenge with honesty. The report will be considered locally through the existing assurance groups, with a report ultimately coming to Board.
d) Jitka Roberts has been appointed as the new System Improvement Director. This post is a requirement for systems that are in the Recovery Support Programme. Jitka is an experienced NHS transformation and turnaround director. She has many years' experience working in the NHS in the North West of England and has recently spent time supporting the Lincolnshire Health and Care Collaborative. Jitka will take up her role on 1st November.
e) NHS England has published its new Operating Framework to take account of the introduction of Integrated Care Systems. The framework sets out the purpose of NHS England, its areas of value, the desired leadership behaviours and accountabilities it is seeking and its medium term priorities and long term aims.
f) A new Emergency Services Chapel has been dedicated to the emergency services and the NHS at Lincoln Cathedral. This space offers a place where family and friends can gather, reflect and pause with quiet contemplation for those who have given their lives to the emergency services and the NHS.
g) A new Patient Safety Incident Response Framework (PSIRF) is being introduced in the NHS to replace the Serious Incident Framework. The PSIRF makes no distinction between patient safety incidents and serious incidents. The PSIRF sets out the approach to developing and maintain effective systems and processes for responding to patient safety incidents for the purposes of learning and improving patient safety. It is anticipated that the new PSIRF framework will be introduced over the next 12 months.

Trust Overview

a) At month 6, the Trust reported a year to date deficit of £11.2m against a year to date plan of break-even. After adjustments, this equates to a deficit of £11.3m in relation to the system financial plan. The focus of the financial recovery continues to be on bed numbers, agency costs, CIP delivery and COVID costs.

b) The Trust's Patient Experience Team has been praised at a national awards event for all of its work to improve patient experience. Data Insight Manager Martyn Staddon was crowned the winner in the 'Using Insight for Improvement' category for the development and implementation of a patient experience dashboard. Jennie Negus, Head of Patient Experience, took a runner-up spot in the 'Engaging and Championing the Public' category. Sharon Kidd, Patient Experience Manager, was a finalist in the 'Personalisation of Care' category.
c) The Trust has been celebrating 'Black History Month' in October, supported by the BAME staff network. The focus of the events has been 'Time for change: Action not words'. Topics covered include living legends, and the importance of allyship.
d) The National NHS Staff Survey 2022 is now live and staff across the Trust, including Bank staff, are being encouraged to feed back what it is like to work at ULHT. The survey is confidential and is run by the Picker Institute.
e) The staff vaccination programme is continuing, with staff being offered both their flu vaccination and their COVID booster vaccination.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	18 October 2022
Chairperson:	Rebecca Brown, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
	Assurance in respect of SO 1a Issue: Deliver high quality care which is safe, responsive and able to meet the needs of the population **Clinical Harm Oversight Group Upward Report** The Committee received the report noting the continued use of the C2AI tool which had resulted in progressive reduction of reported levels of harm with the highest scores almost eliminated. Concern was noted regarding e-outcomes and time critical clinical follow-ups being completed however a project manager had been identified to support clinicians and resolve barriers that may be in place. A further, more detailed review of this item will take place by the Committee. Confirmation was provided of cancer clinical harm reviews, which had reverted to patients with cancer treatments being eligible for harm reviews. **Executive/Non-Executive Visits** The Committee noted that visits had not been taking place due to Covid-19 restrictions however was pleased to note that these would recommence following the lifting of restrictions. **Serious Incident Summary Report** The Committee received the report noting the position presented. **High Profile Cases** The Committee received the report noting the content. **Claims and Inquests Report** The Committee received the report noting the content and requested that future reporting offered further detail including benchmarking and

	comparison to previous year's data to provide a more detailed understanding of the position. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report noting the first case of MRSA, had been recorded for the Trust in year. A further increase in C.Difficile cases was also noted. The Committee noted that actions in place to address this and noted that there had been an increase both regionally and nationally. The Committee noted that the Director of Infection Prevention and Control responsibilities would be passed from the Director of Nursing to the Medical Director in the coming weeks with the Committee congratulating the Director of Nursing on the achievements in IPC. **Medicines Management Task and Finish Group Upward Report** The Committee received the report noting the continued limited assurance in respect of medicines management. It was noted that the DKA task and finish group was now a project within the Integrated Improvement Plan, reporting to the Patient Safety Group. Discussion would take place with the relevant groups regarding how this would be progressed with a proposal on the development to be offered to the Committee in November. Concern was noted regarding the number of actions and the lack of traction however, it was reflected that this was discussed through performance meetings with actions in place for improvement. **Patient Safety Group Upward Report** The Committee received the report noting that an update had been offered to the group from the Deteriorating Patient Group and was advised that the Deteriorating Patient Lead was due to commence in October. This would support strengthening of the group. The group had discussed the update from the Hospital Transfusion Group regarding the amber alert position for bloodstocks however; the Committee noted that this had since moved on. Division reporting continued to offer assurance to the group, and it was agreed that NatSSIPs and LocSSIPs reporting would be coordinated with the Divisions in order to provide an update to the Committee. **Maternity and Neonatal Oversight Group Upward Report** The Committee received a verbal update from the meeting noting that a further update in respect of the Ockenden benchmarking exercise had been received. National guidance continued to be awaited however it was noted that 2

	requirements had been retracted/amended. There being a named midwife and continuity of carer. Continuity of carer remained a requirement however the deadline for introduction had been removed. The Committee noted the Clinical Negligence Scheme for Trusts (CNST) and recognised the risk to non-compliance with the timescale of completion for standard 8, PROMPT Training, due to the revised deadline. This was being raised with the region with other organisations noting the same concern. A gap analysis would be conducted in respect of current court proceedings on allegations of a single nurse harming babies, once complete this would be reported to the Committee. The group received the quarterly ATTAIN report which demonstrated evidence of ongoing oversight. The Committee noted the recent system quality meeting where the work achieved by the Trust in maternity services was acknowledged with a focus on the leadership of the Director of Nursing and Divisional Head of Nursing and Midwifery. The Committee offered to the Board, through the appendices the Ockenden letter, CNST scorecard and ATTAIN report. **Ambulance Handover Delays** The Committee received an update, which focused on quality of care and the harm of patients experiencing delays, these being harm to those waiting on ambulances and those in the department for too long. The Committee noted that clinical harm reviews were conducted for all ambulance handovers over 120 minutes with work to triangulate with incident reporting. Additional verbal assurance was received from the DON and COO on the further mitigation to reduce the risk to patients and it was agreed that these actions would be added to the slide deck for completeness. The actions in place to support improvement were noted with a focus on flow, discharge and pathway improvements. Joint working was taking place with East Midlands Ambulance Service NHS Trust, which enabled identification of risk.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report noting that stakeholders had identified an issue of patients waiting on elective waiting lists and it was noted that the patient panel were undertaking work to offer feedback on the actions being taken.

	The Committee noted that, once published, the National Inpatient Survey results would be benchmarked, and a full summary reported to the Committee. The number of hours offered by volunteers to the Trust in the past 3 months had reached nearly 9k with the Committee commending those who had supported the Trust and offered their time. **Duty of Candour** The Committee received the monthly report noting a reduction in compliance in month however noted that work continued to support staff to complete Duty of Candour.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report and was pleased to note that Gynaecology had offered a presentation into the outcomes of progress of the specialty following the GIRFT review. It was noted that there was an intention to cease auditing of consent and documentation for those areas with poor compliance against the completion of a required action plan due to limited audit resource. Concern was noted by the Committee whilst supporting the approach due to concern that this could create an area of risk. It was noted however that the Divisions would take the issue back to the business units and this would also be challenged through the clinical audit group. **Confidential Enquiries** The Committee received the report noting the process to monitor compliance which was now being seen through the reports. Significant work from the central team to support staff had resulted in all checklists related to the organisation being completed. It was noted that some actions remained outstanding the Committee would receive, at a future meeting, a dashboard to monitor progress.
	Assurance in respect of other areas: **DBS Check – Response from referral to People and OD Committee** The Committee received the update following the referral made to the People and Organisational Development Committee to understand the position of progress against DBS checks. The Committee requested representation at the next Committee meeting in order to better understand the position and improvements achieved given the recent high-profile case reported in the media.

	Committee Performance Dashboard The Committee received the dashboard noting that the papers on the agenda would cover the items described however held discussion around VTE. The Committee noted the improvement in performance however there would be a proposal o the Trust Leadership Team for additional support for VTE assessment. Post-partum haemorrhage (PPH) was also noted with the Committee informed of the work being undertaking with the regional obstetric lead. The Committee also noted that a PPH lead had been appointed and updates would be offered through the relevant reporting group. **Integrated Improvement Plan** The Committee received the report noting the month 6 position and move from limited to moderate assurance as progress was made on a number of objectives. The Committee noted the DKA pathways and the need for a dedicated programme manager to move this forward due to the wide-ranging nature across divisions. The Committee sought to understand the capacity in place to deliver the IIP and relevant programmes noting that this continued to be required in addition to the development of competency to deliver. **CQC Action Plan** The Committee received the report noting that, following the significant progress the previous month, that there had been little change in month. It was noted that monthly meetings continued to take place to support the divisions and directorates. **Quality Impact Assessments (QIAs)** The Committee received the quarterly report noting the progress of QIAs which had occurred in the previous quarter. The Committee noted that there were no open Covid-19 QIAs and 15 QIAs had been signed off in Q2. The Committee was pleased to note that the process to review QIAs continued to perform well and recognised the significant improvement in consistency of process across all areas of the Trust.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for	None

Assurance	
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register and reflected that the discussions held by the Committee could support in providing updates to the identified risks.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*01 November 2022*
Item Number	*Item 8.1*

Upward Report from the Maternity Neonatal Oversight Group (MNOG)

Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Libby Grooby, Head of Midwifery*
Report previously considered at	*Quality Governance Group (Verbal)*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish collaborative models of care with our partners	*X*
4b Becoming a university hospitals teaching trust	
4c Successful delivery of the Acute Services Review	

Risk Assessment	Not Applicable
Financial Impact Assessment	Not Applicable
Quality Impact Assessment	Not Applicable
Equality Impact Assessment	Not Applicable
Assurance Level Assessment	Moderate

Recommendations/ Decision Required	• *Trust Board are asked to note for assurance the documents provided to underpin the verbal upward report provided to the Quality Governance Committee (QGC) following the*

October meeting of the Maternity Neonatal Oversight Group (MNOG).

Executive Summary

- Due to the close proximity of the October Maternity Neonatal Oversight Group (MNOG) and the Quality Governance Committee (1 day), the Director of Nursing and MNOG Chair, provided a verbal upward report to the committee. The formal written upward report will be submitted to the November meeting of QGC.

- To underpin the verbal update provided to QGC, seven key documents are shared with Trust Board, these are attached with Board papers and the list below summarises the list of those documents shared:

    - **Appendix A** refers to the formal confirmation letter detailing changes to the midwifery continuity of carer (MCoC) Ockenden requirement. Updates will be provided once further national guidance is received.

    - **Appendix B** refers to an updated triangulation report received by the group.

    - **Appendix C** provides the Maternity & Neonatal Monthly Safety Assurance Report which provided a comprehensive overview for the group's assurance including an update on progress with staffing initiatives.

    - **Appendix D** provides the Maternity & Neonatal Improvement Plan as at October 2022 which demonstrated clear triangulation with the monthly safety assurance report (reported as Appendix C).

    - **Appendix E** goes further and provides a more detailed assessment of those areas in the improvement plan (at Appendix D) identified as 'RED'.

    - **Appendix F** refers to the ATAIN Quarterly Report: April – June 2022.

    - **Appendix G** provides the latest ATAIN Scorecard Data for the Trust.

Classification: Official

Publication reference: PR2011

To:
- Trust chief nurses
- Trust directors of midwifery
- Trust COO
- Trust CEO
- Trust medical directors
- Trust clinical directors for obstetrics

cc.
- Regional directors
- Regional chief nurses
- Regional medical directors
- Regional chief midwives
- ICB chief nurses
- LMNS Chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

21 September 2022

Dear colleagues

Midwifery Continuity of Carer

We are writing to you to set out essential and immediate changes to the national maternity programme in the light of the continued workforce challenges that maternity services face. There will no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans that work for them.

Over the past two years staff have had to work in ways that they never imagined, in difficult circumstances and we know that maternity services are experiencing stress and strain. The top priority for maternity and neonatal services must continue to be ensuring that the right workforce is in place to serve women and babies across England.

At the heart of the MCoC model is the vision that women should have consistent, safe and personalised maternity care, before, during and after the birth. It is a model of care provision that that is evidence-based. It can improve the outcomes for most women and babies and especially women of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods. This model of care requires appropriate staffing levels to be implemented safely.

There is no longer a national target for MCoC. Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths. We hope this will enable your services to improve in line with the evidence, at a pace that is right.

We know trusts have submitted their MCoC plans and will have considered safe staffing levels in submitting their plans. Thank you for your work on these and your efforts to implement MCoC to date

We expect you to continue to review your staffing in the context of Donna Ockenden's final report. Your local LMNS, regional and national colleagues are here to support you with this including how to focus MCoC on those women from vulnerable groups who will benefit the most from this care.

As we have said previously:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Trusts are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so.

Approved educational institutions (AEI's) educating pre-registration midwifery students will continue the implementation of the future midwifery standards of the NMC. It is

expected that midwifery students will be taught the MCoC model, alongside other approaches to safe, high-quality care for women. The NMC has written to education providers to confirm that this remains a requirement of registration and to suggest how this can be achieved when students are placed in those organisations that are not able to fully implement MCoC at this time. Where this is the case, students will still benefit from practice supervisors and assessors being able to explain and discuss the concept and we would ask for your support to encourage this to happen.

With the advice of the independent working group established after the final Ockenden report, we will publish a national delivery plan for maternity services this winter which will bring together actions for maternity services, including next steps for improving continuity across all professional groups.

Yours sincerely,

Dame Ruth May
Chief Nursing Officer, England

Prof Jacqueline Dunkley-Bent OBE
Chief Midwifery Officer
National Maternity Safety Champion
NHS England

Dr Matthew Jolly
National Clinical Director for Maternity and Women's Health
National Maternity Safety Champion
NHS England

Claims Scorecard, Complaints & Incidents
REPORT for Maternity & Neonatal Oversight Group

Jules Bambridge
Lead Midwife for Patient Safety

October 2022

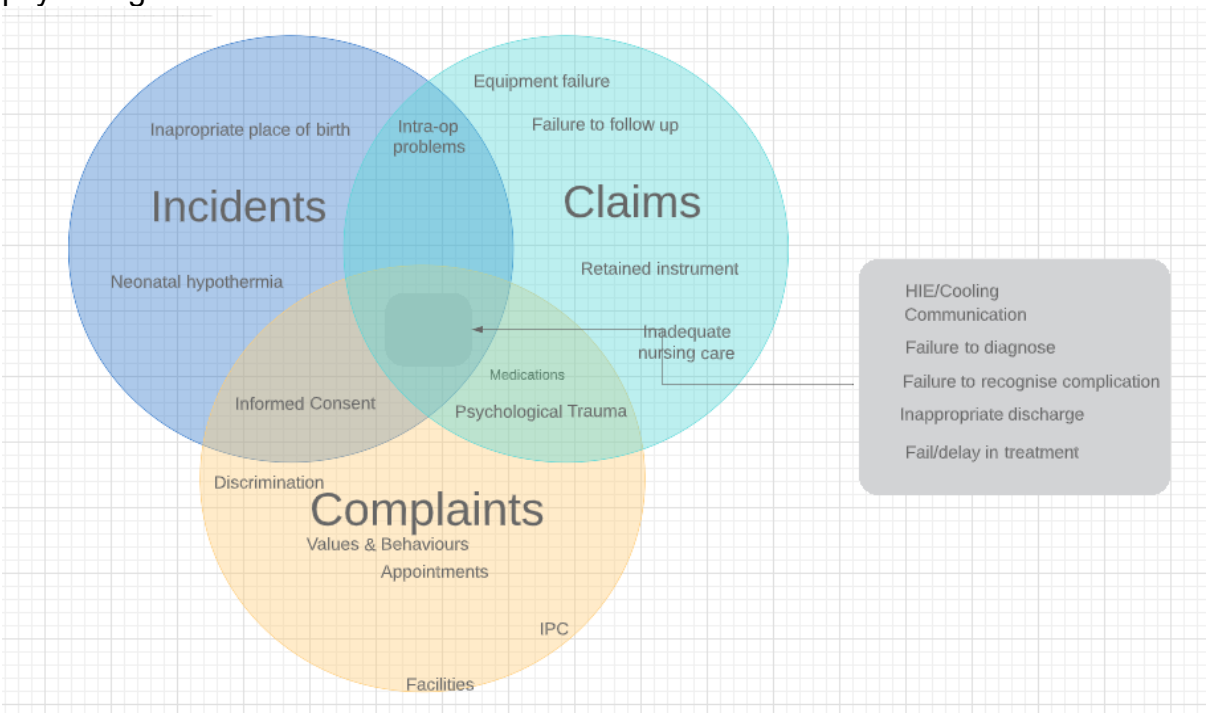
The Trust claims scorecard for 21/22 was released in June 2022, a dashboard of obstetric claims can be found here.

Claims Scorecard
21-22 Obs Dashboarc

Triangulation of the broad themes across claims, incidents and complaints identified 6 main themes;

- HIE/Cooling
- Communication
- Failure to diagnose
- Failure to recognise complications
- Inappropriate discharge
- Failure/delay in treatment

There are also themes around informed consent, intra-operative complications, psychological trauma and medications use.



A significant amount of work has already been commenced to address these themes

- The appointment of a lead midwife and lead obstetrician for fetal monitoring to support a reduction in babies require cooling and diagnosis of HIE
- The Workplace Innovation programme aims to
    - improve multidisciplinary communication and escalation of clinical concerns
    - review pathways of care through process mapping to identify areas for improvement related to timely diagnosis and treatment
- Ongoing work to improve education and training, including the introduction of frequent practical skills and drills procedures to address identification and escalation of clinical concerns
- iNeed escalation project to ensure staff feel comfortable asking for help with clinical concerns and obtain timely and appropriate responses from clinicians.
- Personalised Care and Support Planning project to improve communication with women and families, including shared decision making and improving informed consent processes and give women autonomy over their care.
- Funding awarded from EMAHSN to support improvement work with the TwinsTrust to improve the recognition and treatment of complications in multiple and preterm pregnancies

Conclusion

As a proactive learning team this triangulation gives additional evidence to support that the service has identified the correct areas for targeted improvement. We will continue to monitor themes on a quarterly basis.

United Lincolnshire Hospitals NHS Trust

Maternity & Neonatal Safety Assurance Report

Libby Grooby, Interim Head of Midwifery
As at 10 October 2022

Maternity & Neonatal Safety Assurance Report – Key Highlights

Trust: United Lincolnshire Hospitals NHS Trust **Date:** As at 10 October 2022 (Aug data)

Executive Summary:

This report outlines progress against the maternity and neonatal transformation work. The full Maternity & Neonatal Dashboard is provided at **Appendix A**. Other relevant in-month developments & updates are also included in a separate section of the highlight report.

CNST: 10 Steps-to-Safety

No	Safety Action	Predicted RAG	Comments / Actions Being Taken
1	National Perinatal Mortality Review Tool		Work is on track to achieve compliance
2	Maternity Services Data Set (MSDS)		Work is on track to achieve compliance
3	Transitional Care Services		Work is on track to achieve compliance
4	Clinical Workforce Planning		Work is on track to achieve compliance
5	Midwifery Workforce Planning		Element around supernumerary status of the co ordinator
6	SBLCB V2		Training element is at risk due to junior doctors rotation
7	Service User Feedback / Co-produced Services		Need further evidence to demonstrate compliance
8	Training Plan		At risk due to junior doctor rotation and ability for staff to attend training
9	Safety Champions		Work is on track to achieve compliance
10	HSIB / Early Notification Scheme		Work is on track to achieve compliance

Saving Babies Lives Care Bundle (SBLCB) V2

No	Requirement	RAG	Comments / Actions Being Taken
1	Reducing Smoking		Implemented. Ongoing audit programme in place to ensure requirements are embedded in practice
2	Fetal Growth Restriction		Implemented. Ongoing audit programme in place to ensure requirements are embedded in practice
3	Reduced Fetal Movements		Implemented. Ongoing audit programme in place to ensure requirements are embedded in practice
4	Fetal Monitoring During Labour		Implemented. Ongoing audit programme in place to ensure requirements are embedded in practice
5	Reducing Pre-term Birth		Implemented. Business case for fetal fibronectin monitoring submitted to CRIG

Continuity of Carer

Compliance	19.44%↓ booked on pathway in month 10.59%↓ of those booked on pathway delivered by team	
National target (new)	Continuity of carer to be the default model of care to all women by March 2024. Building blocks to be in place by March 2022. Co-designed plan to be in place by July 2022 Report to Trust Board Nov 21	BR+ report included guide for CoC staffing. Business Case being developed
Progress against plan	Team 1 Gainsborough - Launched August 2019 Team 2 Sleaford - Launched September 2020 Team 3 Skegness – Launch paused due to recruitment issues Team 4 Wolds - Launched Further roll out paused.	

Outliers: Red Flags

KPI	National Rate	Trust Rate	Comments / Actions Being Taken
Smoking at time of delivery	<9.6%	14.40%↓	In house team appointed and now in post Conversations around NRT ongoing
PPH ≥ 2L	<1.30%	1.31%↑	April saw the launch of the revised metrics for which we are green. Need to continue to monitor
PROMPT Training	>90%	65.22%↓	Plan in place to ensure achievement of target by 05.01.23. see training deep dive for August 22
Avoidable term admissions – data a month behind	<5%	PHB 3.23%↓ LCH 6.22%↓	Task and finish group set up Dedicated time for MW
Sickness - Neonates	Trust rate 4%	LCH 6.4%↓ PHB 14%↑	Reg'd/Unreg'd - All being managed but has been escalated to PRM
Hypo-thermia	0	LCH 1 - PHB 1↑	Relaunched warm bundle One BBA
QIS	70%	69.5%↑ LCH 75%↓ - PHB	Clear trajectory and robust education programme and all new staff attend the network foundation programme for pre QIS training.

RAG RATING MATRIX

Blue	**Completed & embedded**
Green	**Completed & ongoing and / or not yet fully embedded**
Amber	**In progress / on track**
Red	**Not yet completed / significantly behind agreed timescales / needs support**

‘Deep Dives’

This section of the report provides high level reporting on specific ‘Deep Dives’ arising from either incidents or outliers: red flags including as requested by the Maternity & Neonatal Oversight Group.

There are no ‘deep dives’ to report this month. The claims scorecard – providing information on triangulation of claims with complaints and incidents – is provided as a separate agenda item.

Learning Lessons

Overview for the reporting period:

As at 1 September 2022, there were 101 (128 last report) open incidents for Obstetrics & Community Midwifery, 47 (59 last report) of which are overdue.

All team leads contacted to identify outstanding Datix and reviews that are required. Ongoing challenges remain for Lincoln site due to operational pressures and the need for the senior management team to cover clinical staffing gaps.

No ATAIN meetings held for August and September (LCH) and August (PHB). LCH team to consider additional risk meeting to support number of MDT reviews required.

There were 9 (16 last report) open incidents in Neonates, 5 (3 last report) of which are overdue.

As at 1 September 2022, there were 3 Serious Incidents (SIs) in Obstetrics – IDs 289011, 285078, 285725 and 2 being overdue. Two SI booked for presentation at SI Panel 10/10/2022.

There were no SIs in Neonates.

3 ongoing cases being investigated by HSIB IDs 279214, 288645 and 294094, with one being overdue.

There were 2 closed SIs for Obstetrics – 256823 and 277495.

ULHT SI Update – see below

ULHT SI DI and HSIB Update September 20

SPC Charts to demonstrate data relating to Datix and SI actions

SPC Charts MNOG Datix.xlsx

SPC Chart Actions.xlsm

Specific Requirements	Number	Details	Learning / Actions Taken
Number of incidents graded as moderate or above (reported August 2022)	1– Obstetrics 0 - Neonates	1. **294094-** Home birth undiagnosed breech extensive resuscitation and transfer to Nottingham for therapeutic cooling.	1. Initial MDT held and action plan- no care issues identified from ULHT perspective. HSIB referral declined as MRI normal despite clinical presentation of HIE 3. ULHT to consider feasibility of presentation scanning for home birth women.
Other Incidents considered at SI / Rapid Review Panel (discussed in August 2022)	1 – Obstetrics 1 - Neonates	1. **290080 (low harm)** - NNU- Monitoring of metabolic bone disease treatment (Vitamin D and Calcium) in this ex premature baby was being carried out. Abnormal results warranted stopping treatment and discussing with specialist. It appears that medication not stopped but plan was made to discuss with specialist (metabolic bone team Sheffield Children Hospital) for advice. Renal USS showed nephrocalcinosis. 2. **291776 (no harm) -** 34/40 Stillbirth- Full PMRT to be completed.	1. Guideline updated with checking of Vitamin d levels clearly stated. Shared with network due to guideline from Nottingham having been used. Network to update own guidelines to reflect learning from incident.
Serious Incidents - New (reported August 2022)	0 - Obstetrics 0 – Neonates 1 - HSIB	1. **HSIB – 294094-** HSIB referral declined.	1. See above. Recommended consideration of presentation scanning.

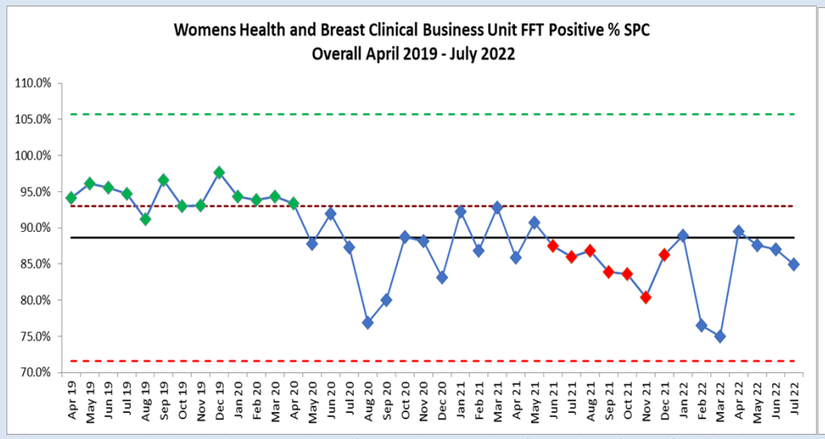
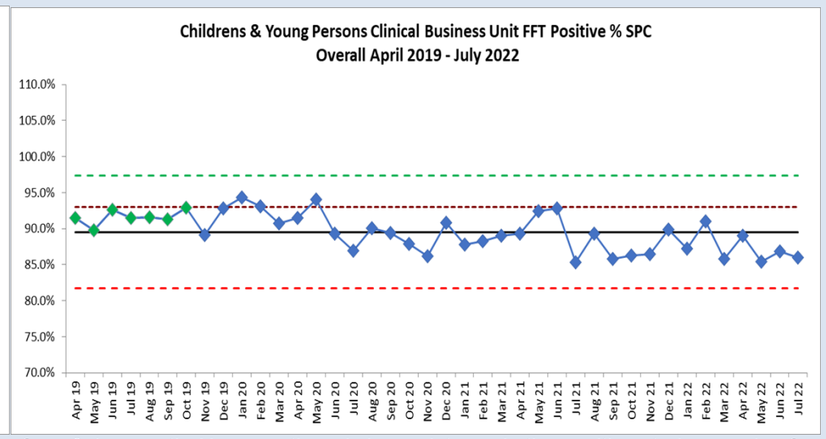
Serious Incidents – Closed (August 2022)	2 – Obstetrics 0 – Neonates	1. 256823 – Massive obstetric haemorrhage- external review completed. 2. 277495 – Missed 3rd degree tear, birth trauma and ongoing bladder concerns.	1. MDT work required around MOH- now included within QI project and led by patient safety midwives. Linked with regional and national teams. 2. Learning surrounding intrapartum and postpartum bladder care – education and guideline updates required.
HSIB Investigations	3 current	1. 279214 – Awaiting report- delayed. 2. 288645 – Interviews completed. 3. 294094 – HSIB referral declined.	1. Family meeting with HOM held- awaiting final report overdue September 2022- delays due to bank holiday. 2. Interviews completed September 2022.
Key themes & trends Identified from the above incidents and any additional actions being taken		1. Initial Action plans required regarding HSIB cases and SI to ensure immediate Actions completed prior to final report completion. 2. Electronic fetal monitoring remains a high risk issue identified through SI/DI/HSIB and Datix incidents- now added to the risk register. 3. Bladder care- education and training required. 4. NLS recurrent theme- education and training required. 5. Live skills and drills to be implemented pan-site to include local cases and learning. 6. Learning events surrounding PPH and hypertension to be implemented.	
Number of overdue actions from incidents / SIs / HSIB and actions being taken	As at 1 September 2022, in Obstetrics, there were 208 (295 last month) ongoing actions – 135 of these are overdue. In Neonates there were 2 actions, 2 of these are overdue. Weekly Action plan meetings recommenced with senior team and specialist midwives to include HSIB, PMRT, SIs, DI's and Complaint actions. Handlers informed of outstanding actions to review on 1:1 basis and cross-reference to Maternity Improvement Plan if appropriate.		

Service User Voice Feedback

Brief overview for the reporting period:

As at 1 September 2022, there were 7 open complaints in Obstetrics & Community Midwifery (2 overdue): L29808, P32224, P32579, L32776, L32846, P32892 and P33387. There are 0 open complaints in Neonates.

There were no PALS concerns received in Obstetrics or Neonates since the last report and as at 1 September 2022, there were no open PALS in Obstetrics or Neonates.

Specific Requirements	Number	Details	Learning / Actions Taken
Number of complaints received	1 – Obstetrics 0 - Neonates	1. P32892 -	Communication remains a theme from complaints and PALS.
Number of PALS received in August	0 – Obstetrics 0 - Neonates		As above.
Number of compliments* ***Information taken from SUPERB (Single Unified Patient Experience Reporting Board)***	39 – Obstetrics 40 – Neonates	39 for PHB Labour Ward 13 for Neonates LCH, 17 for Neonates PHB	Compliments are shared with the relevant teams.
Feedback received by Maternity & Neonatal Voices Partnerships		Verbal update	
Key themes & trends identified from the above activity and any additional actions being taken		**Communication** – ongoing work to highlight to the teams around importance of communication. Workplace innovation work Human factors training mandatory Plan for MVP to support conversations around language	
Number of overdue actions from complaints / PALS and actions being taken		As at 1 September 2022, there were 3 open Obstetric complaint actions. All 3 are overdue completion. There are 0 open Neonatal complaint actions.	
Friends and Family Test		The highlight report for August 2022 shows a National average recommended rate of 93%, a Trust average of 86% and Maternity have achieved 96% No data for NNU as same cohort of women.   We see a consistently low number of negative stories from the ‘Care Opinion’ ranging from 0-1 a month. However there is inconsistency in the positive stories ranging from 2 – 25 a month	

Staff Experience & Feedback

Overview for the reporting period including staff feedback from frontline champions and walkabouts:

- Please also refer to the separate report from the Maternity NED 'Safety Champion.
- Ongoing work from the SDMC – feedback meeting highlighted the positive achievements including the place mats and also discussed future projects.
- Change Champions in place who have joined the SDMC to support progression of work
- Fortnightly updates for midwifery teams have recommenced. Opportunity for staff to hear what's going on and feedback any issues.

Other in month Developments & Updates

For September

- Senior team from maternity and neonates are joining the first cohort in a leadership programme which will be completed by all teams nationally.
- 13 new starter in Maternity in September. 1st cohort from Lincoln university
- Bereavement suite opening on Pilgrim site 12th October
- Funds have been received to participate in the TAMBSA project. This will support our work with Twin pregnancy's.
- Peer Review – representatives from the East Midlands Neonatal ODN visited ULHT on 14th September 2022 to review our neonatal services against service specification. The meeting was hugely successful and the team gave some very positive feedback.
- NNU have a new ANNP trainee started in post with two further starting January 23.
- Outreach team is now funded 7/7 so team are out to advert to fill the 1.4 WTE vacancy
- NNU are applying for ward accreditation

Update from Maternity & Neonatal Safety Collaborative (Improvement Delivery Group) Meeting:

Escalations from Maternity & Neonatal Safety Collaborative – October meeting focused on the Maternity & Neonatal Safety Improvement Plan (SIP)

Several of the actions were closed

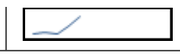
Copy of v1.1
Maternity Neonatal

- The SIP has been updated to include the oversight and assurance for each action or group of actions
- Evidence has been gathered and filed in a dedicated file for those completed actions which have then been RAG rated 'blue'
- All the 'blue' actions were reviewed in the Maternity & Neonatal Safety Collaborative this month and closure (i.e. evidence of embedding) was agreed by the group
- All closed actions have been moved to the archive tab

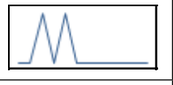
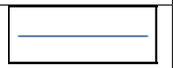
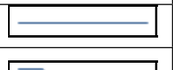
Appendix A

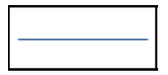
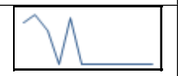
ULHT Maternity & Neonatal Quality Dashboard 2022/23

Activity Indicators ULHT																				
Metric	Threshold R	Threshold A	Threshold G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Total Number of bookings benchmarked to 5200				Careflow Maternity (CM)		487	522	474	468	482								2433		
Women booked by 9+6 weeks	<67.50%		>67.50%	CM/HES Data 2021		70.64%	67.24%	68.78%	68.16%	72.82%										
Women booked onto Continuity Pathway	<22%		>22%	CM/ULHT default plan		22.59%	20.69%	25.74%	19.44%	19.29%										
BMI >25 at Booking				CM/PHE 2018		53.18%	56.51%	55.06%	55.98%	56.22%										
BMI >35 at Booking				CM/PHE 2018		12.94%	13.22%	13.50%	13.68%	12.45%										
BMI >40 at Booking				CM/PHE 2018		5.95%	4.79%	5.27%	3.63%	5.19%										
Total number of Births				CM		367	363	362	393	385								1870		
Total Number of Live Births				CM		365	363	362	391	384								1865		
Unassisted Vaginal Birth Rate	<57%		>57%	CM/HES Data 2020		54.22%	55.65%	51.10%	50.38%	54.55%										
Home Birth Rate	<2.40%		>2.40%	CM/ONS 2020		1.09%	2.48%	2.76%	1.02%	1.30%										
Forceps and Ventouse	>12%		<12%	CM/HES Data 2020		10.08%	10.74%	9.67%	11.20%	9.09%										
Total Caesarean Section Rate				CM		34.88%	31.96%	38.40%	37.40%	35.58%										
Emergency Caesarean Section				CM		21.80%	20.11%	23.20%	20.36%	23.64%										
Elective Caesarean Section				CM		13.08%	11.85%	15.19%	17.05%	11.95%										
Women booked on Continuity Pathway received care in labour/birth by continuity Team	<70%		>70%	CM/NHSIE		40.00%	23.08%	34.04%	10.59%	29.41%										
Induction of Labour Rate	>40%		<40%	CM/HES Data 2021		38.46%	41.46%	38.76%	36.69%	36.13%										
Smoking at Booking				CM/MSDS 2021		13.76%	14.94%	18.99%	15.81%	13.07%										
Smoking at the time of Delivery	>9.6%		<9.6%	CM/NHSD 2021		14.29%	11.48%	14.89%	17.31%	14.40%										

GDM at delivery				CM		13.74%	14.29%	13.48%	17.05%	21.73%											

Maternal Morbidity Indicators ULHT																					
Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
PPH ≥1.0 litre	>8.60%		<8.60%	CM/Obs CYMRU		7.42%	10.08%	11.52%	11.37%	10.99%										
PPH ≥1.0 litre SVB	>4.90%		<4.90%	CM/Obs CYMRU		1.92%	3.92%	3.09%	0.78%	1.83%										
PPH ≥1.0 litre Instrumental	>18.40%		<18.40%	CM/Obs CYMRU		1.37%	0.84%	1.12%	3.10%	1.83%										
PPH ≥ 1.0litre EL/LCS	>8.50%		<8.50%	CM/Obs CYMRU		1.37%	1.68%	1.69%	4.39%	1.57%										
PPH ≥ 1.0litre EM/LSCS	>19.80%		<19.80%	CM/Obs CYMRU		2.75%	3.64%	5.62%	3.36%	5.76%										
PPH ≥2.0 litre	>1.30%		<1.30%	CM/Obs CYMRU		0.27%	0.84%	1.40%	0.52%	1.31%										
3rd and 4th degree Tear	>3%		<3%	CM/OASI post-bundle stats		2.47%	1.12%	2.53%	1.29%	1.57%										
Admission to ITU	>1		0	Inpatient Matron		0	1	2	0	0								3		
No of PN Readmissions up to 42 days of birth	>3.40%		<3.40%	Self serve NMPA 2021		4.12%	2.24%	4.78%	3.62%	3.14%										

Neonatal Mortality & Morbidity Indicators ULHT																					
Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Unexpected Term admissions to the NICU (based on Term births)	>5%		<5%	NNU/NHSIE ATAIN project		6.90%	4.68%	6.34%	5.21%											Reports 1 month behind. April & May corrected in July
No. of babies transferred for therapeutic cooling	>1		0	NNU		0	0	1	0	1								2		
Pre-Term Birth 23+0-36+6 wks	>6%		<6%	CM/SBL		4.90%	5.79%	8.56%	7.12%	9.35%										
No. of Antenatal stillbirths	≥1			CM		2	0	0	2	1								5		
No. of Intrapartum stillbirths	≥1			CM		0	0	0	0	0								0		
Rolling stillbirth rate (12 months)	>3.8 per 1000		<3.8 per 1000	CM/ONS 2020		3.43	3.23	3.03	3.28	3.08										
No. of NND	≥1			CM and NNU		0	0	0	0	0								0		
Rolling NND rate (12 months)	> 2.2 per 1000		<2.2 per 1000	CM and NNU/ONS 2020		0.64	0.65	0.65	0.44	0.22										

AN Steroids Eligible / Full course Administered	<100%		100%	NNU		5/1	4/1	5/3	9/2	15/4										
AN Magnesium Sulphate Eligible / Administered	<100%		100%	NNU		2/2	0/0	2/2	3/3	2/2										
SGA detection rate	< 41.2%		>41.7%	ANC/SBL Perintatal Institute		57.14%	69.38%	46.00%		63.24%										

Workforce Indicators ULHT																				
Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Midwife to Birth Ratio (funded)	01:27		01:26			01:26	01:26	01:26	01:26	01:26										
Midwife to Birth Ratio (Actual)	01:27		01:26			01:25	01:25	01:25	01:27	01:26										
1-1 in labour	<99%		>99%	CM/CNST		100.00%	100.00%	100.00%	100.00%	99.71%										
Sickness Rate	>4.3%		<4.3%	Workforce Intelligence		4.10%	3.83%	4.73%	5.65%	5.72%										
Co-ordinator Supernumerary	<96%		>99%	Inpatient Matron/CNST		90.00%	96.50%	96.00%	92.23%	93.75%										
Prompt Training Compliance	<95%		>95%	CE team/ CNST		83.31%	81.64%	68.55%	69.54%	65.22%										
Mandatory Training Compliance	<95%		>95%	CE team/ CNST		92.31%	83.52%	84.15%	81.58%	86.04%										

***PROMPT Training (includes CTG training) – all staff groups as at the end of August 2022**

		Trained	Possible	%
PROMPT	Lincoln MW	128	166	77.11
	Lincoln Drs	13	31	41.94
	Lincoln Anaes	16	22	72.73
	Lincoln HCSW/MSW	4	47	8.51
	LCH Prompt	161	266	**60.53**
	Bank Only MW (Trustwide)	13	20	**65.00**
	Pilgrim MW	97	99	97.98
	Pilgrim Drs	10	23	43.48
	Pilgrim Anaes	10	27	37.04
	Pilgrim HCSW/MSW	9	25	36.00
	PHB Prompt	126	174	**72.41**
	Trust Compliance Prompt	300	460	**65.22**

Recovery training Compliance – September's

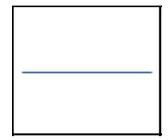
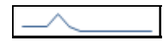
	LCH		PHB	
	Number	%	Number	%
Oct 21	24/64 Increased number of staff needing training after this to include COCOs	37.5%	20/44	45%
March 22	52/110	47%	50/67	75%
June 22	65/110	59.09%	61/67	91.04%
Sept 22	73/111	65.7%	61/67	91.04%

Postnatal Indicators ULHT

Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Skin to Skin Contact at Birth	<80%		>80%	CM/HES 2021		78.90%	78.79%	75.41%	76.21%	80.47%										
Breastmilk at first feed	<68%		>68%	CM/HES 2021		61.64%	64.19%	66.02%	64.45%	64.58%										

Risk Management Indicators ULHT

Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
No. of unit closures	≥1		0	Inpatient Matron		2	1	3	2	2								10		
Number of incidents logged & graded as moderate or above				Risk (Datix)		3	1	3	0	0								7		
No. of SI's Maternity				Risk (Datix)		0	1	1	1	0								3		
No. of Never Events	≥1		0	Inpatient Matron		0	0	0	0	0								0		
No. of HSIB cases				Risk (Datix)		0	0	1	0	1								2		
PMRT commenced within CNST timeframe	<95%		≥95%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%										
PMRT completed within CNST timeframe	<50%		≥50%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%										
Duty of Candour (verbal)	<100%		100%	Risk (Datix)		100.00%	100.00%	N/A	N/A											Reports one month behind
Duty of Candour (Written)	<100%		100%	Risk (Datix)		100.00%	100.00%	N/A	N/A											Reports one month behind
No of current coroners cases / inquests pending				Legal		0	0	0	0	0								0		

No of coroners Regulation 28 (prevention of future death reports) made direct to the trust)		Legal		0	0	0	0	0								0		
No of Formal Complaints		Complaints		1	1	1	4	1								8		

Labour Ward Quarterly Perinatal Mortality Report – June to August 2022

June 2022

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Notified	Case No.	PMRT Complete date	CNST Standards draft deadline date	DATIX PANEL SI
LCH	LFL	16/06/22	22+2	P3, late booker @ 15/40. Prev baby on 1st centile. H/o abruption in 2nd pregnancy. 2 prev c-sections. Smoker. Abruption, EMCS 2.8ltr PPH	20/06/22	82074		20/10/22	288485 Yes No
PHB	Misc	15/06/22	20+6	P2, late booker @ 14/40. Declined screening. Prev baby on the 3rd centile. Anomaly USS- No FH seen	N/A	N/A	N/A	N/A	No No N/A
PHB	Misc	30/06/22	19+1	P1, Prev LLETZ, declined screening. Anomaly USS- increased nuchal fold. No FH seen	N/A	N/A	N/A	N/A	No No N/A
External (PHB)	NND	23/06/22	36/40	P0, low risk. Anomaly-NAD. CMW referred for growth USS ? LGA – 32/40 cardiac anomaly identified. ELCS @ 36/40 breech. RIP baby Archie @ 2 days of age.	By other trust				

July 2022

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Notified	Case No.	PMRT complete date	CNST Standards draft deadline date	Datix Panel SI
PHB	SB	07/07/22	32+3	P3+1, smoker, prev baby 5th centile. Reduced FM-no FH. 1520g 1st centile	11/07/22	82419		11/11/22	289878 Yes No
LCH	Misc	10/07/22	20+1	P1, smoker, 1:48 chance T21, normal CVS. No Fh on anomaly USS @ 19+6. Baby 17/40 in size	N/A	N/A	N/A	N/A	290352 No N/A
LCH	Misc	16/07/22	20/40	P0, PV bleed 19+5, no FH on auscultation. Baby 14/40 in size	N/A	N/A	N/A	N/A	290861 No N/A
LCH	LFL	19/07/22	22+1	P1, prev 33/40 del, Low PappA, ?bicornate uterus, spont delivery at home. No signs of life	21/07/22	82627		21/11/22	291216 No N/A
LCH	SB	28/07/22	34+5	P0+1, SGA 10th C & raised BP from 32/40- PLGF 129. Reduced Fm 34+2, no fh. 1750g-1st centile	28/07/22	82725		28/11/22	291776 Yes No
External (PHB)	NND	DOB 08/07/22	30+2	P0, known abnormalities, CCAM, ascites, hydrops, polyhydramnios. Baby Felix RIP 7 days of age.	By other trust				No N/A N/A
External (PHB)	NND	31/07/22	21+3	P0, Multiple abnormalities. TOP, baby born with signs of life.	N/A As TOP	N/A	N/A	N/A	No N/A N/A

August 2022

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Notified	Case No.	PMRT complete date	CNST Standards draft deadline date	DATIX PANEL SI
PHB	SB	01/08/22	24+3	P1, Holiday maker, attended with bulging membranes, footling breech MCDA twins, Twin 1 RIP 24+3-TTS, Twin 2 31+1 born alive.		82820		01/12/22	
LCH	TOP	12/08/22	22/40	P0, Spina bifida with brain involvement	N/A	N/A	N/A	N/A	292894 No N/A
LCH	TOP	14/08/22	16/40	P1, Spina bifida with head involvement	N/A	N/A	N/A	N/A	No N/A N/A
LCH	TOP	17/08/22	17+4	P2, T21	N/A	N/A	N/A	N/A	No N/A N/A

Total Quarterly losses

Hospital	No of TOPs	No of SBs	No of LFL	No of Misc	No of NND	Total	PMRT cases	External PMRT	
Pilgrim	0	2	0	2	0	4	2		
Lincoln	3	1	2	2	0	6	3		Total PMRT
Total	3	3	2	4	0	12	5	1	6

United Lincolnshire Hospitals NHS
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Neonatal Quality and Safety Dashboard - 2022/2023

Lincoln County Hospital

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit	Live Births	2909	2925	2812	242.4	243.8	234.3	226.6	220	210	209	257	237								1133	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	345	326	371	28.8	27.2	30.9	28.8	27	21	25	37	34								144	
	No of First Episode Admissions	283	282	299	23.6	23.5	24.9	22.0	22	12	21	26	29								110	
	% of First Episode Admissions against Live Births			N/A			11%	9.6%	10.0%	5.7%	10.0%	10.1%	12.2%								N/A	
	No of Admissions to TC	152	202	220	12.7	16.8	18.3	15.4	16	18	17	14	12								77	
	All Ex-utero transfers	73	62	69	6.1	5.2	5.8	6.2	6	6	6	7	6								31	
	Ex-utero transfers <27 weeks	1	2	1	0.1	0.2	0.1	0.4	0	0	0	2	0								2	
	In-utero transfers	4	13	11	0.4	1.1	0.9	0.4	1	0	1	0	0								2	
	In-utero transfers <27 weeks	0	8	6	0.0	0.7	0.5	0.2	1	0	0	0	0								1	
	NNU Term Admissions	143	168	170	11.9	14.0	14.2	12.8	16	5	14	15	14								64	
	Live Term Births	2654	2725	2584	221	227	215	212	211	200	191	241	215								1058	
	% NNU Term Admissions (Live Term births) - Target <5%	N/A	N/A	N/A	5.4%	6.2%	6.5%	6.0%	7.6%	2.5%	7.3%	6.2%	6.5%								N/A	

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Neonatal Quality and Safety Dashboard - 2022/2023

Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	68%	63%	69%	68.2%	70.9%	72.5%	58.9%	57.2%	81.3%								N/A	
		TC	N/A	N/A	N/A	83%	80%	45%	39.1%	38.8%	30.6%	48.3%	37.5%	40.3%								N/A	
		Total (NNU & TC)	N/A	N/A	N/A		67%	61%	58.0%	59.7%	57.9%	55.2%	50.4%	67.0%								N/A	
	Hypothermia on Admission - Ep.1 (<36.5°c)	NNU	34	53	28	2.8	4.4	2.3	0.2	0	0	1	0	0								1	
		TC			15			1.3	1.0	0	3	0	1	1								5	
	(% of first episode admissions)	NNU %			N/A			0.1	1.0%	0.0%	0.0%	4.8%	0.0%	0.0%								N/A	
		TC %			N/A			0.1	6.4%	0.0%	16.6%	0.0%	7.1%	8.3%								N/A	
	Transferred for Therapeutic Cooling		5	0	4	0.4	0	0	0.2	0	0	0	0	1								1	
	HIE (all grades)		8	2	6	0.7	0.2	0.5	0.4	0	0	0	1	1								2	
	Neonatal Deaths (following admission to NNU)		0	1	1	0	0.1	0.1	0.0	0	0	0	0	0								0	
	Neonatal Deaths (delivery room)								0.0	0	0	0	0									0	
	Unit Closures (any)		0	2	0	0	0.2	0.0	0.0	0	0	0	0	0								0	
	No. of Exceptions		8	13	22	0.9	1.1	1.8	1.2	3	0	1	1	1								6	
	No of Serious Incidents (SI)		1	1	1	0.1	0.1	0.1	0.0	0	0	0	0	0								0	

United Lincolnshire Hospitals NHS
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Neonatal Quality and Safety Dashboard - 2022/2023

Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Staffing	Appraisals - % (Target 100%)	Registered and unregistered	N/A	N/A	N/A			86%	86.2%	80.0%	87.2%	86.1%	86.1%	91.7%								N/A	
		ANNPs	N/A	N/A	N/A	75%	75%	71%	75.8%	83.0%	83.0%	71.0%	71.0%	71.0%								N/A	
	Sickness - % (Target - Trust avg <4%)	Registered and unregistered	N/A	N/A	N/A	6.5%	5.1%	6.8%	10.2%	10.5%	11.2%	9.6%	13.1%	6.4%								N/A	
		ANNPs	N/A	N/A	N/A	4.0%	0.6%	4.9%	8.4%	3.5%	3.9%	5.7%	26.0%	2.9%								N/A	
	Mandatory training % (Core Learning) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	94%	91%	90%	94.8%	91.0%	95.0%	96.0%	96.0%	96.0%								N/A	
		ANNPs	N/A	N/A	N/A	96%	97%	90%	95.0%	95.0%	93.0%	96.0%	96.0%									N/A	
	Mandatory training % (Core Learning Plus) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	92%	86%	86%	89.9%	85.0%	86.0%	90.0%	95.0%	93.4%								N/A	
		ANNPs	N/A	N/A	N/A	96%	89%	86%	90.8%	90.0%	91.0%	91.0%	91.0%									N/A	
	BLS (Target >95%)		N/A	N/A	N/A	95%	63%	77%	75.2%	31.0%	80.0%	88.0%	88.0%	89.0%								N/A	
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	N/A	N/A	64%	67.4%	63.6%	66.5%	68.0%	69.3%	69.5%								N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	3.9	4.6	2.3	1.8	2.6	1.6	1.6	1.6	1.6								N/A	
	% staff with in-date NLS (Target 100%)		N/A	N/A	N/A	100%	95%	90%	99.4%	97.2%	100%	100.0%	100.0%	100%								N/A	

United Lincolnshire Hospitals NHS
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Neonatal Quality and Safety Dashboard - 2022/2023

Pilgrim Hospital, Boston

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit	Live Births	1762	1612	1798	146.8	134.3	149.8	146.4	145	153	153	134	147								732	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	209	172	218	17.4	14.3	18.2	16.6	18	19	20	10	16								83	
	No of First Episode Admissions	175	137	191	14.6	11.4	15.9	14.4	14	18	16	9	15								72	
	% of First Episode Admissions against Live Births			N/A			11%	9.8%	9.7%	11.8%	10.5%	6.7%	10.2%								N/A	
	No of Admissions to TC	72	65	80	6.0	5.4	6.7	7.2	10	7	8	7	4								36	
	All Ex-utero transfers	30	28	23	2.5	2.3	1.9	2.2	2	2	4	1	2								11	
	Ex-utero transfers (<32 weeks)	12	7	9	1.0	0.6	0.8	0.8	1	0	1	0	2								4	
	All in-utero transfers	20	14	8	2.0	1.2	0.7	1.2	2	2	1	0	1								6	
	In-utero transfers (<32 weeks)	15	13	5	1.5	1.1	0.4	1.2	2	2	1	0	1								6	
	NNU Term Admissions	87	65	113	7.3	5.4	9.4	7.4	9	11	7	4	6								37	
	Live Term Births	1638	1510	1672	136.5	126	139	135	137	142	140	124	134								677	
	% NNU Term Admissions (Live Term births) Target <5%	N/A	N/A	N/A	5.3%	4.3%	6.7%	5.4%	6.6%	7.7%	5.0%	3.2%	4.5%								N/A	

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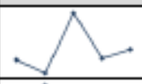
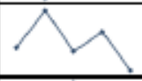
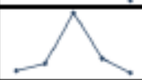
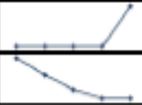
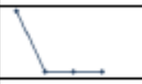
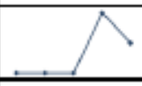
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	46%	44%	42%	39.9%	34.2%	25.4%	64.2%	35.1%	40.7%								N/A	
		TC	N/A	N/A	N/A	50%	39%	51%	59.2%	55.8%	80.6%	53.3%	66.1%	40.3%								N/A	
		Total (NNU & TC)	N/A	N/A			42%	45%	46.4%	41.4%	43.8%	60.6%	45.4%	40.6%									
	Hypothermia on Admission - Ep.1 (<36.5°c) (% of first episode admissions)	NNU	35	39	30	2.9	3.3	2.5	1.2	4	1	1	0	0								6	
		TC			5			0.4	0.2	0	0	0	0	1								1	
		NNU %			N/A			0.2	10.3%	28.6%	16.6%	6.3%	0.0%	0.0%								N/A	
		TC %			N/A			0.1	5.0%	0.0%	0.0%	0.0%	0.0%	25.0%								N/A	
	Transferred for Therapeutic Cooling		2	2	1	0.2	0.2	0.1	0.2	0	0	1	0	0								1	
	HIE (all grades)		2	3	2	0.2	0.3	0.2	0.2	0	0	1	0	0								1	
	Neonatal Deaths (following admission to NNU)		0	0	2	0	0	0	0.0	0	0	0	0	0								0	
	Neonatal Deaths (delivery room)								0.3	1	0	0	0									1	
	Unit Closures (any)		0	0	0	0	0	0	0.0	0	0	0	0	0								0	
	No. of Exceptions		24	23	22	2.0	1.9	1.8	1.6	1	1	1	3	2								8	
	No of Serious Incidents (SI)		0	0	1	0	0	0	0.0	0	0	0	0	0								0	

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Staffing	Appraisals - % (Target 100%)	N/A	N/A	N/A			83%	73.4%	89.0%	85.0%	65.0%	58.0%	70.0%								N/A	
	Sickness - % (Target - Trust avg <4%)	N/A	N/A	N/A	5.5%	6.3%	6.3%	7.5%	6.3%	3.9%	2.3%	11.0%	14.0%								N/A	
	Mandatory training % (Core Learning) (Target >95%)	N/A	N/A	N/A	95%	96%	98%	97.8%	94.6%	98.0%	98.5%	99.0%	99.0%								N/A	
	Mandatory training % (Core Learning Plus) (Target >95%)	N/A	N/A	N/A	92%	94%	96%	95.6%	97.0%	95.0%	93.0%	96.0%	97.0%								N/A	
	BLS (Target >95%)	N/A	N/A	N/A	97%	99%	96%	91.0%	95.0%	82.0%	92.0%	93.0%	93.0%								N/A	
	QIS - % WTE (Target >70%)	N/A	N/A	N/A	62%	67%	70%	74.4%	73.0%	73.0%	75.5%	75.5%	75.0%								N/A	
	No. of QIS in training - WTE	N/A	N/A	N/A	2.0	0.6	1.5	1.6	2.0	2.0	1.0	2.0	1.0								N/A	
	% staff with in-date NLS (Target 100%)	N/A	N/A	N/A	96%	100%	98%	98.4%	100%	100%	100%	100.0%	92%								N/A	

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Maternity & Neonatal Safety Improvement Project Strategy & Improvement Plan

Updated September 2022

Maternity & Neonatal Safety Improvement Project Strategy: Executive Summary

Background & Introduction

Since the publication of the National Maternity Review in 2016 and the implementation of the Maternity and Neonatal Safety Collaborative, ULHT have been on a journey of improvement to optimise safe, personalised evidence-based care for women and families of Lincolnshire. The publication of the Long-term plan further supports the importance of ensuring maternity services optimise positive outcomes to contribute to a healthy population.

The Trust recognises that implementing change at pace and scale within the challenges of limited resources requires approaching innovation, change and quality improvement intelligently. Effectively implementing the national recommendation and locally identified areas for improvement is therefore essential to improving outcomes for women, babies and families across the county and for generations to come. To support this approach, key roles have been developed to enhance capacity and Quality Improvement (QI) training has been offered to clinical staff to enhance our safety and quality improvement ambitions.

ULHT is situated with the Midlands region and is the sole provider of maternity services within Lincolnshire Local Maternity and Neonatal system (LMNS). Since the inception of the LMNS, ULHT has also sought to work collaboratively with stakeholders within the LMNS. Extensive engagement with our Maternity Voices Partnership ensures that our services are responsive to and co-produced with the women and families of Lincolnshire.

Aims of the Strategy

The Maternity & Neonatal Safety Improvement Project Strategy outlines the Trust's ambitions to ensure our maternity service offers safe, evidenced-based, high-quality and personalised and aligned to national drivers (e.g. CNST, Saving Babies Lives, Continuity of Carer) and locally identified areas for improvement (e.g. Learning from Serious Incidents). A key element of the Trust's Maternity & Neonatal Improvement Project Strategy is the desire to learn from other organisations (e.g. Ockenden, CQC). Key quality improvement projects and actions support operational delivery - further details are provided in the full Maternity & Neonatal Improvement Project Strategy document.

The overarching aims of the strategy are to:

- Optimise safety
- Optimise experience
- Improve leadership
- Deliver the 'Better Births' ambitions
- Offer choice and personalised care to women
- Provide assurance

Oversight & Assurance

The Trust's Maternity & Neonatal Oversight Group (MNOG) has agreed the need for a single, combined Improvement Plan which brings together in one place all of the required improvement actions and associated assurances. This plan is provided in the remainder of this document which will remain 'live' as new improvement actions are identified and added. Completed actions will be archived once assurance has been provided to MNOG that actions and changes in practice have been embedded and, where required, ongoing monitoring arrangements are in place to ensure they remain effective.

Evidence available		U:\Midwifery\Action plans & evidence\Maternity Safety Improvement Plan
Version	**Date Updated**	**Update**
Version 1.0	01/10/2022	Plan creation completed and all fields completed
Version 1.1	04/10/2022	Reviewed at MNSC to archive embedded actions with evidence filed
Version 1.2	07/10/2022	Actions OS52 and OS53 added, transferred from Datix
Version 1.3	12/10/2022	Reviewed with PSIT who will forward evidence

Maternity & Neonatal Improvement Plan

RAG RATING MATRIX	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress / on track
Red	Not yet completed / significantly behind agreed timescales

No	Recommendation	Source (e.g. CNST, Ockenden, CQC. HSIB)	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	Progress (as at 14 September 2022)	Previous RAG Jun-22	Current RAG Sep-22	Actual Completion Date Denotes Action Completed	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
Reduce the number of cases of Hypothermia												
OS3	Introduce blanket warming cabinets on to labour ward, include reference to their use in the prevention and management of hypothermia guideline and embed into practice.	ATAIN	Deliver to Labour Wards following safety checks.	Improved quality & safety	Clinical Engineering	31/10/2021	Delivered and in place on Labour Wards at Lincoln & Pilgrim.			31/10/2021		Hypothermia case reviews
			Review use via the low temperature admission case review		ATAIN Lead	31/05/2022	Underway - new midwife assigned to complete case review. ST AY discuss Stevie Dickinson 4/10/22 ATAIN leads to take on audit					
Improve Fetal Monitoring / CTG Interpretation												
OS5	Continue to focus on improving fetal monitoring / CTG interpretation including staff awareness and individual and group training needs with an emphasis on recognition and escalation of an abnormal CTG.	Thematic Review of SIs & Complaints, November 2021 and SIs 265231, 253843, 264475	Implement the improvement actions agreed following the recent internal SBLCBV2 audit, as outlined with the monthly Maternity & Neonatal Assurance report, dated September 2021.	Improved quality & safety	FM Leads	30/06/2022	Underway.					Part of ongoing Fresh Eyes audit programme Maternity & Neonatal Safety Collaborative will retain oversight of this area of work with escalation of issues to MNOG, as required
			Implement CTG on-line training - RCOG EFM package (E lfh).		FM Leads		Feasibility of introducing this training is being explored. 9/9/22 IIA package mandatory, EFM package optional at present, awaiting confirmation to make ?mandatory. EFM whole day in place, EFM competency document in place					
			Implement a process for daily discussion of CTGs - CAT 1/2 CS and ATAIN Babies.		FM Leads / Consultant Midwife		Arrangements reviewed and process changed to twice weekly review. ATAIN TBAM process in place for review frequency					
OS6	Review feasibility of introducing physiological interpretation of CTG at ULHT.	ATAIN & ATAIN Quarterly	Benchmark HIE numbers against Trusts using physiological interpretation. Trusts to benchmark against; GSTT, Kingston.		FM Leads / Consultant Midwife	30/06/2022	This is a significant piece of work - review and benchmarking to be completed following appointment of FM leads. 9/9/22 Kingston excluded due to STAN. Last 10 cases review planned to apply hypothetical physiological interpretation to evidence differenert course of action, expected 9/12/22. 16/9/22 Data received from GSTT.					
			Identify barriers to implementation.									
Improve the Management of Hypoglycaemia												
OS8	Provide up to date, evidence based education to Midwives regarding hypoglycaemia.	ATAIN	Review current hypoglycaemia education provided to Midwives		Patient Safety Lead Midwife / Consultant Midwife		Safety Lead has reviewed MTD teaching. Updated teaching programme provided to staff from November 2021 onwards.					Efficacy to be audited through ATAIN audits
			Arrange meeting to plan education strategy for hypoglycaemia management		Clinical Educators							
Reduce Delays in Treatment / Delivery / Review												
OS9	Introduce traffic light escalation communication	ATAIN	Present QI at LW forum.	Reduction in incidents / harm Improved quality & safety	Patient Safety Lead	31/01/2022 revised date 31/3/23	Work underway - update requested. 21/9/22 iNeed escalation project to be launched 3rd Oct, implemented by 31st March 2023					Once launched seek feedback to be sought from staff
			Step 1: Introduce QI to co-ordinators and role out to LW pan Trust.									
			Step 2: Role out to AAU and PN & AN wards.									
OS10	Audit time of decision made to deliver to delivery for EMCS.	ATAIN	20 notes audit for CS pan Trust.		LW Midwife (KA) / Patient Safety Lead Midwife	31/10/2021	Completed - 82% within NICE recommendations, most were Cat 3, therefore plan to complete looking at Cat and Cat 2 only as part of the ongoing audit plan.			31/10/2021		Part of ongoing audit programme
Induction of Labour Pathway												

OS13	Investigate quality improvement projects to include an MDT approach to IOL.	Feedback from staff to DON	QI projects to include the development of an MDT approach to IOL.	Reduction in last minute IOLs	IOL Midwife / Clinical Lead	31/03/2022	Trialled and discontinued.					Part of ongoing audit programme
OS14	Service already in place that optimises timing and information provision and support to women offered an IOL, to be rolled out to women who are being booked for IOL in their 37th week of gestation.	ATTAIN (Quarterly Report) and SI 243511	Audit to be completed to include a review of discussions around IOL to ensure they include a documented discussion about risks and benefits, in order for mothers to make a fully informed decision.				Audit completed.					
			IOL Checklist to be developed.				IOL checklist and journal developed and in use but needs embedding,					
OS15	Review with digital team regarding documentation / audit trail for women who have unsuccessful IOL.	Deep Dive - Unsuccessul IOL 2021 (May	IOL MW to plan comms around correct data entry, repeat audit following implementation of recommendations.	Improve quality of IOL data	Amy Garratt Safety MW	30/09/2022	Poster completed and displayed around unit					Ongoing audit programme
OS16	Make the use of the IOL checklist mandatory to ensure standardisation of information giving and consent prior to women attending for IOL and also to evidence women are being given the appropriate options when their IOL has been unsuccessful.		Audit 40 sets of notes 6 months after implementation of checklist.	Improve shared decision making and informed consent	Amy Garratt Safety MW	31/08/2022	In process					Ongoing audit programme
OS17			Implement checklist at PHB and audit 40 sets of notes 6 months following.	Improve shared decision making and informed consent	Amy Garratt Safety MW	28/02/2023						Ongoing audit programme
OS18	Consider cervical assessment prior to formal IOL as recommended by NICE to help assess the readiness of the cervix to decide the most suitable method of IOL and ensure women are being counselled appropriately.		Recommended within checklist, include in audit of 40 sets of notes as above.	Improve shared decision making and informed consent	Amy Garratt Safety MW	31/08/2022						Ongoing audit programme
OS19	Discuss every option for continuation of IOL - offer mechanical IOL at each review point if changes to Bishop Score demonstrates mechanical IOL is possible.		Included in rewritten IOL guideline, due to be ratified at next guideline group.	Improve shared decision making and informed consent	Amy Garratt Safety MW	TBC for GG lead						Guideline group inc in quarterly report on guideline position
OS20	Ensure the utilisation of 'Induction of Labour: Managing Delays' to ensure escalation of delays is appropriate and not extensive.		Review 3-6 months after implementation of SOP. Obtain baseline data around delays.	Reduce delays in IOL process	Amy Garratt Safety MW	TBC for GG lead						Ongoing audit programme
OS21	Provide education updates for staff to ensure knowledge of care, management, support options, risks and benefits and optimising techniques surrounding induction of labour.		Practice reference document and Padlet, include in Safety & Risk MMT training.	Improve shared decision making and informed consent	Amy Garratt Safety MW	31/08/2022						Mandatory training presentation
OS22	Repeat audit following implementation of recommendations.		Repeat deep dive 6 months following implementation.	Improve shared decision making and informed consent	Amy Garratt Safety MW	31/08/2022						Ongoing audit programme
OS23	Audit real time IOL action timelines (i.e. admission, commencement, for transfer to labour ward, interval to when transferred to LW etc.). This will provide clear data that may highlight target areas for improvement and also can support the anecdotal perception that delays are fairly common, particularly at LCH.		Review 10 IOL real time action timelines, 2 per day for one week.	Reduce delays in IOL process	Amy Garratt Safety MW	30/11/2022						Ongoing audit programme
Improve Transitional Care Arrangements												
OS25	Avoid unnecessary separation of mother and baby for babies that could be safely cared for in TC.	TC	Undertake deep dive into the notes of these babies and identify the scope for QISR.		NNU Manager	30/11/2021	Audit complete.					TC Audits in place Monthly maternity &

OS28	Transitional care services are in place that support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme (ATAIN).	CNST Year 4 Safety Action 3	The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	Improved quality & safety Improved experience and wellbeing	NNU Matron / NNU Managers	30/06/2022 CNST revised date 5/1/23	TC audit to be recommenced and findings shared quarterly via the Maternity & Neonatal Assurance Report. TC action plan to be developed, as part of the wider Maternity & Neonatal Improvement Plan, and progress overseen by the Board level NED Maternity & Neonatal Safety Champion and via MNOG. 21/9/22 Joint ATAIN/TC action plan approved at MNOG, evidence requested from NNU that audit findings are shared with LMNS/MNOG.					
			Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per NCCMDS version 2 have been shared, on request, with the ODN, LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neo Critical Care Transformation review and to inform future development of TC.		NNU Matron	30/06/2022 CNST revised date 5/1/23	Continue documenting via badgernet. Compliant and evidence in file until next request made by ODN, LMS or commissioner.					
			Quarterly reviews of ATAIN admissions and findings shared quarterly with Board Level Safety Champion. Reviews should include: -TC eligible babies that could not be cared for under TC due to capacity/staffing issues - Number of babies admitted to or remained on NNU due to need for NG tube but NG tube not supported on TC Findings shared quarterly with mat, neo, board level champions, LMNS, and ICS quality surveillance meeting.		NNU Matron / ATAIN Lead	30/06/2022 CNST revised date 5/1/23	Commence reviews of TC babies unable to be d/c to TC for NG tubes and capacity/staffing issues. Continue minuted MDT ATAIN meeting and monthly ATAIN newsletter and amending ATAIN action plan with progress. Ratify ATAIN action plan with safety champions and Board. Increase ATAIN reports to quarterly and share as described. Report progress to safety champions via MATNEOSIP/MNOG meetings. Appoint ATAIN lead to cover maternity Leave.					
Ensure the Provision of Dedicated Staff for Elective Caesarean Section Lists												
OS29	Ensure that where there are elective caesarean section lists there are dedicated obstetric,	ACSA	Create gap analysis from ACSA standards and current service.	Improved quality & safety	Project Manager for Surgery	01/09/2021	Complete.			01/09/2021		Part of ongoing audit programme
			Arrange meeting to discuss actions required to meet 1.7.2.5 and engage relevant services.		General Manager for Women's & Children's Services	01/09/2021	Complete.			01/09/2021		
			Gain update report from maternity unit level 1 theatre regarding theatre lights and timescale for completion.		Patient Safety Lead Midwife	01/09/2021	Lights have been changed and theatres are ready for use pending minor electrical work. Go live linked to wider refurbishment plan and timescales.			01/09/2021		
			ELCS list to be generated and kept for audit purposes.		Anaesthetic Consultant Lead for Obstetrics	01/09/2021	Ongoing requirement - in place.			01/09/2021		
			Draft Business Plan for staffing uplift.		General Manager for Women's and Children's Services	31/10/2022	Postponed due to COVID. Recommended and Working Party set up and work underway.					
			Undertake scoping exercise for availability and costs of training for MW to attend specific recovery training.		Consultant Midwife	01/09/2021	Complete. Please also refer to action 13 on the 'Provide Assurance' Tab.			01/09/2021		
Managing Complex Pregnancy												
OS30	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Ockenden	SOP that states women with complex pregnancies must have a named consultant lead.	Improved quality & safety	Clinical Lead for Maternity, Trust-wide	30/04/2022	In place.			30/04/2022		For review as per Guideline Monitoring guidance

