Bundle Trust Board Meeting in Public Session 2 August 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 5 July 2022

Chair

Item 5.1 Public Board Minutes July 2022v1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log July 2022.docx

6 Chief Executive Horizon Scan

Chief Executive

Item 6 Chief Executive's Report, 020822.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 July 2022 CJG.doc

Item 8.1 Appendix A Application to exit the maternity safety support programme.docx

Item 8.1 QGC Upward Report Appendix A 2022 ATAIN and TC action plan v2.pdf

Item 8.1 QGC Upward Report Appendix A ULT Insight Visit Template 22_23_06_22 Final2.pptx.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 & OD Committee

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

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

12 Integrated Performance Report

Director of Finance & Digital

Item 12 IPR Trust Board - Front page.docx

Item 12 IPR Trust Board July 2022.docx

13 Risk and Assurance

13.1 Risk Management Report

Director of Nursing

Item 13.1 Strategic Risk Report - July 2022.docx

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

13.2 Board Assurance Framework

Trust Secretary

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

Item 13.2 BAF 2022-2023 21.07.2022.xlsx

13.3 Audit Committee Upward Report

Item 13.3 Audit Committee Upward Report July 22 v1.docx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 6 September 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 5 July 2022

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Dr Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Ms Dani Cecchini, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Mr Simon Evans, Chief Operating Officer
Miss Gail Shadlock, Interim Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital/ Director of People and OD
Dr Colin Farquharson, Medical Director
Dr Chris Gibson, Non-Executive Director
Mrs Sarah Dunnett, Non-Executive Director

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Lisa Newboult, Named Professional for Safeguarding Adults – Item 7
Ms Kerry Poberezniuk, Specialist Nurse Safeguarding Adults – Item 7
Dr Maria Prior, Healthwatch Representative
Mr Craig Ferris, Deputy Director of Safeguarding – Item 8.2
Ms Bethan Stoddart, Consultant Microbiologist – Item 8.3
Ms Angie Davies, Deputy Director of Nursing – Item 8.4

Apologies
Mr Andrew Morgan, Chief Executive
Ms Cathy Geddes, Improvement Director, NHSE/I

1028/22	**Item 1 Introduction**

	The Chair welcomed Board members and members of the public who had joined the live stream to the meeting.
1029/22	The Trust Board continue to hold meetings open to the public through the use of MS Teams Live however the format of future meetings was being considered following the lifting of national restrictions. The national operating status at NHS National level had also been downgraded however the Trust continued to be cautious in terms of access to sites in order to maintain the highest levels of infection, prevention and control.
1030/22	The Chair welcomed those members of the public who had joined the meeting virtually.
1031/22	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Jody Clark**
1032/22	**With the changes being approved at the ASR/public consultation, do you think it will be easier to staff the new models (when they are put in place)?** The Director of People and Organisational Development responded:
1033/22	It was believed that the changes would help the Trust to staff the models. The Acute Services Review (ASR) clearly laid out the future of the affected services and therefore removed any uncertainty that may have been in place. This meant that the Trust were clearer about the staff needs and staff were clear about the role they would have in the service.
1034/22	**Q2 from Vi King** **I have asked this question before; please can I ask why the people of Grantham and surrounding areas are being told that there are no fracture clinic appointments at Grantham** **Please can I ask why this is still happening, when I was assured that a person had been employed too solely look after Grantham appointments.** **This is not about complex fractures.** The Chief Operating Officer responded:
1035/22	It was believed that fracture clinic appointments were being offered at Grantham Hospital and the data available was showing that hundred of patients had accessed these clinics.
1036/22	There had been multiple people identified to ensure that fracture clinic access was being made available.

1037/22	The Chief Operating Officer noted that contact had been made with Vi King outside of the meeting requesting specific information in order to identify those who had not been able to access fracture clinic at Grantham. This service was available and whilst a response could not be offered if people contacted the Trust this could be addressed.
1038/22	The Chair urged Vi King to make contact outside of the Board meeting to resolve the issues being described.
1039/22	**Item 3 Apologies for Absence** Apologies were received from Mr Andrew Morgan, Chief Executive and Ms Cathy Geddes, Improvement Director, NHS England/Improvement.
1040/22	**Item 4 Declarations of Interest** There were no new declarations of interest.
1041/22	**Item 5.1 Minutes of the meeting held on 7 June 2022 for accuracy** The minutes of the meeting held on 7 June 2022 were agreed as a true and accurate record.
1042/22	**Item 5.2 Matters arising from the previous meeting/action log** 1914/21 – Endoscopy establishment review – deferred to August 2022
1043/22	821/22 – Specialist services on certain sites to be discussed further at a future Finance, Performance and Estates Committee and upwardly reported to the Board
1044/22	The Chair requested an update on the action to understand the position.
1045/22	The Chief Operating Officer advised that a number of areas of fragile and a specialist service update had been covered in a paper that had not yet been presented to the Finance, Performance and Estates Committee. This would be undertaken through the next cycle and upwardly reported to the Board or for the paper to be received directly to the Board following this.
1046/22	The Chair noted that the action would be discharged as it was in progress and an update would be received either through the upward report or an escalation report to the Board.
1047/22	**Item 6 Chief Executive Horizon Scan** The Deputy Chief Executive presented the report to the Board noting that all parts of the system continued to have significant pressures with a critical incident declared on 15 June.
1048/22	The Board noted that it had been possible to step the incident down within 24 hours thanks to the significantly enhanced system working that had released pathways of

	support outside of the organisation. This meant that the Trust had more discharge capability and the Trust continued to work with system colleagues on the response to this.
1049/22	Following on from the previous months report the Deputy Chief Executive advised that Board that the system had submitted an updated operational plan on 20 June with a breakeven plan for 2022/23. The £32.9m deficit had been reduced through a combination of further centralised funding of £17.7m, which was available on the condition of submission of the breakeven plan. This would cover inflation and other cost pressures and a further £10.2m of further mitigations had been identified. This was offset by £3.6m of additional investment and cost pressures.
1050/22	The Board noted the position and recognised that the system continued to work through the plan.
1051/22	The Deputy Chief Executive advised that work had commenced on the development of the implementation, with the Trust and public, on the 4 services of the acute services review. The Trust would take an active role with the Integrated Care System (ICS) and colleagues on the implementation plans.
1052/22	As of 1 July, NHS Lincolnshire Clinical Commissioning Group functions had been subsumed into the ICS, with the creation of the Integrated Care Board (ICB). The ICB had met on 1 July for this to happened with the ICB a statutory body that had created the Integrated Care Partnership as a statutory committee.
1053/22	The Board noted that congratulations had been offered from the national teams for each ICB that had come in to being on 1 July.
1054/22	The Deputy Chief Executive offered the Trust update to the Board noting the month 2 financial position, reporting a £1.3m deficit against a plan of £0.9m. This was £0.4m adverse, against the initial plan of a year end deficit of £5.3m and was part of the system planned deficit of £32.9m. It was noted however, in light of the system resubmission, the Trust had resubmitted a breakeven plan position.
1055/22	The Deputy Chief Executive noted that the cost of fuel and cost of living continued to rise which was putting significant pressure on staff who were required to travel as part of their role for the Trust.
1056/22	As a result, the Trust had temporarily increased the mileage rate to further compensate whilst the national review of rates was awaited. This would continue to be done to support colleagues and was an approach that was being taken across the Lincolnshire system.
1057/22	The Deputy Chief Executive took the opportunity to advise the Board of the recent Ockenden insight visit that had taken place on the 22 and 23 June, led through the regional midwife and comprising of representations from the regional midwifery and perinatal team, Local Maternity and Neonatal System and Maternity Voices Partnership.

1058/22	The visit had been undertaken to review the progress made by the Trust in respect of the first Donna Ockenden report of December 2020, in light of the issues in maternity services at Shrewsbury and Telford Hospital NHS Trust.
1059/22	There had been an initial 7 immediate and essential actions with the visit reviewing against those 7 actions. Whilst there had been a subsequent 15 actions these were not included in the visit. The feedback received, quoted from the report was 'exceptional' across all aspects of maternity and neonatal services and it was noted that this was more impressive due to the pandemic.
1060/22	This was extremely positive news for the Trusts maternity and neonatal services and all colleagues providing services in addition to the women and babies, born and cared for, through the services.
1061/22	Following the insight visit a meeting, with a number of Board members, took place with the Chief Midwifery Officers office in order to highlight maternity safety and assurance items that would support Trusts in the provision of safe and personal sustainable care.
1062/22	The Deputy Chief Executive felt that this had been a positive conversation and that the Chief Midwifery Officer was impressed with the Ockenden insight visit feedback. This further established that the services had undertaken significant improvements and further reinforced the findings of the Care Quality Commission.
1063/22	The Deputy Chief Executive noted the relaxation of restrictions on visiting to the Trust and noted that these had move to a more pre-pandemic state. Social distancing had been removed in all areas of the Trust and mask wearing in non-clinical areas had also been removed. This remained under constant review and would be further relaxed at the appropriate time.
1064/22	It was noted, as reported in the media, that an increase in Covid-19 patients was being seen. These patients had mild symptoms and guidance was being monitored closely. Presently no further changes would be made to arrangements on mask wearing and social distancing.
1065/22	The Deputy Chief Executive noted that the dress policy for all staff and all staff working in clinical environments had been launched following the culmination of nearly a year of work. There had been significant staff and patient engagement for the approach to developing the policies which aimed to ensure an inclusive and consistent approach to dress and uniform.
1066/22	The policy was compliant with health and safety, infection, prevention and control and laundry requirements with initial feedback from the launch very positive. The policies offered more flexibility whilst maintaining a professional stance to the public and people served.
1067/22	Dr Gibson noted the good news to close the critical incident so quickly and was grateful to the system for the support however noted that this raised the question as to how this level of support was consistent and robust in order to address ongoing issues.

1068/22	Miss Shadlock was pleased to note the Ockenden insight visit feedback and asked if funding the fuel costs would add to the Trust deficit position.
1069/22	The Deputy Chief Executive noted that now the Integrated Care System (ICS) had officially formed on 1 July, with the advent of the ICB, there were good relationships across all parts of the system, across health and social care. In building these and with the work being done there was now more positive, and advancement of, consistent actions and arrangements. As a provider of acute services the Trust was becoming more confident in the support from system colleagues, social care, ICS and community care.
1070/22	The Director of Finance and Digital noted that the estimated cost of the fuel mileage increase was £8k a month for the Trust. Whilst this was not a large number against the given turnover of circa £650m this was an additional cost pressure. There was a need to manage the financial position to achieve a breakeven position and as such this would need to be offset with other savings.
1071/22	The Chair noted that the Board recognised the pressures staff were under and noted that helping with fuel costs was important. There was an employee assistance programme in place to also support staff who required this. Staff were urged to seek the available support and this indicated how seriously the Board took responsibility for staff.
1072/22	Following on from the comments regarding system working and planning, there had been maturity across all partners in the system in the submission of plans to NHS England. There were significant cost pressures but these were shared across the system with much greater clarity on each. Whilst this was positive it was inevitable that there would be further pressures to come and there was a need to see how the impact of Covid-19 progressed. It was a good position in being clear about the scale of the task and the ask of the Trust as an organisation.
1073/22	The Chair noted the decision of the Health Overview Scrutiny Committee (HOSC) regarding the ASR and thanked the Clinical Commissioning Group (CCG) for leading this. The hard work would now start for the Trust and it would be pleasing to see the four services up and running in the new models, particularly through the patient engagement that was intended.
1074/22	On behalf of the Trust Board the Chair formally welcomed Sir Andrew Cash, Chair of the ICB and John Turner, as Chief Executive with the Trust Board looking forward to being full and active partners.
1075/22	The Chair congratulated the Director of Nursing on the outcome of the Ockenden insight visit noting that this had been well supported by the Lead Midwives. Thanks were also offered to Mrs Dunnett as the Non-Executive Director Maternity Safety Champion for the role that had been fulfilled for the past couple of years.
1076/22	The Chair noted that Mrs Dunnett would hand the role over before the end of the summer and as such took the opportunity to offer thanks for the advocacy, challenge and support provided to the team.

1077/22	The Chair also offered thanks to the Director of Nursing for the dress policy review which had been a contentious issue for a number of years. It was pleasing to note that this had been resolved and thanks were also offered to all involved in the development of the policy. The Trust Board: • **Noted the report and significant assurance provided**
1078/22	**Item 7 Patient Story** The Chair welcomed Lisa Newboult, Named Professional for Safeguarding Adults and Kerry Poberezniuk, Specialist Nurse Safeguarding Adults to the Board.
1079/22	The Director of Nursing thanked Ms Newboult and Ms Poberezniuk for joining the meeting and offered the learning disabilities story to the Board.
1080/22	The Trust Board, via the presentation, watched the patient story that described Peter's story and how the team had supported clinical care being undertaken despite Peter having learning difficulties. The Trust Board learnt from the presentation that a court order had been sought in order to ensure that Peter could receive the care required in the safest possible way.
1081/22	The Chair noted that the Board received patient stories, such as these, in order that Board members could understand and appreciate the complexity of some of the patients' needs and the expertise and teamwork required in order to ensure the best patient experience. Irrespective of personal circumstance. The story was both amazing and inspirational.
1082/22	Professor Baker was pleased to receive the story from a service often not receiving the attention it merited being discussed at the Board and asked how long it had taken from determining something needed to be investigated to the process happening.
1083/22	The Named Professional for Safeguarding Adults noted that as the patient was already known to the team, due to issues in the community with general health, when the 2-week referral was made the team were immediately alerted. This took place within 6 weeks of the 2-week wait application and court order going in to place.
1084/22	It was noted however that the court order had been slightly delayed and waiting additional time for the order to go to court for approval.
1085/22	All information had been put in place ahead of the court date and it was noted that this was a complex plan including multiple agencies. Peter had lost a third of his body weight. Dental issues had been ruled out and bloods taken and antibiotics completed through low level care. Supplements had also been supplied by the dietician, so a number of issues had been ruled out prior to reaching this point.
1086/22	Dr Gibson asked how the ambition to support patients in this way could be shared more widely to have others involved in seeing the patients.

1087/22	The Named Professional for Safeguarding Adults noted that development of the service and approach had taken place over the past 2 years. This was not the first case within the Trust and it was noted that the Trust had made case law in order to have anticipatory cases.
1088/22	It was noted that this was the fourth patient where a complex plan was in place and it was noted that the issue at times was people accessing the team. As a result a coordinated physical healthcare group, including the Clinical Commissioning Group, Lincolnshire Partnership NHS Foundation Trust and social care had been created to have a referral mechanism for GPs in to the service to give advice for those patients.
1089/22	This had created the role of Specialist Nurse Safeguarding Adults and would enable information sharing with other to identify what the team could do to support.
1090/22	Following the learning disabilities week staff had been out speaking to others to remind them of the support which the team could offer.
1091/22	The Director of Improvement and Integration noted that as part of the internal performance review meetings there were a number of patient stories. A common theme was outstanding care personally delivered and it was noted that, with the communications team, work would be undertaken to show case real live case studies both internally and externally.
1092/22	It was also noted, that as part of the sunflower launch campaign and the MAPLE staff network, there were a number of staff who dealt with these complex issues and staff who also had disabilities or family members who had disabilities. This was an important topic to be addressed.
1093/22	The Director of Nursing thanked the Specialist Nurse Safeguarding Adults and Named Professional for Safeguarding Adults for sharing the story. It was noted that it had been clear when appointing the Deputy Director of Safeguarding that there was need to bring safeguarding skills and expertise of the team to mental health, learning disabilities, dementia and autism and to expand the resource to be able to do this.
1094/22	There had always been cross over with the Mental Health Act and learning disabilities however there had not previously been the resource to move this forward for the client group, both children and adult. The roles now in place meant that the team could attend to those with added needs ensuring a smooth transition in to acute care, with GPs and social care a good example of demonstrating this.
1095/22	The Director of Nursing noted that the Trust was in the process of signing up to the Treat Me Well campaign with the team engaging with experts by experience. A suite of easy read documents had been approved by the experts who worked with the Trust. The story presented offered an example of how the Trust was expanding vulnerability provision which had benefited patients.
1096/22	The Named Professional for Safeguarding Adults thanked the Board for listening to the story noting that since joining the Trust the level of commitment for the safeguarding and vulnerability agenda now being seen, was a significant move forward over the past few years.

1097/22	There were a number of ideas which had been presented at the end of the presentation with support sought from the Board to progress these, including employing an expert by experience to support training and ward visits.
1098/22	During the learning disabilities week there had been a significant number of staff coming forward who had stated experience of their own children with learning disabilities and how they had struggled and felt isolated. As a result work was being undertaken to identify if a network group for staff would be established, for those who were also carers for people with learning disabilities.
1099/22	The Specialist Nurse Safeguarding Adults thanked the Board for taking the time to listen to the story noting that it was a privilege to have the role in the Trust.
1100/22	It had been surprising through the learning disabilities week the number of staff who had taken the opportunity to talk about children, siblings or relatives with learning disabilities or autism and were struggling with the level of support. These are challenges faced before staff arrive at work.
1101/22	The MAPLE group should be able to help with this, but it was hoped that this could be taken forward to support staff. Having experts by experience working alongside the team had ensured documents were coproduced and there was plans in place to create videos about what it was like for a person with learning disabilities to attend A&E or have a CT scan.
1102/22	Currently the Trust did not showcase what support was in place for those patients and as such this work was underway with communications to develop information available to the public.
1103/22	The Chair congratulated the team on the presentation noting that it was clear that Peter was at the heart of the care and arrangements put in place for treatment.
1104/22	Within the presentation there was a comment about thinking outside of the box. As a Trust Board the Chair noted that the organisation should do this as it would not be possible to move forward and deliver outstanding care personally delivered if this was not done. People needed to push the boundaries of professional thinking and care.
1105/22	The Director of Nursing offered support in terms of the expert by experience alongside the support of the Trust Board to take this forward. 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
1106/22	**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 21 June 2022 meeting.

1107/22	Dr Gibson noted that in addition to the usual business of the Committee annual reports were received on Safeguarding, Infection Prevention and Control (IPC) and Patient Experience along with the Care Quality Commission (CQC) quarterly action update. These would follow as separate items on the Board agenda.
1108/22	The Committee considered and supported the revision in the way clinical harm reviews were undertaken for long waiters in Accident and Emergency as proposed through the Clinical Harm Oversight Group upward report. The reviews were taking a large amount of clinical time, offered a low yield. The Trust would utilise a system whereby Datix would be used to prompt alerts for the undertaking the reviews. The Committee was assured on the process undertaken to provide the alternative approach.
1109/22	Dr Gibson noted, through the Maternity and Neonatal Oversight Group upward report that the Committee had received, for the first time, the claims scorecard. This was a valuable document containing data with further work required to identify themes and trends.
1110/22	Also received was the statutory perinatal mortality report which demonstrated that all Maternity Clinical Negligence Schemes for Trusts standards had been met. Actions to be taken were in relation to the management of anaemia in primary care and some estates issues.
1111/22	It was noted that all appendices received with the report to the Committee were available to Board members in the reading room of the paperless Board solution.
1112/22	The Committee noted the Ockenden insight visit and the positive feedback receive with Dr Gibson support all comments made about the incredible efforts made across the services.
1113/22	Dr Gibson noted the concern raised by the Committee regarding Nettleham Ward decant with delays prohibiting required changes to the estates.
1114/22	The Committee was pleased to note that the Medicines Management Task and Finish Group had reported that a project lead had been established and that a single action plan, taking in to account CQC and internal audit actions had been put in place.
1115/22	Dr Gibson advised the Board that the Committee had received a report from the Mental Health, Learning Disabilities and Autism Group, which was particularly relevant to the patient story, noting the progress that had been made over the past 2 years. The group would now become a sub-group of the Safeguarding and Vulnerabilities Oversight Group, which would provide a governance reporting route to the Committee.
1116/22	The Committee noted the number of serious incident actions that had not been completed within timeframes noting that the Trust continued to set challenging timeframes to complete these. Significant work was being undertaken to improve the position.

1117/22	The Chair noted the change in the clinical harm process noting that it was positive to note these were still being undertaken, supported by the use of technology and therefore the Board were comfortable with the change. It was also noted that the Committee was assured of the change.
1118/22	It was clear that governance was being attended to in a more structured and embedded way given the move of the Mental Health, Learning Disabilities and Autism Group. This demonstrated the maturity of the Board in attending to governance and business in the organisation. The Trust Board: • **Received the assurance report**
1119/22	**Item 8.2 Safeguarding Annual Report** The Director of Nursing introduced the Deputy Director of Safeguarding to the Board and offered the comprehensive report which demonstrated significant improvement across the board with safeguarding and mental capacity.
1120/22	The Deputy Director of Safeguarding noted how the patient story demonstrated safeguarding with this not just about the team but the Trust working with partners.
1121/22	It was noted that since the Deputy Director of Safeguarding had joined the Trust 2 years ago there had been support to deliver and grow the team which had increased 100% in size.
1122/22	The report offered was the second safeguarding report which grew year on year and was a reflection of the work and workload. As the team grew this had seen an increase in the workload which demonstrated that the team were recognised and carried out daily visits within the Trust.
1123/22	The Deputy Director of Safeguarding noted the inclusion of reports from the Safeguarding Boards within the report as it was felt from a governance perspective that it was important to receive feedback.
1124/22	The report continued to describe the impact from Covid-19 however it was noted that there had been an increase in child protection plans, the number of children in care in the Lincolnshire area and the number of complex children's cases. These included eating disordered, requiring joint working with local partners and NHS England.
1125/22	It was noted that the governance framework was becoming embedded and demonstrated by the consideration of the Mental Health, Learning Disabilities and Autism Group being reduced to a sub-group of the Safeguarding Vulnerabilities Oversight Group. This was a positive position to be in.
1126/22	Training had been embedded, particularly for learning disabilities which had launched in the previous November with an 83-87% compliance rate. This was phenomenal despite Covid-19 and had been a resounding success for staff who had fed back how

	helpful the training had been. There was a need to deliver training that supported staff.
1127/22	The Deputy Director of Safeguarding noted that serious case revies continued to be held for both adults and children noting that the county continued to experience domestic homicide reviews. There had been considerable amounts of money spent nationally on domestic abuse and homicides, in the region of £1.7b on domestic abuse. It was noted that there were 2 independent domestic violence advocates within the team who were able to support staff dealing with domestic abuse.
1128/22	Work also continued in maternity services with babies removed at birth and proactive work to ensure this was as smooth as possible.
1129/22	Moving into the next year, deprivation of liberties would become liberty protects and it was anticipated this would be complete by October 2023 to April 2024. Business plans were in place to be able to progress once this had been formalised and would see an expansion of the safeguarding team.
1130/22	Finally, it was noted that work on the learning disabilities and autism agenda continued to be embedded and pushed forward.
1131/22	The Chair thanked the Deputy Director of Safeguarding for the summary of the report and for the leadership of the safeguarding team. Thanks were also expressed to the Safeguarding Boards in Lincolnshire for offering support and for the partnership working.
1132/22	Dr Gibson thanked the Deputy Director of Safeguarding for the report noting the continuation of addressing the challenging area for which regular updates were received by the Quality Governance Committee.
1133/22	Miss Shadlock asked what the most challenging area was from the team's point of view due to the extent of the work undertaken.
1134/22	The Deputy Director of Safeguarding noted that this was difficult to answer due to how safeguarding varied but noted that challenge was always positive. It was noted however that there were national pressures for young people aged 12-13 years to early 20's with eating disorders. This was due to the lack of tier 4 beds and the rise in eating disorders/disordered eating during Covid-19.
1135/22	It was noted that in the last 12-18 months there had not been a time when at least once which was waiting for a tier 4 bed. This was emotionally draining for staff to support the young person when they did not have the skills. However, there were great working relationships with partners to work through this.
1136/22	Ms Cecchini noted that the partnership and system working of the safeguarding team could be used as an example of good practice and noted how this felt cohesive across the system that may benefit a number of teams.
1137/22	The Chair noted the practical example of the case study from the patient story noting that this was supported by the detail within the annual report. The report

1138/22	demonstrated and assured the Trust that it was delivering its legal duties and the proposal for work going forward in 2022/23 was endorsed. The challenges with regard to liberty protect safeguards was noted and had been in discussion for some time. Whilst the safeguarding training targets were not where desired there was a clear intent for there to be an increase in those being trained. The Trust Board: • **Received the annual report noting the moderate assurance** • **Approved plans for 2022/23**
1139/22 1140/22 1141/22 1142/22 1143/22 1144/22 1145/22	**Item 8.3 Infection Prevention and Control Annual Report** The Director of Nursing, as the Director of Infection Prevention and Control, presented the second annual Infection, Prevention and Control (IPC) annual report to the Board for 2021/22 noting that this outlined the Trusts continued zero tolerance approach to preventing and reducing the risk of avoidable healthcare associated infection (HCAI) as well as processes and interventions taken to mitigate any risks. There was a strong commitment to lead on and support initiatives to precent HCAI with many achievements detailed within the report. As well as a high level of divisional engagement and enthusiasm for IPC interventions. An increase in accountability within the divisions had been seen along with ownership of IPC practice and interventions. The Director of Nursing noted that this demonstrated effect governance and public accountability for IPC with the team and service developing through a consultative process in order to achieve greater skill sets and leadership to work towards 7 day working. The Board noted the expansion of the team throughout the year however there were challenges, not unique to the Trust, in being able to recruit experienced IPC practitioners and consultant microbiologists. This posed a challenge to the provision of services. The key objectives of IPC was to provide a strategic and structured framework to develop IPC within the organisation integrated in to the IPC group agenda in order to achieve assurance and monitoring through the framework. The Director of Nursing noted that the group received quarterly board assurance from the health and social care act 2008, code of practice on the prevention and control of infections and Covid-19. This indicated a continued increase in compliance and commitments to sustaining the required IPC lines of enquiry with 2 board assurance frameworks that supported the hygiene code and Covid-19. These had been combined in order to have alignment of both documents. Overall there had been some good progress, especially in relation to estates and facilities programmes of work and policy development.

1146/22	It was noted that there were no red rated interventions with many increasing from amber to green with a good level of sustaining green ratings however the impact of poor environmental infrastructure continued to be challenging. Whilst this was the case the Trust continued to strive to make the best of the estate and to mitigate risks.
1147/22	The Director of Nursing noted that it was mandatory to report cases of HCAI and over the year 2021/22 the Trust was under trajectory which reflected the organisation wide commitment and determination to sustain high standards of IPC. The pandemic may have impacted on the number of cases due to the reduced elective activity and reduced blood cultures taken.
1148/22	It was noted that more challenging trajectories were set each year and case by case reviews of clostridium difficile were completed to identify themes and associated organisation wide learning. The Trust was moving to a place of using established processes to manage Covid-19 as an endemic virus.
1149/22	Covid-19 had posed a challenge with a Trust wide risk-based response. There had been close monitoring of nosocomial cases which continued with local interpretation and response to the national guidance issued. This was enacted to achieve compliance across the system with the Trust acting as a system partner in the response.
1150/22	The Director of Nursing noted that the Covid-19 wards and embedding of project Salus principles, low, medium and high-risk areas, contributed to the provision of high levels of patient care and safety. The risk-based process had been successful in identifying levels of risk and appropriate IPC interventions with support from facilities in the level of cleaning and cleanliness required.
1151/22	The Board was advised that there had been focus on other areas rather than a sole focus on Covid-19. A number of external inspections and visits, identifying significant improvements had taken place. These also identified the responsive approach to strengthen estates and facilities governance arrangements and sustained and required IPC practice in both inpatient and non-inpatient areas.
1152/22	During the inspections all staff had been found to be welcoming with delivery of kind patient care witnessed with no breaches to IPC. The final written letter from regional colleagues was awaited to document the feedback offered.
1153/22	The Director of Nursing advised that there had been notable progress with estates and facilities work in relation to water safety and ventilation, as well as developments of decontamination interventions.
1154/22	Significant progress on the interpretation and implementation of healthcare cleanliness standards 2021 had also been made.
1155/22	The report offered an overview of activity and the development of outbreaks of infection, policies and guidelines, audit programmes, antimicrobial stewardships, laboratory services and occupational health and training.

1156/22	The forward plan demonstrated work and initiatives to progress in to 2022/23 and to update the key IPC objectives signed off at the IPC group.
1157/22	Focus would be given to surgical site infections and surveillance with an IPC post out to advert to offer direct support to the division to take work forward.
1158/22	The Director of Nursing noted that the report was offered to discharge the statutory responsibilities of the Trust in line with the hygiene code and the IPC Board Assurance Framework.
1159/22	The Consultant Microbiologist thanked the Deputy Director of Infection Prevention and Control, in her absence, for the management and turnaround of the department and for the development that had attracted staff and for the initiatives commenced. There had been significant progress since the Deputy Director had joined the Trust. Thanks were also offered to the Director of Nursing for the leadership of IPC.
1160/22	The Consultant Microbiologist highlighted the progress in microbial stewardship and the collaborative with estates and facilities with strong relationships than previously seen. This was demonstrated through the developments in water safety, decontamination and ventilation and the work towards the healthcare cleanliness standards.
1161/22	Whilst Covid-19 have given opportunities to strengthen the IPC service there had been a proactive approach to this in order to maximise safety with minimum disruption. There was a need to now move to a situation of managing patients coming in with Covid-19 to wards appropriate for the specialist need.
1162/22	The Chair noted that the detail of the report had been considered by the Quality Governance Committee and offered Dr Gibson, as the Chair of the Committee, an opportunity to update the Board.
1163/22	Dr Gibson was delighted to receive the report to the Committee noting to receive a successful report was always encouraging however to receive this with the past year of Covid-19 had been extraordinary.
1164/22	Dr Gibson asked if there would be challenges the Board should be aware of in the coming year.
1165/22	The Consultant Microbiologist noted that it was unclear as to the Covid-19 epidemiology and that this could continue to change. It was inevitable that there would be business cases to complete with a possible focus on laboratory services development and a number of initiatives to bring forward for which it would be useful to have the support of the Board.
1166/22	In order to develop posts and the team there had been lateral thinking about how to provide the service should it not be possible to recruit the required staff.
1167/22	The Chair noted it was the view of the Board that if posts could not be recruited to then there would be a need for creative and innovative ideas within the resources available.

1168/22	The annual report and achievements should attract people to want to come and work in the service especially with the developments made against the backdrop of Covid-19.
1169/22	The Director of Nursing offered thanks to the Consultant Microbiologist and Deputy Director of IPC, in her absence, who had made the role of Director of Infection Prevention and Control easier to perform.
1170/22	The Chair noted that the Board received the report as confirmation that it was assured the statutory responsibilities, under the hygiene code and IPC Board Assurance Framework, had been discharged. The Trust Board: • **Received the Infection, Prevention and Control Annual Report noting the moderate assurance**
1171/22	**Item 8.4 Patient Experience Annual Report** The Director of Nursing was delighted to be able to introduce the Patient Experience Annual Report and welcomed the Deputy Director of Nursing to the Board in order to present the report.
1172/22	It was noted that this was the first patient experience annual report to the Board and detailed the activity of the team and the areas to progress in respect of the voice of patient along with the engagement of patients in a meaningful way.
1173/22	The Deputy Director of Nursing was pleased to be able to offer the report to the Board noting that this had been a different year due to Covid-19 with different patients and career, and families in a different environment. The aim had been to continue to hear the patient voice and to engage at every opportunity and to ensure that patient experience was at the forefront.
1174/22	Patient experience was, and continued to be, a strategic objective for the Trust and it was noted that the Patient Panel had been an objective for the past year. This had been set up in the autumn of the previous year.
1175/22	The Patient Panel had found its voice and was an active and proactive panel with 39 presentations having been received along with updates from staff, in addition to determining agenda items that the panel wished to discuss and debate.
1176/22	The Deputy Director of Nursing noted that the Patient Panel had been recognised by NHS England as best practice with a request for the Trust to submit a best practice case study to support the refresh of the national work with people and communities guidance.
1177/22	The panel was a success and was now embedded for the organisation to use in terms of having a patient representative when making changes or undertaking service redesign.