			Submission of an audit plan to regularly audit compliance		Digital Midwife / Quality & Audit Midwife / Patient Safety Lead Midwife		Current project underway. Complex women are allocated a named consultant. Local action plan stipulates monthly reporting on compliance and monitoring until embedded in to practice					Part of ongoing SBL audit programme
OS31	The maternity risk management strategy and / or relevant guideline or SOP should be reviewed to ensure they are clear on the criteria for informing / calling the consultant for direct support for complex cases. There should be ongoing audit of the effectiveness to ensure the agreed requirements are being met.	Thematic Review of SIs & Complaints, November 2021	Compliance to be audited.		Quality & Audit Midwife / Clinical Lead for Maternity Services	30/04/2022	To be added to audit plan and utilising the standards set out within the new RCOG guidance. Requirements of consultants to be reinforced through job planning.					On audit plan
Attention After Birth												
OS32	Support HCSWs on Labour Ward to provide increased postnatal care.	CQC - survey	Support HCSWs on Labour Ward to provide increased postnatal care.	Improved quality & safety Staff satisfaction and wellbeing	Labour Ward Managers	31/03/2022	Training needs identified. Work to be undertaken to develop training support offer. 4/10/22 EE supports HCSWs to provide BF support, undertake all mandatory training and some elements of PROMPT training and MMT					Skills Audit PDSA Cycle
Reducing Smoking in Pregnancy												
OS33	Ensure that every person admitted to hospital who smokes will be offered NHS-funded tobacco dependency treatment by 2023/24. This includes all expectant mothers throughout their antenatal care, as well as exploring how to help partners of pregnancy women so any new-born baby goes home to a smoke free home.	NHS Long Term Plan [Public Health Challenges including smoking also raised as part	Initial Pilot: - available to up to 40% of smokers; - to be delivered in the areas with the highest prevalence of smoking at the time of booking - recruit 1x Specialist Stop Smoking Midwife and 2x Maternity Support Tobacco Dependency Advisors; - implement best practice VBA training.	Reduced risk & improved outcomes	LMNS led with ULHT support	31/03/2022	This initiative is being progressed as a 'system'. Business Case and full milestone plan developed. Update provided to the Maternity & Neonatal Oversight Group on Wednesday, 6 October 2021. There is staff understanding and recognition of the challenges.					Monitored via MNOG and SBLCBv2
			Phase Two: - target to increase to 70% of maternal smokers by March 2023 - recruitment 2x additional Maternity Support Tobacco Dependency Advisors.			31/03/2023						Monitored via MNOG and SBLCBv3
			Phase Three: - target to increase to 100%; - introduce new NHS smoke free pregnancy pathway.			31/03/2023						Monitored via MNOG and SBLCBv4
Midwifery Workforce												
OS34	Review midwifery staffing, shift patterns & rotation of staff	Feedback from staff to DON	Review to include PMA role and ward clerk cover to PN / AN ward.	Improved quality & safety Improved staff morale & wellbeing	Head of Midwifery	30/11/2021	Survey undertaken and results analysed. Actions agreed: - PMA: additional Band 7 wte to be appointed to lead on the further development of the service. 21/9/22 PMA Band 7 role gone for job matching 4/10/22 Review as part of establishment review, PMA role to consistency panel					Bi annual staffing report Workplace Innovation Programme
OS35	The Trust can demonstrate an effective system of midwifery workforce planning to the required standard.	CNST Year 4 Safety Action 5	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.	Improve quality & safety Improved staff	Head of Midwifery	30/06/2022	Establishment Review against Birthrate+ complete and reported to MNOG November 2021. Next report to be submitted prior to CNST submission.					Bi-annual staffing report reported at MNOG
			The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during the shift) to ensure there is an oversight of all birth activity within the service.				In place and monitored. Escalation process in. Included in reporting to MNOG. CNST requires 100% completion, action plan not acceptable to declare compliance. Current significant risk to CNST submission					Bi-annual staffing report reported at MNOG
			All women in active labour receive one-to-one midwifery care.				In place and monitored.					Bi-annual staffing report reported at MNOG

			Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months during the MIS year 4 reporting period.				Establishment Review against Birthrate+ complete and reported to MNOG November 2021. Next report to be submitted prior to CNST submission.					Bi-annual staffing report reported at MNOG
Clinical Staff Workforce												
OS36	Review medical staff / consultant cover	Feedback from staff to DON	Review to include a review of support to junior doctors and review of the midwifery role within the ANC.	Improved quality & staff Improved staff morale & wellbeing	Divisional Clinical Director - Family Health	31/12/21	A review of consultant cover and support to junior doctors is underway. This will include consideration of HEE feedback. See also CNST Year 4 Safety Action 4 - obstetric medical workforce. Some uplift to consultant establishment expected post Ockenden. Linked to the above work, a review of the ANC pathways and role of the midwife in the ANC has been undertaken. Arising from this work there is increased Consultant cover on the ANC at Lincoln.					
OS38	The Trust can demonstrate an effective system of clinical workforce planning to the required standard.	CNST Year 4 Safety Action 5	**Obstetric medical workforce:** Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.	Improved quality & safety Improved staff morale & wellbeing	Clinical Lead for Maternity, Trust-wide	31/01/2022 Updated CNST deadline 05/01/23				Audit started		
	The Trust can demonstrate an effective system of clinical workforce planning to the required standard.		**Neonatal medical workforce:** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. Action plan and related progress details should be shared with the Neonatal ODN. ULHT met BAPM standards for Neonatal medical staffing for year 3.		Deputy General Manager - Children's Services / NNU Matron	31/01/2022 Updated CNST deadline 05/01/23						

			Neonatal medical workforce: The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead. ULHT DID NOT meet service specification standards in Year 3.			31/01/2022 Updated CNST deadline 05/01/23						
Saving												
OS38	The Trust can demonstrate compliance with all five elements of Saving Babies Lives Care Bundle Version 2.	CNST Year 4 Safety Action 6	Trust Board level consideration of how its organisation is complying with the SBLv2. Full implementation of the SBLv2 forms part of the 2019/20 NHS standard contract.	Improved quality & safety	Head of Midwifery	30/06/2022	Each element of the SBLCBV2 has been implemented. There is an ongoing audit programme in place to ensure requirements are embedded in practice.					Ongoing audit programme in place to ensure requirements of
			Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their CCG. Any specific variations from the SBLv2 pathways must be agreed as acceptable clinical practice by our Clinical Network.			30/06/2022						
			The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The Survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net. Evidence of completed quarterly care bundle surveys must be submitted to the Trust Board.			30/06/2022						
Availability of Equipment												
OS39	Ensure the availability of & access to key equipment	Feedback from staff to DON	Concerns highlighted specifically relate to CTG, beds and IT.	Improved quality & safety Improved experience Increased job satisfaction	Divisional Managing Director - Family Health	31/03/2022	There is a bed replacement programme in place. Plans and timescales for maternity element of bed replacement programme needs communicating to staff CTG issue relates to connectors inadvertently being lost / disposed of at a considerable cost to the Division. Ward Managers have confirmed there are sufficient supplies. This issue will continue to be monitored with further reminders and awareness as required. Additional IT equipment ordered. Additional IT equipment requirements will be addressed through the Digital Maternity Assessment (DMA).					Review of Incidents Risk Register at MNOG

Safe Use & Storage of Medicines												
OS40	Trust to ensure that the temperature of the treatment rooms within maternity at LCH are	CQC 2021 Inspection	Wall Thermometer to be ordered and escalation procedure to be reinforced.	Improved quality & safety	Midwife (YC)	30/11/2021	Wall thermometer in place. Daily check added to daily checklist. Staff aware of escalation			30/11/2021		
			Introduce daily checking of treatment room temperatures.									
			Audit the process to ensure compliance.		Inpatient Matrons	31/03/2022	Update required.					Ongoing audit
	The Trust must ensure that all medicines are stored safely and securely.	CQC 2021 Inspection Report	Plan out action in response to audit to close any gaps identified (i.e. order digital thermometers).	Improved quality & safety Improved safety and security of medicines	Head of Midwifery / Matrons	31/03/2022	Action plan from Lincoln site still outstanding - to be completed ASAP. There is not a separate SOP for raised ambient temperatures (Trust Medicines Management policy is followed). If temps are elevated, Pharmacy input is sought.				Action Plan	
			Identify any risks from audit undertaken (i.e. rooms where ambient temperature is routinely 25 degrees or above and take advice from pharmacy around mitigations.		Head of Midwifery / Matrons	31/03/2022	Lincoln action plan received. Pharmacy and QM for medicines contacted to arrange a meeting to review in greater detail.				Action Plan	
			Understand mitigations to environmental challenges in storage of medicines (i.e. age of estate at Lincoln maternity with a lack of air-conditioning/ventilation).		Divisional Managing Director - Family Health	30/04/2022	Project Manager now in place and full design team to be appointed over next couple of weeks. This is for the refurbishment of maternity only, not to support with estate issues in the interim. Linked to above action, feed into this following meeting with Pharmacy and QM for Medicines.				Action Plan	
			Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.		Divisional Managing Director - Family Health	31/03/2022	Issues can be escalated through PRM if cannot be resolved locally (estates issues can be escalated through this route).			31/03/2022	PRM Escalations Risk Register	PRM
Postpartum Haemorrhage (PPH)												
OS42	Streamline MRHP process and ensure it aligns with latest guidance.	SI 263178	Benchmark Maternity PPH guidance against Trust wide MRHP.	Improved safety	Patient Safety Lead Midwife	28/02/2022	Review and simplified and re-issued.			28/02/2022		Maintained under Guideline Process Ongoing monitoring of PPH via dahsboard and PPH review process
Skills & Drills												
OS43	Use skills and scenarios to improve human factors and situational awareness elements of clinical scenarios	SI 254930	Documentation compliance review of PPH proforma for 3 months	Improved Safety	Maternity Safety Team	31/03/2023	Plan audit framework. Plan training to increase awareness of proforma as a prompt rather than audit tool. Included within Newsflash and PPH monthly newsletter. 14/9/22 Transferred from datix actions 21/9/22 PPH QIP in process					Documentation compliance audit
OS44		SI 254930	Increase number of theatre-based skills & drills to include use of PPH proforma		Education Team	31/03/2023	Funds secured for a SimMom which will facilitate high-quality simulation training 14/9/22 Transferred from datix actions.					TNA/Annual Education Plan
OS45		SI 259852	Increase number and frequency of drills in maternity theatre setting.		Education Team	31/03/2023	6.1.2022- Impacted by covid/level of activity in theatre. Plans in place. Trust wide labour ward forum scheduled for 21/1/2022. Only 2 in past 12 months due to covid/activity and poor attendance to be quorate. 14/9/22 Transferred from Datix actions					TNA/Annual Education Plan
OS46		SI 259852	Clinical Education Team to support live drills and scenarios to support maintaining situational awareness during a postpartum haemorrhage.		Education Team	31/03/2023	6.1.2022- Impacted due to covid/activity. Preparations in place for skills and drills. To be implemented when activity/staffing allows. Education team informed or anticipated plan and completion date. - live drills are back on prompt face to face training day, situational awareness included in this,. 14/9/22 Transferred from datix actions					TNA/Annual Education Plan

OS47		SI 261928	Embed NLS skills drills/interactive learning session on labour wards (both sites) using new document – at least fortnightly as continuous learning		Education Team	31/03/2023	Older version ? in use but not embedded. New version under development. To be looked at as a bigger project. 14/9/22 Transferred from datix actions					TNA/Annual Education Plan
OS48		SI 263178	Increase number and frequency of drills in maternity theatre setting		Education Team	31/03/2023	To be part of a project. 14/9/22 Transferred from datix actions					TNA/Annual Education Plan
OS49		SI 269764	Roll out of telephone triage drills-type exercises with maternity staff triaging calls from women		Education Team	31/03/2023	14/9/22 Transferred from datix actions					TNA/Annual Education Plan
OS50		SI 271061	Incorporate Placental Abruption within skills and drills, to include multiple scenarios of clinical presentation.		Education Team	31/03/2023	Extend deadline for ward based skills and drills 14/9/22 Transferred from datix actions					TNA/Annual Education Plan
OS51		SI 271935	MDT training to be included within Live Skills and Drills.		Education Team	31/03/2023	human factors training. Situational awareness on prompt which is attended by anaesthetists, prompt now F2F so live skills and drills is included there - extend deadline 14/9/22 Transferred from datix actions					TNA/Annual Education Plan
OS52		SI 254930	Embed contemporaneous use of 'PPH proforma' in theatre cases, Increase number of theatre-based skills & drills to include use of PPH proforma		Education Team	31/03/2023						
OS53		SI 261928	The Trust re-evaluate current training in neonatal resuscitation to ensure there is a focus on clinical leadership, roles and responsibilities, communication within the team and record keeping. Embed NLS skills drills/interactive learning session on labour wards (both sites) using new document – at least fortnightly as continuous learning		Education Team	31/03/2023						

14038- related to Datix 261928

Maternity & Neonatal Improvement Plan

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No	Recommendation	Source (e.g. CNST, Ockenden, CQC, HSIB)	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	Progress (as at 14 September 2022)	Previous RAG Jun-22	Current RAG Sep-22	Actual Completion Date Denotes Action Completed	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
Responding to Service User Feedback												
1	The Trust can demonstrate that there is a mechanism for gathering service user feedback, and that it works with service users through the Maternity Voices Partnership to co-produce local maternity services including ensuring a 'voice' fr marginalised women.	Ockenden / CNST Year 4 Safety Action 7 / SI 269764	Clear co-produced plan, with MVP that demonstrates co-production and co-design of service improvements, changes and developments.	Improved experience	MVP Lead / Consultant Midwife	30/06/2022	Work has commenced.				Co-produced plan - see additional CNST evidential requirements	MVP via MNOG
Improve Communication												
2	Introduce training to improve communication	Thematic Review of Maternity SIs & Complaints, November 2021	Mandatory study session to be arranged for the whole department on communication / documentation with a focus on the communication issues identified during the Thematic Review.	Improved experience and informed decision making	Clinical Lead for Maternity, Trust wide / Clinical Lead for Labour Ward, LCH	30/06/2022	To be delivered as part of Divisional training programme from April 2002 onwards and to be included in existing events and forums (e.g. governance, audit, CTG meetings) to ensure as wider a coverage of staff as possible. Training to cover patient stories as well as communication issues identified from the thematic review. 9/9/2022 iNeed escalation project underway, expected completion date 31st March 2023 utilising EBC L+S Toolkit					Annual Education Plan
3	Improve the information available for women and families on the process for referral and communication between hospitals		Drafting of new and updating of existing Patient Information Leaflets, where relevant, to include information for women and families on what will happen where referral or communication between hospitals occurs.	Improved experience	Patient Safety Lead Midwife	30/06/2022	In place and ongoing. Information leaflets are available on the maternity webpage and are also available in different languages.					Patient Leaflets monitored by Patient Experience Team for review dates
One-to-one Care												
4	Promote staff awareness of the importance of one-to-one care and providing direct emotional and physical support to women to help to reduce their fears and concerns.	CQC - Maternity Survey	Requirements to be captured as part of staff training.	Improved experience and wellbeing	Consultant Midwife	31/07/2022	Some teaching sessions held during 2021 but to be reflected more formally in mandatory training programme for 2022/23. This is also a focus of the Preceptorship training. 9/9/22 To be included in Personalised Care mandatory training session.				TNA / Training Programme	Monitoring of acuity data Feedback from staff
Reducing Delays in Discharge												
5	Explore midwifery-led NIPE services	CQC - Maternity Survey	Audit of current position and agreement of next steps.	Reduction in delays in discharge Improved experience	Deputy Head of Midwifery	01/02/2022	Actions to be agreed once audit complete. Check with Ed Team.					Feedback from families NIPE failsafe process
6	Review pharmacy and TTO processes	CQC - Maternity Survey	Complete process / patient journey mapping.		Inpatient Matron	30/11/2021	Completed. Linked to pharmacy Business Case. Check w LB.					Pharmacy governance
Environment												

7	Continue to make improvements to the environment.	Feedback from Staff to DON / PLACE Lite / Divisional Improvement Plan / CQC 2021 Inspection - Initial Feedback	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	Improved environment and experience for women and staff Privacy & Dignity requirements are fully met	Head of Midwifery / Deputy Director of Estates & Facilities	30/06/2023	Ward Refurbishment Programme due to commence in January 2022 but will take time to complete. New break room now established on Nettleham. New furniture & fittings ordered from charitable funds. Furniture loaned in the meantime Some immediate works completed further to recent CQC feedback including improvements to privacy & dignity and replacement of ageing furniture and fixtures and fittings. 9/9/22					Monthly Matrons Quality Audit

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Monitoring Fetal Well-being												
3	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	CNST Year 4	Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	Increased opportunities for learning and improvement Increased staff support and wellbeing Improved outcomes	FM leads	30/04/2022						SBL audit programme
			Incident investigations and reviews			31/12/2021				31/12/2021		SBL audit programme
Escalation												
6	Strengthen escalation process (including acting on concerns & feedback to staff)	Feedback from staff to DON SIs 255356, 263178, 264990	Band 7 Co-ordinators identified as a key enablers but need support.	Increased staff support and wellbeing Improved quality & safety Improved staff survey feedback	Head of Midwifery / Interim Matron	31/03/2022	First meeting held with Band 7 Co-ordinators on 14/7/2021. Agreed that there is a need to ensure all staff have an understanding of each other roles and communication of agreed escalation procedures and actions. Maternity escalation plan discussed with B7s – suggestions made to improve guideline based on birth rate acuity data – further meetings to be held. August meeting was not well attended due to leave and operational pressures. Further meeting arranged for September 2021. Some teething problems . Links to ongoing work around culture. Further support / development required for Band 7s.					Workplace Innovation Programme MNOG Maternity and Neonatal Assurance Report

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Accountability & Responsibility											
1	LMNS must be given greater accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them	Lincolnshire Maternity & Neonatal Programme Ambition	To oversee quality in line with Implementing a revised perinatal quality surveillance model.				Awaiting population by LMNS				
			To share information and learning in a structured and systematic way, working with partners to turn learning into service improvement.								
			To oversee local trust actions to implement the seven immediate and essential actions from the Ockenden report.								
			To ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care								
			Co-design and implement a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships and Neonatal Voice.								
			To implement shared solutions wherever possible through shared clinical and operational governance.								
Recovery & Restoration											
2	In recovering the full maternity care pathway LMNS will oversee and support trusts to:	Lincolnshire Maternity & Neonatal Programme Ambition	Reopen any services that have been suspended as a result of COVID-19				Awaiting population by LMNS				
			Remove restrictions on women's access to support, on the basis of a risk assessment and in line with Supporting pregnant women using maternity services during the coronavirus pandemic.								
			Take active steps to support Neonatal family visiting, particularly grandparents and siblings.								
			Minimise the additional risk of COVID-19 for Black, Asian and minority ethnic women and their babies.								
Saving Babies Lives Care Bundle											
3	Implement Element 2.	Lincolnshire Maternity & Neonatal Programme Ambition	Using resources to meet training needs focusing on Uterine Artery Doppler (UAD) and symphysis fundal height (SFH)								
	Implement Element 4.		Baseline assessment of competency assessment and fresh eyes. Fetal monitoring leads to review serious incidents (SI) themes relating to CTGs to be shared with LMNS and lessons learned.								

	Impalement Element 5.		Every provider has a pre-term birth clinic.	Awaiting population by LMNS
			At least 85% of women who are expected to give birth at less than 27 weeks' gestation are able to do so in a hospital with appropriate on site neonatal care.	
			Preterm birth prediction pathway for symptomatic women and tertiary referral criteria for asymptomatic women in place.	
			Regional leaflets for women requiring steroids and magnesium sulphate to be available.	
			Perinatal Optimisation Toolkit in place and pathway evident.	
			IUT guideline in place and missed opportunities for IUTs shared with LMNS.	
			Fetal Fibronectin business case to be finalised.	
Transformation Work stream				
4.	Complete the transformation work stream.	Lincolnshire Maternity & Neonatal Programme Ambition	Support LMNS to embed new NHS smoke free pregnancy pathways available for up to 40% of maternal smokers by March 2022.	Awaiting population by LMNS
			Embed maternal medicine networks so that women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy.	
			Embed the offer to all women with type 1 diabetes of continuous glucose monitoring.	
			Working with EMNODN and LMNS to achieve the ambition of the NCCR and implement specific comprehensive Local Neonatal Improvement plans.	
			Embed Family Integrated care within the Neonatal Service and review Transitional Care strategy.	
			LMNS to oversee local actions to implement the seven immediate and essential actions from the Ockenden report.	
			To Implement the Core Competency Framework and ensure all maternity staff receive multi-disciplinary training – in line with the Ockenden report this must be validated by the LMNS three times over the course of the year.	
			Support LMNS oversight and assurance though the LMNS Perinatal Surveillance Model.	
			Work with LMNS to ensure every woman is offered a Personalised Care and Support Plan, underpinned by a risk assessment and in line with National guidance, by March 2022.	

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Risk Assessment Throughout Pregnancy												
1	A risk assessment should be completed at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance	Ockenden & CQC	Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance.	Improved choice and personalised care Improved quality & safety Improved experience	Consultant Midwife / Patient Safety Lead Midwife / Quality & Audit Midwife	30/09/2022	Risk assessments completed. PCSP Task and Finish co-production group established with support from PMO and CCG to develop and implement PCSPs. Project Manager assigned and new Lead in post, project now restarted					Ongoing audit plan
Informed Consent												
2	All Trusts must ensure women have ready access to accurate information to enable their	Ockenden	Information on maternal choice including choice for caesarean delivery.	Informed consent	Labour Ward Leads	31/05/2022	Task & Finish Group in place and progressing this work.					MNOG MNSC
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc.) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.		MVP Chair / Consultant Midwife		MVP have completed a gap analysis on the Trust's website; awaiting co-produced action plan following interruption to MVP activities. This issue remains under review by the Maternity & Neonatal Oversight Group. 21/9/22 Report not yet received					MNOG MNSC
3	All maternity services must ensure the provision to women of accurate and contemporaneous	Ockenden	Information on maternal choice including choice for caesarean delivery.		Labour Ward Leads	31/05/2022	Task & Finish Group in place and progressing this work.					MNOG MNSC
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc.) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps,		MVP Chair / Consultant Midwife		MVP have completed a gap analysis on the Trust's website; awaiting co-produced action plan following interruption to MVP activities. This issue remains under review by the Maternity & Neonatal Oversight Group. 21/9/22 Report not yet received.					MNOG MNSC
4	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care.	Ockenden	SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.		Matrons	31/01/2022	In place.			31/01/2022	Filed 22/9/22	Ongoing audit plan PCSP ongoing project Ockenden
5	Women's choices following a shared and informed decision-making process must be respected.	Ockenden	SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.		Patient Safety Lead Midwife	30/04/2022	In place.				Filed 22/9/22	Ongoing audit plan PCSP ongoing project
			CQC survey and associated action plans				Failed IOL and subsequent Cat 3 LSCS is being audited at present. This will be reported into the Maternity & Neonatal Oversight Group and if compliance is demonstrated, the action will be completed.					Ongoing audit plan PCSP ongoing project Ockenden Assurance at MNOG
6	Every trust should have the pathways of care clearly described, in written information in	Ockenden	Gap analysis of website against Chelsea & Westminster conducted by the MVP.		MVP Chair	31/05/2022	MVP have completed a gap analysis on the Trust's website; awaiting co-produced action plan					MNOG

			Co-produced action plan to address gaps identified.		MVP Chair / Consultant Midwife							MNOG
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc.) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.		MVP Chair / Consultant Midwife		MVP have completed a gap analysis on the Trust's website; awaiting co-produced action plan following interruption to MVP activities. This issue remains under review by the Maternity & Neonatal Oversight Group.					MNOG
Birth Choices Pathway												
7		BCC Audit	Increase the data that is recorded on the Birth Choices Clinic (BCC) database to enable deeper analysis of time.	Informed consent Improved choice	Consultant Midwife	31/03/23						Ongoing audit plan
8		BCC Audit	Explore previous CS midwife-led counselling pathway to free up ANC time, upskill midwifery team, reduce need for BCC input and improve service users satisfaction (based on Oxford midwife-led Birth After Caesarean care pathway.		Consultant Midwife	31/03/23						PCSP project Monitored through Maternity Assurance Report
9		BCC Audit	Implement bi-monthly BCC forums / sharing meetings between consultant obstetricians and midwives, or ensure the involvement of the consultant midwife in existing consultant obstetrician meetings to support more cohesive working.		Consultant Midwife	31/12/22						PCSP project Monitored through Maternity Assurance Report
12		BCC Audit	Finalise method for recording planned BCC activity on PAS and explore / review how this activity is currently funded / costed.		Consultant Midwife	31/10/22						
13		BCC Audit	Finalise route of administration support to reduce admin workload on consultant midwife.		Consultant Midwife	31/12/22						
14		BCC Audit	Review method for gathering feedback from women.		Consultant Midwife	ongoing	Plan for quarterly text to be sent inviting completions of forms.			23/9/22		Ongoing audit plan

Maternity & Neonatal Improvement Plan

RAG RATING MATRIX	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress / on track
Red	Not yet completed / significantly behind agreed timescales

No	Recommendation	Source (e.g. CNST, Ockenden, CQC, HSIB)	Actions / Key Milestones	Expected Impact	Lead	Forecast Completion Date	Progress (as at 14 September 2022)	Previous RAG Jun-22	Current RAG Sep-22	Actual Completion Date Denotes Action Completed	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
Empowerment of Staff & Use of Professional Judgement												
2	Ensure the empowerment of staff to use professional judgement.	Feedback from staff to DON	Ensure the need for guidelines is fully understood whilst supporting staff to use professional judgement.	Improved staff morale Improved experience for women	Head of Midwifery	31/03/2022 31/03/2023	Work is underway in response previous feedback to refocus on midwifery expertise through: undertaking some 'back to basics' training, re-arranging the birthing room to facilitate a low risk birthing environment in a high risk labour ward etc. This will be led by the PMAs who suggested a 'Midwifery Month'- a time to refocus on midwifery expertise. This topic is now covered on the preceptorship programme. This also links to the cultural work which is underway and empowering Band 6/7s. This will include surveys and focus groups to obtain feedback from staff. This will be a 9-month programme - commenced April 2022.					Workplace Innovation Programme Ongoing culture surveys Work Afterthoughts
Staff Health & Wellbeing												
	Ensure staff health & wellbeing including access to breaks and support following Serious Incidents	Feedback from staff to DON & SI 263179	Review support arrangements for staff following SIs and other traumatic incidents / events.	Improved staff health & wellbeing Improved staff morale	Head of Midwifery	31/10/2021	Following SIs, a hot de-brief is held for staff on the day. A cold de-brief is held a few days later with Chaplaincy input as required. PMA afterthoughts available to all midwives. OH support is also routinely available. Support available to staff will be re-communicated.			31/10/2021		Incident review process
Culture including Attitude & Behaviours												
4	Improve staff morale and address issues with attitude and behaviours in some areas During the CQC 2021 inspection, the CQC commented that: "Not all staff appeared engaged, morale was mixed, and we found an inconsistent safety culture with not all staff happy to challenge".	Feedback from staff to DON / CQC Inspection 2021 - Initial Feedback		Improved staff morale	Divisional Triumvirate	31/03/2023	Linked to staff survey improvements and OD work which is underway - see also 2. above. Results of previous staff and culture surveys to be fed back to staff as part of planned Comms Campaign. Repeat of culture survey planned at a date to be confirmed. Previous surveys to be feedback to staff with support from Jackie Lloyd. 9/9/22 workplace innovation in process.					Workplace Innovation Programme Ongoing culture surveys
Maternity NED Safety Champion												

	The Trust can demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.	CNST Year 4 Safety Action 12	Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).	Strengthened oversight & assurance More timely escalation and mitigation of risk issues	Director of Nursing / NED Safety Champion	30/06/2022 Revised date 5/1/23	Ongoing.					NED reports at MNOG
Perinatal Mortality Review Tool												
9	Trusts to utilise the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard.	CNST Year 4 Safety Action 1	All eligible perinatal deaths from 1st September 2021 should be notified to MBRRACE **within two working days** and completed **within one month** of the death.	Strengthened learning & improvement Improved communication with parents	Bereavement Midwife / Patient Safety Midwife	30/06/2022	Underway - reporting requirement now 7 days instead of 2. Currently compliant.					PMRT Quarterly Report via MNOG
			A review using the PMRT for 95% of all eligible deaths of babies that have occurred from 8/8/21 will have been started within 2 months of each death (including home births).			30/06/2022						PMRT Quarterly Report via MNOG
			>50% of deaths suitable for PMRT that occurred from **8/8/21** are reviewed using the PMRT by MDT and completed to at least the point where a draft report has been generated by the tool by **4 months of each death and published within 6months.**			30/06/2022						PMRT Quarterly Report via MNOG
			For 95% of all deaths from 8/8/21, the parents will have been told that a review of their babies death will occur, and their perspective/questions sought. Any anticipated delays will be explained to parents and a timetable for likely completion. If delays are expected, any questions that can be answered should be. Especially if the questions have bearings on future pregnancies.			30/06/2022						PMRT Quarterly Report via MNOG
			Quarterly reports submitted to Trust Board from 8/8/21 that includes details of each death and consequent action plans. These reports should be discussed with the maternity safety champion and Board level safety champion.			30/06/2022						PMRT Quarterly Report via MNOG
10	Trusts & Health Boards and PMRT and governance teams to continue to improve the way in which the PMRT Tool is supported, resourced and implemented	Learning from Standardised Reviews When Babies Die (National Perinatal Review Tool), Third Annual Report, October 2021	Provide adequate resourcing of multidisciplinary PMRT review teams, including administrative support and ensure the involvement of independent external members in the team.	Strengthened learning & improvement Improved communication with parents	Head of Midwifery	30/06/2022	Benchmarking exercise underway against the recommendations. PRMT group convened and strategy being developed. 21/9/22 New Lead in post Advert out for Band 3 PMRT admin role LMNS member currently acting as external, plan to buddy up with another Trust improve external support.					PMRT Tool Quarterly Report via MNOG
			Use the PMRT parent engagement materials to support engaging parents and families in the review process, including them being made aware a review is taking place and being given flexible opportunities at different stages to discuss their views, ask questions and express any concerns. Many parents may want to give positive feedback about the care they received.			30/06/2022	Benchmarking exercise underway against the recommendations. PRMT group convened and strategy being developed. Every parent is offered opportunity to be involved in review process, leaflet out to print around parental involvement 21/9/22 New lead in post.					PMRT Tool Quarterly Report via MNOG
			Use the local PMRT summary reports and this national report as the basis to prioritise resources for key aspects of care and quality improvement activities identified as requiring action.			30/06/2022	Benchmarking exercise underway against the recommendations. PRMT group convened and strategy being developed. 21/9/22 new lead in post PMRT lead to pull report of key aspects of care for QI activities.					PMRT Tool Quarterly Report via MNOG Datix actions
			Improve the quality of recommendations developed as a consequence of reviews by developing actions targeted at system level changes and audit their implementation and impact.			30/06/2022	Benchmarking exercise underway against the recommendations. PRMT group convened and strategy being developed. 21/9/22 New Lead in post PMRT Lead to pull report of recommendations and rate quality of actions, assess for duplications on SIP					PMRT Tool Quarterly Report via MNOG Datix actions

			All PMRT actions to be recorded on Datix from September 2022 and monitored via Thursday Datix action meeting.			31/12/2022	21/9/22 Decision required around timeframe for historical actions not currently on DATIX.					PMRT Tool Quarterly Report via MNOG Datix actions
Maternity Services Data Set (MSDS)												
11	Trusts to submit data to the MSDS to the required standard.	CNST Year 4 Safety Action 2 [Concerns with the Medway System also raised as part of the Feedback from Staff to the DON]	~~Trust Boards to confirm that they have either:~~ ~~- already procured a Maternity Information System complying with the forthcoming commercial framework (to be published by NHSX) and are complying with Information Standard Notices DCB1513 and DCB3066 or~~ ~~- have a fully funded plan to procure a Maternity Information System from the forthcoming commercial framework and comply with the above Information Standard Notices and attend at least one engagement session organised by NHSX.~~ By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme,	Improved data quality Improved oversight & assurance Increased transparency	IT Leads	01/10/22	The ongoing difficulties with the Maternity Medway System; not least difficulties in uploading some performance data will impact on the Trust's compliance with this action. Currently the system does not comply with Information Standard Notices DCB1513 and DCB3066). Work is ongoing with IT and Information colleagues including the trialling of a new BI system which has the potential to improve compliance. Longer term, part of the funding from the Trust's successful digital maternity funding bid is being used to engage external support (Cloud 21) to develop the business case for the eventual replacement of the maternity Medway system. 6/5/22 First element amended, procured/funded action replaced by need for digital strategy by Oct 22					There is oversight of the Maternity Services Compliance with the CNST Safety Actions through the Maternity & Neonatal Oversight Group The ongoing difficulties with the Maternity Medway System also remains a standing agenda item with issues escalated via the Quality Governance Committee, as required
Staff Training												
13	The Trust can evidence that a local training plan is in place to place to ensure that all six core modules of the Core Competency Framework will be included in the maternity unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, the Trust	CNST Year 4 Safety Action 9	90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include **maternity emergencies** starting from the launch of MIS year four in August 2021.	Improved staff knowledge and competency Improved quality & safety	Clinical Educators	1/5/23	Underway. Face to face training not yet reinstated. 22/9/22 Now face to face but CNST compliance risk					CNST and dashboard assurance at MNOG
			90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include **antenatal and intrapartum fetal monitoring and surveillance,** starting from the launch of MIS year four in August 2021.				Underway. Face to face training not yet reinstated. 22/9/22 Virtual training acceptable but CNST compliance risk					CNST and dashboard assurance at MNOG
			The Trust can evidence that 90% of the team required to be involved in immediate **resuscitation of the new-born and management of the deteriorating new-born** infant have attended your in-house neonatal life support training or New-born Life Support (NLS) course starting from the launch of MIS year four in August 2021.				Underway. Face to face training not yet reinstated. 22/9/22 Now face to face but CNST compliance risk					CNST and dashboard assurance at MNOG
13	The Trust should ensure mandatory training is completed by medical staff in line with Trust policy, in particular mental capacity and deprivation of liberty safeguarding training.	2019 CQC Inspection	Report on core training compliance by staff group within the Divisional PRM slides.	Improved staff knowledge and competency Improved quality & safety Strengthened assurance	Head of Midwifery	31/01/2022	PRM report with staffing breakdown from most recent meeting is available.			01/03/2022	PRM Pack	Reporting on training performance generally is monitored at Divisional level through the established governance route: Divisional Clinical Cabinet
			Review the use of the Maternity Services Education Strategy to determine if this is effective in supporting improved training compliance.		Divisional Managing Director - Family Health	30/04/2022	There is a need to revisit the education strategy post-covid recovery and define milestones.				Revised Education Strategy Training Performance Data	
			Achieve Resuscitation core training level of 95% for medical staff.		Divisional Clinical Director - Family Health	30/04/2022	In-house trainers to deliver BLS training.				Training Performance Data	
			Achieve 80% training compliance (average across all core training subjects) for medical staff.		Divisional Clinical Director - Family Health	30/04/2022	Performance at 08/032022: PBH: 75.1% & LCH: 68.05%.				Training Performance Data	

			Achieve 95% Trust target for core training compliance for medical staff.		Divisional Clinical Director - Family Health	31/08/2022	Ongoing.				Training Performance Data	
14	The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff	CQC Inspection 2021 - Immediate Feedback & Written Report	Clear trajectories and monitoring of compliance to be agreed for midwives who training / sign off of competence is outstanding.	Improved staff knowledge and competency Improved quality & safety Strengthened assurance	Head of Midwifery / Deputy Head of Midwifery / Consultant Midwife	31/10/2021	Trajectories agreed and communicated to CQC although there has been some slippage on those timescales - see below.			31/10/2021		Performance against agreed trajectories is monitored monthly through MNOG
			Trust to deliver against agreed trajectories.			31/03/2022 (original date) 30/04/2022 & 30/11/2022 (revised dates)	Training is due to be completed at PBH by the end of April 2022 and at LCH by the end of November 2022. In respect of LCH, this is due to the continuity of carer midwives now being included within the training numbers.					
			Competencies to be included as part of roster planning.			31/10/2021	In place. The majority of midwives on the labour ward are B6 and therefore have, for the most part, obtained the necessary competencies as part of their training at B5 level. Assurance has been provided to the Maternity & Neonatal Oversight Group that management and oversight of the roster ensures that there are sufficient numbers of competent staff on shift to recover women following a general anaesthetic. By way of further assurance, it was agreed by the group that future update reports should include a random sample of reports from e-roster to evidence this point.			31/10/2021		
			Monitoring of compliance against the agreed actions and trajectories to be undertaken through the Maternity & Neonatal Oversight Group as part of the monthly Maternity & Neonatal Assurance Report.			31/03/2022	In place & ongoing.			31/03/2022		
External Notification - HSIB / Early Notification Scheme												
15	The Trust has reported 100% of qualifying cases to HSIB and EN for 2021/22.	CNST Year 4 Safety Action 10	Reporting of all qualifying cases to HSIB for 2021/22.	Strengthened opportunities for learning and improvement Improved communication with women and families	Safety Leads	30/04/2022	Ongoing - requirements met.					Monthly maternity & neonatal assurance report / MNOG
			For qualifying cases which have occurred during the period 1 April 2022 to 5 December 2022 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and			CNST Revised Date 5/1/23	Ongoing - requirements met.					
			2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.				Ongoing - requirements met.					
Reporting, Investigation and Learning Lessons from Incidents & Complaints												
16	Mechanisms for learning lessons to be reviewed and strengthened, as required	Thematic Review of SIs & Complaints, November 2021	Actions plans generated from SIs to be more robust and follow SMART principles with follow-up through audit to ensure changes are embedded into practice.	Strengthened opportunities for learning and improvement	Risk Midwife / Patient Safety Lead Midwife	Ongoing	Changes to the SI report and action template will address this requirement. There is more robust QA of SI reports and action plans through the SI Rapid Review Panel. 4/10/22 Actions reviewed by external reviewer					
			Changes in practice to be disseminated in local educational meetings or specific learning lessons event rather than as email communications.			Ongoing	Survey underway to ascertain staff preferences as to how learning is shared.					
			Lessons learned event to be convened covering the themes and learning from the Thematic Review.			Ongoing	Themes and learning from the Thematic Review will be disseminated through existing forums and educational events to ensure as wider a coverage of staff as possible.					
			Introduce and / or strengthen any existing dedicated postnatal mortality & morbidity study days.			Ongoing	In place and ongoing.					
			Ensure the completion of all overdue SI actions as a priority.			Ongoing	Weekly action plan meetings continue to be held with the senior team and specialist midwives and include review of HSIB, PMRT, SI, DI and Complaint actions. Where appropriate, overdue actions are being aligned to relevant work streams within the Maternity & Neonatal Improvement Plan.					

17	Trust to provide assurance that staff are reporting incidents appropriately.	CQC Inspection 2021 - Immediate Feedback	Review current arrangements to ensure they are robust.		Risk Midwife / Patient Safety Lead Midwife	30/11/2021	Current mitigations in place: • DATIX reporting is stable, regular process, • Information from the dashboard is pulled from Medway and cross referenced with DATIX to support appropriate reporting, • Daily sit rep completed and sent to DoN which includes reports of harm which prompt DATIX review, • Risk midwife undertakes daily review of activity and DATIX to support accurate reporting.					Monthly Matrons Audits Safety Huddles
18	The Trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	CQC Inspection 2021 - Final Report	Review the mechanisms for sharing learning from incidents / SIs etc. to ensure they are reaching all relevant staff groups.		Assistant Director of Clinical Governance / Patient Safety Specialist	Ongoing	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups. 23/9/22 Survey by Safety Culture team, results awaited					Risk newsletter started Sep 2022
Safety Culture Milestones												
19	Undertake Safety Culture Climate Surveys.	Safety Culture Work Programme and Thematic Review of SIs & Complaints, November 2021	Undertake analysis of data provided to Family Health on previous Safety Climate Surveys undertaken through the East Midlands Maternity Network.	Improved Safety Culture Improved staff morale Improved Quality & Safety	Safety Culture Lead / Head of Midwifery	31/10/2021	Analysis completed and report submitted to MNOG in October 2021.			31/10/2021		
			Feedback findings and actions to staff.			30/11/2021	Feedback provided to staff by Divisional team.			30/11/2021		
			Repeat surveys are periodic intervals.			31/03/2022 Survey to be repeated at end of WI programme	Further survey planned for early 2022 facilitated through the East Midlands network. Date not yet provided. The network will communicate directly with the FH Division. 21/9/22 Workplace Innovation programme underway, agreed with Regional Lead EMAHSN that this is an acceptable substitute for culture survey.					
20	Introduce and participate in Safety Walk Rounds.		Safety Culture Lead & Team to join existing walk rounds.		Safety Culture Lead	31/12/2021	Walk rounds currently paused due to operational and COVID restrictions but arrangements in place to join once restrictions are lifted. Needs review of PSIT involvement. 12/10/22 Safety Culture Leads join Quality Matrons Assurance visits					
21	Ensure the continued engagement of the maternity team with the Safety Culture work including the 'Its Safe to Say' Campaign		Increase awareness of the 'Its Safe to Say' Campaign as part of the planned Comms Plan.			31/12/2021	Launch complete - outputs to be aligned with the Culture and Leadership Programme.			31/12/2021		
22	Complete the planned roll-out of Human Factors Training.		Safety Culture Lead to provide insight in to human factors training following incident reviews.			31/12/2021	In progress - part of PSIRF roll-out but support being provided on request. 12/10/22 PSIT involved in some Sis			12/10/2022		
			Safety Culture Lead to support Family Health Division with Human Factors training.			31/12/2021	Human Factors training booked for 2022/23.			31/12/2021		

No	Recommendation	Source (e.g. CNST, Ockenden, CQC, HSIB)	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	Progress (as at 14 September 2022)	Previous RAG	Current RAG	Actual Completion Date	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
								Jun-22	Sep-22	Denotes Action Completed		
1	90% have warm bundle tool completed at birth.	ATAIN	Documentation review of 20 sets of notes across the Trust on the current use of the warm bundle tool.	Improved understanding & awareness Reduction in the number of cases of Hypothermia Improved quality & safety	Patient Safety Lead Midwife	30/06/2022	Review complete - compliance poor at 33% due to quality of documentation. Documentation reprinted and re-issued. Re-review planned by the end of June 2022. New booklets out Sep 2022, ST and AY to complete review at end of September, 20 sets of notes on each site 23/9/22 LCH review completed, awaiting PHB			23/9/22		Re-review of the use of the warm bundle tool to be completed by the end of June 2022.
			Raise staff awareness - audit results and aim to be shared.			31/10/2021	Review results emailed to staff for awareness.			31/10/2021		
			Raise staff awareness - poster to be erected for staff highlighting review results & aim.			31/10/2021	Poster in place.			31/10/2021		
2	Publish guideline for prevention & management of hypothermia in the newborn.	ATAIN	Identify MW, ANNP and Neonatology Registrar to review and update guideline, as required, and Consultant Neonatologist to oversee.		Patient Safety Lead Midwife / Guidelines Team	01/12/2021	The guideline has reviewed and updated to ensure compliance with latest guidance and best practice and re-issued.			01/12//2021	Eidence filed 21/9/22	To be reviewed as per Trust Guideline procedure every 3 years
			Review of guideline to include a literature search for best methods for management of hypothermia of the newborn & review against NICE & BAPM guidelines.			31/01/2022				31/01/2021		
			Develop poster to attach to warming cabinets to inform staff of appropriate use.		Patient Safety Lead Midwife	31/10/2021	Poster in place.			31/10/2021		
			Include directions for use in guideline.		Patient Safety Lead Midwife / Guidelines Team	31/01/2022	Direction for use included in guidelines.			31/01/2022		
4	Investigate practicalities of offering hot cot care to babies on maternity wards.	ATAIN	Research criteria for hot cot use on maternity wards.		Patient Safety Lead Midwife / Consultant Midwife	30/11/2021	Investigated and not feasible. Suitable alterative i.e. blanket warming cabinets now in place. **Close / archive**			25/11/2021	N/A	N/A
			Research costs and funding.			30/11/2021						
			Research staff support strategies (guidelines, education, posters).			30/11/2021						
			Embed the Ockenden recommended actions for FM leads.	Reduction in incidents / harm Improved quality & safety	Clinical Educators	30/04/2022	Please refer to actions 1 - 3 on the 'Improve Leadership' Tab. - FM lead midwife and obstetrician now in post			**21/09/2021**		
			Introduce stickers for interpretation and escalation of IIA in community/low risk settings.		Labour Ward Managers		Stickers created and rolled out. Compliance to be audited as part of 'Fresh Eyes' Audit.					
7	>90% completed hypoglycaemia risk assessment completed following birth	ATAIN	Review 20 sets of notes across Trust on current use of warm bundle tool.	Improved understanding & awareness Reduction in incidents / harm Improved quality & safety	LW Midwife (KA) / Patient Safety Lead Midwife	31/10/2021	Review tool completed - poor compliance identified. Awareness & training being undertaken with a further review in 3 months to test improvements. 23/9/22 Review repeated and disseminated to staff			31/10/2021	Evidence filed 23/9/22	Re-review of the use of the hypoglycaemia risk assessment tool to be undertaken by the end of April 2022
			Email staff regarding review results & aim.				Review results and aim emailed to staff					
			Poster to be erected for staff highlighting review results & aim.				Poster in place.					
11	Support identification, escalation and transfer of emergencies in community settings.	SI 257486	Bespoke CMW emergency training days to be provided.		Consultant Midwife / Community Matron		Training commenced, paused due to service pressures, to restart July 2022. 23/9/22 Training now recommenced				Evidence filed 23/9/22	Monthly monitoring of training compliance via Divisional governance route
12	Improve timeliness of escalation.	SI 257486	Situational awareness and human factors training to be included in prompt training.		Clinical Educators		Training included in PROMPT training within current TNA.				Evidenced filed 23/9/22	
23	Await survey of women and their families experiences of IOL and analyse results to ensure service (and any recommendations) meet the needs of the local population.		Results returned, infographs to be shared and use as basis for service evaluation	Improve shared decision making and informed consent	Amy Garratt Safety MW	31/08/2022				23/08/2022	Evidence filed 22/9/22	Ongoing audit programme
24	Ensure arrangements are in place to discharge babies from NNU when they no longer require NNU care but do require TC.	TC	Explore home care options, Introduction of a neonatal homecare team to reduce the length of stay for babies on the neonatal unit and transitional care.	Improved quality & safety Improved experience and wellbeing	NNU Matron	31/08/2021	Home care fully launched on 2 August 2021.			02/08/2021		Homecare dashboard
			Explore expanding TC bay to facilitate mothers coming back into hospital after discharge. A separate bay would be required for IPC reasons.		NNU Matron / Deputy Head of Midwifery	31/01/2022	Additional TC facilities not feasible with current estate challenges			n/a	n/a	
26	Reduce the amount of babies on IVABs.	TC	To involve Kelly Johnson Project Lead Cost Improvement for family health.		Patient Safety Lead Midwife	31/10/2021	Complete - K Johnson is aware and awaiting invite to meeting, once project leads have been identified. 8/9. SE has been to Network meetings and she has been advised not to audit the sepsis risk calculator and the Network will not be supporting this QI at this time.			31/10/2021		
			Audit maternal sepsis rate. Audit number of sepsis bundles where blood cultures not taken.		Patient Safety Lead Midwife		Audit complete - blood cultures taken in 12/13 cases where they were indicated.			01/11/2021		
			Explore implementing the Kaiser calculator through audit process.		ANNP		Awaiting advice from regional network before commencing audit. 8/9. SE has been to Network meetings and she has been advised not to audit the sepsis risk calculator and the Network will not be supporting this QI at this time.			n/a	N/A	
27	Review criteria for use of prophylactic IVABX in new-borns	ATAIN	Prospective audit for sepsis risk calculator		ANNP / Patient Safety Lead Midwife		Awaiting advice from regional network before commencing audit. 8/9. SE has been to Network meetings and she has been advised not to audit the sepsis risk calculator and the Network will not be supporting this QI at this time.			n/a	N/A	
			Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		NNU Matron	30/09/2021	In place.			30/09/2021	Evidence filed 22/9/22	
			A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.		NNU Matron	30/06/2022 CNST revised date 5/1/23	Secondary data being recorded and collated.				Evidence filed 22/9/22	
			An Action plan to address the issues identified in the TC audit and ATAIN audit has been agreed by with the maternity and neonatal safety champions and Board Level champion.		NNU Matron / ATAIN Lead	30/06/2022 CNST revised date 5/1/23	TC action plan is captured as part of the wider Maternity & Neonatal Improvement Plan, and progress overseen by the Board level NED Maternity & Neonatal Safety Champion and via MNOG.				Evidence filed 22/9/22	
			Progress with the agreed ATAIN action plan has been shared with the maternity, neonatal and Board level safety champion, LMNS and ICS quality surveillance meeting.		NNU Matron / ATAIN Lead	29/7/22	As above. New action plan approved by Board before 29th July deadline, updated action plan now under way			28/7/22	Evidence filed 22/9/23	

			Existing SOP (referred to at action 21 above) to be reviewed to ensure it meets these requirements.		Patient Safety Lead Midwife	31/01/2022	All relevant guidelines / SOPs include clear criteria for informing / calling the consultant for direct support for complex cases. Guidelines / SOPs have been shared with staff and there are also laminated posters in place.			31/01/2022		Audit Job Planning & Appraisal
			Any changes to SOP to be communicated to all relevant staff.		Matrons	28/02/2022				28/02/2022		
37	The Trust can demonstrate an effective system of clinical workforce planning to the required standard.	CNST Year 4 Safety Action 4	**Obstetric medical workforce:** The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report.	Improved quality & safety Improved staff morale & wellbeing	Clinical Lead for Maternity, Trust-wide	31/01/2022 Updated CNST deadline 05/01/23	Discussed between consultants, laminated and put up on labour wards and sent to audit team. All relevant guidelines / SOPs include clear criteria for informing / call the consultant for direct support. Guidelines / SOPs have been shared with staff and there are also laminated posters in place. Compliance to be tested through audit and review of incidents / SIs. Effective system in place for workforce planning. All consultants have job plans.			Guideline filed 22/9/22		Audit Review of Incidents / SIs
	The Trust can demonstrate an effective system of clinical workforce planning to the required standard.		**Anaesthetist medical workforce:** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).		TBC	31/01/2022 Updated CNST deadline 05/01/23				Evidence filed 22/9/22		Ongoing collation and review of rotas
41	The Trust must ensure that all medicines are stored safely and securely.	CQC 2021 Inspection Report	Map out across Maternity at both sites locations where medicines (drugs rooms (inc. fluids), medication fridges, mobile trolleys) are stored	Improved quality & safety Improved safety and security of medicines Compliance with regulations	Head of Midwifery / Matrons	15/03/2022	Audit undertaken and medicines storage locations within maternity has been mapped.			15/03/2022	Map of Locations	Daily assurance spot checks Formal review in six months Action plan and outputs from daily assurance checks and formal six month review reported and monitored through Quality Dashboard meeting
	The Trust must ensure that all medicines are stored safely and securely.	CQC 2021 Inspection Report	Undertake gap analysis audit against Trust's Medicines Management Policy that relates to storage and security.	Improved quality & safety Improved safety and security of medicines Compliance with regulations	Head of Midwifery / Matrons	15/03/2022	Gap analysis undertaken against policy as part of the audit process.			15/03/2022	Gap Analysis Audit	
	The Trust must ensure that all medicines are stored safely and securely.	CQC 2021 Inspection Report	Develop audit tool for use by Maternity Matrons to undertake gap analysis against medicines storage section of medicines management policy.	Improved quality & safety Improved safety and security of medicines Compliance with regulations	Head of Compliance	03/03/2022	Pharmacy team have supported this action and have made use of the established Safe & Secure audit tool. This will be undertaken by matrons and pharmacy team working collaboratively.			04/03/2022	Audit Tool	
1	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing.	Ockenden	Name of dedicated Lead Midwife and Lead Obstetrician to be confirmed.	Improved quality & safety Improved fetal wellbeing	Clinical Lead for Maternity, Trust-wide	30/11/2021	Fetal Monitoring leads in place. As outlined below, there is an outstanding action in respect of recording this on off-duties / rotas (Midwife rotas available but unable to sufficiently evidence obstetric lead dedicated time; waiting for job planning.) - FM MW rotas now available - Awaiting Consulatnt job plans 9/9/22 Awaiting BM job plan			21/9/22	Job descriptions and job planning for both roles	SBL audit programme
			Copies of rotas / off duties to be available to demonstrate they are given dedicated time.			30/04/2022					Job planning and rotas filed	SBL audit programme
2	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: •Improving the practice of monitoring fetal wellbeing •Consolidating existing knowledge of monitoring fetal wellbeing •Keeping abreast of developments in the field •Raising the profile of fetal wellbeing monitoring •Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported •Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. •The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. •They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Ockenden	Job Description to be developed which has in the criteria as a minimum for both roles and confirmation that roles are in post.	Improved leadership Increased staff support and wellbeing Improved outcomes Improved quality & safety Improved fetal wellbeing	Clinical Lead for Maternity, Trust-wide / Consultant Midwife	31/12/2021	In place			31/12/2021	Job descriptions and job planning for both roles	SBL audit programme
			Improving the practice & raising the profile of fetal wellbeing monitoring				Fetal monitoring leads in place. Leads are able to demonstrate time for dedicated fetal monitoring activities but unable in all instances to document on off-duty and rotas at present. Role included in the job description of the midwifery education team.				Ockenden approved evidence filed	SBL audit programme
			Consolidating existing knowledge of monitoring fetal wellbeing									SBL audit programme
			Keeping abreast of developments in the field									SBL audit programme
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g. clinical supervision									SBL audit programme
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.									SBL audit programme
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.									SBL audit programme
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.									SBL audit programme

3	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Ockenden	Name of dedicated Lead Midwife and Lead Obstetrician	Increased opportunities for learning and improvement Increased staff support and wellbeing Improved outcomes Improved quality & safety								See Improving Leadership Actions 1 &2	SBL audit programme
Maternity Workforce Planning													
4	Director/Head of Midwifery is responsible and accountable to an executive director	Ockenden	HoM/DoM Job Description to be amended to reflect explicit signposting of responsibility and accountability to an executive director	Clear leadership and accountability	Head of Midwifery / Director of Nursing	31/03/2022	JD updated.			21/9/22	JD filed	MNOG
Visibility of Leadership													
5	Improve visibility of leadership including 'out of hours' (OOH) support.	Feedback from staff to DON	Visibility of leadership within the Division is an area that has improved significantly in the staff survey. The Divisional Triumvirate to build on the progress to date.	Increased staff support and wellbeing	Head of Midwifery	30/11/2021	The Head of Midwifery (HoM) and Deputy HoM now alternate between sites ensuring daily visibility of senior midwifery leadership on each site. A weekly email confirms senior leadership availability / movements. A 9.00 'huddle' is in place - see also section on escalation Managers on call contact sheets are being reviewed to evaluate OOH calls to collate themes. Outcome discussed at matrons' meetings to agree recommendations and required actions. Early indications are that these arrangements are having a positive impact Feedback on agreed actions to be communicated to staff including additional support which can be provided as part of the planned Comms Campaign.			Ockenden feedback praised senior leadership team for visibility Weekly email of movement in place at ops meetings On call contact sheet have been reviewed		Workplace Innovation Programme MNOG Maternity and Neonatal Assurance Report
		An audit of 1% of notes demonstrating compliance.		Consultant Midwife / Patient Safety Lead Midwife / Quality & Audit Midwife	01/03/2022	Complete			01/03/2022	Filed 22/9/22	Ongoing audit plan PCSP ongoing project Ockenden Assurance at MNOG	
		CQC survey and associated action plans.				In place.				Filed 22/9/22	Ongoing audit plan PCSP ongoing project Ockenden Assurance at MNOG	
		An audit of 5% of notes or a total of 150 which is ever the least from January 2021, demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.		Quality & Audit Midwife		Birth Choices Clinic in place and women supported along these pathways but see also actions 7 - 14 below. Consultant Midwife to complete audit. Unsuccessful IOL and subsequent Cat 3 LSCS is being audited at present. This will be reported in to the Maternity & Neonatal Oversight Group and if compliance is demonstrated, the action will be completed and closed.				Filed 22/9/22	Ongoing audit plan PCSP ongoing project Ockenden Assurance at MNOG	
		Information on maternal choice including choice for caesarean delivery.		Labour Ward Leads		In place.				Filed 22/9/22	PCSP Project	
11		BCC Audit	Develop a 'You Said, We Did' poster for staff based on feedback.		Consultant Midwife	31/3/23	Poster developed, circulated and displayed			23/9/22	Filed 23/9/2	Ongoing audit plan
10		BCC Audit	Explore the possibility of set criteria for referral to the BCC.		Consultant Midwife	Action decided against, remove				n/a	n/a	n/a
Responding to Staff Feedback / Concerns													
1	Ensure safety dashboard is visible to both maternity and neonatal staff	CNST	Ensure safety dashboard is in place in all ward locations across both sites highlighting the local statistics against national drivers	Strengthened oversight & assurance Increased staff awareness Improved staff morale	Digital Midwife	31/05/2021	Dashboard available on both units. In place and complete. **Close / archive**			31/05/2021		To include in Monthly matrons audit

3	Ensure staff health & wellbeing including access to breaks and support following Serious Incidents	Feedback from staff to DON & SI 263178	Review arrangements and facilities for staff to access breaks	Improved staff health & wellbeing Improved staff morale	Head of Midwifery	31/12/2021	Following discussions with staff, revised break strategies are being piloted for one month on Nettleham and Bardney – these are bespoke to each ward following discussions with staff. Once complete, the pilot will be evaluated to determine whether there has been an improvement and / or whether additional actions are required. The HoM and Deputy HoM ensure staff are taking breaks as part of their daily site presence. Monitoring of breaks is also included as part of the Band 7 quality audits. The staff council has now been formed and 8 midwives pan-Trust have joined. The council is currently focusing on improvements to staff well-being. Staff break boards in place and breaks allocated					Workplace Innovation Programme Ongoing culture surveys
External Clinical Specialist Opinion												
5	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated	Ockenden	Ensure there is a policy or SOP in place for involving external clinical specialists in reviews Audit to demonstrate this takes place.	Increased transparency & independence of reviews	Head of Midwifery Safety Leads	30/11/2021 31/03/2021	The requirement for external input in to SIs is included within the Trust's Incident Management Policy.					
6	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their Maternity Safety Champions.	Ockenden	Confirmation of an identified Trust Board Non Executive	Improved oversight & assurance - 'Ward to Board' Raising the profile & increasing the women and family voice	Trust Chair	31/12/2021	NED Safety Champion in place with reporting / assurance through MNOG, QGC and up to the Trust Board. **Close / archive**			Evidence filed 22/9/21		MNOG / QGC . Trust Board Approved by Ockenden
7	The Trust can demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.	CNST Year 4 Safety Action 9	The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.	Strengthened oversight & assurance More timely escalation and mitigation of risk issues	Head of Midwifery	30/06/2022 Revised date 5/1/23	Pathway benchmarked. A monthly Maternity & Neoatal Assurance Report is shared, internally, with the Maternity & Neonatal Oversight Group and as part of the Upward Report to the Quality Governance Committee and Trust Board and externally with the LMNS / quality group.			Evidence filed 22/9/22		Monthly maternity & neonatal assurance report / MNOG
	The Trust can demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.	CNST Year 4 Safety Action 10	Board level safety champions present a locally agreed dashboard to the Board on a quarterly basis. To include, as a minimum, the measures set out in Appendix 2 of the Perinatal quality surveillance model, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.	Strengthened oversight & assurance More timely escalation and mitigation of risk issues	Head of Midwifery / Director of Nursing / NED Safety Champion	30/06/2022 Revised date 5/1/23	A monthly Maternity & Neoatal Assurance Report is shared, internally, with the Maternity & Neonatal Oversight Group and as part of the Upward Report to the Quality Governance Committee and Trust Board and externally with the LMNS / quality group. There is a separate written report from the NED Safety Champion.			Evidence filed 22/9/22		MNOG / QGC . Trust Board
	The Trust can demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.	CNST Year 4 Safety Action 11	Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes.	Strengthened oversight & assurance More timely escalation and mitigation of risk issues	Head of Midwifery	31/03/2022 23/9/22 Targets removed	Following publication of the second Ockenden report, the Maternity & Neonatal Oversight Group has recommended that further roll out of MCoC should cease and that the Trust should continue to support at the current level of provision - decision to be reviewed in 3 months. This does not mean that women will not continue to be added to the pathway where teams are already established. 22/9/22 Targets removed by CMO			Evidence filed 23/9/22		MCoC regularly reviewed at MNOG
Enhanced Safety - Implement the Perinatal Clinical Surveillance Model												
8	Ensure there is a plan to implement the Perinatal Clinical Quality Surveillance Model	Ockenden	Full evidence of full implementation of the perinatal surveillance framework by June 2021. Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	Improved oversight and assurance	Consultant Midwife / Patient Safety Lead Midwife	01/01/2021	In place and compliant but reporting on claims data is outstanding.				see Ockenden 1 Submission	MNOG / QGC . Trust Board Approved by Ockenden
12	Trusts to submit data to the MSDS to the required standard.	CNST Year 4 Safety Action 2 [Concerns with the Medway System also raised as part of the Feedback from Staff to the DON]	Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022. The data for January 2022 will be available on the dashboard during April 2022.	Improved data quality Improved oversight & assurance Increased transparency	IT Leads	5/1/23				07/09/22	MSDS scorecard confirming compliance filed	
13	Trusts to submit data to the MSDS to the required standard.	CNST Year 4 Safety Action 2 [Concerns with the Medway System also raised as part of the Feedback from Staff to the DON]	January 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded at the first antenatal booking appointment for 90% of women booked in the month.	Improved data quality Improved oversight & assurance Increased transparency	IT Leads	5/1/23				07/09/23	MSDS scorecard confirming compliance filed	
14	Trusts to submit data to the MSDS to the required standard.	CNST Year 4 Safety Action 2 [Concerns with the Medway System also raised as part of the Feedback from Staff to the DON]	January 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.	Improved data quality Improved oversight & assurance Increased transparency	IT Leads	5/1/23				07/09/24	MSDS scorecard confirming compliance filed	
15	Trusts to submit data to the MSDS to the required standard.	CNST Year 4 Safety Action 2 [Concerns with the Medway System also raised as part of the Feedback from Staff to the DON]	Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022 for the following 5 metrics: **COC** 1 The proportion (%) of women placed on a CoC pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. 2. The proportion (%) of women receiving CoC. **PCSP** 3. The proportion (%) of women who have an antenatal care plan by 16+1 weeks gestation age (119 days) that also have a personalised care and support plan. 4. The proportion (%) of women who have a birth care plan by 34+1 week's gestation age (245 days) that also have a personalised care and support plan. 5. The proportion (%) of women who have a postpartum care plan by 36+1 weeks gestation age (259 days) that also have a personalised care and support plan.			5/1/23				07/09/25	MSDS scorecard confirming compliance filed	
18	The Trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	CQC Inspection 2021 - Final Report	Review and re-issue the Incident 'Trigger List'.		Risk Midwife	31/03/2022	The incident 'Trigger List' has been provided to all staff and discussed at team meetings. This is linked to the Trust-wide piece of work looking at mapping of the various processes that share learning across both sites.			31/03/2022		MMT Now embedded in delivery workflow

18	The Trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	CQC Inspection 2021 - Final Report	Review the corporate assurance tools to understand what questions are regularly asked of staff and determine if further assurance relating to incidents could be included within these (i.e. ward accreditation review process).		Head of Compliance	30/06/2022	Quality Matron audit					
12	The Trust can evidence that a local training plan is in place to place to ensure that all six core modules of the Core Competency Framework will be included in the maternity unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, the Trust can evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4.	CNST Year 4 Safety Action 8	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4 in August 2021.	Improved staff knowledge and competency Improved quality & safety Strengthened assurance	Clinical Educators	1/5/23	Underway.			TNA filed 22/9/22	TNA	CNST and dashboard assurance at MNOG

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Maternity Safety Improvement Plan

HEADLINE REPORT for Maternity & Neonatal Oversight Group

Jules Bambridge
Lead Midwife for Patient Safety

October 2022

The Maternity Safety Improvement plan is a dynamic live document for the collation and monitoring of the actions plan generated through national maternity reports and assurance requirements.

As of 13th October 2022 the MatSIP is broken down into 7 sections

Section	Total Actions	**Red** Date Passed or non-compliance expected	**Amber** In progress, completion expected	**Green** Completed, awaiting evidence of embedding	**Blue** Embedded action with evidence, to be signed off at MNSC prior to closure
Optimise Safety	74	9	27	38	0
Optimise Experience	7	3	2	2	0
Improve Leadership	3	0	1	2	0
Deliver MNP Ambition	28	Awaiting population by LMNS			
Choice & Personalised Care	17	4	6	6	0
Provide Assurance	44	11	7	26	0
Archived Actions	71	Completed, embedded and signed off by MNSC for closure			

The following actions are currently rated Red due to expected completion date being passed or there is a concern over compliance upon reaching the expected completion date.

Most of these actions are in progress and completion expected by the end of 2022. However actions related to CNST (OS35 and PA13) are at high risk of non-compliance, despite the updated guidance NHSR released on 11th October 2022.

Action No	Action Milestone	Responsible Lead	Due Date	Comments
OS3	Review use via low temp admission case review	ATAIN Lead	~~31/6/22~~, ongoing audit	Previously assigned to LWC but difficult to achieve due to acuity, now being completed by ATAIN leads as ongoing audit but small backlog to clear
OS5	Implement the improvement actions agreed following the recent internal SBLCBV2 audit, as outlined with the monthly Maternity & Neonatal Assurance report, dated September 2021	ANC Matron /FM Leads	30/6/22	Unable to confirm this is completed due to unavailability of AN Matron
OS6	Benchmark HIE numbers against Trusts using physiological interpretation. Trusts to benchmark against; GSTT, Kingston. Identify barriers to implementation.	FM Leads	30/6/22	This is a significant piece of work - review and benchmarking to be completed following appointment of FM leads. 9/9/22 Kingston excluded due to STAN. Last 10 cases review planned to apply hypothetical physiological interpretation to evidence different course of action, expected 9/12/22 16/9/22 Data received from GSTT
OS35	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during the shift) to ensure there is an oversight of all birth activity within the service.	HoM / Inpatient Matrons	05/12/22	Date not yet due but significant risk to CNST compliance, new CNST guidance released 11/10/22 with clearer guidance, requires retrospective review of BR+ to confirm compliance
OS40	Trust to ensure that the temperature of the treatment rooms within maternity at LCH are monitored to ensure that medicines are stored at the correct temperature and that there is restricted access to these rooms. - Audit the process to ensure compliance	Inpatient Matrons	31/3/22	Update from Lynn Kirk - Project Manager 4/10/22 Lincoln and Pilgrim Maternity have been identified as locations to trial the Stanley smart temperature monitoring equipment. Audit completed at Lincoln (Nettleham and Bardney ward to identify equipment and location for installation, audit to be completed at Boston on 7/10/2022 Lincoln and Boston Maternity teams have been provided a template to identify staff who will require training on the equipment and who will require access and training on the mobile view (the web-based system that will allow the teams to access the recorded data) Template was sent 30/09/2022 The pilot will also roll out new ways of working to include a booklet for the daily room temperatures to be stored in, this booklet also provides links to training, Temperature guides on what to do if your Ambient, Fridge, or Freezer temperature is above or below a certain level and escalation process along with easy to follow guides for all staff on using the equipment and process flow. The booklet will stay on the ward and will have a page per thermometer to prompt staff to check all areas and will last a full year, therefore no more loose papers spread across multiple rooms. The roll-out of the new smart technology will provide the wards the accurate room temperatures recorded and a link to the daily checks to allow this to be audited if required. The access to accurate reliable data will therefore form your evidence of temperature excursions and working with the Pharmacy teams and estate and facilities a solution can then be found. The pilot is due to go live in October, we have a delay currently due to an outbreak of Covid within the Pharmacy team, however, Clinical Engineering and the project are moving forward to collate the information required to ensure we continue to move forward until we have the Pharmacy resource back in place and a go-live date can be agreed.
OS41	The Trust must ensure that all medicines are stored safely and securely. - Plan out action in response to audit to close any gaps identified (i.e. order digital thermometers) - Identify any risks from audit undertaken (i.e. rooms where ambient temperature is routinely 25 degrees or above and take advice from pharmacy around mitigations. - Understand mitigations to environmental challenges in storage of medicines (i.e. age of estate at Lincoln maternity with a lack of air-conditioning/ventilation).	HoM / Matrons	30/4/22	

OE1	Clear co-produced plan, with MVP that demonstrates co-production and co-design of service improvements, changes and developments.	MVP Chair / Consultant Midwife	30/6/22	HoM to discuss with MVP/LMNS
OE2	Mandatory study session to be arranged for the whole department on communication / documentation with a focus on the communication issues identified during the Thematic Review.	Clinical Lead for Maternity Trustwide / Clinical Lead for Labour Ward LCH	30/6/22	To be delivered as part of Divisional training programme from April 2002 onwards and to be included in existing events and forums (e.g. governance, audit, CTG meetings) to ensure as wider a coverage of staff as possible. Training to cover patient stories as well as communication issues identified from the thematic review. 9/9/2022 iNeed escalation project underway, expected completion date 31st March 2023 utilising EBC L+S Toolkit
OE5	Explore midwifery-led NIPE services - Audit of current position and agreement of next steps	DHoM	01/02/22	Update required
CPC1	Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc.) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	MVP Chair / Consultant Midwife	31/5/22	HoM to discuss with MVP/LMNS
PA10	Provide adequate resourcing of multidisciplinary PMRT review teams, including administrative support and ensure the involvement of independent external members in the team.	HoM / PMRT lead	30/6/22	Benchmarking exercise completed. PRMT group convened and strategy being developed. 21/9/22 New Lead in post, plan for Band 3 admin post LMNS member currently acting as external, plan to buddy up with another Trust improve external support, PMRT Lead to pull report of recommendations and rate quality of actions, assess for duplications on SIP and identify QIP
	Use the local PMRT summary reports and this national report as the basis to prioritise resources for key aspects of care and quality improvement activities identified as requiring action.	HoM / PMRT lead	30/6/22	
	Improve the quality of recommendations developed as a consequence of reviews by developing actions targeted at system level changes and audit their implementation and impact.	HoM / PMRT lead	30/6/22	
PA13	90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four in August 2021.	Education team	5/12/22	Underway. Face to face training not yet reinstated. 22/9/22 Now face to face but CNST compliance risk
	90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include **antenatal and intrapartum fetal monitoring and surveillance,** starting from the launch of MIS year four in August 2021.			
	The Trust can evidence that 90% of the team required to be involved in immediate **resuscitation of the newborn and management of the deteriorating newborn** infant have attended your in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021.			
PA14	Review the use of the Maternity Services Education Strategy to determine if this is effective in supporting improved training compliance.	Divisional Managing Director - FH	30/4/22	See Education Report
	Achieve Resuscitation core training level of 95% for medical staff.	Divisional Clinical Director - FH	30/4/22	
	Achieve 80% training compliance (average across all core training subjects) for medical staff.		30/4/22	
	Achieve 95% Trust target for core training compliance for medical staff.		31/08/22	
	The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff - Clear trajectories and monitoring of compliance to be agreed for midwives who training / sign off of competence is outstanding.	HoM/DHoM	31/10/21	

ULHT Quarterly ATAIN Report

Quarter 1 – April to June 2022

Samantha Tinkler – Patient Safety Midwife
Anusha Young – Patient Safety Midwife

Introduction

The Avoidable Term Admission into Neonatal unit (ATAIN) audit has been ongoing nationally, aiming to reduce the number of infants born at term (>37+0 gestation) requiring admission to the neonatal unit, and the subsequent separation from their mothers.

There is a vast amount of evidence that suggests separation of mothers and babies can lead to significant interruptions to the bonding experience which is essential in developing relationships, protecting maternal mental health and improving sustainable breastfeeding rates (Minkas et al, 2021, Hawdon, 2017, Crenshaw, 2014). The multidisciplinary team has a responsibility to ensure that mothers and babies are kept together wherever possible, embedding improvements to reduce the need for neonatal care and designing services that facilitate certain cares to be delivered at the mother's bedside.

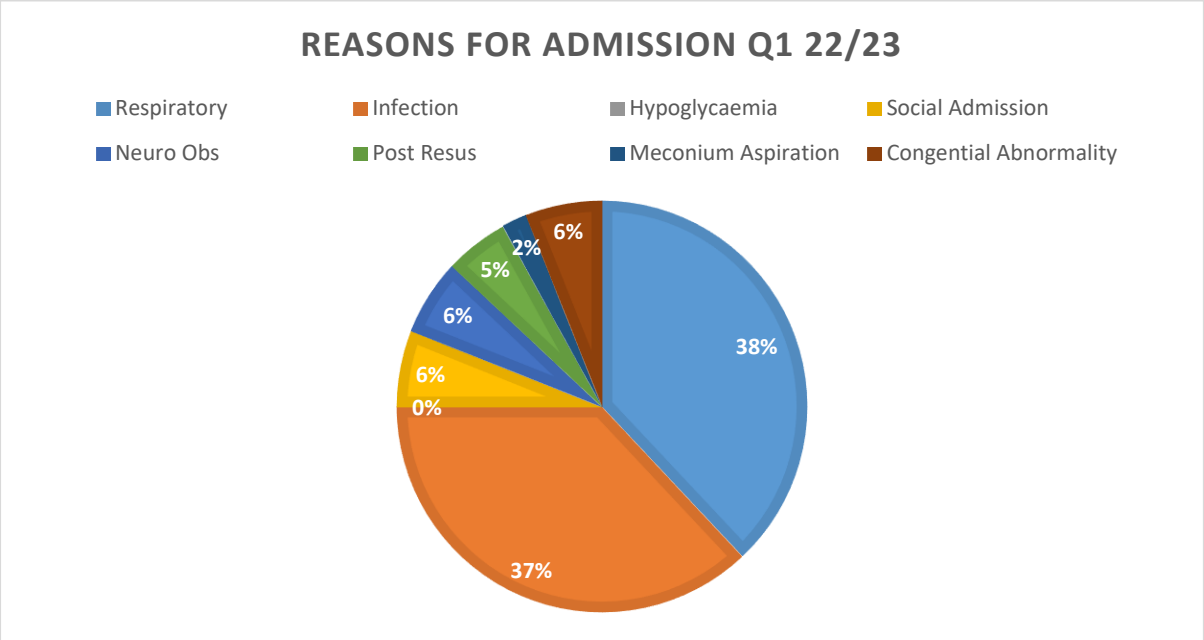
Overview

Between 1st April and 30th June 2022 (Q1) there were 62 term admissions to the Neonatal Units (NNU) in ULHT that met the inclusion criteria for ATAIN review. Of the 62 term admissions, 34 babies were admitted to the Neonatal Unit at LCH and 28 babies were admitted at PHB. Exclusion criteria includes those babies admitted for surgery, known congenital abnormalities and cases undergoing SI or DI review.

Of the 62 admissions, 7 were considered avoidable. Of those 7, 3 were also considered not appropriate. 55 admissions were considered unavoidable and appropriate.

Trends in admission reasons, Q1 Apr-Jun 2022

The first trend in this quarter data was the number of admissions for respiratory symptoms. Across the Trust, there were 25 admissions to the NNU for observation or treatment of respiratory symptoms.



Trend 1: Respiratory Symptoms, 25 babies admitted (38%)
Trend 2: Infection, 24 babies admitted (37%)

Respiratory Symptoms as the most common reason for admission:

Across the Trust there were 25 admissions to the NNU for observation and/or treatment of respiratory symptoms.
This can be broken down into two groups; babies who required respiratory support at birth, often characterised by chest recession and low saturations; and babies who went on to develop respiratory symptoms (usually signs of increase work of breathing) in the first few hours after birth. Some babies required treatment with oxygen therapy whilst others were only observed and did not require any treatment.
The numbers are similar to the last quarter with 26 admissions, however last quarter this indication made up 63% of the total admissions, whereas this quarter this indication is attributed to 38% of admissions.

On initial review of these babies there are a number of characteristics identified that require further review. Further analysis will inform improvement projects. These characteristics include:

- Mode of birth, specifically Lower Segment Caesarean Sections (LSCS)
- Gestation at time of birth
- The use of steroids when planning elective birth via LSCS prior to 39+3 weeks gestation

Further analysis and scoping will inform whether the babies that do not require oxygen therapy could care be managed in a Transitional Care environment rather than NNU, reducing separation of mother and baby.

Babies born with symptoms of Newborn Respiratory Distress Syndrome (NRDS), even in mild cases, will usually require oxygen and thus require admission for care on the NNU.

More commonly, babies may exhibit increased work of breathing without any risk factors for infection or other acute cause. This is particularly common in babies born by planned LSCS. In the lead up to birth, the fetus produces cortisol – this is a stress hormone that prompts rapid fetal lung preparation, preparation for the transition between fetal and neonatal life. Repetitive contractions during labour then rapidly increase the production of this hormone, with the result of preparing and pre-empting birth. Cortisol produces a similar effect on fetal lungs as artificial surfactant given to very preterm babies to aid plasticity and function of the lungs.

When babies are born by planned LSCS they are likely to not yet have begun their pre-birth hormone production, and they do not benefit from the additional hormone surge during labour. We know this because we see a higher incidence of respiratory symptoms in babies born via planned LSCS before labour when compared with babies born via any method after the onset of labour.

These respiratory symptoms are usually presentations of Transient Tachypnoea of the Newborn (TTTN). This is a transient period of time where the baby has increased work of breathing whilst their hormone response ‘catches up’ and their lung function is optimised. The usual presentation is fast or laboured breathing in the first hours after birth. Being a transient presentation, these symptoms usually self-correct and last less than 24 hours. These babies usually do not require oxygen therapy, however close monitoring is important – for some babies, using energy for work of breathing might then allow other systems to become less stable (most commonly this would be glucose metabolism and/or thermoregulation).

Differentiation between TTTN and NRDS is clinically important. Precise diagnosis is likely to prevent unnecessary admissions for observations/treatment. There are many clinical considerations to be taken here – education and experience for staff is vital to enable gained

confidence in the ability to recognise and manage TTTN on the maternity wards (baby with mother), avoid unnecessary and potentially premature admissions when the likely cause is transient (TTTN) but also to effectively identify deterioration that might suggest TTTN is not the underlying cause for symptoms.

Research findings and local audit demonstrate that babies born electively (IOL or LSCS) at early term gestations (37-39 weeks) and babies born by planned LSCS are more likely to exhibit respiratory symptoms. It is logical to consider that these babies have simply not had adequate pre-birth preparation.

Corticosteroids have been offered for preterm births for many years. This medication is given via injection to the mother in two doses, 12-24 hours apart. Steroids stimulate the production of cortisol in the fetus and promote lung maturation/readiness. More recently, practice has been to offer steroids to women who have 'at risk' factors that make their infants more likely to exhibit respiratory symptoms (for example, women with diabetes who plan a LSCS birth prior to 39 weeks).

Infection as the second most common reason for admission

The second trend for this data set is admissions for infection, or query infection – these make up 38% of total admissions.

Across the Trust, there were 24 admissions to the NNU for sepsis investigation, observation and/or treatment. As in Q4, admissions for infection continue to be a trend. On review of the ATAIN scorecard (Appendix 1) infection admissions do appear to be decreasing for Q1. Admission peaked in April 2022 but have since decreased and remained stable through Q4 21/22 and Q1 22/23.

Multiple factors may be contributing to this trend; such as length of time of spontaneous rupture of membranes, coupled with multiple vaginal examinations during induction of labour and intrapartum care. The plan from the previous report was to perform a deep dive of babies admitted with infection - this is still in progress and is planned to have an increased data set for the next quarterly report (Q2 Jul-Sep 22). This includes length of time from spontaneous rupture of membranes to birth and number of vaginal examinations performed after rupture of membranes. Prolonged rupture of membranes (>24hrs) is associated with

increased rates of chorioamnionitis (infection/inflammation of the placental tissues and amniotic fluid, sometimes extending to the fetus and/or mother).

At the point of rupture membranes, around 1:200 women might develop chorioamnionitis, increasing to around 1:100 around 24 hours after rupture of membranes. Current practice is to recommend augmentation of labour (artificially inducing contractions) around 24 hours post-rupture of membranes. However, augmentation of labour is associated with an increased number vaginal examinations, which is associated with increasing likelihood of infection. Therefore, it is reasonable to consider that the process of augmentation of labour and required vaginal examinations may increase the chance of infection further. Whilst, to a degree, this might be unavoidable, capturing data around how many examinations against which women and babies develop infection will enable us to identify if there are ways to reduce/limit any impact.

Steroid Use

As discussed in the previous report, the use of steroids for women planning birth via elective (planned) LSCS between 37+0 and 38+6 had been well-embedded in the Trust. Recent evidence of XX sample and *Xgraded* quality methodology suggests there may be a link between steroid administration and slightly lower education attainment at age 5. We await further evidence and direction. There is some disparity in steroid administration between sites and between Consultants.

Avoidable admissions: reasons for and explanations

In Q1 there were 7 admissions that were classified to be avoidable. In ATAIN, 'avoidable' is a fairly undefined term. With resigned services the number of 'avoidable' admissions could be considered greater, however we have interpreted this as babies who were admitted for either social reasons or where there was no further capacity in Transitional Care.

Social Admission	1
Did not require admission for observation	1
Could have been cared for in TC for increased observation - ? Capacity issue on TC.	1
Change in care could have prevented admission	4

Social Admission

Any admission for social reasons is considered avoidable. Under new Maternity Incentive Scheme Year 4 guidance, Safety Action 3 states that babies admitted because parents did not want to stay in hospital for transitional care will not need to be reviewed as part of the ATAIN programme so this will be considered in future reviews.

Updated Maternity Incentive Scheme Year 4 Recommendations

On 6th May 2022 an updated release of the MIS Year 4 programme was launched with updated guidance on the ATAIN review process. Full details can be found in Appendix 2. This includes:

- Reviews of ALL babies transferred or admitted to NNU (regardless of length of stay or admission on BadgerNet): **Timeframe From 18th July 2022 -** This is a cohort of infants not previously recorded in ATAIN. We anticipate a significant rise in rates locally and mirrored nationally. The ATAIN target remains the same – therefore significant work is needed to address the trends identified to work towards target.
- TC audit and reporting to recommence: **Timeframe from 16th June 2022**
- Evidence that findings of all reviews of term babies transferred or admitted to a NNU are reviewed quarterly and the findings have been shared quarterly with the safety champions and Board level champion, the LMNS and ICS quality surveillance meeting **Timeframe: from Q1 2022/2023**
- An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point f). Evidence that progress with the action plan has been shared with the neonatal, maternity and Board level safety champions, LMNS and ICS quality surveillance meeting each quarter: **Timeframe Evidence of action plan (points b and f) agreed with Safety Champions and Board level champion and signed off by the Board no later than 29/7/22.**

These have been updated again on 11th October 2022 and further information will be provided in the next Quarterly report.

Summary and recommendations:

- Adopt and progress recommendations from MIS Year 4
- Continue to review data trends using the TBAM review method
- Explore TTTN toolkit implemented in another Trust and identify areas applicable locally.
- Await further national guidance/research to amend practice for administration of steroids.
- Continue work to review and improve clinical escalation processes. . Implement iNeed to embed RCOG escalation toolkit interventions.
- ULHT identified pilot site for development of NEWTT2 tool
- Plan for roll out of midwife-led IV antibiotic administration for babies (initially with TC staff) to avoid babies needing to be separated for this care. Proposal in process; competency framework to go to NMAAF; proposed launch date 1st January 2023.

References:

Minkas: Preterm care during the COVID-19 pandemic: A comparative risk analysis of neonatal deaths averted by kangaroo mother care versus mortality due to SARS-CoV-2 infection - PubMed (nih.gov)

Hawdon: Reducing risk without mother-baby separation – Dr Jane M Hawdon - Baby Friendly Initiative (unicef.org.uk)

Appendix 1: ATAIN Scorecards:

ATAIN: Admissions Scorecard

Lincoln County Hospital 2022

Indication	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Total Live Births	221	205	203	211	200	209						
Term admissions total	11	16	13	15	5	14						
% of live term births (target <6%)	4.97%	7.8%	6.4%	7.1%	2.5%	6.7%						
Avoidable admissions total	1	4	2	0	0	3						
% avoidable admissions	8.3%	25%	15.4%	0.0%	0.0%	14.2%						
Hypoglycaemia	1	0	0	0	1	0						
Jaundice	0	0	0	0	0	0						
Respiratory symptoms	6	11	7	4	3	9						
Sepsis	1	2	5	9	0	2						
Congenital anomaly*	1	1	0	1	1	0						
Social admissions	0	1	0	0	0	2						
Asphyxia/Neuro	1	0	0	1	0	0						
Hypothermia	3	1	0	0	0	1						
Other reasons	0	1	1	0	0	0						

ATAIN: Admissions Scorecard

Pilgrim Hospital, Boston 2022

Indication	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Total Live Term Births	134	114	134	137	142	153						
Term admissions total	9	7	8	9	12	7						
% of live births (target 6%)	6.7%	6.1%	5.9%	6.6%	8.5%	4.6%						
Avoidable admissions total	0	2	2	1	1	2						
% avoidable admissions	0%	28.6%	25%	11.1%	8.33%	28.6%						
Hypoglycaemia	0	2	1	0	0	0						
Jaundice	0	0	0	0	0	0						
Respiratory symptoms	2	1	4	4	2	3						
Sepsis	0	1	2	3	7	3						
Congenital anomaly	0	0	0	0	1	1						
Social admissions	0	1	0	1	0	0						
Asphyxia/Neuro	1	3	1	1	1	0						
Hypothermia	0	1	0	2	0	0						
Other reasons	0	0	2	0	1	0						

ATAIN: Admissions Scorecard

ULHT Trust-wide 2022

Indication	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Total Live Term Births	355	319	337	348	342	362						
Term admissions total	20	23	21	24	17	21						
% of live births (target 6%)	5.6%	7.2%	6.2%	6.9%	4.9%	5.8%						
Avoidable admissions total	1	6	4	2	1	5						
% avoidable admissions	4.8%	26%	19.0%	8.3%	5.8%	23.8%						
Hypoglycaemia	1	2	1	0	0	0						
Jaundice	0	0	0	0	0	0						
Respiratory symptoms	8	12	11	8	5	12						
Infection/ Sepsis	1	3	7	12	7	5						
Congenital anomaly	1	1	0	1	2	1						
Social admissions	0	2	0	1	0	2						
Asphyxia/Neuro	2	3	1	2	1	0						
Hypothermia	3	2	0	2	0	1						
Other reasons	0	1	3	0	1	0						

Appendix 2: Updated MIS Year 4 Safety Action 3: ATAIN/TC

Required Standard			Minimum evidential requirement	Time Period
a)		Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning for all babies in transitional care.	- Evidence of NNU involvement in care planning - Admission criteria meets a min of at least one element of HRG XA4 but could extend beyond to BAPM TC Framework for Practice - There is an explicit staffing model - The policy is signed by maternity/neonatal clinical leads and should have auditable standards - The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	In place by Thursday 16th June 2022
b)		The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and ICS quarterly surveillance meeting each quarter.	- An ongoing audit trail is available which provides evidence that ongoing audits from Year 3 of the maternity incentive scheme of the pathway of care into TC are being completed as a minimum of quarterly. If for any reason reviews have been paused, they should be recommenced using data from **Q1 of 2022/23** financial year - Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions.	In place since Year 3, recommence from Q1 of 2022/23
c)		A data recording process (electronic and/or paper based for capturing ALL babies transferred to NNU regardless of the length of stay, is in place	- Data is available (electronic and/or paper based) on all term babies transferred or admitted to the NNU. This will include admission data captured via badgernet as well as transfer data which may be captured on a separate paper or electronic system - If a data recording process is not already in place to capture all babies transferred or admitted to the NNU should be in place no later than **Monday 18th July 2022 (??TC babies for cannula/abx)**	Reviews of ALL babies regardless of length stay to start no later than Mon 18th July 22

d)		A data recording process for capturing existing transitional care activity (regardless of place - which could be a Transitional Care (TC), PN ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0 and 36+6 weeks at birth who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.	- Data is available (electronic and/or paper based) on transitional care activity (regardless of place - which could be a TC, PN ward or virtual outreach pathway etc.) - Secondary data is available (electronic or paper based) for babies born between 34+0 and 36+6 at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days were supplemental O2 was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting.	In place from Year 3, if not to be in place by 16/6/22
e)		Commissioner returns for HRG 4/XA04 activity as per National Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the ODN, LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies	Commissioner returns for HRG 4/XA04 activity as per NCCMDS v2 are available to share on request, for example to support service development and capacity planning, with the LMNS, ODN and/or commissioners.	On request

f)		Reviews of (?ALL/?TERM) babies admitted to the NNU and continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all NNU transfers or admissions regardless of length of stay and/or admission on BadgerNet. In addition, reviews should report on the number of transfers to the NNU that would have met current TC admissions criteria but were transferred or admitted to the NNU due to capacity or staffing issues. The review should also record he number of babies that were transferred or admitted or remained on the NNU because of a need for NG feeding but could have been cared for on TC if NG feeding was supported there. Findings of the review have been shared with Mat, NNU and Board Level Safety Champions, LMNS, ICS quality surveillance meeting on a quarterly basis.	- An audit trail is available which provides evidence that ongoing reviews from year 3 of the MIS of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from Q1 of 2022/23 financial year - If not already in place, an audit trail is available which provides evidence that reviews from Monday 18th July 2022, now include ALL term babies transferred or admitted to NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from Q1 of 2022/23 financial year - Evidence that the review includes: the number of transfers or admissions to NNU that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for NG tube feeding but could have been cared for on a TC if NG feeding was supported there. - Evidence that findings of all reviews of term babies transferred or admitted to a NNU are reviewed quarterly and the findings have been shared quarterly with the safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.	In place from Year 3, if recommenced from Q1 2022/23
g)		An action plan to address local findings from the audit of the pathway (point b) and ATAIN reviews (point f) has been agreed with the maternity and neonatal safety champions and Board Level Champion.	- An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point f). Evidence that progress with the action plan has been shared with the neonatal, maternity and Board level safety champions, LMNS and ICS quality surveillance meeting each quarter.	Evidence of action plan (points b and f) agreed with Safety Champions and Board level champion and signed off by the

			- Self-certification by the Trust board and submitted to NHSR sing the board declaration form	Board no later than 29/7/22
h)		Progress with the revised ATAIN action plan has been shared with the Safety Champions, LMNS and ICS Quality Surveillance meeting.		Quarterly

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

ATAIN: Admissions Scorecard

Lincoln County Hospital October 2022

1 July case still to be reviewed. September admissions still under review

Indication	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Total Live Term Births	221	205	203	211	200	209	241	215	226			
Term admissions total	11	16	13	15	5	14	15	12	16			
% of live term births (target <6%)	4.97%	7.8%	6.4%	7.1%	2.5%	6.7%	6.2%	5.6%	7.1%			
Avoidable admissions total	1	4	2	0	0	3	TBC	1	TBC			
% avoidable admissions	8.3%	25%	15.4%	0.0%	0.0%	21.4%	TBC	8.4%	TBC			
Hypoglycaemia	1	0	0	0	1	0	0	0	0			
Jaundice	0	0	0	0	0	0	0	0	1			
Respiratory symptoms	6	11	7	4	3	9	8	7	7			
Sepsis	1	2	5	9	0	2	5	4	6			
Congenital anomaly*	1	1	0	1	1	0	1	0	1			
Social admissions	0	1	0	0	0	2	0	0	0			
Asphyxia/Neuro	1	0	0	1	0	0	1	1	0			
Hypothermia	3	1	0	0	0	1	1	0	0			
Other reasons	0	1	1	0	0	0	0	2	2			

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

ATAIN: Admissions Scorecard

Pilgrim Hospital, Boston October 2022

September admissions still under review

Indication	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Total Live Term Births	134	114	134	137	142	153	124	134	133			
Term admissions total	9	7	8	9	12	7	4	6	7			
% of live births (target 6%)	6.7%	6.1%	5.9%	6.6%	8.5%	4.6%	3.2%	4.5%	5.3%			
Avoidable admissions total	0	2	2	1	1	2	2	2	TBC			
% avoidable admissions	0%	28.6%	25%	11.1%	8.33%	28.6%	50%	33.4%	TBC			
Hypoglycaemia	0	2	1	0	0	0	1	1	1			
Jaundice	0	0	0	0	0	0	0	0	0			
Respiratory symptoms	2	1	4	4	2	3	1	2	3			
Sepsis	0	1	2	3	7	3	3	2	2			
Congenital anomaly	0	0	0	0	1	1	0	0	0			
Social admissions	0	1	0	1	0	0	0	0	0			
Asphyxia/Neuro	1	3	1	1	1	0	0	1	0			
Hypothermia	0	1	0	2	0	0	0	0	0			
Other reasons	0	0	2	0	1	0	0	0	1			

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

ATAIN: Admissions Scorecard

ULHT Trust-wide September 2022

1 July case still to be reviewed. September admissions still under review

Indication	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Total Live Term Births	355	319	337	348	342	362	365	349	359			
Term admissions total	20	23	21	24	17	21	19	20	23			
% of live births (target 6%)	5.6%	7.2%	6.2%	6.9%	4.9%	5.8%	5.2%	5.7%	6.4%			
Avoidable admissions total	1	6	4	1	1	5	TBC	3	TBC			
% avoidable admissions	4.8%	26%	19.0%	4.2%	5.8%	23.8%	TBC	15%	TBC			
Hypoglycaemia	1	2	1	0	0	0	1	1	1			
Jaundice	0	0	0	0	0	0	0	0	1			
Respiratory symptoms	8	12	11	8	5	12	9	9	10			
Infection/ Sepsis	1	3	7	12	7	5	8	6	8			
Congenital anomaly	1	1	0	1	2	1	1	0	1			
Social admissions	0	2	0	1	0	2	0	0	0			
Asphyxia/Neuro	2	3	1	2	1	0	1	2	0			
Hypothermia	3	2	0	2	0	1	1	0	0			
Other reasons	0	1	3	0	1	0	0	2	3			

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NHS United Lincolnshire Hospitals NHS Trust

ATAIN: Agreed delineation criteria (2022)

Assumed Avoidable

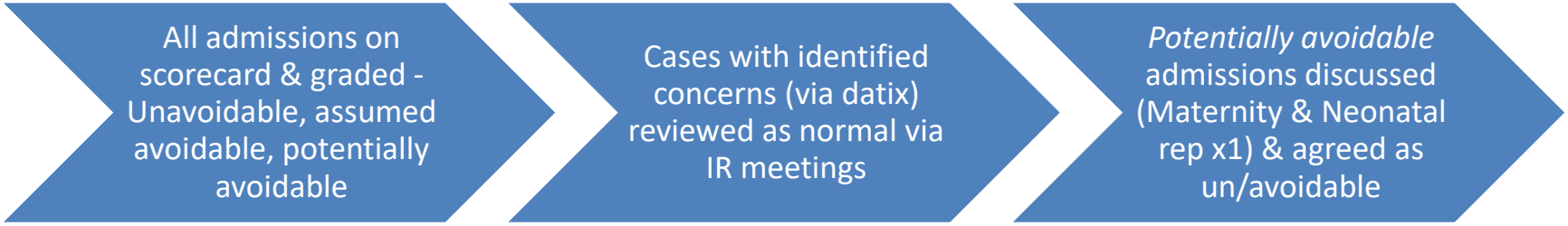
Routinely recorded as avoidable

Social reasons (separation from family; mother in ICU etc.)
No Transitional Care capacity

Potentially Avoidable

MatNeo discussion to identify whether un/avoidable

Hypothermic babies with no other clinical indicator **or** hypothermia is the assumed cause of other clinical factors
Babies born via elective Caesarean section <39+2 with symptoms of Respiratory Distress Syndrome
Babies admitted with x1 amber NEWS
Babies admitted <6 hours of birth with symptoms of Transient Tachypnea of the Newborn **and** no other clinical risk factors
Babies on hypoglycaemia monitoring where either of the initial two blood glucose readings is low, indicating admission



Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	11 October 2022
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2022/23 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Lack of Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Safer Staffing** The Committee received the report noting the continued extreme pressure through the emergency department during September which was impacting on patient flow and the ability to appropriately staff areas. Whilst some escalation beds had started to close these had been reopened in order to support the demand being seen. Staffing therefore remained challenging however care hours per patient day and fill rates had reflected, in September, an overall improved/sustained position. The Committee noted that position was testament to the oversight and control processes in place and the proactive nature of the team supporting the temporary workforce. It was noted that there had been an increase in pressure ulcers and decrease in falls however the harm levels were low which could be triangulated to the staffing fill rates. **Establishment Review – Endoscopy** The Committee received the endoscopy establishment review which had been conducted in consultation with staff noting that a full and comprehensive review had been completed. The proposal presented would see an investment and planned recruitment to posts, subject to Finance, Performance and Estates Committee and Trust Board approval. The Committee supported the proposal onward to the Board for approval.

	Workforce Strategy and Organisational Development (WSOD) Group Upward Report The Committee received the report noting that the group had considered the terms of references and quoracy requirements. The Committee noted the proposal to establish and education and learning team with work underway to consider mandatory training to ensure realistic expectations for staff and quality of the training being delivered. The recently launched appraisal process was noted following the decommissioning of the previous system, with the Committee noting the move to an appraisal season. **Committee Performance Dashboard** The Committee received the dashboard noting the position presented. **GMC Junior Doctor Survey and Guardian of Safe Working, Junior Doctor issue update** The Committee received an update from the Deputy Medical Director in relation to Junior Doctors noting the discussions held at the Junior Doctor forum to address issues of vacancies in certain specialities. A level of reassurance was received by the Committee that issues were stabilising and was assured of the work due to be proposed through executive led forums to undertake a cultural review.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Culture and Leadership Group Upward Report** The Committee received the upward reporting noting the commencement of the Cultural Ambassador recruitment campaign which had been approved by the group. The work of United Against had been supported with the next campaign focusing on aggression, violence and abuse. The Committee noted the current response rate to the Staff Survey at 19% which was reported as 5-6% higher than average for acute Trusts. Civility, dignity and respect had been highlighted as emerging themes with the Committee noting that work would take place in this area.

	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **University Teaching Hospital Group Upward Report** The Committee received the report noting the three key milestones of the group remained the rural healthcare strategy, clinical academics in post and increased research opportunities. Work was underway with the University of Lincoln for a joint research office to be in place to support progress and a joint research event was due to take place on 14 November to support this. The Committee noted the discussions being held with the University of Lincoln regarding the pace of progress and was keen that this continued to develop. A further update on progress would be presented to the Committee in November.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report noting that limited assurance was offered in respect of the month 6 update. The Committee noted that the update offered an accurate reflection of the current position in respect of the programmes relevant to the Committee. **Reporting Group Terms of Reference** The Committee received an update in respect of the reporting groups agreeing that dual reporting would take place for the Nursing and Medical Workforce Transformation Groups through to the Workforce, Strategy and OD Group and to the Improvement Steering Group to offer focus and oversight of both workforce and finance aspects. The terms of reference were received for the University Teaching Hospital Group with the Committee requesting a review of the membership to ensure appropriate clinical representation. **People Directorate Objective/Priorities update** The Committee received the update noting the progress that had been made to date however noted that workforce planning required strengthening in order for transformation within the organisation to take place. It was noted that there would be a workforce planning tool piloted with NHS England which would support progress to be made. Lead staff had been identified to receive training.

	People Board Update The Committee received the update for information noting the current position within the system and the representation of the Trust at the People Board. **CQC Action Plan** The Committee received the report noting the progress that had been made during September resulting in there being 4 remaining red actions, from 11. The Committee noted that the progress that had been made was recognised by the CQC.
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 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	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

Voting Members	O	N	D	J	F	M	A	M	J	J	A	S	O
Geoff Hayward									Meeting Cancelled		Meeting not held		
Philip Baker (Chair)	X	X	X	X	X	X	X	X		X		X	X
Sarah Dunnett	X	X	X	X									
Gail Shadlock					X	X	X	A		A			
Karen Dunderdale	X	X	X	X	X	X	D	X		X		X	X
Paul Matthew	X	X	X	X	X	X	X	X		X		X	X
Martin Rayson													
Colin Farquharson	X	X	X	X	X	X	A	X		X		D	D
Chris Gibson												X	X
Vicki Wells												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:	20 October 2022
Chairperson:	Dani Cecchini, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Report** The Committee received the report noting the limited assurance offered. The Committee was advised of a recent RIDDOR reportable incident which resulted in a concern being raised with the Health and Safety Executive who had been satisfied with the Trust response. The Committee noted the fire risk and the ongoing work which would be reported in more detail to the Committee in November. Specifically noted were issues highlighted as part of the risk assessment work and also requirement to improve training and to ensure appropriate storage. The procurement for provision of the 6 Facet Survey is ongoing. **Emergency Planning Group Upward Report** The Committee received the report noting the update from the group and sought to understand the assurance on the EPRR standards which had been presented with significant assurance. The Committee was informed that the changes that had been made to the standards could result in the level of assurance being down graded due to the implementation of the new standards and change in approach to the review. The outcome of the formal review was awaited. The Committee recognised the position of business continuity plans and noted that recent events had tested the Trusts plans offering a level of assurance. **Low Surface Temperature Report** The Committee received the report noting that significant assurance and the need for approval of budgets to commence work on third party sites.

	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contract and CRIG Upward Report** The Committee received the report noting the limited assurance. A deficit position of £11m was reported with an in month deterioration of £2.2m. The deficit position was largely driven by shortfalls in CIP delivery, inability to close excess beds and inability to remove COVID related expenditure. The forecast to year end remains at breakeven. The efficiency report detailed the position with £24m of plans identified and £17m expected delivery which offered limited assurance to the Committee. Focus would be afforded to this at the meeting in November. The Committee noted the update offered with regard to contracting and the progress of the contracting work programme and status of contracts with NHS England and the Integrated Care Board which offered moderate assurance. The capital report offered moderate assurance with the Committee noting the reported position with slippage in some schemes which was being managed. A request was made for the Committee to approve the maintaining of a £2m over commitment of the capital programme and for delegated authority to be approved to the Director of Finance and Digital and Chief Operating Officer in order approve reallocation of the capital as required in the remainder of the year to prioritise mitigating schemes. The Committee supported the request noting that this had been a successful approach in the previous year and recommended onward to the Board for approval. The CIRG Upward report was received with moderate assurance noting that some items would support management of the slippage in some capital schemes. **e-Financials outage** The Committee received the report noting moderate assurance due to the need to review business continuity plans during the outage to confirm that these would be suitable for an extended period of time. The Committee again noted the effort of the finance team to maintain the service during the system outage.
	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Hospital Group Upward Report** The Committee received the report noting that there had been progress on a number of items.

	The electronic patient record had been discussed at a recent meeting with progress due to be made through a national and regional meeting in order to identify the level of funding. The Committee noted that the EPMA pilot was now live and had been received well. Further work was required on ADTs (Admit Discharge and Transfer) and once resolved the pilot would be assessed and rolled out. The Office 365 tenant had now been confirmed enabling the Trust to integrate with NHS Mail. **Digital Strategy** The Committee received the Digital Strategy noting that this offered a clear direction of travel for the coming 3 years with clear actions to be taken to delivery. The Committee noted that this offered significant assurance however raised concern that the actions required did not have associated funding and that there may be a staff resourcing issue to deliver. The Committee approved the strategy for onward consideration and approval by the Trust Board.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report and noted the continued deterioration in respect of urgent and emergency care and specifically recognised that there was now an increase in demand in addition to the continued discharge difficulties. The Committee was pleased to note the continued use and success of same day emergency care which, for the Lincoln site, was seeing 30% of all medical admissions being care for and going home same day. Uplifts in pathway 1 capacity was now being seen with the Committee being reassured that actions were now taking place, assurance was yet to be received. The Committee noted that planned care, in August, had seen a reduction in the waiting list and whilst there had been an uptake in referrals in September this placed the Trust in a positive position. Outpatients remained and area of concern in respect of the waiting list however there had been reduction over time in the partial booking waiting list. Mixed performance was noted in diagnostics with a decision taken to prioritise patients with suspected cancer which would impact endoscopy performance.

	The Committee noted performance in cancer services and the concerns noted from specialist commissioners with regard to breast screening recovery. This had been escalated with action being taken to improve performance to expected levels. It was noted however that this would take time given the ongoing challenges in the cancer site work.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 3f Urgent Care **As reported at SO 3d**
	Assurance in respect of SO 4a Establish new evidence based models of care No reports due
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review **Acute Services Review (ASR) Update** The Committee received the update which offered the context of how the ASR was progressing however it was noted that further clarity of the oversight was required. There were processes in place with progress being made with regard to stroke services, for which the Trust was leading the process and agreed that controls were in place for objective 4c. The Committee noted that the Trust Board would receive an update to the Private Board meeting on current progress.
	Assurance in respect of other areas: **Winter Plan** The Committee received the report noting that national updates continued to be received and the limited assurance offered. The Committee noted the concerns regarding winter from the system, regionally and nationally and whilst some areas provided significant assurance this was not consistent across all aspects of the plan. Modelling offered an insight in to demands changing and it was noted that there would be a likely increase in infectious diseases, such as respiratory diseases and Covid-19, over the winter period following activity seen in the southern hemisphere. It was noted however that the level of flu was not expected to be as severe as previous years.

	A number of scenarios were offered within the plan which continued to be worked up as further information became available. **Committee Performance Dashboard** The Committee received the report noting that this offered limited assurance. Significant discussions regarding performance had taken place through the operational performance agenda item. **Integrated Improvement Plan** The Committee received the report noting the limited assurance offered due to the position of the objectives. Progress was noted in a number of areas however the Committee recognised the continuing maturity of the programmes of work. A deep dive in to the improvement programmes would be undertaken and reported to a future meeting. **Improvement Steering Group Upward Report** The Committee received the report noting the improvements that had been made and reflected that the status being reported offered a clear understanding of the position. It was noted that a stock take of the programmes would be undertaken to ensure a clear position. **CQC Action Plan** The Committee received the report noting the moderate assurance. The Committee requested a review of the red actions to confirm that work was underway.
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 risk as 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	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. The Committee agreed that Objective 4c Successful delivery of the Acute Services Review should be down rated to Amber.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	N	D	J	F	M	A	M	J	J	A	S	O
David Woodward, Non-Exec Director	X	X										
Dani Cecchini, Non-Exec Director			X	X	X	X	X	X	X	X	X	X
Chris Gibson, Non-Exec Director	X	X	X	X								
Gail Shadlock, Non-Exec Director				X	A	X	A	A	X			
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	D	X
Chief Operating Officer	X	X	X	X	D	X	D	X	X	X	X	X
Director of Improvement & Integration			X	X	X	X	X	D	X	D	X	X
Sarah Buik, Associate Non-Executive Director										X	X	X

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

Meeting	*Trust Board*
Date of Meeting	*1st November 2022*
Item Number	*Item 10.2*

Digital Strategy Overview

Accountable Director	*Paul Matthew, Director of Finance & Digital / SIRO*
Presented by	*Paul Matthew, Director of Finance & Digital / SIRO*
Author(s)	*Michael Humber, Associate Director of Digital Services / CIO*
Report previously considered at	*FPEC 25th August 2022*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*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 our resources	
3c Enhanced data and digital capability	*X*
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish collaborative models of care with our partners	*X*
4b Becoming a university hospitals teaching trust	*X*
4c Successful delivery of the Acute Services Review	

Risk Assessment	*None required*
Financial Impact Assessment	*None required*
Quality Impact Assessment	*None required*
Equality Impact Assessment	*None required*
Assurance Level Assessment	• *Moderate*

Recommendations/ Decision Required	• *To consider and approve the Digital Strategy.*

Executive Summary

This paper is intended to provide the Trust Board with an overview of the updated Digital Strategy.

This refreshed Integrated Digital Strategy builds upon the digital strategy approved by the Trust Board in 2019 and refines our plans to deliver the ambitious digitisation required to underpin the transformation of the Trust's clinical services as well as support those of the emerging ICS. It will help us to support the people of Lincolnshire to live healthier lives and to manage long-term conditions more effectively, support us to work closely with partners and support us to do more with our limited resources.

Delivering our digital strategy will provide the opportunity for step change transformation by providing secure online access to comprehensive, accurate clinical information to the right care provider, in the right place and at the time it's needed. It will help us to fulfil our mission of outstanding care, personally delivered.

This strategy is key to facilitating the achievement of our ambitions and priorities, and optimising ways of working. We will become a paper-lite organisation with patient records digitised to ensure that they are available whenever and wherever they are needed, including external stakeholders such as patients themselves, GPs, and Social Services.

Our clinical systems will be integrated to ensure the efficient and effecting flow of information and care delivery. Information will be recorded once electronically, at first contact, and shared securely between those providing the patient's care to reduce data duplication, enable proactive patient monitoring and support better multidimensional 'whole person' decisions. All clinical information will be available in real time and will be available on a choice of different devices to meet need and through infrastructure which will be secure, robust and scalable.

This strategy defines a Digital DNA which will have permanency beyond the term of this strategy and provides a clear 3-year strategy delivery roadmap. The roadmap is based on delivering pillars of work and underpinning enablers, which support the Trust to deliver its strategic objectives, integrated improvement plan, and to meet both patient and staff expectations, whilst also meeting the requirements of regional and national strategic drivers.

It defines our Digital DNA – Our long-term digital missions (all delivered with clear governance and engaging methodologies):

- Deliver Organisational Strategy
- Deliver Clinical Strategy
- Improve Patient Experience
- Improve Staff Experience
- Place People at the Centre
- Build a Strong Foundation for Innovation

It defines our digital portfolio:

- Pillars of Work:
    - Electronic Health Record (EHR)
    - Wider Digital Capabilities
    - ICS Collaboration and Delivery
    - Patient Access and Engagement
- Underpinning Enablers:

- Technical Infrastructure
- End User Access
- Digital Capability and Skills
- Benefits Management

Finally, it covers some anticipated strategic themes in the future that will become part of the Digital Strategy as it evolves and matures.

NHS
United Lincolnshire Hospitals
NHS Trust

Digital Strategy 2022-2025

Delivering digitally connected care for excellence in rural healthcare across Lincolnshire

OUTSTANDING CARE
personally DELIVERED

Table of contents

Outstanding care, personally delivered

This refreshed Integrated Digital Strategy builds upon the digital strategy approved during 2019 and refines our plans to deliver the ambitious digitisation required to underpin the transformation of the Trust's clinical services. This strategy supports our vision of Outstanding Care Personally Delivered across Lincolnshire, and to transform outcomes for citizens. It will help us to support the people of Lincolnshire to live healthier lives and to manage long-term conditions more effectively, support us to work closely with partners and support us to do more with our limited resources.

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This strategy defines a Digital DNA which will have permanency beyond the term of this strategy and provides a clear 3-year strategy delivery roadmap. The roadmap is based on delivering pillars of work and underpinning enablers, which support the Trust to deliver its strategic objectives, integrated improvement plan, and to meet both patient and staff expectations, whilst also meeting the requirements of regional and national strategic drivers.

Strategic context

Our digital strategic addresses both local and national strategy

Strategic context: the local perspective

The Trust has agreed a five-year Integrated Improvement Plan (2020-2025). The plan identifies the key priorities for the Trust, ensuring we are focused on the right things, for both patients and staff. The plan is structured around four strategic objectives, underpinned by our values.

Having considered each of the five-year priorities, it is clear that there exists the potential for digital tools to either fundamentally underpin the achievement of our priorities or significantly enhance the expected outcomes, and this digital strategy has been built on this basis.

PRIORITIES FOR OUR SERVICES

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

We will:

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

What this looks like:

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

Strategic context: the national perspective

The Department of Health and Social Care has set out a series of digital drivers and strategies for the NHS to achieve which have been published in a series of papers, such as the 'Five year Forward View', 'Personalised Health and Care 2020', the 'Lord Carter Report' and the 'Wachter Report'. The latest NHS Strategy, the 'NHS Long Term Plan' (LTP) and the Secretary of State for Health and Social Care's tech vision 'The Future of Healthcare', also has a significant focus of digitally enabled care. More recent publications of the 'What Good Looks Like' framework and 'A plan for digital health and social care' reinforce this.

In January 2019 the LTP was published to provide a new service model for the 21st century as medicine advances, health needs change and society develops. It recognises that the NHS has to move forward continually so that in 10 years' time we have a service fit for the future. The LTP emphasises the importance of Integrated Care Systems (ICS) in engaging with all the healthcare organisations in a region, to ensure collaboration and integration of care. It recognises that technology underpins the future NHS setting out the critical priorities that will support digital transformation and provide a step change in the way the NHS cares for patients. The LTP is committed to making digitally enabled care mainstream across the NHS.

What Good Looks Like

Digitise

By March 2025, constituent organisations of an ICS have:

- met a minimum level of digital maturity as set out in What good looks like. Interim milestones are:
  - 90% of NHS trusts with electronic health records by December 2023, and 100% by March 2025
  - 80% of CQC-registered adult social care providers with digital care records by March 2024
- increased cyber security capabilities, resilience, clinical safety and accessibility
- established digital, data and technology talent pipelines, and improved digital literacy among leaders and the workforce
- ensured all health and social care settings have the right infrastructure and connectivity to work digitally

Extract from 'A plan for digital health and social care'

Maternity has additional specific essential strategic drivers as a result of the recent Ockenden Report, which will help to improve safety in maternity services across England. These include ensuring that a robust risk assessment is undertaken at each maternity contact, a key element of the promotion of personalised care planning and safer care.

Our digital strategy needs to ensure that it plans for the Trust to adopt and deliver against these national objectives.

The key digital ambitions from these national agendas are:

- Ensuring that an Electronic Patient Record solution is implemented within the organisation by March 2025.
- Increased cyber security capabilities, resilience, clinical safety and accessibility.
- Established digital, data and technology talent pipelines, and improved digital literacy among leaders and the workforce.
- Ensured all health and social care settings have the right infrastructure and connectivity to work digitally.
- Using decision support tools, including AI to help clinicians apply best practice, eliminate unwarranted variation, and support patients in managing their health and condition.
- Provide straightforward and secure digital access for patients to access and update their electronic records.
- Allowing engagement with services to help patients and carers manage their health.
- Ensure that clinicians can access patient records wherever they are.
- Reducing the burden on staff so they can focus on the patient.
- Integrated care records to pass information between services both in and out of the NHS.
- Enabling improved outcomes across the heath and care system.
- Adopt technology standards to ensure data is interoperable and accessible.
- Improvement of patient safety and quality of care, through the use of technology.

Digital DNA

Our digital DNA links with our strategic objectives, and defines our digital missions

Defining our Digital DNA: our long term digital missions

Fundamental to the development of our digital strategy has been the determination of our Digital DNA. Our Digital DNA links with the strategic objectives of the Trust and defines the strategic considerations we take into account when developing our plans for investment in digital tools and services. Our Digital DNA provides a set of missions which guide us, and have permanency beyond the term of this strategy; and a set of objectives, which set out what we intend to achieve over the term of this strategy.

Our digital missions are:

Deliver Organisational Strategy

Delivery of digital tools and services will always underpin achieving the organisation's strategy - which will include integration with health and care services across Lincolnshire.

Deliver Clinical Strategy

The digital tools and services we deliver will support the delivery of the clinical strategy, and support the delivery of harm free, effective, efficient and modern care services.

Improve Patient Experience

The digital tools and services we invest in will support us to enhance the quality of experience our patients receive, either directly or indirectly, and to interact in realtime with patients.

Improve Staff Experience

Through improved use of digital tools and services, we will support our staff to have access to the right information at the right time, wherever and whenever it is required.

Place People at the Centre

We will place people at the centre of any digital tools and services we deliver. We will ensure clarity about the transformation we are supporting, and engage people in the design.

Build a Strong Foundation for Innovation

We will deliver strong foundations through our digital tools and services, and build on this to become innovative - ensuring that our plans can respond to new opportunities.

Deliver with Clear Governance and Engaging Methodologies

Delivery of digital tools and services will be effectively governed and delivered via structured and clear methodologies, with engagement at the heart.

Defining our Digital DNA: our 3-year digital objectives

Within each of our digital missions, our objectives are:

Deliver Organisational Strategy

- Deliver high quality, safe and responsive patient services, shaped by best practice and our communities.
- Enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT.
- Ensure that services are sustainable, supported by technology and delivered from an improved estate.
- Implement new integrated models of care with our partners to improve Lincolnshire's health and wellbeing.

Deliver Clinical Strategy

- Ensure services are clinically sustainable.
- Ensure services are affordable.
- Ensure services are better integrated and co-ordinated to deliver improved patient experience, and closer to home.
- Ensure care is Consultant-led, 24/7.
- Balance scarce specialist resources and local access.
- Fully utilise in-hospital services.
- Increase use of telemedicine.

Improve Patient Experience

- Digitally support the delivery of harm-free care.
- Enable patients to have greater involvement in decisions relating to their care and to receive personalised care.
- Focus on digital inclusion and the effective provision of accessible information.
- Support realtime engagement with patients.
- Digitally support the engagement of citizens in the co-design of services, in collaboration with system partners.

Improve Staff Experience

- Ensure staff have access to the necessary information at the point of care delivery without overwhelming with information.
- Develop digital skills amongst all staff, with a focus also on the competencies required for those involved in digital delivery.
- Support the development of a mindset of continuous improvement.
- Support all staff to make better use of the time they have.
- Support improvements in staff survey outcomes.

Place People at the Centre

- Build digital capability within divisions and operational teams - not just within the Digital Team.
- Develop our approach to people-centred design - where we engage with stakeholders impacted by investment in digital.
- Improve the usability and accessibility of digital tools;
- Bring a focus to intelligent alerting, to ensure simplicity of digital notifications and messaging.

Build a Strong Foundation for Innovation

- Address current deficiencies in the extent to which digital supports the effectiveness and efficiency of care.
- Build an aspirational mindset of how digital can support process and care pathway enhancement.
- Seek opportunities to innovate, and to develop knowledge across all staff regarding the potential of digitally-enabled care. Embrace enthusiasm, and new ideas.

Deliver with Clear Governance and Engaging Methodologies

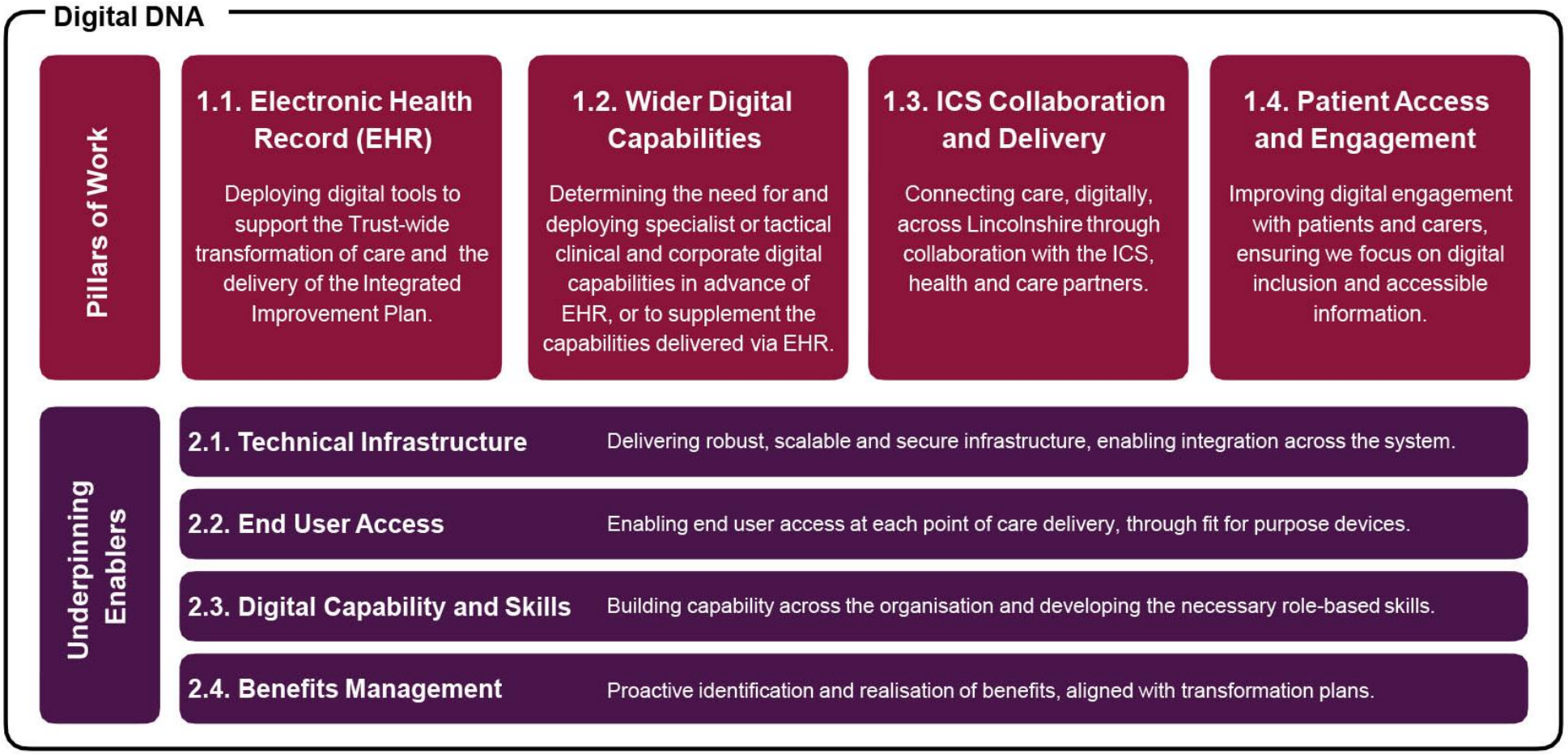
- Ensure that digital delivery is appropriately governed, with clear Senior Responsible Owners, Senior Suppliers and Senior Users engaged in all strategic programmes.
- Deliver this strategy as a Portfolio of work.
- Initiate Programmes and Projects to deliver the Pillars of Work within this strategy.
- Ensure clear ownership within operational teams for the Underpinning Enablers within this strategy.
- Develop delivery capability and capacity across the organisation.

Strategy delivery plan

We will deliver this strategy through a portfolio of strategic programmes and enablers, built on our objectives and missions

Digital portfolio

Building on our Digital DNA we have defined the below portfolio of work, structured into strategic programmes (pillars of work) and critical service delivery activities (underpinning enablers). Each of these elements of delivery within our strategic plan, which are described further in the subsequent sections, and have been developed to support the Trust to achieve the 3-year digital objectives.



Pillars of work: strategic programmes

1.1 Electronic Health Record

This pillar will deliver Trust-wide transformation in the care we deliver to the people of Lincolnshire and will play a key role in supporting the Trust to achieve the aims of our Integrated Improvement Plan. The Electronic Health Record (EHR) pillar will deliver the two components of EHR: the Electronic Patient Record (EPR) and the Imaging and Electronic Document Management Solution (IEDMS) between now and 2025.

We will revolutionise how we manage patient records, and make them available at the point they're needed, whenever or wherever that happens to be. We will transform care pathways, improve the quality, effectiveness and efficiency of care. We will address our significant over- reliance on paper records and moving records around multiple sites, the significant cost of manually administering current paper records, which are often in a very poor state and difficult to use, the minimal information in Core PAS, and our complex landscape of interfaced specialist and departmental applications, and the frustration caused to staff by a complex application landscape, with multiple log-ons, and the often lack of availability of paper records at the point they require them.

Key Objectives

- Procurement of an EPR solution to meet our requirements and commence implementation.
- Procurement of an IEDMS solution to meet our requirements and align implementation with EPR.
- Delivery of the EHR programme by the end of 2025 and achieve the investment objectives defined within the Full Business Cases at the point approved by the Trust Board.

1.2 Wider Digital Capabilities

This pillar will provide governance, development and delivery for wider clinical and corporate digital capabilities, including automation and business intelligence, which may be required in advance of the full implementation of our EHR, or to address specific needs that will not be addressed through the EHR pillar. Any such investments will have met an agreed criteria and have Executive support.

The pillar will work within the governance structure of the Trust to determine the criteria which should be applied to such investments, which will consider:

- The operational and/or clinical need for the digital capability, the opportunity to support transformation ahead of full EHR implementation, and the return on investment (cash, non-cash and quality).
- The opportunity to digitise process, reduce unwarranted variation and to standardise process.
- The need to ensure the implementation of the supplementary clinical solution does not create duplication in process, or duplicate data entry.
- The architectural alignment of the supplementary solution, such as its ability to integrate with EHR, support single sign on, the ease of data migration, and standards-based integration.

Key Objectives

- Determine and agree with the Executive Leadership Team the criteria for such investments.
- Support the process of reviewing, seeking approval for, specifying and procuring any non-EHR clinical solutions.
- Provide governance and delivery management for all non-EHR clinical corporate solutions which the Trust agrees to implement.

1.3. ICS Collaboration and Delivery

Across Lincolnshire, Health and Care organisations are working together to fully develop an Integrated Care System (ICS). At ICS level, a digital strategy is being developed around number of key themes:

- Implementing virtual and integrated health and care services, underpinned by shared data.
- Delivering personalisation and empowerment to citizens, and addressing health inequalities.
- Developing capability, capacity and readiness across Lincolnshire to consolidate and innovate.

Key Objectives

- Contribute to the development of the Lincolnshire ICS organisational and digital strategies.
- Identify opportunity to realise further benefit from existing investment in digital tools and services.
- Actively participate in the implementation of an ICS digital strategy once in place.
- Provide capability and capacity, at system-level, to advance the maturity of digital across Lincolnshire.

1.4. Patient Access and Engagement

Key to the achievement of the NHS Long Term Plan is the engagement of patients to make better informed choices to both live healthier lives, and to seek support and intervention as health issues arise. Patients rightly expect they'll receive the same digital experience in health and care as they experience elsewhere in their lives; and are dissatisfied when this isn't the case.

We will seek to offer patients accessible digital tools and applications that support them not only to interact with the Trust and their care providers (to, for example provide Patient Reported Outcome Measures), but to also support them to take ownership of their own health and wellbeing. Patients expect to be able to book appointments online, check their personal health data and interact with care teams via messaging and online consultations.

We will develop the digital tools we make available to patients to support the development of our digital engagement and two-way interaction; whilst ensuring we remain inclusive and are technically able to provide accessible information, aligned with national standards.

Key Objectives

- Develop a detailed plan for the level of digital tools and services the Trust may be able to deliver directly to patients, to support greater two-way interaction, with clearly defined benefits.
- Undertake a technical audit of our current solutions, to assess compliance with the Accessible Information Standards (AIS).
- Ensure AIS compliance is a mandatory requirement in future procurements.

Underpinning enablers

2.1. Technical Infrastructure

The demands placed on our infrastructure will continue to increase. We need to be confident that it meets both the demand today, and in the future. This is a critical underpinning enabler to achieving the ambitious plans within this digital strategy.

Building on recent work we will standardise an industrial strength infrastructure, and will focus on ensuring that our infrastructure is robust, has adequate capability, adequate capacity, adequate availability with a robust posture to cyber security, with a commitment to continuous improvement.

It is likely that there will be an increasing need to accommodate cloud-based solutions, however there will be a continued need to host our own systems for performance and cost reasons. We will take a pragmatic approach to our future infrastructure requirements and use a hybrid-cloud methodology.

The integration of digital services with the wider system across Lincolnshire will become increasingly important. Our infrastructure will not create technical barriers to achieving this.

Key Objectives

- Complete Technical Infrastructure, Integration and Cyber Security reviews, which commenced during 2021.
- Agree feasible plan to implement recommendations, seeking budget approval through business cases, where appropriate and necessary.
- Engage with the wider health and care system to develop wider technical infrastructure plans to support greater levels of integration.

2.2. End User Devices

Ensuring that our staff have access to the devices they need in order to align the use of digital with transformed care pathways will be essential.

Building on recent work to improve access to the most appropriate end user devises, we will continue to ensure that limitations of how the Trust has implemented digital does not dictate how we deliver care. We will ensure that devices support transformed workflows and processes wherever necessary, acknowledging that this covers hospital, community and remote working settings.

We will engage end users in determining what devices will be made available across a range of roles within the Trust. We will trial devices before adoption to ensure we capture and address any issues before their use becomes commonplace. We will ensure that where feasible and appropriate, end users have an amount of choice, and we will be ready to support each device we deploy. We will take this approach whilst ensuring the security of data and devices to protect the organisations, and our patients.

Key Objectives

- Implement user piloting of new end user devices to assess suitability and support requirements, in advance of rollout.
- Implement a level of choice, by role, where feasible and appropriate.
- Aligned with our EHR pillar of work, review the entire estate of end user devices and build a strategy to ensure we are able to support transformed work flow and an increased requirement to access digital records.

2.3. Digital Capability and Skills

Our ambitious plans will require new capabilities amongst the staff supporting the delivery of those plans. We will build this capability both within the Digital team and across the organisation. Pillars of work will be resourced by the Digital team working in collaboration with operational and clinical staff, with staff from across the organisation seconded to fill key roles in programme and project teams. This approach will help to ensure that digital tools and services delivered, support wider transformation, and delivered successfully, are adopted within operational and clinical practice, and that benefits are realised.

We will invest in supporting staff to develop digital skills through both structured learning, as part of our pillars of work, and through less structured knowledge sharing and thought leadership. We will consider what core competencies are required by those working within digital programmes and projects, and will invest in staff to ensure we are able to deliver successfully. Where it is necessary to engage partners, knowledge sharing and transfer will be a key part of any deliverables.

Key Objectives

- Identify resource and skill requirements across pillars of work, and build resource plan - both for the Digital team and from across the organisation.
- Develop competency framework for staff supporting digital programmes and projects.
- Deliver formal learning as part of programmes and projects.
- Identify opportunities for knowledge sharing and thought leadership.

2.4. Benefits Management

The introduction of new digital tools and services will enable new ways of working, which will normally enable a range of benefits, across the categories of cash releasing, non-cash releasing and quality. In practical terms, the benefits may improve self-management of long term conditions, increase capacity, improve efficiency, deliver faster diagnosis, support the administration of the right medication, reduce average length of stay, reduce the likelihood of readmission, and achieve better outcomes for patients.

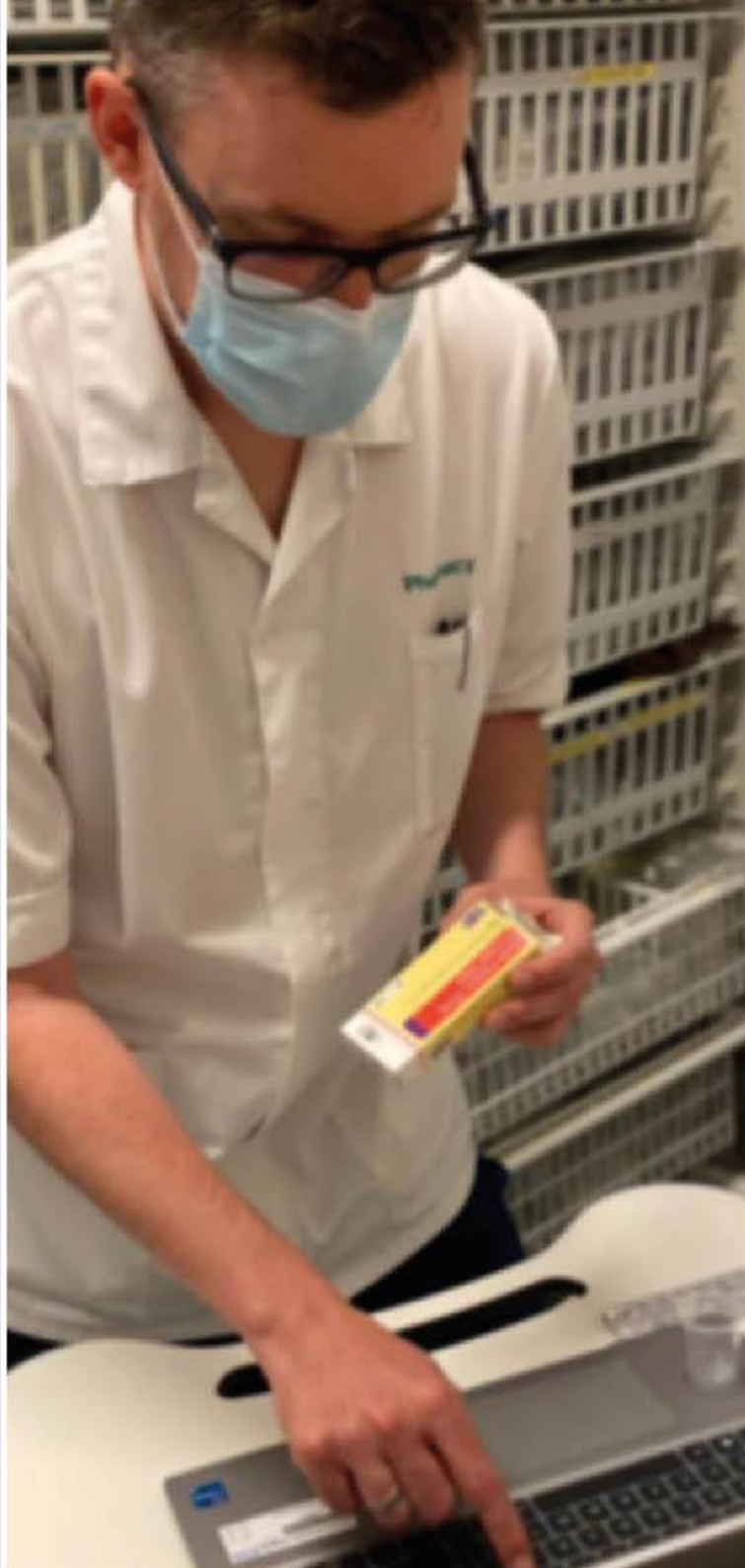
For each programme and project, we will work with operational and clinical teams to identify, quantify and seek ownership of benefits, and ensure that there are realistic plans in place for their realisation. We will provide the methodology for benefits realisation, support operational and clinical staff to determine which can be realised, and track the achievement of benefits. We will also support the development of a culture of seeking to measure effectiveness of digital tool and service implementation, and measure benefits.

Key Objectives

- Define and implement benefits management framework and methodology.
- Support programmes and projects to identify, quantify, measure and track benefits realisation.
- Ensure that multiple programmes and projects are not seeking to realise the same benefit and resolve conflict in ownership where this is the case.

Digital roadmap

We will deliver our strategic programmes and enablers against a set of key milestones between 2022/23 and 2024/25



Key activities: Pillars of Work

Each Pillar of Work will develop a programme plan and detailed strategy to action plan, against which delivery will be managed.

	Objective	2022/23				2023/24				2024/25			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.1. Electronic Health Records	Procurement of an EPR solution to meet our requirements and commence implementation												
	Procurement of an EDMS solution to meet our requirements and align implementation with EPR												
	Delivery of the EHR programme by the end of 2025 and achieve the investment objectives defined within the Full Business Cases at the point approved by the Trust Board												
1.2. Wider Digital Capabilities	Determine and agree with the Executive Leadership Team the criteria for such investments												
	Support the process of reviewing, seeking approval for, specifying and procuring any non-EHR clinical solutions												
	Provide governance and delivery management for all non-EHR clinical and corporate solutions which the Trust agrees to implement												

	Objective	2022/23				2023/24				2024/25			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.3. ICS Collaboration and Delivery	Contribute to the development of the Lincolnshire ICS organisational and digital strategies												
	Identify opportunity to realise further benefit from existing investment in digital tools and services												
	Actively participate in the implementation of an ICS digital strategy once in place												
	Provide capability and capacity, at system-level, to advance the maturity of digital across Lincolnshire												
1.4. Patient Access and Engagement	Develop a detailed plan for the level of digital tools and services the Trust may be able to deliver directly to patients, to support greater two-way interaction, with clearly defined benefits												
	Undertake a technical audit of our current solutions, to assess compliance with the Accessible Information Standards (AIS)												
	Ensure AIS compliance is a mandatory requirement in future procurements												

Key activities: Underpinning Enablers

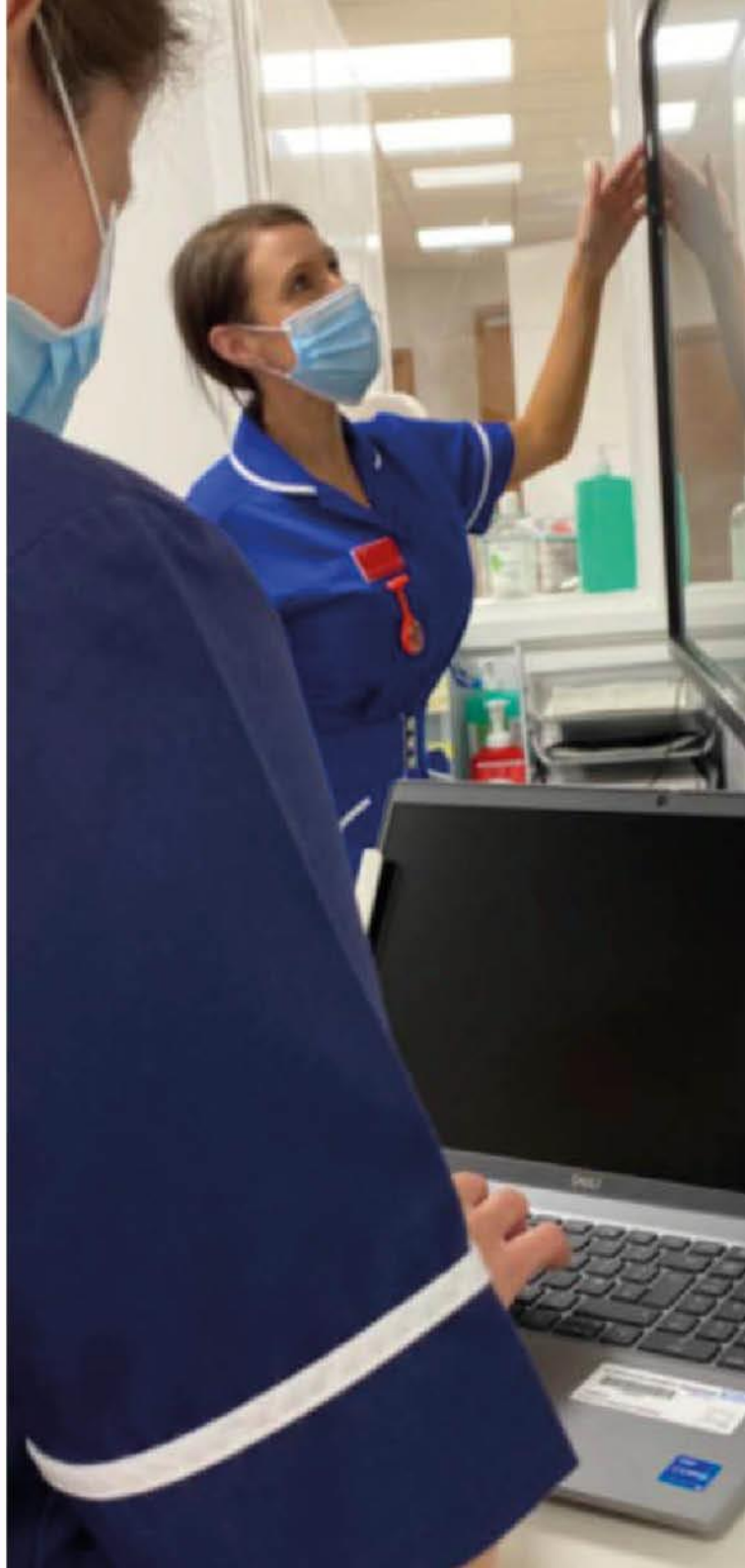
Each Underpinning Enabler will develop a plan of work and detailed strategy to action plan, against which delivery will be managed.

	Objective	2022/23				2023/24				2024/25			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.1. Technical Infrastructure	Complete Technical Infrastructure, Integration and Cyber Security reviews, which commenced during 2021												
	Agree feasible plan to implement recommendations, seeking budget approval through business cases, where appropriate and necessary												
	Engage with the wider health and care system to develop wider technical infrastructure plans to support greater levels of integration												
2.2. End User Devices	Implement user piloting of new end user devices to assess suitability and support requirements, in advance of rollout												
	Implement a level of choice, by role, where feasible and appropriate												
	Aligned with our EHR pillar of work, review the entire estate of end user devices and build a strategy to ensure we are able to support transformed work flow and an increased requirement to access digital records												

	Objective	2022/23				2023/24				2024/25			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.3. Digital Capability and Skills	Identify resource and skill requirements across pillars of work, and build resource plan - both for the Digital team and from across the organisation												
	Develop competency framework for staff supporting digital programmes and projects												
	Deliver formal learning as part of programmes and projects												
	Identify opportunities for knowledge sharing and thought leadership												
2.4. Benefits Management	Define and implement benefits management framework and methodology												
	Support programmes and projects to identify, quantify, measure and track benefits realisation												
	Ensure that multiple programmes and projects are not seeking to realise the same benefit and resolve conflict in ownership where this is the case												

The impact

We will change the experience of those receiving and delivering care across a range of stakeholders



The impact of delivering this digital strategy

The delivery of our Digital Strategy will improve the experience for both our patients, and of our staff. Below are just some examples of how we plan to make a difference.