1178/22	The Deputy Director of Nursing noted the desire to develop experts by experience, as heard through the patient story. This would offer benefit as would the move to expert reference groups. There was a desire to engage with different patients who could become experts by experience. This work would continue through the year and would support the Trust to ensure patient voice and engagement was in place and part of co-production and design in the Trust.
1179/22	The Board noted that the pandemic had slowed the progress of work and there was a need to work with and support patients from those communities where the Trust needed to work in a different was to reach out. Good progress was being made.
1180/22	The Deputy Director of Nursing noted that patient experience had driven the visiting agenda, which was particularly important through the pandemic. It was important to note that social isolation was something quickly discovered as part of patient experience as visiting was constrained.
1181/22	As a result, a number of actions had been taken to address this with workstreams planned, for example the family relative campaign, We Care To Call. There was national interest with the Trust working with other Trusts on this.
1182/22	Following an internal audit, which looked at 7 areas around data it was encouraging to note that it had been possible to provide assurance against all areas, 5 with significant assurance and 2 with partial assurance. Actions were in place to be able to bridge the gaps in assurance with all actions completed.
1183/22	The CQC had fed back in the latest inspection report that the patient voice and experience was at the forefront of the organisations approach and was heard throughout the inspection.
1184/22	Whilst updates were received to the Patient Experience Group regarding diversity, equality and inclusion further work was required to further support conversations and an approach to health inequalities.
1185/22	There was an intention to create a library of patient stories, that would be offered internally and externally in order to support learning as a result of patient feedback.
1186/22	There had been a change in the thought process to one of patients having a good experience from patients being at risk of having a poor experience. With the right starting point this would ensure that staff gave and patients received the best experience.
1187/22	The Chair thanked the Deputy Director of Nursing for the first annual report noting the passion and energy given to this for patients.
1188/22	Dr Prior noted that the report was comprehensive and that it was encouraging that there was the importance shown to focus on patient experience and engagement but also the ‘so what’ element and involvement.

1189/22	Miss Shadlock was interested to know if those who had complained or complimented that Trust received a complimentary copy of the report. With the emphasis on learning it would be positive to share this rather than people seeking out the report.
1190/22	The Deputy Director of Nursing noted that as this was the first annual report it had not been offered out routinely but welcomed the idea.
1191/22	Dr Gibson noted, as chair of Quality Governance Committee, that it was pleasing to see such a high-quality report and to be able to recommend this to the Board. What had been noted was the move from a reflective to proactive approach with the Trust doing innovative and proactive things to support patient experience. It was hoped this would continue.
1192/22	The Chair noted the positive mindset of giving patients the best experience possible and it was a palpable shift in the mindset to involve patients. This had been identified as a gap but was being taken forward and again, the report was set in the context of Covid-19 but had still achieved.
1193/22	It was noted that there were various sources demonstrating improvement notwithstanding the Trust continued to receive complaints. However, the work around equality and diversity required focus and ongoing work with input to the health inequalities work at the recent Board Development session. It was pleasing to note that this would be taken forward in 2022/23.
1194/22	Dr Prior requested a copy of the report for Healthwatch which would be shared.
1195/22	The Chair noted that the Board was assured that the Trust was engaging in a more positive way with patients and endorsed the approach being taken to patient experience. The Trust Board: • **Received the Patient Experience Annual Report noting the moderate assurance**
1196/22	**Item 8.5 CQC Actions Quarterly Report** The Chair noted that whilst the report had been considered by the Quality Governance Committee there was a need for the Board to receive this directly and have a clear understanding of the action plan.
1197/22	The Director of Nursing offered the report to the Board on the must and should do recommendations following the latest inspection. There had been an increase in the blue, embedded actions and a decrease in red, those overdue. The actions in green were completed and remained static.
1198/22	The must do actions, specifically around the urgent and emergency pathway and the checking of children on the child protection register and process. There had been a significant improvement in staff being trained with 100% of staff requiring training having been trained in child protection processes. Evidence was being worked through and an audit to be undertaken to confirm the position.

1199/22	Evidence of implementation of the urgent and emergency care standard operating procedure to reduce ambulance delays was being worked through and although this, and the previous action, had been red rated the suggestion to the Board was that these were low risks due to key mitigations in place.
1200/22	Must do actions for maternity services and the medicines being stored safely, due to ambient room temperature, had work ongoing to mitigate the risk. At present the risk was medium and was associated with estate issues however there had been some innovative solutions being worked through by Family Health and Estates teams. Some mitigations were already in place.
1201/22	The report outlined the progress on the should do actions and the interim actions to be taken. In order to provide assurances on the arrangements in place the Medical Director and Director of Nursing were meeting monthly with the divisions.
1202/22	The Director of Nursing noted that the action plan was offered to the Board at appendix 1 to detail the must and should do actions.
1203/22	The Chair noted that the report was clear with a sense of grip and control on all actions, particularly the must do actions with good progress on the should do actions. An appropriate response was being taken in the organisation to take action against those that needed to be attended to.
1204/22	The Quality Governance Committee received the action plan regularly and reviewed the quarterly report. The Board was pleased to see the strengthening assurance mechanisms in place that demonstrated a strong and embedded governance framework for attending to quality matters in the Trust. The Trust Board: • **Received the report noting the moderate assurance**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1205/22	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee – no meeting held**
1206/22	The Chair noted that the Committee had not met in June and therefore there was no upward report to be received.
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1207/22	**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 23 June 2022 meeting.

1208/22	Ms Cecchini noted that the Committee continued to receive limited assurance in respect of estates due to the ongoing and known risks to the infrastructure. The Committee heard that the team were taking a performance improvement approach but also noted that Lincolnshire Fire and Rescue had highlighted the condition of corridors as a particular risk following on site attendance due to the Lincoln fire.
1209/22	The Committee continued to receive significant assurance on the low surface temperature works with work continuing to ensure properties occupied but not owned were compliant.
1210/22	Ms Cecchini noted the moderate assurance received in respect of finance however raised concerns due to the Trust being off plan, not withstanding the new plan submission. The biggest area of concern was the significant cost improvement programmes (CIP) that were outstanding. The Committee were however assured that actions were in place to identify the outstanding CIP.
1211/22	There had been an expectation at the Committee that contracts would be signed on 1 July and the Committee had heard that the business case for the Pilgrim Emergency Department would be considered on 11 July by the Joint Investment Scrutiny Committee.
1212/22	The Committee received the Digital Hospital Group upward report noting the escalation of Ophthalmology and practice variation around the use of electronic patient records. A report with recommendations had previously been received by the Committee which would now oversee the implementation of the recommendations.
1213/22	Limited assurance had been received in respect of the Data Security and Protection Toolkit however significant progress had been made with many red rated areas moving to green. The outstanding red items relation to training and data flow mapping.
1214/22	Operational performance had offered limited assurance and as referenced in the Chief Executives report, the recent MADE event had resulted in no patients waiting more than 12 hours and most seen within 4. It was noted however that this was not sustainable.
1215/22	Ms Cecchini noted the improvement in P2 turnaround with patients being seen within 4 weeks or just over. Significant concern was noted regarding 62-day cancer with compliance deteriorating from the previous month.
1216/22	The Board Assurance Framework had offered moderate assurance with lengthy discussions undertaken by the Committee around updates and when these were expected to be seen. There was confidence that the Committee would be able to report an updated position to the Board in August.
1217/22	Ms Cecchini noted the data quality update received in relation to the CQC should do items around the consideration of data flow and the timeliness of reporting to the Board. When considered the Committee was satisfied with the timetable around this and considered the action closed.

1218/22	The Committee was concerned to received limited assurance in relation to the Integrated Improvement Plan (IIP) and the newly formed Integrated Steering Group (ISG). The Trust was considerably behind plan in some areas and reflected the planning process having taken the first quarter of the year.
1219/22	KPIs and baselines were still awaiting agreement with the ISG reporting the majority of schemes not within timeline with some delays within this.
1220/22	Mrs Dunnett asked, in relation to the fire, if the Trust had received subsequent enforcement notices and if the steering group was looking to implement lessons learnt across other sites.
1221/22	The Chief Operating Officer noted that there had been no enforcement notices, or notices at all, following the fire. Once on the largest debriefs ever done had been undertaken post event, as required after any major incident. This was conducted as a multi-agency face to face session. There was a substantial amount of praise within the report and some measures put in place to change buildings ensuring these were safe.
1222/22	What had been identified, as raised by Ms Cecchini, was that the corridors had been identified as containing too many obstacles, including beds and moveable objects and constrained movement. A campaign was now in place to ensure items left in corridors were rapidly moved and stored appropriately, this would be run alongside staff side and health and safety staff.
1223/22	Lessons learnt had been shared at the Emergency Planning Group and would be shared at the Fire Safety Group where all divisions and support services were represented. Monitoring would be through these groups.
1224/22	The Chair noted the quality of the debrief document noting the praise and thanks to staff with the report demonstrating the maturity of some of the learning and developments required from this.
1225/22	The Chair noted the low surface temperature work that continued and reflected that this now read more positively than it had done in the past 6 months. The CIP position was noted, and it was recognised that there would be a need for a more focused and collective consideration of this.
1226/22	Whilst it was positive that the ISG was set up a stock take would be need to see what difference would be made as the Trust moved towards the end of the summer and in to the autumn. The Trust Board: • **Received the assurance report**
1227/22	**Item 10.2 Estates Strategy** The Chair noted that the strategy presented was an interim strategy that offered the assurance that had been sought for some time.

1228/22	The Chief Operating Officer noted that the paper described why the approach had been taken whilst the Trust was undertaking expressions of interest for the hospital improvement programme. This was the national programme set to improve the quality of estates and hospitals across the country.
1229/22	This was a substantial national programme that would take some years to work through the application and development process. As such a strategy to take the Trust through the 2-3 years and support with investment decisions and channel improvements was required.
1230/22	The Chief Operating Officer offered thanks to the estates team and colleagues from across the organisation for the work completed. This included system colleagues who had worked to translate some of the national and regional strategies and ambitions into the document presented.
1231/22	Early iterations of the document had been shared previously with the Board and the final version presented would be used in earnest with confirmation of the document sought from the Board.
1232/22	The strategy presented 2 sections, the first year zero to 2 followed by the longer-term strategy, which would be the fundamentals of the application for the hospital improvement programme. These projections were for hundred multi-million-pound schemes and were described in the 2 years and beyond programme.
1233/22	Within the heart of the document was the narrative to guide the Trust to where money should be spent to tackle some of the greatest infrastructure challenges and the prioritisation system use to identify those areas.
1234/22	The Chief Operating Officer noted however that this could change as more was identified about the infrastructure meaning that some programmes of work may need to change in priority. It was also possible that this may shift due to the availability of national funding.
1235/22	The strategy listed all major programmes to understand what areas needed to be addressed however this was not a complete package of funding. The strategy described all areas needed to be addressed however this was more than the capital allocation.
1236/22	The Chief Operating Officer stated however that there was confidence in the ability of the Trust to source funding in order to be able to deliver some of the schemes given the track record of the organisation over the past year. Success such as Grantham Theatres, Lincoln respiratory and the accident and emergency.
1237/22	These sites were the product of the strategy and how this would be taken forward and offered a framework to navigate the next steps in the Estate's development, capital builds and focus of efforts and attention.
1238/22	Professor Baker noted the comprehensive report but reflected that this was salutary as it demonstrated the extent of the estates which required significant endeavour. It

	was noted that monies would be competitive with concern about how the Trust would manage the 5 years out if large amounts of money were not secured.
1239/22	The Chief Operating Officer noted that there was a huge risk that had been carried over the past decade. The risk report described some of the infrastructure risks that had been managed for some time. The optimism came form the recent years of experience, having developed a reputation as an organisation and system, that could use capital monies effectively and deliver innovative programmes on time and on budget.
1240/22	The reputation had led to the Trust having access to greater elements of capital than before. Whilst there was a desire not to downplay the infrastructure risk there were substantial elements in environmental, electrical, water and mechanical. These were at the top of the priorities with some work addressed in the past years before the risks had started to reduce. Some of which could be seen for example through the fire safety work.
1241/22	Dr Gibson noted that each iteration of the strategy became clearer and asked how this would link to the clinical strategy and how the ASR would influence the sites of the Trust. There was also optimise noted in the planning assumptions relating to left shift and what may move out to the community and caution was noted as to what would be done in the estates strategy until there was clarity on what was happening.
1242/22	The Chief Operating Officer noted that in relation to the clinical strategy this was particularly important as this was beyond the interim period described. The longer-term strategy had assumptions in place based on legacy modelling which tied in with areas such as ASR and left shift. This then moved into the hospital improvement expression of interest however this was only the first of many stages which would need to move through business case process and had 4 parts. Each one of those parts would move in more detail about how and what estates and hospitals would do. This would address any discrepancies or risks in terms of the assumptions made of left shift. In all likelihood this was 2-3 years away.
1243/22	In the interim period this did not take decisions to close down or remove elements of the clinical capacity meaning that it was possible the Trust may end up with more physical estate than needed. There had been a conservative approach over the coming 2 years with a focus on the heart of infrastructure, not clinical and ensuring that the hospitals could function at high levels of efficiency, not building new wards.
1244/22	Mrs Dunnett noted that there was now a clear framework to move forward in the short than longer term. As Maternity Safety Champion, Mrs Dunnett noted that maternity services had been a focus for some time noting the difficulties on the Lincoln site. There had been delays with the decant which were assumed to be due to operational pressures impeding the ability to deliver the 0-2 year plan. Mrs Dunnett asked how risks would be managed during the period due to the level of challenge.
1245/22	The Chief Operating Officer noted that maternity, not just at Lincoln, was a major focus of the capital programme noting that the difficulties in the past were due to the reliance on other areas of the estate in order to make the decant process work.

1246/22	The Trust had developed, progressively, more innovative plans to try to create decant facilities, on both sites. The plan at the Pilgrim site was now well in motion in terms of development works, which also tied into the emergency department work. Lincoln however was particularly challenging due to the reliance on inpatient services and to a small degree, outpatients.
1247/22	As the Trust was running at such high levels of bed occupancy and wards open, far above plan, it had not been possible to enact the decant at the pace required. This was partly due to Covid-19 pressures but also challenges on the emergency department pathways and discharge difficulties.
1248/22	It was expected that this would be resolved as part of the emergency pathway which would unlock the ability for moves to take place around the hospital. This would create not only a better maternity service but also address some co-location issues in the family health division. This remained an absolute priority with alternative options in place.
1249/22	Ms Cecchini sought to understand the system perspective and how the Trust would priorities its estate when there was insufficient funding to resolve issues in all Lincolnshire NHS estates and asked how well progressed system conversations were in this regard.
1250/22	The Chief Operating Officer noted that the Trust, other than primary care, was the largest in terms of square meters. Once this was addressed a large proportion of estate in Lincolnshire would be addressed. It was noted however that primary care was a more difficult issue to resolve.
1251/22	Work had been undertaken with community and mental health colleagues, hence the capital programme running as it was. There was a lot of high-quality estate in Lincolnshire with a PFI and relatively new estates, the bulk of the worst quality estate sat with the Trust.
1252/22	It was noted that the capital allocations were well worked through due to the work required for the hospital improvement bids, there was a need however to understand the difference of the 2-year to 3-5 year window and what would happen nationally.
1253/22	Ms Cecchini noted the estate not owned by the Trust, but that was operated out of, and noted interest in understanding the strategies associated with these.
1254/22	The Chief Operating Officer noted that this could be offered to the Finance, Performance and Estates Committee but noted that since Covid-19 there had been a change in operating requirements of clinical spaces. There had been a substantial increase in building standards for clinical space, requiring more space and distance between patients and services. This was important for IPC and meant that where there had previously been sufficient space, more space was now required.
1255/22	Mrs Dunnett asked how this was being shared with staff and how expectations were being managed.

1256/22	The Chief Operating Officer noted that work was being undertaken on communications which should celebrate the work done and work in the pipeline, major projects and those things that people would see a difference in such as hospital aesthetics.
1257/22	Work was underway with the clinical divisions to ensure departments understood the prioritisation of their own estate and facilities. The detail of this was being worked through and it was hoped that this would feature as part of the regular divisional catch ups. Direct face-to-face discussions would also take place. Whilst this was the current approach this may change.
1258/22	The Chair noted the points raised by Ms Cecchini noting that there had been some previous system work that could be offered as background reading to support the proposed session at the Finance, Performance and Estates Committee. There was also a workshop due to take place in September which Ms Cecchini would be welcome to join.
1259/22	The Chair noted the work in producing the estates strategy which was set in the context of the new operating environment across the system. This was underpinned by technical elements for both estates and activity, demand and left shift.
1260/22	It was noted that whilst this was a framework it shifted from reactive to a proactive approach that mapped out the key risks and highlighted them to offer more information to either mitigate but also respond to if required in a prioritised way.
1261/22	The next step would be the development of the clinical strategy however this would all the Trust Board to be more in control of the spend and to effectively manage risk in the interim. The Trust Board: • **Received the Estates Strategy noting the significant assurance** • **Approved the Estates Strategy**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1262/22	No items
1263/22	**Item 12 Integrated Performance Report** The Director of Finance and Digital noted that performance had been considered through the upward reports of the Committees and advised that the executive scorecard continued to report a number of blanks.
1264/22	This was developing work with some of the specific metrics and measurement of these continuing to be worked through. Over the course of the coming week it was expected that this would complete to enable reporting to be in place in July. This would then provide trajectories for improvement against those items.
1265/22	

1266/22	The Chair noted that this needed to be in place ahead of coming to the Board in September to provide an opportunity, as a Board, to review the position ahead of the winter pressures with focus to be afforded to the scorecard performance and position of a range of metrics. **Action: Trust Secretary, 6 September 2022** It was recognised that the Committees worked with this each month and was upwardly reported to the Board however this was a period where a new Board was forming and as such a stock take was required. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
1267/22	**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 risks rated very high, in relation to planned care, emergency departments and fall which had been seen previously.
1268/22	Cardiology diagnostics, in particular echocardiograms, was a new risk in month which had been reviewed through the Quality Governance Committee as well as learning from patient safety incidents and use of hard copy documentation.
1269/22	The Director of Nursing also noted the maternity environment risk which had increased to a high rating and the 3 workforce risks with the potential for quality and safety implications. These included staff morale, recruitment and retention of staff.
1270/22	A review of workforce risks had been undertaken and would be presented to the next People and Organisational Development Committee.
1271/22	The Board noted that there were no very high risks for finance, performance or estates however the finance risk register had also been reviewed and would be presented to the Finance, Performance and Estates Committee in July.
1272/22	In addition to the report the appendix offered the list of strategic risks that should be recognised by Board members having been seen through the Committees.
1273/22	The Chair noted that these would have been reflected on during the Committees with discussions undertaken. There was a sense, on reading the report and tacking this back into minutes and upward reports of the Committees that the risk register was becoming dynamic.
1274/22	Whilst this had taken some time to achieve it had been worth waiting for as it was now felt that the risk register was informing the thinking as a Board and moving to a position of understanding risk and the mitigating actions in place. The Trust Board:

	• **Accepted the top risks within the risk register** • **Received the report and noted the significant assurance**
1275/22	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the report to the Board noting that this had been considered by all Board Committees during June 2022, with the exception of the People and Organisational Development Committee.
1276/22	The Trust Secretary noted the request for specific detailed reviews of some areas of the Board Assurance Framework (BAF) by the Committees noting that these would be completed by the Executive leads and relevant teams.
1277/22	The updates would be received by the Committees in July with a particular focus being offered to the new elements within the framework for 2022/23. There had also been focused input from the Director of Improvement and Integration on adjustments following the update work on the Integrated Improvement Plan.
1278/22	The Trust Secretary noted that there had been no changes to the ratings within the BAF.
1279/22	The Chair was pleased to note that the document was being used dynamically and challenge being made to the content with the Committees leading on conversations. Thanks were expressed to the Executive Directors for engaging in these discussions.
1280/22	Following a further round of updates to the Committees it was believed that the BAF would be settled, and it could then continue to progress with the Board being able to consider the assurances of what had been set out. The Trust Board: • **Received the report noting the moderate assurance**
1281/22	**Item 14 Any Other Notified Items of Urgent Business** The Chair advised the Trust Board of the successful recruitment round that had been completed, attracting some high calibre individuals who would be joining the Trust in August.
1282/22	There would be 4 new Non-Executive Directors, 2 substantive and 2 associate Non-Executive Directors. Once the fit and proper persons process had been completed formal announcements would be made. It was hoped that the new colleagues would be able to join in time for the August Board meeting.
1283/22	As a result of the successful appointment this would mean that Miss Shadlock would be leaving the Board having been on secondment from Lincolnshire Community Health Services NHS.
1284/22	The Chair expressed appreciation for the contribution Miss Shadlock had offered to the Trust noting the particularly the patient perspective and insight offered.

1285/22	The Chair wished Miss Shadlock all the best in Non-Executive Director roles both in and out of the NHS.
1286/22	The next scheduled meeting will be held on Tuesday 2 August 2022, arrangements to be confirmed taking account of national guidance.

Voting Members	**6 July 2021**	**3 Aug 2021**	**7 Sept 2021**	**5 Oct 2021**	**2 Nov 2021**	**7 Dec 2021**	**1 Feb 2022**	**1 Mar 2022**	**5 Apr 2022**	**3 May 2022**	**7 June 2022**	**5 July 2022**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	A	X	X	A	X	A	X	X	A	X	X	X
Geoff Hayward	X											
Gill Ponder												
Neill Hepburn	A											
Sarah Dunnett	X	X	X	X	X	X	X	X	A	X	A	X
Elizabeth Libiszewski	X	X	X	X	X	X						
Paul Matthew	X	X	X	X	X	X	X	A	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	A	A
Mark Brassington	X	X										
Simon Evans			X	X	X	X	X	X	X	X	X	X
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X
David Woodward	A	A	X	X	X	X						
Philip Baker		X	X	X	X	X	X	X	X	X	X	X
Colin Farquharson		X	X	X	X	X	X	X	X	X	X	X
Gail Shadlock							X	X	X	X	X	X
Dani Cecchini							X	X	X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
7 December 2021	1914/21	Action Log	Establishment reviews for endoscopy and ED would be received once considered at Committee in Jan/Feb 2022 Endoscopy review to be received in July	Director of Nursing	~~01/03/2022~~ ~~05/07/2022~~ 02/08/2022	Deferred to August
7 June 2022	821/22	Public questions	Specialist services on certain sites to be discussed further at a future Finance, Performance and Estates Committee and upwardly reported to the Board.	Chief Operating Officer	21 July 2022	Closed
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	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*2 August 2022*
Item Number	*Item number 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Dr Karen Dunderdale, Deputy Chief Executive/Director of Nursing*
Author(s)	*Dr Karen Dunderdale, Deputy Chief Executive/Director of Nursing*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to be under significant pressure, as is the case across the country. Significant work is underway to improve flow through the system and to improve ambulance response and handover times. The summer holiday period always adds additional demand into the Lincolnshire system as people travel to the east coast for their holiday at a time when NHS staff are also looking to take annual leave. The recent heatwave resulted in organisations enacting their heatwave and business continuity plans, relating to both services to patients but also staff wellbeing.

b) The Government has announced the pay awards for NHS staff for 2022/23, based on the recommendations of the various pay review bodies. A number of trades unions are discussing industrial action with their members and it will be important for the system to have contingency plans in place should action be taken.

c) Guidance has been received from NHS England relating to the COVID autumn booster and flu vaccination programme expansion. Additional cohorts of people will now be offered the flu vaccine and COVID booster doses. There are well established processes and procedures in place in the county for delivering vaccination programmes and these will be utilised to deliver this expanded programme.

d) Following the establishment of the NHS Lincolnshire Integrated Care Board on 1st July 2022, work is underway to put in place a Memorandum of Understanding (MoU) between the ICB and NHSE England. This MoU will set out how the ICB and NHSE will discharge their respective duties; the governance arrangements across the ICB and its partner organisations; how NHSE, the ICB and NHS provider Trusts will work together to implement the requirements of the NHS Oversight Framework; and how any specific development needs will be met.

e) The provider collaborative in Lincolnshire, Lincolnshire Health and Care Collaborative (LHCC), has been operating for a number of months now. This new way of working is a key component of the ICS, alongside the Integrated Care Partnership and the Integrated Care Board. A stocktake of LHCC will be taking place over the coming weeks to understand the current ways of working, identify any issues around governance and the delivery model and to provide any recommendations on action that could be taken to strengthen the current arrangements. This stocktake outcome will be reported to the NHS Lincolnshire Leaders Group on 24 August. The Terms of Reference for this stocktake are currently being finalised.

Trust Overview

a) At Month 3, the Trust reported a year to date deficit of £5183k against a year to date plan of break-even. Action is being taken to bring the plan back on track, including through more effective delivery of CIP programmes.
b) The Full Business Case for the redevelopment of the Emergency Department at Pilgrim Hospital Boston has been approved in principle by the Department of Health and Social Care. Ministerial approval is now awaited, the timing of which is important if the Trust is to avoid having to re-negotiate the Guaranteed Maximum Price (GMP) with the contractor.
c) The outcome of the public consultation on the future of Nuclear Medicine Services in the Trust will be reported to the September Board meeting held in public.
d) A very positive meeting was held with NHS England on 21st July to discuss the Trust's exit from 'special measures'. The meeting focused on the challenges that the Trust had faced, the progress that has been made, the lessons learnt and what ongoing support was needed to ensure that the improvements were maintained. The Trust was commended on the progress that has been made and the impressive leadership that was evident in the Trust and the wider system.
e) The Trust has commenced the pre-procurement phase of the electronic Patient Record (ePR) programme. This involves supplier pre-market engagement sessions. These allow the Trust to market itself to potential suppliers and for the Trust to better understand potential ePR suppliers and their systems.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	19 July 2022
Chairperson:	Chris Gibson, 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 noted the report from the group and the continued use of the C2AI system to support patient prioritisation. The Committee was pleased to note the continued reduction in patients with high scores who were receiving care in a timely manner. The updated clinical harm review process continued with the Committee noting that regular updates would be provided through the upward report to the Committee following scrutiny by the group. The Committee noted the look back exercise being completed in respect of harm monitoring results noting that a number of patients were identified through the Datix search who did not meet the exacting definition required for harm reviews. This confirmed the need to continue to triangulate all available data. **Ward/Department Accreditation** The Committee was pleased to receive the update in relation to the Ward Accreditation programme that continued to be undertaken noting that a number of wards were in a position to apply for the bronze higher level award. The Committee was assured of the robust process in place in order for wards and departments to work towards and achieve the increasing levels of accreditation that demonstrated delivery of quality and safety indicators. **Serious Incident Summary Report**

	The Committee received the report noting the position presented and the continued work to reduce open actions. The Committee noted a small number of long overdue actions and received assurance that these were being addressed through the process in place to support the divisions to complete overdue actions. **High Profile Cases** The Committee received the report noting the content. **Patient Safety Alerts Quarterly Report** The Committee noted the full review that had been undertaken of the 2 systems in operation in respect of field safety notices (FSNs) that had identified the number of open FSNs. The Committee noted the intention to create a group that would consider the open FSNs and determine the action required to close these. It was suggested that a risk stratification process be considered to address those FSNs which required more immediate focus. **Safeguarding Group Upward Report** The Committee welcomed the Specialist Nurse Safeguarding Children who offered an update to the Committee from the Safeguarding Group. The Committee noted the progress in respect of child protection information sharing and the associated CQC action for which significant progress had been made with 100% of staff being trained. The update on Deprivation of Liberty Protect was noted and the Committee acknowledged that there was yet to be a confirmed date that this would be introduced. The Committee noted the withdrawal of support to the Trust from Lincolnshire Partnership Foundation NHS Trust in respect of the clinical holding team however was assured that this could be managed by Trust staff. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the update noting that the recent increase in Covid-19 and outbreaks had seen exceptional IPC practice and processes to manage these. It was noted that a recent downward trend in staff and patient outbreaks was being seen. The Committee was pleased to note the continued overall good compliance with the Health and Social Care Act IPC criteria noting that the position was further supported by recent external visits to the Trust. The Committee wished to alert the Board to the written confirmation from the NHS England Regional IPC of the Green rating achieved for IPC in both inpatient and non-inpatient areas. This was a significant achievement, especially against the backdrop of Covid-19.

	Medicines Management Task and Finish Group Upward Report The Committee noted that the meeting had not taken place due to timing of the group however was pleased to note that there was now dedicated project management in place. Progress had also been made in respect of the action plan and the focus of this with lead owners identified for actions. A formal update would be received at the August Committee. **Patient Safety Group Upward Report** The Committee received the report noting the commencement of the thematic review of Serious Incidents, year to date, as commissioned by the Director of Nursing and Medical Director. It was noted that these were returning to pre-pandemic levels however further work was required. The incident analysis report had identified a change in themes with a need to understand the position, but it was felt that these could be due to post-pandemic fatigue with more no and low harm incidents being seen. It was noted that the incident reporting tool considered all incidents and further work would be required to be able to understand how incidents could be flagged to other Committees, such as HR to the People and OD Committee. **Nursing Midwifery and AHP Advisory Forum Upward Report** The Committee took the report as read noting that there were no escalations to be alert to. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the report noting the Trust application to exit the Maternity Safety Support Programme which would be submitted imminently (appended). This was a positive move forward for the Trust and recognised the progress that had been made across maternity and neonatal services. The Committee was pleased to receive the Ockenden insight visit feedback which had been undertaken to review the Trust against the 7 immediate and essential actions identified through the first Ockenden report. The feedback is appended to the report for Trust Board members. The feedback stated that the visit had been 'exceptional' and offered positive feedback to the teams for the efforts and work undertaken. The Committee received the ATAIN report (appended) noting that this supported the Clinical Negligence Scheme for Trusts and Ockenden actions. The Committee noted a number of red items within the report however were assured that this was a reflection of the Trust wishing to ensure that actions were embedded and evidenced before these were

	rated as green. The Committee continued to receive assurance from the group and noted the report offered by the Non-Executive Director Maternity Safety Champion.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report noting the update offered. **National Inpatient Survey - Cancer** The Committee welcomed the Deputy Lead Cancer Nurse to the meeting and received the national cancer inpatient survey. It was noted that the results presented were for the 2020 year which had been a voluntary year due to Covid-19. The Trust was one of 55 to take part in the survey and it was noted that whilst there was no national comparison available a look back had been undertaken by the Trust and ICB on the past 5 years. The Trust was in general improving as demonstrated by the results and the look back, with an action plan in place to address 6 identified themes. The Committee noted that this would be monitored through the Cancer Patient Expert Group and the Patient Experience Group. **Complaints Annual Report** The Committee received the Complaints Annual Report which detailed the 2021/22 activity which had been impacted by Covid-19 and the ability for clinical staff to support responses due to the operational pressures. The Committee noted the increase in complaints and the complexity of these however it was recognised that the themes remained the same as reported quarterly to the Committee. The report highlighted the actions to be taken over the coming year in respect of improving the timeliness of responses and the introduction of a business partner model to better support the divisions.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the GIRFT report received by the group and the focus on high volume low complexity cases along with 3 high risk cancer areas. It was noted that the focus of GIRFT would move from being process to outcome focused. The Committee was pleased to note the positive outcome of the mandated organ donation report noting that whilst these were low

	numbers the quality of service was high. **Confidential Enquiries - NCEPOD Report** The Committee received the report noting that since the previous report there had been a further checklist completed. It was noted that through progression of the work the report would monitor implementation of studies and offer a position statement to the Committee. **Clinical Audit Annual Report** The Committee received the annual report noting the effort of the clinical governance team in moving forward clinical audit within the organisation. It was noted that the Trust now participated in all required national clinical audits. The Committee was pleased to note the increased resource in the team which had allowed for a business partner approach to be implemented to support the divisions. This had resulted in improvements of the quality of clinical audits. The Committee noted the scale of audit undertaken in the Trust and noted the positive report offered. It was suggested that, where possible, numeric or quantitative outcome data would be beneficial within the report.
	Assurance in respect of other areas: **CQC Action Plan** The Committee received the monthly update noting the progress being seen and the intention to seek assurance on those actions from previous inspection reports. Assurance was received in respect of the system in place to monitor and ensure actions were embedded before this was completed on the action plan. The Committee noted that this supported the Trust ambition to move beyond Requires Improvement to Good. **Quality Impact Assessments** The Committee noted the ongoing work in relation to Quality Impact Assessments and the sampling of QIAs to ensure those not going to panel were appropriately completed at local level. The Committee noted the internal audit which had been completed and the update processes in place that had strengthen the QIA panel and process. Assurance was gained in the understanding of open QIAs and that in

	certain circumstances these would be received back once mitigations had been put in place in order to confirm if these had or had not been effective or if there were unintended consequences as a result. **Integrated Improvement Plan** The Committee received the report noting that further work was required to finalise the metrics within the report. Work would be completed through the Trust Leadership Team in order to work through the data points and baseline positions with the divisions. The Committee noted the intention to complete work by the end of the month which would then be seen through the Performance Review Meetings. **Committee Performance Dashboard** The Committee received the performance dashboard noting the content and reflecting that the reports received by the Committee had enable discussions in relation to the reported performance.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register.
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	A	S	O	N	D	J	F	M	A	M	J	J
Elizabeth Libiszewski Non-Executive Director	X	X	A	X	X							
Chris Gibson Non-Executive Director	X	A	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	A		X	X	X	X	X	A
Neill Hepburn Medical Director												
Karen Dunderdale Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Simon Evans Chief Operating Officer	D	D	D	X	D	D	X	D	X	D	D	A
Colin Farquharson Medical Director	X	X	X	A	X	X	X	X	X	X	X	X

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

Date 30.06.22

Report to request to exit NHS England / Improvement Maternity Safety Support programme (MSSP)

Executive summary

United Lincolnshire Hospitals NHS Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of maternity services, on the Pilgrim site, in June 2019. At this time Pilgrim was rated as Requires Improvement and Lincoln site was Good. The initial Maternity Service Support Meeting to launch this was held on 10th December 2020.

Following an unannounced inspection in October 2021, the CQC has revised ratings for the Maternity Service to Good on both sites.

This paper identifies the supporting evidence for this improvement as well as work underway to continue to improve the quality and safety of Maternity services to facilitate the Trust in maintaining and further improving the CQC rating.

Key points outlined in this paper are:

- The process for entering and exiting the MSSP
- Completed actions from the 2019 CQC visit
- Ongoing action and progress
- Sustainability plans for actions
- Organisational development work
- Compliance with Ockenden and CNST

Action required/recommendation **(for decision, for discussion, for information)**

The Board/Committee/Group is asked to: Note the contents of the paper and support an application to exit MSSP

Application to Exit the MSSP Programme

Introduction

United Lincolnshire Hospitals NHS Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of maternity services in June 2019. Following a further CQC unannounced inspection in October 2021, the CQC has revised ratings for the service to Good. The Trust has therefore met the required criteria to exit the MSSP.

The NHS England / Improvement Maternity Safety Support Programme (MSSP)

The overall objective of the MSSP is to deliver a maternity safety support initiative, led by NHS England/ Improvement. The CQC supports this through the provision of intelligence to identify priorities for improvement and assurance that required changes have been made. NHSE/I then provide a programme of support that is designed to be flexible and adaptive to meet the individual needs of the Trust's improvement journey.

Criteria for entry to the MSSP are maternity services which have:

- An overall rating of inadequate
- An overall rating of requires improvement with an inadequate rating for either Safe and Well-Led or a third domain
- Been issued with a CQC warning notice
- Dropped their rating from a previously outstanding or good rating to requires improvement in the Safety or Well Led domains
- DHSC or NHS England /Improvement request for a review of services or inquiry
- Been identified to CQC with concerns by HSIB

A Maternity Improvement Advisor was allocated to United Lincolnshire Hospitals NHS Trust in December 2020, to work with the executive and divisional leaders to support the delivery outcomes identified in the CQC Report.

The key areas of focus of the MIA have been-

- Professional Support and guidance for the senior midwifery team via 121s and joining key meetings. Including peer support for the Consultant Midwife and Interim Consultant Midwife
- Undertaking site walkarounds, meeting staff and giving feedback to the senior team
- Support with the provisional of Bereavement facilities on the Pilgrim Site
- Support with the planning of the refurbishment of the Lincoln Site including the inclusion of a Birth Centre
- Participating in the MNOG and other key meetings
- Supporting the review of the Risk Resource in Maternity
- Support with a review of the Maternity Dashboard

Criteria for leaving the programme has been met as the CQC improved the rating by at least one in the safe & well led domains. This has been achieved and therefore the Trust seeks to exit the programme through this formal paper presented to the Regional Provider Oversight Committee.

Supporting evidence to Exit MSSP

Following the CQC Inspection in June 2019 the Trust promptly developed an action plan with clear Divisional and Executive oversight.

A Maternity and Neonatal oversight group chaired by the Director of Nursing was formed. This group has met monthly (in addition to Governance processes). The group includes the key Medical, Nursing/Midwifery and operational senior team members, CCG partners and the NED Safety champion.

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

United Lincolnshire NHS Trust
CQC Improvement Action Plan: Maternity

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating BRAG
CQC2021-03	Maternity	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.	Maternity	Action taken at the time of the inspection. Trolleys with medications were moved to a secure area.	Dr Suganthi Joachim (Division Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Divisional Managing Director)	31-Oct-2021	Green
						Maternity	Wall thermometer ordered. Daily check added to the daily check list. Staff aware of escalation process if needed.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Oct-2021	Green
						Maternity	Map out across Maternity at both sites locations where medicines (drugs rooms (inc. fluids), medication fridges, mobile trolleys) are stored	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue

Maternity	Undertake gap analysis audit against Trust's Medicines Management Policy that relates to storage and security (i.e. have locations that store medicines got digital thermometers?)	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue
Maternity	Develop audit tool for use by Maternity Matrons to undertake gap analysis against medicines storage section of medicines management policy.	Jeremy Daws (Head of Compliance)	03-Mar-2022	Blue
Maternity	Plan out action in response to audit to close any gaps identified (i.e. order digital thermometers).	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Green
Maternity	Identify any risks from audit undertaken (i.e. rooms where ambient temperature is routinely 25 degrees or above and take advice from pharmacy around mitigations.	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Green
Maternity	Understand mitigations to environmental challenges in storage of medicines (i.e. age of estate at Lincoln maternity with a lack of air-conditioning/ventilation).	Simon Hallion (Divisional Managing Director)	30-Apr-2022	Red

						Maternity	Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Green
CQC2019-080	Maternity	Trust	2019 Comprehensive Inspection	Should Do	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. [Links to CQC2021-06]	Maternity	Report on core training compliance by staff group within the Divisional PRM slides.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Jan-2022	Green
						Maternity	Review the use of the Maternity Services Education Strategy to determine if this is effective in supporting improved training compliance.	Simon Hallion (Divisional Managing Director)	30-Apr-2022	Green
						Maternity	Achieve Resuscitation core training level of 95% for medical staff.	Dr Suganthi Joachim (Divisional Clinical Director)	30-Apr-2022	Red
						Maternity	Achieve 80% training compliance (average across all core training subjects) for medical staff.	Dr Suganthi Joachim (Divisional Clinical Director)	30-Apr-2022	Red
						Maternity	Achieve 95% Trust target for core training compliance for medical staff.	Dr Suganthi Joachim (Divisional Clinical Director)	31-Aug-2022	Amber

CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Suganthi Joachim (Divisional Clinical Director); Simon Hallion (Divisional Managing Director); Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	Amber

CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	CYP / Maternity	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	Carol Hogg, Hayley Warner, Emma Young, Kristie Rennison, Karen O'Connor, Kay Probert (Sisters/Clinical Educators/Play Specialists) C/O Rebecca Thurlow (Lead Nurse, CYP) Matrons within Maternity, C/O Emma Upjohn (Deputy Head of Midwifery/Lead Nurse Breast/Gynae)	30-Apr-2022	Green
Mat 3	Maternity	Lincoln County Hospital	2021 'Interim Action'	Immediate	The physical environment was in poor condition although we appreciate estates have been on site addressing our issues. [Links to CQC2021-14]	Maternity	Immediate action taken to improve privacy and dignity and replace ageing furniture.	Dr Suganthi Joachim (Division Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Divisional Managing Director)	31-Oct-2021	Blue
						Maternity	Formally appoint a design team to develop a business case for Maternity (and then scope additional milestones once progressed to this stage).	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Red

CQC2019-082	Maternity	Lincoln County Hospital	2019 Comprehensive Inspection	Should Do	The trust should ensure risks are clearly identified and documented in an appropriate format. [Links to CQC2021-18]	Maternity	Revised risk register format now being used. Continue to embed the use of this in strengthened governance structures.	Dr Suganthi Joachim (Divisional Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Managing Director).	31-Mar-2022	Green
CQC2021-28	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	Maternity	The incident 'Trigger List' has been provided to all staff and discussed at team meetings. On the back of this link in with the Trust piece of work looking at mapping of the various processes that share learning across both sites.	Paula Izod (Risk Midwife)	31-Mar-2022	Green

						Maternity	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups.	Helen Shelton (Assistant Director of Clinical Governance / Patient Safety Specialist)	TBC	Amber
						Maternity	Review the corporate assurance tools to understand what questions are regularly asked of staff and determine if further assurance relating to incidents could be included within these (i.e. ward accreditation review process).	Jeremy Daws (Head of Compliance)	30-Jun-2022	Amber

CQC2021-29	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff.	Maternity	Midwives whose training / sign off of competence is outstanding to have obtained competencies. In the interim, where there is a case and a midwife who has not received the training for GA recovery, the theatre recovery nurses will remain in attendance. *NB: Original action planned to have fully completed competence for those midwives outstanding by Dec-21. However, to attain competence requires a full-day in Theatres and there is insufficient capacity in Theatre rotas for these staff to be attain competence until end of the financial year 21/22 (an average of 1-2 midwives a week can attend).* *16-Mar-22: Timescale reset from 31-Mar-22 to 30-Apr-22 (PHB) and 31-Oct-22 (LCH).*	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-Apr-2022 (PBH); 31-Oct-2022 (LCH).	Red

						Maternity	Look at further strengthening, reduce the likelihood still further, by including this competency as part of roster planning. Scope out during October 2021. *Action amended subsequently to being provided to CQC:* *The majority of midwives on the labour ward are B6 and therefore have, for the most part, obtained necessary competencies as part of their training at B5 level*	Libby Grooby (Divisional Head of Nursing and Midwifery)	01-Dec-2021	Green
						Maternity	Monitoring of compliance and assurance through the Maternity and Neonatal Assurance Group.	Yvonne McGrath (Consultant Midwife)/ Emma Upjohn (Interim Deputy Head of Midwifery)/Lead Nurse Breast/Gynae	31-Mar-2022	Blue
CQC2021-30	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should improve the completion of safety, quality and performance audits to ensure these are consistently completed effectively, to enable safety and quality concerns to be identified and acted upon.	Maternity	BAU: Ongoing review and assurance that environmental audits do assess the estate and escalate appropriately into MNOG.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	Green

Mat 7	Maternity	Trust	2021 'Interim Action'	Immediate	****NEW** CQC Concern: 26-Nov-21:** • 121 care during birth figures for the past year for both sites with figures for each site separately • PROMPT training compliance rates for each site separately broken down into midwifery and medical staff	Maternity	1:1 care in labour is monitored through the acuity tool and reported monthly via the dashboard. The target is 100%. Data shared with CQC demonstrating compliance figures. If 1:1 care falls below the 100% target on any occasion there is a robust escalation policy to ensure 1:1 care. This consists of reprioritising use of existing staff time, which impacts on non-direct patient care activities planned i.e. training.	Libby Grooby (Divisional Head of Nursing and Midwifery)	01-Dec-2021	Green
						Maternity	In response to increased sickness levels and operational pressures, staff booked on training, including PROMPT, were sometimes redeployed to help ensure patient safety, including to support with 1:1 care in labour. This had an impact on the Trust's PROMPT training rates. The Trust's trajectory to achieve 90% compliance once more with PROMPT training is by 31 March 2022.	Libby Grooby (Divisional Head of Nursing and Midwifery)	05-Jan-2023	Red
2019-081	Maternity	Trust	2019 Comprehensive Inspection	Should Do	The trust should ensure systems to monitor waiting times in line with national standards are implemented.	Maternity	Incorporate the Antenatal Assessment Unit audit data within the Maternity dashboard for upward reporting into maternity governance and MNOG.	Karen Ludkins, (Antenatal Matron)	31-Mar-2022	Blue
						Maternity	Initiate a 'deep-dive' process to review any areas of performance that prompt further investigation (i.e. poor compliance) and present the summary of this review to MNOG.	Karen Ludkins, (Antenatal Matron)	31-Mar-2022	Red

						Maternity	Determine if additional administration resource can be identified to support bringing the audit data up to date for reporting purposes.	Karen Ludkins, (Antenatal Matron)	28-Feb-2022	Blue
2019-083	Maternity	Lincoln County Hospital	2019 Comprehensive Inspection	Should Do	The trust should ensure they collect data relating to the percentage of women seen by a midwife within 30 minutes and if necessary by a consultant within 60 minutes during labour.	Maternity	Include the matrons audit dashboard as an appendix to the exception reports to support upward reporting into divisional governance arrangements.	Emma Upjohn (Interim Deputy Head of Midwifery/Lead Nurse Breast/Gynae)	31-Jan-2022	Blue

Ockenden and CNST Compliance

Following release of the first Ockenden report Trusts were asked to submit evidence for compliance against the 7 IEA's. One year on, Trusts were asked to report, to the Trust Board, the LMNS and the NHSE/I regional maternity team, on progress with the remaining actions in respect of both Ockenden and Kirkup. ULHT has made significant progress in implementing the required improvement actions. Overall compliance following the further self-assessment exercise undertaken confirmed continued good levels of compliance; with ULHT maternity services meeting 117 of 123 Ockenden actions (95%) and 29 of 33 Kirkup actions (88%). This evidence was submitted to the NHSE/I regional team ahead of the 15 April 2022 deadline.

The10 remaining actions are in progress / on track for completion by the end of Quarter 2, with the exception of Personalised Care and Support Plans (PCSPs). PCSPs represent a significant shift in culture within maternity services and will require time to become fully embedded. Support with this work has been sourced internally from the PMO and externally from the CCG to establish PCSPs in to practice.

An on-site visit by the regional maternity team was undertaken on 22nd/23rd June, supported locally by the LMNS and MVP. This was to test the embedding of the Ockenden and Kirkup improvement actions. The feedback from the visit was very positive and all issues identified were in line with the Trusts benchmarking and action plan.

The Trust has also supported the establishment of further Safety Leads within maternity services to support the ongoing improvement work and the embedding of this within the service.

The Trust submitted full compliance with yr 3 CNST. Yr 4 CNST has recently been relaunched and is currently being benchmarked against.

Sustainability

To give assurance regarding the sustainability of the MSSP improvements the following table summarises the sustainability plan for the MSSP actions. Once agreed the actions below will be incorporated into the Overall Maternity Improvement plan with MNOG oversight.

Sustainability Plan

MSSP Key Action/CQC improvement actions	Current progress	Plan for Sustainability	Lead	Monitoring arrangements	Trajectory for completion
Professional Support and guidance for the senior midwifery team.	External support currently provided by MIA and Regional Chief Midwife	MIA support to be stepped down gradually.	Chief Nurse	PDRs Discussion at 121s	Full step down will be achieved once there is evidence of progress against all actions
	External support currently provided by MIA and Regional Chief Midwife	Joint discussion and plan for support to be agreed by the Trust Chief Nurse and in consultation with the Regional Chief Midwife	Regional Chief Midwife	Oversight at NMOG	January 2023
Peer support for the Consultant Midwife and Interim Consultant Midwife	External support currently provided by Consultant Midwife MIA	Joint discussion and plan for support to be agreed by Consultant Midwife and Head of Midwifery	Head of Midwifery	Oversight at NMOG	Ongoing support as above January 2023
Provision of Bereavement facilities on the Pilgrim Site	Works are currently underway	There are some delays which have been escalated	Head of Midwifery Matron Inpatient Services	Oversight at NMOG	August 2022
Risk Resource in Maternity	Risk team resource has been reviewed and are in post	Yearly review of risk resource and capacity across the MDT	HoM and CD	Oversight at NMOG	**Complete**
	Risk team resource has been reviewed and are in post	Risk and safety team further strengthened wit recruitment to a further 4 Safety lead midwives.	HoM and CD	Oversight at NMOG	**Complete**

Development of the Maternity Dashboard	Dashboard has been redesigned and is now providing oversight	Review of dashboard metrics when required. Minimum yearly	LMNS	Oversight at NMOG	**Complete**
Estate challenges: Understand mitigations to environmental challenges in storage of medicines (i.e. age of estate at Lincoln maternity with a lack of air-conditioning/ventilation).	Plans have been finalised and OBC in progress	Added to risk register Roll-out of Stanley remote temperature probes in planning stages (Maternity are a pilot site) Estates review undertaken	Director of estates	Oversight at MNOG/PRM	**Complete**
The physical environment was in poor condition and need a plan to address.		Formally appoint a design team to develop a business case for Maternity (and then scope additional milestones once progressed to this stage).	Director of Estates	Oversight at NMOG	July 2022
No bereavement facility on Pilgrim site		Building work has commenced	Director of Estates /Matron In-Patients	Oversight at CBU governance meetings/MNOG/ PRM	September 2022
Achieve 80% training compliance (average across all core training subjects) for medical staff.		Ongoing monitoring of training compliance on maternity dashboard	Suganthi Joachim	Oversight at Governance/MNOG	August 2022
Achieve 95% Trust target for core training compliance for medical staff.		Ongoing monitoring of training compliance on maternity dashboard	Suganthi Joachim	Oversight at Governance/MNOG	August 2022

The trust should ensure the requirements of duty of candour are met.		Continue to monitor and track performance with support from the Trust's Risk & Governance team. Currently 100% compliance for written and verbal.	Simon Libby Suganthi	Oversight at Governance/MNOG	**Complete**
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.		Midwives whose training / sign off of competence is outstanding to have obtained competencies. In the interim, where there is a case and a midwife who has not received the training for GA recovery, the theatre recovery nurses will remain in attendance.	PDM/Consultant midwife/Inpatient matron	Oversight at MNOG	September 2022
In response to increased sickness levels and operational pressures, staff booked on training, including PROMPT, were sometimes redeployed to help ensure patient safety, including to support with 1:1 care in labour. This had an impact on the Trust's PROMPT training rates.		Plan in place to achieve in line with CNST	PDM/Consultant midwife/matron	Oversight at MNOG	The Trust's trajectory to achieve 90% compliance once more with PROMPT training is by 5th January in line with CNST January 2023

Avoidable Term Admissions Into Neonatal Units

Created: May 2022

Governance meeting responsible for oversight: ATAIN MDT monthly meeting, MNOG

Ratified by Trust Board by 29th July 2022

Responsible Leads: Catherine Franklin, Rachel Wright, Carole Chapman, Jules Bambridge

Trend Identified	Last updated	Overall RAG	Key Ongoing Actions
Review Process and Data Collection	06/07/2022		
Priority 1: Infection (emerging)	07/07/2022		
Priority 2: Respiratory (stable, high)	08/07/2022		

Review process and data collection								
Objective	Actions	Responsible Person(s)	Date Started	Date Due	Progress	Links to	RAG Rating	Ongoing Monitoring/Review Plan
Data Collection	Develop plan to train and embed use of Badgernet on NNU	Cathy						
	Improve recording of admission reason and diagnosis on discharge on BadgerNet					ATAIN Q4 2021/22 Report		
	NNU to design data collection for term TC ward attenders to NNU	Rachel/Carole		01/07/2022	Completed 30/6/22	CNST Year 4 - to start from 18/7/22		Monthly ATAIN meetings
	Review TC auditable standards from BAPM for inclusion in reporting	Bryony/Rachel		15/09/22 (include in Q2 TC report)				
Transitional Care	Quarterly TC audit and report	Bryony & Carole	From Q1 2022/23	31/07/2022		CNST Year 4		
	Quarterly review of babies who could have been admitted to TC	Bryony/Rachel/Jules	From Q1 2022/23	31/07/2022		CNST Year 4		
	Benchmark against TC BAPM guidance	Cathy		15/09/2022 (include in Q2 TC report)				
	Benchmark against TC HRG criteria	Cathy & Ruth		15/09/2022 (include in Q2 TC report)				
	Survey of TC experiences	Cathy		15/09/2022 (include in Q2 TC report)				
CNST	Standard e) practice run of HRG 4/XA04, Commissioner returns for HRG 4/XA04 activity as per National Critical Care Minimum Data set (NCCMDS) verson 2	Ruth and Cathy		01/07/2022		CNST Year 4		
Observations	Review NEWTT2 chart for implementation with recommendations for implementation	Cathy/Jules/Rachel/Carole		01/09/2022 or when released		ATAIN Q4 2021/22 Report		
Review process	Commence TBAM method of review	ATAIN Leads	01/06/2022	01/06/2022	TBAM Started	CNST Year 4		Quarterly ATAIN reports

Infection							
Objective	Actions	Responsible Person(s)	Date Started	Date Due	Links to	RAG Rating	Ongoing Monitoring/Review Plan
Preventing Infection	Deep dive into ATAIN cases with infection, in particular number of VE, with recommendations	ATAIN Lead		31/07/2022	ATAIN Q4 2021/22 Report		
	Audit WebV for recording of observations during labour	ATAIN Lead/Matron		01/09/2022	ATAIN Q4 2021/22 Report		
	Audit 20 sets of notes for decision to delivery interval	ATAIN Lead/Obs Audit already in place?		31/07/2022	ATAIN Q4 2021/22 Report		
	Fetal Four - speak to Heather						
	Share learning of recognition, escalation and management of maternal tachycardia in labour	FM Leads		31/07/2022	ATAIN Q4 2021/22 Report		
Increase number of babies having IV Abx on PN Ward	Midwives education pack for baby IV abx - include in preceptorship	Sally Dawes/Katy Carr		30/09/2022	ATAIN reviews		
	Midwives to help with TC cares	George/Lorri		30/09/2022	ATAIN reviews		
	"Shared care model"	Inpatient & NNU Matrons, Ward Managers		30/09/2022	ATAIN reviews		
	Bay for lodging mums to do TC	Sal Dawes/Lorri/Emma					Not possible
Reducing NNU transfers	Septic Screen on wards	NNU Staff		30/09/2022	ATAIN reviews		
	Cannulation on wards	NNU Staff		30/09/2022	ATAIN reviews		

Respiratory							
Objective	Actions	Responsible Person(s)	Date Started	Date Due	Links To	RAG Rating	Ongoing Monitoring/Review Plan
Ensure the right babies are born at the right time	Deep dive into timing of GDM birth, particularly ELLSCS	Sarah Dudley and Diabetic Lead Consultants		30/08/2022	ATAIN Q4 2021/22 Report		
	Review GDM guidance regarding timing of birth			31/08/2022	ATAIN Q4 2021/22 Report		
	Review evidence for timing ELLSCS for babies 39+3 over a weekend	ATAIN Lead		01/09/2022	ATAIN Q4 2021/22 Report		
Ensure babies are born optimally	Review of use of steroids at ELLSCS <39+0	Sarah Dudley and Diabetic Lead Consultants	10/06/2022	31/07/2022	ATAIN Q4 2021/22 Report		
Recognition & management of respiratory problems	Review evidence for diagnosis and management of TTN vs RDS	ATAIN Lead / ANNP		01/09/2022	ATAIN Q4 2021/22 Report		
Escalation	Review Each Baby Counts L+S toolkit implementation for escalation and sbar processes	Safety Lead FM Leads		01/09/2022	ATAIN Q4 2021/22 Report		
Triangle of deterioratio	Explore education to support understanding of - increased work of breathing = low temperature = unstable BGs = increased work of breathing			01/09/2022	ATAIN Q4 2021/22 Report		
	Fourth stage of labour			01/09/2022	ATAIN Q4 2021/22 Report		

United Lincoln Hospitals NHS Trust

Maternity Services – Overview findings of Regional and System Insight Visit

22nd & 23rd June 2022

NHS England and NHS Improvement

Visit Purpose

An Insight visit to ULT NHS Trust maternity services was completed on the 22nd & 23rd June 2022.

The purpose of the visits was to provide assurance against the 7 immediate and essential actions from the Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

Conversations were held with members of the senior leadership team and many front line staff ranging in job roles. Emerging themes from conversations were organised under the immediate and essential actions headings

1. Enhanced Safety
2. Listening to Women & Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well-Being
7. Informed Consent
8. Workforce Planning and Guidelines

Insight Visit Team members: Janet Driver Regional Chief Midwife Midlands Perinatal Team ;Sandra Smith Deputy Regional Midwife Midlands Perinatal Team; Chantal Knight Senior Governance and Assurance Lead Midwife Midlands Perinatal Team; Susie Al-Samarrai Regional Obstetric Lead Midlands Team; Scott Johnston Maternity Improvement Adviser NHSE ;Sue Liburd Non Executive Director NHS Lincolnshire CCG and Independent Chair Lincolnshire LMNS; Sue Jarvis Programme Manager Lincolnshire LMNS ;Rebecca Hogan Programme Delivery Manager

Key Headlines

Points for Celebration

- An outstanding senior leadership team who are credible , well liked and respected
- Excellent Executive and NED visibility across maternity services
- An inspirational Head of Midwifery who is at the forefront of driving improvement across the service
- A loyal caring and compassionate staff who genuinely enjoy working at the units and describe their colleagues as ‘family’.
- Many examples were seen of QI projects in place including PeriOpt Project; information place mats; updated discharge video in all languages
- A strong governance methodology was visible across the division with good connections with the corporate team particularly in incident management and robust assurance processes
- Although the maternity units have issues with longstanding estates issues, which are in the process of being addressed, the areas were well utilised with a good use of information boards for staff and women and their families
- A skilled cohesive and enthusiast team of specialist midwives & consultant midwife who are continually driving improvement

Key Headlines

Points for Consideration

- Consider an 8A role as Governance Lead for senior oversight of the Governance agenda-to lead the safety specialists midwives and support the DHOM and HOM
- Continue to progress the business case and procurement of a Maternity IT system which achieves the national standards required and assists the maternity services to extract data easily to report Ockenden compliance for assurance purposes
- Continue the work underway with the MVP to update the Trust website with clear information on choice for place and mode of birth - consider benchmarking against Birmingham Women's and Children's website, which is fully compliant
- Consider developing the link with the MVP and Obstetric team to ensure feedback from women can be heard and any concerns addressed
- The PMA service offered is excellent-progress the appointment of a substantive Lead PMA role who can lead the team with appropriate banding and renumeration
- Consider strengthening the buddy relationship with the Nottinghamshire LMNS via an MOU

Summary of Insight Visit Review of Ockenden IEAs Status

IEA	i	ii	iii	iv	v	vi	vii	viii
1) Enhanced safety								
2) Listening to women and families	N/A	N/A						
3) Staff training and working together								
4) Managing complex pregnancy								
5) Risk assessment throughout pregnancy								
6) Monitoring fetal well-being								
7) Informed consent								
Workforce Planning								
Guidelines								

System improvement requirement

IEA1 Enhanced Safety

- Points for Celebration
- SI's and learning are clearly shared at LMNS Board
- Good internal MDT review of PMRT cases

Points for Recommendation

- Work towards external review for all PMRT cases by MDT clinicians which is recommended - prioritise the complicated PMRT cases that would benefit from external review and consider using a thematic review process to review groups of cases e.g. fetal abnormality/severe prematurity to maximise the learning
- PMRT reviews are currently led by the bereavement midwife - consider the governance team overseeing coordination with MDT involvement, including bereavement Midwife; PMA; Practice Educator; Obstetric and Midwifery clinical opinion -for robust learning across all specialities

IEA1	RAG
Q1 - Dashboards	
Q2 – External review of SIs	
Q3 – SIs to Board/LMNS	
Q4 - PMRT	
Q5 - MSDS	
Q6 - HSIB	
Q7 - PCQSM	
Q8 – SIs to Board/LMNS	

IEA2 Listening to Women & Families

Points for Celebration

- Outstanding NED in post who is visible to staff and is fully sighted on all maternity concerns and issues
- Posters with details of all maternity safety champions were visible in clinical areas
- Monthly meetings of the maternity safety champions were well embedded and resulted in good feedback to staff

Points for Consideration

- Dates of future meetings of safety champions could be included in posters along with focus area's for the month
- System Feedback- Continue with the plans to strengthen the opportunities for the MVP to capture and feedback to the Trust service user feedback

IEA2	RAG
Q9 – Advocate role	N/A
Q10 – Advocate role	N/A
Q11 – NED	
Q12 - PMRT	
Q13 – Service user feedback	
Q14 – Bimonthly safety champ meetings	
Q15 – Service user feedback	
Q16 – NED	

IEA3 Staff Training and Working Together

Points for Celebration

- Strong leadership for training governance requirements and governance with cohesive working with PMA ;fetal monitoring lead; safety specialist and bereavement midwives
- Comprehensive understanding of training data and training compliance rates across many staff groups
- Twice daily consultant ward rounds are well embedded and feedback from staff is positive and supportive
- Joint 9am call cross site for patient flow and escalation of concerns

Points for Consideration

- As the specialist midwives for various aspects of governance come into post continue to embed the strong governance process' around SBLCB, PRMT etc

IEA1	RAG
Q17 – MDT Training	
Q18 – Cons. Ward Rounds	
Q19 – Ring-Fenced Funding	
Q20 -	
Q21 – 90% MDT Training	
Q22 – Cons Ward Rounds	
Q23 – MDT Training Schedule	

IEA4 Managing Complex Pregnancy

Points for Celebration

SBLCB2 Compliance is achieved and embedded

Points for Consideration

The majority of women have face to face interaction with their named consultant however a small group of consultants work differently- utilising midwives to feedback plans of care-Progress the work underway to ensure all women who require a named consultant have a face to face consultation

IEA4	RAG
Q24 – MMC Criteria	
Q25 – Named Consultant	
Q26 – Complex Pregnancies	
Q27 – SBLCBv2	
Q28 – Named Cons/Audit	
Q29 – MMC	

IEA5 Risk Assessment Throughout Pregnancy

Points for Celebration

- Women with complex pregnancies receive a PCSP

Points for Consideration

- Continue the work in progress to ensure all women receive a PCSP. The introduction of a ‘fit for purpose’ maternity digital care record will ensure this is achievable

IEA5	RAG
Q30 – Risk assessment	
Q31 – Place of Birth RA	
Q32 – SBLCBv2	
Q33 – RA recorded with PCSP	

IEA6 Monitoring Fetal Well-Being

Points for Celebration

- SBLCB2 is implemented and embedded. Excellent progress is seen to achieve the CO reading standard at 36 weeks gestation, smoking cessation referral services and strong leadership

Points for Consideration

- Currently overall MDT training compliance is very near the 90% requirement with a clear trajectory and plan to achieve-continue the good progress to full attainment

IEA6	RAG
Q34 – Leads in post	
Q35 – Leads expertise	
Q36 – SBLCBv2	
Q37 – 90% MDT Training	
Q38 – Leads in post	

IEA7 Informed Consent

Points for Celebration

Points for Consideration

- System feedback - The MVP should complete the written feedback from the review of the Trust website undertaken over 12 months ago. This will ensure the Trust have the correct guidance to ensure the website is fit for purpose.
- System feedback - The system should consider mechanisms to strengthen methods of obtaining wide ranging service user feedback and opportunities and methods to strength co-production between the Trust and service users.
- The Trust could consider reviewing Birmingham Women's and Children's website, which is fully compliant

IEA7	RAG
Q39 – Accessible Information, Place of Birth	
Q40 – Accessible Information, All Care	
Q41 – Decision making and Informed Consent	
Q42 – Women's Choices Respected	
Q43 – Service User Feedback	
Q44 - Website	

Workforce Planning & Guidelines

Points for Celebration

- Visible strong leadership from the Head of Midwifery and senior leadership team in place, meeting frequently to discuss current concerns and solutions
- Wide range of specialist midwifery roles in place who were extremely knowledgeable, enthusiastic and inspiring
- 7 day Matron cover for senior support and oversight
- Robust process for management of Guidelines and NICE review

Points for Consideration

- Consider creation of a NICE Exception report/Action plan for guidance not achieved or deviated from
- Consider the introduction of a Director of Midwifery post in line with the RCM Strengthening midwifery leadership: a manifesto for better maternity care

WFP & G	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Additional Points for Celebration

- The PMA is facilitating student midwife dissertations as QI projects promoting team engagement retention of staff and great work already completed
- Introduction of both a Birth Choice Clinic led by the Consultant Midwife and a Birth After Thoughts Clinic led by the PMA
- Excellent use of ward boards to display important information including SBLCB2 workplans, Governance information ,Escalation plan and staff feedback from women. These boards were mirrored on both sites for consistently of messaging
- Innovative social media infographic with monthly statistics which is very well received by women
- Staff were able to articulate a positive culture in which they felt confident to challenge decision making and escalate any concerns across both sites
- Weekly Ockenden staff updates on teams for information sharing highlighting progress
- MNOG is an excellent vehicle for oversight and assurance.
- The MVP Chair is driving some innovative work around the support for military families which will inform opportunities for spread of good support practices across England

Additional Points for Consideration

- The system is encouraged to review the working practices of the LMNS and its approach to quality, assurance and oversight going forward. The insights team were concerned that the MVP Chair was acting outside the normal parameters of the MVP. Of particular concern where the number of meetings the Chair appeared to be having with bereaved parents whose care was being reviewed by either HSIB or the Trust. There are clear and well established feedback routes for these women and their families, which the MVP should be directing parents towards for support as opposed to attempting to deal with them directly.
- The MVP chair, in part, because of the time she spends with families, has not been able to complete some pieces of work, or been able to fully engage with the Trust in a meaningful and shared learning approach which would allow for these type of concerns raised to her at engagement events to be addressed in the context of continuous quality improvement feedback loop.
- The MVP chair lead work to review the Trust website regarding information for women over a year ago as a part of the interim Ockendon report actions. This review work has not yet formally been fed back to the Trust, informal verbal feedback has been given however there is a urgent need to collate this feedback formally so the work can be concluded.
- There is a need for clarity around numbers of women that are providing feedback to the LMNS & MVP. The MVP Chair spoke about percentage of families whose feedback is negative but she was unable to provide numbers of families she had engaged with in order to inform the percentages quoted i.e. 90% of how many families had negative feedback.
- Moving forward the LMNS team needs to provide concise clear evidenced based feedback with data sets, that can support the Trust improvement to work, the LMNS is key partner in quality improvement and needs to work jointly with the trust to build on the excellent work already achieved to date.
- There are clear opportunities for the system to move towards streamlined oversight meetings across the system which would reduce meeting attendance allowing all system partners to take on and seek assurance from all parties in one meeting, this could be achieved by reviewing the current MNOG, it has many system partners at the table, a refresh of TOR would potentially negate the need for an LMNS quality meeting which would have similar attendees and functionality and or the current LMNS quality meeting could assume the function of the MNOG either way the LMNS needs to consider streamlining the quality oversight meetings .
- There is a clear need for LMNS colleagues to understand the meaning of joined up ‘system oversight and assurance’. This is different to the CCG contract management process, with all partners at the table being accountable for the oversight and the QI process to support improvements where required. LMNS needs to have effective structures and infrastructure in place to support quality management, combining quality planning, quality assurance/ control and quality improvement functions.