As a patient, you will…

- Experience a journey with us that is more expedient, more efficient, less time consuming and less confusing.
- No longer need to repeat yourself when dealing with different care providers. Your care provider will have ready access to your information, literally in the palm of their hand - when and where you need them to have it.
- Have secure access to your own records - as you do to your online bank.
- Be able to see where you are on your personalised care pathway - and know what to expect next.
- Be able to book and change your appointments online, hold ‘virtual’ appointments with our health professionals and received pro-active advice about your condition - particularly if we’re supporting you to manage a long term condition.
- And, with your permission, when it will benefit your care, we’ll share your information with other care providers across Lincolnshire, such as your GP and social services.

As a member of staff, you will…

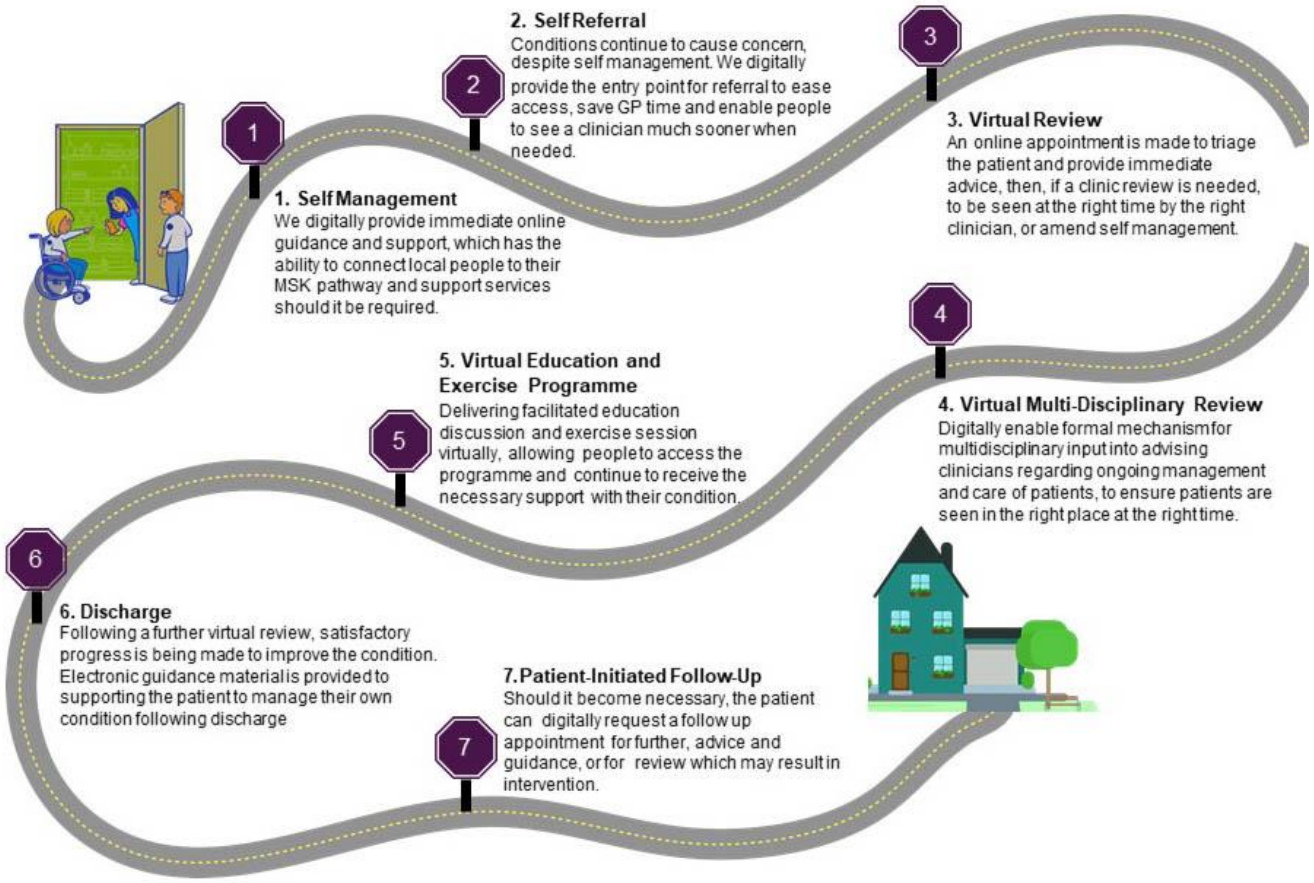
- Have access to comprehensive electronic patient records, available when and where you need them, via a range of devices (inc. mobile, bedside and electronic whiteboards).
- No longer experience missing notes or need to spend time sorting through disorganised paper records.
- Access all the clinical information you need in real time through a single ‘portal’ - no longer needing you to sign on to a multitude of different clinical systems.
- Be able to access apps and decision support tools to aid the care you deliver, and to intelligently provide you with the most relevant information.

- Benefit from medical device integration with our patient records, to ensure you are made aware of important clinical information, such as at the very first signs of deterioration in condition.
- Be able to have confidence that your patients' information will be kept safe and secure.

Example patient pathway

Our Digital Strategy isn't really about the technology – it's about how the technology can support us to transform patient pathways and the care we're able to deliver.

As an example, common musculoskeletal (MSK) conditions often do not require specific or specialist treatment . They may resolve if people follow simple, evidence-based advice. NHSX has gathered use-cases where digital technology has been used to provide immediate day-to-day support, while connecting people to their local MSK pathway and support services. By using technology, people are able to access trusted, evidence-based advice in a consistent and standardised way.



Measuring success

We will monitor the impact of delivering this strategy by tracking our progress against international, national and local measures

HIMSS Electronic Medical Records Adoption Model

The HIMSS Electronic Medical Record Adoption Model (EMRAM) provides an international framework and algorithms to methodically score hospitals around the world relative to their Electronic Medical Records (EMR) capabilities.

This eight-stage (0-7) model measures the adoption and utilisation of electronic medical record (EMR) functions across an organisation.

Although official validation for a stage requires an activity to be undertaken in partnership with HIMSS, it is not unusual for NHS organisations to use it as a baseline for measuring digital maturity and progress with developing their maturity.

Current self assessment:

The table illustrates our current state self assessment against the elements of functionality that should be adopted across the Trust in each of the EMRAM stages.

We have determined that our Trust would currently be considered at the Stage 1 of maturity using this model.

Ambition through delivering this strategy:

Over the coming 3 years, through the delivery of our strategic programmes and enablers, most notably our Electronic Health Record programme, we would expect to have developed our level of maturity. We would expect to be considered at stage 5 within this model.

Stage	Element	Status
7	Complete Electronic Patient Record	Not Compliant
	External Health Information Exchange	Partially Compliant
	Data Analytics	Not Compliant
	Governance	Partially Compliant
	Disaster Recovery	Partially Compliant
	Privacy and Security	Partially Compliant
6	Technology Enabled Medication	Not Compliant
	Blood Products and Human Milk Administration	Not Compliant
	Risk Reporting	Not Compliant
	Full Commissioning Data Sets	Not Compliant
5	Physician Clinical Documentation (using structured templates)	Not Compliant
	Intrusion / Device Protection	Not Compliant
4	Computerised Physician Order Entry with Clinical Decision Support	Not Compliant
	Nursing and Allied Health Documentation	Not Compliant
	Basic Business Continuity	Partially Compliant
3	Electronic Medication Administration Record	Compliance in Progress
	Role Based Security	
2	Common Drug Reference	Partially Compliant
	Internal Interoperability	
	Basic Security	
1	Laboratory Information Management System	Fully Compliant
	Radiology and Cardiology Information Systems	
	Pharmacy Stock Control	
	Picture Archiving Communication Systems	
	Digital non-DICOM Image Management	
0	No Ancillary Systems	

For full definitions: HIMSS EMRAM Model

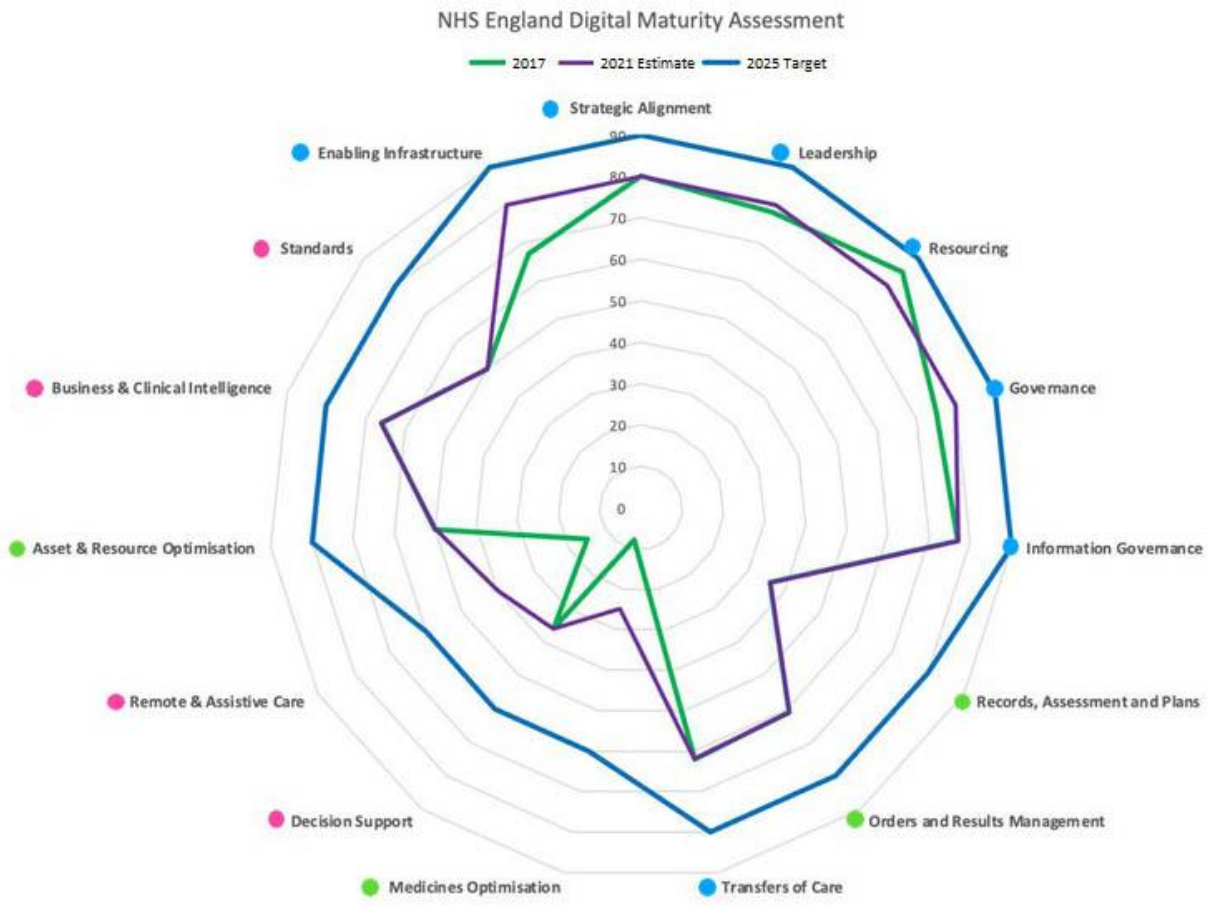
NHS England Digital Maturity Assessment

The Digital Maturity Self-Assessment can help providers by:

- Providing a framework to identify opportunities for improvement and further development.
- Encouraging knowledge sharing initiatives with similar organisations.

This chart shows our Digital Maturity Self Assessment using this NHS England model across 2017, estimated current state in 2021 and target future state in 2025, as a result of executing this strategy. In 2017, we were assessed as displaying a relatively high level of readiness to deliver and run effective digital services that meet staff and patients' needs.

Each of the aspects have been categorised as either **foundational**, **evolutionary** or **revolutionary**, depending on the extent to which they support the transformation of care. The illustration provides us with a good basis on which to focus both current and future strategic plans. As an example, it tells us that by the end of this strategy period we can expect to have made good progress in the foundational and evolutionary areas, yet still have the opportunity



For full definitions: [NHS England DMA Model]

to progress some revolutionary areas, such as further developing Decision Support as well as Remote and Assistive Care.

Integrated Improvement Plan Key Metrics

Progress against achieving the IIP is being monitored through scorecards for the Executive team, and for each Division. This Digital Strategy will support the Trust to achieve its IIP, and the table below sets out the extent to which the achievement of each Executive-level metric may be influenced by the delivery of this strategy.

Goal	Measure ID	IIP Domain	Measure	Digital Influence	Strategy Links
Strategic Metrics	1	Patients	Top 25% of Acute Trusts for 'Overall' Inpatient experience	High	1.1, 1.2, 1.4
	2	Patients	Achieve zero avoidable harm	High	1.1, 1.2
	3	Patients	Top 25% for SHMI	Medium	1.1, 1.2, 1.3
	4	People	Top 25% for Acute Trusts across all 10 themes in staff survey	High	1.1, 1.2, 2.1, 2.2, 2.3
	5	Partners	Deliver 62 day classic cancer standard (85%)	High	1.1, 1.2
	6	Partners	Deliver <4hr wait for patients in Emergency Departments (95%)	Medium	1.1, 1.2
	7	Partners	Deliver maximum wait for 10 week pathway for elective patients (92%)	Medium	1.1, 1.2
	8	Partners	Reduce ULHT outpatient activity by 30%	Medium	1.1, 1.2, 1.3, 1.4
	9	Services	Delivery breakeven revenue position	High	1.1, 1.2, 1.3, 2.4
	10	Services	Deliver £200m capital plan	Low	-
Priority Objectives	11	Patients	Number of medication errors is <10%	High	1.1, 1.2, 2.2, 2.3
	12	Patients	Reduce number of patient fall incidents	Medium	1,1, 1.2, 1.4
	13	People	Improve %age of staff that recommend their immediate manager	Low	-
	14	Partners	First non-elective admission by 10.00am	High	1.1, 1.2, 1.4
	15	Services	Reduce agency spend by 25%	High	1.1, 1.2, 1.3, 2.4
Watch Metrics	16	Patients	Reduce complaints around discharge by 50%	High	1.1, 1.2, 2.4
	17	Patients	Reduce complaints about the experience in A&E by 95%	Medium	1.1, 1.2, 2.4
	18	Patients	Time to screening and treatment for sepsis (1hr)	High	1.1, 1.2, 2.2, 2.3
	19	Patients	Reduce incidence of pressure ulcers	High	1.1, 1.2, 2.2, 2.3
	20	People	Improve %age of staff who feel trusted and value	Low	2.2, 2.3, 2.4
	21	People	Increase number of managers trained in coaching skills	Low	2.3
	22	Partners	Increase the proportion of patients seen by a decision maker within one hour	High	1.1, 1.2
	23	Partners	Reduction in the new to follow up ratio	High	1.1, 1.2
	24	Partners	First OPA within 4 weeks	High	1.1, 1.2
	25	Services	Improve CIP performance to a minimum of 4% by 2021/22	Low	-

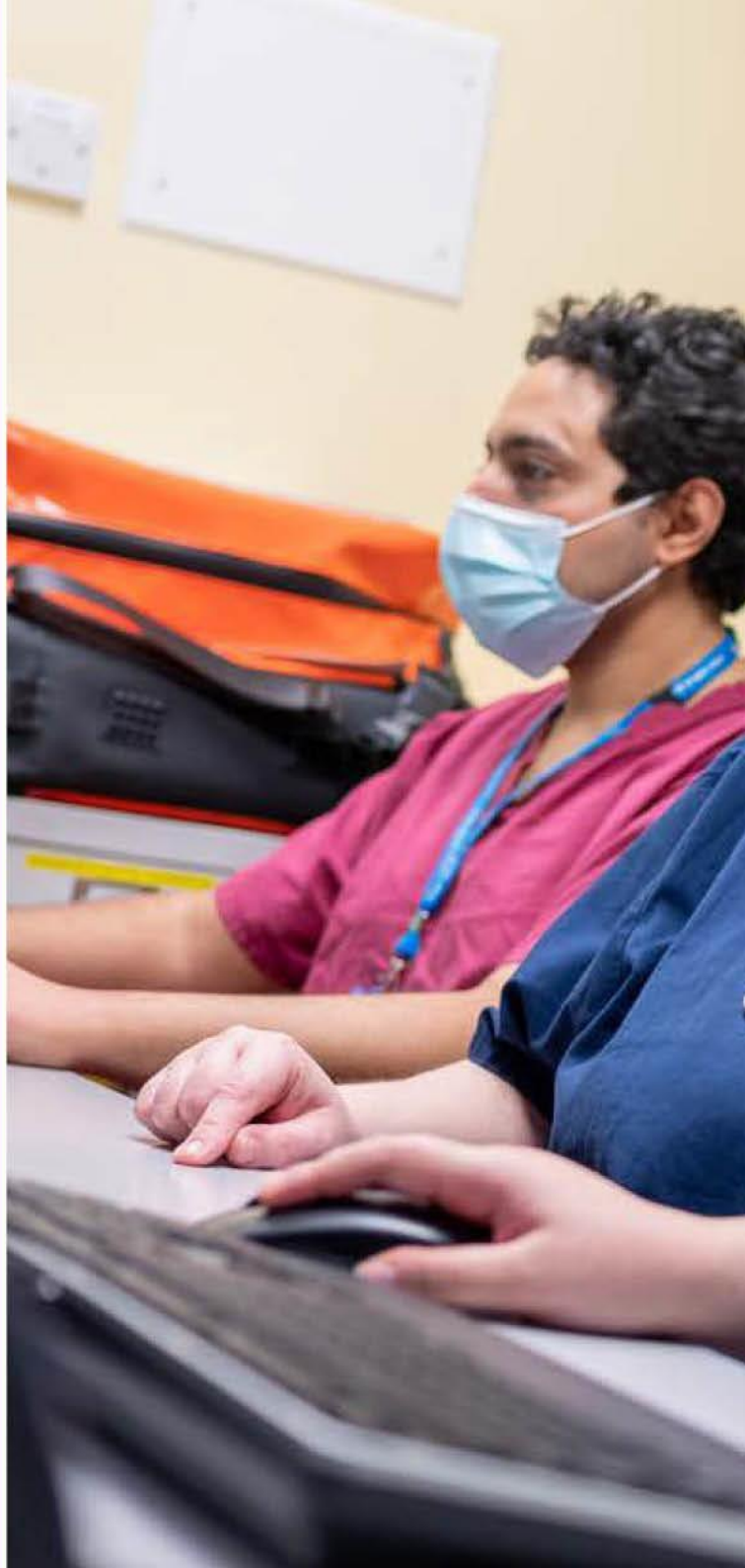
Across most of these measures, the most influential elements of this strategy will be the delivery of the Electronic Health Records and Wider Digital Capabilities strategic programmes.

Patient Access and Engagement and our Underpinning Enablers will support us further; and ICS Collaboration and Delivery will prepare us for the future.

Based on version 3 of the IIP Planning document, dated 26 April 2021

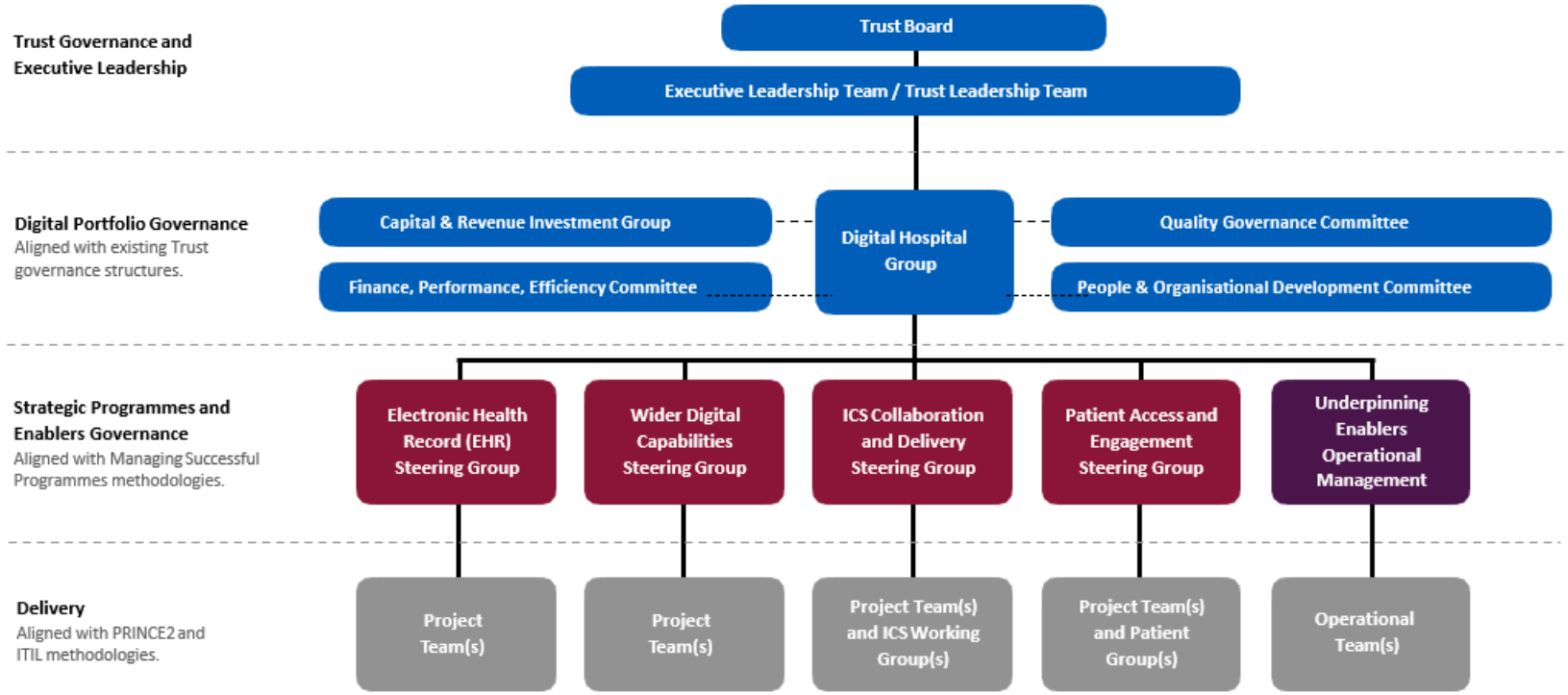
Delivering successfully

We will organise our delivery functions to successfully implement our strategic programmes and enablers



Governance and delivery model

The scope of work within this strategy will be managed as a portfolio of work so as to achieve the outcomes of the strategy as a whole, and not only the component parts. Delivery will be established via Programme Teams and Operational Leadership Teams, within Digital. Programmes will establish Project Teams, as necessary or deliver via Operational Teams, in the case of underpinnings enablers. We will deliver through widely recognised standards-based methodologies. The Trust Board and Executive Leadership Team shall execute their responsibilities via the already established governance structures.



Operational plans, and service delivery will be reviewed and aligned with the delivery of this strategy to take account of an increased reliance upon digital services to support the core operations of the Trust.

Beyond this strategy

We will, during the term of this strategy, be considering how we will continue to enhance our use of digital in to the future

Anticipated strategic themes in the future

During the delivery of this strategy, we will be considering how we will continue to enhance our use of digital, to support the Trust to achieve its strategic objectives and improvement plans in to the future.

We expect the following to be key themes in future strategies:

Embed and Enhance Electronic Health Records

We expect to spend between 2 and 3 years from FBC approval, implementing an integrated electronic patient record and an electronic document management system. Both of these implementations will create the opportunity for significant transformation of how we deliver care.

At the point the solutions go live, we should consider the organisation to be in the process of transforming and a period of post go-live optimisation will be required in order to ensure we deliver the expected cash releasing, non-cash releasing and quality benefits. Our next strategy will provide a focus for the optimisation of our investments to achieve the greatest possible return on those investments.

Insight Driven Operations through Enhanced Data

We have ambitions to make greater use of organisational and clinical data to drive insights which support us to deliver improved operations and improved care.

Following the implementation of our electronic health records programme, we will be in a position to ensure an effective business intelligence strategy and delivery plan is in place. This will require investment in our current approach to data warehouse and tools which will allow us to process and present the data to support operations.

We anticipate being in a position to deliver a greater level of dashboards and self-service tools to allow our data to be used effectively by relevant stakeholders across the Trust.

ICS-wide Integration which Supports New Pathways

Lincolnshire’s newly formed Integrated Care System will transform how we support the people of Lincolnshire to live healthier and happier lives. We expect to develop new models of care and increased standardisation of services across the organisations that make up the ICS. Digital will have a key role to play in achieving truly integrated care. We will align with an emerging ICS Digital Strategy, and expect to focus on making the most of existing investments, technically integrating solutions to enhance the sharing of data, developing shared / collaborative services to support effective use of capability and capacity, and improving the quality of a shared care record.

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United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1st November 2022*
Item Number	*Item 12*

Integrated Performance Report for September 2022

Accountable Director	*Paul Matthew, Director of Finance & Digital*
Presented by	*Paul Matthew, Director of Finance & Digital*
Author(s)	*Sharon Parker, Performance Manager*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*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 our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	*X*
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	*X*
3f Urgent Care	*X*
4a Establish collaborative models of care with our partners	
4b Becoming a university hospitals teaching trust	
4c Successful delivery of the Acute Services Review	

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

Recommendations/ Decision Required	• *The Board is asked to note the current performance. The Board is asked to approve action to be taken where performance is below the expected target.*

Executive Summary

Quality

Infection Prevention and Control

There have been 11 cases of Clostridium Difficile for the month of September with the Trust now over trajectory by 15 cases for the year to date. These have been sporadic cases and the Trust has had x1 outbreak to date on Greetwell ward at Lincoln County Hospital which involved 3 cases. Each case is being reviewed and a thematic review/action plan being put into place. Deep cleaning has taken place. The ULHT position is in keeping with a national picture.

One case of MRSA Bacteraemia has been identified which is currently under investigation.

Falls

There have been 3 falls resulting in moderate harm, 2 falls resulting in severe harm and 2 falls where death is currently attributed at the time of reporting. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated which may result in changes with harm levels post investigation. A number of themes have been identified across the organisation in particular unwitnessed falls and repeat falling. Actions to recover can be seen below however of note.

Pressure Ulcers

The number of category 2 PU is 49 and unstageable PU is 7 for the month of September. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. The highest number of incidents continue to be reported across the Emergency Care pathway. The Tissue Viability nurses and Quality Matron team are working with the ED's to develop dedicated grab packs for each category of skin damage. These will provide visual aids to support accurate categorisation and appropriate dressings to make it easier for staff to implement care in a timely way.

Venous Thromboembolism Risk Assessment

Compliance against this metric has seen a slight increase at 94.88% for the month of September.

Medications

For the month of September, the number or incidents reported in relation to omitted or delayed medications has seen an increase at 31% and for those incidents reported as causing harm, an increase at 13.3%. A number of work programmes through the IIP continue and are currently being monitored through the Medicines Management Task and Finish group.

SHMI

The Trust SHMI has reduced for September and is currently at 105.77. The Trust remains in Band 2 with 'As expected'. The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.

Trust participation National Clinical Audits

A slight decrease was noted for the month of September to 98% due to the none participation in the National Diabetic Foot Audit. This is currently under review through CEG.

eDD

The Trust achieved 91.4% with sending eDDs within 24 hours for September 2022 against a target of 95%. A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric at their monthly Performance Review Meeting.

Sepsis compliance – based on August data

IVAB ED child - The administration of IVAB for paediatrics in ED is at 77.8% for August 2022.

IVAB Inpatient Child – The administration of IVAB for inpatient paediatrics is at 85.7% for August 2022.

Screening/IVAB Inpatient Adult – Screening compliance for inpatient adults was at 85% and for the administration of IVAB at 86% for August 2022.

Actions to recover for all sepsis metrics can be reviewed below, of note harm reviews have been undertaken and no escalations as a result.

Operational Performance

At the time of writing this executive summary (12th October 2022), the Trust has 63 positive Covid inpatients. There are 2 patients requiring Intensive Care intervention.

This report covers September's performance, and it should be noted the demands of Wave 5/6 have begun to decrease. The Trust moved at pace into the *Recovery* and *Restoration* of services, but increased covid related patient admissions and staff sickness has impacted on this. The teams across the organisation continue to transition to 2022/23 and the recovery of waiting times and return towards pre-Covid access.

A & E and Ambulance Performance

Whilst the summary below pertains to September's data and performance, the proposed revised Urgent Care Constitutional Standards continue to be adopted and run-in shadow form. There is no timeframe currently for the revised standards to reach formal agreement. Performance against these will be described in the supplementary combined operational performance FPEC paper.

4-hour performance improved slightly against August performance of 59.48% being reported at 59.94% in September.

There were 869 12-hr trolley waits, reported via the agreed process in September. This represents a decrease of 219 from August. Sub-optimal discharges to meet emergency demand remains the root cause. However, due to extended waits in our Emergency Departments for admission, the decision was made to support patients in total time in the department and not Decision to Admit application.

Performance against the 15 min triage target demonstrated an improvement of 1.96%. 82.26% in September verses 80.30% in August.

Overall Ambulance conveyances for September were 3,858, an increase of 100 conveyances from August (3,758). There were 885930 >59minute handover delays recorded in September, a decrease of 45 from August, representing a 4.84% decrease. Delays experienced at LCH and PHB have seen increased levels of overcrowding in EDs made more difficult whilst continuing to manage pathways with differing levels of infection risk. That being said, September experienced a decrease in >120mins handover delays compared with August, 426 in September compared with 517 in August, representing a 17.61% improvement. >4hrs handover delays also decreased. A total of 100 in September compared to 123 in August. This represents an 18.70% decrease.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 4.95 days against an agreed target of 4.5 days The average bed occupancy for September, was 97.97%. System Partners are challenged with identifying timely support to facilitate discharge from the acute care setting, Pathway 1 capacity (Domiciliary care) continues to be unable to meet the demand and is a large contributor to increased LoS. All delays of greater than 24 hours are escalated within the System.

Referral to Treatment

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

August demonstrated a decrease in performance of 0.28%. August outturn was 49.50 %. The Trust reported 7,168 which is a decrease on the reported July position. A decrease of 78. The position is slowly improving but requires close monitoring and scrutiny.

The Cancer/Elective Cell continue to meet weekly, with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation cell to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 52+ and 78+ week patients on the 18-week monitoring lists.

At the end of September, the Trust reported 6 patients waiting longer than 104 weeks but none of these waits were associated with a lack of capacity to treat but related to patient choice and complexity. All were ULHT patients. Focus has now turned to clearing the remaining 104 week waiters by the end of October with an early look at November position. Discussions are taking place with NHSE weekly. Current forecast is to have 2 at the end of September, 1 being down to patient choice with the other down to complexity and transfer to NUH for treatment.

Waiting Lists

Overall waiting list size has increased since July. August reported 71,271 compared to July's position of 69,947 an increase of 1,324. Work continues between Outpatient department and the Clinical Business Units regarding returning better access to our bookable services for primary care and patients' choice.

The recovery plan for ASIs has been developed, including a recovery trajectory. September demonstrated a reduction (645 verses 657 in August) which is above the agreed trajectory of 550. Additional resource has been directed to resolving missing outcomes which is having an adverse effect on the bookings team being able to move the ASIs to open referrals.

DM01

DM01 for September reported a 52.46% compliance against the national target of 99%. A negative variation of 46.54% against the national target but a 1.61% improvement on the August outturn. Whilst the main area of concern remains Echocardiography, DEXA has developed a backlog due to a 50% reduction in capacity associated with the fire at LCH and Endoscopy backlog due to outpatient recovery, in particular, colorectal.

Cancelled Ops

The compliance target for this indicator is 0.8%. September demonstrated a 3.5% compliance. This is a deterioration of 0.69% on August and a negative variance of 2.25% against the agreed target.

The target for not treated within 28 days of cancellation is zero. September experienced 38 breaches against this standard verses 37 in August.

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

Cancer

Trust compliance against the 62day classic treatment standard is 55.07 (against 85.4% target.) This demonstrates an deterioration improvement of 3.37% in performance since the last reporting period and is 30.33% below the nationally agreed compliance target.

Residual impacts of COVID-19 on the delivery of the cancer pathways remains evident for 31 day and 62-day standards although as per previous statements Cancer pathways remain the highest priority in the recovery of services and the ring-fencing of capacity.

104+ day waiters have increased in line with the trajectory. There are currently 158135 patients waiting >104 days against a target of <10. The current figure is an increase of 35 patients since the last reporting period. The highest risk speciality is colorectal with 110 greater than 104 weeks.

Workforce

Mandatory Training – Mandatory training rates have remained constant over the past 3 months yet after a slight increase in August of the rate has started to decrease last month but remains stable at around 89%. Issues in recording learning due to IT software have had an impact on courses completion rates. A solution continues to be sought by the Digital team and remains an unresolved issue. Further work is on-going in terms of reviewing the 'core' and 'role specific' modules required to be undertaken by our staff moving forward and also a review of the target to make it realistic and attainable.

Sickness Absence – The trend has increased by 0.03% to 5.32% which is still above the target of 4.5%. We are experiencing a slight increase in Covid absences which continues to be monitored daily. Extensive work is continuing to get full engagement of using Absence Management System (AMS) Trust wide. The AMS Refresher training sessions continue to be run across all Divisions to be completed by the 31st December 2022 and early indications show an improved compliance following attendance at the training. Sickness data is also tabled at the divisional FPAM (Finance, People & Activity) meetings.

Additional resource within HR has been appointed to concentrate solely on absence management across the organisation to provide the assurance that all absence is being managed as per policy. This piece of work will support the full data cleanse and forward movement of all absence management.

Staff Appraisals –The WorkPAL contract was decommissioned on 1st of July 2022. Ongoing service pressures and staffing challenges in the Trust have impacted appraisal completion rate over the past 6 months. This month we see an decrease from 60.76% to 60.46%. Further work is in progress in terms of reviewing the 'annual cycle' timings, targets and appropriate systems whilst work continues with Senior HRBP's and completion rates being monitored at the monthly FPAM meetings.

Staff Turnover – Turnover has fluctuated between 15.6 to 15.9% over the last 3 months (Trust Target 14.5%), with a 0.3% decline in September against August. Operational pressures, staffing and culture challenges mean that an increasing proportion of staff are looking for other avenues outside the Trust. The OD team offers face to face / Teams exit interviews to gather deeper insights on the reasons for leaving (in addition to ESR / EF3 form results). People Promise Manager continues to work with the Trust and ICB to explore retention and bring best practice into the organisation to address the challenges. The recent analysis illustrates that 17% of resignations could be avoided through better management, relationships and career opportunities if offered in the Trust. It is anticipated that increased recruitment activity will in time reduce workforce challenges and offer support to challenged clinical areas in reducing turnover.

Vacancies – We saw a 0.7% decrease in vacancy factor in September, this was due to us having a significant number of starters and newly qualified nurses joining the Trust. We need to keep an ongoing focus on HCSWs and Nurses over the coming months, with a particular focus on International Nurses, as this supply route expands. The Trust are working in partnership with the Humber ICB and other stakeholders within the Lincolnshire ICB to recruit directly from India with representatives from the Trust travelling to India to interview in person.

Finance

The Trust submitted a revised financial plan for 2022/23 of a break-even position; the plan is inclusive of a £29m cost improvement programme.

The Trust delivered a deficit of £2.2m in September (£2.2m adverse to plan) and the Trust YTD delivered a deficit of £11.2m deficit (£11.2m adverse to plan).

After removing gains from disposals of £0.1m, the Trust YTD delivered a deficit of £11.3m in relation to system achievement.

CIP savings of £6.8m have been delivered YTD (£4.7m adverse to planned savings of £11.4m).

Capital funding levels for 2022/23, agreed through Trust Board & FPEC, show a plan of c£38.4m; capital expenditure incurred YTD equated to £8.1m.

The June 2022 cash balance is £57.6m, which is a decrease of £30.7m against the March year-end cash balance of £88.3m.

Paul Matthew
Director of Finance & Digital
October 2022

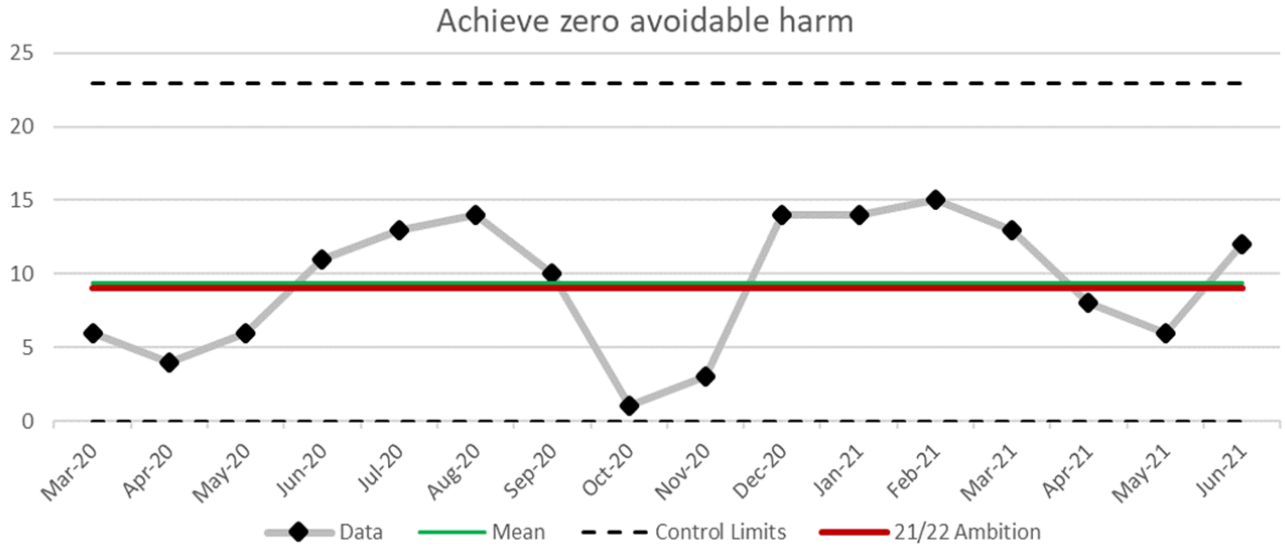
Statistical Process Control Charts

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

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

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

An example chart is below:



Statistical Process Control Charts

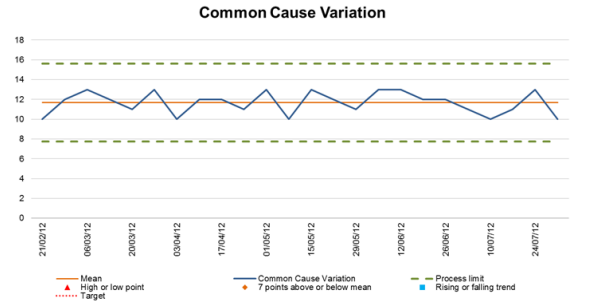
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

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

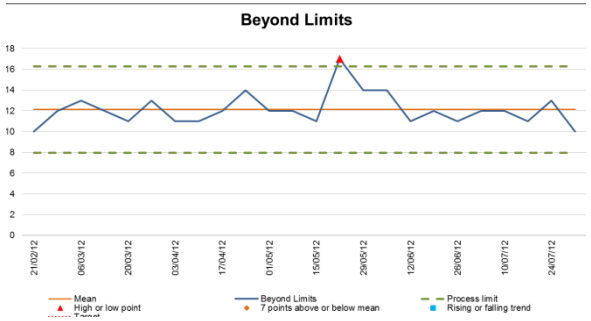
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



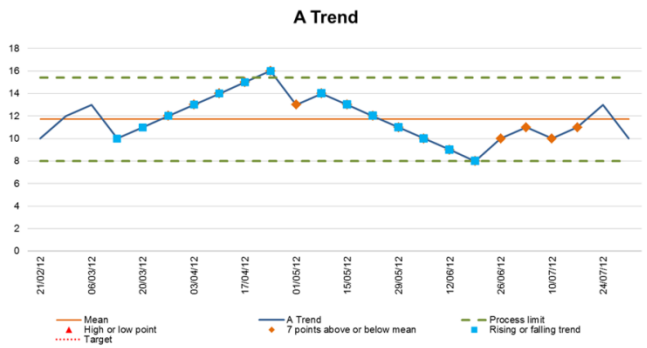
Extreme Values

There is no Icon for this scenario.

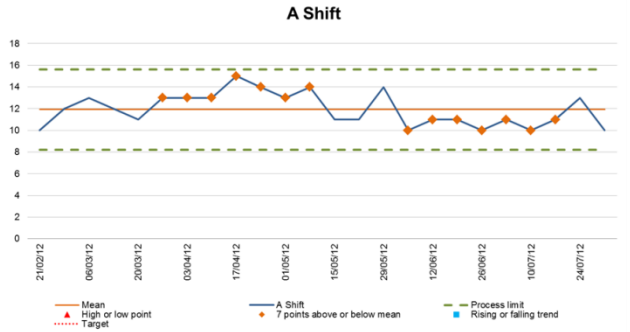


Statistical Process Control Charts

A Trend (upward or downward)



A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

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

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NHS United Lincolnshire Hospitals NHS Trust

EXECUTIVE SCORECARD

Measure ID	Domain	Measure	Measure Definition	SRO	2022/23 Ambition	Tolerance	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Latest month pass/fail to ambition	Trend variation
1	Patients	Implementation of the SAFER bundle	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients.	COO	10.00%	1.00%	13.91%	14.19%	13.25%	12.45%	14.23%	13.27%	F	
2	Patients	SHMI performance	Summary Hospital-level Mortality Indicator. National data published by NHS Digital is for rolling 36 month period ending 5 months prior to current month	MD	100	5 points	4th Quartile (109.48) (107th of 122)	4th Quartile (108.32) (102nd of 122)	4th Quartile (106.63) (91st of 121)	3rd Quartile (106.13) (84th of 121)	3rd Quartile (106.68) (89th of 121)	3rd Quartile (105.77) (87th of 121)	F	
3	Patients	Reduction in moderate and severe harm and death incidents	Serious incidents (including Never Events) of harm - Moderate, severe and death - per 1000 OBD	DoN	0	0.17	0.43	0.45	0.30	0.39	0.53	0.17	P	
5	Patients	Reduction in medication incidents leading to moderate & severe harm or death	Total number of Medication incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	DoN	0	0.07	0.17	0.00	0.03	0.07	0.10		F	
6	Patients	Reduction in DKA incidents resulting in moderate & severe harm or death	Total number of DKA incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	MD	TBD	TBD	0.03	0.00	0.00	0.03	0.03	0.03		
7	Patients	Achievement of the IPC BAF	% of green/compliant items from the IPC COVID BAF C1501 v1.8 (quarterly)	DoN	95.00%	1.00%		96.80%			96.80%		P	
8	Services	Financial Plan	Variance aganst plan (£'000)	DoF	£0	£0	(51)	(176)	(4,956)	(1,148)	(2,688)	(2,153)	F	
9	Services	Percentage of patients spending more than 12 hours in department	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	COO	1.00%	5.00%	16.03%	15.16%	14.71%	15.77%	20.04%	17.72%	F	
10	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	COO	503	100	4,694	5,282	6,216	7,246	7,168		F	
11	Services	28 days faster diagnosis	Number of patients diagnosed within 28 days or less of referral as a percentage of total Cancer pathways.	COO	75.00%	5.00%	52.63%	58.10%	59.40%	61.76%	54.30%		F	
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	DoPOD	9.00%	1.00%	10.55%	10.31%	12.08%	11.35%	10.73%	10.02%	F	
13	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	DoPOD	90.00%	2.00%	54.06%	57.62%	59.14%	60.30%	60.76%	60.46%	F	
13	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	DoPOD	95.00%	2.00%	89.27%	90.26%	89.76%	89.72%	89.86%	89.62%	F	
14	People	Improved Pulse Survey results (Quarterly staff survey)	Improvement in the % of people rating their likelihood of referring the Trust to Friends and Family (Agree & Strongly Agree)	DoPOD	55.00%	5.00%	44.62%			47.59%			F	
15	Partners	Health inequalities and Core20PLUS indicators	Metric being worked up through review of health inequalities data availability		TBD	TBD								
16	Partners	Increased recruitment/academic posts (across the ICS)	Number of posts appointed	DII	10	2					0		F	
18	Partners	Early Warning Discharge Indicators	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, for pathway 1-3 patients.	COO	50%	10.00%	77.53%	76.32%	79.90%	77.97%	80.45%	78.89%	F	

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Jul-22	Aug-22	Sep-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	7	8	11	41	F	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	1	1	F	
	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	0.01	0.02	0.02	0.07		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1						
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.17	0.17	0.24	0.18	F	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	0	1	4	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	3	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	5	6	7	30	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	94.41%	93.57%	94.88%	94.65%	F	
	Never Events	Safe	Patients	Director of Nursing	0	1	0	0	3	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.74	6.11	6.89	5.80	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	13.0%	8.1%	13.3%	12.62%	F	

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-22	Aug-22	Sep-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	66%	0%	None due	33.00%	P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	94.95	95.30	95.34	94.48	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	106.13	106.68	105.77	107.17	F	
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	98.00%	99.67%	F	
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	90.50%	89.60%	91.40%	90.12%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	87.0%	85.0%		90.81%	F	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	85.7%	95.3%		87.88%	P	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	90.0%	86.0%		93.41%	F	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	33.3%	85.7%		72.73%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	92.8%	93.0%		90.70%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	85.4%	90.7%		85.28%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	93.9%	92.0%		92.81%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	44.4%	77.8%		60.71%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	3.28	3.08	2.44	3.08	P	
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	93.00%	70.00%		88.20%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	90.00%	63.00%		83.80%	F	

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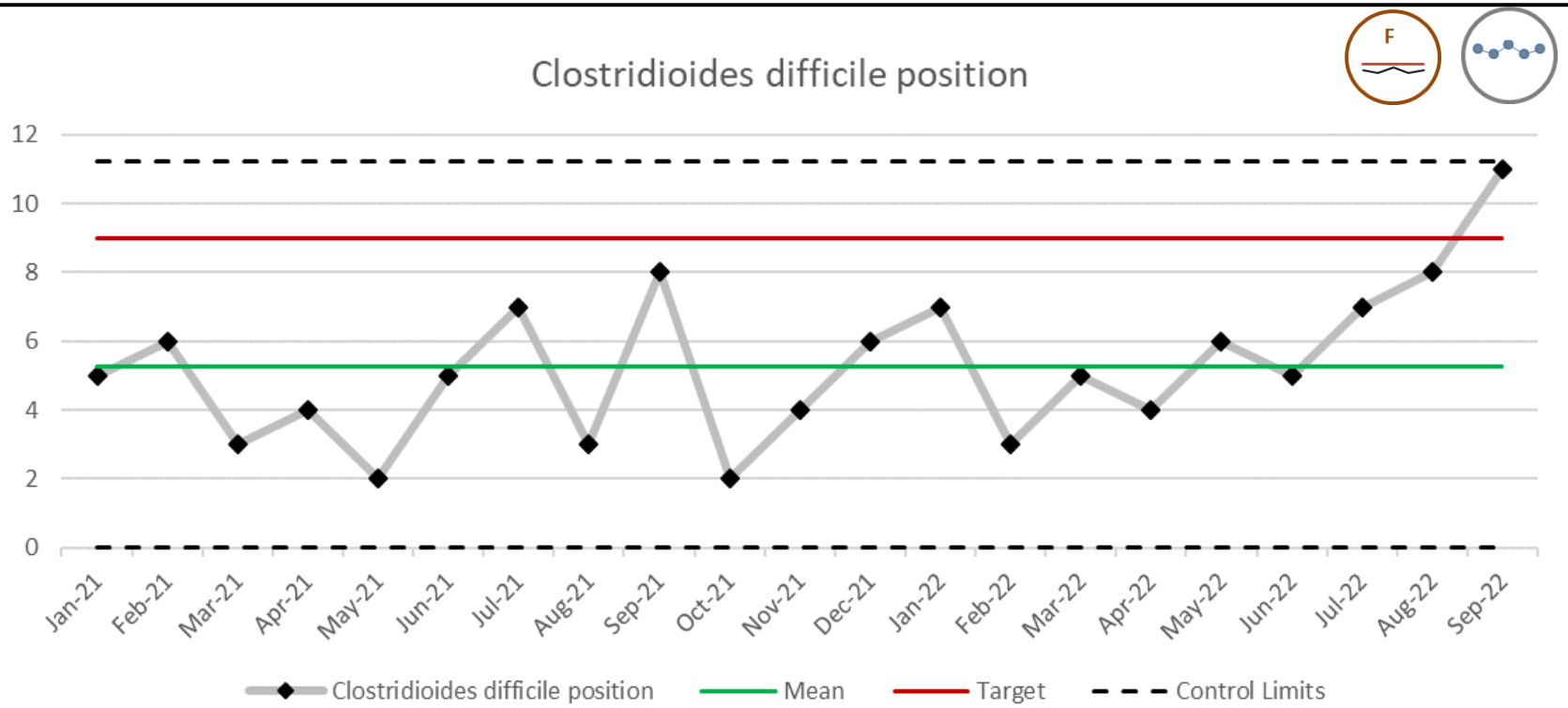

Sep-22
11
Variance Type
Metric is currently experiencing Common Cause Variation
Target
9 per month
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Clostridioides difficile position.

What the chart tells us:
The Trust is over trajectory for Clostridioides difficile cases by 15 cases for the year to date. There have been 41 hospital onset cases out of a trajectory of 56 for the year.

Issues:
Overall, these have been sporadic cases. However, this month there have been 2 periods of increased incidence- i.e. a second case of Clostridioides difficile occurring > 48 hours post admission (not relapses) within a 28 day period. This occurred on 9A at PHB and Belton ward at GDH, both wards having 2 cases.

Actions:
The wards were subsequently deep cleaned and curtains changed and cases discussed at Review meetings. The ribotyping for the cases on 9A were different so these cases were not related. The ribotyping for Belton ward is awaited. Each case is being reviewed and a thematic review/action plan has been put into place and is being tabled at the next IPCG meeting. The IPC team are reviewing all cases twice weekly.

Mitigations:

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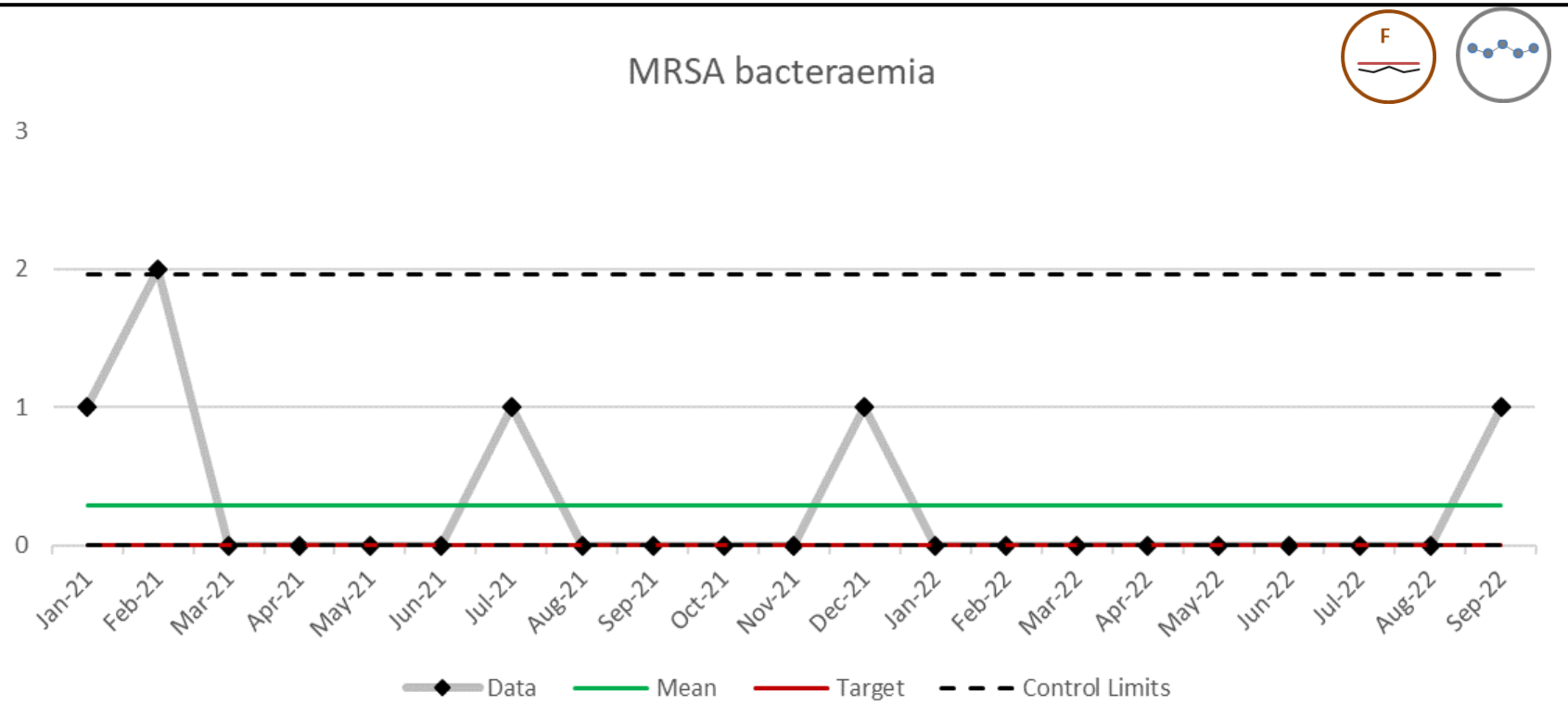

Sep-22
1
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
MRSA Bacteraemia

What the chart tells us:
There has been 1 case on EAU at GDH.

Issues:
This case is currently being investigated and the likely source is an infected cannula site.

Actions:

Mitigations:

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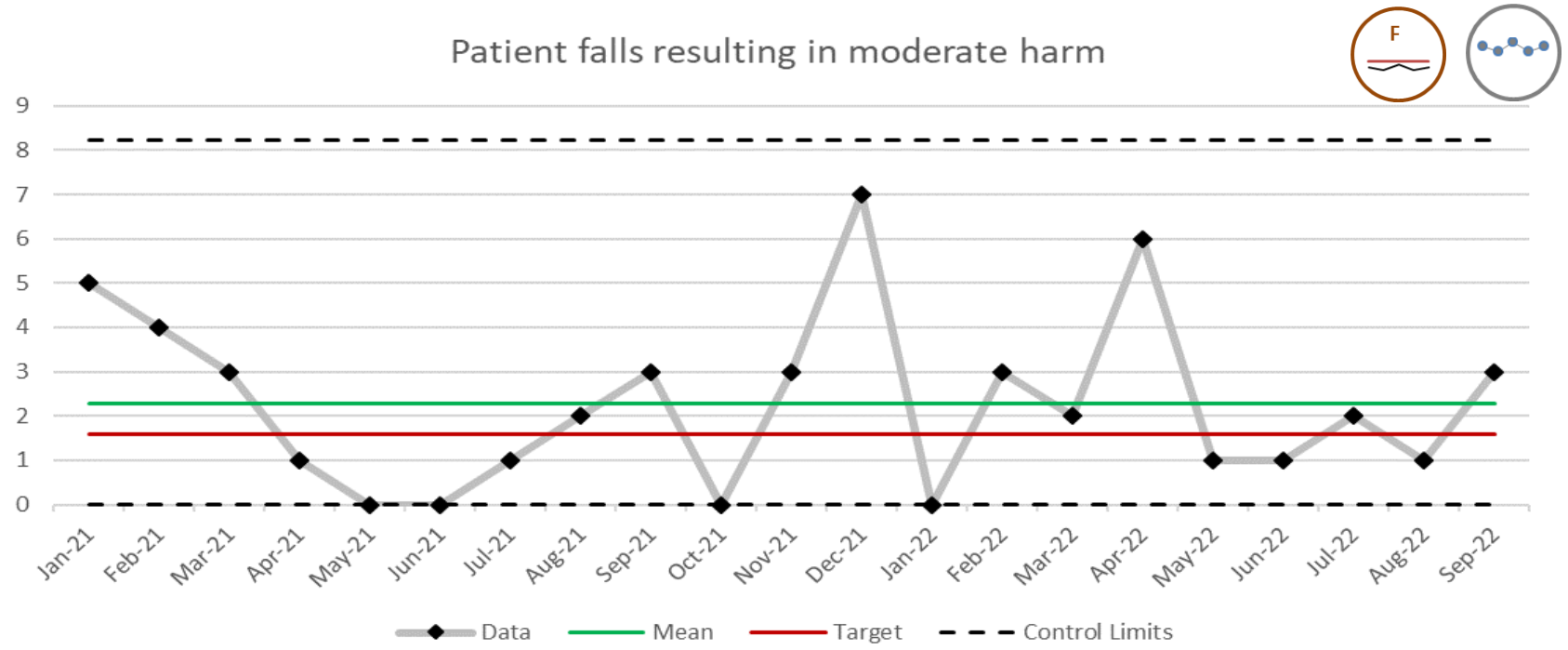

Sep-22
3
Variance Type
Metric is currently experiencing Common Cause Variation
Target
1.6
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:

Patient falls resulting in moderate harm.

What the chart tells us:

There has been 3 falls resulting in moderate harm in September. This is an increase from the 1 reported in August.

We are currently at 16 moderate harm falls incidents for Q1, and Q2 against an improvement target of ≤19 per annum

These incidents are validated through the incident review process and the appropriate level of investigation instigated.

Issues:

Overall this month inpatient falls saw a decrease of 43 (August 204, September 161).

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

1. Movement to / from bed or stretcher
2. Unwitnessed falls, including where visibility of patients and / or enhanced supervision or assistance could not be or was not effectively provided
3. Movement to / from chair
4. Using toilet / commode, with a focus on male patients slipping from the bed whilst using a bottle
5. Patients cognitive ability to understand the risk of falling
6. Lights not working / poor lighting

Actions:

- A regular bite size falls prevention education programme open to all staff has commenced which will link with themes and learning from incidents.
- December's Focus on Fundamentals 'Frailty' month will include falls prevention as a key theme.
- Falls Prevention Ambassadors have been relaunched which will help develop knowledge, skills and confidence in all aspects of falls prevention. This will provide an additional resource who can cascade their learning back in the clinical area.

Mitigations:

Director of Nursing

ElfH falls prevention training being promoted whilst awaiting our package to be uploaded.

Falls Prevention Steering Group (FPSG) remain sighted on areas with increased incidences where deep dives are to be undertaken.

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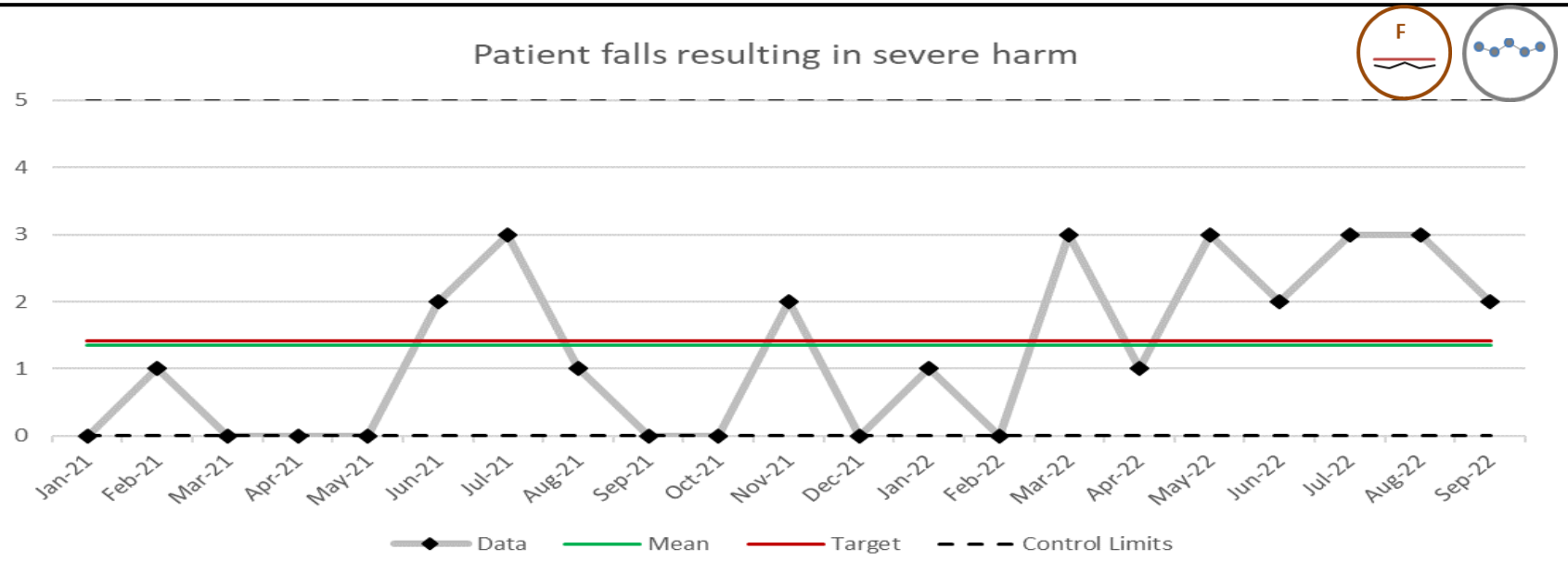

Sep-22
2
Variance Type
Metric is currently experiencing Common Cause Variation
Target
1.4
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:

Patient falls resulting in severe harm.

What the chart tells us:

There have been 2 falls resulting in severe harm in September. This is a reduction from the 3 reported in August.

We are currently at 14 severe harm falls incidents for Q1 and Q2 against a target of ≤ 17 per annum.

These incidents are validated through the incident review process and the appropriate level of investigation instigated.

Issues:

Overall this month inpatient falls saw a decrease of 43 (August 204, September 161).

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

7. Movement to / from bed or stretcher
8. Unwitnessed falls, including where visibility of patients and / or enhanced supervision or assistance could not be or was not effectively provided
9. Movement to / from chair
10. Using toilet / commode, with a focus on male patients slipping from the bed whilst using a bottle
11. Patients cognitive ability to understand the risk of falling
12. Lights not working / poor lighting

Actions:

1. New pictorial resources are being utilised in clinical areas. Falls prevention ambassadors have been identifying further ideas for bespoke posters in specialist areas to enhance falls prevention messages and working with patients to ensure they are relevant. The resources will be made readily available on the Focus on Fundamentals falls prevention area of the intranet
2. Twilight unannounced visits with a focus on falls prevention are scheduled on all sites in October, outcomes and any recommendations for further action will be presented to Falls Prevention Steering Group (FPSG).
3. Quality Matron, Therapy and Moving and Handling teams will be undertaking further work to identify what actions need to be taken to reduce falls when patients are transferring such as from chair/toilet.
4. A number of clinical areas have implemented falls prevention trollies to ensure that all think yellow visual aids, patient information and pre and post falls resources are easily available. The falls prevention working group will plan for wider rollout.

Mitigations

Director of Nursing

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

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

Quality | Operational Performance | Workforce | Finance

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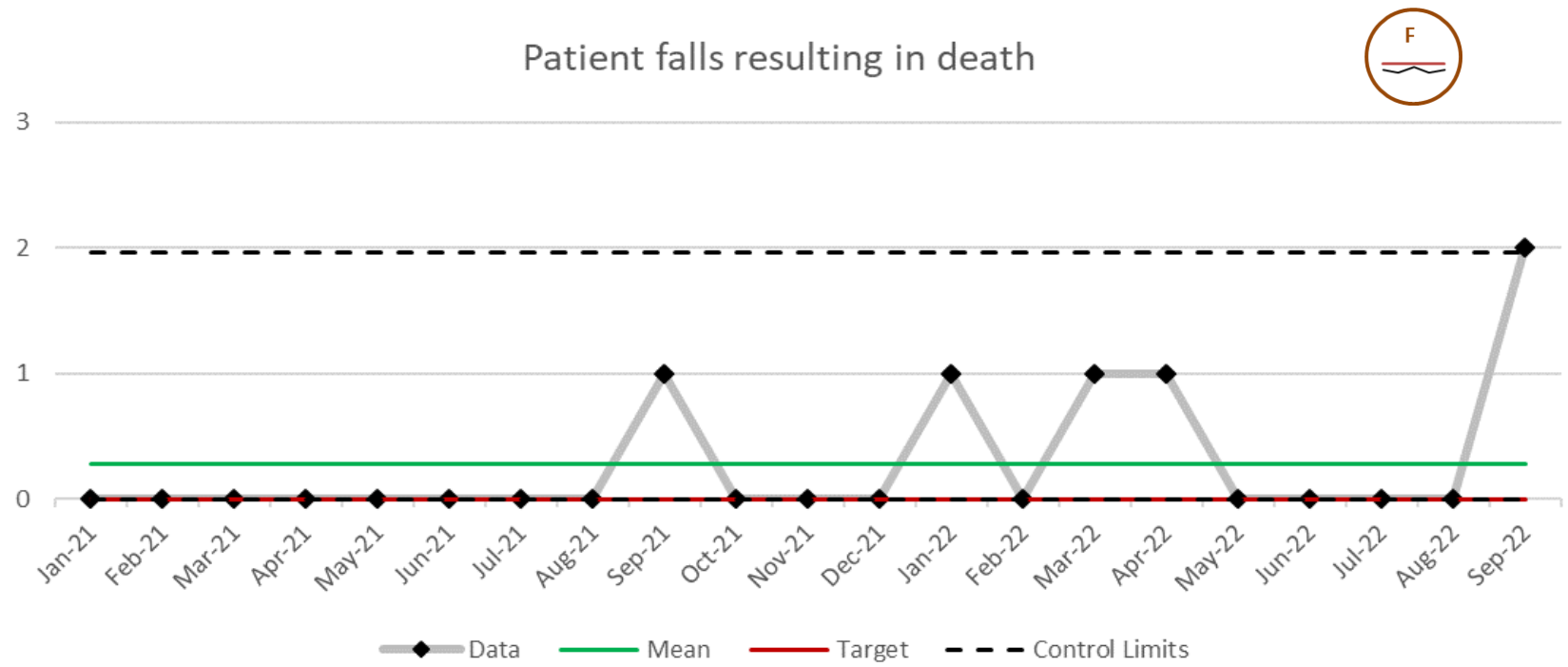

Sep-22
2
Variance Type
Metric is currently experiencing Special Cause Variation – outside the control limits
Target
0
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:

Patient falls resulting in death.

What the chart tells us:

There has been 2 falls reported where the patient died in September. This is an increase from 0 in August.

These incidents are validated through the incident review process and the appropriate level of investigation instigated.

Issues:

Overall this month inpatient falls saw a decrease of 43 (August 204, September 161).

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

- Movement to / from bed or stretcher
- Unwitnessed falls, including where visibility of patients and / or enhanced supervision or assistance could not be or was not effectively provided
- Movement to / from chair
- Using toilet / commode, with a focus on male patients slipping from the bed whilst using a bottle
- Patients cognitive ability to understand the risk of falling
- Lights not working / poor lighting

Actions:

- A regular bite size falls prevention education programme open to all staff has commenced which will link with themes and learning from incidents.
- December's Focus on Fundamentals 'Frailty' month will include falls prevention as a key theme.
- Falls Prevention Ambassadors have been relaunched which will help develop knowledge, skills and confidence in all aspects of falls prevention. This will provide an additional resource who can cascade their learning back in the clinical area.

Mitigations:

Director of Nursing

Elfh falls prevention training being promoted whilst awaiting our package to be uploaded.

Falls Prevention Steering Group (FPSG) remain sighted on areas with increased incidences where deep dives are to be undertaken.

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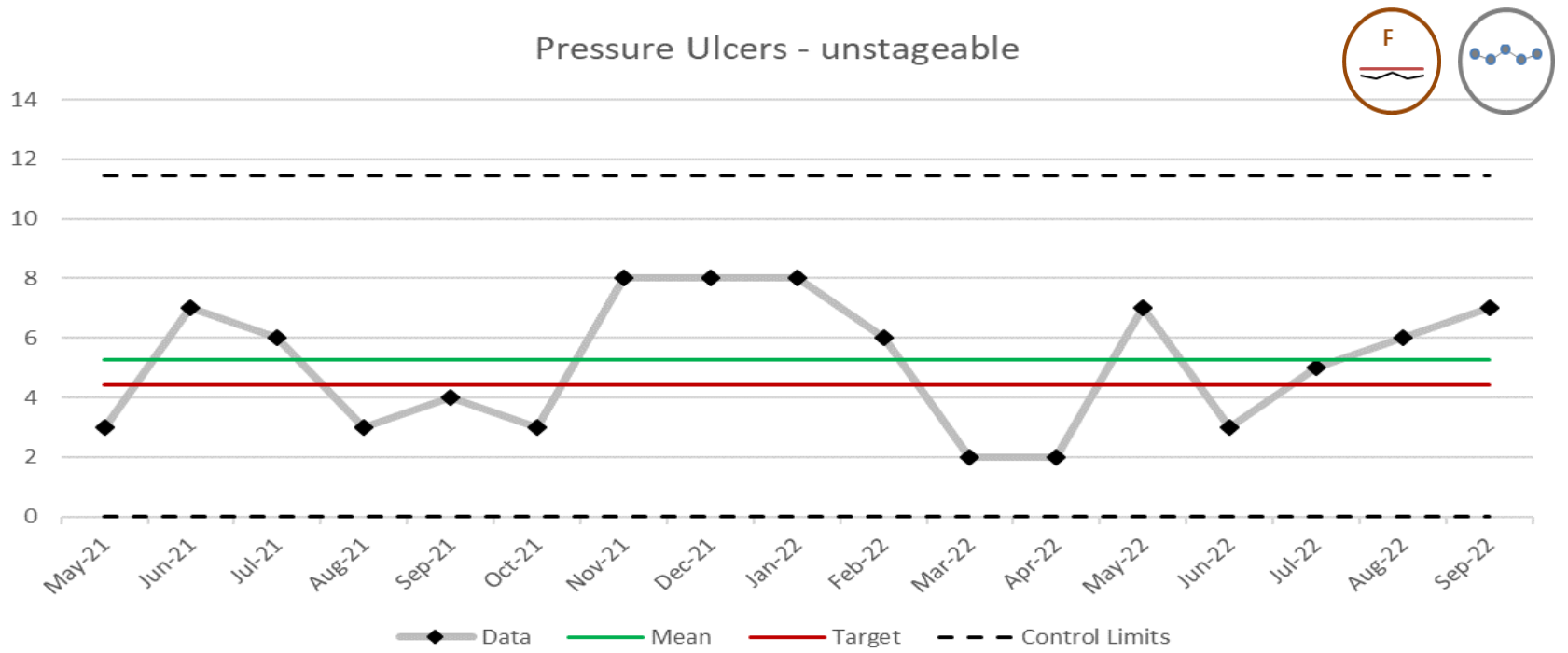
NHS United Lincolnshire Hospitals NHS Trust



Sep-22
7
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.4
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
Unstageable Pressure Ulcers.