Offers of Support to Trust

The visiting team would like to express thanks to all the staff who on the day of the visit were very welcoming in sharing their thoughts regarding the maternity services.

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	12 July 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** **NHS and System People Plan update** The Committee received the report noting that the Health Scrutiny Committee were due to receive an update in respect of the work underway in respect of the workforce and recruitment due to concerns raised by local MPs. The Committee noted that there was a system plan in place in order to recruit to those hard to recruit to posts and there would be promotion of working and living in Lincolnshire to increase retention. **DBS Update** The Committee noted that work had been completed around the current DBS process with the paper proposing a new process. The Committee approved the proposals presented noting that this would ensure the Trust was in line with actions required as a result of the Savile Enquiry. The Committee noted that there was confidence in the inbound process supported by the Head of Recruitment and that this was now a historical issue. **Appraisal Update** The Committee received the update position and the proposed approach to reset management of appraisal and individual performance and was pleased to note that work would be undertaken to reset the culture of appraisals. The Trust had decommissioned the existing provider of the software solution to support appraisals as this had not had the desired impact. The Committee noted that an interim process would be in place to launch in mid-July.

	The Committee noted the intention to move to an appraisal season meaning that all staff would undertake appraisals at a specific time of year. It was noted that the move away form the existing system to ESR may show movement in current appraisal rates. **Safer Staffing – June and July reports** The Committee received the June and July reports following the cancellation of the meeting in June noting that Covid-19 continued to impact on safer staffing. The Committee were assured of the continued processes in place to enable the Trust to deliver safer staffing noting that during May and June there was an increasing number of fill rates. The increase seen in the fill rate, when triangulated with quality indicators, had demonstrated a reduction in incidents with the Committee receiving moderate assurance.
	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 report noting the updates offered in respect of the organisational development work within estates and facilities. The Committee noted the need for the group to continue to develop and engage staff to build solutions to make change. The group would develop a delivery plan which would ensure progress was made where required. **Guardians of Safe Working Annual Report** The Guardian of Safe Working joined the Committee to present the report noting that concerns had been raised by Junior Doctors in relation to safe staffing. The Committee noted the concerns raised and agreed that, due to the quality impact, this would be referred to the Quality Governance Committee for consideration. Centralised rota coordination, through a central medical staffing function, would support resolution of the concerns raised and work was underway to ensure that this function was established within the Trust. **Anti-Racism Campaign Junior Doctor Feedback** The Committee received a verbal update noting that the campaign had been received well with no concerns raised to date.

The Committee noted that the anti-racism campaign was being monitored through the Junior Doctor forum and any concerns would be altered to the Committee.

Freedom to Speak Up Guardian Quarterly Report
The Freedom to Speak Up Guardian joined the Committee to present the report noting the increase in the number of contacts in the past quarter.

The Committee noted that the update policy had been considered and were pleased to note that staff were accessing the service and raising concerns. It was recognised that very few of the concerns raised were anonymous and supported the openness and transparency of the Trust.

It was noted that student nurses did not appear to be aware of the FTSU Guardian and as such work would be undertaken to identify how this group of staff could be communicated with to ensure awareness of the Guardian.

Equality, Diversity and Inclusion Final Objectives
The Committee ratified the virtual approval of the objectives which had been undertaken in June as the Committee had not met.

Workforce Race Equality Standard and Workforce Disability Equality Standard Data Submission
The Committee received the report including the data submission which was due to be made in August.

Work would commence on the WRES/WDES action plans which would be reported to the Committee through the EDI Group and were required for publication in the autumn.

The Committee approved the data submission.

EDI Group Upward Report
The Committee received the report noting that following the sign off of the EDI objectives the delivery plan for year 1 now required completion.

Following the successful launch of the anti-racism campaign the group was now keen to support more 'United against' campaigns with the next campaign proposed as United Against Violence and Aggression.

The Committee noted the intention to increase the membership of the group noting concern that this could become ineffective if too large however noted that this would ensure appropriate representation at the group.

Pulse Survey Feedback
The Committee noted the overview provided in the report of the reset of the approach to the Pulse Survey. This was now mandated for all NHS

	Trusts and asks staff to respond to the engagement questions from the National Staff Survey. The Committee noted that the Trust had taken the decision to include additional questions to seek a wider understanding of the position of the Trust. The results would be offered back to the Committee at the appropriate time. **GMC Junior Doctor Survey Update** The Committee was advised that the GMC Junior Doctor Survey had not yet been released with an update to be offered to the Committee once available.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Medical School Update** The Committee noted the update offered in respect of the Medical School noting the recent quality visit that had been undertake. A verbal update indicated that the visit had been uniformly positive with the written report awaited. The Committee was pleased to note the positive progress being made with the Medical School successfully delivering the undergraduate course. The Committee noted that as the programme transferred to the University of Lincoln there would be an opportunity to ensure that the medical education financial systems was correctly in place. **Research and Innovation Governance Group Upward Report** The Committee received the report noting the content however reflected that this did not offer assurance to the Committee. Concern was noted in the Trust's position on NIHR adopted studies following successful performance during Covid-19 related trials. It was noted that this could impact the ability to achieve University or Teaching Hospital status. It was noted that through the development work with the reporting groups support would be offered to ensure correct direction of travel for the group and to support the production **University Teaching Hospital Group Upward Report** The Committee received the report noting the content and identifying the disconnect between this group and the Research and Innovation Governance Group and recognised the need for these to be interlinked.

	Discussion would take place about representation on each of the groups to ensure that these areas of work were moving at the right pace and in the same direction. **Medical Revalidation** The Committee was pleased to note the significant assurance provided in respect of medical revalidation with a 99% compliance rate. The Committee noted that for the 1% who were non-compliant these were approved deferrals.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the performance dashboard noting the consistent performance month on month in respect of the metrics. The Committee reflected that this demonstrated that the Trust was not yet in a position where the actions being put in place were having a significant impact. It was noted that it would take some time for the impact to be achieved however trajectories were in place. The Committee noted the work underway within the Workforce Intelligence Team in order to offer a new scorecard tot the Committee that would offer cohesive and intelligent data on a single page. **Topical, legal and regulatory update** The Committee received the update for information noting the content of the report. **Reporting Groups Terms of Reference** The Committee received the reporting groups terms of reference, excluding those of the University Hospitals Group, noting these would be received at a future meeting. The Committee considered the roles of the groups and the assurances that would be offered to the Committee through upward reporting. Consideration was given to the reporting of the nursing and medical workforces with an agreement that an additional group would be established for the medical workforce. The Committee noted that a group currently met regarding nursing. The Committee identified the interdependency of the Research and Innovation Governance and the University Hospitals Teaching Group noting the need to ensure some consistent representation across the groups.

	Integrated Improvement Plan The Committee received the report noting that a number of items within the report had been considered during the performance dashboard discussions. **CQC Action Plan** The Committee received the report noting that this offered the current position of actions relevant to the Committee. The Committee noted the cross over of a number of actions to other Committees noting that the actions presented were either red rated as these had gone past time or were low risk actions only seen by the Committee. The Committee considered the position of the item on the agenda and agreed that items would be presented on a rotation basis to ensure that this was considered in sufficient detail.
Issues where assurance remains outstanding for escalation to the Board	No items
Items referred to other Committees for Assurance	The Committee wish to refer to the Quality Governance Committee concern raised by the guardians of safe working – pertaining to shortages of Junior Doctors impacting on patient safety
Committee Review of corporate risk register	The committee received the risk register noting the current risks presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	No areas identified
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

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

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	21 July 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 comprehensive estates report noting the work of the Director of Estates and Faculties and the Estates Team in response to the recent unprecedented heatwave. The success of the response had been identified by NHS England who had noted the effort and preparation that had gone into the response seen. The Committee noted the activity being undertaken to review and consider redefining of confined spaces across the Trust noting that this was being supported by an Authorising Engineer and external review would be sought from the British Safety Council. Fire Safety issues following the recent fire at Lincoln continued to be overseen through the Task and Finish group to address issues with storage and the use of corridors. It was also noted that the would be focus from the Fire Safety Group on staff training. **Emergency Planning Group Upward Report** The Committee received the upward report noting the requirement of Emergency Planning and Preparedness which now required a new system of evidence collection. The Committee was pleased to note that the Trust was well placed in order to be able to respond to this change. The Committee noted the requirement to improve CBRN training which once completed would be tested through a live exercise. The Committee noted the update offered in respect of the fire major incident that had occurred in the Trust and received a verbal update on the recent unprecedent heatwave.

	The Committee noted the significant assurance that was offered. **Low Surface Temperature Report** The Committee noted the update offered and the 75% completion rate of the works required. The Committee raised concern regarding the locations not owned by the Trust however received assurance that work would be undertaken by the Trust with remittance to be sought from the landlords. Significant assurance was received by the Committee on the works to date and the continued actions to manage other locations.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contract and CRIG Upward Report** The Committee noted that the revised plan submission had taken place on 20 June with a breakeven position submitted. It was noted that there had been an element of correction in the position which reported year to date a £5.2m deficit. The Committed noted the analysis of the reported deficit position noting the action to move the Trust back in line with plan where possible. The Committee raised concern regarding the current bed position and the associated cost impact on the Trust however recognised that work would be undertaken to review and consider action against the current position. The efficiency report was received with the Committee noting that there was £17m of planned cost improvement programmes (CIP) with a forecast of £13m. Discussions would be held with the divisions in order to formally identify additional schemes. Plans were in place to progress with the Committee clear on the understanding of the current position. The Committee noted the capital allocation of £41m which had reduced to £38.4m in order to address delivery of schemes across the system, including the Pilgrim Emergency Department project. Whilst the capital plan was currently behind plan the Committee was not concerned regarding full in year delivery. The Committee received the CRIG upward report and noted the ongoing contracting discussions that were taking place. **IFR16** The Committee received the report noting that this detailed the impact of IFR16 on the Trust with the Audit Committee receiving the technical assurance. The Committee noted the impact of the negative £70k to the Trust.

	CIP Programme The Committee received the report noting the position of the transformation, transactional and targeted CIP. Work would be undertaken with the division to identify schemes and establish and process and structure in which to move forward. The Committee noted the heat map that had been presented to identify possible areas of impact. The Committee noted the assurance on the process had been received however noted concern that this was not yet linked to actual delivery and to consider the recurrency of identified items. The Committee noted the limited assurance and recognised the work being undertaken in relation to CIP which was well described.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group upward report** The Committee received the report noting the poor performance related to Subject Access Requests and Freedom of Information requests. Due to the time constraints of the Committee, it was agreed that this, along with the Data Security Protection Toolkit Submission and 2022/23 action plan would be received to the August Committee for detailed consideration.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee noted the continued extreme levels of overcrowding in the emergency departments however noted that the greatest risk of this and ambulance handover delays was in the community. This was a national concern with regional escalation, and it was noted that actions were in place to decompress and address the issues. The Committee noted the positive position in planned care for 104 week waits with the Trust joint best in the region. Concern was noted however for the possible increase in non-admitted waiting lists and the progress in the IIP project for outpatients. Diagnostics continued to be challenging with the Committee noting the continued difficulties as a result of the recent fire with the addition of the impact on diagnostic services due to the unprecedent heatwave. Cancer performance in respect of the 62-day backlog demonstrated substantial progress however it was again noted that operating had been impacted due to the loss of a number of cases as a result of the heat.

	The Committee noted the sustained level of breast cancer 2 week waits noting that performance was being maintained with some small signs of improvement which were believed to be sustainable.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 4a Establish new evidence based models of care **Objective 4a Update** The Committee received the report noting that the items to be discussed under this objective would be received through the IIP report to the Committee. The Committee would continue to receive the IIP report and request regular consideration of those items to be received under the objective.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the report noting the contents with discussions about performance items being undertaken through the reports offered to the Committee. Concern was noted in respect of pathway 1 and the length of stay of patients with the Committee noting the ongoing system activity underway to increase capacity within the local authority and community care to support the discharge of patients on pathway 1. The Committee noted the limited assurance that was received however recognised the positive actions in terms of urgent care. Delivery of these was awaited in the coming month. **PRM Upward Report** The Committee received the report noting the continued work to develop the PRMs following the completion of the planning activity. The Committee was pleased to note that there was substance in the discussions held as identified through the report noting the continued theme of accountability in order to progress. **Improvement Steering Group Upward Report** The Committee received the report noting the update offered across the Trust wide programmes of work and the ongoing quality improvement training being offered to staff across the Trust. Concern was noted on the lack of progression for the medical workforce programme however the Committee was reassured that work was

	underway to identify the focus for delivery. It was anticipated that an update would be received by the group at the next meeting. The Committee noted that the report did not offer an update on CIP noting that the group purpose was to manage the deliver of CIP. Accountability of the PMO team and division would be required in order to ensure this progressed and provided a focus on CIP and alerting the Committee to any identified areas. **Deferred items** Due to the Committee wishing to undertake detailed discussions of the items considered during the meeting the decision was taken to defer a number of items to the August Committee.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee 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 3b Efficient use of resources should be down rated to Red.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	2nd August 2022
Item Number	
Integrated Performance Report for June 2022	
Accountable Director	Paul Matthew, Director of Finance & Digital
Presented by	Paul Matthew, Director of Finance & Digital
Author(s)	Sharon Parker, Performance Manager
Report previously considered at	N/A

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

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

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

Executive Summary

Quality

Falls

There has been 2 falls in June resulting in severe harm. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. Trust wide falls improvement project continues with divisions and corporate staff creating falls prevention A3's. PDSA's will be generated into more specific lines of work.

Pressure Ulcers

The number of category 2 PU is 36 and category 4 PU is 2 for the month of June. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. The Quality Matron and Tissue Viability team are working with the Chief Nursing Information Officer to explore the provision for photography for tissue viability and access to community systems, this will allow a more joined up approach to patient care saving time and resources and will help to validate community-acquired damage.

Venous Thromboembolism Risk Assessment

Compliance against this metric has reduced to 94.5% for the month of June. Further monitoring will be required to see if this is a downward trend.

Medications

For the month of June, the number or incidents reported in relation to omitted or delayed medications is at 24% a continued reduction over the last three reporting periods. A Medicines Management project group has now commenced and aims to raise the profile of medicines management and ultimately reduce the number and potential severity of medicines incidents.

SHMI

The Trust SHMI is 106.63, a continued decrease in the last three reporting periods. 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.

eDD

The Trust achieved 90.4% with sending eDDs within 24 hours for June 2022 against a target of 95% with 93.4% being sent anytime within the month. A proposal has been developed and agreed to how eDDs will be managed going forward within the Trust. This has been in collaboration with our system partners. eDD will also be monitored through the Divisional Performance review meetings.

Sepsis compliance – based on May data

Screening / IVAB / inpatient child - Screening compliance for inpatient paediatrics was 81.4%, screening compliance for paediatrics in ED was 88.5%, with the administration of IVAB for inpatient paediatrics 57.1% and 83.3% in ED for May 2022. Screening compliance for adult in ED was 89.6%. Clinical Harm reviews continue as indicated and actions to recover can be seen further within this report.

Duty of Candour (DoC) – May Data

Verbal compliance for May was 96% against a 100% target and 84% for written against a target of 100%. The Clinical Governance team are now notifying clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion. A significant improvement with compliance has been seen and maintained.

Operational Performance

As we move from pandemic to endemic, a number of restrictions have been lifted and the guidance for Infection, Prevention and Control measures have become a 'moveable feast'. At the time of writing this executive summary (14th July 2022), the Trust has 100 positive inpatients. There are 3 patient requiring Intensive Care interventions.

This report covers June's performance, and it should be noted the demands of Wave 5/6 have significantly increased. The Trust moved at pace into the *Recovery* and *Restoration* of services, but increased covid related 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 June's data and performance, the proposed new Urgent Care Constitutional Standards continue to be adopted and run-in shadow form. Performance against these will be described in the supplementary combined operational performance FPEC paper.

4-hour performance deteriorated slightly against May performance of 63.63% being reported at 62.10% in June.

There were 692 12-hr trolley waits, reported via the agreed process. This represents an increase of 1.74% from May. Sub-optimal discharges to meet emergency demand remains the root cause.

Performance against the 15 min triage target in June demonstrated a deterioration of 1.55%. 82.62 in May verses 84.17% in May.

Overall Ambulance conveyances for June were 3778, a decrease of 302 conveyances in May (4080). This represents a 1.54% decrease against May. There were 722 >59minute handover delays recorded in June, a decrease of 26 from May, representing a 3.48% 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. June demonstrated an increase in >120mins handover delays compared with May, 346 in June compared with 334 in May, representing a 3.47% deterioration. >4hrs handover delays increased. A total of 87 in June compared to 76 in May. This represents a 12.65% increase.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 5.25 days against an agreed target of 4.5 days The average bed occupancy for May 2022, was an average of 92.47%. Multi agency discharge meetings continue to take place twice daily. All patients on pathways 1, 2 and 3 are reviewed, with a noted increase of patients being identified as medically optimised patients across the entire week (7days). System Partners are challenged with identifying timely support to facilitate discharge from the acute care setting, Pathway 1 capacity (Domiciliary care) has not been able to meet the demand and is a large contributor to increased LoS. All delays of greater than 24hours are escalated within the System. Elective Length of Stay is now with the agreed parameters.

Referral to Treatment

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

May demonstrated an increase in performance of 2.53%. May outturn was 52.41%. The Trust reported 5,292 incomplete 52-week breaches for May end of month compared to 4,694 in April. The Trust remains in a strong position when compared to other regional providers.

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

As of 14th July, the Trust reported 1 patient waiting longer than 104weeks.

Waiting Lists

Overall waiting list size has increased since April. May reported 67,585 compared April 66,320, an increase of 1,265. 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. June demonstrated an increase (988 verses 984 in May) 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 June reported a 52.43% compliance against the national target of 99%. A negative variation of 46.57% against the national target and a 5.23% decline on the May outturn. Whilst the main area of concern remains Echocardiography, DM01 was significantly impacted by the fire at LCH and is seen by the additional MRI breaches.

Cancelled Ops

This indicator has not been met since July 2021. The compliance target for this indicator is 0.8%. June demonstrated a 2.17% compliance. A negative variance of 1.37% against the agreed target.

The target for not treated within 28 days of cancellation is zero. June experienced 21 breaches against this standard verses 22 in June.

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 45.58% (against 85.4% target.) This demonstrates a deterioration in performance of 2.62% since the last reporting period.

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

104+ day waiters are reducing in line with the trajectory. There are currently 123144 patients waiting >104 days against a target of <10. The current figure is a reduction of 21 patients since the last reporting period.

Workforce

Mandatory Training – Mandatory training rates have remained constant over the past 3 months yet after a slight increase from 89.27% to 90.26% last month the rate has slightly decreased again. Staffing challenges and the lack of protected time while on shifts being cited as the main reasons for staff not completing their core learning. In addition some technical issues have had an impact on courses accessibility and record of learning which may have skewed the outcome to which a solution was currently being worked on.

Sickness Absence – The sickness rate remains stable around 5.2%, even though there is an increase in Covid related absences.

Work is continuing to support the recording and monitoring within the Absence Management System (AMS) which is identifying managers need to ensure that the data recorded in the system is accurate and up-to-date as this will and does affect the system reporting on 'unknown' and 'no reason' absences being recorded. This continues to have a positive impact in reducing the 'blank' reasons.

Work has started on People Management Essentials (PME) training, which cover a section on AMS and management responsibilities. Currently undertaken by Medicine and Estates and Facilities, this will continue across all divisions.

The Employee Assistance Programme (EAP) service provides a complete support network that offers expert advice and compassionate guidance 24/7, covering a wide range of issues. We strongly believe in providing an EAP service that offers not only reactive support when someone needs it but also proactive and preventative support to deliver the best possible outcomes.

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 increase from 57.62%to 59.14%

Staff Turnover – Turnover has remained at over 14.5% for the past 3 months. Operational pressures, staffing and culture challenges meant that an increasing proportion of staff are looking for other avenues outside the Trust. The OD team offers face to face / Teams exit interviews to gather deeper insights on the reasons for leaving (in addition to ESR / EF3 form results).

Vacancies - We have seen an increase in the vacancy position due to having a gap in updated establishment report from Finance (March & June 2022). We are now financed for significantly more staff in Nursing & Midwifery and AHPs; hence, the vacancy factor has increased.

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 £3.8m deficit in June (£5.0m adverse to a £1.2m surplus plan) and YTD the Trust delivered a £5.2m deficit (£5.2m adverse to a break-even plan); CIP savings of £2.7m have been delivered YTD (£1.3m adverse to planned savings of £4.0m).

Capital funding levels for 2022/23, agreed through Trust Board & FPEC, show a plan of c£38.4m; capital expenditure incurred YTD equated to c£2.2m.

The June 2022 cash balance is £67.2m, which is a decrease of £21.1m against the March year-end cash balance of £88.3m.

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

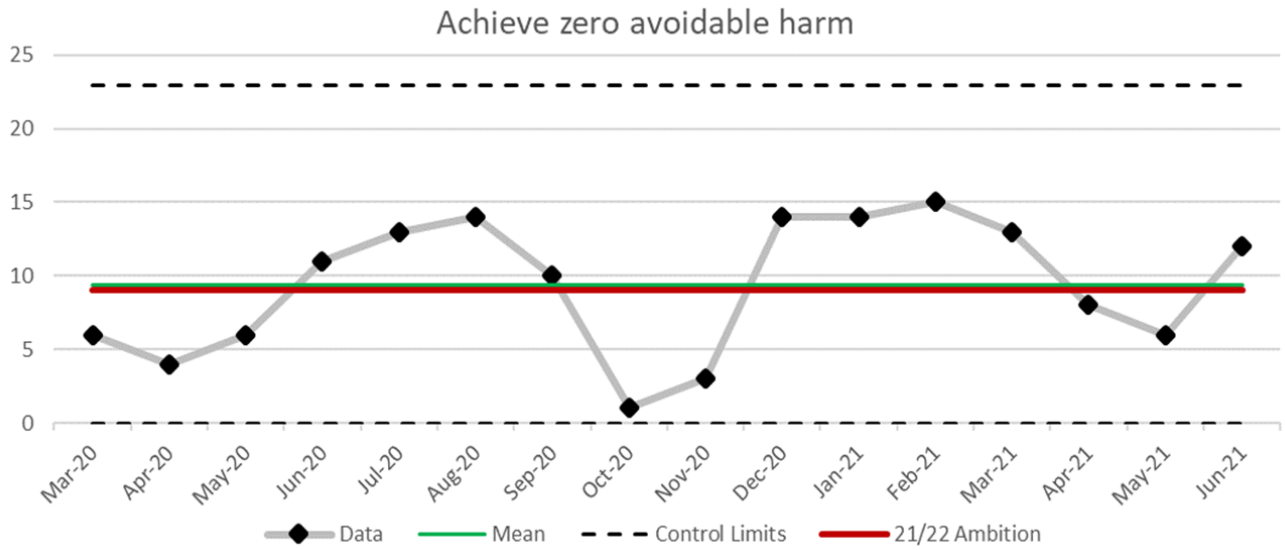
Statistical Process Control Charts

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

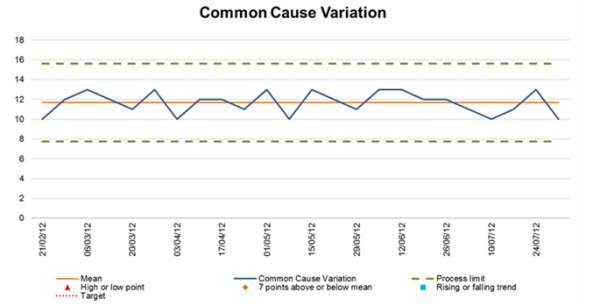
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

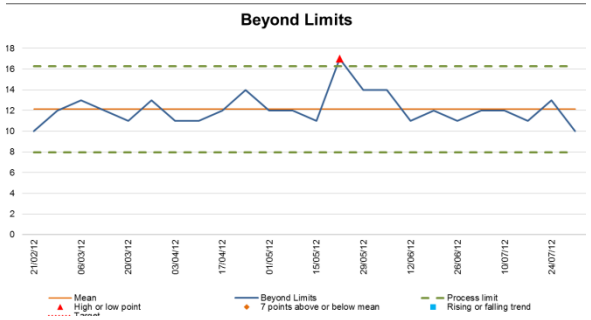
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



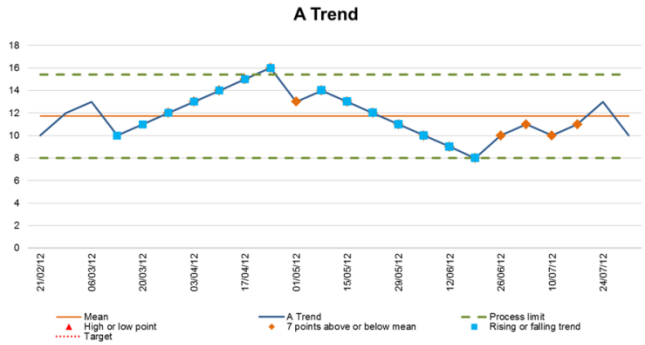
Extreme Values

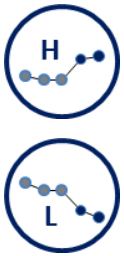
There is no Icon for this scenario.



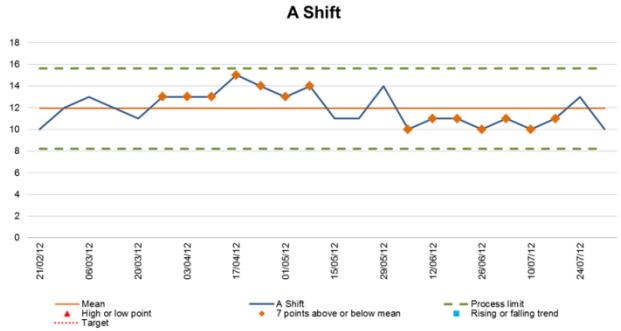
Statistical Process Control Charts

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	2022/23 Ambition	Tolerance	£'000	Apr-22	May-22	Jun-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.	10% reduction	2.00%						
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	105	2 points		4th Quartile (109.48) (107th of 122)	4th Quartile (108.32) (102nd of 122)	4th Quartile (106.63) (91st of 121)		
3	Patients	Reduction in moderate and severe harm and death incidents	Serious incidents (including Never Events) of harm - Moderate, severe and death.	TBD	TBD		13	14	9		
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)	TBD	TBD		5	0	1		
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)	TBD	TBD						
4	Patients	Maternity (compliance with Ockenden recommendations and compliance with CNST)	Compound metric based on compliance	Green	TBD						
7	Patients	Achievement of the IPC BAF	Count of number of red scores, or is average risk score decreasing?	TBD	TBD						
8	Services	Financial Plan	Variance aganst plan	£0	TBD	£'000	-£51.00	-£176.00	-£4,956.00		
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.	1.00%	5.00%		20.28%	19.16%	18.54%		
10	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	503	100		4694	5282			
11	Services	28 days faster diagnosis	Number of patients diagnosed within 28 days or less of referral as a percentage of total Cancer pathways.	75.00%	5.00%		52.63%	58.10%			
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	10.00%	2.00%		10.55%	10.31%			
13	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	90.00%	5.00%		54.06%	57.62%			
13	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	95.00%	2.00%		89.27%	90.26%			
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	TBD	TBD						
15	Partners	Health inequalities and Core20PLUS indicators	Access standards by Ethnicity?	TBD	TBD						
16	Partners	Increased recruitment/academic posts (across the ICS)	Number of posts appointed	10	TBD						
17	Partners	Risk and gain share (provider collaborative)	TBD	TBD	TBD						
18	Partners	Early Warning Discharge Indicators	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 1 (or 1-3) patients.	50% reduction	2.00%						

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Apr-22	May-22	Jun-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	4	6	5	15	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.00	0.13	0.07	0.07		
	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	0.35	0.03	0.13		
	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	0.27	0.13	0.10	0.17	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	1	1	3	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	1	2	3	F	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	2	7	3	12	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	95.35%	95.16%	94.50%	95.00%	F	
	Never Events	Safe	Patients	Director of Nursing	0	1	1	0	2	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.73	5.17	5.14	5.35	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	20.9%	9.9%	10.5%	13.77%	P	

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Apr-22	May-22	Jun-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	None due	None due	None due		P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	94.19	92.60	94.47	93.75	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	109.48	108.32	106.63	108.14	F	
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	100.00%	100.00%	P	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	88.60%	90.20%	90.40%	89.73%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	94.8%	93.5%		94.13%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	84.7%	81.4%		83.05%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	98.2%	97.5%		97.83%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	87.5%	57.1%		72.30%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	87.4%	89.6%		88.51%	F	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	80.0%	88.5%		84.25%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	92.3%	91.8%		92.07%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	28.0%	83.3%		55.67%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	3.43	3.23	3.03	3.23	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%	82.00%	96.00%		89.00%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	82.00%	84.00%		83.00%	F	

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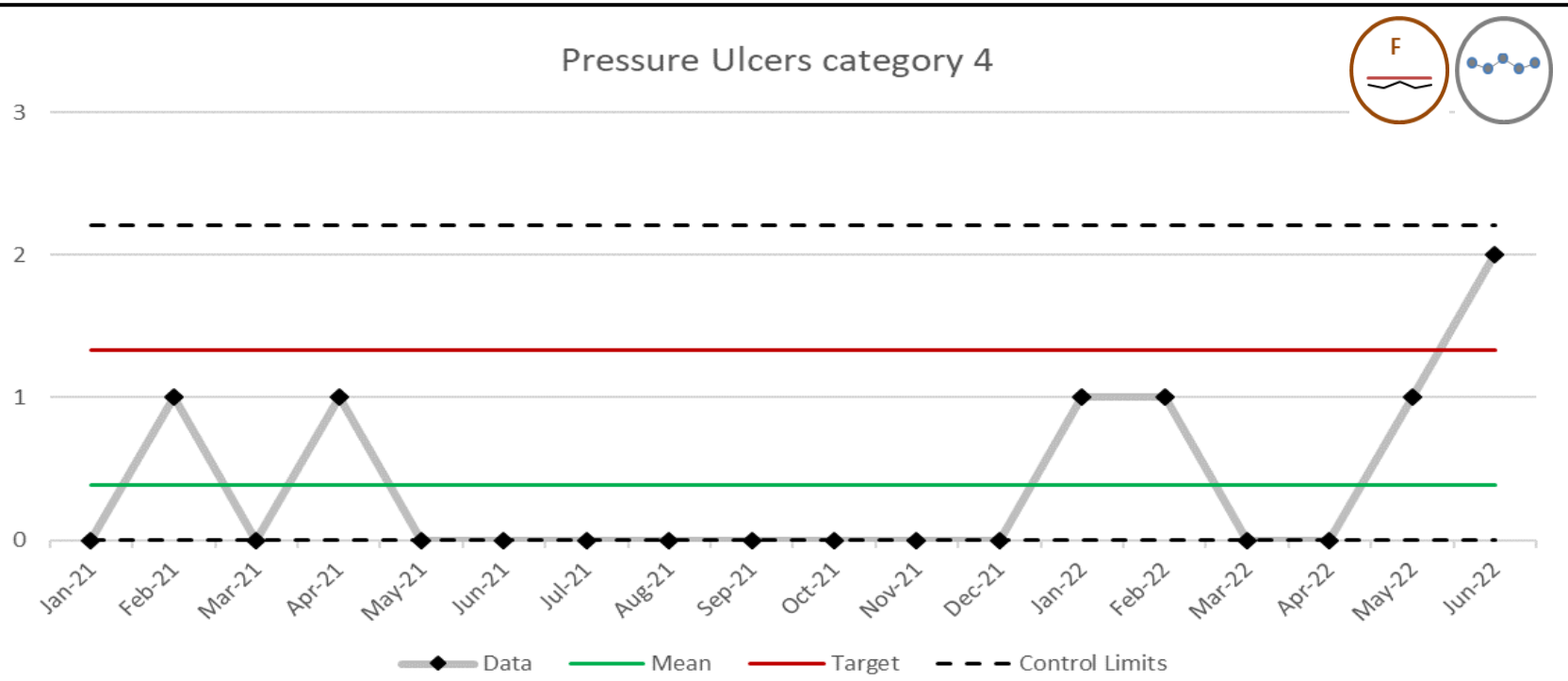

Jun-22
2
Variance Type
Metric is currently experiencing Common Cause Variation
Target
1.3
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Pressure Ulcers Category 4.

What the chart tells us:
We are currently at 2 against a threshold of 1.3 per month

Issues:
There have been two category 4 pressure ulcers reported in June. These will be investigated in accordance with the serious incident framework.
Both incidents were reported at LCH, this is an increase from 1 in May.

Both have evolved from Unstageable pressure damage.

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

The Lead Professional for Safeguarding and Mental Capacity and Tissue Viability team are supporting the investigation process and the clinical teams involved.

Mitigations:
Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.

The patient pressure ulcer incident panel also have sight of any other areas of concern that are not raised through the serious incident process.

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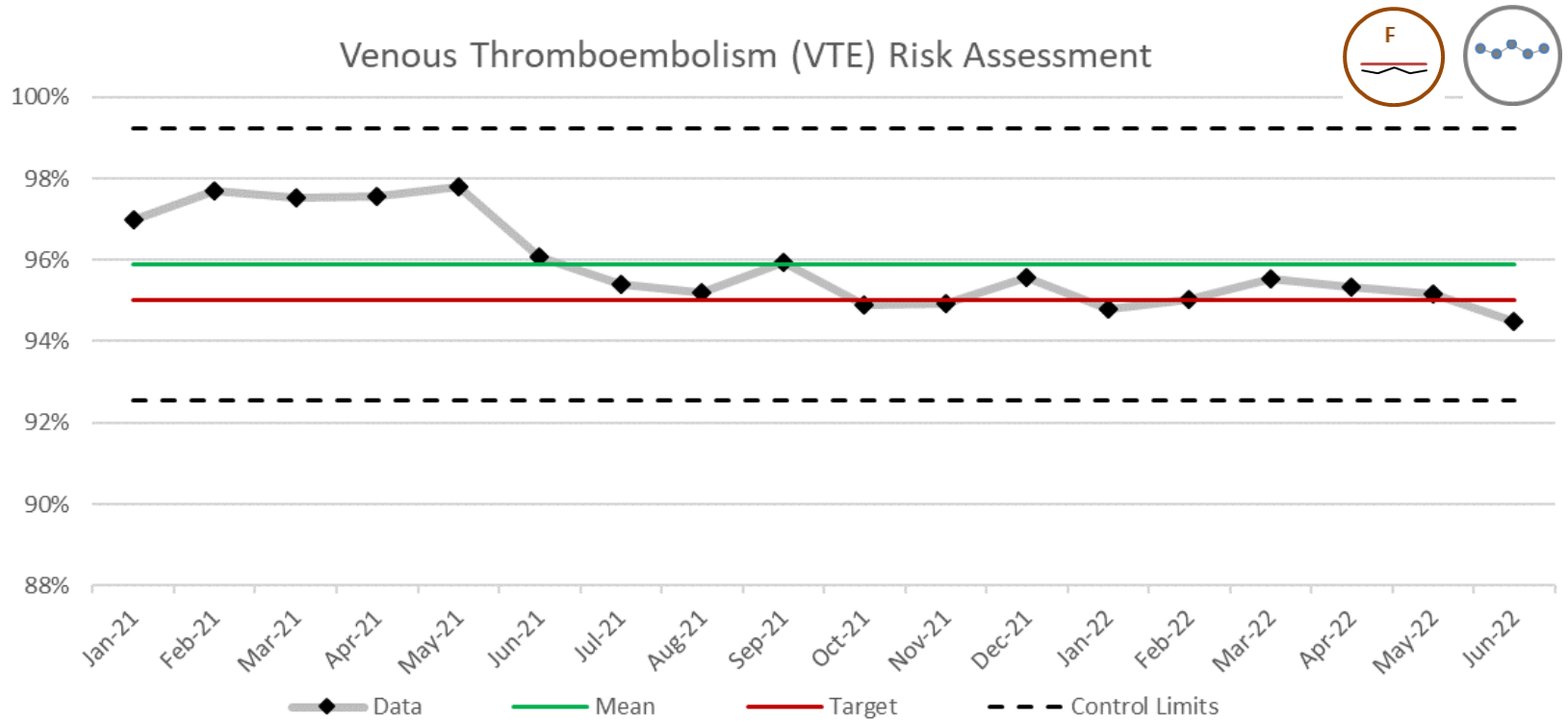

Jun-22
94.50%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

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 94.50%.

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

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

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

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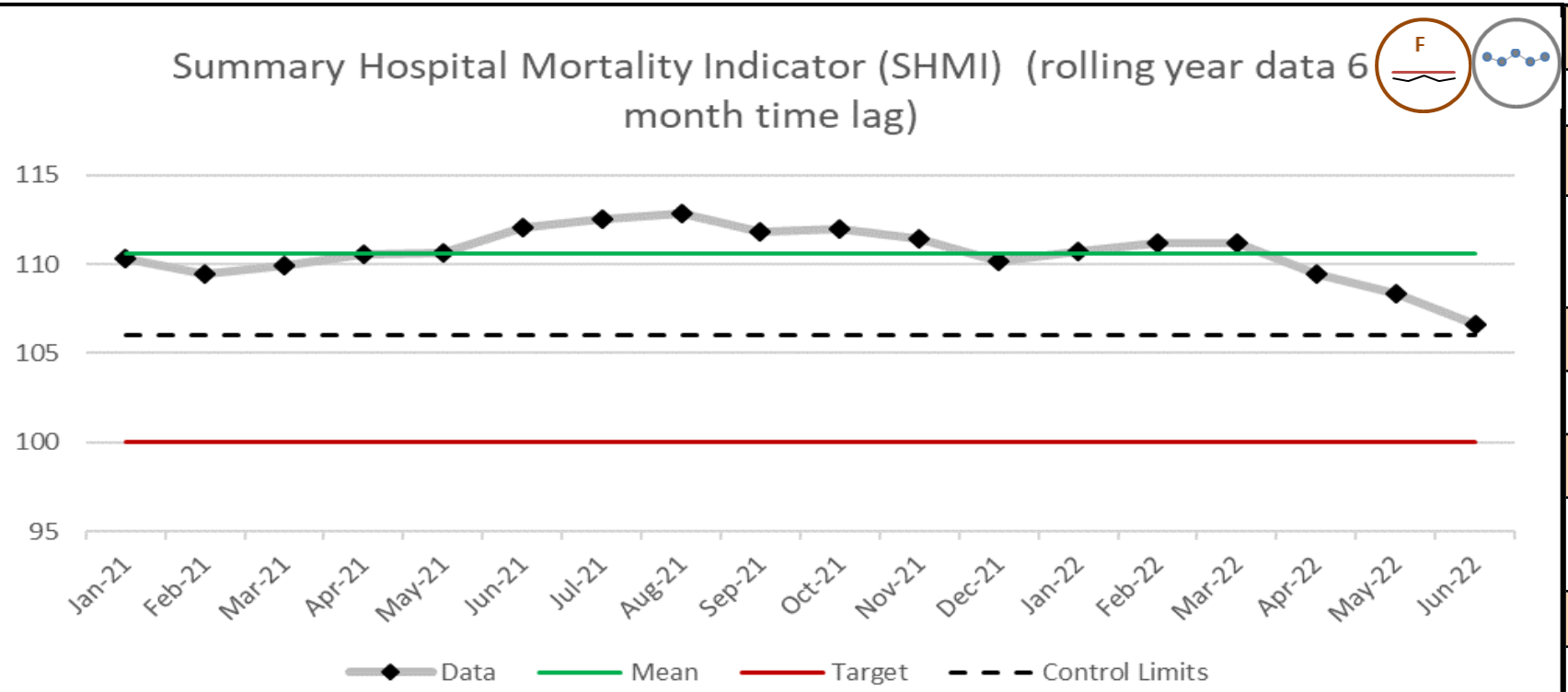

Jun-22
106.63
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
ULHT SHMI is 106.63; a decrease of 1.69 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 Feb 21 – Jan 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 will commence reviewing all deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified.

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

HSMR is 94.47 - within expected.

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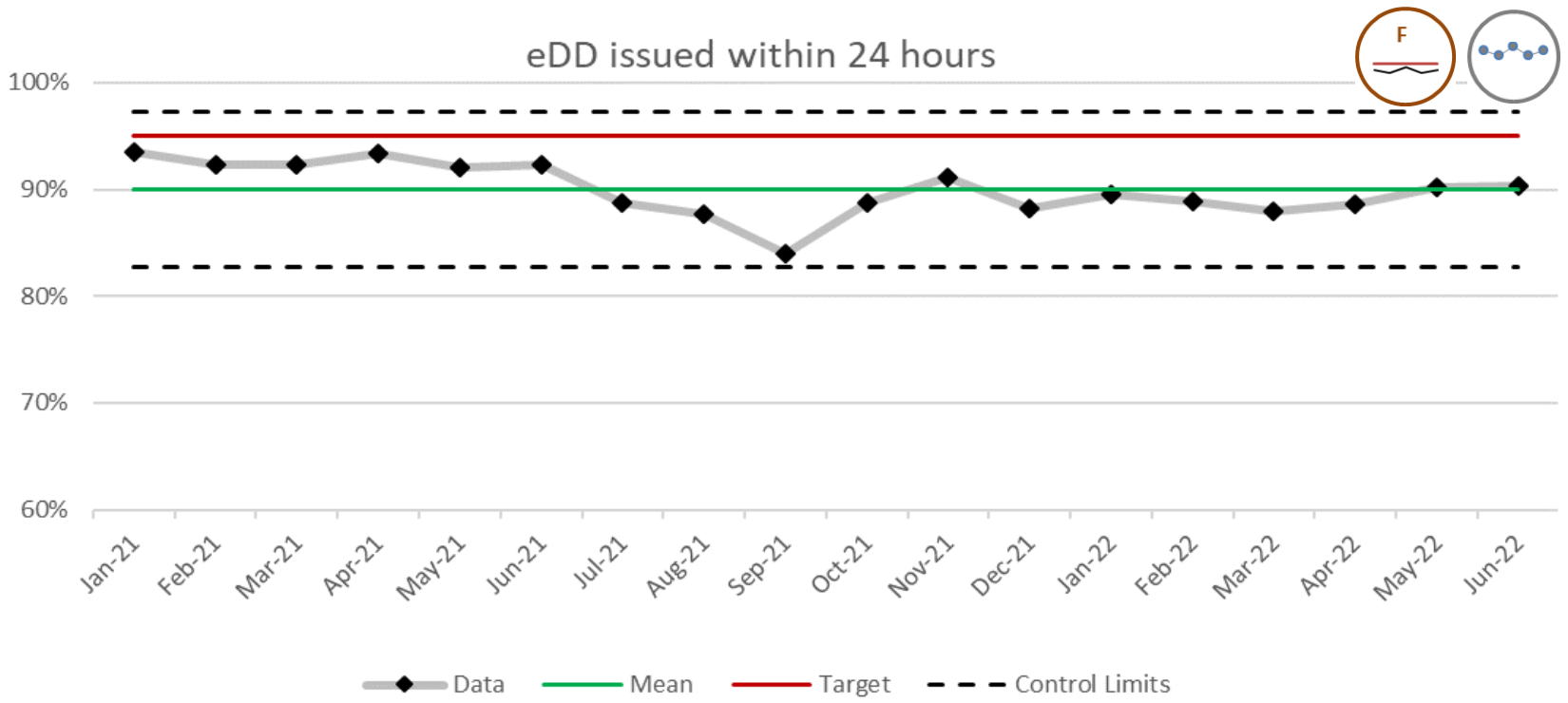

Jun-22
90.40%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
The metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
The Trust is not achieving the 95% target, for June the Trust achieved 90.4% for this standard. The Trust however achieved 93.4% for eDDs sent anytime within the month of June.

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

The highest proportion of eDDs not sent were from Lincoln Discharge Lounge and Family Health. Discharge lounge data was interrogated and these patients should not have been included as they were received from A&E.

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

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

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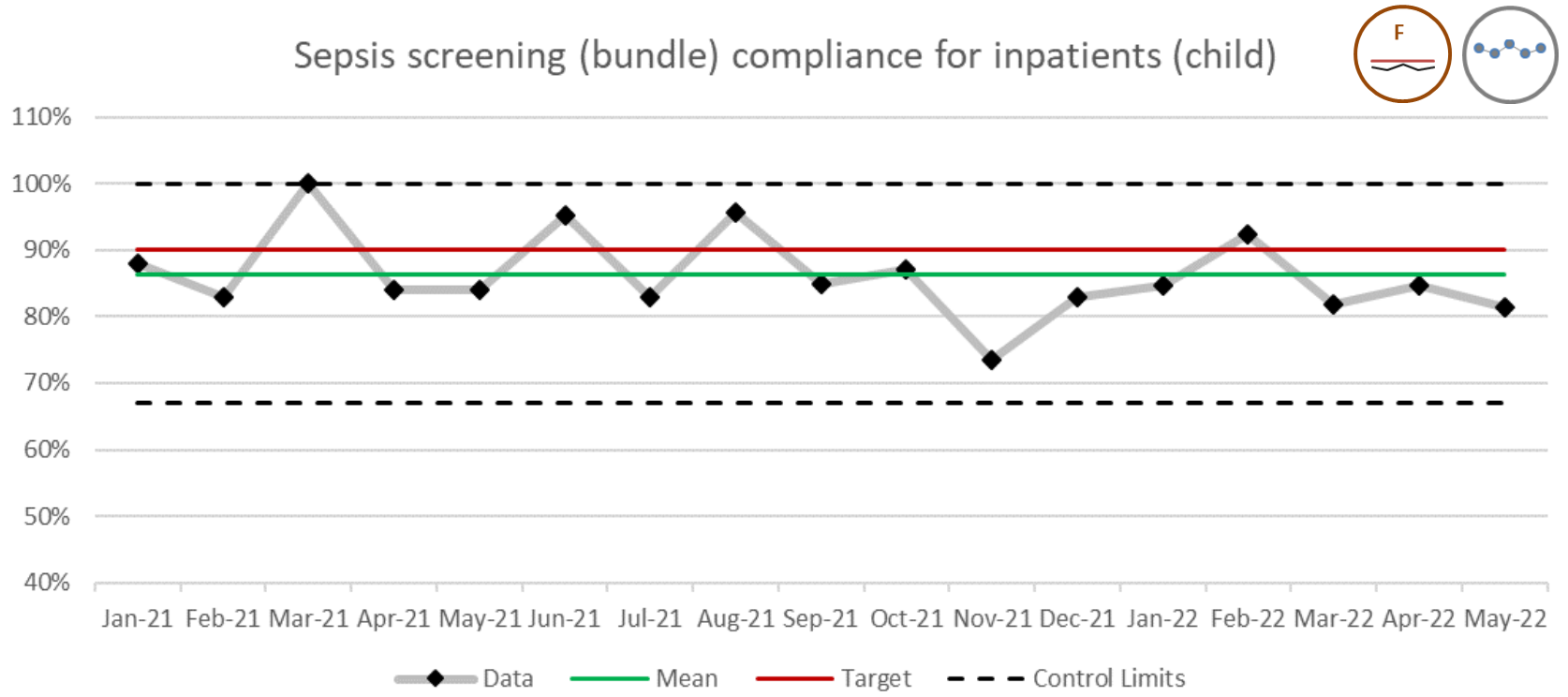

May-22
81.4%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The current compliance is at 81.4% against a target of 90%. This is for 44 out of 54 patients.

Issues:
There were 10 patients found to have not had a screen completed. 8 of these were found to have a viral cause, 1 patient had a delay seeing doctors due to another sick child at same time and 1 had observations entered in error giving wrong PEWS score to a patient – No harm found.

Actions:
Educator at Lincoln is currently doing harm reviews for missed screens the aim is that the link nurse at Pilgrim will take on this role
The Medical team at Lincoln had training on Monday 23rd May. There are plans to roll out this training out to Paediatric Drs across site.
Sepsis training Simulation also took place on 18th May 2022.
Further training offered to Wards and doctors.

Mitigations:
The Educator on wards at Lincoln is doing harm reviews and is able to address issues with staff quickly. There has been no harm found from May reviews.
Ongoing meeting between Ward sisters, Clinical educators and Sepsis practitioner at both sites in order to highlight any issues or training needs.
Sepsis practitioner visiting wards regularly in order to offer support.

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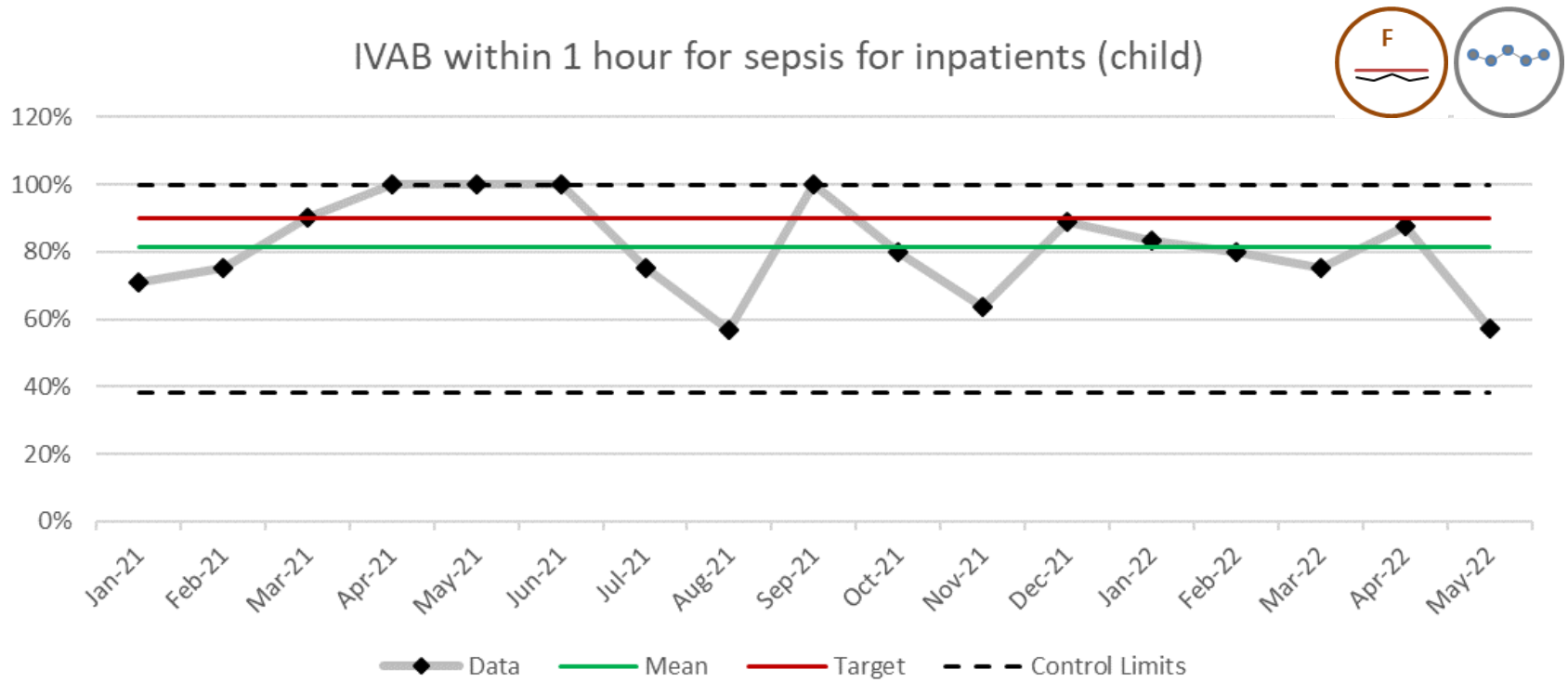

May-22
57.1%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The current compliance is at 57.1% against a target of 90%.
There were 4 out of 7 patients that received antibiotics within the one hour time frame.

Issues:
There were 3 patients who had delayed antibiotics. The harm reviews showed that there was no harm to patients from the delay. One delay was due to difficulties getting IV access for the patient. Antibiotics were given as soon as IV access obtained. A second delay was that doctors were busy with another sick child at the time. The 3rd child doctors wanted to wait for blood results prior to treating.

Actions:
Discussions are being held regarding further staff having cannulation training but this will take some time.
Simulation training has happened on both main sites and generated good discussion.
The Sepsis practitioner carried out training for Paediatric doctors at Lincoln and plans to carry this out across sites.
Training has also been offered to new starters.

Mitigations:
Regular meetings taking place between CYP Practitioner, Ward Sister and Clinical Educators to highlight issues early and formulate action plans.
There are also plans for increased MDT meetings regarding Paediatric Sepsis to encourage engagement. Dates to start from July 2022
CYP Practitioner is also meeting with Ward doctors to discuss any issues around sepsis.

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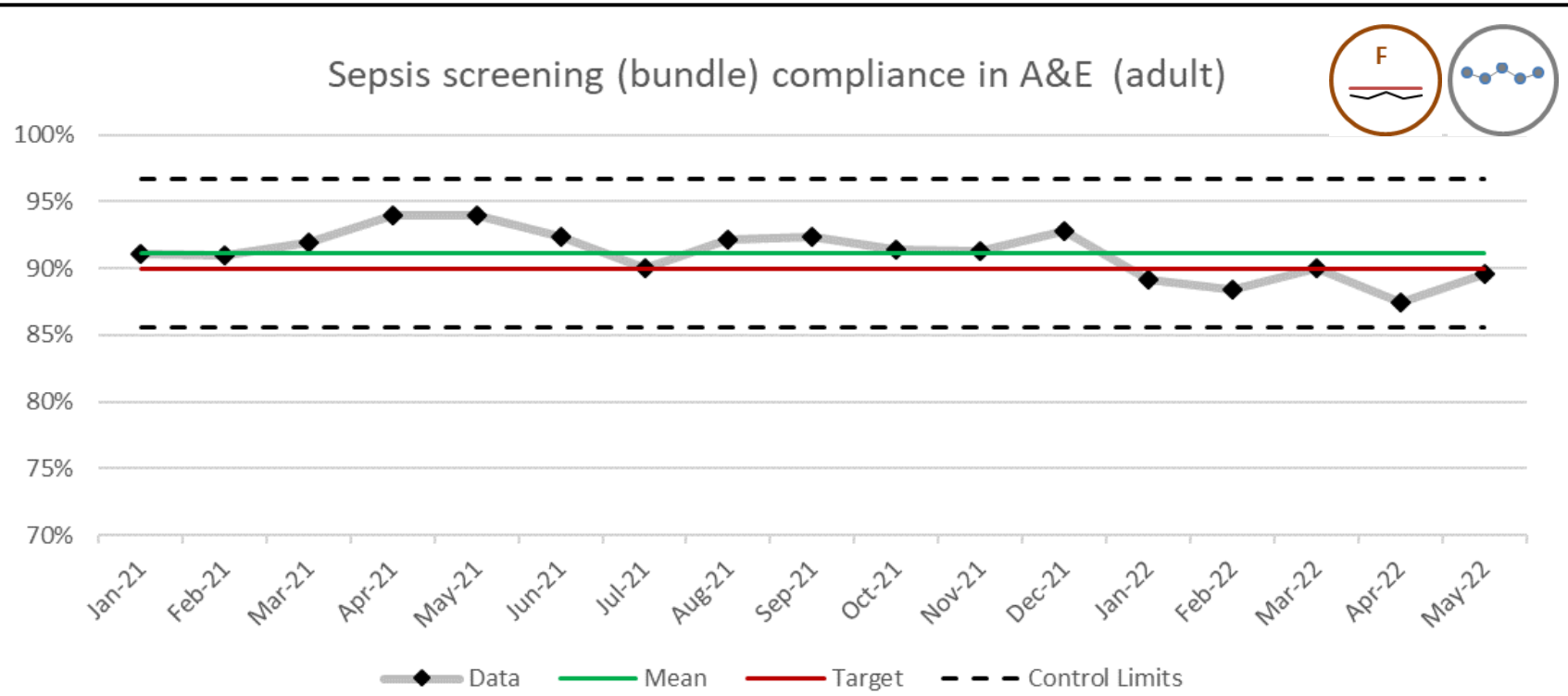
NHS United Lincolnshire Hospitals NHS Trust



May-22
89.6%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance in ED is 89.6% against a target of 90%. This represents 699 of 780 patients screened within the hour.

Issues:
The compliance has improved on last month although it remains below 90%. This is attributable to Lincoln ED where the monthly figures were 84.83%. A Lincoln focused action plan has improved engagement and increased support around teaching has shown an improvement in compliance. Thematic analysis reveals a shortcoming in Agency nurse compliance and issues at the point of handovers of care.

Actions:
Weekly meetings with key ED staff and the sepsis practitioners have commenced and this has already led to increased engagement and adoption of different ways of working.
Additional support of a clinical educator at Lincoln to reflect PHB is required and recruitment is underway appoint to this key role. Nurse in charge oversight has been implemented to support processes and staff.

Mitigations:
All missed screens are subject to a harm review by the respective sepsis practitioners for that site and this will continue with reporting to the focus group each fortnight.
Additional assurance is provided by the establishment of a group of key staff focusing on local improvements for Lincoln ED.
Barriers to improvement are reported to the Deteriorating patient group for escalation and includes the issues around e-learning.

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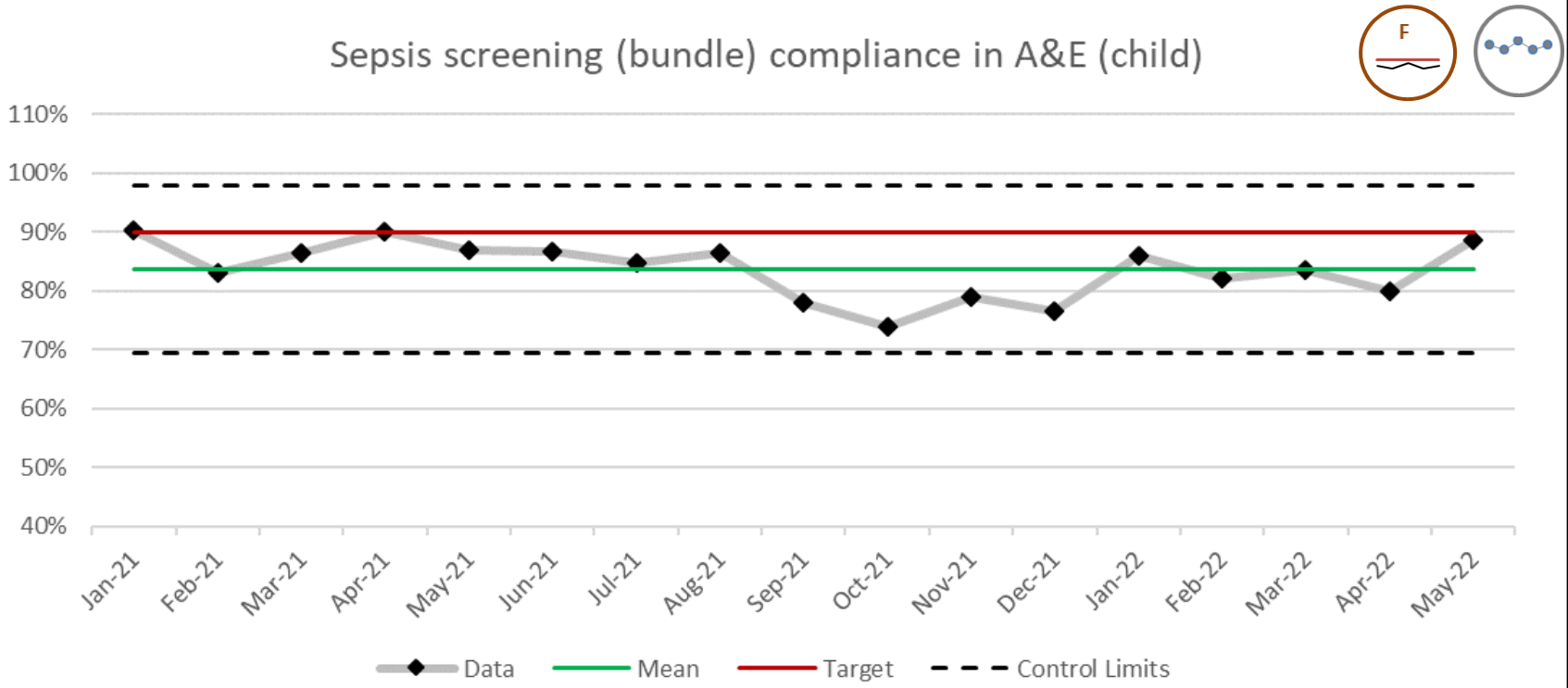
NHS United Lincolnshire Hospitals NHS Trust



May-22
88.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance in ED is 88.5% which is below the 90% target. 217 of 245 patients received screening for sepsis within the hour. This is the highest score for a year.

Issues:
ED has recently seen a large turnover of staff. Staff have reported that they are struggling with the Paediatric workload as a single Paeds Nurse in the ED department.
There is also a marked increase in children attending ED this month as well as those having a higher acuity.

Actions:
Sepsis Practitioners are currently doing increased walk rounds in the department and offering any assistance if needed. Harm reviews are carried out for all delayed / missed screens.
A member of medical team has been identified as a link at Lincoln. A nurse has also been identified as a link nurse
Two nurses in ED have been shown how to pull data so they can observe this throughout month.

Mitigations:
There are ongoing fortnightly Sepsis meetings for ED at present, Issues are discussed at these and action plans are put in place quickly to try and assist the department compliance. Previous action plans are also reviewed at these meetings.
There is also a plan for increased meetings between the link Nurse and doctor in ED and Sepsis Practitioner.

Quality | Operational Performance | Workforce | Finance

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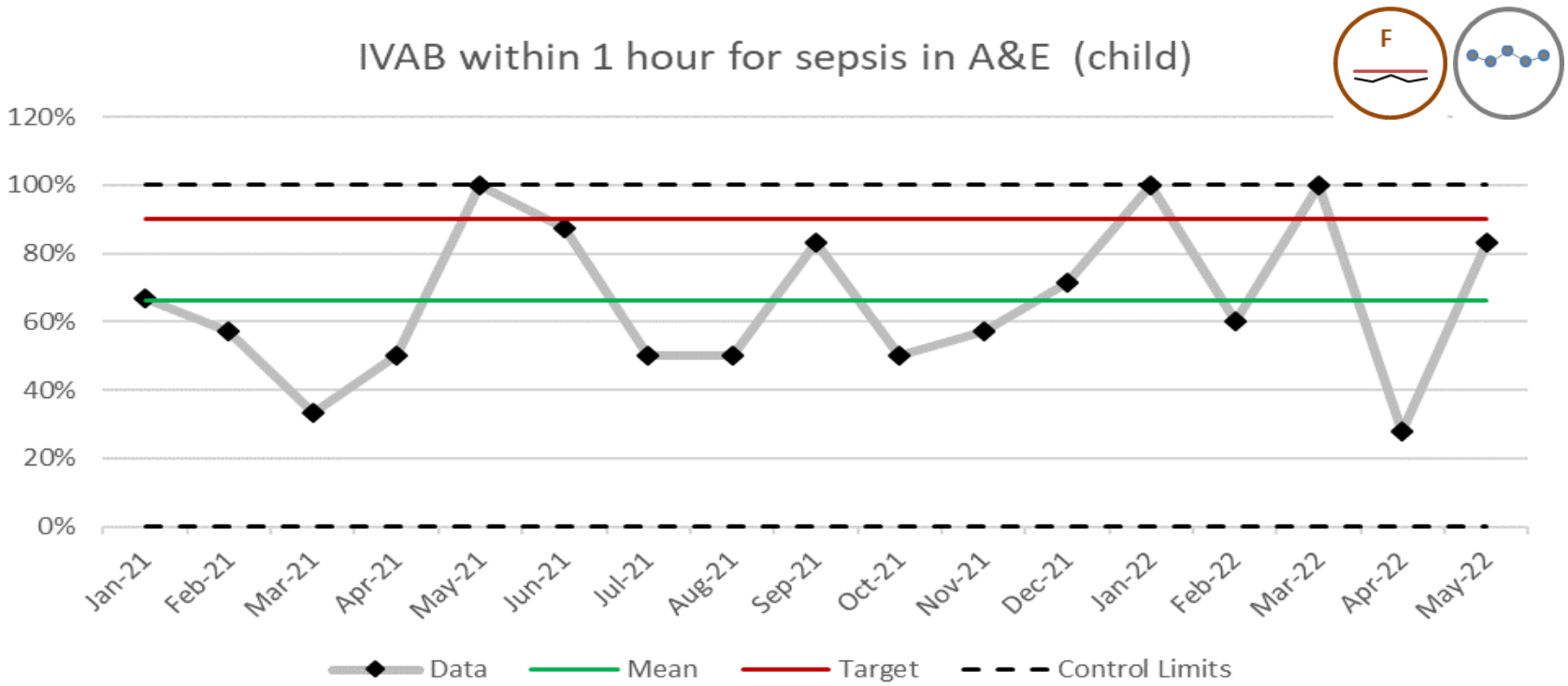

May-22
83.33%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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 83.33%, which is 5 of 6 patients, and is below the 90% target. There is a marked improvement against last month.