What the chart tells us:
We are currently at 7 incidents against a threshold of 4 per month.

Issues:
The number of incidents have increased by 1 in comparison to August 2022.

Through validation it has been noted a contributory factor to a number of incidents were incomplete or delayed skin inspection leading to late recognition of the tissue damage to the patient and delay in the implementation of appropriate preventative pressure care.

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

Learning from incidents will continue to be regularly shared at Skin Integrity Group (SIG) and at the Sister/Charge Nurse and Matrons forums.

A pilot to develop the role of the Skin Integrity Ambassadors has commenced in October 2022. Updates will be provided to SIG.

TV team are networking nationally to identify any new practice currently being developed to support during current operational pressures.

An educational day for the Tissue Viability link nurse/ambassadors is planned to be delivered on International Stop the Pressure Day in November 2022.

Mitigations:
Skin Integrity care is reviewed in the weekly ward/dept. leader's assurance and monthly Matrons audits.

The monthly Quality Metrics review meeting chaired by the Director of Nursing monitors ward and departments' performance relating to skin integrity.
Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.
The Patient Pressure Ulcer Incident Panel also have sight of any other areas of concern that are not raised through the serious incident process.

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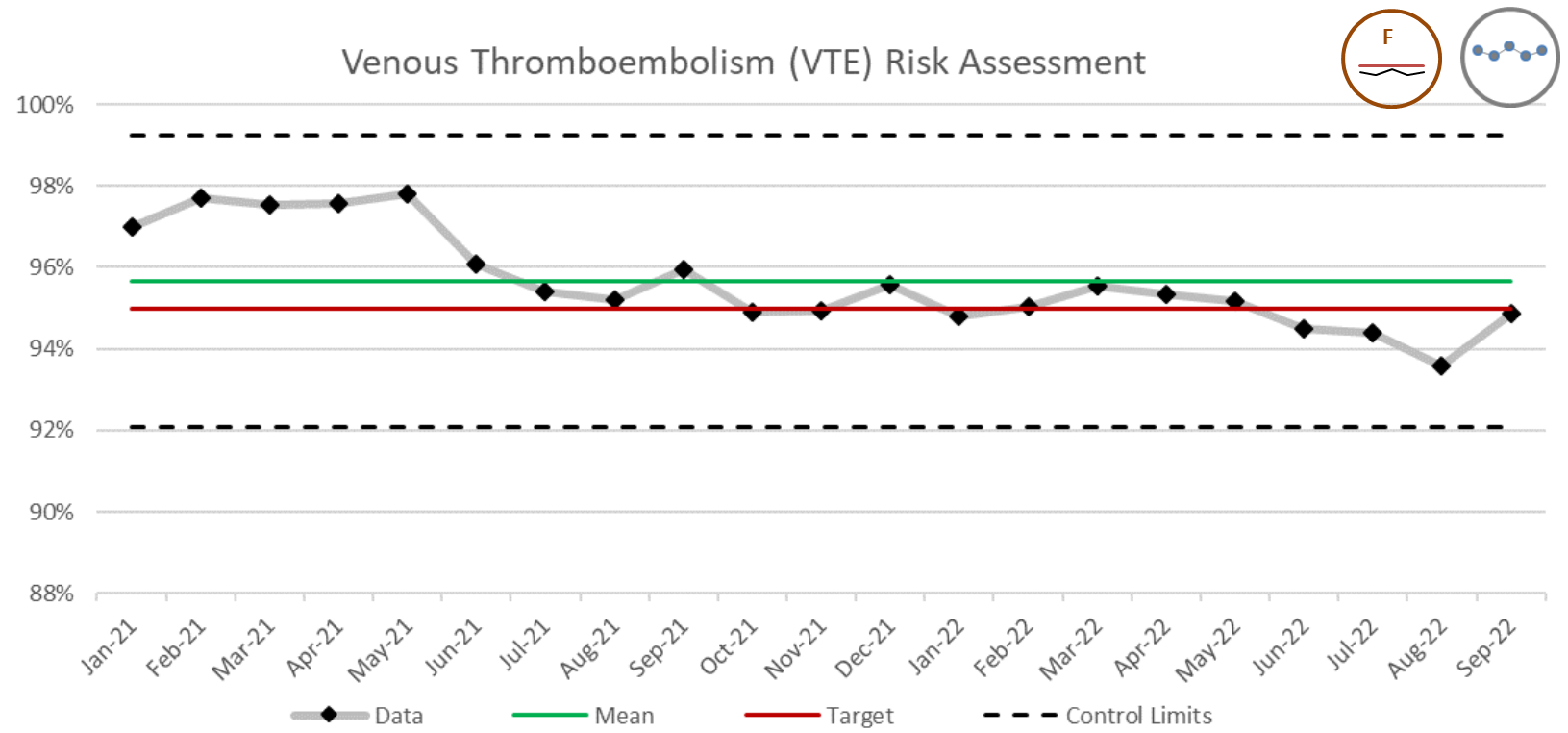

Sep-22
94.88%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is failing the target
Executive Lead
Medical Director

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

What the chart tells us:
VTE risk assessment performance is just below 95% target, currently at 94.88%.

For discussion at the QGC meeting:

Please discuss at QGC to determine the appropriate Trust wide owner to provide narrative. Responsibility has been delegated to Divisions but we need someone to provide the overarching Trust level narrative on this measure.

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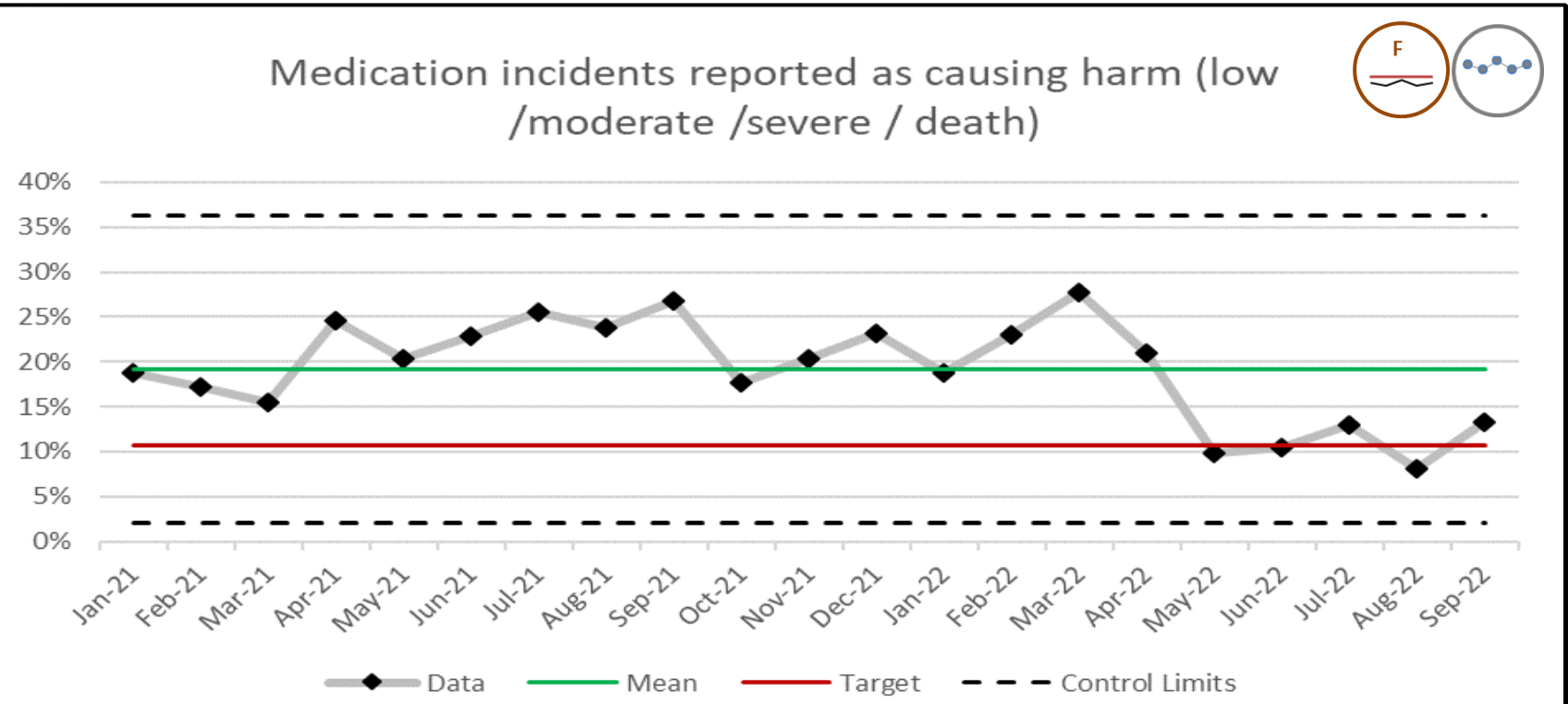

Sep-22
13.3%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10.7%
Target Achievement
Metric is failing the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of September the number of incidents reported was 203. This equates to 6.89 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 13.3 % which is above the national average of 11%.

Issues:
The majority of incidents are at the point of administration of medication and the main error is omitting medicines.

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

Mitigations:

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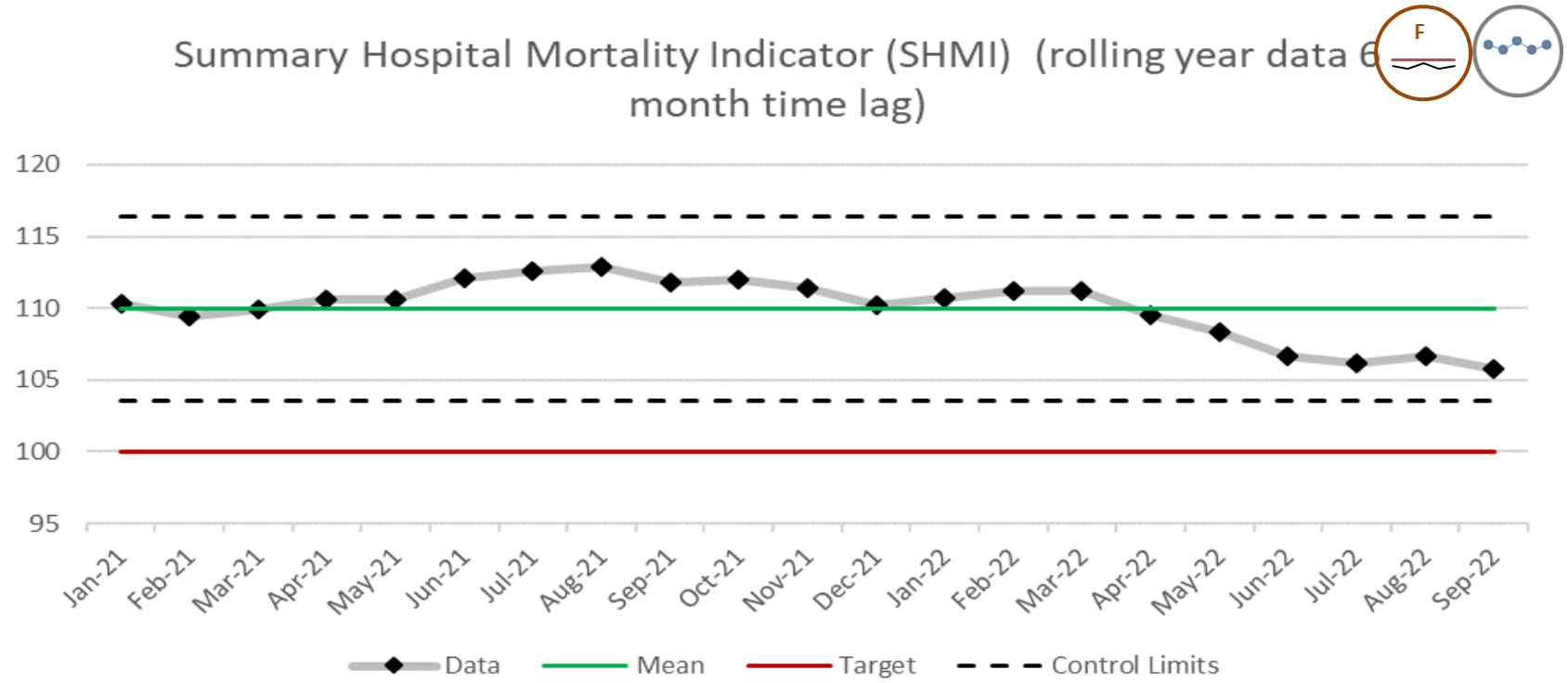

Sep-22
105.77
Variance Type
Metric is currently experiencing Common Cause Variation
Target
To remain in "as expected" range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
ULHT SHMI is 105.77; a decrease from the last reporting period. The Trust has remained in Band 2 with an 'As expected'

Issues:
The COVID-19 pandemic has impacted on the Trusts SHMI. The data period is reflective from May 21 – April 22.

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

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

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

Learning is shared at the Lincolnshire Mortality Collaborative Group which is attended by all system partners.

HSMR is 95.34-lower than

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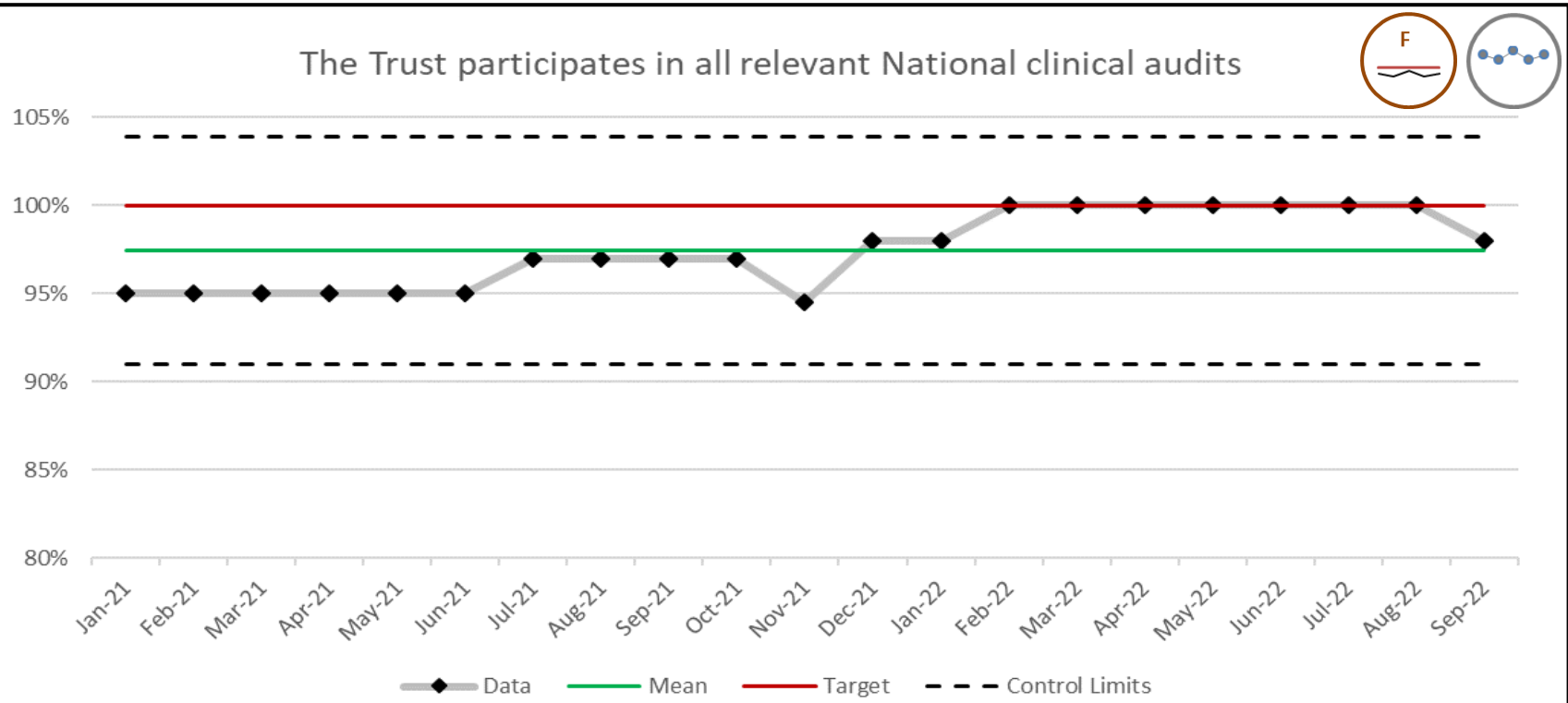

Sep-22
98.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
% participation in relevant National Clinical Audits.

What the chart tells us:
Participation has decreased from 100% to 98%.

Issues:
None participation in the National Diabetic Foot Audit.

Actions:
Monitored by the Clinical Effectiveness Group.

Mitigations:
Clinic letters to be used to provide the information the process is under review to ensure data is submitted.

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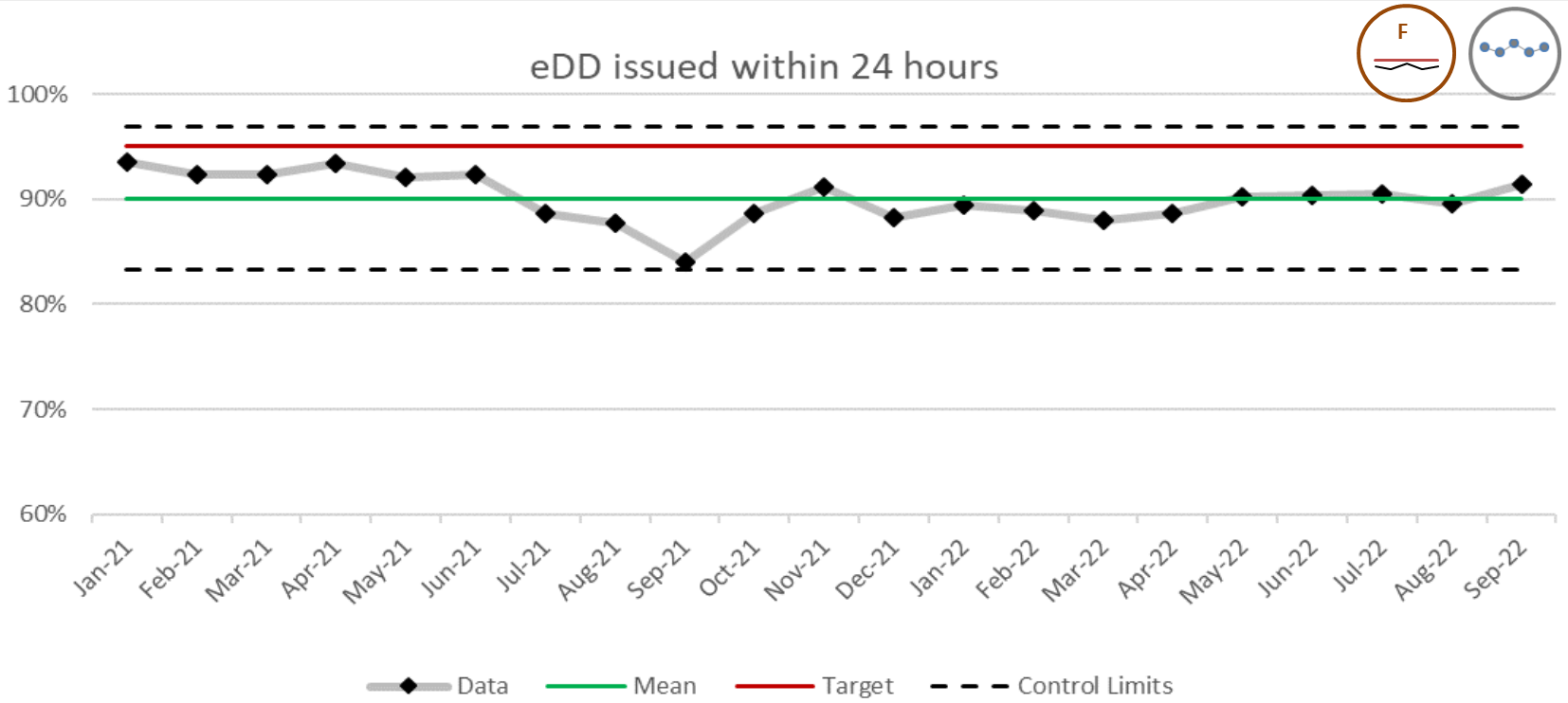

Sep-22
91.40%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 91.40%.

Issues:

Actions:
A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric at their monthly Performance Review Meeting.

Mitigations:

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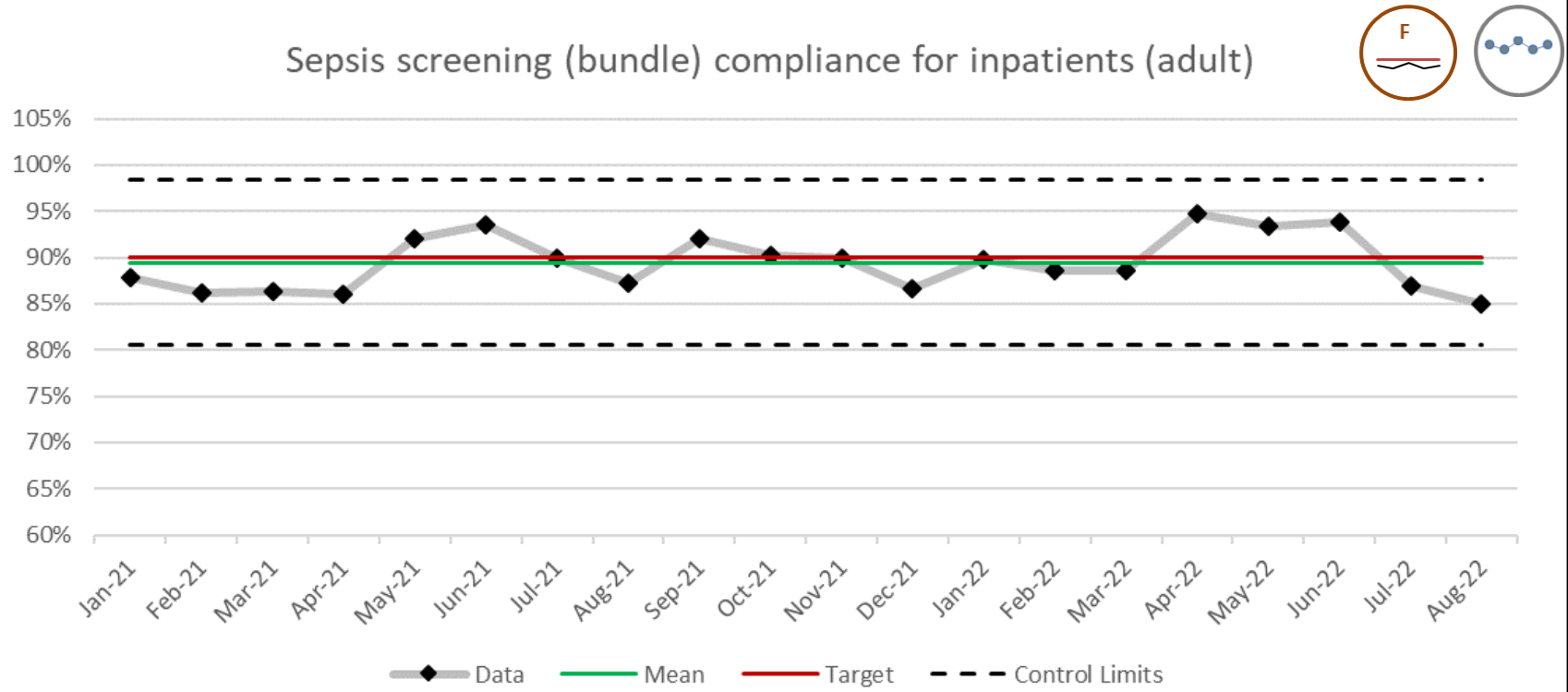

Aug-22
85.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance for adult inpatients is 85% against a standard of 90%. This represents 257 of 304 patients or 47 patients who had a missed or delayed screen.

Issues:
This has been the second drop in compliance in a row and suggests that the inpatient ward areas are struggling with deciding when to screen for sepsis. This stems primarily from a worsening of compliance in medical wards. Thematic analysis is still underway but ward leaders report that the changing patterns of recruitment is having an impact.

Actions:
A number of wards have reported issues with newly appointed staff having little understanding of sepsis or how to complete a screen on web v.
Targeted teaching is taking place on those wards that have identified specific training needs and wards are being signposted to a voice over video that demonstrates how to complete a screen on web v. The sepsis team are also heavily involved in rolling out the AIM course which is designed to meet the needs of newly qualified/appointed nurses.

Mitigations:
Monthly audit continues for all wards and thematic analysis is undertaken to help understand the reasons behind any shortfalls. Sepsis practitioners are increasing their presence on the wards to help with visibility and to raise awareness. The wards each have a link nurse and the practitioners are working closely with them to ensure local scrutiny and ownership.

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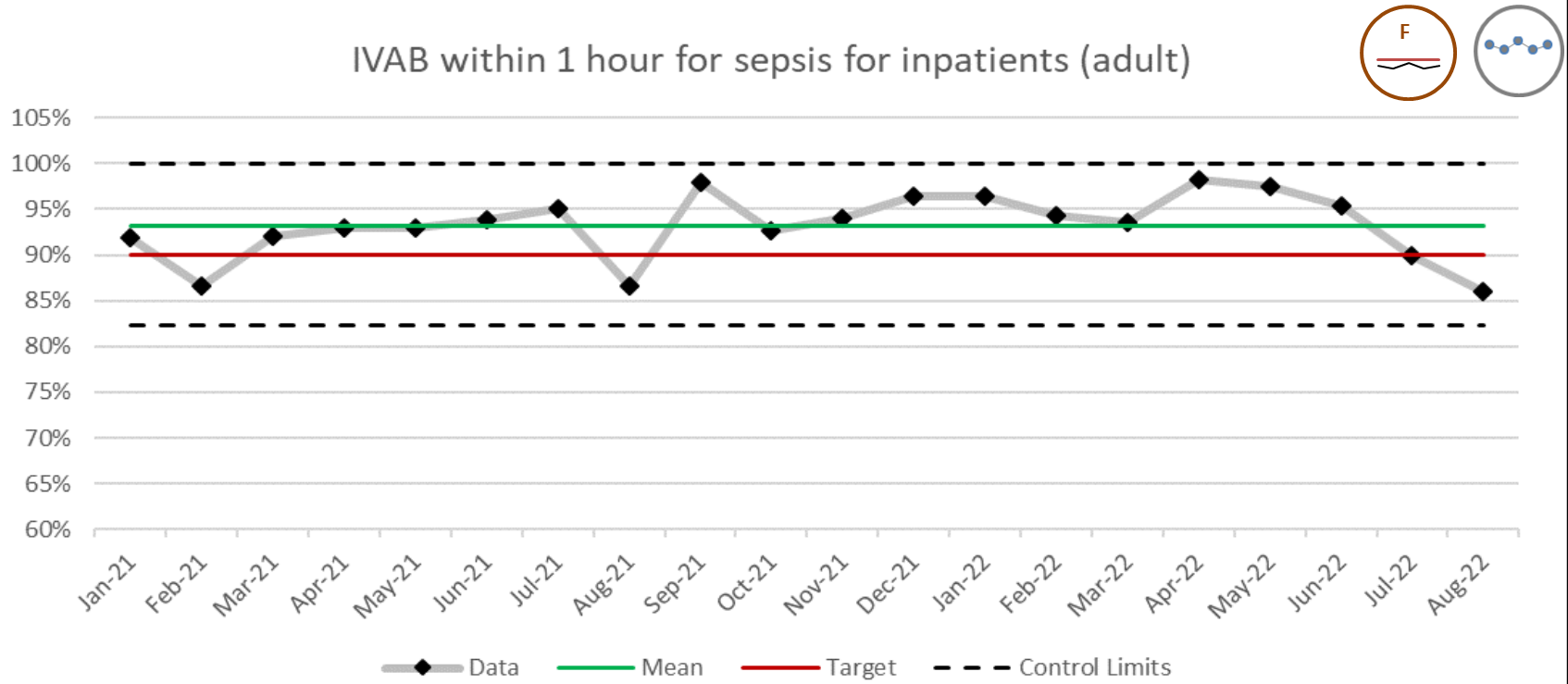

Aug-22
86.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Compliance for delivery of antibiotics within 1 hour has fallen below the 90% standard for the first time in a year at 86%- 131 of 146 patients – representing 15 patients who had missed or delayed treatment.

Issues:
The delivery of antibiotics as a marker of prompt treatment for sepsis has usually been a strong indicator that patients are being kept safe and it is concerning that this compliance has fallen. The numbers are relatively low and it is not possible to draw concrete conclusions on any trends but harm reviews are being conducted on each case.

Actions:
Once harm reviews have been completed, an action plan will be commenced to address any shortfall in practice. The sepsis practitioners will be continuing to target education on wards that need more support and are presenting case studies of lessons learnt to the foundation doctors to emphasise their primary role as prescribers.

Mitigations:
We are now involved in the antimicrobial stewardship group with the lead pharmacists and this will improve our reach and profile. The numbers remain low and there is only one case awaiting rapid review so this will allow us to increase our scrutiny of each individual case.

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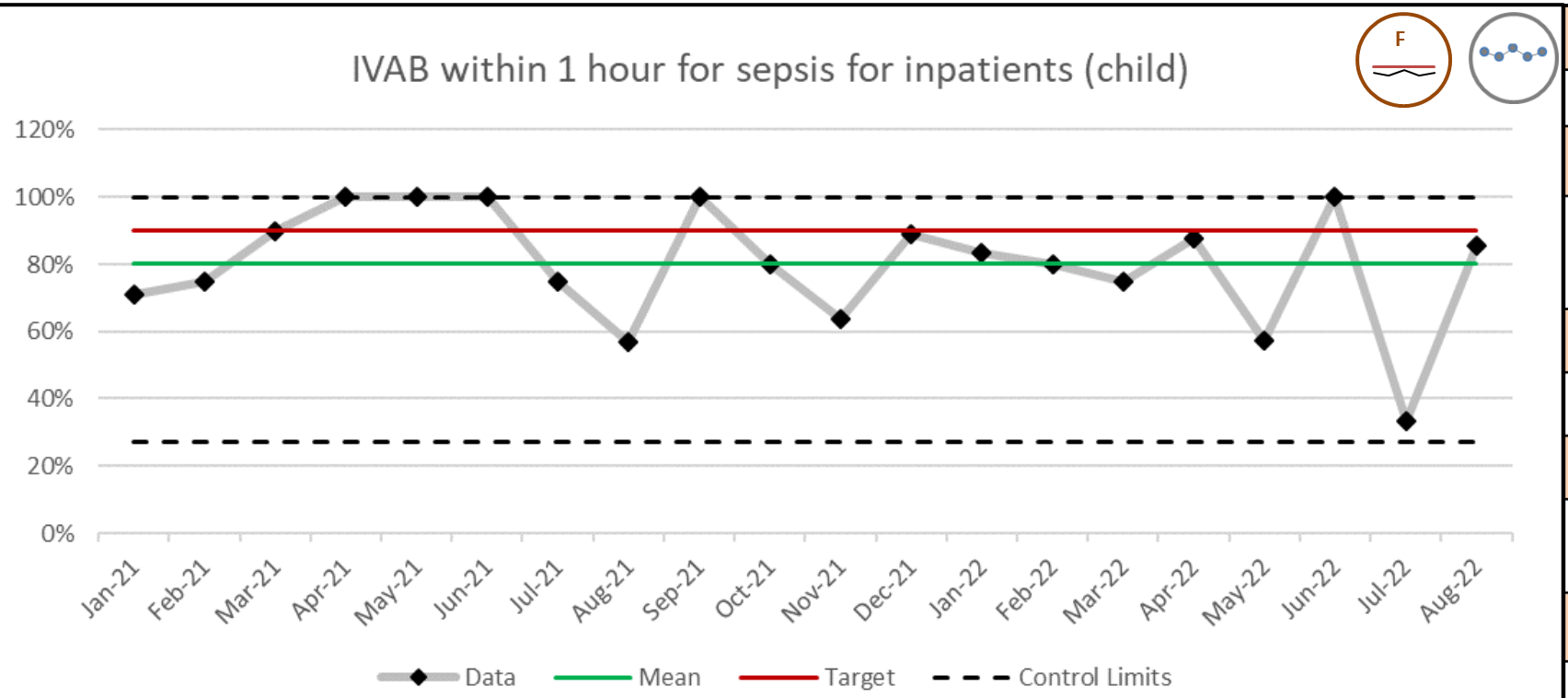

Aug-22
85.7%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The treatment figures for inpatient Sepsis were very disappointing this month at 85.7%. 6 out of 7 patients received IV antibiotics within the hour.

Issues:
There was 1 patient with delayed treatment within the inpatient areas. This is a great improvement on the last month. The delay was due to the parents not giving their consent for the child to have antibiotics. Following discussion with the family it was decided to wait for blood results and then deciding treatment plan.

Actions:
A harm reviews was completed for this patient and no harm was found from delay.
This delay was due to a consent issue from parents and will be discussed in Drs teaching.

Mitigations:
Sepsis training has now been implemented early in the new Drs rotation. They have all had Sepsis training within their first week as well as a Sepsis Simulation for training. Screening is being audited throughout the month and any issues are escalated early. There are regular discussions being held between Clinical Lead, Ward Managers and Clinical Educators to address any concerns. Sepsis compliance is also discussed at Speciality governance.

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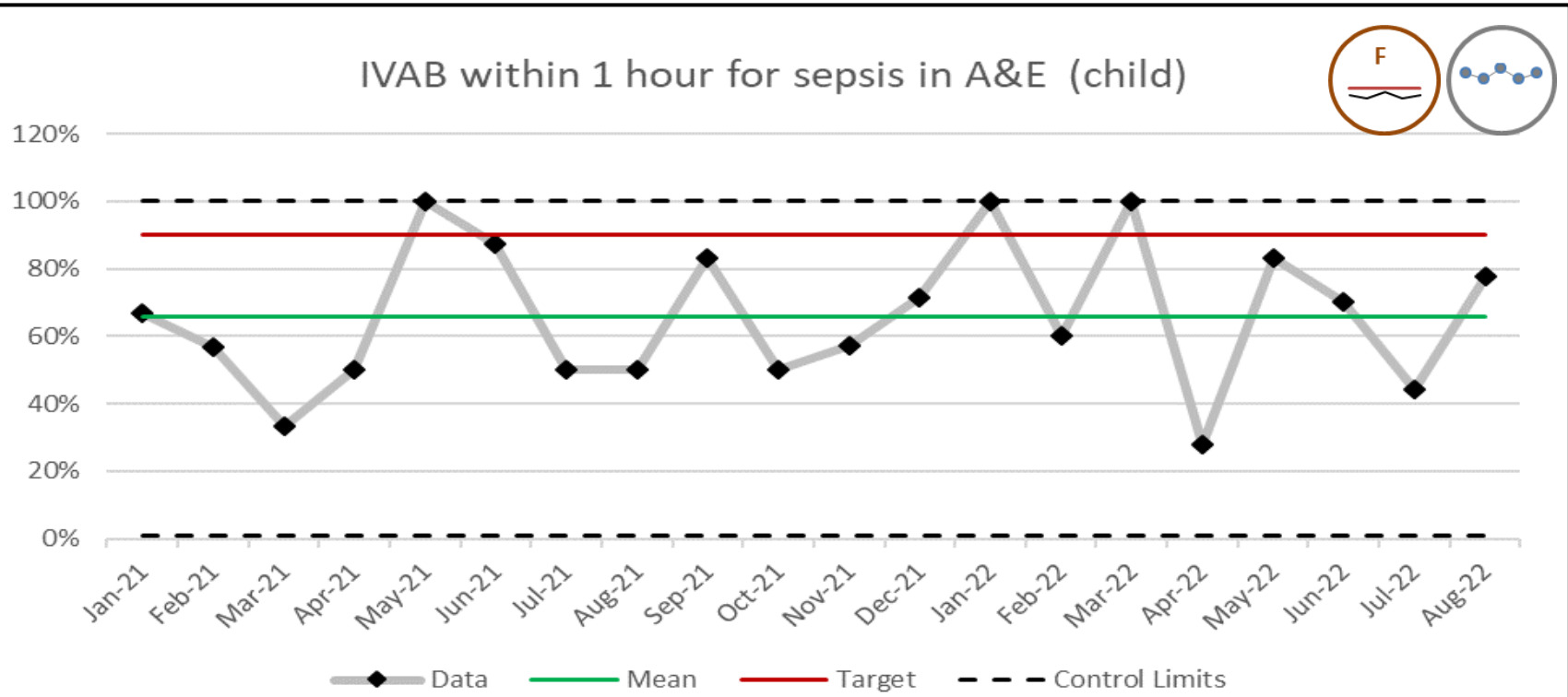


Aug-22
77.80%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

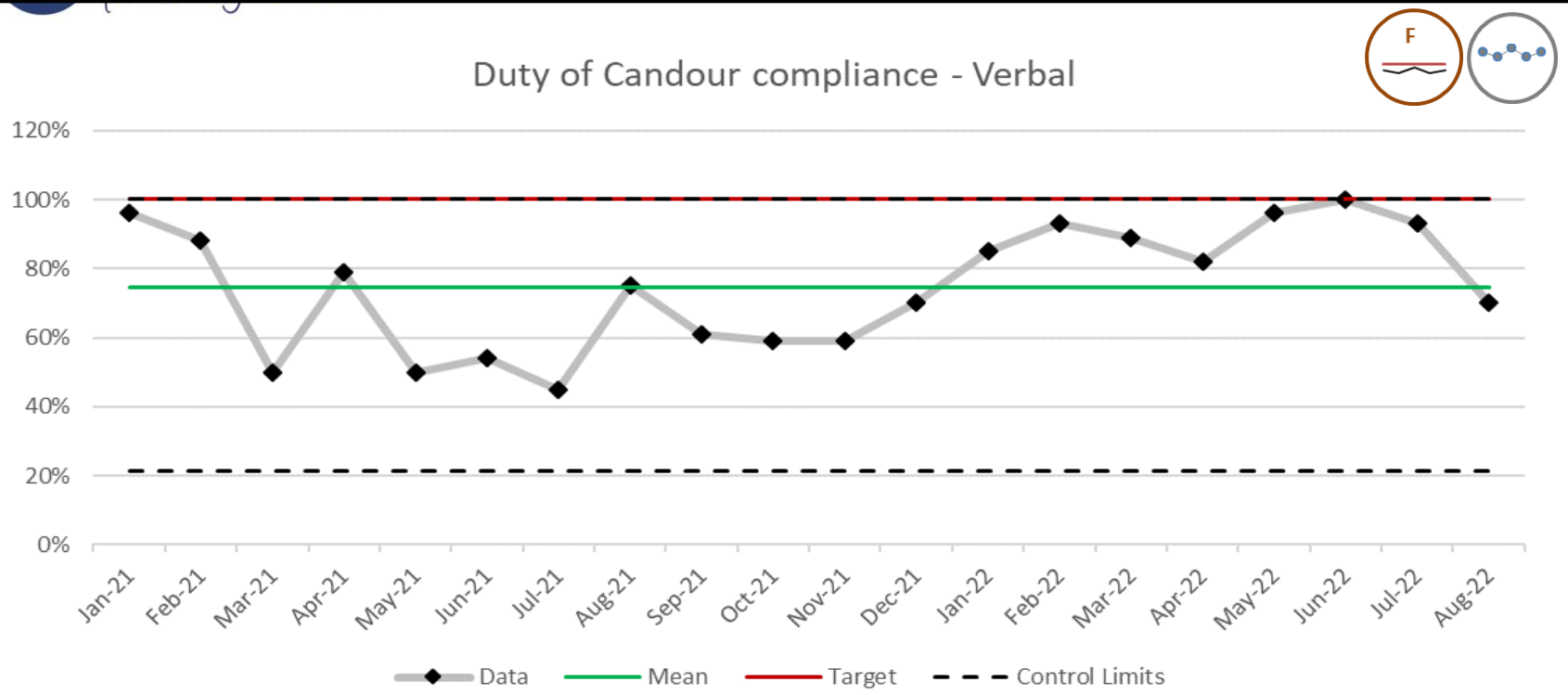
Background:
IVAB within 1 hour for sepsis for in A & E (child).

What the chart tells us:
The data this month shows that the IVAB compliance was 77.8%, which is 7 of 9 patients, and is below the 90% target. There is a marked increase compared to last month.

Issues:
There were 2 patients in ED this month that were delayed in receiving antibiotics. One child was very unwell on admission and having seizures, which were very difficult to control. Drs were working to maintain safe airway and control seizures. IVAB given at 2 hours. The second patient had a prolonged delay as the Drs wanted to do a lumbar puncture before starting antibiotics. This delay was a number of hours.

Actions:
A harm review was completed for both patients and no harm was found. Sepsis training has been undertaken for new Doctors starting in August.
Simulation training is to be reintroduced in ED areas as soon as possible.
There will be more training with ED staff about how to fill in/ use the unsure option appropriately.

Mitigations:
Harm reviews completed for the patients. No Harm found.
There are ongoing meetings between the Sepsis team and ED which happen every other week. There appears to be more engagement from ED staff, especially those with a Paediatric interest, which is a positive.
Paediatric Lead also informed of delay due to Lumbar Puncture. All staff have been emailed to say that this is inappropriate.



Aug-22
70%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

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

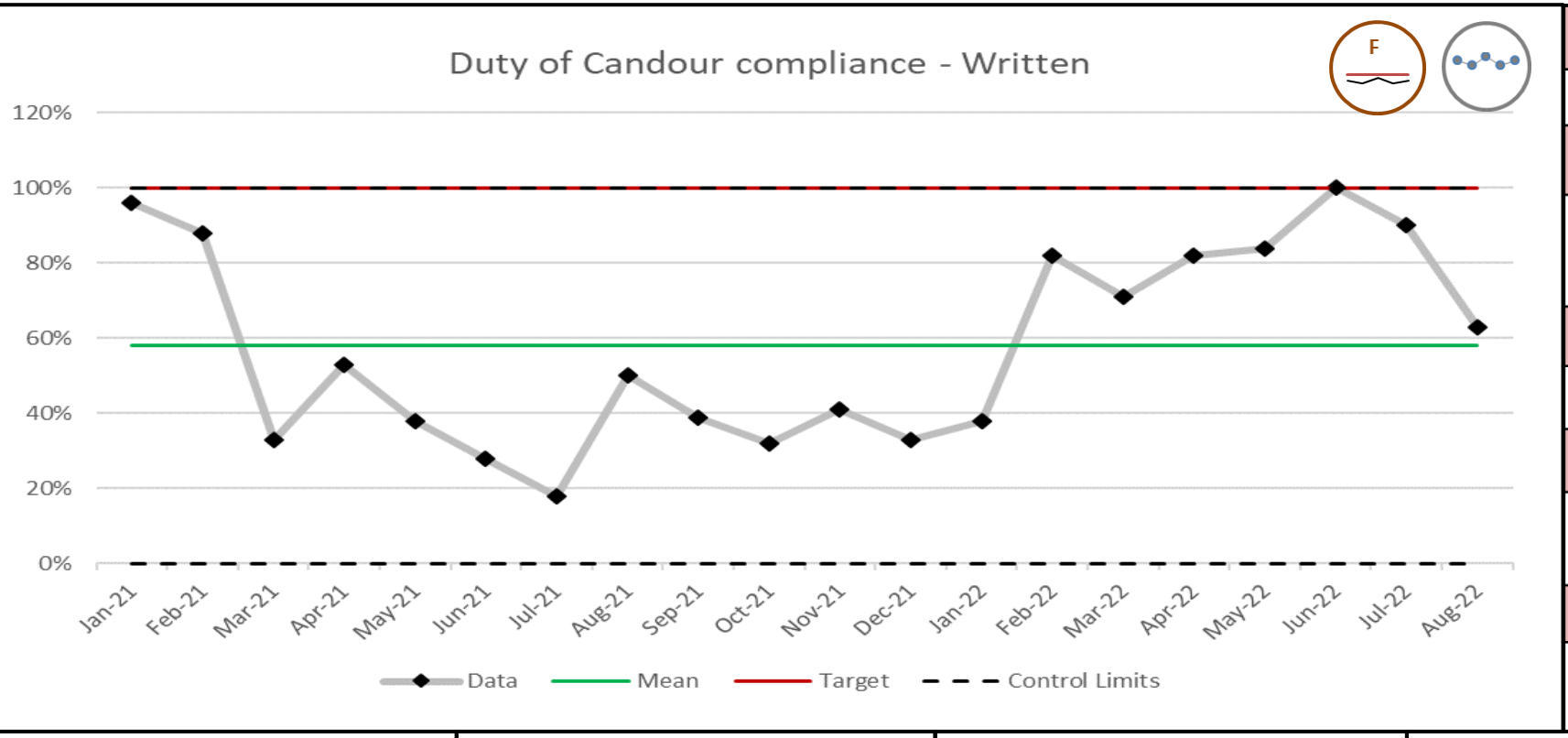
What the chart tells us:
The Trust does not consistently achieve 100% compliance within a given month.

Issues:
Duty of Candour is frequently completed after month-end data is produced and reported on, therefore these figures may not represent the current level of compliance for earlier months.

Actions:
Duty of Candour for a number of COVID cases from 2021 can now be carried out following completion of the thematic review.

Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's and performance is included in monthly divisional governance reports.

Mitigations:
Risk & Governance Coordinators are sighted on each day's incidents, including Duty of Candour requirements and are working closely with the Divisional teams to improve compliance.



Aug-22
63%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The Trust does not consistently achieve 100% compliance within a given month.

Issues:
Duty of Candour is frequently completed after month-end data is produced and reported on, therefore these figures may not represent the current level of compliance for earlier months.

Actions:
Duty of Candour for a number of COVID cases from 2021 can now be carried out following completion of the thematic review.

Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's and performance is included in monthly divisional governance reports.

Mitigations:
Risk & Governance Coordinators are sighted on each day's incidents, including Duty of Candour requirements and are working closely with the Divisional teams to improve compliance.

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-22	Aug-22	Sep-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.25%	0.43%	0.38%	0.23%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	60.10%	59.48%	59.94%	61.39%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	752	1088	869	4826	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	78.84%	80.30%	82.26%	81.92%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	7246	7168		30,616	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	49.78%	49.50%		50.47%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	69,947	71,271		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	51.37%	55.07%		50.54%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	56.08%	42.30%		57.46%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	32.14%	18.52%		23.13%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	93.67%	92.12%		91.20%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	99.21%	95.41%		97.59%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	80.00%	75.00%		70.78%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	97.89%	96.70%		96.84%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	53.33%	69.57%		66.42%	90.00%			

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PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-22	Aug-22	Sep-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	79.72%	64.00%		68.78%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	53.12%	50.85%	52.46%	53.76%	99.00%	F	L	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	2.87%	2.36%	3.05%	2.35%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	23	37	38	172	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	63.75%	68.60%	63.64%	70.60%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	50.00%	46.51%	43.94%	51.24%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,756	3,758	3,858	3,838	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	796	930	885	817	0	F	A	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	113	135	158	805	60	F	A	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.11	3.19	2.64	3.04	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.85	5.12	4.95	5.04	4.5	F	A	
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	23,034	22,951	23,128	23,103	4,524	F	A	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	33.36%	33.18%	29.71%	37.60%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	38.07%	38.21%	41.32%	37.79%	45.00%	F		

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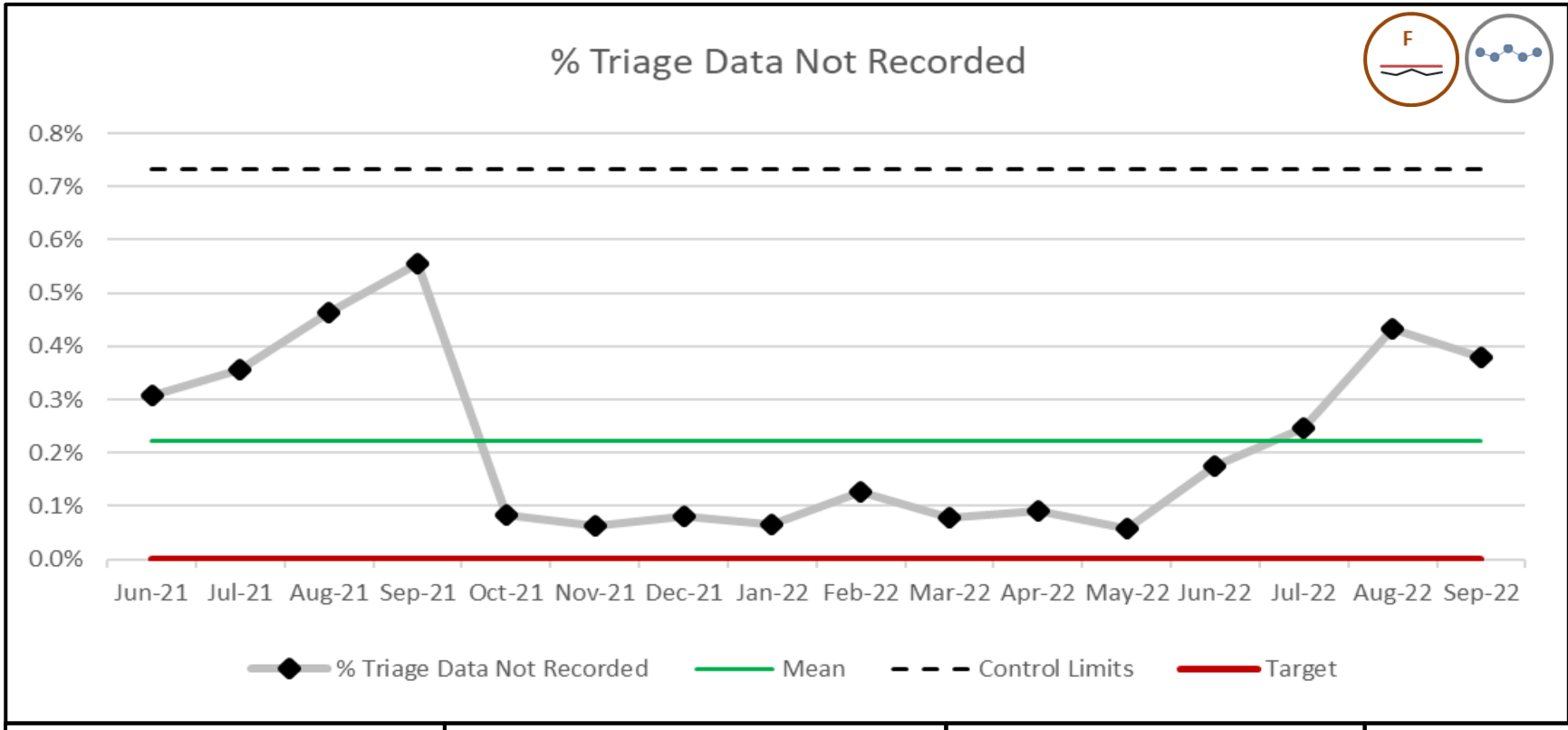


Sep-22
0.38%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%.
September reported 0.38% data not recorded verses 0.43% in August.
September demonstrated a 0.05% positive variation compared with August.
This metric is below target.

Issues:

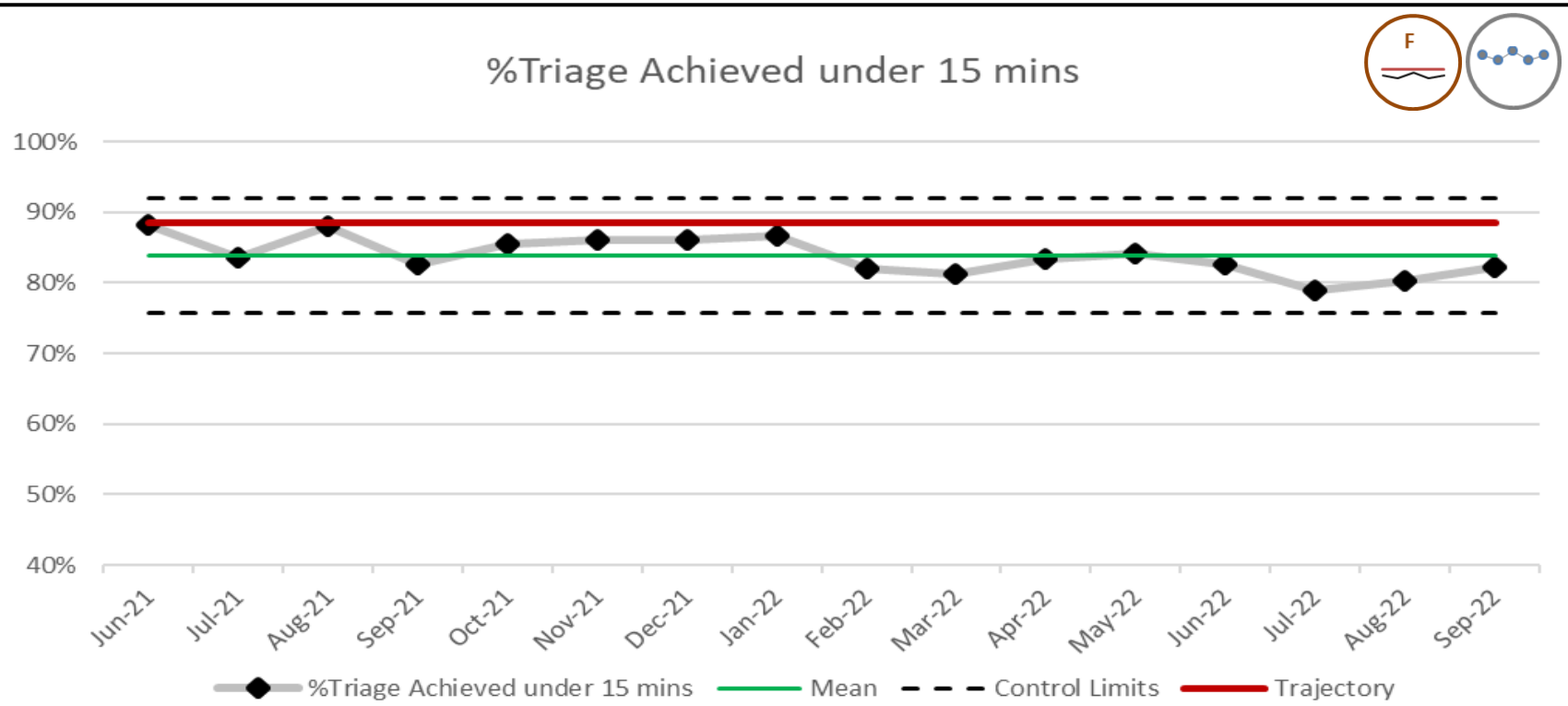
- Timely inputting of data.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been less problematic at all three sites.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP) and an increased incidence of only 1 triage stream against the standard of 2 streams.
- Staffing gaps, sickness and skill mix issues
- Increased demand is still cited as a causation factor.

Actions:

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

Mitigations:

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



Sep-22
82.26%
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%.
September outturn was 82.26% compared to 80.30% in August.
This demonstrated an improvement in performance of 1.96% compared with August and a 6.24% negative variance against the agreed target.

This target has not been met.

Issues:

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

Actions:

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

Mitigations:

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

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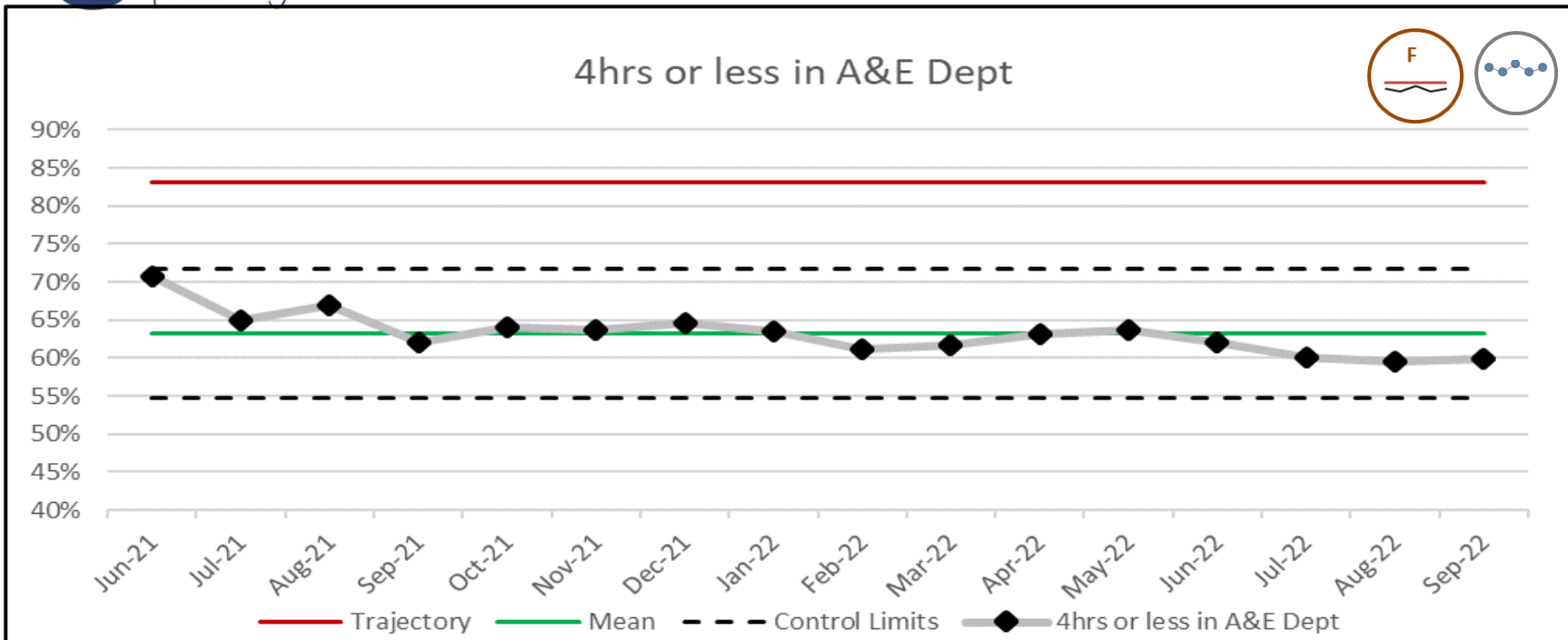
NHS United Lincolnshire Hospitals NHS Trust



Sep-22
59.94%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

The national 4-hour standard is set at 95%. The agreed trajectory for compliance for ULHT is set at 83.12%. This target has not been reset since April 2021.

What the chart tells us:

The 4-hour transit target performance for September was 59.94% compared to 59.48% in August which is a slight improvement of 0.46%. The target compliance is 83.12% and is an historic target that has been unchanged in 2 years.

Issues:

The Emergency Departments saw a 2.31% increase in attendances in September (395 patients) compared to August. 16,938 combined attendances (ED and UTC) in September compared to 16,538 combined attendances in August.

Of the 16,938 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 11,344 and type 3 accounted for 5,470. This is an increase on type 1(2.23%) and a decrease of type 3 (2.22%).

Inadequate daily discharges to meet the admission demand remains the main issue leading to extended ED LOS.

Ongoing medical and nursing gaps that were not Emergency Department specific.

Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps.

Escalation of some SDEC areas into Inpatient areas.

Actions:

Reducing the burden placed upon the Emergency Departments further will be though the continued expansion of Same Day Emergency Care (SDEC) Services, maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients, the System flow and discharge improvement programme, increased pathway 1 (D2A) capacity and the 'Care Closer to Home' programme.

Mitigations:

EMAS continue to enact a targeted admission avoidance process.

The Discharge Lounge at LCH and PHB continues operating, where possible, a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and transport home. The closure of the Discharge Lounges due to inadequate staffing sits solely with the Chief Operating Officer and the Director of Nursing but can be delegated to Dep Chief Operating Officer/ Gold Commander Out of Hours Increased CAS and 111 support especially out of hours.

EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.

Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.

OUTSTANDING CARE personally DELIVERED

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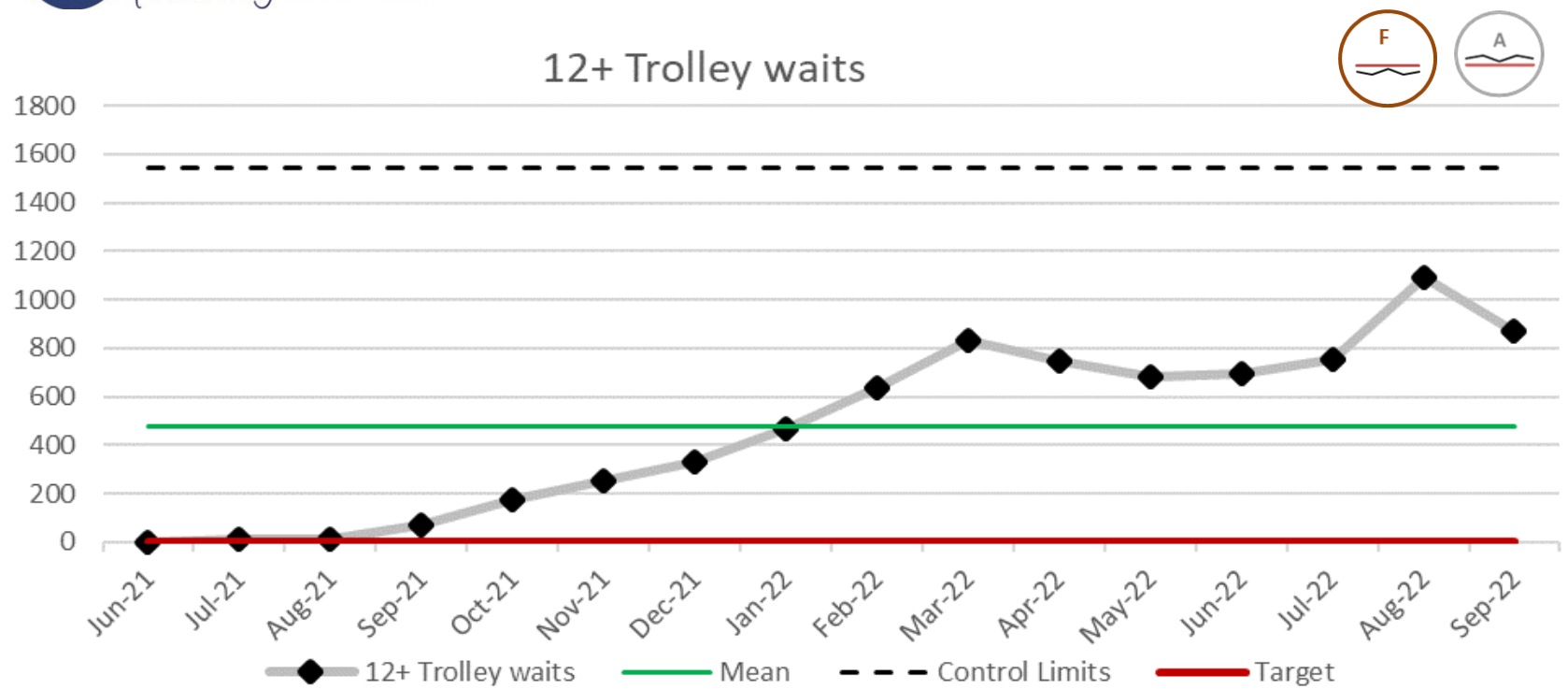

Sep-22
869
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
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:
September experienced 869 12-hr trolley wait breaches. This is the unvalidated position. This is a decrease of 219 12-hr trolley wait breaches compared to August. This represents a decrease of 20.13%. This equates to 17.52% of all type 1 attendances for September.
What the chart does not explain is the internal decision to move from 12hr DTA to total time in ED to minimise exposure risk.

Issues:

Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings. The actual number of 12hr trolleys wait breaches, whilst anticipated against flow predictions, exceeded actual expectations.
August has experienced an increase in incidental positive covid cases and nosocomial transmission, which as restricted the use of several inpatients' beds, impacting further on flow.
To prevent nosocomial transmission, the use of boarding areas as per the Full Capacity Protocol areas has been problematic.
The Trust has made the safety and risk-based assessment to move to total time in ED as opposed to the 12hr DTA standard.

Actions:

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

Mitigations:

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

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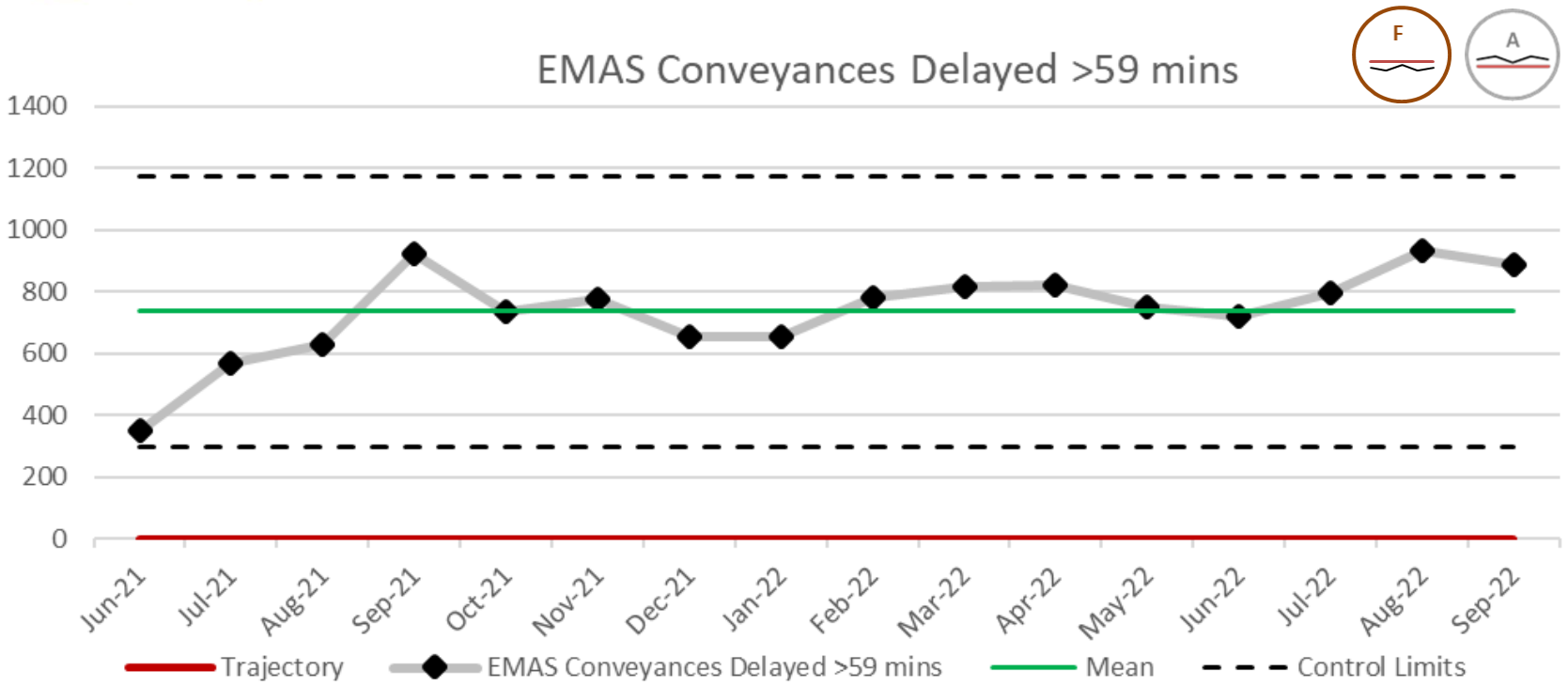


Sep-22
885
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
September demonstrated a decrease in greater than 59 minutes' handover delays 885 in September compared to 930 in August. This represents a 4.84% decrease.
What the chart does not tell us is the decrease of >2hrs in September 2022 (426 in September verses 517 in August) and a decrease in >4hr delays (100 in September vs 123 in August)
Overall conveyances saw an increase in September compared to August by 2.6%

Issues:

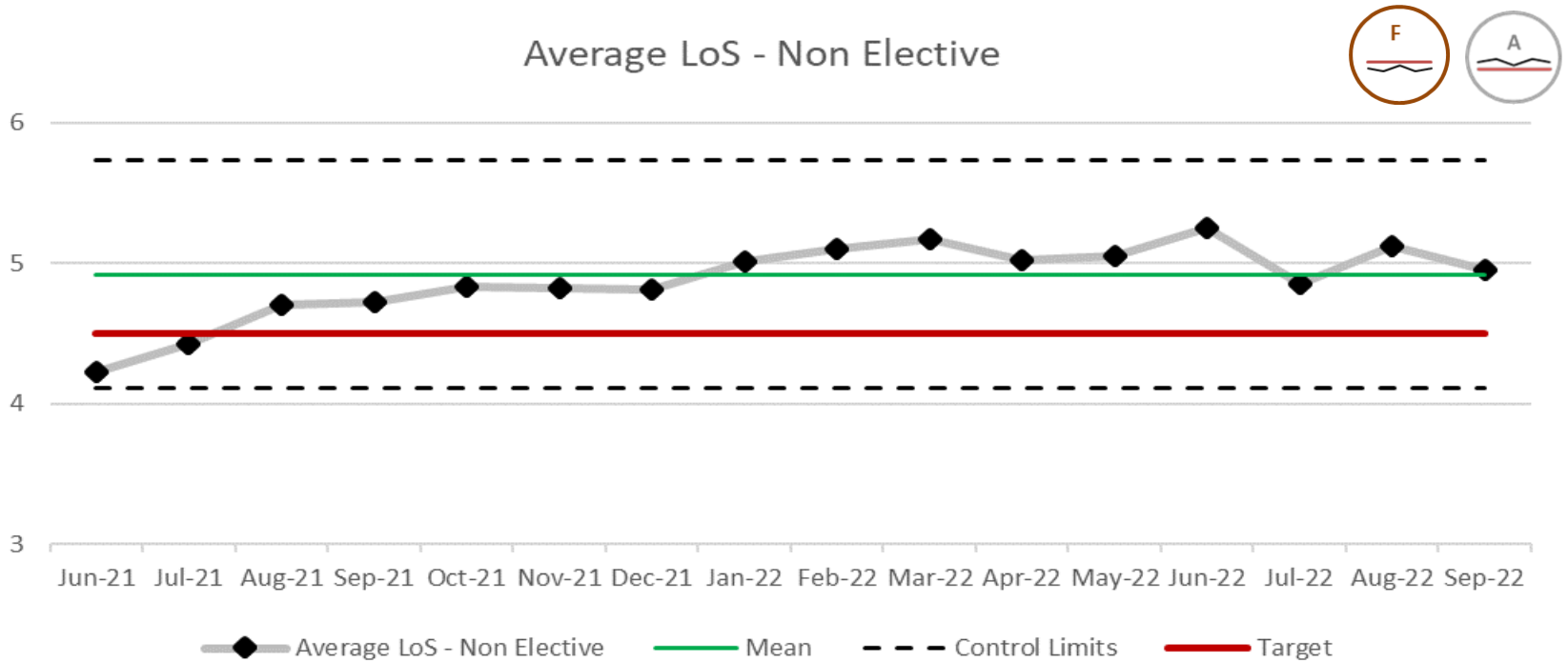
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number of category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

Actions:

All ambulances approaching 30 minutes without a plan to off load is escalated to the Clinical Site Manager and then in hours Tactical Lead to secure a resolution and plans to resolve are feedback to the DOM. Out of hours, the responsibility lies with the Tactical on Call Manager.
Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
The rapid handover protocol has now been revisited and agreed. Designated escalation areas have been identified/confirmed to assist in reducing delays in handover.
August saw an increase in formal requests from EMAS to enact the rapid handover protocol and also the newly endorsed immediate handover protocol.