Issues:
There was 1 patients in ED this month that was delayed in receiving antibiotics. This was due to the child being transferred to the ward prior to starting treatment. Paediatric Drs had requested this as they were busy on ward and unable to attend ED.

Actions:
A harm review was completed for this patient and no harm was found. Although the percentage is low there is in fact only 1 patient delayed. Numbers of children requiring treatment in ED were low and figures had improved on last months.

Mitigations:
Harm reviews completed for the patient. No Harm found.
There are ongoing meeting 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.

Quality | Operational Performance | Workforce | Finance

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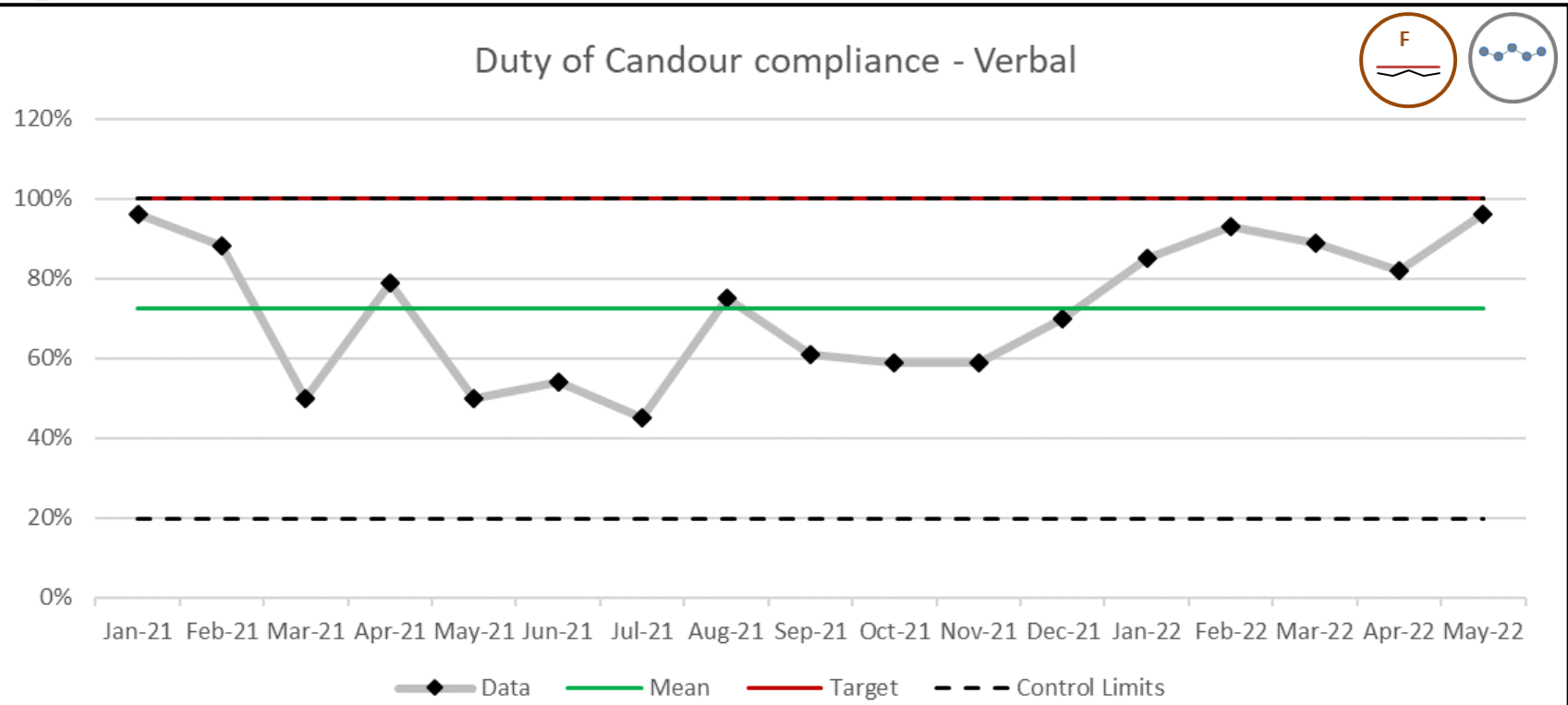
NHS United Lincolnshire Hospitals NHS Trust



May-22
96%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
The last 7 months have seen strong improvements with verbal duty of candour.

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

Actions:
The Clinical Governance team are now liaising directly with clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's.

Mitigations:
Duty of Candour now built into Clinical Governance in house training package

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

Quality | Operational Performance | Workforce | Finance

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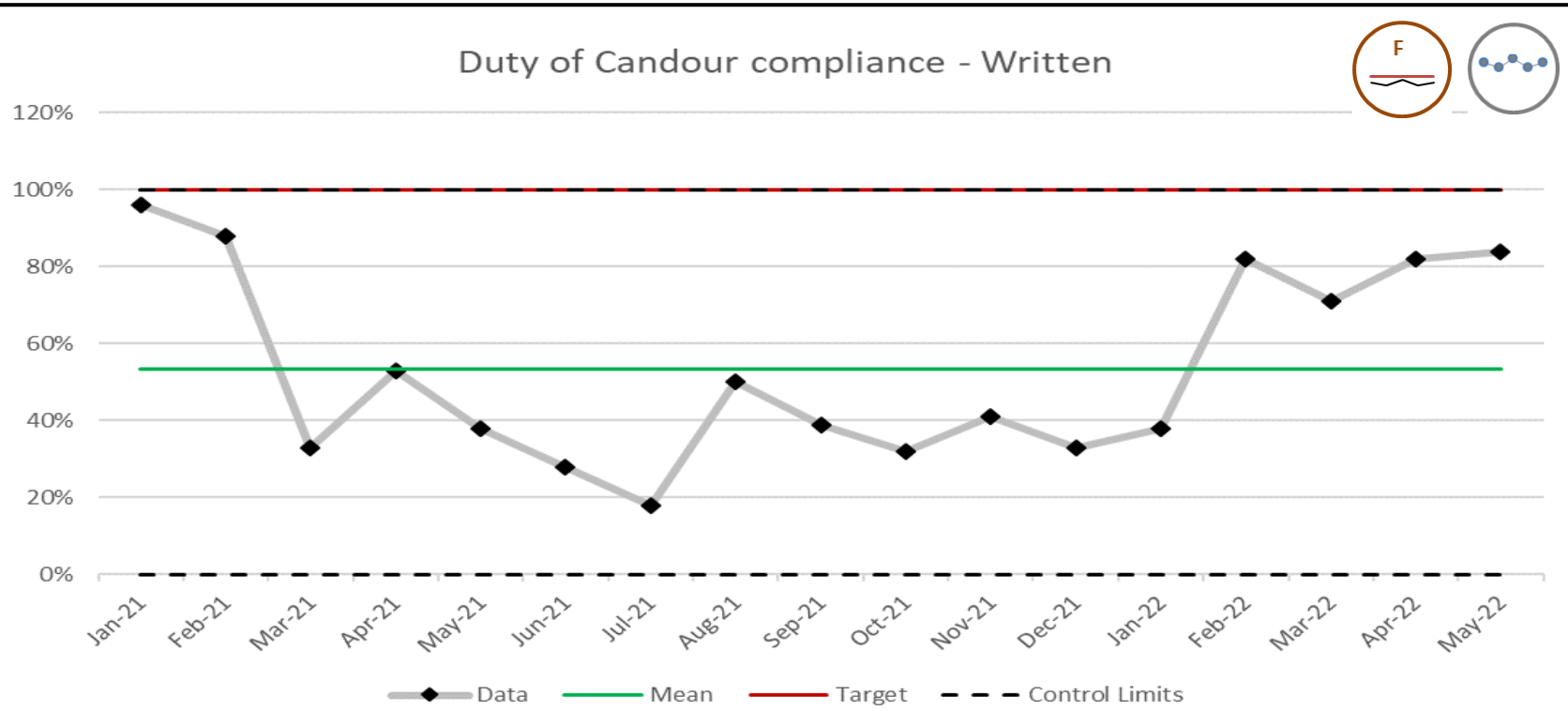


May-22
84%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
Compliance has improved in the last 3 months but is still not reaching 100%

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

Actions:
The Clinical Governance team are now notifying clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's.

Mitigations:
Duty of Candour now built into Clinical Governance in house training package

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

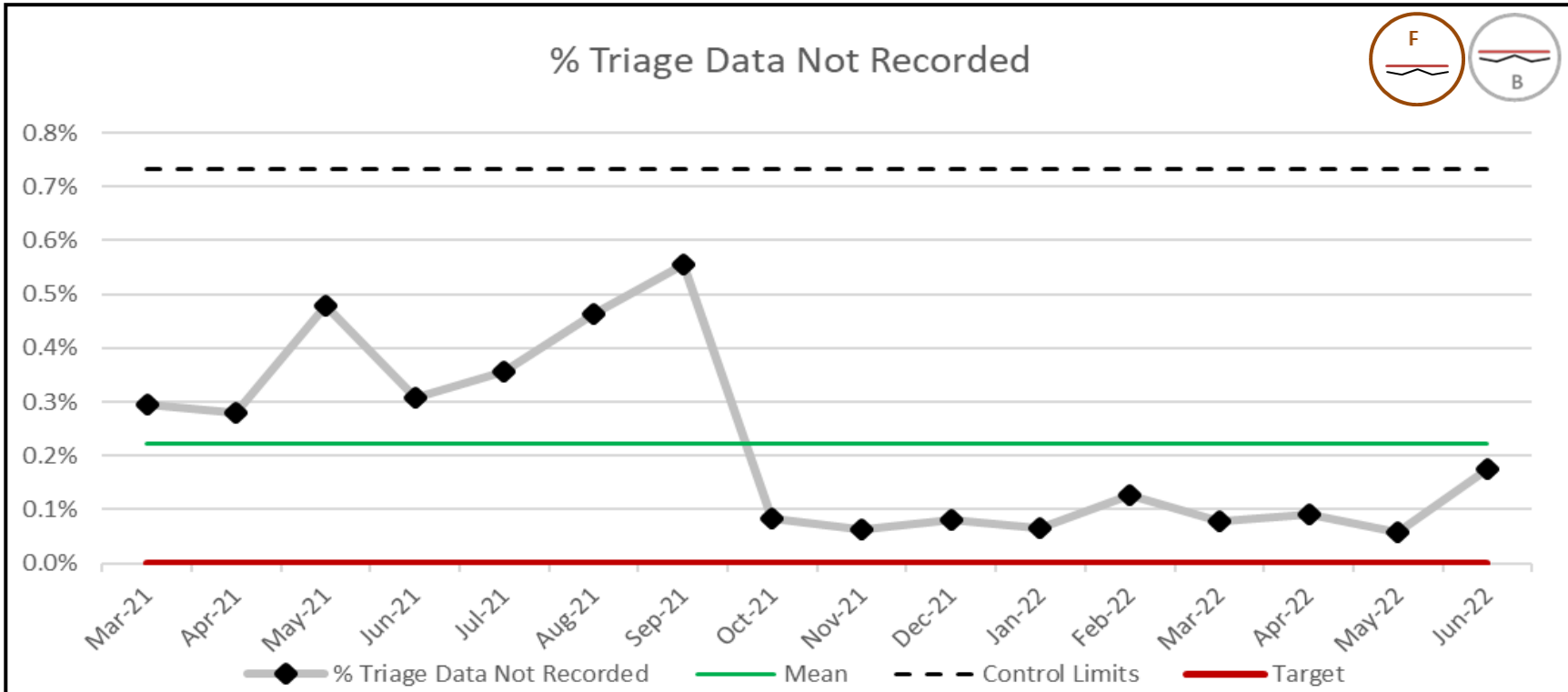
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Apr-22	May-22	Jun-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.09%	0.06%	0.17%	0.11%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	63.08%	63.63%	62.10%	62.93%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	745	680	692	2117	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	83.34%	84.17%	82.62%	83.38%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	4694	5292		9,986	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	49.88%	52.41%		51.14%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	66,320	67,585		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	48.20%	45.58%		46.89%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	66.80%	73.15%		69.98%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	13.60%	22.15%		17.88%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	91.10%	89.36%		90.23%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	97.10%	97.24%		97.17%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	70.97%	64.29%		67.63%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	94.30%	97.22%		95.76%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	81.25%	55.56%		68.41%	90.00%			

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Apr-22	May-22	Jun-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%	66.10%	70.11%		68.11%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	56.03%	57.66%	52.43%	55.37%	99.00%	F	B	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	2.09%	1.58%	2.17%	1.95%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	33	20	21	74	0	F	A	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	71.95%	76.71%	78.95%	75.87%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	45.12%	53.42%	68.42%	55.66%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,799	4,080	3,778	3,886	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	819	748	722	763	0	F	A	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	132	144	123	399	30	F	A	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.70	3.82	2.79	3.10	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	5.02	5.05	5.25	5.11	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	23,562	22,856	23,087	23,168	4,524	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	43.92%	43.28%	40.07%	42.47%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	36.17%	37.66%	39.98%	37.82%	45.00%	F		



Jun-22
0.17%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
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%.
June reported 0.17% data not recorded verses 0.06%.
June demonstrated a 0.09% negative variation compared with May.
This metric is below target.

Issues:

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

Actions:

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

Mitigations:

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

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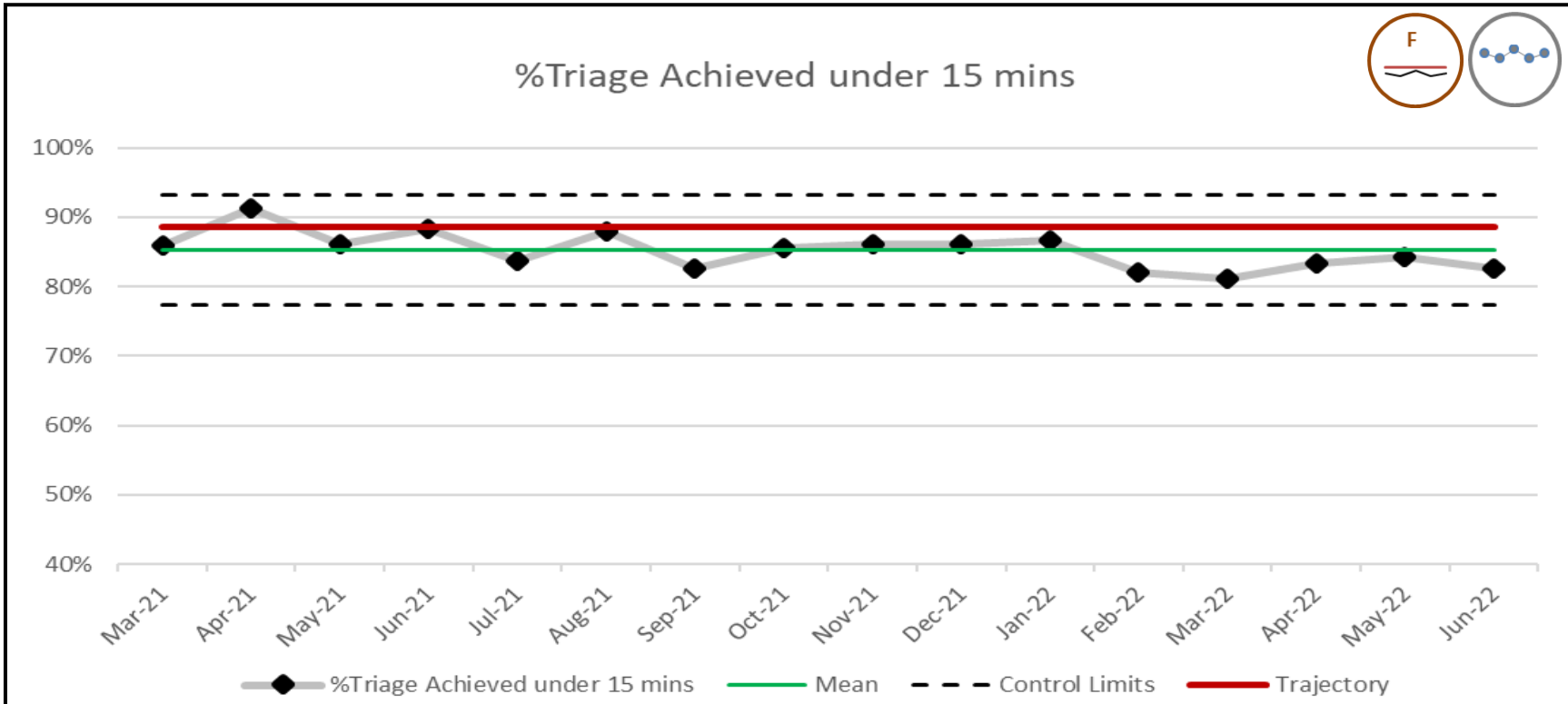

Jun-22
82.62%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of triage achieved under 15 minutes.

What the chart tells us:

The compliance against this target is 88.50%.
June outturn was 82.62% compared to 84.17% in May.
This demonstrated a deterioration in performance of 1.55% compared with May and a 5.88% 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 but is improving.
- There is a recording issue for UTC transfers of care to ED that skews that data.
- Dual department roles. For example, the second triage nurse is also the allocated paediatric trained nurse, whilst reduced is still on occasion, problematic.
- Inability to maintain agreed staffing template, particularly registrants, due high to sickness and agency cancellations at short notice.
- The ability to effectively maintain two triage streams continues to be mainly out of hours but improvement is noted.

Actions:

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

Mitigations:

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

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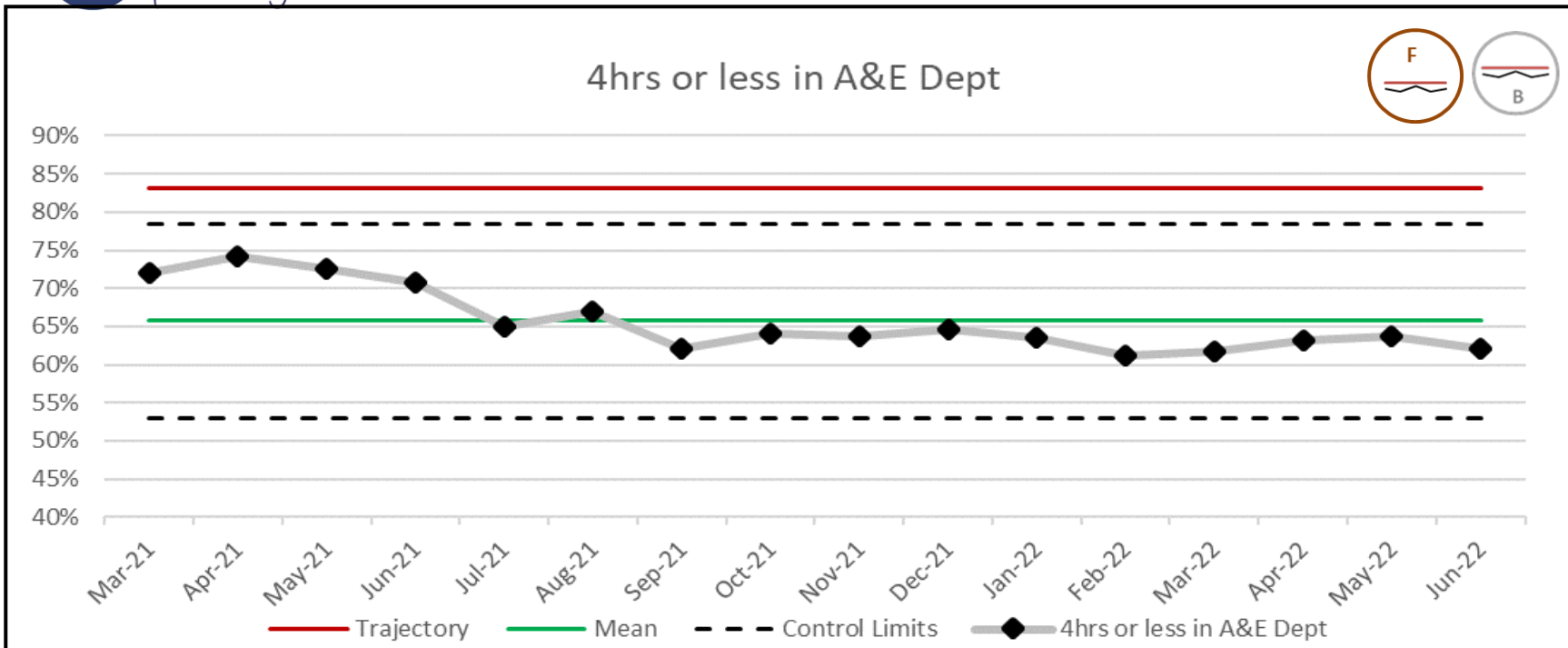

Jun-22
62.10%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

The current 4-hour transit target performance for June was 62.10% compared to 63.63% in May which is a deterioration of 1.53% and is 21.02% below the agreed target.

Issues:

The Emergency Departments saw a 3.13% decrease in attendances in June (569 patients) compared to May.
17,654 combined attendances (ED and UTC) in June compared to 18,223 combined attendances in May.
Of the 17,654 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 11,488 and type 3 accounted for 6,166. This is a decrease on type 1 and type 3 attendances is across all 3 acute sites.
Inadequate daily discharges to meet the admission demand remains an issue leading to extended ED LOS.
Ongoing medical and nursing gaps that were not Emergency Department specific.
Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps.

Actions:

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

Mitigations:

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

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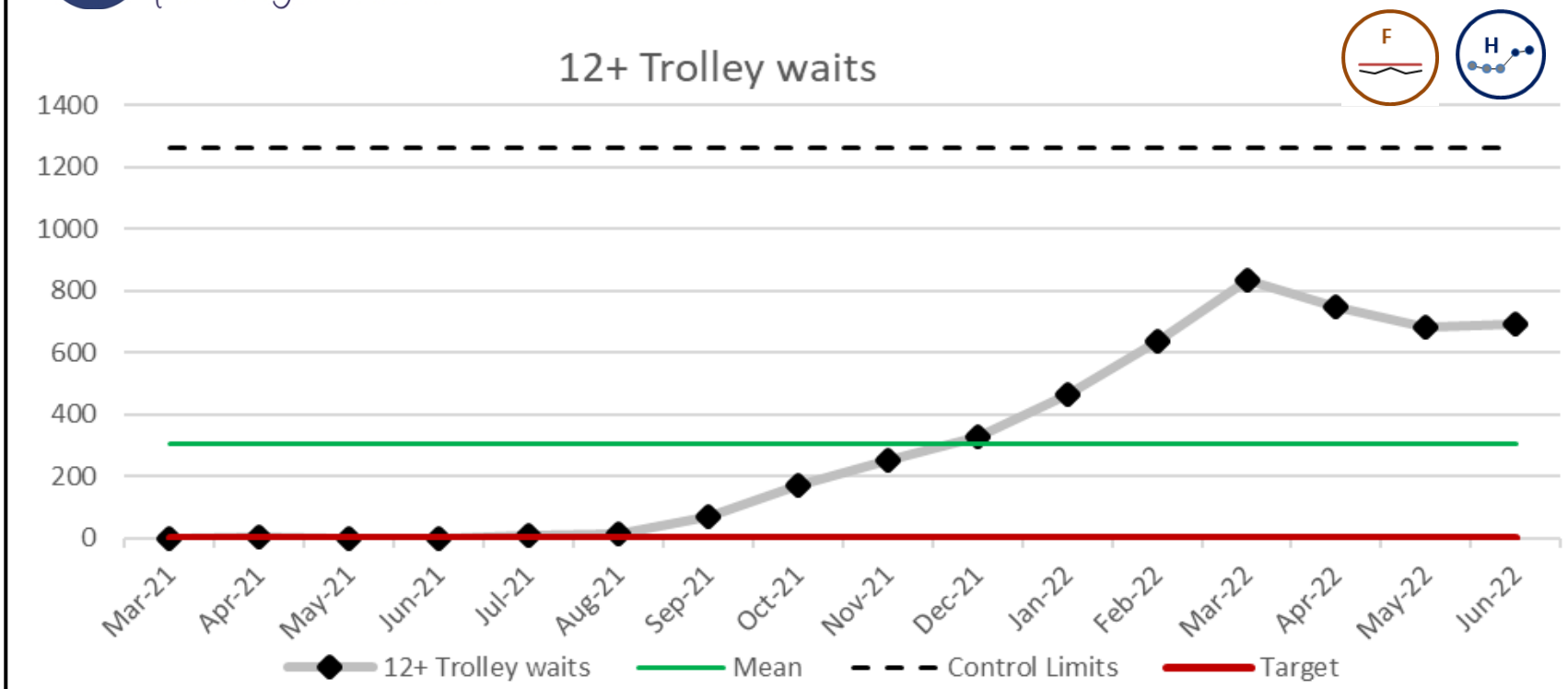

Jun-22
692
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

June experienced 692 12-hr trolley wait breaches. This is the unvalidated position. This is an increase of 12 12-hr trolley wait breaches compared to May. This represents an increase of 1.74%. This equates to 6.02% of all type 1 attendances for June.

Issues:

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

Actions:

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

Mitigations:

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

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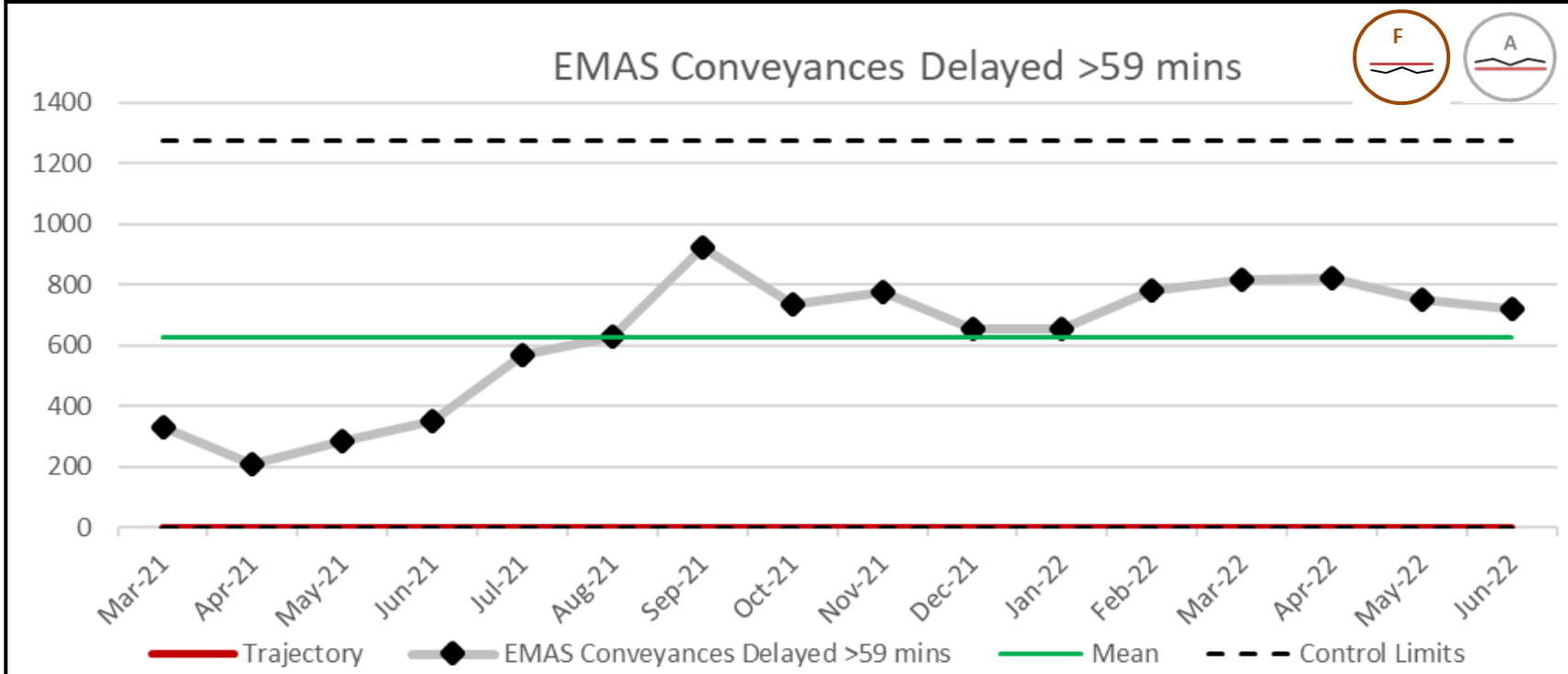

Jun-22
722
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

June demonstrated a slight decrease in greater than 59 minutes' handover delays 722 in June compared to 748 in May. This represents a 3.48% decrease.
What the chart does not tell us is the increase of >2hrs in June 2022 (346 in June vs 334 in May) and an increase in >4hr delays (87 in June compared to 76 in May).
Overall conveyances reduced in June (3778 vs 4080 in May). This is a 1.54% decrease.

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 are being identified/confirmed to assist in reducing delays in handover.
June saw an increase in formal requests from EMAS to enact the rapid handover protocol.

Mitigations:

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

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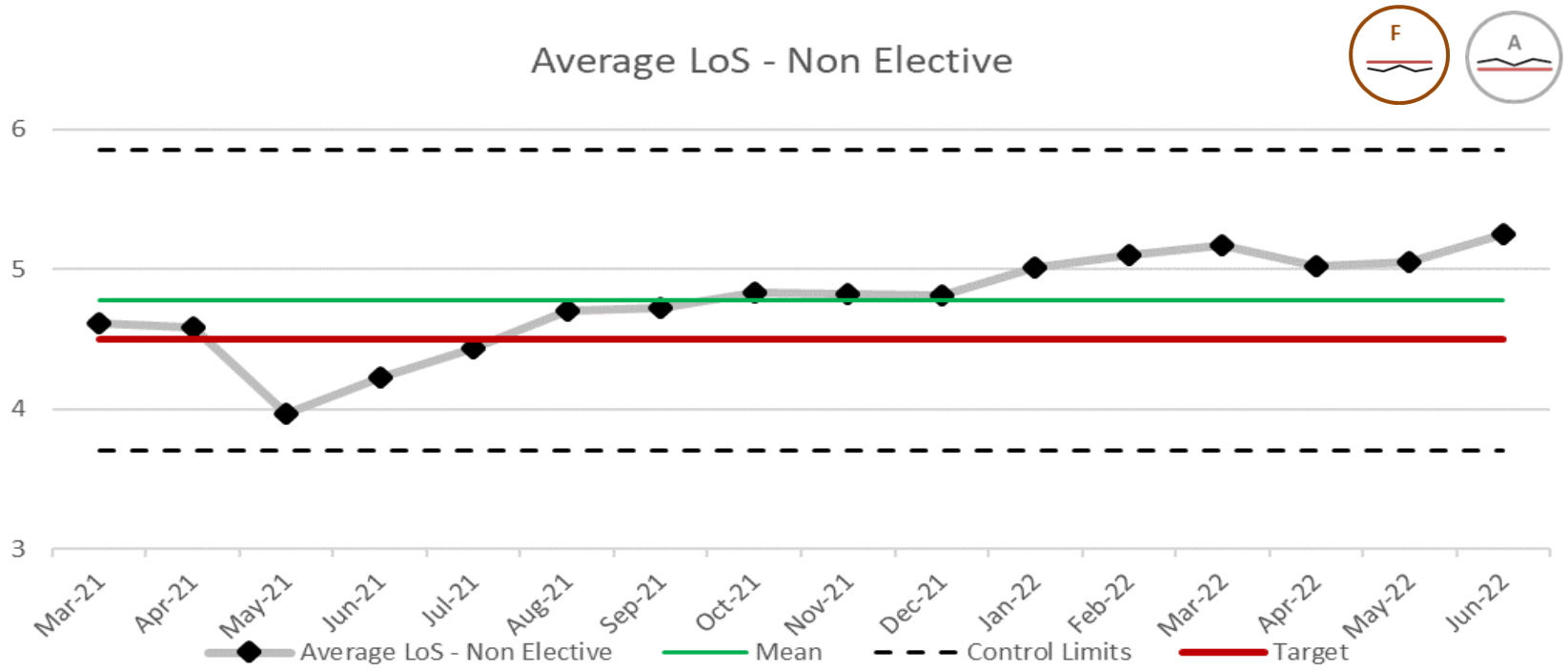

Jun-22
5.25
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 5.25 days in June vs 5.05 in May. This is an increase of 0.20 days
compared with May
This is a 0.75 variance against the agreed target.