Mitigations:

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



Sep-22
4.95
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for non-Elective inpatients.

What the chart tells us:

The agreed target is 4.5 days verses the actual of 4.95 days in August vs 5.12 in August.
This is a decrease of 0.17 days
compared with August.
This is a 0.45-day variance against the agreed target.

Issues:

Numbers of stranded and super stranded patients are static in number.
Increasing length of stay of all pathways 1-3. The most significant increase in volume of bed days is Pathway 1 Domiciliary care but since the advent of the joint D2A process and additional funding benefits are being realised but there remains insufficient capacity to meet the increasing demand.
The launch of the Integrated Discharge Hub has gained more traction on moving discharges forward at an improved pace.
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers and reduced medical staffing leading to delays in senior reviews.
Increased number of positive covid cases requiring a longer length of stay and increased 'contact' patients leading to delayed discharges.
Pathway 0 patient discharging remains slow to show improvement even with focused input from ECIST and dedicated System Support.

Actions:

These actions are repetitive but still appropriate
Focused discharge profile through right to reside data.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Use of rapid PCRs to ensure no delay once social care plans are secured.
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.
Line by line review of all pathway 0 patients who do not meeting the reason to reside.
System and regional support to re-embedding SAFER via the appointment of System Discharge and Flow specialists.

Mitigations:

Divisional Bronze Lead continues to support the escalation of exit delays to the relevant Divisions and Clinical Business Units.
Continued reduction in corporate and divisional meetings to allow a more proactive focus on increasing daily discharges. However, this is not sustainable.
A daily site update message is now sent at 6am alerting Key Leaders to ED position, flow and site OPEL position by Site.
The move to working 5 days over the 7 a Day period is in train.
A new rolling programme of MADE has been agreed and the frequency has been agreed as an 8-week rolling programme.

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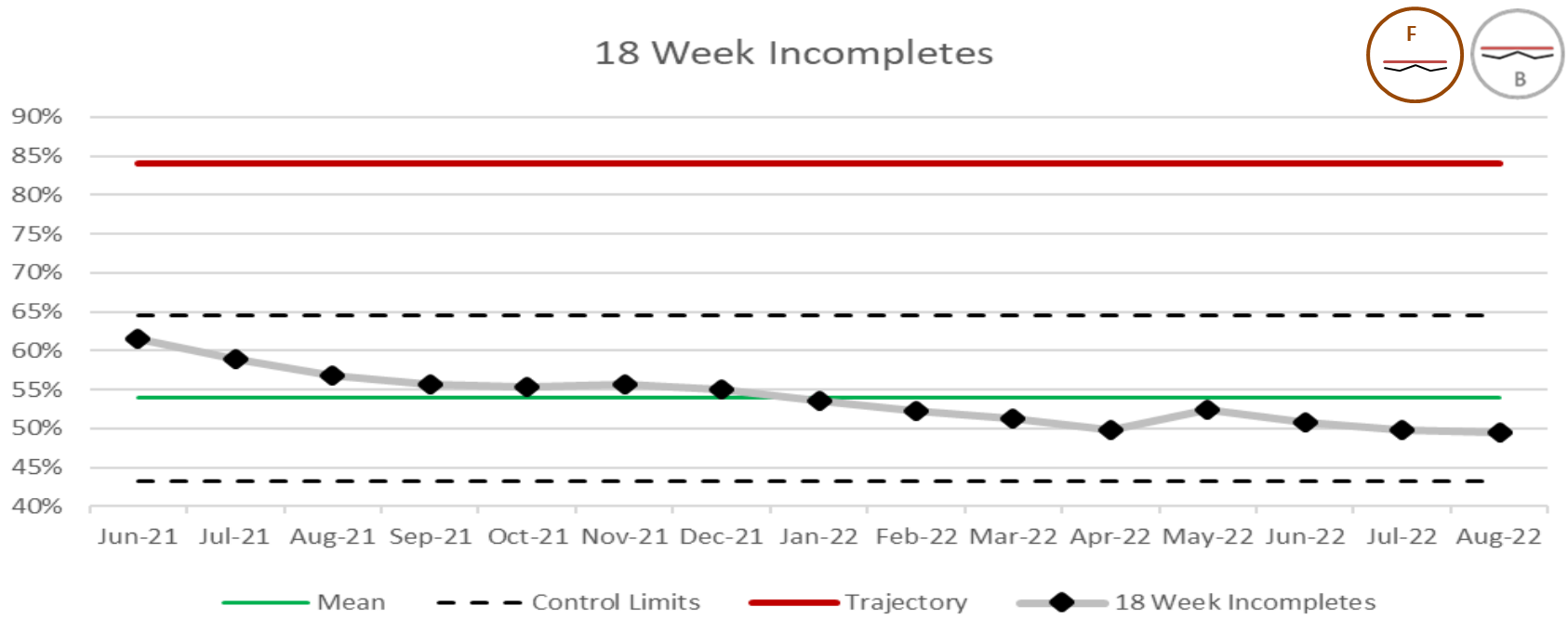

Aug-22
49.50%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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. August saw RTT performance of 49.5% against a 92% target, which is 0.28% down on July.

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 – 6026 (increased by 71)
- Gastroenterology – 4131 (increased by 224)
- Dermatology – 2938 (decreased by 290)
- Gynaecology – 2567 (increased by 68)
- General Surgery – 2410 (increased by 18).

Actions:
Priority remains focussed on clinically urgent and Cancer patients. National focus has now turned to patients that are over 78 weeks with the target to be at zero by March 2023. Resource is now targeted at patients >48 weeks as these have the potential to be >78 weeks in March 2023. Recent schemes to address backlog include;

- Validation programme (October)
- Outpatient utilisation
- Tertiary capacity
- Outsourcing
- Use of ISPs
- Missing Outcomes

Mitigations:
Improvement programmes established to support delivery of actions and maintain focus on recovery.
HVLC/Theatre Productivity – To ensure best use of theatres and compliance with HVLC procedures
ORIG – To ensure Outpatients are fully utilised and efficiency schemes are implemented and well used.
Focus on capturing all activity
Clinical prioritisation – Focusing on clinical priority of patients using theatres.

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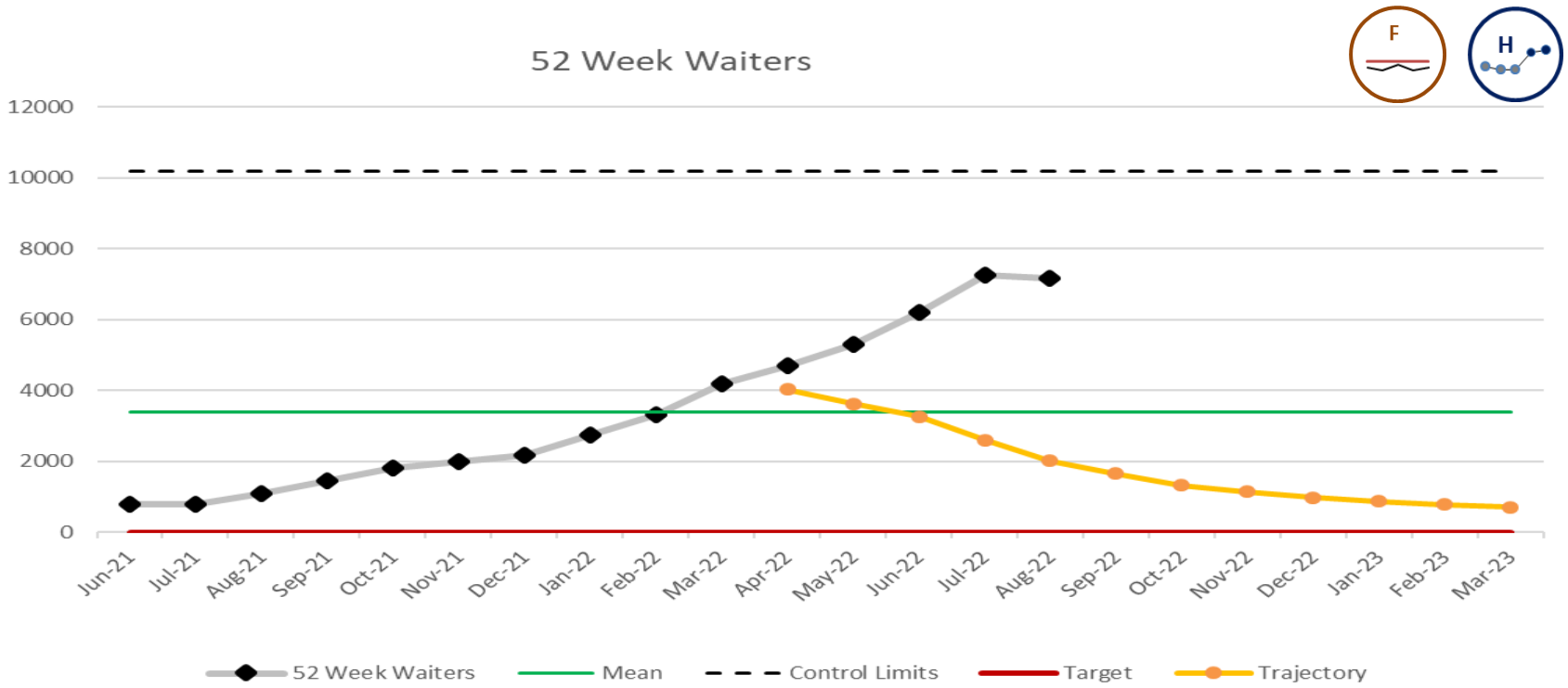


Aug-22
7168
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

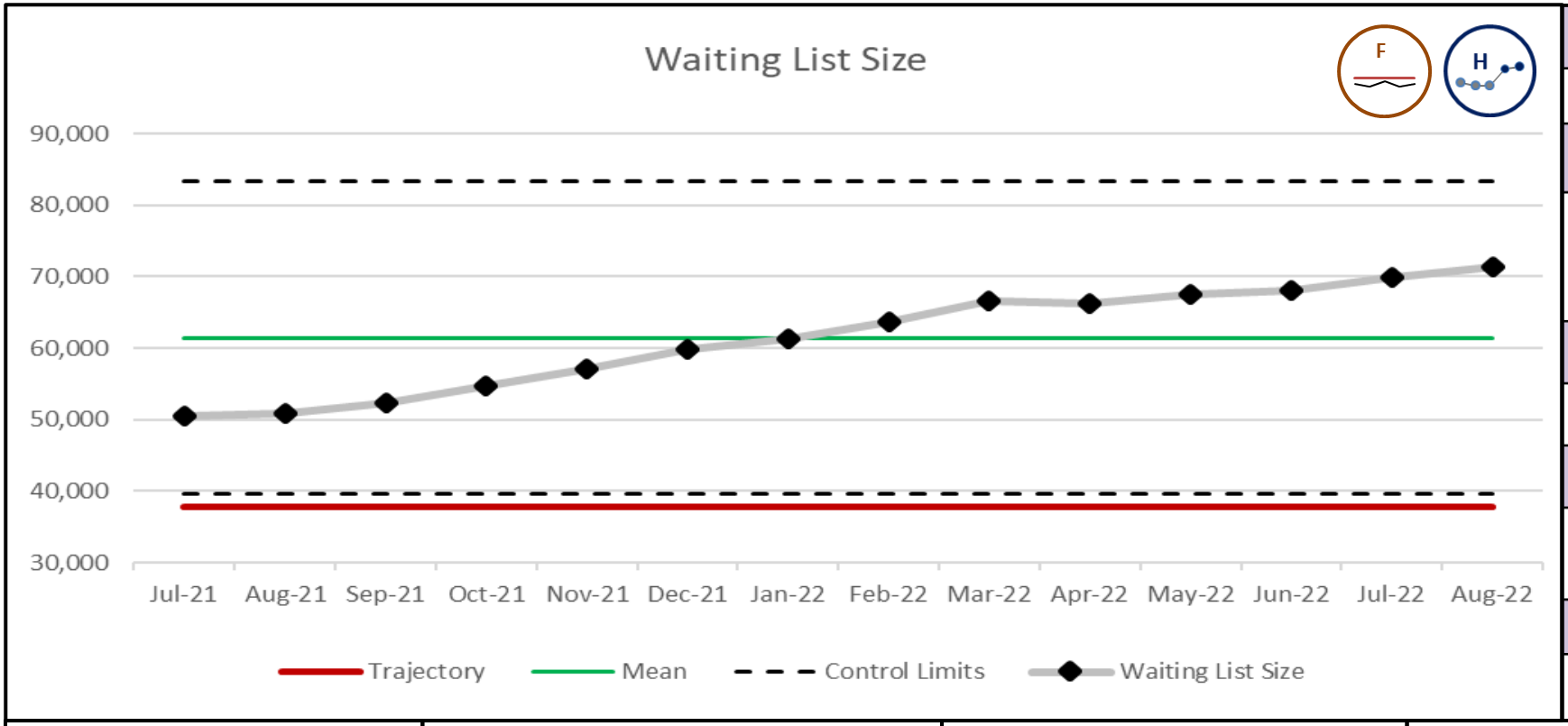
Background:
Number of patients waiting more than 52 weeks for treatment.

What the chart tells us:
The Trust reported 7168 incomplete 52-week breaches for Aug, a decrease of 78 from July.
Whilst significantly over trajectory, this is the first month the number of 52-week breaches has decreased in over a year.

Issues:
Whilst regional position is strong with 78 & 104 week wait patients, performance is less assured regional with 52. Both admitted and non-admitted patients sit within this backlog, however, the most significant pressure sits in the non-admitted pathways.

Actions:
Improvement programmes as described above for RTT performance. In addition, all patients >52 weeks are monitored weekly through ptl with emphasis on longest waiters. Validation programme due to start in October with Technical validation of pathways followed by administrative review by contacting patients to review need for treatment.

Mitigations:
Admitted patients are individually graded and allocated a priority code utilising C2AI. This is then monitored through the clinical prioritisation group.
Theatre productivity and HVLC compliance are worked through by the theatres group to support admitted pathways.
ORIG supports delivery of Outpatient improvements for the non-admitted pathways.



Aug-22
71,271
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 July, with August showing an increase of 1324 to 71,271.
This is more than double the pre-pandemic level reported in January 2020.

Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including; fire, COVID sickness, heatwave and urgent care pressures
The five specialties with the largest waiting lists are;

- ENT – 9001
- Gastro – 5930
- Ophthalmology – 5899
- Dermatology – 5629
- Gynaecology - 5276

Actions
Improvement programmes as described above for RTT performance. In addition, all patients >52 weeks are monitored weekly through ptl with emphasis on longest waiters. Validation programme due to start in October with Technical validation of pathways followed by administrative review by contacting patients to review need for treatment.

Mitigations:
>52 week patients are monitored and discussed at a weekly PTL meeting and also with system partners at a weekly ICB meeting. Transferring of appropriate admitted patients to ISP's continues. Non admitted patients in the most pressured specialities continue to be transferred out with an established process now in Dermatology, ENT and Gastroenterology.

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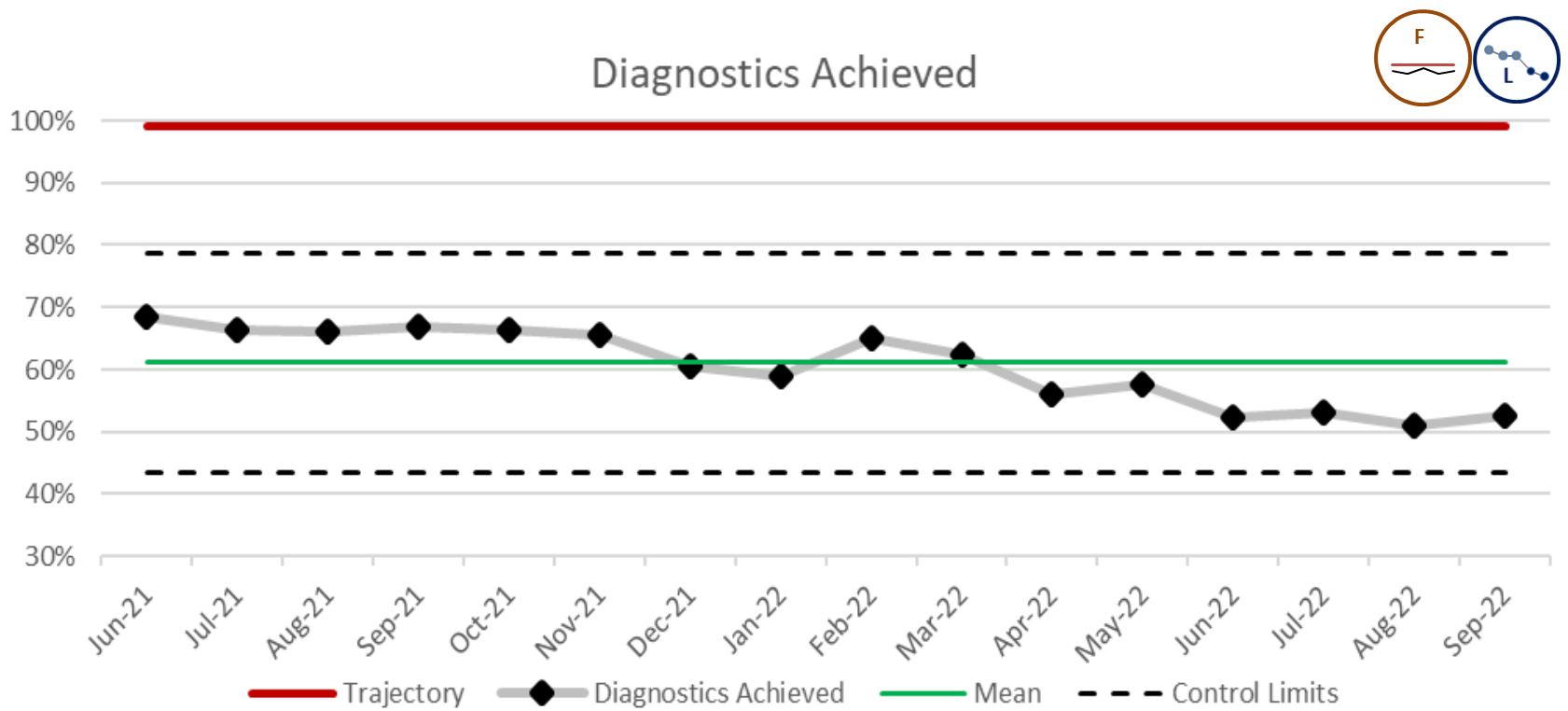


Sep-22
52.46%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

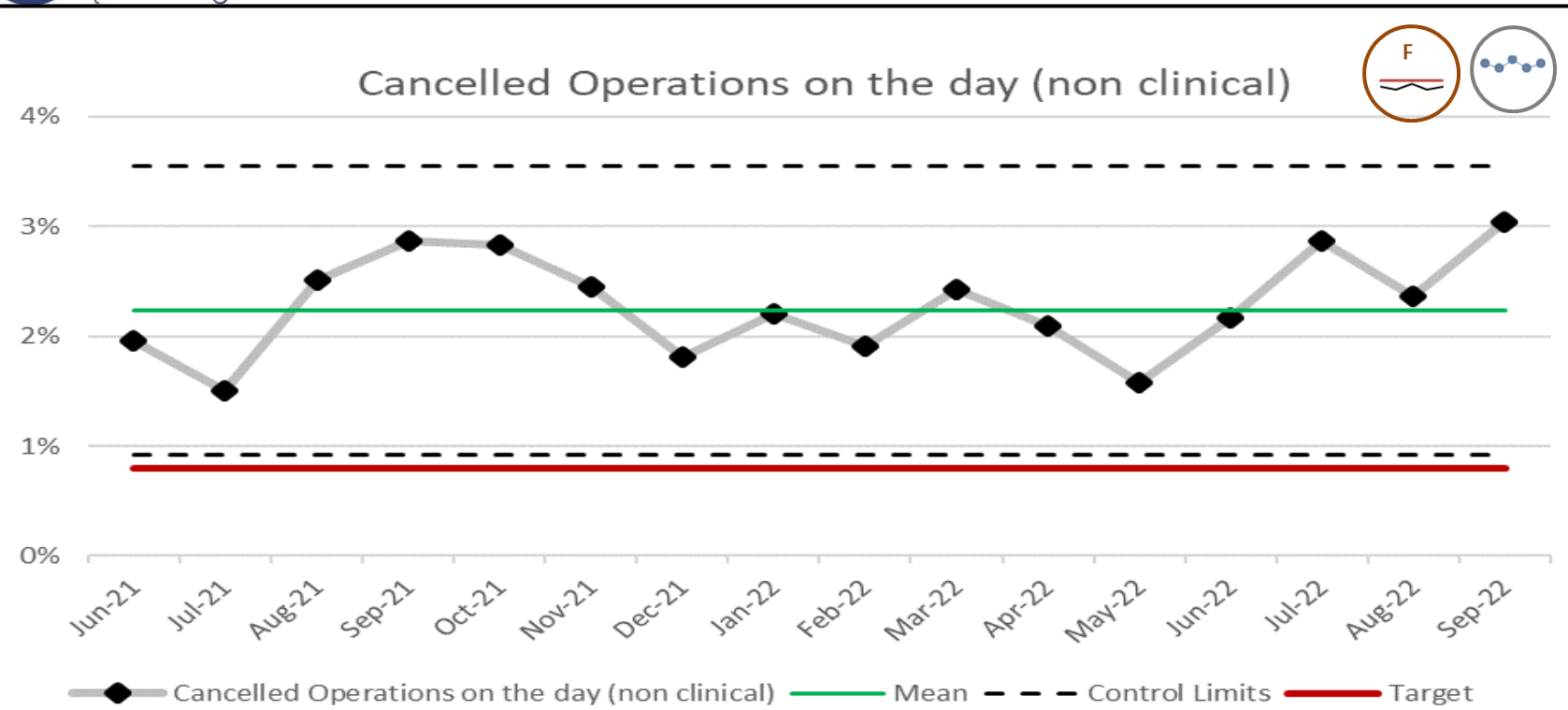
Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 52.46% against the 99.00% target.

Issues:
CT Has a backlog 148 but most of these are cardiac patients. MRI has a lack of capacity due to an 11% year on year growth although there are breaches in US we are seeing a decline in breaches month on month. Cardiac Echoes have a considerable backlog.
Dexa has grown a backlog due to a 50% reduction in capacity due to the fire. We are now seeing a backlog growing In endoscopy due to the recovery In outpatient backlogs Such as colorectal pathway.

Actions:
Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes. Additional US lists are happening. Additional support is being sought from cardiology to reduce the CT cardiacs. A plan for Cardiac echo have an additional 4 locums from June and have reduced slot time to 30 minutes. All areas have completed a recovery trajectory to NHSE.

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



Sep-22
3.05%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us
September shows an increase to 3.05% for patients who have had their operation cancelled on the day of surgery and remains above the agreed trajectory of 0.8%.

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

1. Lack of time
2. No theatre staff
3. Patient DNAd

Actions:
Further information is being gathered with regard the high number of patients cancelled due to lack of time. This information is currently being gathered by the theatre team and will be used to robustly challenge the overrunning of theatre sessions. We are also looking at contacting patients that DNAd.

Mitigations:
An increase in Sickness related absence within our surgical colleagues meant a higher than usual number of on the day cancellations. Some theatre sessions started late due to staff covering sickness.

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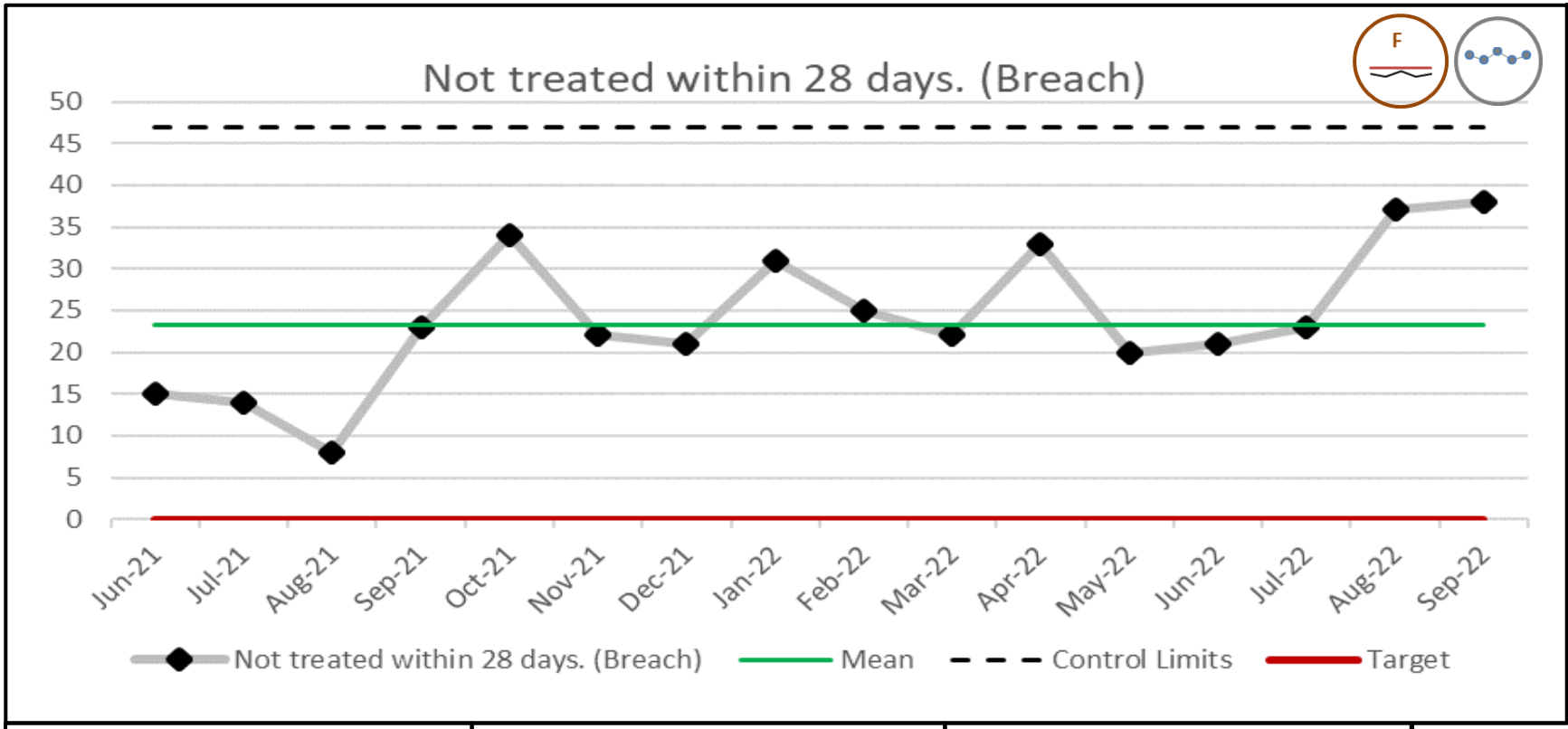

Sep-22
38
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The number of breaches for September is 38, which is an increase of 1 from 37 in August. The agreed target of zero has not been achieved.

Issues:
Availability of lists with surgeons is reported as the main reason for reduced ability to rebook patients within 28 days.

This is further exacerbated by annual leave and reduced number of general anaesthetic slots within certain specialties.

Actions:
The waiting list team within the Surgical Division continue to work alongside the CBUs to reschedule patients who have experienced any on the day non-clinical cancellations.

Mitigations:
Our Consultancy colleagues, Four Eyes, are continuing to support implementation of robust procedures for booking patients as well as an improved 642 process and shared learning.

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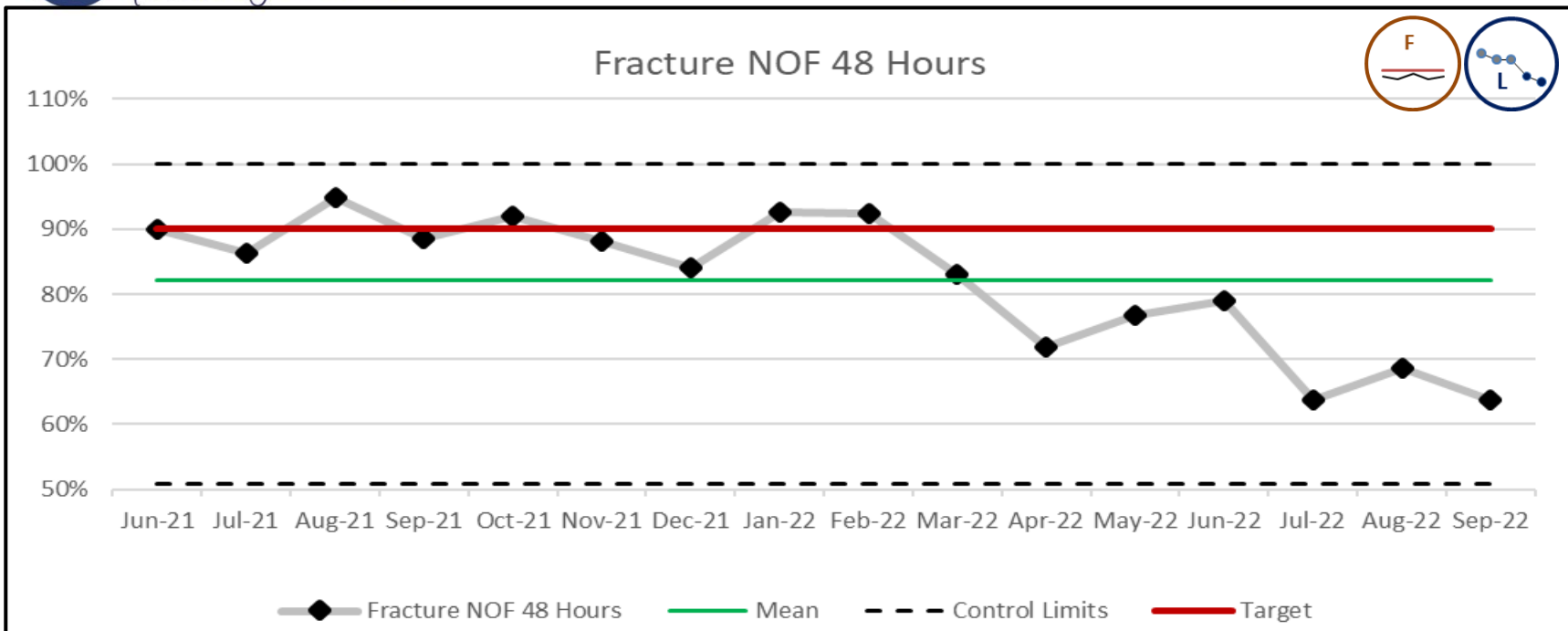

Sept-22
63.64%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of fracture neck of femur patient's time to theatre within 48 hours.

What the chart tells us:

September performance out turned at 63.64 % against the agreed target of 90%.

Both sites underperformed with PHB at 67.74% and LCH 60.00%, which has led to deterioration in performance.

Issues:

Increase in trauma demand over recent months.
High vacancy rate in theatres and anaesthetic sickness has limited capacity for additional theatres.
Due to increase in trauma demand and the types of injuries seen, certain procedures have been clinically prioritised ahead of NOF patients.
Delays for NOF's included reduced theatre capacity, patients medically unfit to proceed and the need for specialist surgeon availability due to complexities.
UTAH hub not in place, which will support quicker turnaround of diagnostic needs for NOF patients. This will also help create ring fenced NOF beds.
Loss of Radiology support for additional lists creating trauma backlogs.
Temporarily occupied the escalation ward at PHB to support increased orthopaedic demand not available from 12th September. No further access to access to 7A due to medicine demand and occupation of the ward.

Actions:

NOF pathway project ongoing to ensure pathway from EMAS response through to patient discharge post-surgery being fully optimised and responsibilities/protocols are clear.
Forward planning of theatre lists required based on historical peaks in activity seen.
'Golden patient' initiative to be fully implemented.
Ensure robust processes in place to utilise Trust wide trauma capacity and beds.
Additional Specialty Trauma lists identified to Theatre to ensure prioritisation of Theatre staffing ensuring minimal cancellations and backlog of trauma.
Additional trauma lists continue to be identified in periods of high trauma with escalation to Surgical MD when staffing proves challenging.
Current involvement with LCHS in Task and Finish Group for improving outcomes, particularly neck of femur length of stay.

Mitigations:

Ensure trauma lists are fully optimised.
Reduce 'on the day' change in order of the trauma list where clinically appropriate.
Daily attendance at the trauma meeting by the clinical business unit to improve communication, visibility of current position and increased support for theatre utilisation and extra capacity needed.
Alternative #NOF pathways created on Digby Ward.
Once daily additional CBU review of trauma and plans to ensure capacity maximised for clinical priority.

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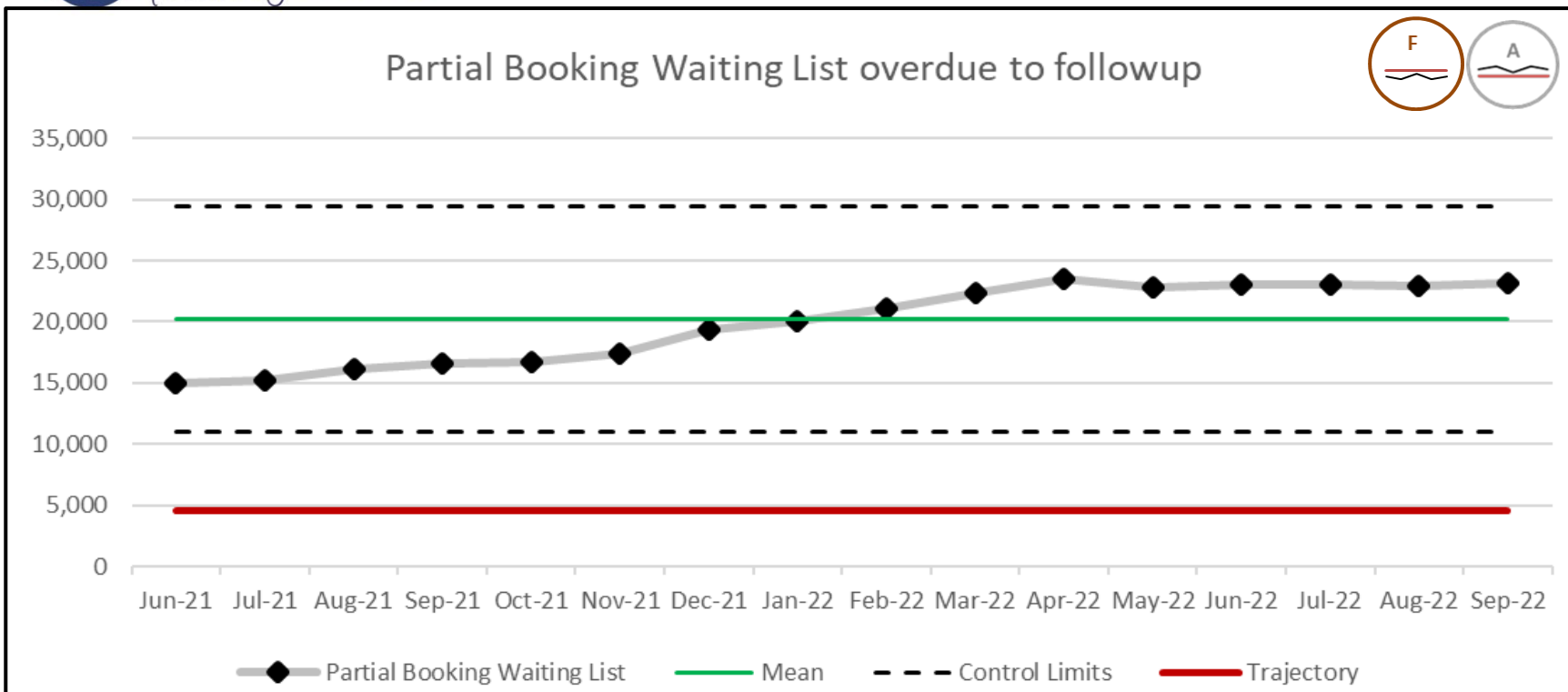

Sep-22
23,128
Variance Type
Metric is currently experiencing Special Cause Variation – Above the trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 23,128 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased and has continuously increased since until April 2022. Since then the PBWL has remained reasonably stable with minimal increases and decreases per month.

Issues:
The organisation is continually pressured in a number of areas especially in urgent / emergency care, requiring patient flow to be prioritised. This has meant ED, ward and theatre cover has taken priority over outpatient cover.

Actions:
Specialities had agreed plans to increase activity for 2022/23 which will improve their PBWL position and reduce patient waits. The specialties have struggled to fully enact the plans. Personalised Outpatient Plan being worked on to maximise validation, clinical triage, technological solutions and PIFU. Arrangements being made for external validators to start reviewing the PBWL patients and prioritisation of patients by the end of October 2022.

Mitigations:
Outpatients support organisational priorities in ED and urgent care taking individual outpatient clinics down, if support required across the sites at short notice.

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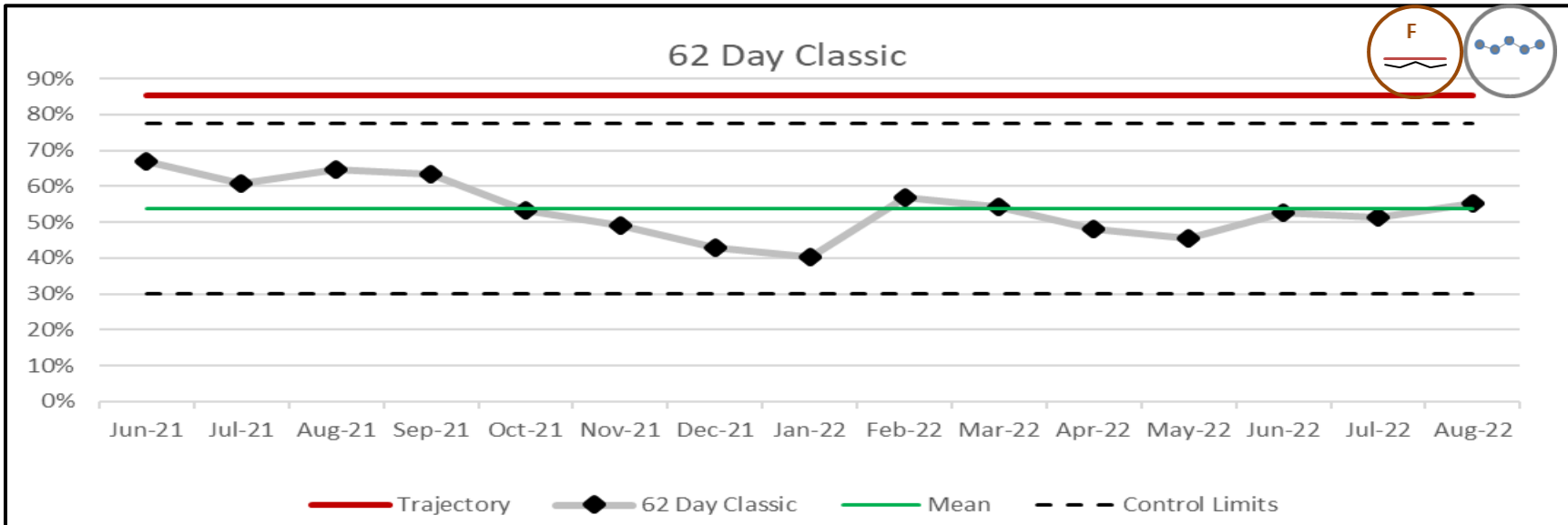


Aug-22
55.07%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 55.07% against an 85.4% target.

Issues:

The impact of ongoing pathway, staffing and capacity challenges.

Patients not willing to travel to where our service and / or capacity is.

Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology and Lung.

Limited theatre capacity continues to impact cancer pathways across the Trust, with all Specialties vying for additional sessions. Anaesthetic assessment and Pre-op capacity is also limited and impacts the ability to be able to populate lists at short notice.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program. Recruitment in Oncology is ongoing, working with HR, Holt and Advanta to secure locums, NHS locum or substantive posts. 2 posts have recently been offered and another vacancy remains. There is a significant lack of consultants nationally and very few available from agency.

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

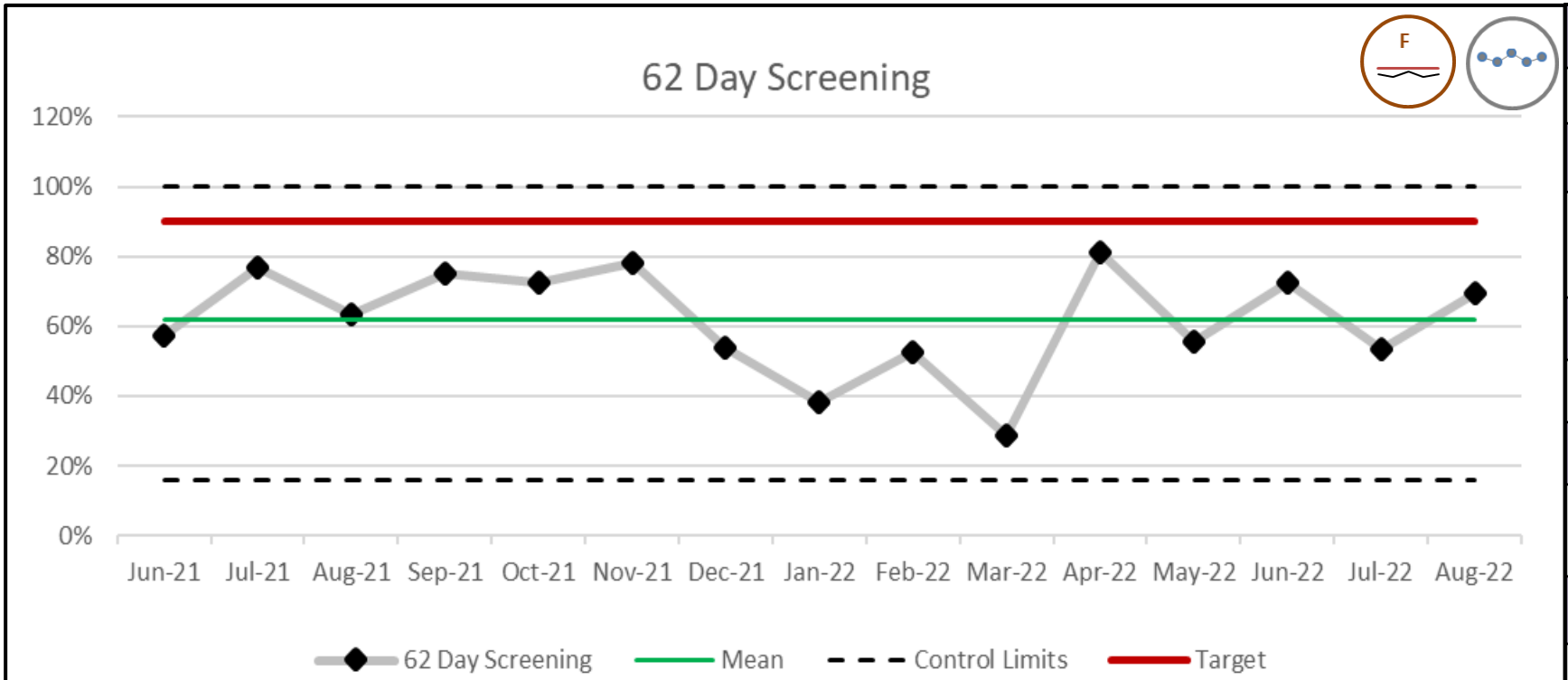
Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists.

Mitigations:

Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at Grantham and will alleviate capacity issues once up and running.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-22
69.57%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

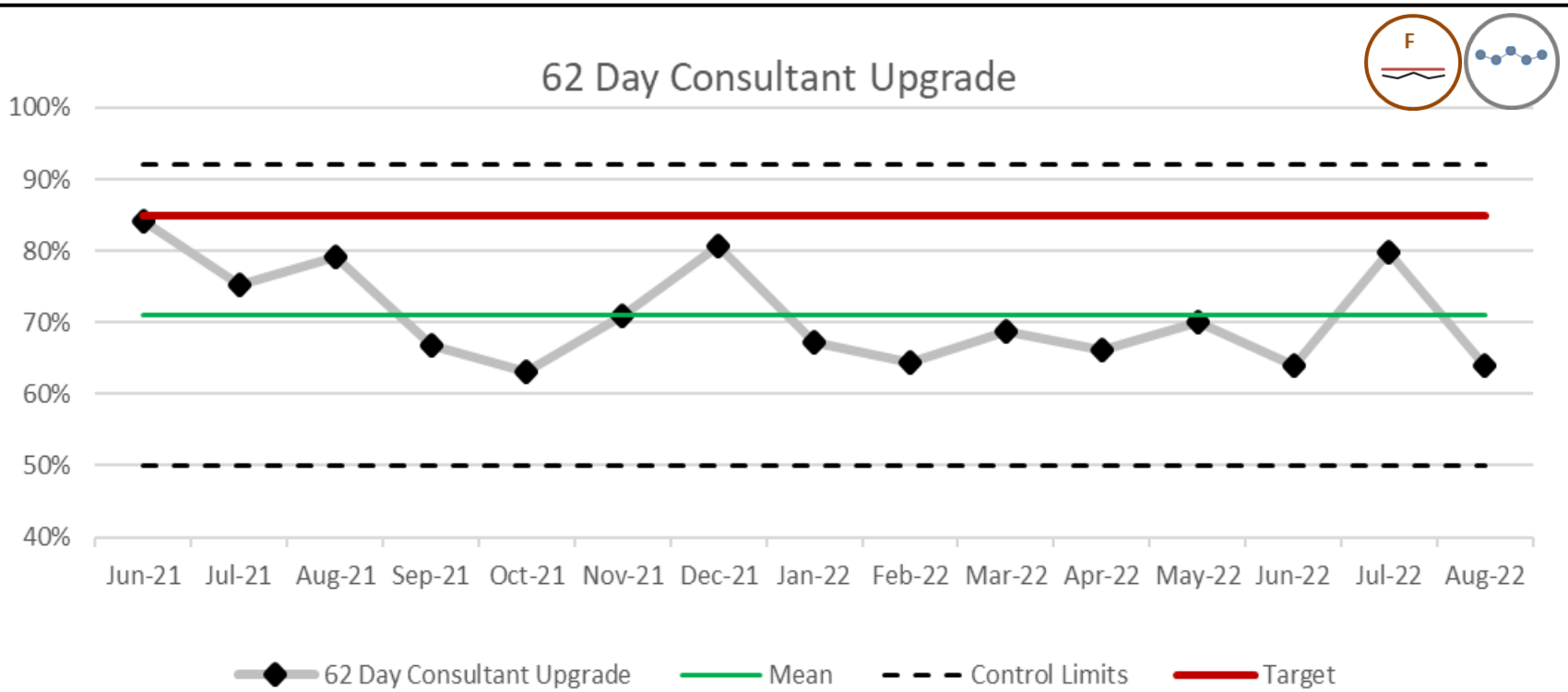
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 69.57% against a 90% target.

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

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

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



Aug-22
64.00%
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 64.0% against an 85% target.

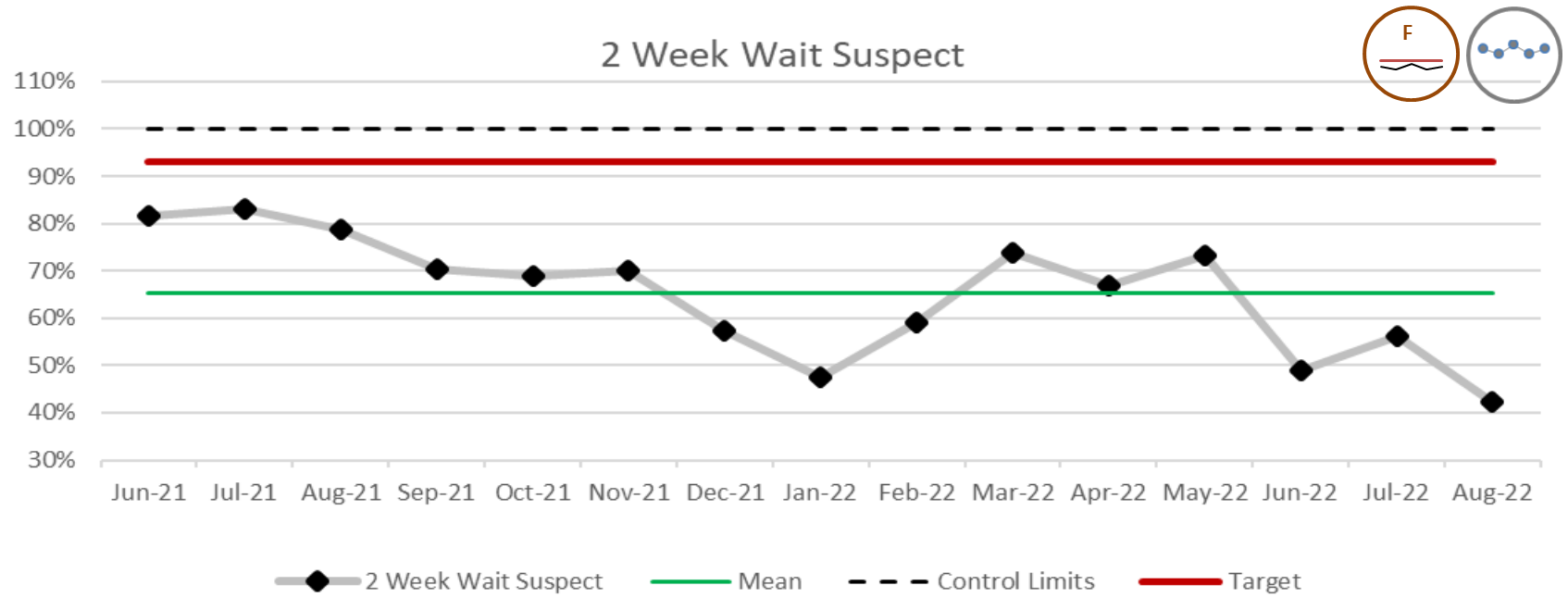
Issues:
See issues on previous page – 62 day classic.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-22
42.30%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 42.30% against a 93% target.

Issues:

The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with 18% of the Trust's 14 Day breaches within that tumour site. Of greater concern in August was colorectal performance which accounted for 42% of the Trust's 14 day breaches.
Patients not willing to travel to where our service and/or capacity is available.
Nurse Triage / CNP capacity issues in colorectal specialty.

Actions:

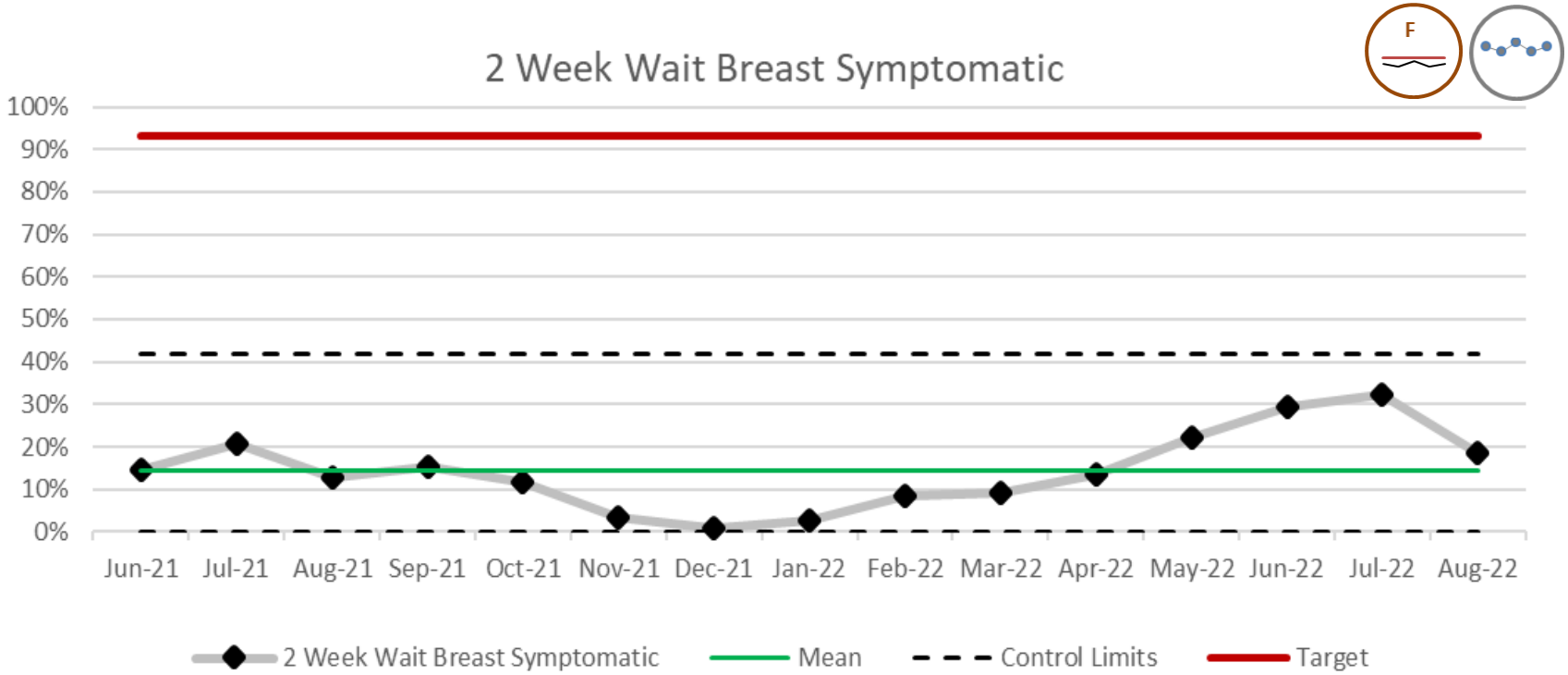
The Trust is actively seeking to implement RDC pathways for brain, haematuria and Upper GI at the earliest opportunity. A pathway review for gynaecology and a direct access ultrasound pathway has also been identified as a priority.
3 Respiratory consultant posts have been recruited to across LCH and PHB with start dates TBC. There will still be 2 posts remaining vacant. An ongoing BC for increase in consultant workforce to 10-15 consultants is in place.
A Gynae review of specialist nurse workforce, referral redesign work and oncology strategy follow up meeting is to be scheduled following the successful initial meeting in the summer.
For colorectal, recruitment to nursing posts is underway and additional clinics are being sourced where possible. Short and long term measures are being put in place to address the volume of referral and 1st OPA backlog.
These and other key action progress are tracked through the Urgent Care Cancer group chaired by the Medical Director and run with full system partner involvement.

Mitigations:

Radiology now supporting with normal CT Triage. Work is ongoing to move Spirometry into Community Diagnostic Centres.

Additional weekend Urology clinics continue to be set up to resolve capacity issues. Work is being undertaken with Endoscopy to increase capacity across sites and ensure efficient utilisation of current clinic capacity. Plans in place to improve STT capacity by the end of the calendar year. Recruitment for CBU booking clerks is underway.

Increasing numbers of skin referrals have continued – additional weekend clinics in place to mitigate. Case of Need in place to increase waiting room capacity at PHB.



Aug-22
18.52%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 18.52% against a 93% target.

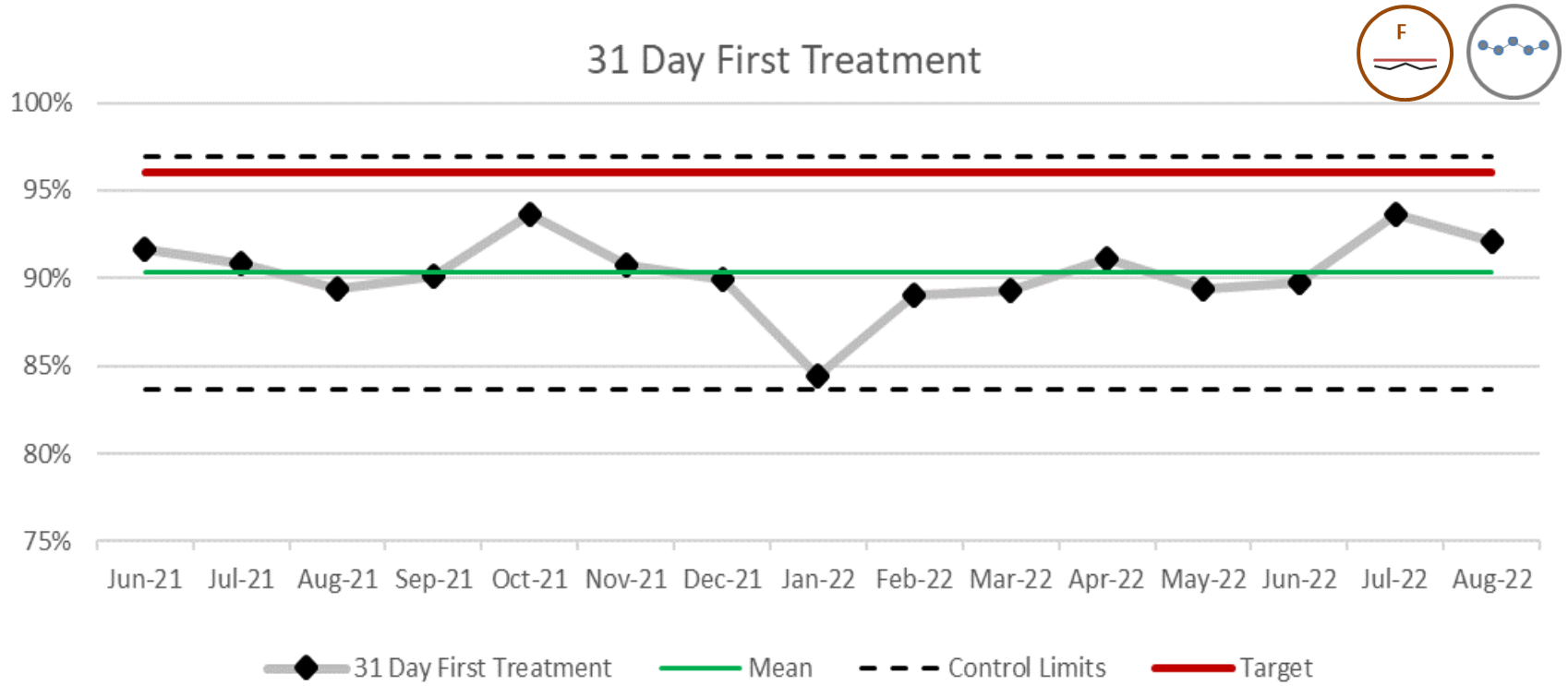
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

Actions:
A comprehensive review of Breast Services and consultant workload is ongoing.

Mitigations:
A mastalgia pathway is now up and running with primary care and system partners which has the potential to reduce inbound referrals by circa 15%.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-22
92.12%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

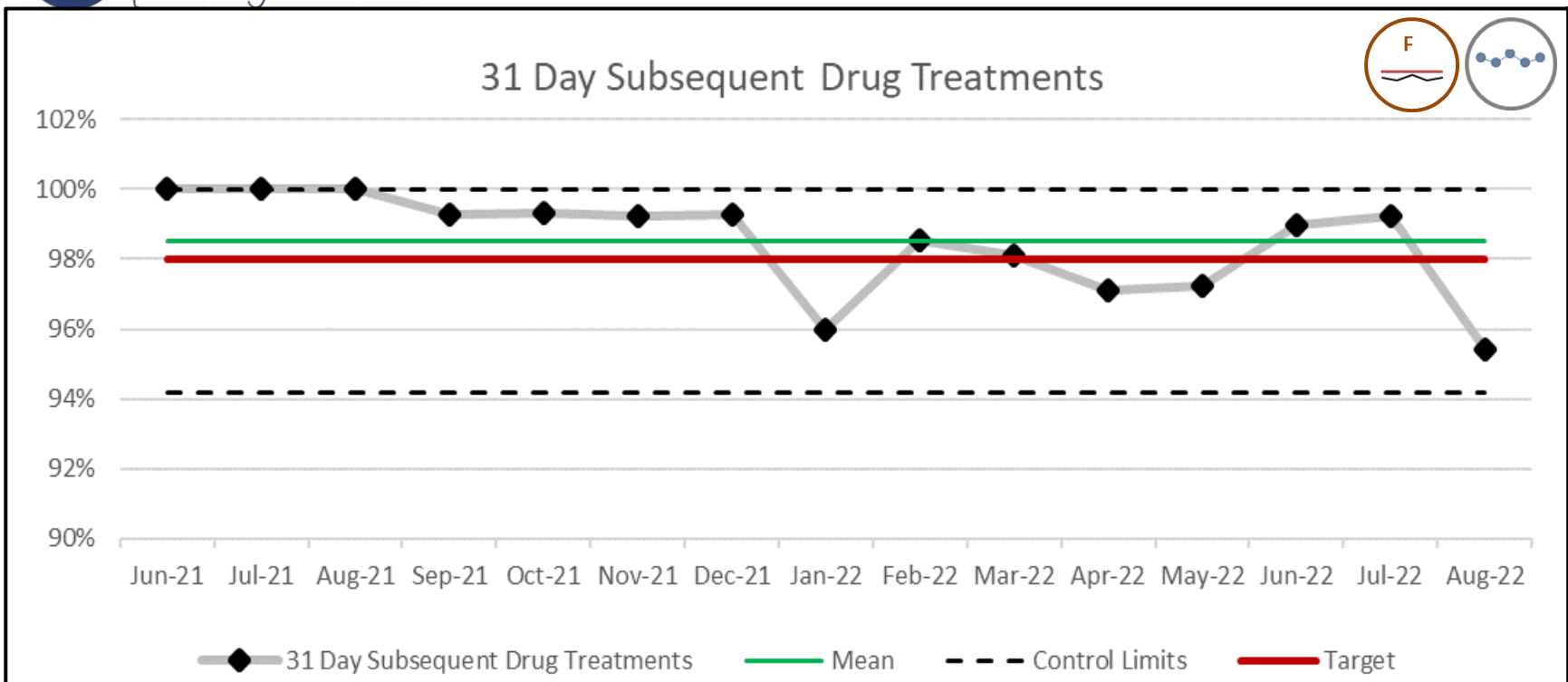
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 92.12% against a 96% target.

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

Actions:
Recruitment in Oncology is ongoing, working with HR, Holt and Advanta to secure locums, NHS locum or substantive posts. 2 posts have recently been offered and another vacancy remains.
Work has commenced on building the new theatres at Grantham.
For Colorectal, a Deep Dive and pathway analysis is underway, supported by CCG colleagues. The subsequent work streams emerging from this are ongoing.

Mitigations:
Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists.



Aug-22
95.41%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

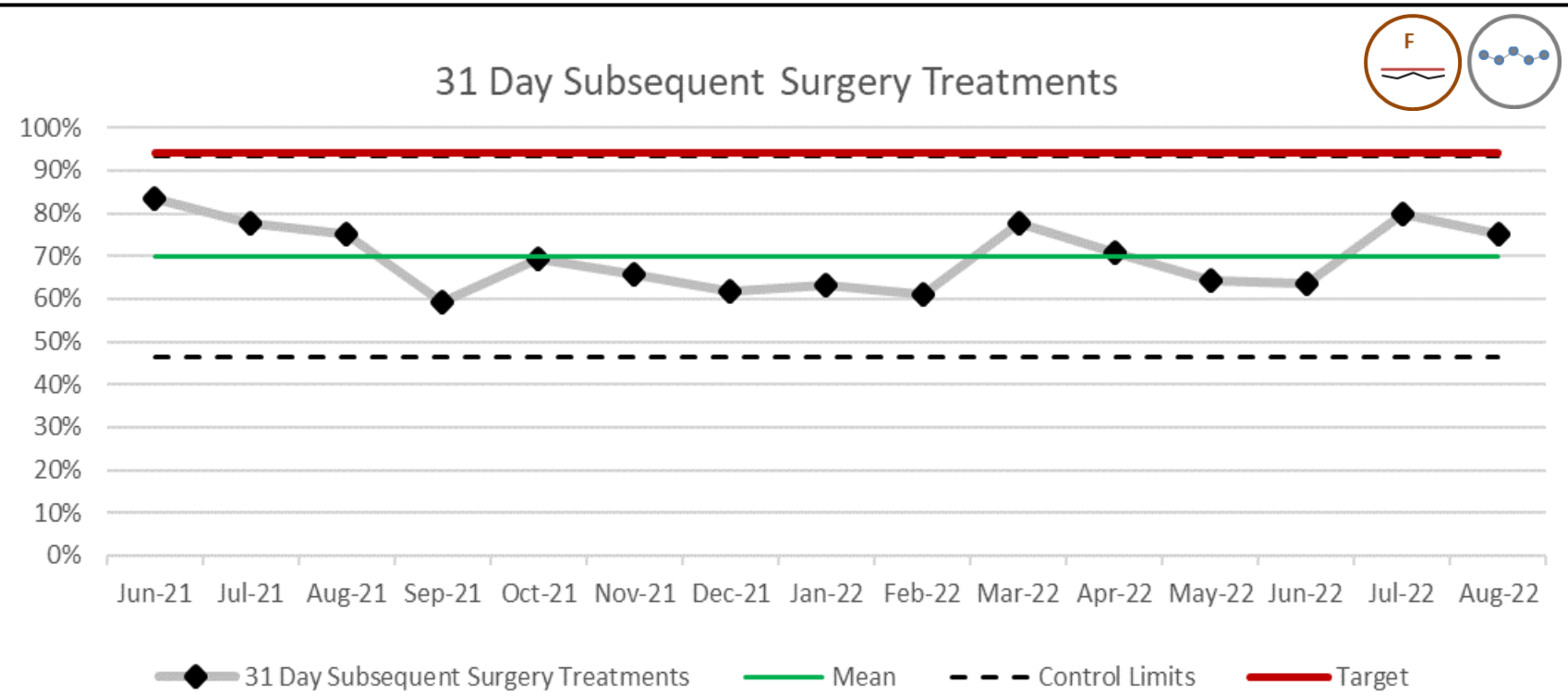
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was drugs.

What the chart tells us:
We are currently at 95.41% against a 98% target.

Issues:
The inability to deliver the 31 Day standards was primarily attributed to the reduction in theatre capacity.
In August, for the subsequent standards the Trust was successful in the Radiotherapy, narrowly missed the Drug standard, and failed in the Surgery standard.

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

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



Aug-22
75.00%
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 75% against a 94% target.

Issues:
The inability to deliver the 31 Day standards was primarily attributed to the reduction in theatre capacity.
In August, for the subsequent standards the Trust was successful in the Radiotherapy, narrowly missed the Drug standard, and failed in the Surgery standard.

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

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

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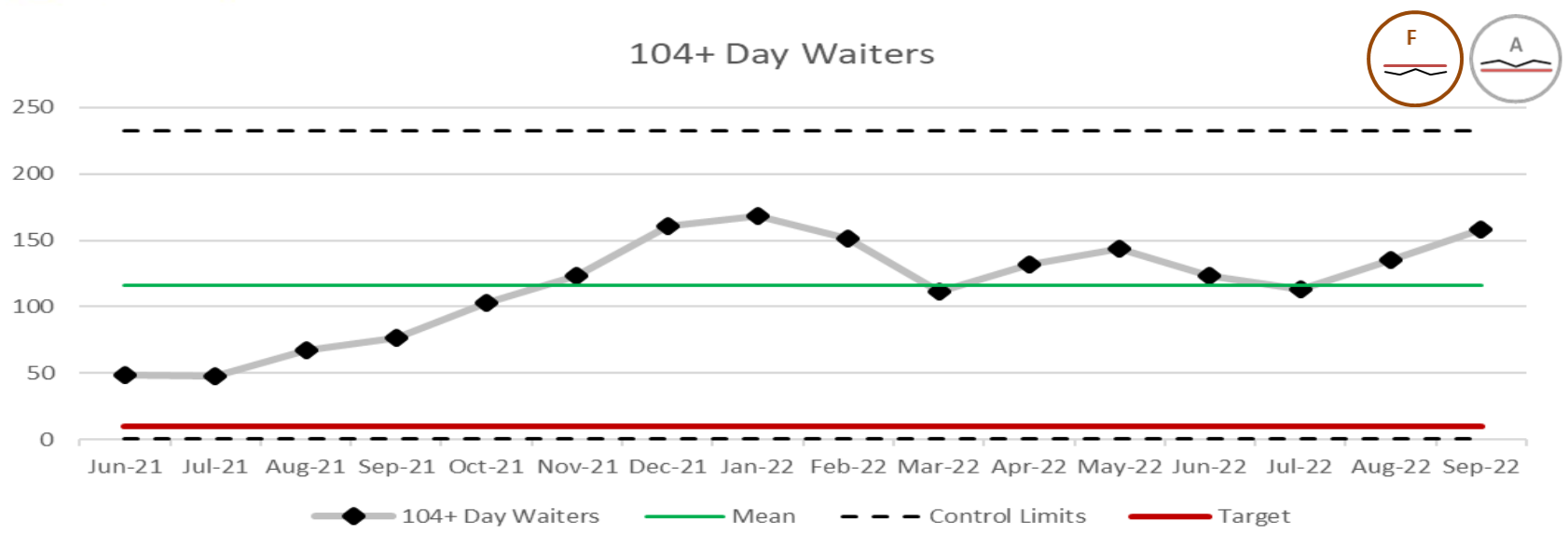
NHS United Lincolnshire Hospitals NHS Trust



Sep-22
158
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 13th October the 104 Day backlog is at 158 patients. The agreed target is <10.