Issues:

Numbers of stranded and super stranded pts continues to increase.
Increasing length of stay of all pathways 1-3. The most significant increase in volume of bed days is Pathway 1 Domiciliary care but since the advent of the joint D2A process, benefits are being realised but there remains insufficient capacity to meet the increasing demand.
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers and reduced medical staffing leading to delays in senior reviews.
Increased number of positive covid cases requiring a longer length of stay and increased 'contact' patients leading to delayed discharges.

Actions:

These actions are repetitive but still appropriate
Focused discharge profile through right to reside data.
Cancellation of elective activity and SPA time to allow for daily consultant review of all patients.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Use of rapid PCRs to ensure no delay once social care plans are secured.
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.

Mitigations:

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

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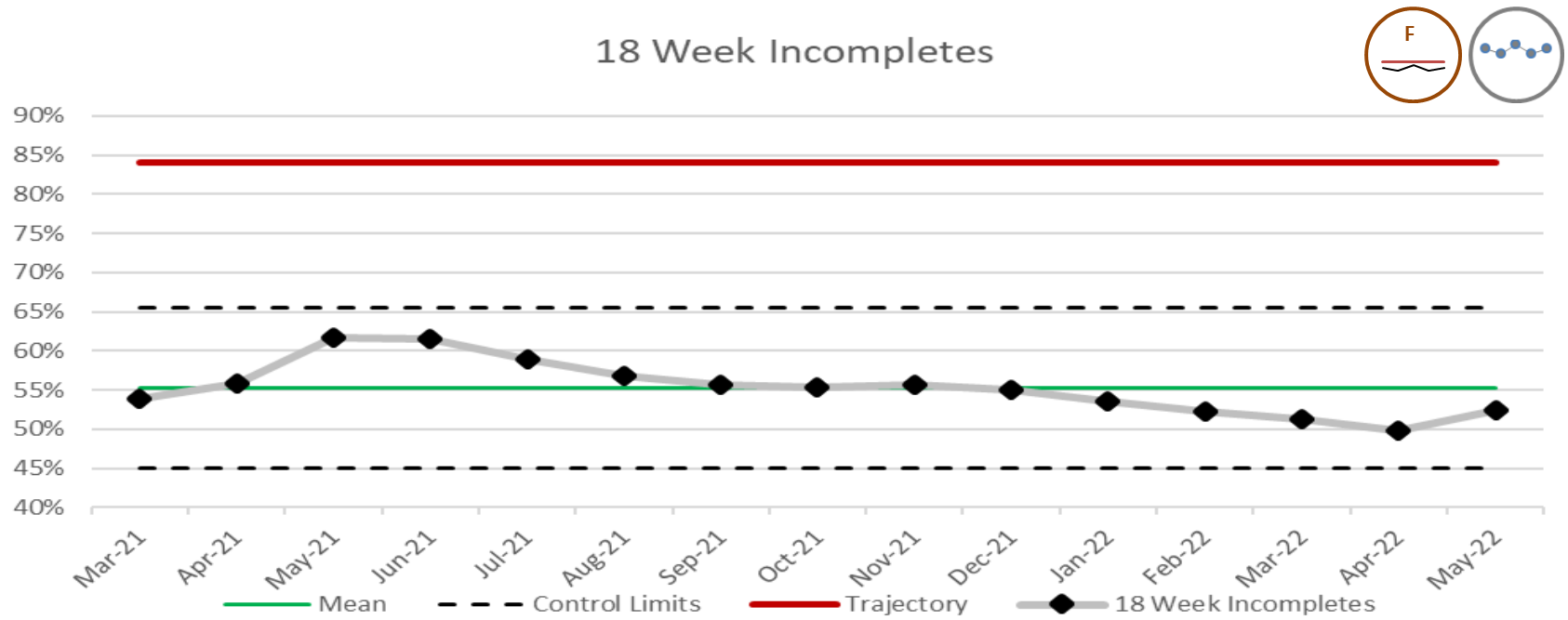

May-22
52.41%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There is significant backlog of patients on incomplete pathways. May saw RTT performance of 52.41% against a 92% target, which is 2.53% up on April.

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 – 5495 (decreased by 57)
- Gastroenterology – 3322 (decreased by 102)
- Dermatology – 2896 (decreased by 181)
- Gynaecology – 2641 (decreased by 191)
- General Surgery - 2218 (decreased by 43).

Actions:
Planned routine elective work remains challenging. Available capacity is being focussed on cancer, long waiting patients, paediatrics, day cases and patients classified as being P2. Following last month's IPC update relating to vaccination status and isolation for admitted patients, there has now been an update regarding Outpatients. IPC are now supportive of Outpatient areas dropping the 2m rule and all areas will go back to full capacity. This will increase Outpatient capacity by 30-40% in some areas.

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

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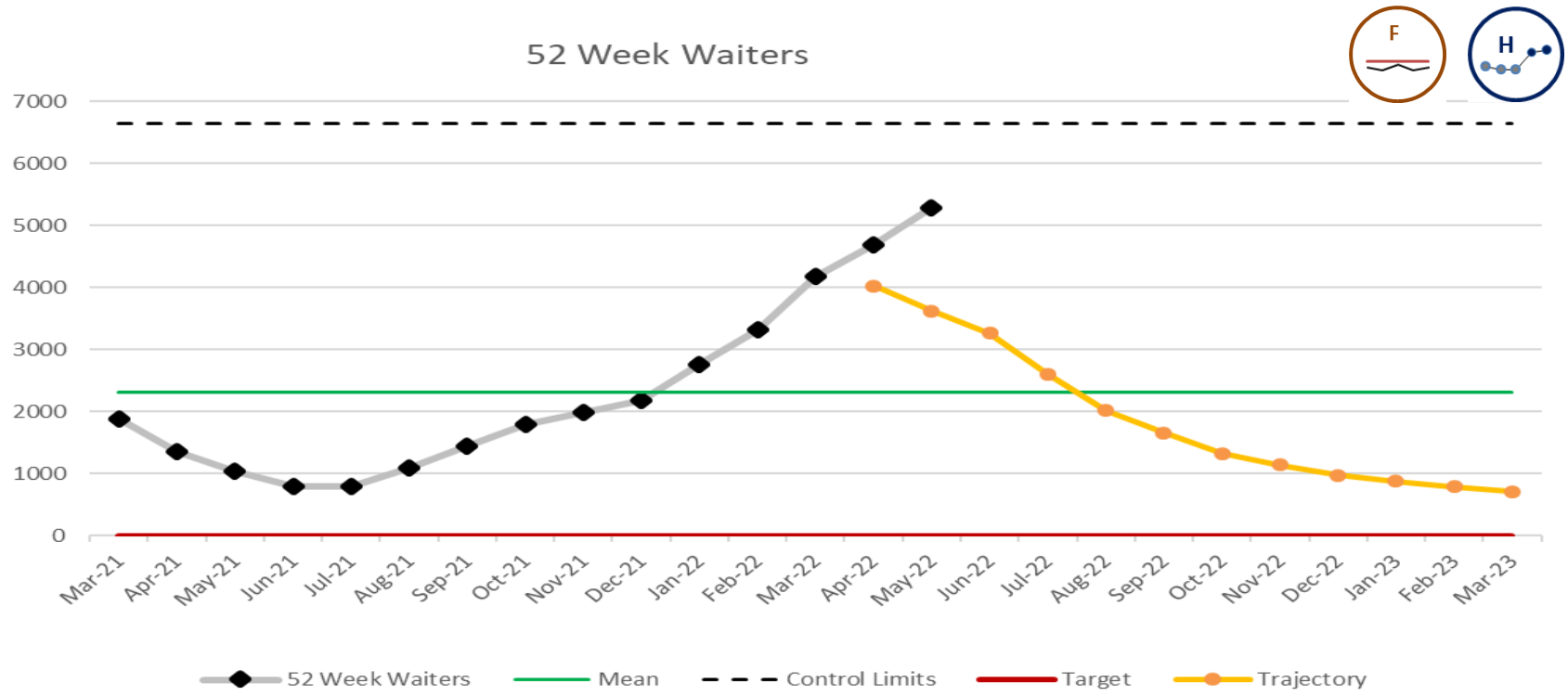

May-22
5292
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 5292 incomplete 52-week breaches for May. An increase of 598 from April.
The number of 52-week breaches has increased considerably since August.

Issues:
Both the admitted and non-admitted position remains very challenging. Current capacity challenges and staffing issues are all impacting on service delivery, which is, in turn, detrimentally affecting the 52-week position. Our regional position remains strong. ULHT continue to support regional colleagues with their 104 week waiters and this is being prioritised over our 52 week positions.

Actions:
Admitted patients are individually graded and allocated a priority code. The introduction of C2AI appears to be having a positive effect on the efficiency and effectiveness of this process. All patients waiting more than 52 weeks are required to have a harm review completed. The harm review process is discussed at the Clinical Harms Oversight Group with a new piece of software being developed in-house to better enable monitoring and recording.

Mitigations:
Non admitted patients continue to be reviewed, utilising all available media.
Patients waiting 78 weeks and above are individually monitored and tracked for their urgency, wait time and priority code where applicable. Recent IPC changes to admitted and Non admitted pathways will support increased activity and a reduction in long waiters.

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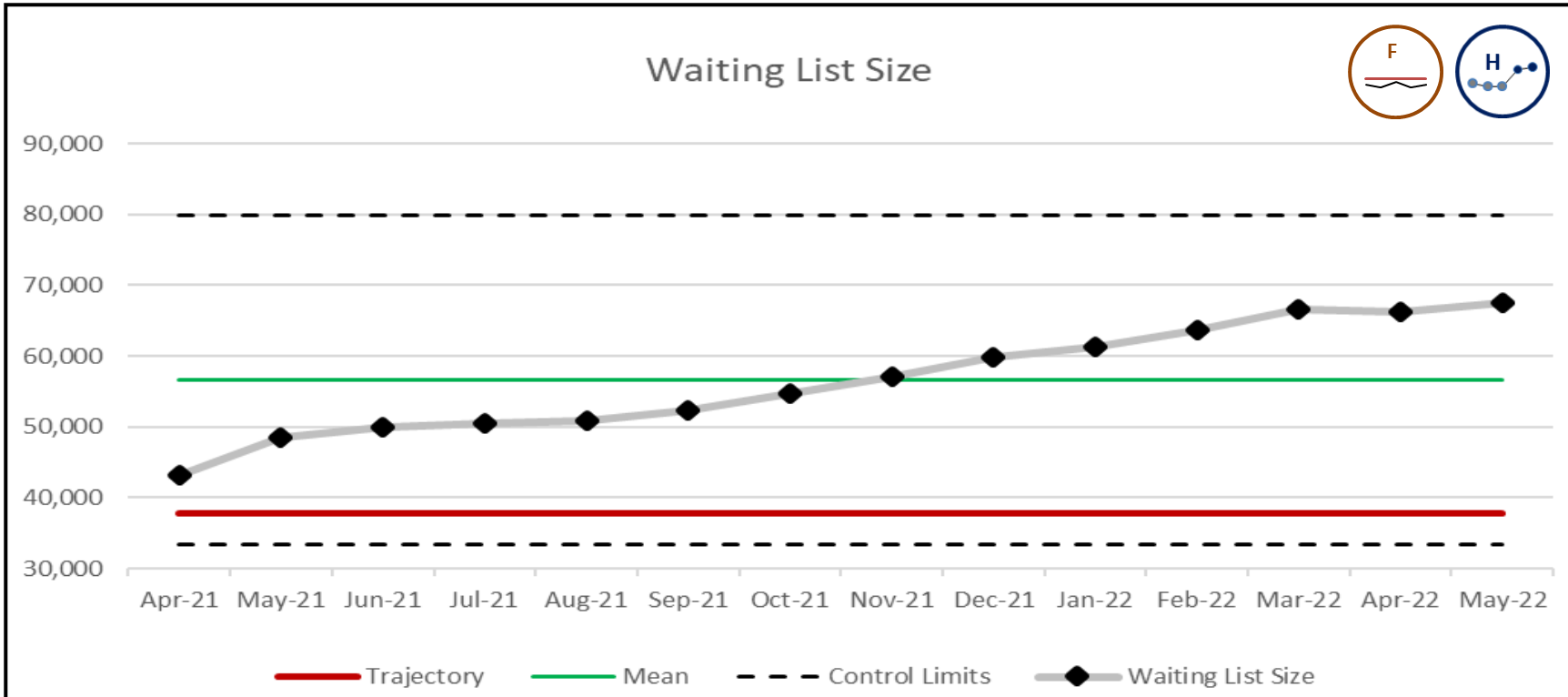
NHS United Lincolnshire Hospitals NHS Trust



May-22
67,585
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 April, with May showing an increase of 1265 to 67,585.
The incomplete position for May 2022 has increased by approximately 29,559 more than the reported pre pandemic size in January 2020.

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

- Respiratory Medicine + 335
- Dermatology + 185
- General Surgery + 164
- ENT + 138
- Cardiology + 118

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

- Urology – 154
- Ophthalmology - 80
- Paediatric Trauma And Orthopaedics - 35
- Gynaecology - 34
- Nephrology - 31

The Trust reported 11,886 over 40 week waits; an increase of 306 on April. Patient numbers waiting over 26 weeks increased by 515.

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

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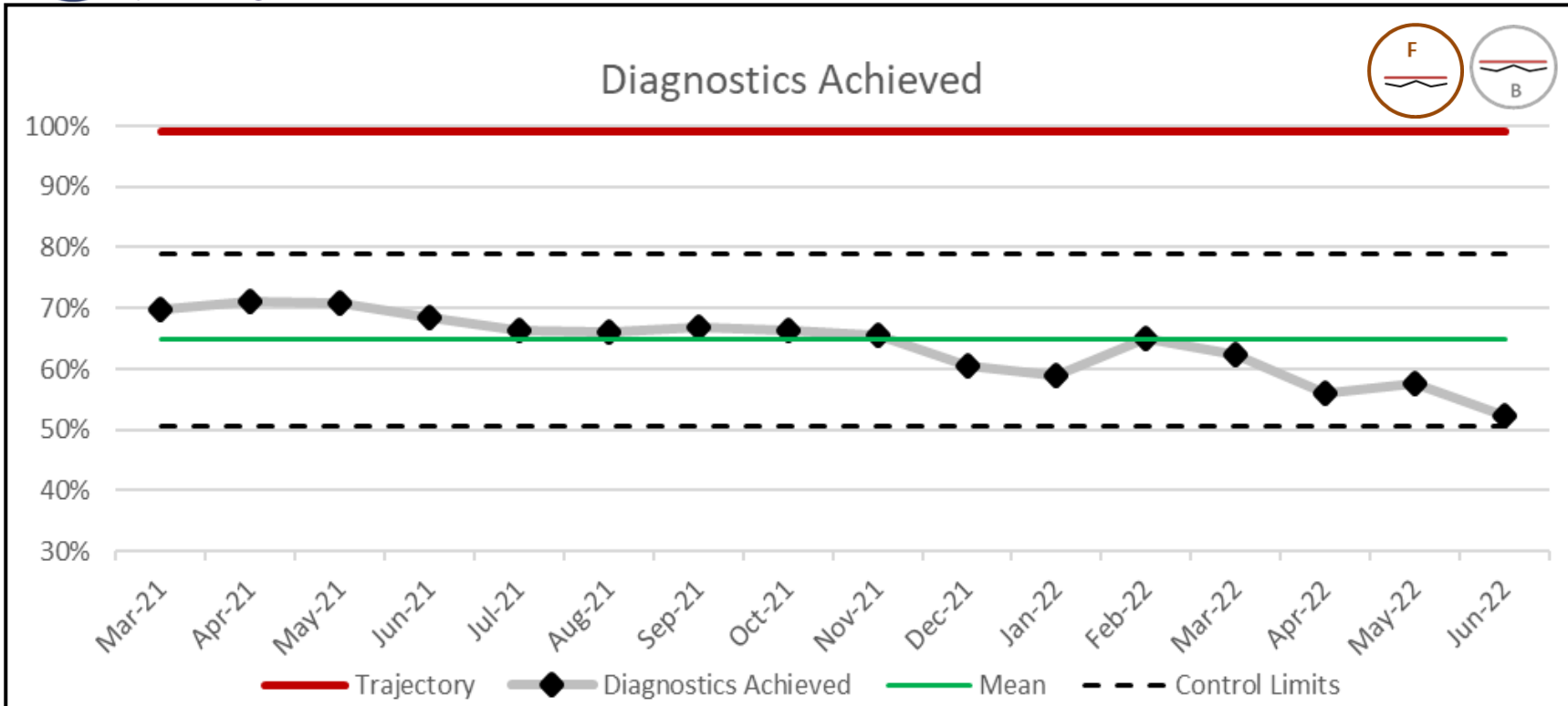
NHS United Lincolnshire Hospitals NHS Trust



Jun-22
52.43%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
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 52.43% against the 99.00% target.
CT, MRI, lost capacity and caused breaches due to the fire.

Issues:
CT, MRI have lost capacity due to the LCH fire, All areas have lost capacity due to social distancing, demand is still higher than capacity for some procedures so causing increased backlogs for some specialities and increasing the number of breaches declared each month for those specialities. Although there are breaches in US we are seeing a decline in breaches month on month. Cardiac Echoes have a considerable backlog and have grown in month by over 800. Medicine
Audiology have had capacity issues due to sickness and maternity.

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 by A plan to extend Mobile scanners is being discussed with finance to aid recovery (CT, MRI). Cardiac echo have an additional 4 locums from June and have reduced slot time to 30 minutes.

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.

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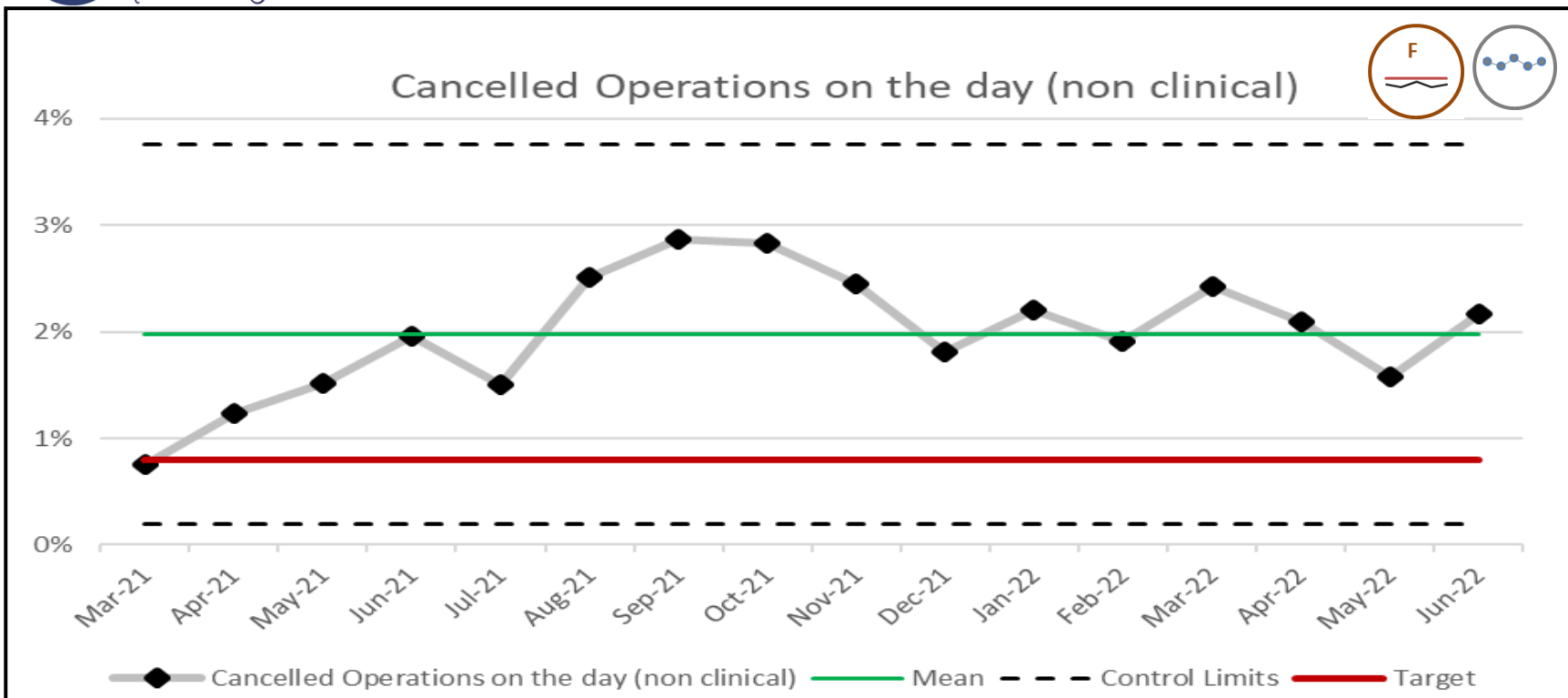

Jun-22
2.17%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us
June shows an increase to 2.17% in patients who have had their operation cancelled on the day of surgery and therefore remains above the agreed trajectory of 0.8%.

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

- Lack of time;
- Equipment unavailable;
- Lack of general beds;

Actions:
The theatre team are working with Four Eyes to support improvements with start times and processes in order to improve our theatre use.

Starting our theatres on time will reduce the number of patients cancelled due to lack of time.

Mitigations:
Persistent escalation of beds and reduced hospital flow, as well as increased ED activity across our larger sites, means that maintaining the ring fenced beds continues to be challenging.

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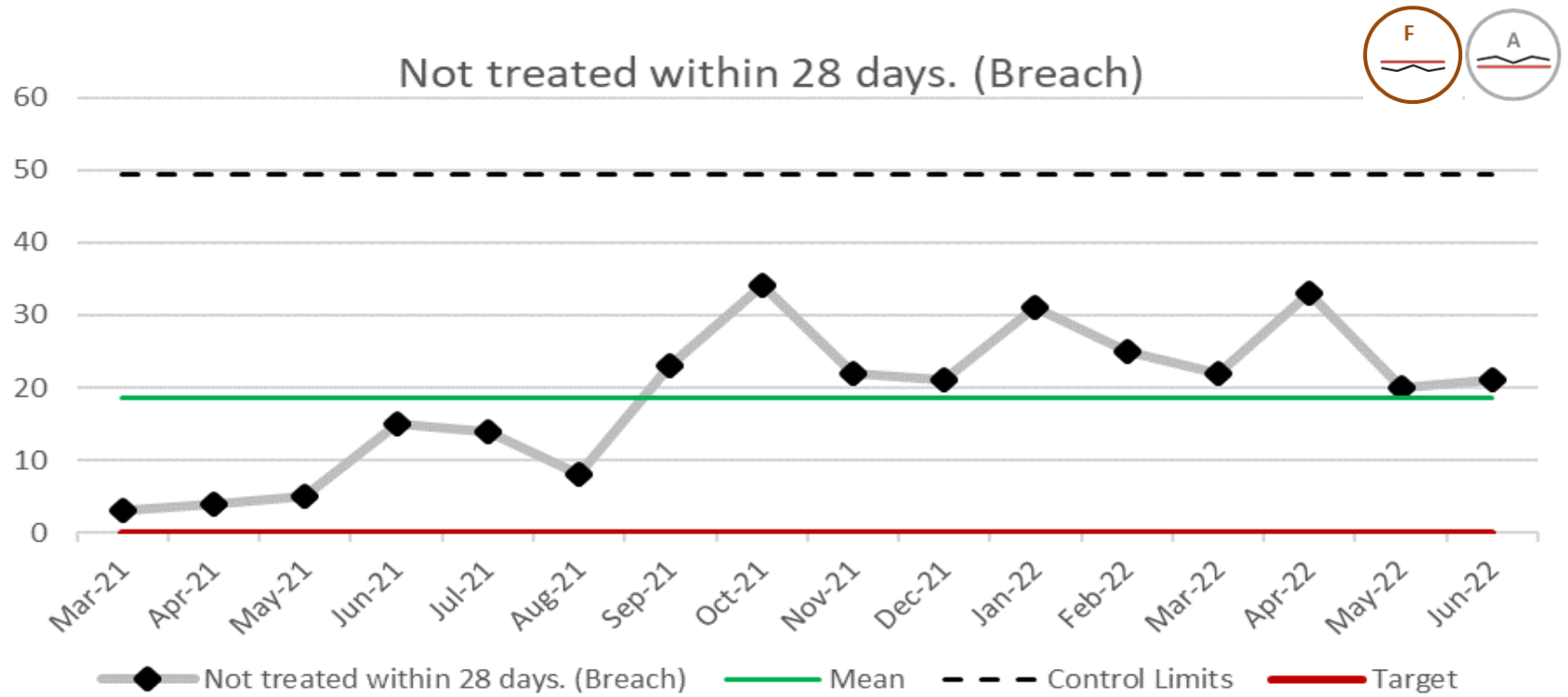

Jun-22
21
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
This chart shows the number of breaches during May 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 June is 21, which is a slight increase from 20 in May.
The agreed target of zero has not been achieved.

Issues:
Pre Assessment availability continues to be one of the biggest challenges as well as a rising number of absences amongst theatre staffing, anaesthetists and surgeons.

Short time length of MRSA swab results means patients need a swab no more than 6 weeks old, which is significantly shorter than a large number of NHS Trusts.

Actions:
The waiting list team within the Surgical Division continue to work together to reschedule patients who have experienced any on the day non-clinical cancellations, identifying any requirement for additional capacity to the CBU teams.

There is a continued focus on outsourcing appropriate patients, which will enable improved capacity within the Trust.

Mitigations:
The Pre Assessment team are working in conjunction with the waiting list lead to identify opportunity for additional capacity for pre assessment.

There is also work underway to increase the number of patients being outsourced appropriately to our partner organisations

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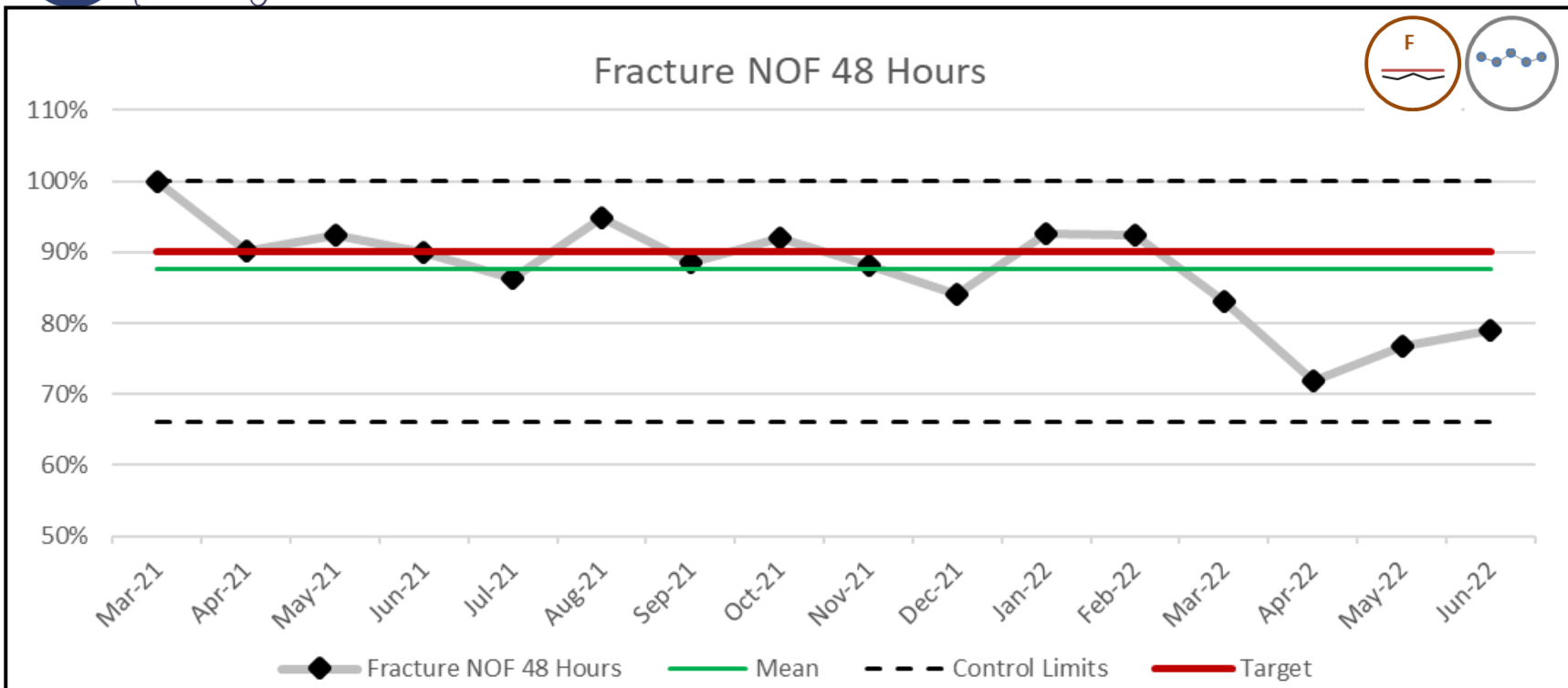

Jun-22
78.95%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of fracture neck of femur patients time to theatre within 48 hours.

What the chart tells us:

June performance out turned at 78.95% against the agree target of 90%.

Both sites underperformed with PHB at 77.78% and LCH 80.65% which has led to deterioration in performance, although this is overall improved from April & May 2022.

Issues:

Increase in trauma demand over recent months, particularly during BH weekends in May and June
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.

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.

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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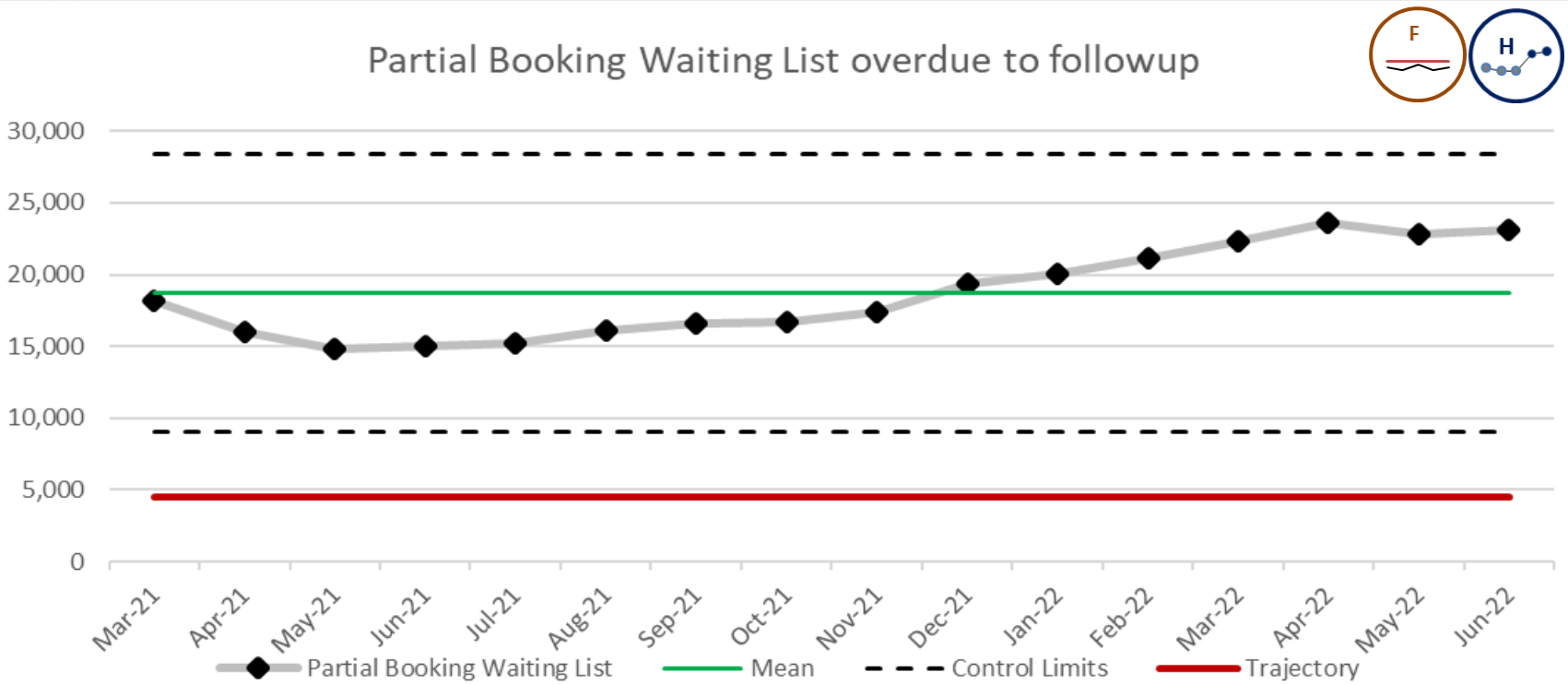

Jun-22
23,087
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 23,087 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased.
Recovery work took place and reduced the number of patients overdue but this has increased on an upward trend since July 2021.