There are four tumour sites of concern
Colorectal 110 (majority awaiting diagnostics, outpatients and clinical review)
Urology 12
Lung 12
Upper GI 11

Issues:

The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced theatre capacity across the Trust, all Specialties vying for additional sessions.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Gynaecology, Head And Neck and Lung.
Approximately 16% 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.
Recruitment in Oncology is ongoing, working with HR, Holt and Advanta to secure locums, NHS locum or substantive posts. 2 posts have recently been offered and another vacancy remains.
For Colorectal, a Deep Dive and pathway analysis is underway, supported by ICB and EMCA colleagues. The Deep Dive's subsequent work streams are ongoing.

Mitigations:

Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity.
Tumour site specialties are working with TACC to ensure the best possible utilisation of lists.
A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-22	Aug-22	Sep-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	89.72%	89.86%	89.62%	89.75%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	11.35%	10.73%	10.02%	10.84%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.28%	5.29%	5.32%	5.27%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	15.06%	15.09%	14.82%	14.84%		F	A	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	60.30%	60.76%	60.46%	58.72%		F		

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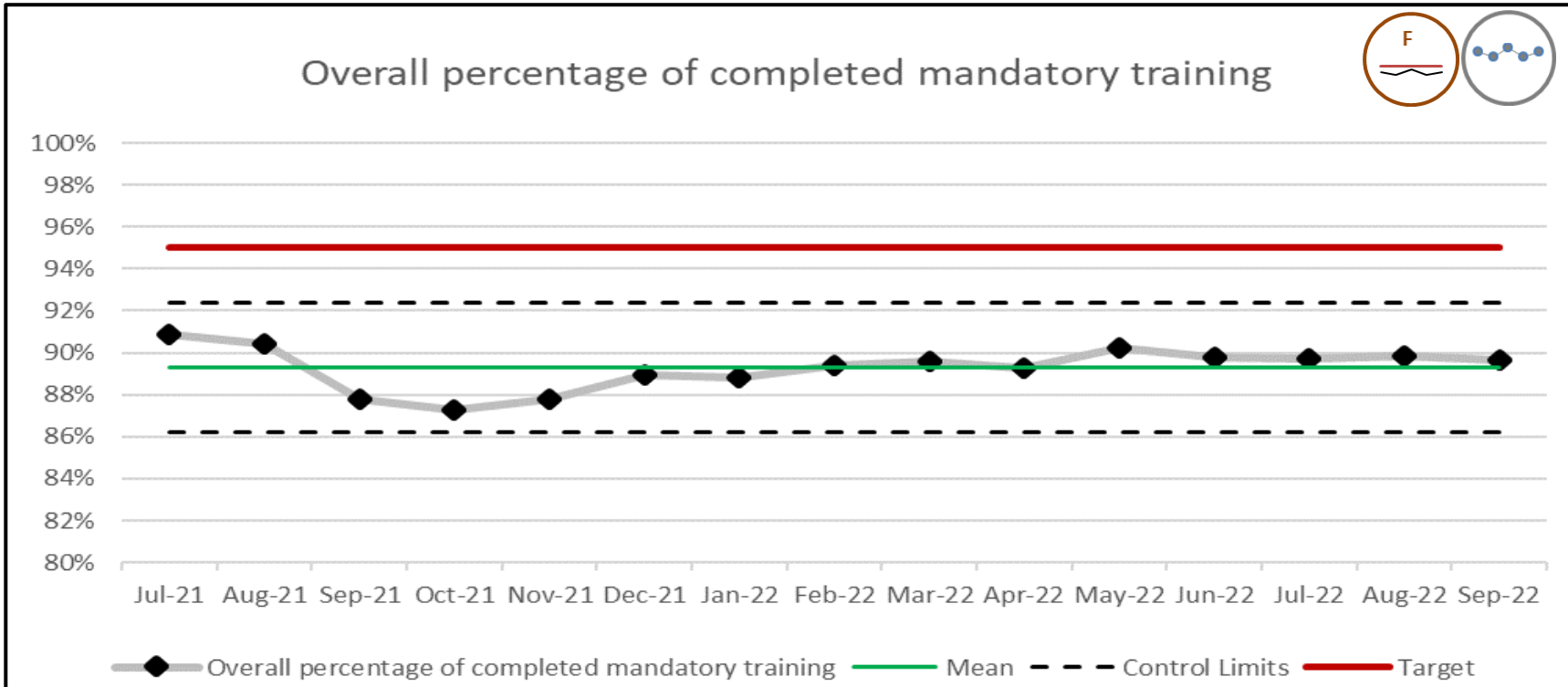

Sep-22
89.62%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Mandatory training remains stable over the past month with very slight decrease

Issues:
- Protected time for learning continues to be a challenge for staff – especially front line staff.
- Anecdotal feedback reports lack of time to access core learning while on shift and difficulties to access from home devices.
- Issues of recording of learning by ESR cited as having an impact on rates
- Core learning suite too large and under review.

Actions:
- The lack of a central learning and development team has been added on the risk register. The pending restructure will see a new Education team established.
- Discussion around protected time for training has not progressed.
- SHRBP's continue to work with their Areas and support compliance.
- Work continues with regards to single contract Bank staff and mandatory training/payment for training.

Mitigations:
Issues of access and recording of learning to be addressed by digital team.

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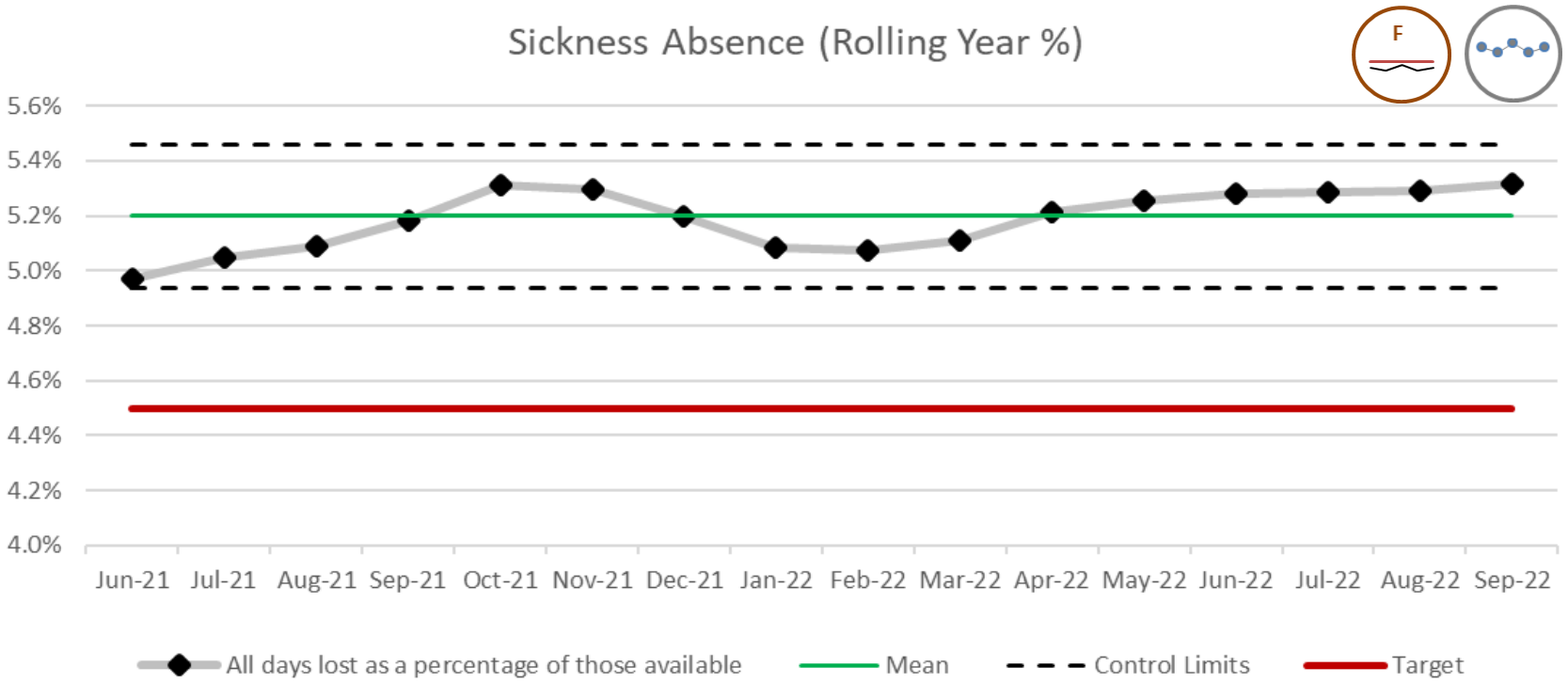

Sep-22
5.32%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The rate has increased by 0.03% to 5.32% which is still above the target of 4.5%.

Issues:

- We are currently seeing a slight increase in the number of Covid absences. This continues to be monitored daily.
- Stress & Anxiety remains the top reason for absence, followed by other MSK problems.

Actions:

- Extensive work is continuing to get full engagement of using AMS Trust wide with all senior management training now having been completed. The AMS Refresher training sessions continue to be run across all Divisions to be completed by the 31st December 2022.
- A new Interim HR Advisor has been appointed to concentrate solely on absence management across the organisation to provide the assurance that all absence is being managed as per policy. This piece of work will support the full data cleanse and forward movement of all absence management.

Mitigations:
Please note that by gaining full engagement in the use of AMS, we will see an increase in the absence rate before we see an improvement due to accurate, full reporting.

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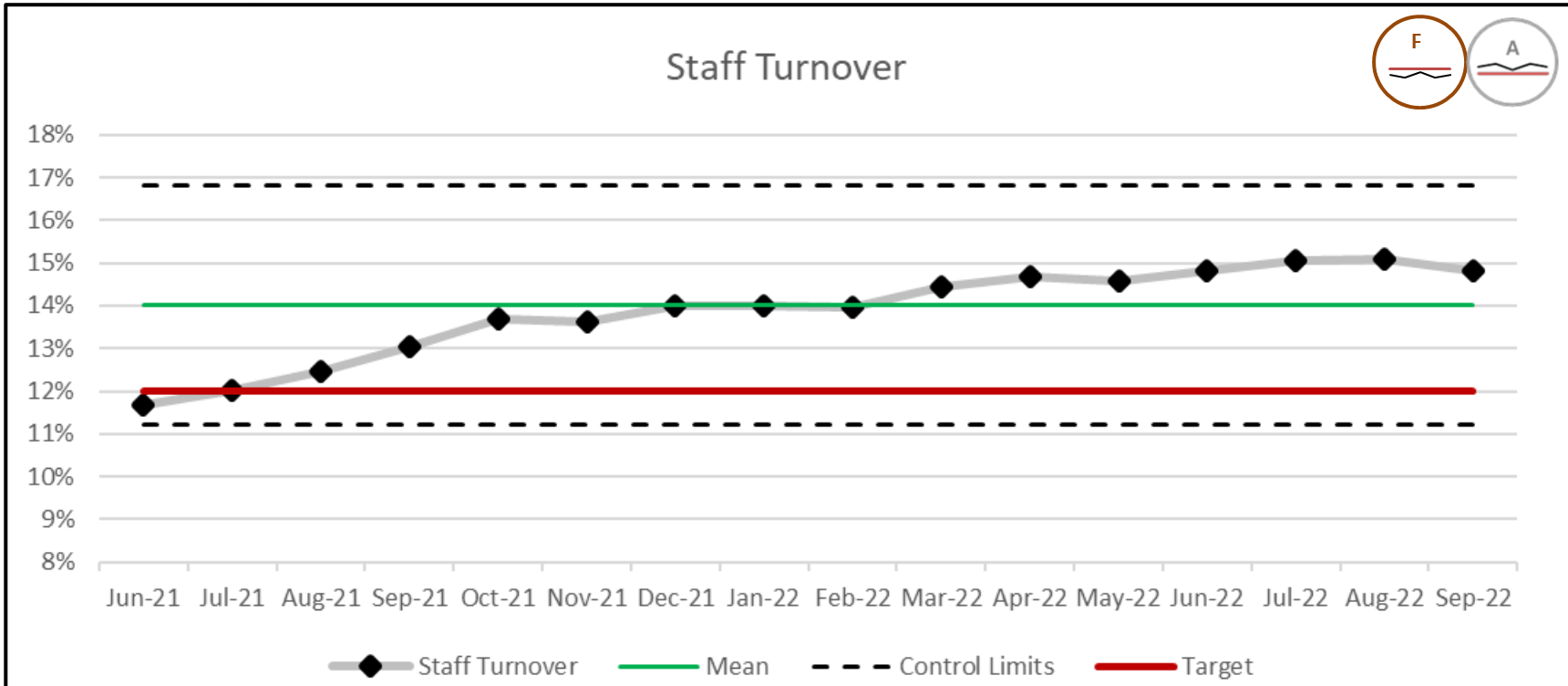
NHS United Lincolnshire Hospitals NHS Trust



Sep-22
14.82%
Variance Type
Metric is currently experiencing Special Cause Variation – above the trend
Target
12%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

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

What the chart tells us:
Turnover rates have stabilised over the past 3 months but still higher than expected as per other partners in the system and Trusts regionally.

Issues:
Recent Analysis of exit survey data shows reasons as follows

- 20% retirement age
- 16% lack of work life balance
- 13.5% relocation
- 10% lack of development opportunities
- 7% incompatible work relationships
- 6.5% promotion
- 5% ill health

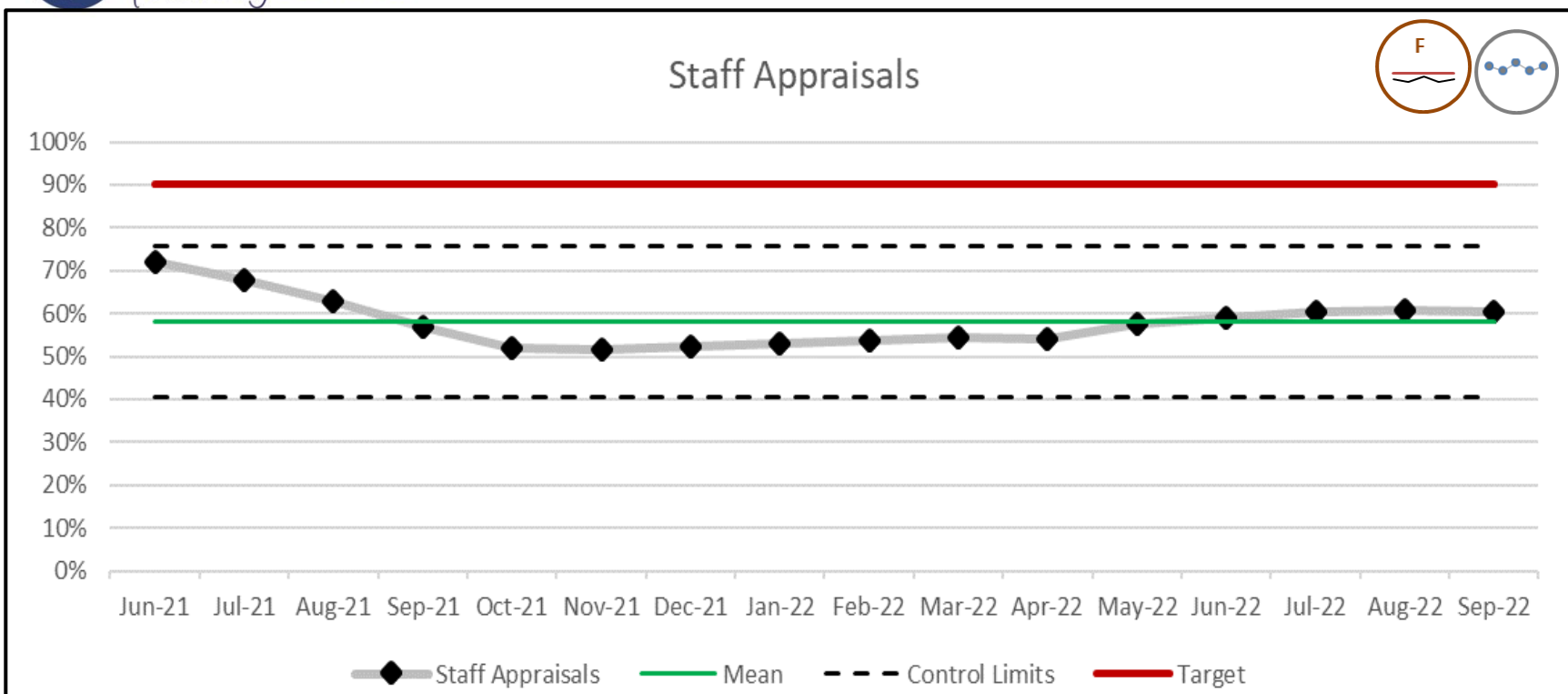
Actions:

- A Culture and leadership ambassador recruitment programme started October 22
- A People Promise Manager dedicated to ULHT
- Leadership and management training programmes specific to divisions started in July 22

Mitigations:
See actions

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-22
60.46%
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 60.46%.

What the chart tells us:
Operational pressures and staffing challenges continue to impact appraisal completion rates. The completion rate slightly decreased in September 22.

Issues:

- Operational pressures are causing an impact on completion.
- Appraisal discussions stood down in previous months still felt in September 22 due to back log
- Staffing issues and increased turnover impact availability of staff to attend appraisals with manager working clinically.

Actions:

- Appraisal completion to be focussed through the divisions regardless of operational pressures Od and HRBPs to continue to prioritise message to divisions
- Appraisal clinics offered by OD to all who require support. Specific focus for Estates and Facilities, Medicine and Surgery to bring rates up since May 2022.
- Dedicated appraisal page with resources to support Managers in place end of July 22.
- Appraisal Training available since September 22

Mitigations:
See actions

Financial Position Month 06 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

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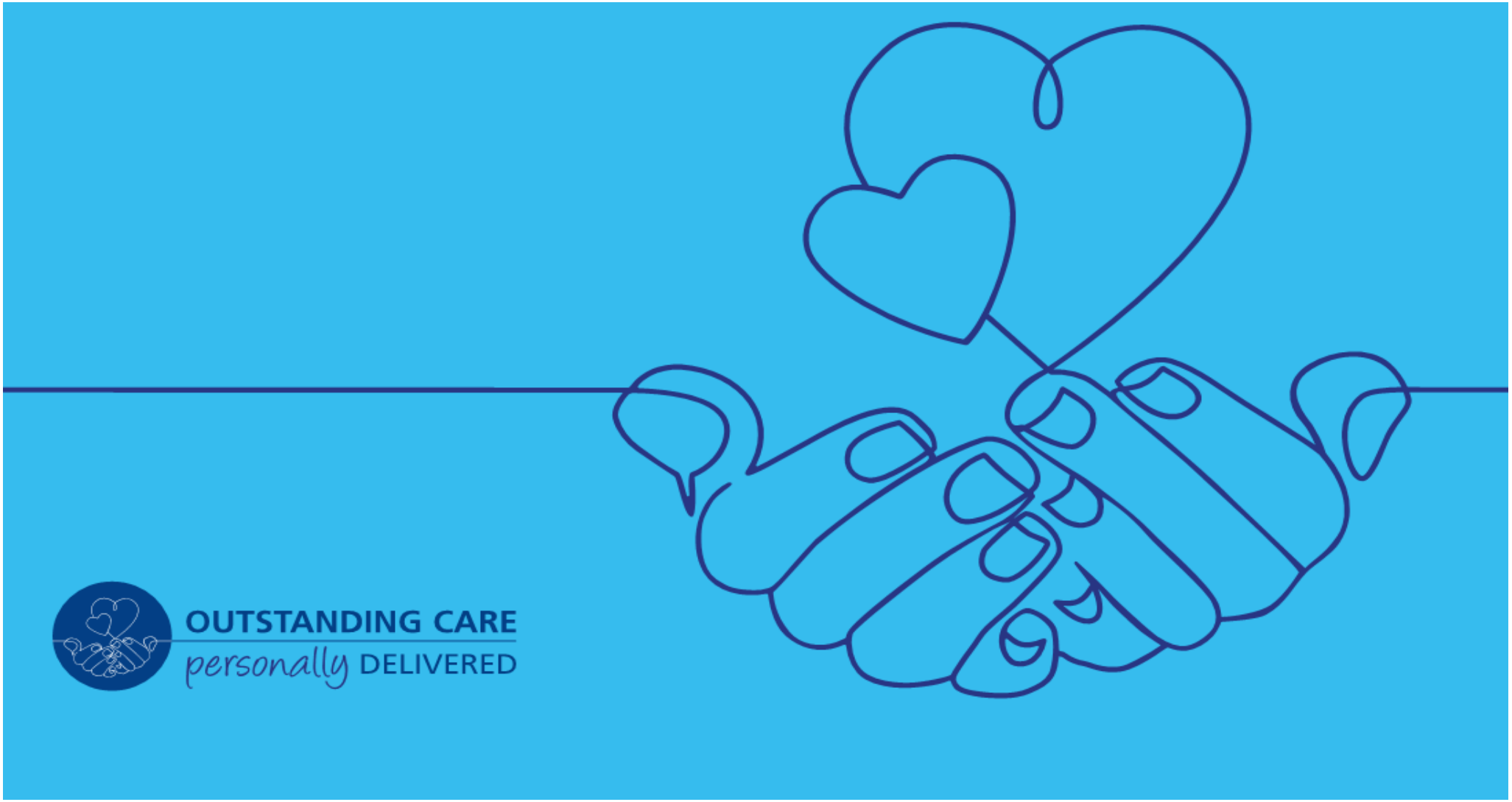
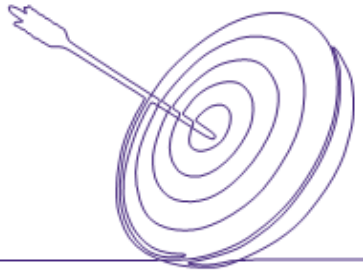


Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)



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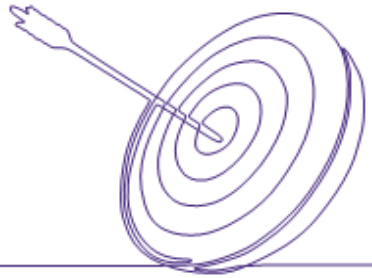
	Current Month			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	52,456	58,069	5,613	314,835	322,795	7,960
Other operating income	3,043	3,801	758	18,036	21,113	3,077
Employee expenses	(35,835)	(44,302)	(8,467)	(216,941)	(237,681)	(20,740)
Operating expenses excluding employee expenses	(19,080)	(19,398)	(318)	(112,517)	(114,403)	(1,886)
Operating Surplus / (Deficit)	**584**	**(1,830)**	**(2,414)**	**3,413**	**(8,176)**	**(11,589)**
Net Finance Costs	(641)	(386)	255	(3,811)	(3,440)	371
Other gains/(losses) including disposal of assets	0	10	10	0	126	126
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(57)**	**(2,206)**	**(2,149)**	**(398)**	**(11,490)**	**(11,092)**
Remove capital donations/grants/peppercorn lease I&E impact	57	52	(5)	398	317	(81)
Adjusted financial performance surplus/(deficit)	**0**	**(2,154)**	**(2,154)**	**0**	**(11,173)**	**(11,173)**
Less gains on disposal of assets	0	(12)	(12)	0	(141)	(141)
Adjusted financial performance surplus/(deficit) for system achievement	**0**	**(2,166)**	**(2,166)**	**0**	**(11,314)**	**(11,314)**

- The above table shows that the Trust delivered an adjusted deficit of £2.2m in September (£2.2m adverse to plan) and YTD has delivered an adjusted deficit of £11.2m (£11.2m adverse to plan).
- The September position includes the impact of the higher than planned national pay awards and the additional funding received in relation to this.
- After removing gains from disposals of £0.1m, the Trust YTD has delivered a deficit of £11.3m in relation to system achievement.
- Actual CIP savings of £6.8m have been delivered YTD, such that YTD delivery is £4.7m (40.8%) adverse to planned savings of £11.4m.

Finance Spotlight Report
(Key areas of focus - Income)



United Lincolnshire Hospitals NHS Trust

The Income position is £11.0m favourable YTD to plan; this includes:

- **NHS Patient Care income contract - favourable variance of £7.9m**; this includes £4.9m pay award funding, over performance of £1.2m re Variable Drugs (Lincs and NHSE) for which there will be an offset in Non Pay, £1.1m of NHS England prior year income for the true-up, and £0.6m mutual aid income for working being undertaken for Leicestershire ICB in T&O.

- **NHS Patient Care - additional potential investment**: Bids have been submitted to NHSE Specialised for c£2m additional non-recurrent funding schemes to be spent by 31st March. These are currently with NHSE for review.

- **Radiology fire - favourable variance of £1.6m**; the financial plan did not include the I&E impact of the Radiology fire; this variance offsets an adverse variance of £1.6m in expenditure (mainly in Non Pay in relation to hire of clinical equipment).

- **Non-Patient Care services - £0.5m favourable to plan.**

- **Education & Training - favourable variance of £0.3m** (including notional income re the apprenticeship levy); this variance offsets an adverse variance of £0.3m in Non Pay.

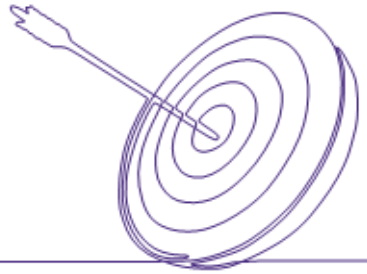
- **Bad debt provisions - favourable variance of £0.2m**; this reflects a one off change in month 2 which offsets an adverse variance of £0.2m in Non Pay.

- **Injury cost recovery – favourable variance of £0.1m.**

- **Research & Development – favourable variance of £0.1m**

- **Various income lines – favourable variance in total of £0.3m.**

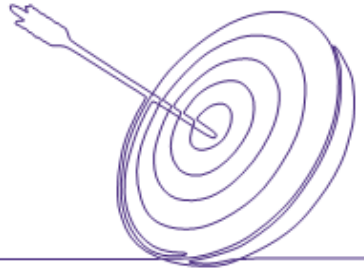
Finance Spotlight Report
(Key areas of focus - Pay)



United Lincolnshire Hospitals NHS Trust

- **The YTD Pay position is £20.7m adverse to plan including under delivery on Pay CIP of £4.0m.**
- Actual Pay expenditure in September of £44.3m was £4.6m higher than £39.7m in August.
- The September position includes an estimate of £0.2m for the additional bank holiday in September (for which there was no allowance in the financial plan); the 2022/23 pay award and arrears were paid to most staff groups in September; the pay award exceeded the provision made in accordance with planning guidance by £5.2m and the income position reflects additional funding of £4.9m in relation to this; Providers were instructed not to accrue for the excess in previous periods.
  - **Substantive pay is £4.2m adverse to plan (inclusive of £1.2m of technical CIP delivery)**
    - Expenditure of £35.5m in September is £4.6m higher than expenditure of £30.9m in August; this is driven by the payment of the 2022/23 pay award and arrears which exceeded accruals by £4.9m (the cost of which is offset in Income); Bank Pay in September includes a further £0.3m re the impact of the pay award (given the link between bank rates and substantive pay scales).
  - **Agency pay is £12.1m adverse to plan**
    - Expenditure of £4.9m in September is £0.4m higher than expenditure of £4.5m in August.
    - YTD efficiency savings of £0.5m in Agency Pay are £6.4m adverse to plan; the YTD position also reflects higher than planned bed numbers, sickness levels & vacancies.
  - **Bank Pay is £4.4m adverse to plan**
    - Expenditure of £3.9m in September is £0.4m lower than expenditure of £4.3m in August; this reflects higher than planned bed numbers, sickness levels and vacancies.

Finance Spotlight Report
(Key areas of focus - Other)



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Non Pay

- The YTD Non-Pay position is £1.9m adverse to plan including under delivery on CIP of £1.7m; £1.9m of the technical CIP savings released YTD have been in Pay & Income rather than Non Pay as planned.
- Non Pay expenditure in September of £19.4m was £0.4m lower than £19.8m in August; this decrease includes £0.1m decrease in the pharmacy ascribe drugs feed, and a net decrease of £0.3m re other miscellaneous movements; it is noted that in Month 5 Non Pay was largely based upon July actuals.
- The YTD position reflects generally lower than planned activity levels, but this under spend has been more than offset by c£2.4m of unplanned expenditure for which there is an offset within income e.g. £1.6m in relation to the radiology fire, £0.6m in relation to mutual aid, and £0.2m in relation to a one off adjustment re Bad Debt.

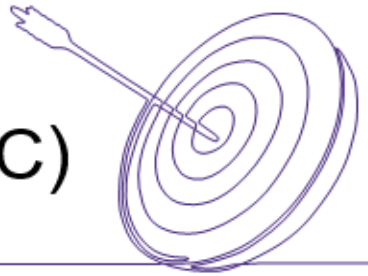
CIP

- The original financial plan assumes that the Trust will deliver CIP savings of £25m (3.6%) in 2022/23; the plan resubmission increased the total CIP savings requirement by £4.0m.
- The financial plan assumed CIP savings delivery of £11.4m by the end of month 6; actual savings of £6.8m (59.2%) have been delivered, such that YTD delivery is £4.7m (40.8%) adverse to plan.

Capital

- Capital funding levels for 2022/23 agreed through Trust Board & FPEC show a plan of c£38.4m; Capital spend incurred YTD equates to c£8.1m.

Finance Spotlight Report
(Key areas of focus – Cash & BPPC)



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NHS Trust

Cash

- The September 2022 cash balance is £57.6m; this is a decrease of £30.7m against the March year-end cash balance of £88.3m. Whilst there are still significant backlogs since the August Cyber attack, the level of payments made in September (£35m) exceeded the monthly average over the preceding 12 months (£25m), contributing to an in month reduction in the cash balance of £12.5m.

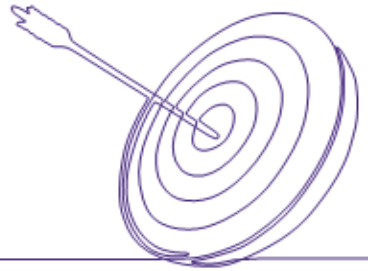
BPPC

- The BPPC performance for the six months to September was 75% / 67% by value / volume of invoices paid (appendix 5d); this compares to the full year performance in 2021/22 of 89% / 83%.

The cyber-attack in August meant that relatively few invoices were registered or cleared in month. Whilst the system was available from early September the hangover from August is likely to stretch over a number of months. This expectation reflects the fact that with the system being unavailable for 28 days, virtually all invoices received are already beyond the 30 day target.

Performance during August and September alone were 66% / 72% by value and 51% / 55% by volume of invoices paid.

Finance Dashboard



NHS
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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

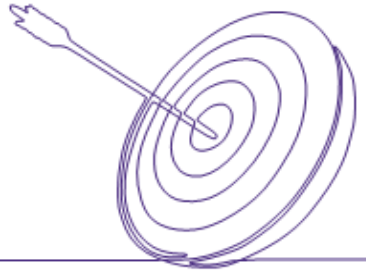
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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 three full financial years and the current 2022/23 position are as follows

Finance and use of resources rating	Full Year ending:				Actual
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	SEP 2022
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	0.39
Capital service cover rating	4	4	4	1	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(4.99)
Liquidity rating	4	4	1	1	2
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(3.25%)
I&E margin rating	4	4	2	2	4
Agency metric	77.00%	110.00%	113.00%	120.00%	~~1.00%~~
Agency rating	4	4	4	4	~~1~~
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(3.25%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	4

*The Trust Agency Ceiling upon which the Agency Metric is dependent is now at System level rather than individual Trust

Balance Sheet



NHS
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NHS Trust

	31-Mar-22	30-Sep-22 Plan	30-Sep-22 Actual	31-Mar-23 Forecast
	£000	£000	£000	£000
Intangible assets	7,675	6,764	6,804	6,032
Property, plant and equipment	267,753	275,045	268,114	290,020
Right of use assets	12,751	12,863	11,664	11,374
Receivables	1,848	1,848	1,806	1,848
Total non-current assets	**290,027**	**296,520**	**288,388**	**309,274**
Inventories	6,006	6,006	6,445	6,006
Receivables	15,520	23,372	31,620	26,305
Cash and cash equivalents	88,297	46,974	57,569	49,672
Total current assets	**109,823**	**76,352**	**95,635**	**81,983**
Trade and other payables	(89,017)	(63,366)	(81,773)	(69,591)
Borrowings	(2,381)	(3,290)	(2,583)	(2,855)
Provisions	(8,774)	(6,895)	(8,435)	(2,073)
Other liabilities	(1,130)	(1,130)	(5,739)	(1,130)
Total current liabilities	**(101,302)**	**(74,681)**	**(98,530)**	**(75,649)**
Total assets less current liabilities	**298,548**	**298,191**	**285,492**	**315,608**
Borrowings	(14,264)	(13,507)	(13,029)	(12,087)
Provisions	(3,182)	(3,171)	(3,099)	(3,099)
Other liabilities	(11,572)	(11,320)	(11,321)	(11,069)
Total non-current liabilities	**(29,018)**	**(27,998)**	**(27,449)**	**(26,255)**
Total assets employed	**269,530**	**270,193**	**258,043**	**289,353**
Financed by				
Public dividend capital	704,178	705,241	704,180	724,498
Revaluation reserve	29,294	28,946	28,938	28,591
Other reserves	190	190	190	190
Income and expenditure reserve	(464,131)	(464,184)	(475,266)	(463,925)
Total taxpayers' equity	**269,530**	**270,193**	**258,043**	**289,353**

Note 1: The closing balance sheet for 2021/22 has been restated for the impact of the introduction of IFRS16.

The impact in balance sheet terms is to recognise 'Right of Use' assets with the offset being an increase in Borrowings (£12.83m) and the I&E reserve (£0.13m).

Both the plan and actual for 2022/23 are stated on an IFRS 16 basis.

Note 2: Cash has reduced by £10.6m in September as we start to recover from the cyber-attack upon the Trust's finance system provider in August.

Note 3: Trade and other receivables continue to be supressed below pre-pandemic levels and will remain so throughout 2022/23 with the continuation of block contract payments.

Note 4: The overall level of Trade and other payables at £81m remains above historic levels by circa £15-20m. This driven by the heightened level of trade creditors, but also Annual leave (£8m) and other pay accruals.

Note 5: The level of provisions is anticipated to reduce in year with the settlement of specific payroll provisions.

Cashflow reconciliation – April 2022– March 2023

NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-22	30-Sep-22		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Operating surplus / (deficit)	549	3,413	(8,176)	6,537
Depreciation and amortisation	15,736	9,750	9,666	19,192
Impairments and reversals	7,340	-	-	-
Income recognised in respect of capital donations	(27)	-	-	(50)
Amortisation of PFI deferred credit	(503)	(252)	(251)	(503)
(Increase) / decrease in receivables and other assets	11,261	(7,852)	(16,006)	(10,735)
(Increase) / decrease in inventories	504	-	(439)	0
Increase/(decrease) in trade and other payables	9,745	(7,275)	10,420	(5,807)
Increase/(decrease) in other liabilities	(457)	-	4,609	-
Increase / (decrease) in provisions	5,860	(1,860)	(383)	(6,745)
Net cash flows from / (used in) operating activities	**50,008**	**(4,076)**	**(560)**	**1,889**
Interest received	34	120	400	680
Purchase of intangible assets	(994)	-	-	-
Purchase of property, plant and equipment	(35,132)	(33,296)	(26,262)	(51,494)
Proceeds from sales of property, plant and equipment	148	-	149	149
Net cash flows from / (used in) investing activities	(35,944)	(33,176)	(25,713)	(50,665)
Public dividend capital received	26,610	1,061	-	20,318
Other loans repaid	-	-	-	(403)
Capital element of finance lease rental payments	-	(1,171)	(1,073)	(2,413)
Interest paid	(1)	-	-	-
Interest element of finance lease	-	(58)	(56)	(119)
PDC dividend (paid)/refunded	(6,418)	(3,901)	(3,324)	(7,224)
Cash flows from (used in) other financing activities	-	(2)	-	(8)
Net cash flows from / (used in) financing activities	20,191	(4,071)	(4,453)	10,151
Increase / (decrease) in cash and cash equivalents	**34,255**	**(41,323)**	**(30,726)**	**(38,625)**
Cash and cash equivalents at 1 April - brought forward	54,042	88,297	88,297	88,297
Cash and cash equivalents at period end	**88,297**	**46,974**	**57,571**	**49,672**

Note 1: Cash held at 30 September was £57.6m against a plan of £47.0m. This represents a decrease of £30.7m against the March year-end cash balance of £88.3m. Whilst there are still significant backlogs following the August Cyber attack, the level of payments made in September (£35m) exceeded the monthly average over the preceding 12 months (£25m), contributing to an in month reduction in the cash balance of £12.5m.

Note 2: Principle reasons for the cash variance to plan of £10.6m are:

- The backlog of trade payables associated with the cyber-attack and system outage through August.
- Lower levels of capital spend versus plan as at 30 September.

Note 3: Underlying cash balances remain significantly increased on 2019/20 levels primarily due to:

- The continued block payment regime
- The payments backlog associated with cyber-attack.
- Receipt in March 21 of £7.1m to cover future outgoings associated with accrued annual leave.
- Increased levels of provisions to offset risks associated with current litigation and contractual obligations.

Note 4: Despite pressures / risks associated with the in- year financial position, no immediate cash pressures are anticipated.

The forecast year end cash position is anticipated to be circa £45-50m.Looking into 2023/24, depending upon mitigation of risks and changes in the financial regime, cash balances are likely to reduce.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1 November 2022*
Item Number	*Item 13.1*

Strategic Risk Report

Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Kathryn Helley, Deputy Director of Clinical Governance*
Author(s)	*Paul White, Head of Risk & Governance*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*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 our resources	*X*
3c Enhanced data and digital capability	*X*
3d Improving cancer services access	*X*
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	*X*
3f Urgent Care	*X*
4a Establish collaborative models of care with our partners	*X*
4b Becoming a university hospitals teaching trust	*X*
4c Successful delivery of the Acute Services Review	*X*

Risk Assessment	*N/A*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Significant, with some improvement required (based on Internal Audit Report – March 2022)*

Recommendations/ Decision Required	• *The Trust Board is invited to note the content of the Risk Report.*

Executive Summary

This Strategic Risk Report focuses on the highest priority risks to the Trust's objectives as defined within the Board Assurance Framework (BAF). All references to the risk register concern risks that have previously been reported to the lead assurance committee.

There are 10 quality and safety risks currently rated Very high (20), which relate to:

- the recovery of planned care pathways;
- delayed ambulance handovers;
- the availability of accurate patient and medicines information;
- the potential for serious patient harm due to a fall;
- the processing of echocardiograms;
- the ability to learn lessons from previous patient safety incidents

Within the Trust's workforce risk profile there are 4 Very high risks (20):

- Recruitment and retention of staff (revised July 2022)
- Workforce culture (revised July 2022)
- Fragility of Stroke services

There are also 3 active finance, performance & estates risks that are rated Very high (20) at present:

- Potential for a major fire;
- Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
- The cost of reliance upon a high number of temporary clinical staff

There are also 36 active risks with a current rating of High (15-16).

Details of all active High and Very high risks are provided in **Appendix A**. Any changes to the risk register that have not yet been presented to the appropriate lead assurance committee are not included in this report.

Purpose

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

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

1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). Details of all active Very high and High risks (15-25) are provided in **Appendix A**, organised by strategic objective and current risk rating however a summary of Very high risks is provided below in sections 2.3-2.13. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level.

1.2 The Risk Register Confirm and Challenge Group continues to meet on a monthly basis, reviewing all High and Very high risks as well as receiving presentations from clinical and corporate business areas on a rotational basis to enable constructive feedback to be provided.

1.3 Active risks that have a performance, service continuity and reputation impact as well as a quality of care impact are reported to the Quality Governance Committee as the lead for assurance. In addition, the Finance, Performance & Estates Committee now receives regular updates on progress with managing these risks so as to maintain oversight from a performance and reputation perspective.

1.4 Similarly, the People and Organisational Development Committee receives a regular report on workforce risk as assurance lead, with a summary of Very high workforce risks that have a potential quality and safety impact also being reported to the Quality Governance committee for information.

1.5 This report is an amalgamation of the most recent reports to each of the assurance committees of the Trust Board. Any changes to the risk register that have not yet been reported through the appropriate committee are not included.

2. Trust Risk Profile

2.1 There are 333 active risks, approved and recorded on the Trust risk register. There are 17 risks with a current rating of Very high (20-25) and 36 rated High (15-16).

2.2 **Table 1** shows the number and proportion of active risks by current rating and proportion of the overall Trust risk profile:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
6 (1%)	**59** (17%)	**215** (64%)	**36** (10%)	**17** (5%)

Strategic objective 1a: Deliver harm free care
Assurance lead: Quality Governance Committee

2.3 There are currently 7 Very high risks and 7 High risks to this objective. A summary of the 7 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4877	If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (non-admitted / outpatients) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	22/06/2022
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	23/09/2022
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	21/09/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5016	If there is not sufficient flow through the Trusts Emergency Departments due to demand outstripping capacity and insufficient availability of beds in the hospitals it may result in increased likelihood of long waits in the departments for patients, increase likelihood of patient harm, delays in care and poor patient experience	Very high risk (20)	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	12/10/2022
4624	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	Very high risk (20)	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents, monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	10/10/2022
4622	If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients.	Very high risk (20)	- Safety Culture Project, part of Integrated Improvement Plan (IIP) - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previously called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ	10/10/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm and a poor clinical outcome	Very high risk (20)	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	29/09/2022

Strategic objective 1b: Improve patient experience
Assurance lead: Quality Governance Committee

2.4 There are currently no Very high risks and 6 High risks to this objective.

Strategic objective 1c: Improve clinical outcomes
Assurance lead: Quality Governance Committee

2.5 There are 3 Very High risks and 2 High risks to this objective. A summary of the Very high risks is provided below. A previous Very high risk that has since been reduced concerns the potential for failure of the HDR (high dosage rate) Unit in Radiotherapy. A summary of the 2 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4828	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust. Update 4th July 22- 26th July, ePMA functionality version 10.21 will be upgraded. ePMA pilot from 13/09/22, full Trust wide roll out- mid Oct.	14/10/2022
4731	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could lead to delayed diagnosis and treatment, reducing the likelihood of a positive clinical outcome and possibly causing serious harm	Very high risk (20)	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	23/09/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4972	Safety risk from an inability to provide a fully funded epilepsy service that complies with relevant NICE guidance.	Very high risk (20)	1. Development of business case to enable establishment of fully funded epilepsy service.	10/10/2022

Strategic objective 2a. A modern and progressive workforce
Assurance lead: People & OD Committee

2.6 There are 2 Very high risks and 2 High risks to this objective. A summary of the 2 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5020	If there is a continued reliance on bank and agency staff for medical workforce there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Very high risk (20)	Robust recruitment plan International recruitment Medical Workforce Management Project	12/10/2022
5019	If there is a continued reliance on bank and agency staff for nursing workforce there is a risk that there not sufficient fill rate in each department which will impact on patient safety and have a negative impact on the CBU budget	Very high risk (20)	Robust recruitment plan International recruitment	12/10/2022
4991	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience.	Very high risk (20)	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	12/07/2022

Strategic objective 2b. Making ULHT the best place to work
Assurance lead: People & OD Committee

2.7 There are currently 1 Very high risks and no High risks to this objective

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4990	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally	Very high risk (20)	1. National mandate for NHS organisations to run Pulse Survey every quarter (1,2&4) 2. Comprehensive and robust positioning to complement NHS Staff Survey and part of a wider staff listening and engagement plan 3. You said campaign to drip feed/communicate how staff intelligence is improving working environment and services - now live	12/07/2022

Strategic objective 2c. Well-led services
Assurance lead: Audit Committee

2.8 There are currently no Very high risks or High risks to this objective.

Strategic objective 3a: A modern, clean and fit for purpose environment
Assurance lead: Finance, Performance & Estates Committee

2.9 There are currently 2 Very high risks and 2 High risk to this objective. A summary of the 2 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - PPM reporting for FEG and FSG By Estates Teams - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk	13/09/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4648	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	Very high risk (20)	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022 - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	13/09/2022

Strategic objective 3b: Efficient use of our resources
Assurance lead: Finance, Performance & Estates Committee

2.10 There are currently 1 Very high risk and 4 High risks to this objective. A summary of the 1 Very high risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4664	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	Very high risk (20)	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	22/06/2022

Strategic objective 3c: Enhanced data and digital capability
Assurance lead: Finance, Performance & Estates Committee

2.11 There are currently no Very high risks and 1 High risks to this objective.

Strategic objective 4a: Establish new evidence based models of care
Assurance lead: Finance, Performance & Estates Committee

2.12 There are currently no Very high and 1 High risks to this objective.

Strategic objective 4b. To become a University Hospitals Teaching Trust

Assurance lead: People & OD Committee

2.13 There are currently no Very high or High risks to this objective.

3. Conclusions & recommendations

3.1 The highest priority quality and safety risks at present relate to:

- the recovery of planned care pathways;
- delayed ambulance handovers;
- the availability of accurate patient and medicines information;
- the potential for serious patient harm due to a fall;
- the processing of echocardiograms;
- the ability to learn lessons from previous patient safety incidents

3.2 The most significant workforce risks at present relate to:

- the recruitment and retention of clinical staff; and
- the impact of workforce morale on quality of care and services

3.3 Within finance, performance and estates the most significant risks at present relate to:

- fire safety; and
- the cost of reliance upon temporary clinical staff

3.4 The Trust Board is invited to review the content of the report and note the most recent updates to significant risks, no further escalations at this time.

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective						**1a. Deliver Harm Free Care**																			
4622	Patient safety (physical or psychological harm)	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group	09/04/2018	20	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	If the Trust fails to learn lessons when things go wrong with patient care, so that changes can be made to improve policies and procedures, there is an increased likelihood of similar occurrences in the future which could have a significant adverse effect on a large number of patients.	National Policy: - NHS National Patient Safety Strategy - NHS National Reporting and Learning System (NRLS) ULHT Policy: - Analysing and Learning from Patient Safety Incidents, Complaints, Claims and Coroners Inquests Policy (approved April 2019, due for review April 2022) ULHT governance: - Trust Board assurance through Quality Governance Committee (QGC) and sub-groups"	- Recurring themes in patient safety incidents, complaints, PALS & claims (e.g. patient falls SIs; pressure ulcer incidents; DKA incidents) - Recurring themes in audits / reviews of risk / incident / complaints / claims management"	10/10/2022	Extremely likely	High	Very high risk	20	- Establishment of Patient Safety Improvement Team - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previoulsy called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ - Prepare for implementation of new Patient safety Incident Response Framework (PSIRF) in 2022 (replacement for Serious Incident Framework)	[14/10/2022 10:30:38 Rachael Turner] Risk reviewed-no change. - Patient Safety Improvement Team now established within Clinical Governance - Datix CloudIQ has been approved for connection to the new national learning system - Business case for Datix CloudIQ approved and final sign off undertaken September; plan will be to roll out over the next 6 months Directorate review (May 2022) - agreed that this would remain Very high (20) subject to learning lessons work being completed and evidence that repeated incidents are reducing -Reviewed at SMT 13/06/22-no change. -Reviewed at SMT 22/08/22 - Business case for DatixIQ approved and implementation to commence shortly over the next six months. Patient Safety Incident Response Framework (PSIRF) now released; Clinical Governance team to develop an implementation plan over the next 12 months including all key stakeholders.	4	31/01/2019	31/03/2023	30/11/2022
4750	Physical or psychological harm	Evans, Simon	Rojas, Mrs Wendy	Theatre Safety Group	14/01/2022	20	Risk assessments	Surgery	Care CBU	Theatres		Emergency alarm bell system/phones/call system not available within Theatres Trustwide to facilitate effective calls for assistance. ACSA standards not being met - will result in failure to achieve service accreditation	Clinical governance arrangements within TACC / Surgery Division. Operational patient safety practices within Theatres. Estates project approval & implementation arrangements.	Reported incidents highlighting lack of call system	07/09/2022	Quite likely	High	High risk	16	Estates to review current provision, identify and implement solutions for both sites to eliminate risk Use of personal alarms / manual call system to be implemented as interim measure	7.9.22 - Additional update to confirm this is for ALL theatres as per email trails. Emails chasing estates re importance. Asked by Divisional Clinical Lead to upgrade to high risk taking into account two recent incidents within Theatres at Pilgrim. Lead Nurse for TACC working with Matron to implement increased safety precautions - awaiting update.	4	23/11/2021	30/09/2022	28/10/2022
4779	Physical or psychological harm	Evans, Simon	Ratcliff, Carl		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	23/08/2022	Quite likely	High	High risk	16	defined plans to address backlog for at risk areas	Plans in place to address backlogs across all areas. Significant area of risk for TIA. 23.08.22 Remains an issues although noting covid cases have dropped. Will be resolved once the improvement work on wards in completed to remove outliers and pts are in the correct place with appropriate bed numbers	4	31/03/2022	30/06/2022	01/12/2022
4789	Physical or psychological harm	Evans, Simon	Ratcliff, Carl		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	29/09/2022	Extremely likely	High	Very high risk	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	Echo backlog remains high. Meridian re-engaged to support service. Number of measures being undertaken to increase capacity. Progress being reported into planned care board. Discussed at Risk Register Confirm & Challenge Group on 25 May 2022. Agreed that this is a broader quality of care and experience risk potentially impacting on a large number of patients, rather than a specific risk of serious harm. 23.08.22 Proposals been completed for internal improvement and also use of CDC - both will start in October. Funding and approvals being sought- will update once completed 10.08.2022- Meridian deep dive completed. Recommendations being reviewed by General Manager. Further options for recovery include R&R	4	31/03/2022	31/03/2023	01/11/2022

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4877	Physical or psychological harm	Evans, Simon	Carter, Mr Damian	Patient Safety Group	28/03/2022	20	Risk assessments	Surgery				If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care admitted pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	22/06/2022	Extremely likely	High	Very high risk	20	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	Risk lead updated to Head of Operations.	8	31/03/2023	31/03/2023	31/07/2022
4878	Physical or psychological harm	Evans, Simon	Carter, Mr Damian	Patient Safety Group	28/03/2022	20	Risk assessments	Corporate	Operations		Trust-wide	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care non-admitted pathway & booking systems / processes (outpatients) - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Outpatient Recovery Group; Reports through Divisional PRMs (for performance), and FPEC and System Planned Care Group - Clinical Harm Oversight Group	2ww first O/Ps back within national target Urgent 1sts 90% <13 weeks by 31.03.23 Time critical follow ups (452/2657 overdue) – target to eliminate (mainly neurology, cardiology, rheumatology) by 31.03.23 RTT non-admitted: Clear >104wws by 31.03.22 Clear >78wws by 31.03.22 (with few remaining by 30.06.22) Clear >65wws by 30.09.22 Clear >52wws by 31.12.22	23/09/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	210622 No change due to major pressure on the system due to covid backlog. 230922 An externally procured validation team have been identified and they are due to start end of October. Risk transferred to Operations from Outpatients following discussion re ownership.	8	31/03/2023	31/03/2023	31/10/2022
4879	Physical or psychological harm	Evans, Simon	Rimmer, Lucy	Patient Safety Group	28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU			If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	21/09/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	4/8/22 Confirmed it is an ongoing corporate risk being managed at divisional level. Ongoing	8	31/03/2023	31/03/2023	31/10/2022
4947	Physical or psychological harm	Farquharson, Colin	Saddick, Ahtisham	Medicines Quality Group	17/06/2022		Policy/Protocol Issues	Clinical Support Services	Pharmacy CBU			There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	NICE guidance NG5 states that in an acute setting, that we should accurately list all of the patient's medicines (including prescribed, over-the-counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another – for example, if they are admitted to hospital.	We conduct monthly medicines reconciliation audits, which consistently have shown us failing to meet NICE targets and we are operating significantly below the national average. This audit is presented at the MQG.	14/10/2022	Extremely likely	High	Very high risk	20	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	[14/10/2022 16:16:26 Rachel Thackray] Business case for additional staff in progress.	8	30/06/2023		15/08/2022
4958	Physical or psychological harm	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group	30/06/2022	12	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	The Trust may not be able to fully and effectively implement the requirements of the National Patient Safety Strategy, resulting in potential missed opportunities to significantly improve patient safety and possible non-compliance with national standards	National policy: - NHS Pateint Safety Strategy: Safer culture, safer systems, safer patients ULHT policy: - Patient Safety Improvement Team (Clinical Governance) - Patient Safety Specialists ULHT governance: - Patient Safety Group (lead) / Quality Governance Committee (assurance)	Frequency and severity of patient safety incidents reported. Monitoring implementation of the National Patient Safety Strategy.	10/10/2022	Quite likely	High	High risk	16	Patient Safety Strategy implementation plans, including: - Preparations for introduction of the new national Patient Safety Incident Response Framework (PSIRF) - Upgrade to Datix CloudIQ to enable information upload to the new national Learning from Patient Safety Events (LFPSE) system - Recruitment and induction of Patient Safety Partners (PSPs)	[14/10/2022 10:32:27 Rachael Turner] Risk reviwed no change As a result of delays to the procurement of Datix Cloud IQ, along with an estimated implementation timeline of 6 months to upgrade the system, there is now an increased likelihood of not being ready to integrate with the LFPSE system by the April 2023 due date. Rating increased from 12 to 16. Update 08/09/2022 - communication received this week from RL Datix to say that DatixWeb (the Trust's current version) has now been approved for connection to the LFPSE system). This development will mitigate the system integration aspects of the risk.	4	31/03/2023	31/03/2023	30/11/2022

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5016	Physical or psychological harm	Wall, Mrs Tracey	Thomson, Cheryl		02/09/2022	25		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is not sufficient flow through the Trusts Emergency Departments due to demand outstripping capacity and insufficient availability of beds in the hospitals it may result in increased likelihood of long waits in the departments for patients, increase likelihood of patient harm, delays in care and poor patient experience	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	12/10/2022	Extremely likely	Extreme	Very high risk	25	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	[12/10/2022 17:20:43 Helen Hartley] No changes made at governance	25	02/09/2023		11/11/2022
5041	Physical or psychological harm	Grooby, Mrs Libby	Mangal, Miss Bhavana		26/09/2022	15		Family Health	Women's Health and Breast CBU	Obstetrics		If CTGs (Cardiotocography) are interpreted as per 2018 NICE pathways, rather than via physiological interpretation; • The number of women who receive potentially avoidable intervention will be at a higher level level of cases resulting in increased risk of complications for mother, lower levels of satisfaction, higher rates of birth trauma expressed in a subsequent pregnancy and additional complexities in subsequent pregnancies. • Trust / Service Reputational damage due to ongoing HIE and HSIB cases/ SI investigations. • Financial impact where litigation from poor outcomes • Staff experiencing increased exposure to stressful incidents and frustration at utilising tools from NICE when there is a better and more up to date evidence base.	Following NICE is a reasonable position for the Trust to follow, although is directly the described risk. The Trust have recognised the risk from multiple Serious Incident investigations which has led to Regional Forum discussions, where the conclusion was a consensus that amending guidelines, training/teaching leading to practice change. We also send all of our midwives on one day CTG masterclass every 4 years, and all labour ward coordinators, registrars and consultants on advanced CTG masterclass every 4 years. This teaches most recent evidence around physiology but is not matched by the tools the Trust use for classification (NICE) therefore this causes frustration.	• Datix incidents, Serious Incident investigation root causes and or contributory factors from CTG interpretation + number of HSIB referrals	26/09/2022	Reasonably likely	Extreme	High risk	15	"• Completion of Trust benchmarking vs FIGO has been undertaken to understand position/practice (completed) • Development of a standalone Fetal Monitoring Lead Midwife post (completed) • Recruitment of a Fetal Monitoring Lead Midwife (Completed) • Job planning time of a Consultant Lead for Fetal Monitoring (incomplete- missing 1 PA). Not currently job planned. • Develop Trust plan for full transition / implementation of this significant practice change (to be reviewed and systematic approach needed). "	Awaiting update from NICE	10	01/03/2023	31/03/2023	31/12/2022
4974	Physical or psychological harm	Hallion, Simon	Naydeva-Grigorova, Tanya		14/07/2022	9	Professional Guidance	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Safety risk from an inability to provide a diabetes service that complies with relevant NICE guidance and ensures ability to secure best practice tariff.	1. Two Consultant Paediatricians (TN-G and AB) are currently managing all children with diabetes;	1. Audit of compliance with NICE guideline NG18 - Diabetes (Type 1 and Type 2) in Children and Young People: Diagnosis and Management and Adults and NICE quality standard QS125 - Diabetes in Children and Young People.	10/10/2022	Quite likely	High	High risk	16	1. Business case being developed to address resources shortfall (e.g. dietitian, psychologist, admin support, additional nurses) - agreed in principle at CRIG meeting. 2. Increase in clinic capacity to meet demand as per consultants database	09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR 1. Risk discussed at Risk Register Confirm and Challenge meeting - risk and grading agreed as appropriate.	3	31/07/2023		10/01/2023
#	hy	nz	wl		#	#	of es	ni	nc	ad		"Not reporting over exposures to CQC.	Exposure properties stored within record and verify system (ARIA) which has	Retrospective assesment of patients imaging can	#	ui	gh	gh	#	Take case of need 2021_37V2 to CRIG for:	A PO has been raised to upgrade to TB 2.7	4	#	#	#
4935	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha		26/05/2022	16	Workforce Metrics	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care		Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale).	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Rotas (gaps). Agency spend - financial risk. Number of Datix incidents recorded.	19/10/2022	Quite likely	High	High risk	16	Recruit to vacant posts.	[19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		25/11/2022

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4901	Regulatory compliance	Cooper, Mrs Anita	Richardson, Carol		21/04/2022	16	External Inspections	Clinical Support Services	Cancer Services CBU	Blood Transfusion	Trust-wide	If the Trust is found to be non-compliant with Blood Safety and Quality Regulations (BSQR 2005) relating to the design or application of local policies and procedures including blood tracking, it could result in regulatory action that: (a) damages the reputation of the organisation and leads to a loss of confidence amongst regulators, partner organisations, patients and staff, (b) leads to prosecution of the Trust and (c) forces closure of one or more Blood Banks with a "Cease and Desist" notice placed on blood transfusion, which would impact on most areas of Trust clinical work.	Hospital Transfusion Committee (HTC), accountable to the Patient Safety Group (PSG). Board oversight through Quality Governance Committee (QGC). Use of Blood-tracking system software for fridge lockdown and traceability purposes. Blood transfusion policies, procedures & guidelines Staff training. Specialist blood transfusion practitioners. Incident reporting procedures & system (Datix). NHS Blood & Transplant service (NHSBT).	Datix , audit , external inspection	27/07/2022	Quite likely	High	High risk	16	To use the blood tracking system and ensure the system is updated regularly to maintain effective service.	220622 Ongoing.	3	31/03/2023		15/08/2022
4863	Physical or psychological harm	Fulloway, Mr Ian	Bilton, Mr Chris		25/02/2022	12	Policy/Protocol Issues	Clinical Support Services	Diagnostics CBU	Radiology	Grantham & District Hospital	MRI GRANTHAM. Tranference of cardiac or bariatric patients to GDH from PHB and LCH, for imaging on the scanner. There is no holding bay, and patients can be brought very early or picked up very late before and after scan. Limited MRI staff are unable to care for these patients as they are also caring for current patients on the scanner. Patients have to be held in the corridor as there is no holding bay. with limited staff, and the fact their duties are split between patient on scanner and patient in corridor, is inviting risk.	Patients on trolleys will always arrive with an escort. cardiac patients will only be scanned when there is a cardiologist present.	Patient safety incidents related to transfer to MRI Grantham	19/10/2022	Extremely likely	Medium	High risk	15	to have a ward to ward transfer, so patients have somewhere safe to wait until called for scan.	[19/10/2022 13:42:38 Ian Fulloway] Lisa Pim has met with key stakeholders - it has been agreed from a surgical perspective that patients can receive temporary care on GSU whilst awaiting ambulance transfer back to base site – we are still waiting to hear from medicine colleagues the arrangements from their perspective. Lisa Pim has chased up once and will chase again today 17.10.2022 Conversations have taken place with senior management but no change. No change, same issues. Trying to engage through forums the other divisions.	6	31/03/2023	31/03/2023	16/11/2022
4624	Physical or psychological harm	Davies, Angela	Addlesee, Sarah	Patient Falls Steering Group	08/11/2021	16	Aggregation of Incident/Claims & Complaints/PALS	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	National policy: - NICE Clinical Guideline CG161: Assessment and prevention of falls in older people (2013) - PHE Falls and fracture consensus statement: Resource pack (2017) ULHT policy: - Falls Prevention and Management Policy (approved April 2021, due for review March 2023) ULHT governance: - Lead Quality Matron - Weekly Falls Investigation Panel / Training package tiered approach / Weekly spot check audits / Monthly Quality Metrics Dashboard meetings /ward review visits - Patient falls steering group / Nursing, Midwifery & AHP Forum / Quality Governance Committee	Frequency, location and severity of patient falls incidents reported: - The numbers of reported falls incidents are demonstrating an increasing upward trend therefore will not achieve the strategic objective to achieve harm free care. - Operational pressures have resulted in patients having prolonged periods sitting in Emergency Departments whilst waiting assessment and for inpatient beds to become available. This may contribute to an increase in some patients overall frailty level and subsequent deconditioning which increases the vulnerability to an individual falling. - Longer length of stays have demonstrated a correlation to risk of a patient falling whilst in the care of the Trust. Patient falls reported April 2021-March 2022 Total -1916 Moderate harm -22 Severe -12 Death -4 Patient falls reported April 2022-May 2022 Total -344 Moderate harm -7 Severe-4 Death-1	10/10/2022	Extremely likely	High	Very high risk	20	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	[14/10/2022 10:29:24 Rachael Turner] Risk reviewed-no change. • Weekly Falls Investigation Panel embedded / Falls Prevention Steering Group meets monthly / Falls improvement work ongoing across the Trust and focused pieces of work identified through the steering group / training package approved at NMAAF in Jan 22. • A Falls QI Project Development and Implementation Group has been established which has multidisciplinary representation from divisional and corporate teams. Dedicated support is being provided by the Improvement Academy. Oversight and monitoring will be provided by FPSG who will receive monthly updates on actions being taken and progress made by the QI group. • A schedule of face to face falls prevention and Flojac training commenced in April 2022 delivered within clinical areas by the Quality Matron and Health & Safety teams. Wards identified as having higher falls occurrences are being prioritised. • The Chief Nursing Information Officer (CNIO) has been working with the Quality Matron team to identify how the identification and handover of patients vulnerable to falling can be improved through the support of digital applications. • Update 17/08/22 Case of Need for a Falls Prevention Service was presented at CRIG meeting on 22nd July 2022 CRIG supported the ask of the	4	31/12/2021	31/03/2023	30/11/2022
4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Maternity & Neonatal Oversight Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors.	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	14/10/2022	Quite likely	High	High risk	16	1. Use of tamper proof boxes/trays being purchased. 2. The only control to prevent the risk is to prepare the injections prior to administration (within 30 minutes) as per guidance (National and Trust). 3. If the practice is to continue, the prepared products should be labelled to include the recommended information. A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day.	Following a Datix (ref no: 255637), it has been identified that intravenous medication required for a Lower Segment Caesarean Section (LSCS) is being prepared in advance of the procedure in case of an emergency. The Lead Obstetric Anaesthetist has discussed the practice with the team and the consensus is that for safety the drugs need to be prepared in advance for potential emergencies. The team has sourced tamper proof drug trays to store the drugs once prepared. This risk assessment has been done for Pilgrim Hospital, Boston. However, the practice seems to replicate at Lincoln County Hospital. Full risk assessment is attached to Datix. 17/5/22 No change 150622 Ongoing awaiting confirmation on drugs that can be bought in. Risk is in the medical quality drugs agenda to agree and finalise.	4	30/09/2022	31/03/2023	13/01/2023

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4646	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Patient Safety Group	14/12/2021	20	Policy/Protocol Issues, Risk assessments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	28/09/2022	Quite likely	High	High risk	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB are on hold with provisions in place to allow NIV to be delivered in the bay where there are x 4 monitored beds (IPC agreed) Risk discussed at Risk Register Confirm & Challenge Group in May 2022. Still inconsistencies with timeliness against BTS standards, particularly at Lincoln, and inability to ring-fence beds but an improving position. Agreed that risk remains high but has reduced. Recommendation for rating to change from 20 to 16.Overall compliance monitored with a monthly NIV report. Case of need for funding of ward nurses in new environment agreed to ensure BTS standards are delivered, SFBC now required- commenced and in process, ew costings awaiting due to agreed pay rise on agenda for change	4	30/09/2022	31/12/2022	28/12/2022
Strategic Objective						**1b. Improve patient experience**																			
ID	**Risk Type**	**Manager**	**Handler**	**Lead Oversight Group**	**Opened**	**Rating (inherent)**	**Source of Risk**	**Division**	**Clinical Business Unit**	**Specialty**	**Hospital**	**What is the risk?**	**Controls in place**	**How is the risk measured?**	**Date of latest risk review**	**Likelihood (current)**	**Severity (currently)**	**Risk level (current)**	**Rating (current)**	**Risk reduction plan**	**Progress update**	**Risk level (acceptable)**	**Initial expected completion date**	**Expected completion date**	**Review date**
4701	Reputation	Grooby, Mrs Libby	Upjohn, Emma		13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	26/09/2022	Reasonably likely	Extreme	High risk	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15 26/09/2022 - Unchanged	6	31/03/2025	31/03/2025	31/12/2022
4724	Physical or psychological harm	Lalloo, Yavenuscha	Cooper, Mrs Anita		13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	26/09/2022	Extremely likely	Medium	High risk	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.	Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	30/11/2021	31/03/2023	31/10/2022

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4629	Reputation	Davies, Angela	Negus, Jennie	Patient Experience Group	09/04/2018	12	Risk assessments	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If we do not listen to the voices of our patients, carers and families through not seeking out, hearing and appreciating their experiences and then acting on them, we will fail in our ambition to deliver patient centred care.	• Patient & Carer Experience Plan and associated workplan. • Patient experience metrics and reporting (FFT, Care Opinion, PALS & Complaints, Healthwatch data, compliments all of which are triangulated through SUPERB); • National survey reports (inpatient, UEC, Maternity, NCPES, CYP). • Patient Experience Group - rolling programme of divisional assurance reporting. • Patient Experience upward reports to Quality Governance Committee through agreed reporting schedule. • Monthly Patient Panela dn expert reference groups reporting upwards to Patient Experience Group. • Patient Stories at Trust Board. • PLACE annual inspections and internal PLACE Lite visits. • Ward and department assurance visits as part of Quality Accreditation programme. • Carers Policy • Care of the Dying Patient and Care after Death procedures and guidelines. • Visiting Procedures. • Policy for the Development of Written Patient Information. • Complaints & PALs Policy	Patient feedback; volume and theme: • PALs & complaints • FFT • Care Opinion • National and local surveys • Healthwatch data • Patient Panels and expert reference groups • Patient feedback through ward assurance and Quality Accreditation programme • Patient stories • Triangulated data through SUPERB	16/06/2022	Quite likely	High	High risk	16	• Continue delivery of Patient Experience Training programme. • Support teams to use SUPERB and Envoy (FFT) dashboards to access their data and intelligence. • Continue to promote & spread Academy of FAB NHS Stuff to share and celebrate achievements, motivate, and energise teams • Develop Patient and Carer Experience Plan workplan. • Deliver IIP project improving communication and engagement with patients. • Explore development of further Expert Reference Groups. • Continue to develop Patient Panel. • Continue current work to embed patient voice and experience within QSIR programmes. • Strengthen divisional assurance reporting to spotlight actions taken as a result of feedback received including o Patient stories o You said, we did o Learning & improvement o Adoption of 'What Matters to You' • Develop new database to record patient experience activity and initiatives. • Analyse trends and themes in patient experience data to inform the need for targeted support and interventions by Patient Experience Team. • Consolidate and support the FAB Experience Champions network to support local actions and improvements.	• Training programme running weekly March – June and then monthly thereafter. >110 staff attended to dat. • Academy of FAB NHS team scheduled to visit in July to highlight ULHT as part of 2022 Fab Change Day. • Patient and Carer Experience Plan due to June PEG, workplan to be developed on approval. • Continue to deliver IIP project improving communication and engagement with patients. • Settle and embed Expert Reference Groups: o Sensory Loss o Breast Mastalgia o Cancer – first meeting end May 22 o Dementia Carers – out to advert • Patient Panel continues to develop & their story shared with Trust Board in May. • Divisional assurance reporting template refreshed and circulated. • Additional Patient Experience Manager commenced in March 2022. • FAB Experience Champions network meetings scheduled. Rating increased from 12 to 16.	4	30/09/2019	31/03/2023	30/09/2022
4980	Reputation	Davies, Angela	Negus, Jennie	Patient Experience Group	25/07/2022	16	Patient Surveys	Corporate	Nursing Directorate	Patient Experience	Trust-wide	Patient engagement can inform service design and evaluation as well as enhance its delivery and governance. It is the process of building the involvement of patients, families and carers, supporting their active involvement in order to enhance their care, care experience, safety, quality and patient-centredness. If we do not build the expectation to engage with our patients then we will not achieve patient centred care and if we do not reach out to 'hard to reach' groups our intelligence will fail to be diverse and inclusive.	• IIP project driving delivery of engagement and communication with patients and public. Reaching Out objective within this focuses on hard to reach groups. • Patient Panel meets monthly. • Expert reference groups in development: o Sensory loss group established o Breast Mastalgia group established o Cancer group established (first meeting May 2022) o Dementia Carers group in development • Patient Experience Training • Stakeholder involvement at Patient Experience Group: o Healthwatch o Carers First o Young Carers o Maternity Voices • Monthly reports from Healthwatch with feedback and queries. • Continued implementation of 'What Matters to you' initiative	• IIP milestone reports including Reaching Out objective. • Patient Panel evaluations. • Upward reports to Patient Experience Group • Expert reference groups evaluations will be undertaken. • Patient Experience Training requires a staff pledge on completion; these are being analysed and themes collated. • Stakeholder feedback and engagement at Patient Experience Group • Evaluations and outputs from implantation of 'What Matters to You' initiative through QSIRv	16/06/2022	Quite likely	High	High risk	16	• Deliver against IIP milestones. • Reaching out project objectives targeting hard to reach communities: o Mental Health o Learning Disabilities & Autism o Traveller community o Children and Young People o BAME & Easter European groups o LGBQT+ Older People: • Scoping development of further Expert Reference Groups. • Seeking to secure Neonatal Voices representative and involvement. • Launch of Cohort 2 QSIRv What Matters to You.	• IIP milestone plan to be updated following communication of Year 3 priorities. • Reaching out project: o Mental Health – links established with MH colleagues, options being explored to reach in to seek feedback and engagement. o Learning Disabilities & ASD – new ULHT LD nurse in post; exploring means for working with existing experts by experience. o Traveller community – link established with development team and community nursing. o Children and Young People – Youth Panel and Expert Family groups being explored. o BAME & Easter European groups – links being explored within communities. o LGBQT+ - links established with ED&I lead to scope. o Older People: o Launch of Dementia Carers Expert Reference Group planned for July 2022 o Proposal for Virtual Ward Expert Reference group being considered by CCG colleagues. • Seeking applicants for Cohort 2 What Matters to You	4	31/03/2023	31/03/2023	31/10/2022
4985	Reputation	Sanz Torres, Aurora A	Cawley, Martin		28/07/2022	16	Professional Guidance	Clinical Support Services	Cancer Services CBU	Radiotherapy		Not meeting NHSE/Service specification. Not being able to offer complete SABR technique.	Shared MDT with Nottingham Patient transferred to Nottingham if unable to treat	Number of patients of patient referred to Nottingham.	26/09/2022	Quite likely	High	High risk	16	Take case of need 2021_37V2 to CRIG for: Upgrade of Linear accelerators to version 2.7 Version 2.7 enables upgrade of the AlignRT system for improved functionality in motion management of SABR.	MGC PO for TB 2.7 has been raised. The upgrade to AlignRT will be scheduled once the TB2.7 is settled. Expect this can happen in December or early January depending on availability of engineers from VisionRT. This is now work in progress ____ Awaiting case of need to be presented to CRIG.	8	17/07/2023	31/01/2023	31/01/2023
Strategic Objective						**1c. Improve clinical outcomes**																			
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4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	14/10/2022	Extremely likely	High	Very high risk	20	Planned introduction of an auditable electronic prescribing system across the Trust. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct	[14/10/2022 16:05:51 Rachel Thackray] Pilot being undertaken in cardiology w/c 10 October 2022 which will take place over the next month. This will then be reviewed following completion. Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. 17/5/22 No change 150622 Discussed that a further risk is to be added concerning accurate medicines reconciliation as defined in NICE medicine and optimisation guidance NG5. And connection to staffing. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct.	4	31/03/2022	30/09/2022	15/08/2022
4905	Physical or psychological harm	Cooper, Mrs Anita	Bradley, Mrs Lesley		22/04/2022	12	assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on acute wards, delayed discharges, delayed referral to response times. Patient reviews delayed for botox treatment.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Prioritisation guidelines.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service.	26/09/2022	Extremely likely	Medium	High risk	15	Getting locums and bank staff in place. Good use of relocation allowance. Actively managing the waiting lists and dealing with urgent cases to avoid harm eg telephone contact with patients. Case of need for GDH orthopaedic staffing. Case of need for rehabilitation consultant post. Case of need for upper GI dietician. Case of need for Neuro Psychology staff on Ashby. Case of need for OT staff at PHB and LCH in ITU. Over recruitment of band 5s in dietetics. Competency frameworks and preceptorship.	130622 Looking at staffing vacancies and looking at line by line post analysis. OT IR 8 posts KPI's for Integration include reduce vacancies Promotional Commms for AHP week and Trac being produced to attract staff Improved recruitment strategies.	9	30/06/2023		31/10/2022
4928	Physical or psychological harm	Evans, Simon	Ratcliff, Carl		28/04/2022	16	Professional Guidance	Medicine	Cardiovascular CBU	Cardiology	Trust-wide	Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across Cardiology arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	23/08/2022	Quite likely	High	High risk	16	defined plans to address backlog for at risk areas	Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Additional details to be added to risk reduction plan. 10.08.2022- New consultant starting September 2022- 2 x clinics per week for new patients only Existing new patients currently being validated by support manager. TOE list capacity being utilised for PBWL patients. Plans in plan for PIFU for cardiology (next meeting end of August 2022).	16	30/06/2022	31/03/2023	01/12/2022
4972	Physical or psychological harm	Hallion, Simon	Herath, Dr Durga		14/07/2022	9	Clinical Audit Reports	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Safety risk from an inability to provide a fully funded epilepsy service that complies with relevant NICE guidance.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition.	Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People.	10/10/2022	Quite likely	Extreme	Very high risk	20	1. Development of business case to enable establishment of fully funded epilepsy service.	[11/10/2022 13:22:37 Alison Barnes] Adverts out for b6 and b7 epilepsy nurses, with interest, cost pressure whilst sorting funding. 09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR 1. Risk discussed at Risk Register Confirm and Challenge meeting - risk and grading agreed as appropriate. 12/09/2022 - Risk Register Review. Risk remains the same, now have permission to recruit. In process of sorting funding.	3	11/07/2023	11/07/2023	30/11/2022
4731	Physical or psychological harm	Evans, Simon	Parkin, Mr Lee	Medical Records Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Draft policy produced further discussion with changes required with Divisional Clinical Lead - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	23/09/2022	Extremely likely	High	Very high risk	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Digital Hospital Group. 120522 - Review of policy is underway – sent to h/recs managers for amendments before being sent for sign off to Lee and via the CRG 210622 Now further update until Nov. In Nov expect to get preferred bidder for it. Updates will come from Electronic records system project. 23/09/2022 - No further updates	4	30/06/2018	31/03/2023	21/10/2022

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4819	Regulatory compliance	Cooper, Mrs Anita	Clark, Paul		16/01/2022	20	Risk assessments	Clinical Support Services	Diagnostics CBU	Radiology		Lack of radiology support for the symptomatic and breast screening services. unable to cover the required clinics needed to deal with the symptomatic demand and screening demand. Backlog of 220 2ww and 5000 breast screening. just able to support current 2WW demand difficult to reduce the backlog.	Diagnostics clinical governance arrangements / CSS Division Exploring overseas recruitment Secured additional breast screening support for 12 months-mobile van and agency staffing. Providing overtime shifts 7 days to help provide additional capacity. we are looking to increase mammographers by agency and have recruited to the vacant poss but will take 1 year to get the Cert thats allows them to undertake screening.	Monitoring radiology 2ww performance/ screening round length	19/10/2022	Extremely likely	Medium	High risk	15	continued recruitment of radiologists, mammographers, consultant mammographer and the use of locums when available, working closely with family health to maximise capacity via weekly capacity meeting. Working with outsourcing companies and additional Locums to provide extra screening capacity to try and shorten the current screening round length.	NHSE have raised concerns around the screening round length and have asked for a plan to reduce back to 36 months, Looking for locums, NHS England raised concerns about backlog. 290622 Have additional international and UK mamographers. Now 21 days backlog. due to staff leaving due to retirement and moving jobs this has caused the risk score to be increased to 15 as there has been a drop in capacity.	6	30/09/2022	30/09/2022	16/11/2022

Strategic Objective	2a. Have a modern and progressive workforce

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4741	Service disruption	Farquharson, Colin	Sanz Torres, Aurora A	Workforce Strategy Group	13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung Clinical oncology - head and neck, skin, upper GI (RT only). Lack of cover for leadership roles (Chemotherapy lead)	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements	Monitoring tumour site performance data	21/09/2022	Quite likely	High	High risk	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements. 220622 Agency Clinical oncologists recruited. So improved cover for Head and neck and melanoma. Ongoing	4	31/03/2022	31/03/2023	30/12/2022
4762	Service disruption	Pim, Lisa	Rojas, Mrs Wendy		14/01/2022	15	Risk assessments	Surgery	Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	16/09/2022	Extremely likely	Medium	High risk	15	Review of current recruitment strategy. Advertisement for vacant posts.	16/09/2022 Skill continues to be an issue. Additional clinical educator to be appointed to support training needs of team. Level 3 beds still capped at 8. Risk continues and includes skill mix as well as numbers of staff. Mitigation - ongoing recruitment, block booking of Agency staff, daily review of staffing undertaken, liaison with University of Lincoln to support new starters	6	30/06/2021	30/09/2022	30/12/2022
5019	Finances	Wall, Mrs Tracey	Thomson, Cheryl		02/09/2022	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is a continued reliance on bank and agency staff for nursing workfroce there is a risk that there not sufficient fill rate in each department which will impact on patient safety and have a negative impact on the CBU budget	Robust nursing plan for every post meetings Daily operational matrons identified for Lincoln and Pilgrim Daily safer staffing lead identified for escalation Establishment review DON	Plan for every post meetings Budget reports	12/10/2022	Quite likely	Extreme	Very high risk	20	Robust recruitment plan International recruitment	[12/10/2022 17:24:02 Helen Hartley] No change at governance	20	02/09/2023		12/11/2022
5020	Finances	Wall, Mrs Tracey	Thomson, Cheryl		02/09/2022	20		Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels	Plan for every post meetings Budget reports	12/10/2022	Quite likely	Extreme	Very high risk	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[12/10/2022 17:24:16 Helen Hartley] No changes made at governance	20	02/09/2023		12/11/2022

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4862		Ratcliff, Carl	Bland, Michael		22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU			Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting.	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The Business Unit have this week (06/09) put a bid in to the EMCA to gain funding of 250K to support a General Medicine to work in Respiratory so that our Substantive teams can be released to support Respiratory Cancer Capacity - This bid is currently being reviewed. We have worked in the background to book x 2 Agency Locum General Medicine Consultants 1 at Boston and 1 at Lincoln which will take us over budget, but supports the respiratory patients of lincolnshire and the welfare of consultant staff.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	09/09/2022	Quite likely	High	High risk	16	Close working with Agency to try and recruit agency locums to temporarily fill gaps. Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff. Additional funding from Cancer alliance for Gastro and Resp to allow for additional Gen Med Locum to reduce burden on current workforce. Remote working in place to support outpatients where possible. Agency spend supporting out of hours workload - for example, covering the substantive consultants on calls to allow them to focus on Cancer work instead of on call - supporting patient care.	Most recent update: Dear Carl, Following the catch up earlier, Claudia, Ashley and I have compiled our thoughts on what could go down to support the services..... Option Take down: Benefits Risks: 1 Do Nothing None Cancer patients continue to wait prolonged periods for care. • Inpatient services at LCH and PHB continue to become extremely depleted • Welfare of current consultant workforce continues to suffer, potentially leaving to sickness / prolonged absence • Boston have only x2 Consultants, currently utilising support from already depleted LCH Team. (If annual leave / sickness, we have only 1 consultant on the Pilgrim site) 2 Grantham inpatient respiratory services (Preferred) Releases x1 Agency Locum Consultant who can ?potentially? go over to Lincoln (as per previous agreement) • Releases a consultant to cover the rota to a 'safe' level Non-compliance with ASR due to taking out inpatient respiratory services at GDH • ?1 consultant from the Acute on Call rota at Grantham	4	30/12/2022	30/12/2022	01/12/2022

Strategic Objective	2b. Make ULHT the best place to work

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4948	Physical or psychological harm	Rimmer, Lucy	Costello, Mr Colin		17/06/2022	20	Workforce Metrics	Clinical Support Services	Pharmacy CBU			Workload demands within Pharmacy persistently exceed current staffing capacity which leads to work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. This may result in the failure to meet the national and local targets for KPIs	Business Continuity Plans on ward coverage when staffing low	Sickness rates/vacancy rates and staff turnover - highlight that retention is problematic at current. Staff survey highlights issues low staff morale within the department. Medicines reconciliation, datix incidents and omitted doses highlight that the trust is underperforming and not meeting targets at current	06/10/2022	Extremely likely	High	Very high risk	20	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options.	[06/10/2022 14:12:57 Lisa-Marie Moore] Business case still in progress No change		30/06/2023	02/10/2023	07/11/2022
5028	Physical or psychological harm	Ratcliff, Carl	Thomson, Cheryl		02/09/2022	16		Medicine	Urgent and Emergency Care CBU			If the ongoing operational pressures continue within UEC CBU, there is a risk to staff welfare leading to increased sickness, and a reduction in staff satisfaction.	ULHT Wellbeing offer available for all staff National staff survey results UEC governance meetings	Staff absence rates Staff turnover recruitment and retention		Quite likely	High	High risk	16	Development of UEC Staff Engagement and Wellbeing strategy		16	02/09/2023		02/12/2022

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4990	Reputation	Matthew, Mr Paul	Low, Claire	Workforce Strategy Group	08/08/2022	20		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally.	1. National and local lessons learnt for engaging staff effectively with surveys 2. Dedicated 'staff experience/engagement' role proposed to lead programme of work (including corporate and local action planning)	1. Pulse Staff Survey response rate (quarterly) 2. NHS Staff Survey response rate (annual)	12/07/2022	Extremely likely	High	Very high risk	20	1. National mandate for NHS organisations to run Pulse Survey every quarter (1,2&4) 2. Comprehensive and robust positioning to complement NHS Staff Survey and part of a wider staff listening and engagement plan 3. You said campaign to drip feed/communicate how staff intelligence is improving working environment and services - now live	1. Pulse Staff Survey - Q2 (July'22) 2. Reset approach (communication, engagement of and management) for sign off - ELT (June'22) 3. Local action planning process - now live 4. 7 Big Ticket Priorities proposed following NHS Staff Survey	4	31/03/2023	31/03/2023	31/08/2022
Strategic Objective		**3a. Have a modern, clean and fit for purpose environment**																							
ID	**Risk Type**	**Manager**	**Handler**	**Lead Oversight Group**	**Opened**	**Rating (inherent)**	**Source of Risk**	**Division**	**Clinical Business Unit**	**Specialty**	**Hospital**	**What is the risk?**	**Controls in place**	**How is the risk measured?**	**Date of latest risk review**	**Likelihood (current)**	**Severity (currently)**	**Risk level (current)**	**Rating (current)**	**Risk reduction plan**	**Progress update**	**Risk level (acceptable)**	**Initial expected completion date**	**Expected completion date**	**Review date**
4647	Reputation	Evans, Simon	Davey, Keiron	Fire Safety Group	14/12/2021	20	External Inspections	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees	- Compliance audits against fire safety standards - Progress with fire safety improvement plans - PPM compliance assurance (current lack of required detail for internal and regulator assurance)	13/09/2022	Extremely likely	High	Very high risk	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	LFR previously served ULH with an Enforcement notice and action plan (since removed) in which the storage of items within corridors was highlighted: "Article 14(2) Emergency Routes and Exits There are combustible materials and items that pose an ignition risk are located on escape routes within the hospital. It required that Corridors and stairways that form part of an escape route should be kept clear of obstruction and hazard free at all times. Items that maybe a source of fuel or pose an ignition risk should not normally be located on any corridor or stairway that will be used as an escape route." In light of identified storage issues and subsequent non-compliance with these requirements, there is now a high potential for immediate enforcement notice with a view to prosecution in accordance with the regulator's compliance code. Task & finish group set up to address storage issues at local and at senior levels. Fire Safety Advisors working with local managers; IR1s reported when storage issues are identified, with escalation to divisional leads where necessary. Lack of PPM assurance identified - escalated to	4	30/06/2022	31/03/2024	31/10/2022

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4648	Physical or psychological harm	Evans, Simon	Davey, Keiron	Fire Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	13/09/2022	Quite likely	Extreme	Very high risk	20	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	Rating increased on review to 20 - combustible storage in common areas frequently found (including life lobbys); emerging lessons learned from recent arson incident at LCH (including spread of smoke beyond the room of origin). Actions undertaken recently - IR1s issued to local managers and owners of storage risk, including escalation to senior managers. Setting up task & finish group to look at storage issues. Reviewed all fire risk assessments in Diagnostics across all 3 sites; other FRAs for public areas have also been reviewed. Reviewed all external security patrols and implemented alterations to routes to ensure possible higher risk areas are also patrolled. New tagging points added to patrol routes. Implementation of further required actions continues to progress.	10	31/03/2022	31/03/2025	31/10/2022
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	10/02/2022	Reasonably likely	Extreme	High risk	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	Scheme of work and design currently being produced.		30/10/2020	31/03/2023	30/06/2022
4937	Physical or psychological harm	Parkhill, Michael	Fitzmaurice, Philippa	Health and Safety Group	08/06/2022	12	Professional Guidance, Risk assessments	Corporate	Estates and Facilities	Health and Safety	Trust-wide	Health & Safety Executive regulatory action from non-compliance to health & safety legislation under the Management of Health and Safety at Work Regulations 1992, employers must assess the risks posed to the health of employees by workplace exposure.	Current arrangements in place provide staff with a referral process to Occupational Health for staff where health surveillance may be required when activities include the potential for exposure to: •Noise, hand-arm or whole body vibration •Solvents, fumes, dusts, biological agents, and other substances hazardous to health including contamination from a sharps or other incident •Asbestos, lead, ionizing radiation, work with compressed air or any other work which requires medical examinations and / or other forms of assessment under specific regulations. Policies Control of Substances Hazardous Health Training provided through Core Learning recorded via ESR undertaken as elearning on COSHH related substances and associated legislation. Governance of processes and systems through Trust Health & Safety Committee, site based health & safety forums department individual risk groups and Trust web based Datix system for reporting incidents.	Audits annual undertaken as part of health & safety management systems and by employees and their managers with direct referral to Occupational Health. Key departments have established their own monitoring arrangements with external providers but this is not consistent both in product type and or frequency of surveillance.	11/07/2022	Quite likely	High	High risk	16	Scoping exercise undertaken by health & safety to ascertain current position against best practise and other Trusts of same size. Review of the Trusts'present product provider of the service delivery to departments in terms of content duration and cost. Above information provided as a briefing paper. Monitoring of datix related incidents of accidents/ near miss to substances.	Risk made live as approval / oversight confirmed from Mike Parkhill as Director of Estates & Facilities. These risks were also shared/ acknowledged with members of the Trust H&S Committee- Chair being Simon Evans.	2	08/12/2022	31/12/2022	30/11/2022

Strategic Objective	3b. Make efficient use of our resources

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4664	Finances	Matthew, Mr Paul	Young, Jonathan		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	National policy: - Agency spending cap set by Government ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Annual budget setting process cascades and apportions the Trust temporary staffing spend limits to the Divisions and Directorates. - Monthly financial management & monitoring arrangements are in place to identify variation temporary staffing financial plans at all levels of expenditure from department up to Trust. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Financial Review Meeting (FRM)	22/06/2022	Extremely likely	High	Very high risk	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	The Trust has exited the 21/22 financial year with an agency spend of c£44m. This has in part been driven by COVID pressures and a large number of escalation beds open increasing the requirement for temporary staff. The Trust has agreed an ambitious CIP programme that is heavily focused on agency reductions through the recruitment of staff and reducing the number of NEL beds required. This will take time to embed. Reviewed at RRC&CG - score increased from 16 to 20.	8	31/03/2023	31/03/2023	31/07/2022
4665	Finances	Matthew, Mr Paul	Young, Jonathan	Financial Turnaround Group	11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £25m CIP target for 22/23. If the Trust fails to deliver The CIP Plan it will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to achieve their financial plans.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial plan inclusive of CIP. (Transformational) - Establishment of the service framework to prioritise Speciality improvement reviews. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process from 1st April. (Transactional) ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process - Programme Management Office (PMO) & dedicated Programme Manager. - Introduction of the Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes - Refresh of the FRMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I The Trust monitors internally against its CIP targets inclusive of specific Divisional and Scheme targets Divisional focus against Transactional schemes is reviewed at the relevant FRM Trust focus against Targeted and Transformational schemes is reviewed at the Improvement Steering Group	22/06/2022	Quite likely	High	High risk	16	- Refresh of the CIP framework and training to all stakeholders. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust IIP and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	The Trust has delivered its CIP plan for the past 3 years, albeit a reduced requirement during the 2 financial years that cover COVID. The Trust is embedding a new Improvement framework with CIP included within it and is also working with system partners to make financial improvements due to pathway changes. This will take time to embed and alongside the operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the CIP target. Reviewed at RRC&CG - agreed score of 16.	4	31/03/2023	31/03/2023	30/09/2022
4957	Finances	Young, Jonathan	Young, Jonathan		28/06/2022	16	Professional Guidance	Corporate	Finance and Digital	Finance	Trust-wide	The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. The national planning assumption is that all COVID costs incurred in Acute settings in relation to COVID will cease from 1st June 2022 aligned to the anticipated reduction in COVID patients to extremely low levels.	National policy: - Government financial planning assumptions due to COVID ULHT policy: - Financial plan set out the Trust Budget allocations in respect of COVID spend - Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). ULHT governance: - Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. - Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base. - The Planning and Recovery Steering group will provide oversight of the COVID costs.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FRM.	22/06/2022	Quite likely	High	High risk	16	Alignment of the Directorate and Divisional budgets to the national strategy for the removal of COVID costs from 1st June 20222. By exception reporting of all COVID costs not removed from financial positions.	The Trust incurred c£13m of direct costs in relation to COVID with a further indirect cost e.g. staff sickness. The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	8	31/03/2023	31/03/2023	30/09/2022
5045	Service disruption	Evans, Simon	Carter, Mr Damian		14/10/2022	15		Corporate	Operations	Operations	Trust-wide	The Trust may not be able to deliver fully on its improvement ambitions due to the impact of responding to level of emergency care demand affecting the capacity of senior leaders to concentrate on work designed to produce sustainable change.	Integrated Improvement Plan (IIP): - strategic planning process - programme and project management approach - IIP governance arrangements at Board / Trust Leadership Team (TLT) / Divisional performance management levels Improvement & Integration Directorate resource capacity and capability: programme and project delivery teams.	Monitoring level of emergency care demand - continues to be at exceptionally high levels. Monitoring delivery of IIP programmes / projects. Resource capacity amongst senior leadership and programme / project support - acknowledgement of existing gaps.	14/10/2022	Reasonably likely	Extreme	High risk	15	Management of operational priorities through TLT, PRM and leadership structures. Review of current plans and activities through performance and improvement forums to identify opportunities to reduce the number of project packages that would enable senior leadership and / or programme support resources to be reassigned.	[14/10/2022 16:35:01 Paul White] Initial risk assessment completed with Chief Operating Officer.	10	30/06/2023	30/06/2023	31/01/2023

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4965	Finances	Hallion, Simon	Edwards, Nick		11/07/2022	9	Workforce Metrics	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Financial risk due to reliance upon temporary staff (nursing and medical) to cover vacancies.	1. Scrutiny of rosters to ensure optimal use of existing staffing resources; 2. Review of all shifts that are placed with either Nursing or Medical Bank to ensure these are required; 3. Use of bank staff in preference to agency staff in view of potential cost savings; 4. Utilisation of tier 1 and 2 agencies in view of potential cost savings; 5. Use of long line agency in view of potential cost savings and increased assurance that shifts are safely staffed.	1. Reviewed via temporary staffing expenditure and safe staffing metrics; 2. Agency spend reviewed via at FPAM	12/09/2022	Extremely likely	Medium	High risk	15	1. Robust recruitment and retention plan for nursing and medical staff across Children and Young People Clinical Business Unit.	09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR Discussed at Risk Register Confirm and Challenge meeting. Confirmed that risk is solely financial as there is mitigation in place to ensure quality and safety are maintained (eg long line booking of regular agency staff). Some discussion about whether this risk should sit on the divisional risk register or whether it is captured in the corporate risk that focuses on the impacts of vacancies. To discuss at forthcoming risk meeting.	3	31/07/2023		31/10/2022
4384	Finances	Matthew, Mr Paul	Young, Jonathan		24/09/2018	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	If there is a substantial unplanned reduction in the Trust's income, or missed opportunities to generate income, it could have a significant adverse impact on the Trust ability to achieve the annual financial plan. Failure to deliver the nationally activity targets of 104% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire.	National policy: - NHS financial planning and monitoring processes ULHT policy: - Trust and System Financial Plans built from the bottom up Trust Divisional Demand and Capacity Plans. - The Trust national activity submission was aligned to the delivery of 104% activity targets for planned care PODs ULHT governance: - Internal weekly internal Planning and Restoration meetings to review progress - Improved counting and coding, including data capture and missing outcome reductions. - Shared risk and gain share agreements for the Lincolnshire ICS.	The Trust is monitored externally against the Trust activity target through the monthly activity returns. The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets. The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns.	22/06/2022	Quite likely	High	High risk	16	Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 104%.	The Trust and the Lincolnshire ICS ability to achieve the 104% activity target is a concern. The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 104% activity target. Reviewed at RRC&CG - agreed current score as 16.	8	31/03/2023	31/03/2023	31/12/2021
Strategic Objective						**3b. Make efficient use of our resources**																			
ID	**Risk Type**	**Manager**	**Handler**	**Lead Oversight Group**	**Opened**	**Rating (inherent)**	**Source of Risk**	**Division**	**Clinical Business Unit**	**Specialty**	**Hospital**	**What is the risk?**	**Controls in place**	**How is the risk measured?**	**Date of latest risk review**	**Likelihood (current)**	**Severity (currently)**	**Risk level (current)**	**Rating (current)**	**Risk reduction plan**	**Progress update**	**Risk level (acceptable)**	**Initial expected completion date**	**Expected completion date**	**Review date**
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the required data protection / privacy impact assessment process is not followed consistently at the start of a system change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	National policy: - Data Protection Act 2018 - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy (approved May 2018, due for review May 2021) & supporting appendices ULHT governance: - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group - Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles	Internal audit review of data protection / PIA processes	24/03/2022	Quite likely	High	High risk	16	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process.	Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues. Reference to DPIAs in Data Security and Awareness mandatory training. Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required. Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data.	4	31/03/2022	31/01/2023	30/06/2022
Strategic Objective						**4a. Have established collaborative models of care with our partners**																			
ID	**Risk Type**	**Manager**	**Handler**	**Lead Oversight Group**	**Opened**	**Rating (inherent)**	**Source of Risk**	**Division**	**Clinical Business Unit**	**Specialty**	**Hospital**	**What is the risk?**	**Controls in place**	**How is the risk measured?**	**Date of latest risk review**	**Likelihood (current)**	**Severity (currently)**	**Risk level (current)**	**Rating (current)**	**Risk reduction plan**	**Progress update**	**Risk level (acceptable)**	**Initial expected completion date**	**Expected completion date**	**Review date**

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5046	Service disruption	Evans, Simon	Carter, Mr Damian		14/10/2022	15		Corporate	Operations	Operations	Trust-wide	To avoid Trust clinical services becoming overwhelmed, resulting in a significant and prolonged adverse impact on the local community, the delivery of a safe winter plan has a high degree of dependency on system partners achieving a substantial reduction in demand for beds through the successful implementation of essential community schemes.	Local healthcare system operational winter planning process. Urgent Care Partnership Board sign off on winter plan and associated risks.	Monitoring levels of emergency demand. Monitoring levels of bed occupancy at each hospital. Trust clinical / ward staffing levels. Community / local authority capacity, finance and staffing data.	14/10/2022	Reasonably likely	Extreme	High risk	15	Chief Executives forum weekly review of winter plan and implementation of required demand reduction schemes. ULHT Urgent Care Improvement Programme to monitor delivery and impact of actions.	[14/10/2022 16:57:10 Paul White] Risk assessment completed with Chief Operating Officer.	10	31/01/2023	30/06/2023	31/01/2023
Strategic Objective						**For our people: Our people to lead, work differently and feel valued, motivated and proud**																			
ID	**Risk Type**	**Manager**	**Handler**	**Lead Oversight Group**	**Opened**	**Rating (inherent)**	**Source of Risk**	**Division**	**Clinical Business Unit**	**Specialty**	**Hospital**	**What is the risk?**	**Controls in place**	**How is the risk measured?**	**Date of latest risk review**	**Likelihood (current)**	**Severity (currently)**	**Risk level (current)**	**Rating (current)**	**Risk reduction plan**	**Progress update**	**Risk level (acceptable)**	**Initial expected completion date**	**Expected completion date**	**Review date**
4991	Service disruption	Matthew, Mr Paul	Low, Claire	Workforce Strategy Group	08/08/2022	20		Corporate	People and Organisational Development	Operational HR	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	ULHT policy: - Workforce planning processes - Recruitment & Selection Policy & Procedure - Rota management systems & processes - Locum temporary staffing arrangements - Workforce management information - Core learning / Core+ programmes? ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Vacancies & turnover rate. Staff survey results relating to job satisfaction / retention. Core learning compliance rates?	12/07/2022	Extremely likely	High	Very high risk	20	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	1. New to care recruitment being extensively used for HCSW role with 14 appointed & a further 40 offered. 2. Nursing associate recruitment embedded 3. Medical Support Worker role now looking to be embedded as business as usual. 4. Agency providers increased to a minimum of three for key roles, rather than 1 previously. 5. Restructure process started within wider HR team will result in significant greater capacity for recruitment activities and overall oversight and proactivity. 6. Restructure process started, to introduce internal agency aspect to ULHT recruitment. 7. Medical recruitment expertise aspect being reintroduced via restructure, support already in place via agency staff. 8. Relationship with LRDP now embedded, GMC registered Drs and MSWs recruited. 9. Agreement reached with third party supplier to support Philippines recruitment for difficult to recruit AHP roles. 3 recruits in progress	4	31/03/2023	31/03/2023	31/08/2022
4992	Regulatory compliance	Matthew, Mr Paul	Low, Claire	Equality, Diversity and Inclusion Group	08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	WRES (Workforce Race Equality Standard): low compliance/ limited improvement and action to address indicators i.e. increase senior representation and better lived experience of BAME staff working in ULHT. Risk is this results in low number of applications for vacancies which then remain unfilled (difficulty attracting talent); poor turnover rates (difficulty in retaining talent) and a poor employer brand locally, regionally, nationally and overseas. This will impact on the culture of the organisation and the ability to recruit with increased turnover. Wider risk with regards to broader protected characteristics linked to the delivery of the EDI objectives.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	12/07/2022	Quite likely	High	High risk	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	1. EDI Group and regular reporting established (for assurance) 2. Anti racism strategy and delivery plan socialised with stakeholders and live 3. NHS Staff Survey results - deep dive and analysis of lived experience of staff with protected characteristics 4. Draft EDI objectives 2022-25 - socialised and ready for sign off (end June) 5. ULHT workstream lead - addressing BAME disciplinary gap (Lincs Belonging Strategy) 6. People Promise Manager successfully appointed from end May'22	4	31/03/2023	31/03/2023	31/10/2022
4993	Regulatory compliance	Matthew, Mr Paul	Low, Claire	Equality, Diversity and Inclusion Group	08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	WDES: (Workforce Disability Equality Standard): limited awareness and implementation of reasonable adjustments and other forms of support which results in limited equality and equity of opportunity for staff classified as having a 'disability'; impedes Trust's ambitions to create an inclusive culture and foster belonging; difficulties in attracting as well as retaining talent	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	12/07/2022	Quite likely	High	High risk	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	1. WDES action plan prioritised for engagement, development and delivery 2. July 2022: ULHT review datasets, declaration rates (from 1/7/22 ULHT required to submit metrics and narrative data via the DCF online platform by Aug'22). 3. End October 2022: deadline for ULHT to publish WDES 2022 annual report (include metrics report and WDES action plan)	4	31/03/2023	31/03/2023	31/10/2022
Strategic Objective						**For our services: Sustainable services making best use of resources, technology and estate**																			

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4641	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	23/11/2021	16	Risk assessments	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	19/05/2022	Quite likely	High	High risk	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	Risk reviewed, description amended to reflect broader range of threats to the digital infrastructure. Current score increased to 16. Have purchased a significant number of Radios, to allow communication in the event of failure. We've completed a Network Core Switch replacement at Pilgrim new Data (DC3) at Pilgrim to provide resilience at site backup across site has been improved. Recovery Vault is in the process of implementation The Metro-Cluster is in the process of implementation.	4	31/03/2023	31/03/2023	18/08/2022
4938	Regulatory compliance	Rimmer, Lucy	Cooper, Mrs Anita		09/06/2022	15	Clinical Audit Reports	Clinical Support Services	Cancer Services CBU	Blood Transfusion	Trust-wide	No formal contract in place for electronic Blood tracking, hence failure to meet blood safety & quality regulations 2005. ULHT Current contract expired 28/2/2022 - A risk of 'Cease and Desist' order being placed on blood banks Trust wide if an inspection is carried out by Medical Healthcare Regulatory Agency (MHRA) The delay in renewing this contract by the end of August means that the ipod devices used for bed side transfusion checks, the apple licences will expire. Ipods will not be able to be used increasing the risk of wrong blood to patient. The new contract has outlined that licences for ipods will not be required as all data will be stored on the cloud.	Msoft e solutions have extended maintenance and support service whilst the renewal of contract is being considered. Blood tracking system remains functional at present	data analysis	02/09/2022	Quite likely	High	High risk	16	Business justification and case of need is being submitted to CRIG for renewal of 5 year contract. Securing a new contract will remove the risk of blood bank closure by MHRA and result in compliance to Blood Safety and Quality Regulations (BSQR) .	Ipod licences expire on August 23rd. Even though Msoft are providing support the application update from Msoft might require further finance (apple licence). Funding not approved by DOF, risk remains the same.	2	01/08/2022		11/07/2022

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*1 November 2022*
Item Number	*Item number 13.2*

Board Assurance Framework (BAF) 2022/23

Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*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 our resources	*X*
3c Enhanced data and digital capability	*X*
3d Improving cancer services access	*X*
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	*X*
3f Urgent Care	*X*
4a Establish collaborative models of care with our partners	*X*
4b Becoming a university hospitals teaching trust	*X*
4c Successful delivery of the Acute Services Review	*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	• *Moderate*

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure* • *Confirm the proposed AMBER rating of objective 4c – Successful delivery of the Acute Services Review*

Executive Summary

The relevant objectives of the 2022/23 BAF were presented to all Committees during September and the Board are asked to note the updates provided within the BAF.

Updates provided to the Committees and offered to the Board are identified by green text.

Following review through the Committees the Finance, Performance and Estates Committee are proposing the objective 4c – Successful delivery of the Acute Services Review be rated amber from green.

Updates provided to the Committees and offered to the Board are identified by green text.

The following assurance ratings have been identified:

Objective		Rating at start of 2022/23	Previous month (September)	Assurance Rating (October)
1a	Deliver harm free care	Green	Green	Green
1b	Improve patient experience	Amber	Amber	Amber
1c	Improve clinical outcomes	Amber	Green	Green
2a	A modern and progressive workforce	Red	Amber	Amber
2b	Making ULHT the best place to work	Red	Red	Red
2c	Well led services	Amber	Amber	Amber
3a	A modern, clean and fit for purpose environment	Amber	Amber	Amber
3b	Efficient use of resources	Amber	Red	Red
3c	Enhanced data and digital capability	Amber	Amber	Amber
3d	Improving cancer services access	N/A	Red	Red
3e	Reduce waits for patients who require planned care and diagnostics to	N/A	Amber	Amber

	constitutional standards			
3f	Urgent Care	**N/A**	**Red**	**Red**
4a	Establish collaborative models of care with our partners	**Amber**	**Amber**	**Amber**
4b	Becoming a University Hospitals Teaching Trust	**Red**	**Red**	**Red**
4c	Successful delivery of the Acute Services Review	**N/A**	**Green**	**Amber**

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2022/23 - October 2022

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

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Programme of work in place to implement the requirements of the National Patient Safety Strategy (culture and systems) Human Factors faculty in place and face to face training restarted. Commencing next steps of cultural work with external agency. Pascale survey work continues to be undertaken. Safe to Say Campaign launched. (PSG)	Further work required in conjunction with People and OD to develop the Just Culture framework. Issues linking National Patient Safety Training to ESR are impacting on our ability to meet National training requirement.	To be considered as part of the Trust Culture and Leadership Programme	Safety Culture Surveys Action plans from focus groups and Pascal survey findings. Regular update reports to the Patient Safety Group and upwardly reported to QGC and through TLT. Theatre Safety Group reporting progress against a Quality Improvement plan to PSG. Regular upward reports received from Divisions.	None identified	Not applicable		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	None identified.	Not applicable	Upward reports from QGC sub-groups 6 month review of sub-group function Annual review of QGC takes place.	None identified	Not applicable		
						Effective sub-group structure and reporting to QGC in place (CG)	None identified.	Not applicable	Sub-Group upward reports to QGC	None identified.	Not applicable		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamination and other estates- related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		
						Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). Infection Prevention and Control BAF in place and reviewed monthly IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	Non-compliance with some aspects of the Hygiene Code.	Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC. IPC policies have been updated / developed / written in line with the timetable. •Estates and Facilities/Decontamination Lead has made good progress with estates and facilities work and is awaiting a place on a specialist decontamination course. • Good progress with achieving and sustaining standards of environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve Very good progress with work to achieve compliance with new National Standards of Cleanliness directive and this continues to be taken forward via a Task and Finish Group with monthly monitoring by the IPCG • Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG. Training has been delivered to approximately 40 members of staff to undertake SJR's. Bespoke training and support offered from the Mortality team to the Divisions. (PSG)	Gaps in the number of structured judgement reviews undertaken - this is not across all Divisions, good practice exists and is demonstrated through the mortality group. Impact of Covid-19 on coding triangles	Following the success in UTOO for ACP's contributing to the SJR reviews, further training is going to be rolled out to the MDT.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Dr Foster data on depth of coding. Dr Foster data is now available.	Gap identified in the ability to draw learning from SJR's due to ongoing delays with completion Inconsistent approach to Mortality and Morbidity meetings across specialties.	Local data sources are used where possible. Gaps in learning mitigated by ME process and escalation of concerns via incident management processes. New Deputy MD reviewing MORaLs and M&M meetings with a view to making recommendations.	Quality Governance Committee	**Green**
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG)	Clinical harm review processes not all documented & aligned with incident reporting Recognition of a skills gap for investigations at different levels of the organisation	Implementation of a Clinical Harm Delivery Group reporting into the Clinical Harm Oversight Group which is a sub-group of QGC. Appointment of a Clinical Harm and Mortality Manager Investigation training will be addressed as part of the implementation of the PSIRF and National Patient Safety Strategy. Plan to refocus PRM with a specific focus on quality and safety.	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports Strong divisional reporting to MORALs	None identified.	Not applicable		
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Improvement seen across all divisions in terms of development of NatSIPs/LocSIPs, however audit is required in order to provide assurance of implementation.	Individual Divisional meetings now in place; quarterly reporting to PSG Additional support provided to medicine from the Patient Safety Improvement Team	Audit of compliance	Pilot audit tool developed and currently being trialled prior to full rollout.	Review occurring through the Divisional meetings with quarterly reporting 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 maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19			Medicines Quality Group in place with a focus on reducing medication errors Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit MQG and MMT&FG will retain oversight of the relevant IIP programme of work, including DKA. (MQG & MMT&FG)	Lack of e-prescribing leading to increase in patient safety incidents due to medication errors Gaps identified within the recent internal audit undertaken by Grant Thornton	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Medical Director led Medicines Management Task & Finish Group convened to ensure the required pace and progress of delivery of the Improving the Safety of Medicines Management IIP. Divisional representation at the Task & Finish Group confirmed as Divisional Clinical Director or Divisional Nurse. Action / Delivery Group also in place and meeting fortnightly to progress actions and reporting to the Task & Finish Group.	Upward Report from the Medicines Quality Group to QGC Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group	Medicines Quality Group have not been receiving reports regarding progress with the medicines management IIP; there has been a lack of Divisional attendance at the Medicines Quality Group	Divisional representation at Medicines Quality Group reinforced by Medical Director and Director of Nursing and template for divisional reporting of BAU medication safety activities in to Medicines Quality Group developed and in place		
						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training occurs through MNOG.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA (Ensuring early detection and treatment of deteriorating patients) (PSG)	Work required to develop the maturity of the group. New Chair identified and full review of membership and remit required. Maturity of some of the sub-groups of DPG not yet realised. This will be considered as part of the review of DPG.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF 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	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 Number of incidents occurring regarding lack of recognition of the deteriorating patient	DPG meeting not meeting as frequently due to loss of Chair. New Chair identified and commenced in post October 2022.			
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	New funding needed to continue restraint training delivery. Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months. Further work has taken place with LPFT to consider a joint approach to training - awaiting options paper from LPFT	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting from Mental Health/ Learning Disability and Autism Oversight Group	No active Restraint training available within the trust	Small business case paper being submitted for funding decision at the end of March 2022 - if successful plan to start training delivering in July 2022. Adhoc session being delivered to Security providers to ensure appropriately trained Datix being monitored by safeguarding team to ensure review of any restraint incidents		
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG) One central monitoring process now in place.	Review of compliance metrics required.	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads(CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				

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						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 - the group continues to develop its maturity Meeting may be stood down due to operational pressures at time of operational extremis.	The Group meets monthly and has a work plan and schedule. If the meeting is stood down, then the papers are reviewed and Chairs report provided.	Upward reports to QGC monthly and responds to feedback Review of ToR in May 2022 and annually as part of the work schedule. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report Divisional Reports have developed in reporting maturity and include a patient story / risks and issues / actions. This is a well embedded part of the PEG meeting.	Themes from the Divisional assurance reports and the Complaints reports and others sources of information are being triangulated, so oversight across the themes is clear, this is work in progress.	Overall report being developed and monitored through PEG.		
						Patient Experience & Carer plan 2019-2023 (PEG)	There has been a delay in the output of some objectives in the Plan	Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level. Patient & Carers Experience Plan is currently being reviewed and will be approved at next PEG (Sept 22).	Patient Experience & Carer Plan progress report to Patient Experience Group .	Limited assurance until the plan is reviewed.	The new plan will be seen at the next PEG		
						Quality Accreditation and assurance programme which includes weekly and monthly audits which include feedback on patient experience from patients in the clinical areas.(PEG)	Further development of alignment of findings in audit data to patient experience surveys overarching plan and other sources of patient experience information. Annual Ward / Dept quality review visits may be paused due to operational pressures in times of extremis.	Head of pt experience can access the audit date. Deep dives into areas of concern as identified in quality metrics dashboard meetings Update reports to PEG and QGC as required. Weekly and monthly audits continue to take place including during times of extremis.	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, which include the patient experience team as part of the visit team. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support.		

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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	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. You Care - We Care to Call (YCWCC) Campaign pilot being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. Communication working group set up to look at a range of communication issues affecting patient experience.	Upward reports and minutes to the Patient Experience Group IIP reporting to Support & Challenge group.	Diversity of patient engagement and involvement is limited.	CCG exploring dev of a Health Inequalities cell to combine efforts in reaching out. Date not yet secured. ULHT Experts by Experience project progressing with Mastalgia Expert ref group (ERG)established, Cancer Board recruiting 2022 discussions continue with Gastro & CYP (Expert Families). Cancer ERG commenced May 22; Dementia Carers ERG commenced August 22.	Quality Governance Committee	**Amber**
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting.	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work.	Report to PEG through complaints & PALs reports; upward reports from Visiting Review working group. Visiting experience section within complaints & PALs reports.		Complaints/PALs reports to include visiting concerns; div ass reports to include visiting related issues. Visiting review indicates inconsistency in EoL visiting; criteria and process being strengthened. Request to ME's to ask relatives about visiting experience at EoL.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports will need to develop in maturity regarding patient experience	Head of Pt Experience to discuss with EDI lead to ensure data is relevant and triangulated.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic;	PLACE Lite continues & reports to PEG.		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements.	Discharge experience reports to PEG quarterly.	Lead Nurse for discharge to attend PEG in October.	Patient Experience Team to meet with Lead Nurse for Discharge to support and ensure experience data is collected, analysed and acted upon.		

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						Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust.	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics.	Review of Terms of Reference to be undertaken. Invites to speakers to come direct from Mr Simpson as Chair of the Group in future.	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	Isolated pockets where upward reports are not always submitted.			
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (CAG) with quarterly reports to QGC (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed and workshops planned with leads, led by the Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates meaning that reporting to QGC is not as up to date as expected.	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate Meeting to take place with Medical Director and Audit Leads to discuss role and expectations, however attendance has been impacted by operational pressures.		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable	Quality Governance Committee	**Green**
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	Not applicable		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down although this is due to recommence.	National reports to be presented at Governance Meetings once produced		
						Specialised services quality dashboards (SSQD)	SSQD data collection now commenced again post Covid. Areas with outliers identified with some plans for improvement, however not all required areas currently have plans.	Continued support from the Clinical Effectiveness Team and requirement to attend CEG and provide update on progress.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	Actions plans not yet received for all necessary areas.	Continued requirement to attend CEG to provide updates.		
						Process in place for implementing requirements of the CQUIN scheme.	Plans now in place for delivery of 2022/23 CQUINs, although assurances not yet received that these are fully implemented.	CQUIN delivery group commenced again.	Quarterly reports to CEG and upwardly reported to QGC	Some gaps identified in reporting processes.	Being dealt with via the CQUIN delivery group		
						Process in place for ensuring high quality of record keeping including Medical Records Group.	Medical Records Group not meeting regularly.	Refocus of the Medical Records Group planned by the new Chair.	Programme of record keeping audits taking place.	Audits do not demonstrate compliance with record keeping standards.	Divisional governance leads to pick up within each area.		
						Process in place for monitoring of and implementation of NCEPOD requirements.	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.				
						Enhance clinical effectiveness by ensuring that care delivered to patients is based on evidence based, best practice leading to improved clinical outcomes			Implementation of the SAFER bundle				

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SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)	People System Plan has been reviewed and objectives agreed	System People Team/People Board	System PP - Each 'pillar assigned system lead Progress/assurance reported to People Board (quarterly) Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan Priorities agreed for 2022/23		Monthly updates on progress are tabled at local People Team Meeting and People Team Board, with each of the pillar leads agreeing key performance indicators. The final people hub role (Attraction Lead) was appointed week and commencing in post in October 2022. Regular monthly pillar lead meetings also are now embedded in the diary to escalate any issues/offers of support.		
						Workforce planning and workforce plans	Overall vacancy rate declining	A new pillar for workforce planning and transformation is being created as part of the People Directorate restructure. The Trust have an Associate Director of Transformation and Workforce planning in post who is leading workforce planning in conjunction with HRBP's, finance and improvement team. This is established and regular reviews are now in place.	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend.	Some areas remain hard to fill however full and comprehensive workforce plans are in place 'plan for every post' and workforce scorecards are in place and are reported through to the Operational Workforce and Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board.	The workforce plan was submitted and work continues to measure the deliverables set against the plan with HR/Finance and Planning. Working closely with the SHRBP's pipeline and vacancy information is tabled at the FPAM meetings and a full scorecard is now tabled with escalation in place for People & OD Committee highlight report. A system wide Workforce Model is in development via KPMG and will be launched mid-October 2022, which will provide a platform for robust, triangulated planning for the ICB and Providers.		
						Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up and completion of actions. Recruitment key performance metrics feature as part of the People & OD scorecard which is tabled at the Workforce Strategy and Operational meeting and then is reported upwards by expectation to People & OD Committee via the highlight report.		Recruitment has been busy with doctors rotation and a new AAC process which is being currently being rolled out. Additional resource has been sourced and bi weekly recruitment deep dive is now held by Deputy Director of People & OD. Recruitment are working very closely with the divisions/HR and as a system a potential overseas trip is being planned for India (nurses/AHP's). Recruitment training is due to go live with Managers in October and the recruitment team has now been aligned to three distinctive areas - AFC/Medical/Overseas.		

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2a	A modern and progressive workforce	Director of People and Organisational Development	Vacancy rates rises Turnover increases Sickness absence rises Under-investment in education & learning Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce	4362	CQC Safe CQC Responsive CQC Effective	Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established (8B - 12 month) Temp/12 month fixed term People Promise Manager appointed (Liz Smith - ULHT) from end May 2022	IIP projects on hold	IIP Projects New Appraisal launched (Jul22) - aligned with PP and supported with new resources and information to improve quality and frequency of Appraisals Appraisal Improvement Plan - agreed Sept'22 Mandatory Training Improvement Plan to be developed Mandatory Training Reference Group established to provide oversight Mandatory Training Assurance Group to be established (ensure representation from business areas and staff groups) Talent management - on hold	Regional Midlands Talent Board Model Employer ambition Executive CQC Assurance Panel Appraisal compliance Mandatory training compliance	Appraisal compliance levels not at expected level Mandatory Training compliance not at agreed level	Newly reset Appraisals process for AfC staff now in place and further work required to move to an Appraisal 'season' and incrementally introduce 360 feedback to process. Review of mandatory and statutory training essential subjects ongoing Consideration of platform and ease of access for all staff groups identified as areas for development	People and Organisational Development Committee	**Amber**
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff - To be discussed following review of development offer (on hold)					
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	The AMS project has been relaunched and additional capacity identified. Training has started to be rolled out with divisions and a position paper is currently being prepared. Reporting will start to feature as part of the Workforce Cell meetings and monthly one to ones with key HR staff. Work continues to highlight absence stats through the PRM meetings via the SHRBP's and AMS have presented an overview of the reporting functionality to HR and Trust executives which will move forward in terms of deep dives into the data available. Sickness data is now included as part of the Finance People and Activity Meetings (FPAM) in which the SRHBP's present key metrics and plans to address escalation issues.		

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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 Establish ULHT Education and Learning service (pending P&OD restructure)	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 System LEAD (Learning, Education and Development) Board to provide system oversight (agreed)		Linked to restructure and a more internal focus on the talent academy ensuring maximisation of the apprenticeship levy and the creation of an Education Department.		
						Creation of robust Workforce Plan •Values based recruitment and retention •Maximising talent management opportunities •Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn' Promote benefits and opportunities of Apprenticeships			Improved vacancy rates		Direct link to workforce planning. Review of assessment centres and time to hire are key pieces of work currently under way. Final stages of reviewing the ACC process for consultant recruitment.		
						Improve the consistency and quality of leadership through:- Reset leadership development offer and support (Leadership SkillsLab and PME) •Improved mandatory training compliance •Improved appraisals rates using the WorkPal system •Developing clear communication mechanisms within teams and departments			Appraisal rates and training development Workforce and OD Group IPR - Appraisal compliance Culture and Leadership Group		Measured through the people metric scorecard and escalated to the People & OD Committee if needed.		
						Providing a stable and sustainable workforce by:- •Ensuring we have the right roles in the right place through strong workforce planning •Reducing vacancy rates and ensuring that posts are filled through a positive and values recruitment approach •Reducing our agency staffing levels/spend •Strengthening the Medical Workforce Job Planning processes							

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						NHS People Plan & System People Plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future	Awaiting sign off of system people plan Delivery of IIP projects in early stage of delivery	People Plan - in draft System EDI Strategy underway 5 pillar -leads confirmed (ULHT Lead for leadership and lifelong learning)	People Board		Linked to delivery of the system People Plan agenda as above.		
						Alignment with People Promise Reset and alignment of Trust values & staff charter (with safe culture) Reset ULH Culture & Leadership	Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Group Culture and Leadership Programme Group upward report	Delivery of agreed output	Improved function of group and reporting to be in place for November report		
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) Leadership SkillsLab - launched June'22		Leadership SkillsLab - launched June'22	National Quarterly Pulse surveys (mandated from July'22) 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		

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	Lincs Belonging Strategy EDI Delivery Plan 2022-25	EDI Group (report to PODC) live from Dec 2021 Reset of ULHT EDI objectives 22-25 (PSED) from Jun'22	EDI Group membership reset - to ensure representation and coverage	Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NNSS	New WRES_22/23 Action Plan New WDES_22/23 Action Plan	Ongoing monitoring of WRES and WDES action plans and EDI Objectives delivery plan (Y1) through Committee. WRES/WDES and Internal Audit actions being monitored through Committee. The Trust has committed to implement and embed the Leading Inclusively with Cultural Intelligence (CQ) programme across the Trust and develop a social movement of intentionally inclusive leaders. A launch event has been held for CQ and masterclass sessions now created for members of the Trust leadership team to enrol. Work continues for the creation of a dedicated intranet website and members page.	People and Organisational Development Committee	**Red**
						Staff networks	Universal Terms of Reference Strategic goals and objectives	Continued work to embed the networks and provide them with effective support Following recruitment of new SN Chairs - agree Universal Terms of Reference Support groups in developing strategic objectives for the next 12 months	EDI Group Council of Staff Networks		Governance for EDI Recruitment process for SN Chair/VC - Feb'22		
						Demonstrate that we care and are concerned about staff health and wellbeing		EAP implementation from May'22	System Health & Wellbeing Board Linc People Board (NB. Wellbeing Pillar) Employee Wellbeing Group (pending)	OH KPIS to be agreed (for reporting to PODC) System Hub activity Wellbeing activity (for reporting to Workforce and OD Group)	Commence reporting from 2022		
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian		Junior doctor forum	Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee		Junior Dr Survey results (alignment with NNSS21 findings)		

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						Embed compassionate and inclusive leadership (aligned to People Promise)			Culture and Leadership Group Culture and Leadership Programme Group upward report		Robust programme of Cultural Intelligence training now in Phase 2 of delivery by the Head of EDI.		

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2c	Well led services	Chief Executive	Risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes 4 sessions during Oct / Nov 21 Risk Register Confirm and Challenge Group ToRs Upgrade to datix system Full Risk Register review	Policy and Strategy document updated	Complete	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**
						Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6			
						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy management reviewed and updated	Move of policies in to SharePoint reliant on progress with Trust intranet. Timeline delayed through Covid Divisional breakdown of policies requiring review being shared with PRMs	Review of document management processes - Complete New document management system - SharePoint - In place Reports generated form existing system - Complete All policies aligned to division and directorates - Complete Single process for all polices clinical and corporate - Complete	Fortnightly ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
						Ensure system alignment with improvement activity							

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SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 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. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.	Finance, Performance and Estates Committee	**Amber**
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments PLACE Full assessments starting in September 22	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response. With PLACE Full assessments starting in September gaps will be closed further.		
						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	Improvement teams have started in 2022/23 working through value for money and financial efficiency schemes included development of Housekeeping, Security and Portering Business Cases for future models	MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Groups will report through to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not with Annual Reporting providing assurance and gap analysis on all AE domains.		

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						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report Letter from British Safety Council on External Review				
						Implement Year 1 of our Estates Strategy	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes					
						CIP - Refresh of the CIP framework and training to all stakeholders. Increased CIP governance & monitoring arrangements introduced. Alignment with the Trust IIP and System objectives CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	Operational ownership and delivery of efficiency schemes Detailed delivery plans supported by clear timelines and metrics	Divisional FPAM to provide oversight of Transactional CIP reporting upward into PRMs, Trust wide oversight for Targeted and Transformational schemes in the Improvement Steering Group, System oversight of organisational cross cutting schemes.	Delivery of the Trust CIP target	Ability of clinical and operational colleagues to engage due to service pressures. Evidence of system and Trust schemes to reduce the operational pressures and beds numbers in the Trust. Traction in year to produce cost out from cross cutting targeted and transformational schemes	Divisional - Progress is being reviewed monthly with Divisions through FPAMs. Trust wide improvement schemes - Progress is being reviewed monthly with Exec, Divisional and Corporate teams through the Improvement Steering Group. System wide - Progress is being reviewed monthly with system partners including Exec, Operational and Corporate teams through various forums.		

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3b	Efficient use of our resources	Director of Finance and Digital	Not identifying and then delivering the required £29m CIP of schemes The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 22/23 financial settlements The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. Failure to deliver the nationally activity targets of 104% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire. Substantial unplanned reduction in the Trust's income, or missed opportunities to generate income	4382 (CIP) - Risk rating 16 4383 (Reliance on agency) - Risk rating 20 4596 (Inflation impact) - Risk rating 6 4384 (ERF Clawback) - Risk rating 16 4957 (COVID costs) - Risk rating 16	CQC Well Led CQC Use of Resources	Inflation - The Trust is working to actively manage its contracts and to flag excess inflation due to market conditions as part of the national collection process in relation to this spend area	Impact of unstable market conditions led to the Trust forecasting excess inflation of £5.8m in its 2022/23 financial plan, primarily in relation to Utility costs but also impacts in other non-pay contracts. As prices continue to rise may be unable to mitigate these cost increases.	Financial plan set out the Trust expectation in respect of inflation aligned to the national allocations Annual budget setting process cascades and apportions the Trust inflation allocation to Divisions and Directorates. Monthly financial management & monitoring arrangements are in place to identify variation of excess inflation against financial plans at all levels of expenditure from department up to Trust. The Trust actively manages its external contracts to ensure value for money.	The Trust is monitored externally against the inflation impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific inflation forecasts Divisional focus against specific contracts (e.g. Utilities) is reviewed at the relevant FPAM	Forward view of market conditions.	Internally through FPAMs and upwards into FPEC. Externally through greater dialogue with suppliers and proactive contract management	Finance, Performance and Estates Committee	Red
						Agency - Financial Recovery Plan schemes: Recruitment improvement; Medical job planning; Agency price reduction; Workforce alignment	Reliance on temporary staff to maintain services, at increased cost Management within staff departments and groups to funded levels. Maximisation of below cap framework rates Rapid ability to on-board temporary staff to substantive contracts	Proposed centralised agency & bank team. Workforce Groups to provide grip Improvement Steering Group to provide oversight Non-Clinical Agency sign off process	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans. Rota and job plan sign off in a timely manner Large scale recruitment plans to mitigate vacancies.	The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups		
						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 104%. National steer is to not clawback under delivery in H1	Maximisation of the Trust Resources - Theatre and Outpatient productivity. Impact of the COVID patients and flow on availability of beds to provide capacity. Ability to recruit and retain staff to deliver the capacity.	Divisional ownership and reporting Improved counting and coding, including data capture and missing outcome reductions. Shared risk and gain share agreements for the Lincolnshire ICS.	Delivery of the 104% target	The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 104% activity target.	The Trust is monitored externally against the Trust activity target through the monthly activity returns The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns		

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						COVID costs - The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID.	The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	Financial plan set out the Trust Budget allocations in respect of COVID spend Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. QIA of risk of removal of all COVID schemes, outcomes reviewed at TLT for decision Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base.	Cease or approved COVID costs continuation as part of the Trust investment prioritisation process.	Correlation between the response to COVID and the new cost base. Ability to remove COVID costs at pace. Prevalence of COVID patients in the Trust.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FPAM.		
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal		EMAS, GPs, mental health, community, social care and care homes data now also available within the Care Portal.		
						Development and approval of Electronic Patient Record OBC		Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of OBC		EPR OBC to be approved by Frontline Digitalisation NHSE/I OBC requirements (including financial) being worked through with Frontline Digitalisation NHSE/I OBC approved at Aug FPEC and Sept Board		

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3c	Enhanced data and digital capability	Director of Finance and Digital	Approval of OBC for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure		CQC Responsive	Rollout of PowerBI as Business Intelligence Platform during 2022/23			Delivering improved information and reports Implement a refreshed IPR Rollout increasing, having replaced QlikView dashboards. New dashboards in place to support Vaccination reporting and HR EF3 processes. Work underway to automate IPR production for Trust Board and Committees, as well as Divisional PRMs.	IPR refresh for 22/23. Completed for Jan 2022	Steady implementation of PowerBI through specific bespoke dashboards and requests.	Finance, Performance and Estates Committee	**Amber**
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues						
						Improve end user utilisation of electronic systems	Business case for additional staff under development						
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion.		
3d	Improving cancer services access	Chief Operating Officer	Insufficient clinical capacity, insufficiently optimised pathways, Dependency on services (primary care, pathology) that are unable to deliver required access or level of service		Cancer Standards 62 day, 14 day and 28 Day FDS	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Cancer Care Integrated Improvement Programme and Assoc Governance System Cancer Improvement Board	Recovery post COVID and risk of further waves Specialty Capacity strategies not in place Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) East Midlands Cancer Alliance Increased Oversight	Cancer board assurance and performance reports Deep Dive information and reports on gap analysis Routine Performance and pathway data provided by Sommerset system	Process information below the cancer stages are not always captured Some digital systems are not linked and not all wait information is recorded e.g. MIME system	Targeted Improvement (Daily reviews) of key concern specialties increase the scrutiny of reporting and pathway performance led by COO	Finance, Performance and Estates Committee	**Red**
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer	Insufficient clinical or physical capacity, insufficiently optimised pathways		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Planned Care Integrated Improvement Programme and Assoc Governance System Planned Care and Diagnostic Group	Recovery post COVID and risk of further waves Specialty strategies not in place Elective Theatre Programme Transformation team not yet established.	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Outpatient Improvement Group Foureyes Theatre Improvement Programme GiRFT and High Volume Low Complexity Programme Group	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and NHSE Review data			Finance, Performance and Estates Committee	**Amber**

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3f	Urgent Care	Chief Operating Officer	Insufficient clinical capacity or expertise, inefficiently configured services, failure of system partners to provide capacity or reduce demand to pathway and excessive demand above capacity available		Emergency Care Clinical Indicators (12hr, 4 hour CRTP, 60 minute decision and 15 minute triage)	Daily System control meetings in collaboration with 3x daily internal capacity meetings. Integrated Improvement plan for urgent care and Urgent Care improvement Group. System Urgent Care Partnership Board. LHCC Improvement Programme Board and LHCC Board	Recovery post COVID and risk of further waves Internal professional standards not embedded External dependencies lack of visibility of capacity and system control to move risk/capacity between services. E.g. community care hours, care home ,assessment capacity etc.	External reviews used to identify gaps in services and assess capacity shortfalls. Emergency Care Intensive Support Team, IMPOWER specialist consultants and Dr Ian Sturgess specialist consultant reviews identify control and process and capacity gaps.	Improvement against strategic metrics Suite of performance metrics and benchmarking % of patients in Emergency Department >12 hrs (Total Time) Reports produced by ECIST IMPOWER and Improvement Consultants	Gaps in Early Warning Dashboard Pathway 1 capacity admission avoidance impact, waits and capacity for primary care.	LHCC Programme Board reviewing Early Warning Dashboard - additional reports on progress LHCC Programme Board reviewing progress Weekly CEO Forum review where evidence is and any gaps	Finance, Performance and Estates Committee	**Red**
SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
			Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and			Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority specialities for service reviews by July 2022.		
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements in 22/23- (1) continued improvements in patient safety and experience (2) reduce long waiting times for treatment (3)make our people feel valued and supported by improving our culture and leadership	Embedding and sustaining cultural change when we remain operationally challenged with staffing issues etc. Ability to demonstrate quick impact on the cultural change due to various interventions as part of our Outstanding Care Together programme will be limited (as these are multi year/multi factorial projects)	ELT/TLT oversight Board / system reporting	Updated IIP reported at relevant Board Committees	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh		

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4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	other planning priorities puts an added constraint on time, capacity and headspace to engage with the ICS agenda. Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor institutions		CQC Caring CQC Responsive CQC Well Led	Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain ULHT anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS	Finance, Performance and Estates Committee	**Amber**
						Developing a business case to support achievement of University Hospital Teaching Trust Status	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee	Further understanding of the costs involved to increase size of R&I department and also to develop an R&I facility	R&I team reworking business case with a phased approach		
						Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increase clinical academics by 20 and RCF funding worth £200k within the last 2yrs Further clarification and implications of the changed guidance on univ hospital status required. Funding for Clinical Academic posts and split with UOL to be agreed	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Contract agreed with UOL for Clinical academic posts. UoL have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - linked to roadmap and Research Event to identify specialties. RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position - now amalgamated into the monthly Steering Group with ad hoc meetings between SRO's where needed to discuss funding for Clinical Academics. ULHT have a recruitment roadmap in place which will include some pump prime from vacancies. Additionally a joint Research Event is being planned for Q3 of 2022/23 with the University to identify future areas of collaboration with research and Clinical Academic recruitment.		

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4b	Becoming a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Improve the training environment for students	Understanding of our offer of the facilities required for a functioning clinical academic department	Revision of the library and training facilities to ensure that facilities are fit for purpose for all staff who will require access to training facilities, library, ICT equipment to be able to perform their role. This will be aligned to the UHA Guidance, and will include those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unknown timescales of completion	University Teaching Hospital Status working group has been renewed with more drive, ensuring representation from key stakeholders and clear milestones for delivery	People and Organisational Development Committee	**Red**
						Developing a joint research strategy with the University of Lincoln	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU, with a local version between ULHT and UoL created as we move forward and understand the finer details of the partnership. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	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	Drafts in place which broadly cover joint research and teaching approach across the organisations, unable to outline in strategy financial commitment. UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group		
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	Evidence bound by UHA requirements	Portfolio of evidence is being captured and is available on the shared drive Identified leads to liaise with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Roadmap developed to identify required evidence for portfolio	Clear understanding of rigidity of UHA requirements Letter to CEO of UHA agreed at TLT on 15/09/2022 and being sent by IID Director to ask for meeting to discuss approach.	Discussions being held to clearly identify opportunity for movement within guidance and steps being taken for a name change application		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	HRBP at ULHT is part of the Steering Group to assist with working through the contractual issues The project team now also includes a HRBP from UoL and has a dedicated project resource aligned.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Having a project lead at UoL has further supported the partnership approach and ability to co-create solutions and gather evidence for the UHA - specifically with regard to Clinical Academic recruitment.		

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4c	Successful delivery of the Acute Services Review		Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data) Engage with services to develop plans as to how best to approach a clinical review, First Implementation Oversight Group meeting scheduled for September	Heat maps now drafted, with service reviews linked with improvement and clinical strategy development Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	Process being developed to identify services for review. This includes the development of a HEAT Tool to identify areas where services are not meeting targets, such as RTT, Cancer, Finance data. Initial discussions with divisions have been had with a view to ensure that the services most needing priority review are identified. Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning at TLT on 13/10/22 for review and sign off. Publish ULHT clinical service strategy end of 2022/23 Working with Divisions to identify ASR implementation requirements with draft outline plans in place for Orthopaedics and Stroke. Stroke Capital/Estates Group meetings now diarised and being led by the Business Case Team.	Finance, Performance and Estates Committee	**Amber**

The Trust Board has assigned each strategic objective of the 2021/22 Strategy to a lead assurance Committee. Outcomes under each strategic objective are aligned to a lead Committee or reserved for review by the Trust Board.

The process for routine reviews and update of the BAF is as follows:

- The corporate risk register is maintained by the Lead Executive, in accordance with the Risk Management Policy
- The BAF is updated with any changes to those corporate risks recorded within it; the Trust Board decides which corporate risks are significant enough to warrant inclusion on the BAF, based on recommendations from Committees
- The lead assurance Committee (or Trust Board, where applicable) reviews the management of risks to each required outcome (as part of their regular work programme), through evaluation of reports and risk assessments provided at Committee by Executive Leads
- The lead Committee identifies any gaps in controls or assurance and ensures there are appropriate plans in place to address them
- The lead Committee decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

To facilitate this process, each Committee will receive regular reports from specialist groups, Executive leads and other sources which provide management information and analysis of relevant key risk, to enable the Committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to the Committees should first have been reviewed and approved by the Executive Lead.

Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1 November 2022*
Item Number	*Item 13.3*

Audit Committee Upward Report

Accountable Director	*Neil Herbert, Audit Committee Chair*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	
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 our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish collaborative models of care with our partners	
4b Becoming a university hospitals teaching trust	
4c Successful delivery of the Acute Services Review	

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report and the actions being taken by the Audit Committee to provide assurance to the Board on strategic objective 2c.*

Executive Summary

The Audit Committee met via MS Teams on the 10th October 2022. The Committee considered the following items:

External Audit

The Committee received the report giving the direction of travel for the audit approach for the 22/23 audit. The Committee were advised that as yet, the final deadline for submission of the accounts had not been confirmed but was expected to be in line with the 21/22 timetable. The External Audit Provider reported that IFRS 16 presented an enhanced audit risk but at present there had been no significant changes in the risk environment which would affect the work. The detailed plan would be presented at the January meeting of the Committee.

The Committee questioned whether the issues with the ledger would impact on the year end audit. The External Audit provider confirmed that whilst the impact was felt in the accounting period there were no specific changes to the approach as a result.

Internal Audit

The Committee received a progress report from the Trust's Internal Audit providers noting delivery of 102 days against a total of 350 days in the agreed audit plan.

The Trust Internal Audit Provider confirmed the resourcing was in place to meet the requirements of the remaining audit plan despite the changes in the team. Work was well underway to agree audit planning briefs with executive leads which would allow audits to be completed in accordance with timescales.

The Committee noted that the planned reviews which should have completed for this meeting had not been finalised. It was noted that this could result in the plan becoming back-end loaded for the issue of reports.

The Committee were agreed a set of KPI's to monitor delivery and quality of the Internal Audit Plan in year.

In reviewing follow up of audit recommendations the Committee noted that 23 actions had been implemented since the last Committee. There were 33 live actions with 26 overdue, of these 1 high risk, 16 medium risk and 9 low risk. This remained an emphasis for management. The Committee would continue to seek assurance on the level of grip and control over progressing agreed actions through the assurance received from the monitoring by the Executive Leadership Team and Assurance Committees. There was a focus on moving the number of outstanding audit recommendations to single digits and bringing updates on all high rated risks and those over six months overdue.

The Committee were advised of the NHSE requirement for a Financial Sustainability Audit which would be commissioned for the ICS by the ICB. It was expected that the report would be received early in 2023.

Counter Fraud

The Committee reviewed and approved the Local Counter Fraud Specialist's Progress report.

Action on areas of the Counter Fraud Functional Standard Return that were rated red (1) and amber (2) continued to progress.

The work on the fraud risk register was noted.

Output from the Annual Staff Fraud Awareness Survey Results was noted. Particular attention was drawn to the free form comments in relation to fraud which had been made by the 959 respondents.

Compliance Report

The Committee received the regular report on compliance noting that this covered the period from July 2022 to September 2022. Oversight of regulatory notices and enforcement actions was noted including the S31 notices and improvement notices.

The Committee noted the removal of a CQC section 31 condition. This left one remaining section 31 notice for the Trust.

The Trust position in relation to waivers of standing orders was much improved with lower volume and value of waivers.

Additional work was requested by the Committee in relation to the transactions outside of Standing Financial Instructions.

Risk Management

The Committee have continued to request assurance on actions being taken to strengthen controls over risks and received a progress report on the risk register reconfiguration to support improvement.

The rigour being brought to risk management through the Risk Register confirm and challenge group was noted. Risk Management will be subject to an internal audit review as part of the 2022/23 plan to provide assurance on function and embeddedness.

Policies Update

The Committee received an update in relation to the policy management project that offered limited assurance.

The Committee noted the resource that was in place and improved progress, offering a clearer understanding of the position. The Committee noted the additional scrutiny by the Divisional Performance Review Meetings and the ongoing review of documentation management and control, along with policy approval processes.

Board Assurance Framework

The Committee confirmed that the Board Assurance Framework remained relevant and effective for the Trust with focus on the appropriate risks. The Committee noted the assurance ratings and the reviews which had been completed through Assurance Committees.

Objective 2c – Well Led Services was the remit of the Audit Committee and the amber rating for the objective was confirmed.

The Committee noted that the Trust would be subject to an internal audit review of the Board Assurance Framework during the 2022/23 financial year and that fieldwork had commenced.

Internal Audit Tender

The Committee considered the process required tendering for internal audit services to be contracted from April 2023. The tender would be offered for all three provider organisations in Lincolnshire and the ICB.