Issues:

The organisation is continually pressured in a number of areas especially in urgent / emergency care that has taken priority over outpatients. The fluctuating impact of Covid also has an impact on conflicting priorities, increasing demand on resources, sickness levels, staffing issues, space and aligning requirements. The Trust is working on a recovery of diagnostic capacity since the fire in the diagnostic area, which has also impacted on outpatient diagnostic capacity.

Actions:

Specialities have agreed plans to increase activity for 2022/23 which will improve their PBWL position and reduce patient waits. Outpatients have reviewed and increased waiting area capacity to allow an increase clinic templates. Resource identified to progress Personalised Outpatient Plan including maximising validation, clinical triage, technological solutions and PIFU. Currently, out to procurement for a validation team to review the PBWL patients and prioritisation of patients.

Mitigations:

Supporting organisational priorities in ED and urgent care taking individual outpatient clinics down, if support required across the sites (site/patient flow and theatres) or so a clinician can support the wards at short notice.

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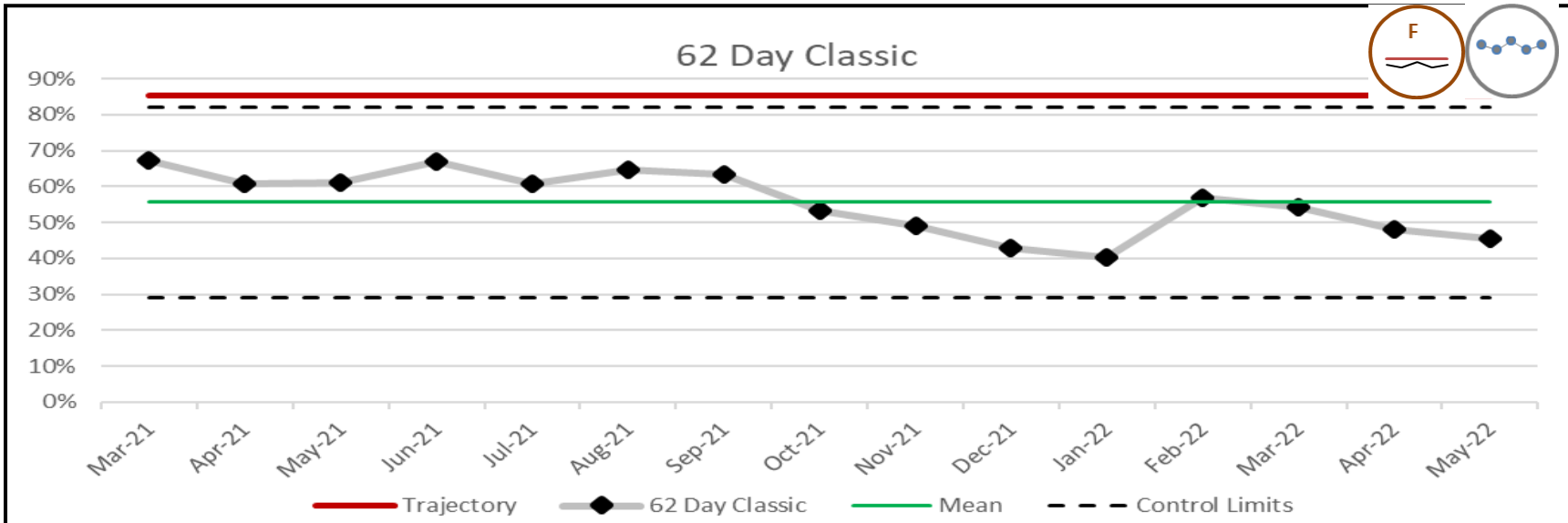


May-22
45.58%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 45.58% against an 85.4% target.

Issues:

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

Pressure on diagnostic services following the fire in Radiology at LCH.

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 'effectiveness' period), though this is continuing to reduce. 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, 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 locums or substantive posts. 2 posts have recently been offered and start dates are TBC. There is a significant lack of consultants nationally and very few available from agency.

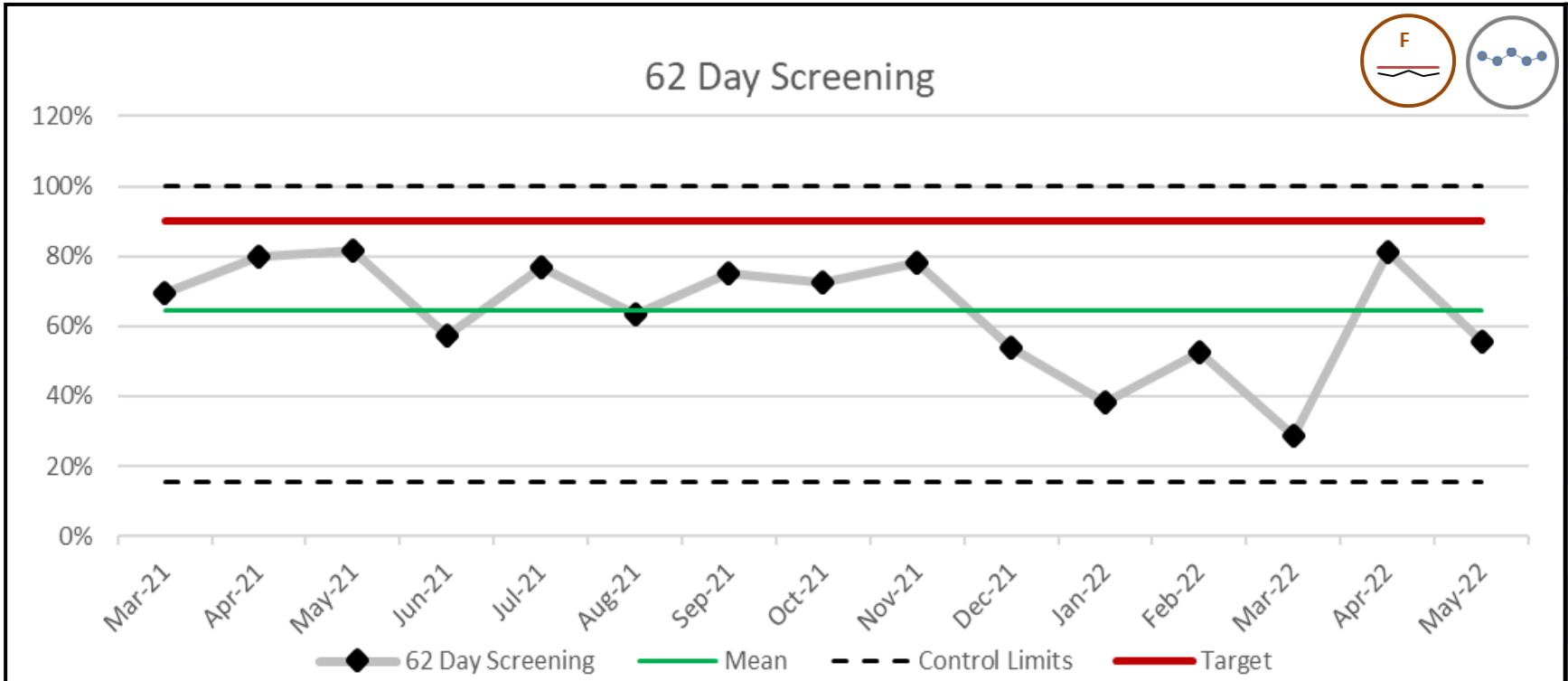
Endoscopy's review regarding endoscopy staffing is now at the point of recruitment. The intention is to increase administrative support by converting fixed term into substantive posts.

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

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.

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.



May-22
55.56%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

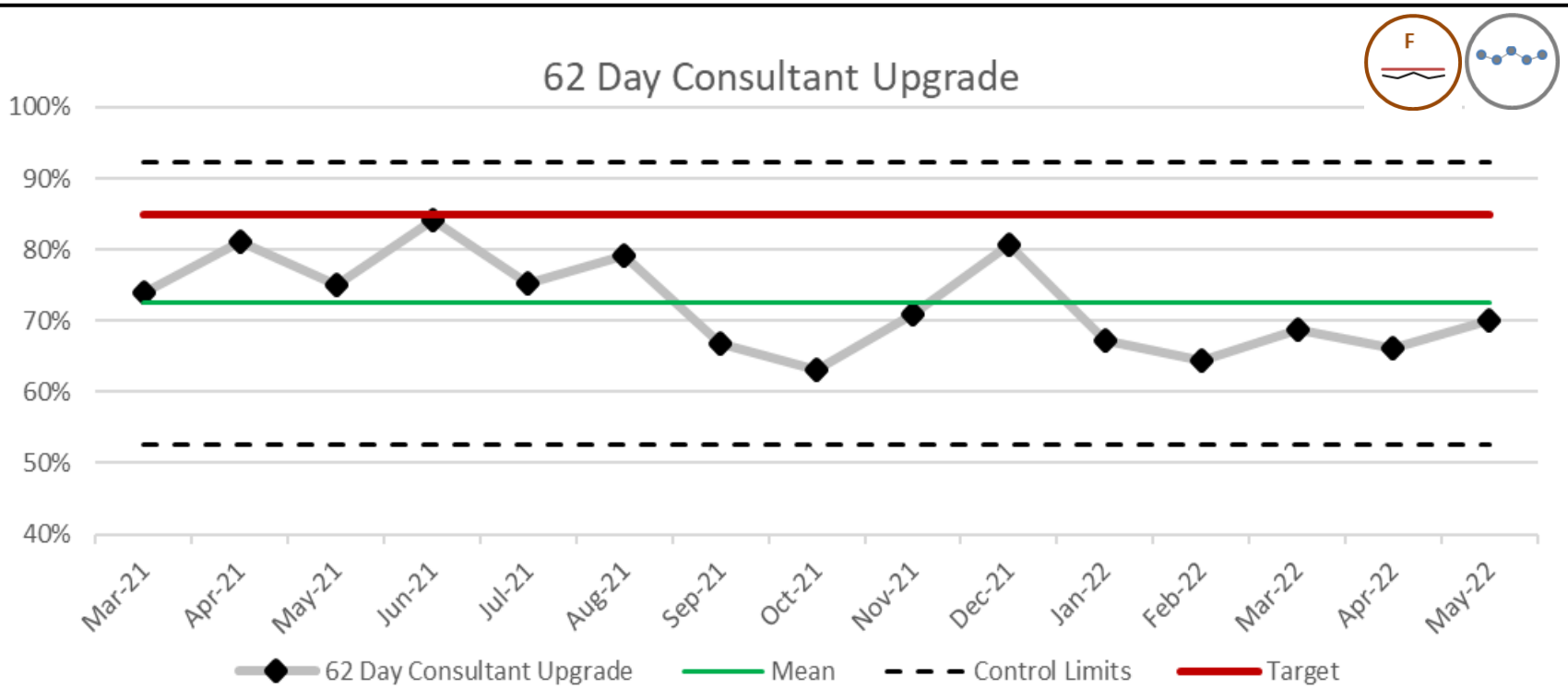
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 55.56% 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.



May-22
70.11%
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 70.11% against an 85% target.

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

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

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

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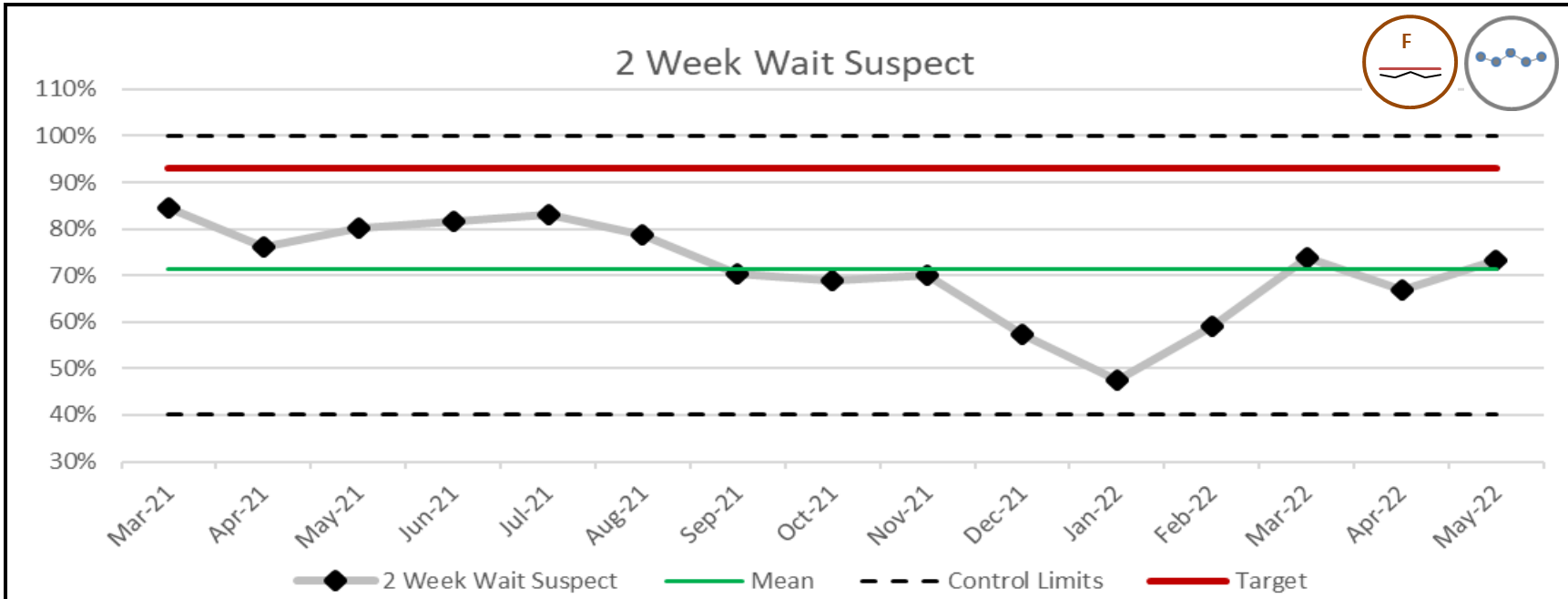


May-22
73.15%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 73.15% against a 93% target.

Issues:

The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with Breast performance being 22.7%: - 44.1% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Lung (47.1%), and Gynaecology (59.9%).
Patients not willing to travel to where our service and/or capacity is available.
Nurse Triage / CNP capacity issues in colorectal specialty.

Actions:

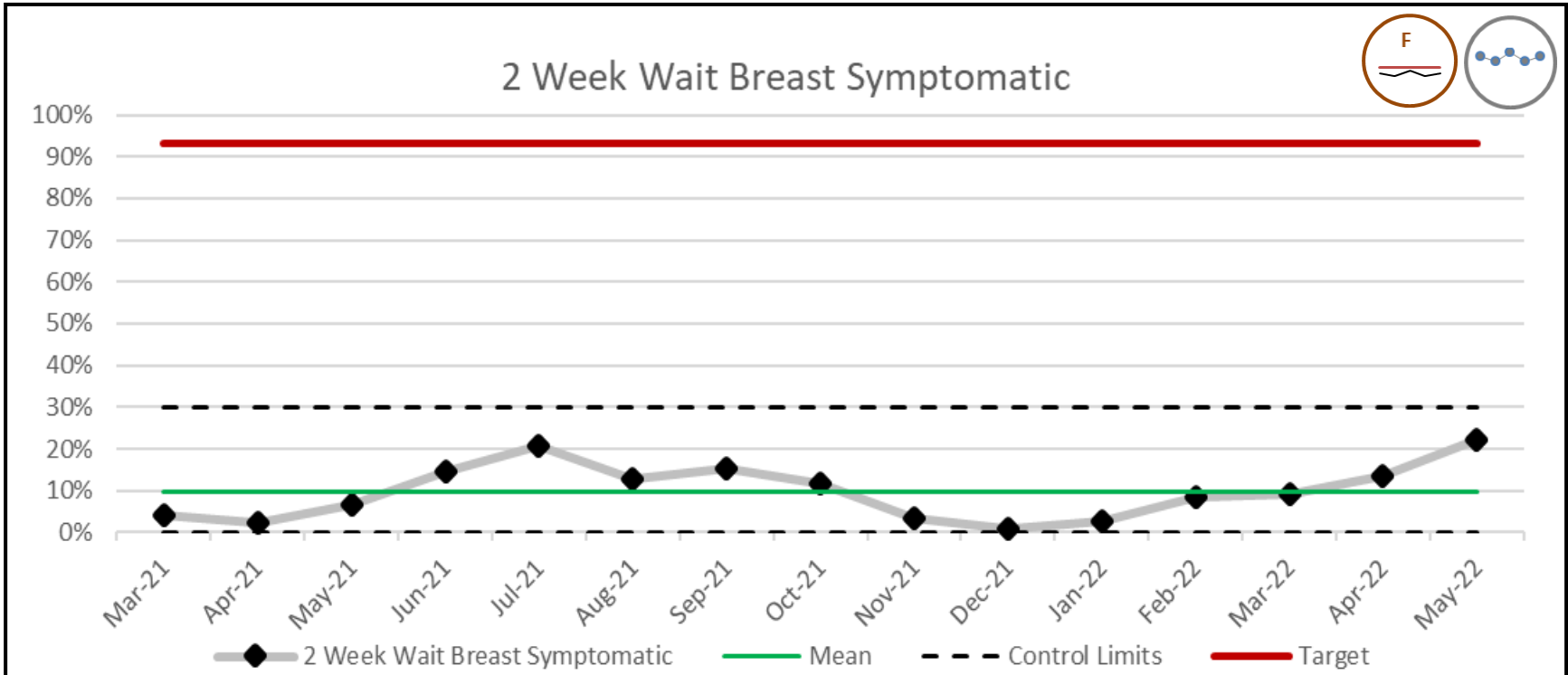
The Trust is actively seeking to implement RDC pathways for brain, haematuria and Upper GI at the earliest opportunity. A pathway review for gynaecology and a direct access ultrasound pathway has also been identified as a priority for 2022.
Overseas recruitment is underway for gastroenterology consultants / Specialty Doctors. 2 posts are in place to commence from July '22.
A Locum Respiratory consultant post has been appointed to for 12 months at PHB – start date TBC. Case of need approved at CRIG in November to increase in consultant workforce to 10-15 consultants.
A Gynae review of specialist nurse workforce and oncology strategy meeting scheduled for 15th July with a plan to resolve through longer term appointment of consultants to mitigate capacity gap.
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:

Agreement in process for Radiology to discharge normal scans on the FReD pathway – to start from August when new staff are in place following model in place at SFH. 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. Recruitment for CBU booking clerks is underway.

Increasing numbers of skin referrals are set to continue throughout summer – additional weekend clinics in place to mitigate. Case of Need in place to increase waiting room capacity at PHB.



May-22
22.15%
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 22.15% against a 93% target.

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

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

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

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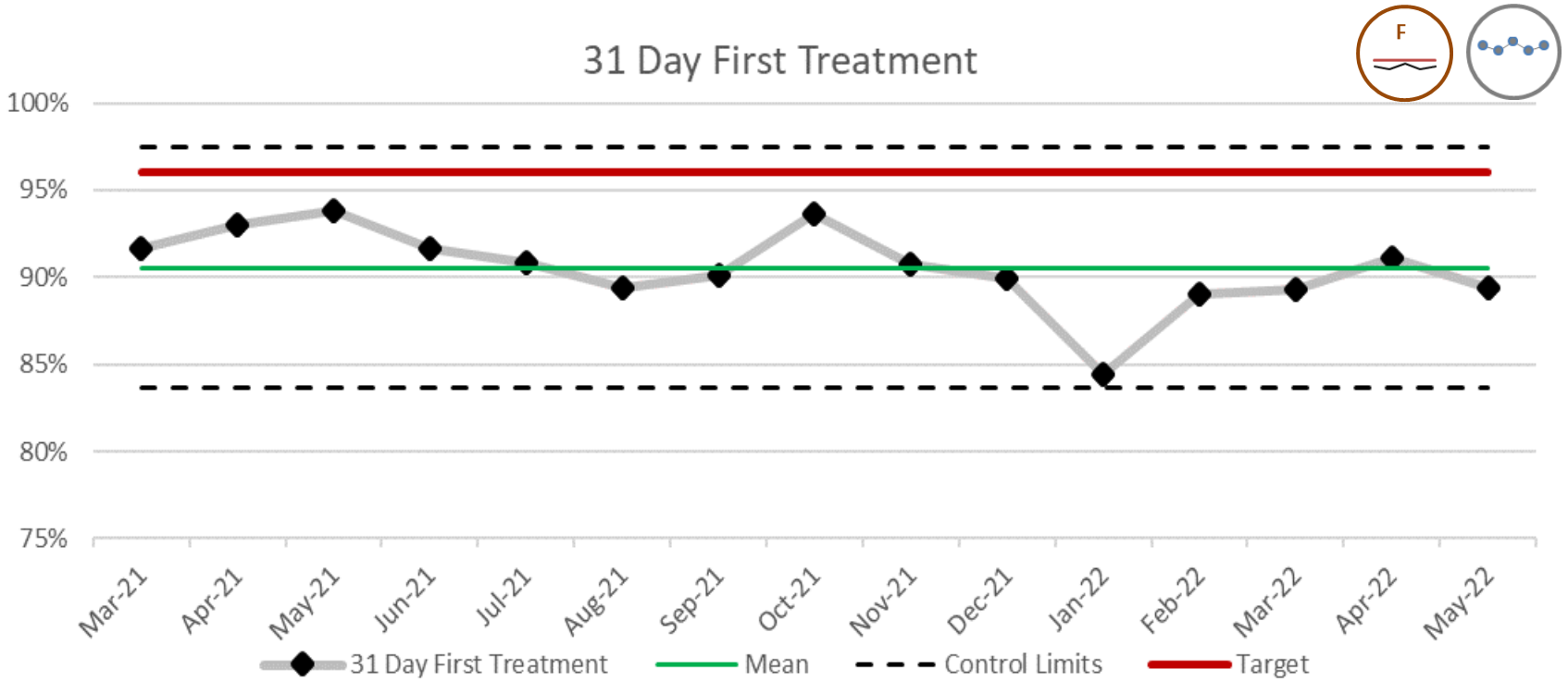


May-22
89.36%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

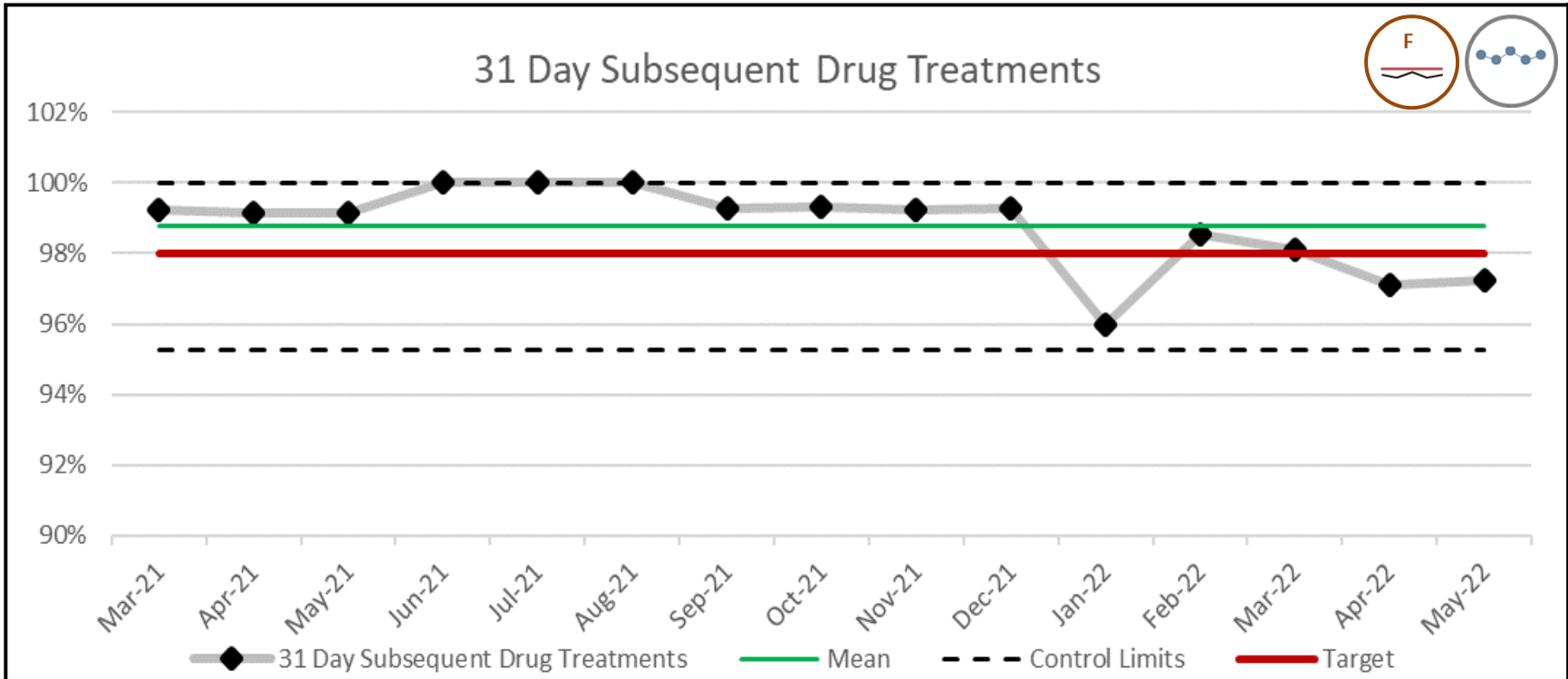
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 89.36% 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 locums or substantive posts. 2 posts have recently been offered and start dates are TBC. There is a significant lack of consultants nationally and very few available from agency.
Work has commenced on building the new theatres at Grantham.
For Colorectal, a Deep Dive and pathway analysis is underway, supported by CCG colleagues.

Mitigations:
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.



May-22
97.24%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

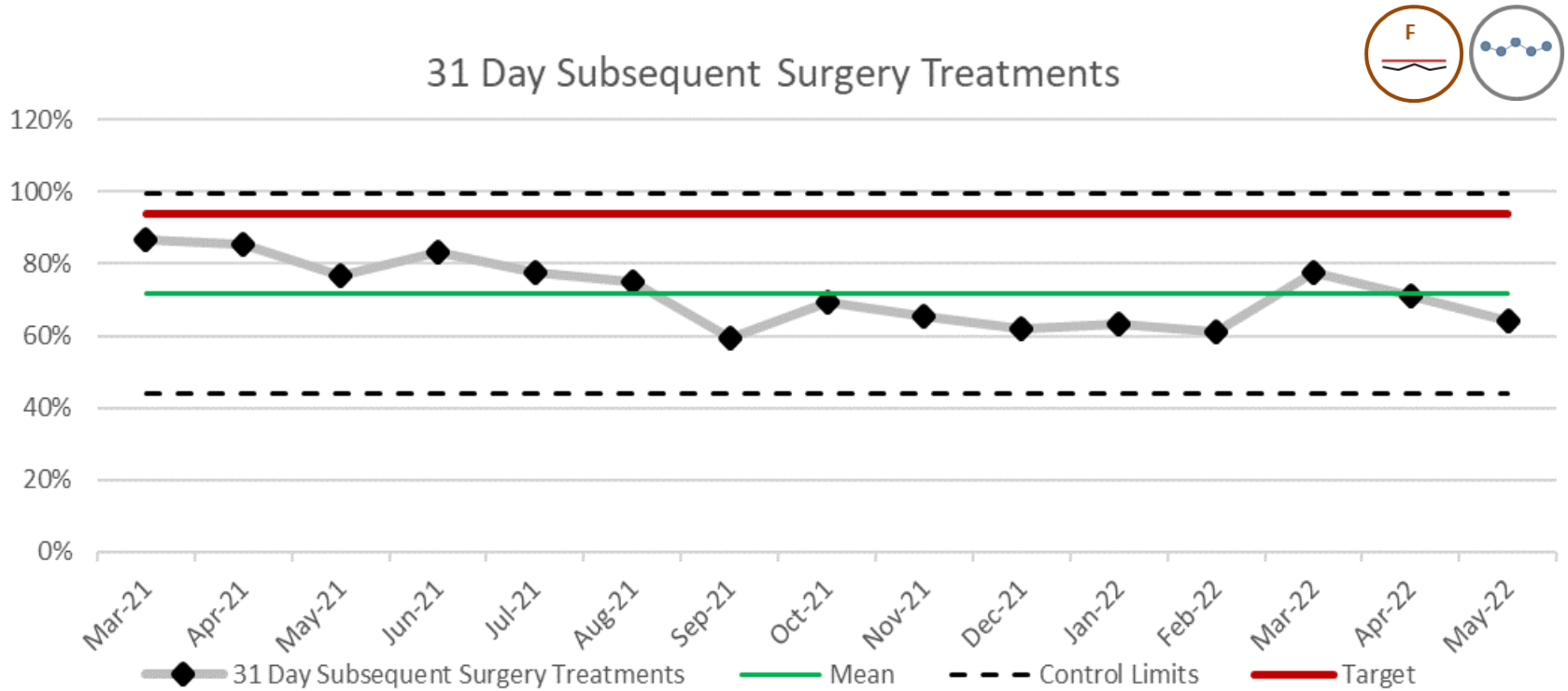
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was drug treatments.

What the chart tells us:
We are currently at 97.24% against a 98% target.

Issues:
The inability to deliver the 31 Day standards was primarily attributed to the reduction in theatre capacity. For the subsequent standards the Trust was successful in the Radiotherapy standard, failing in the Surgery standard and narrowly missing the Drug standard at 97.24%.

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

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



May-22
64.29%
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 64.29% against a 94% target.

Issues:
The inability to deliver the 31 Day standards was primarily attributed to the reduction in theatre capacity. For the subsequent standards the Trust was successful in the Radiotherapy standard, failing in the Surgery standard and narrowly missing the Drug standard at 97.24%.

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

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

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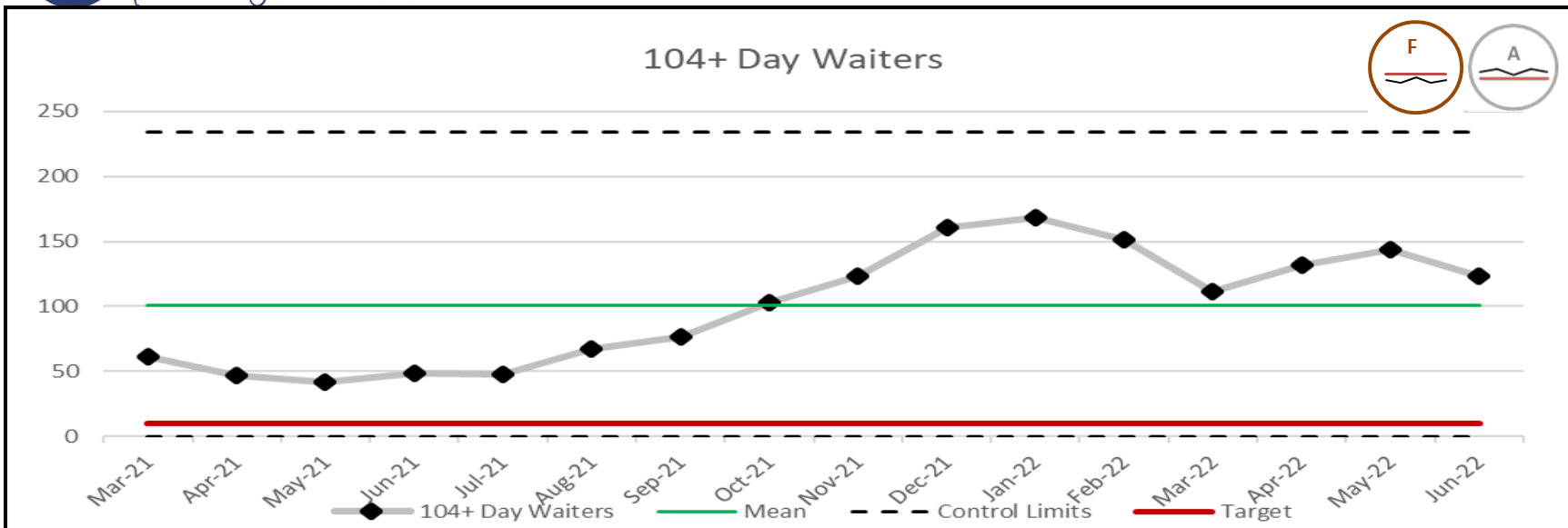

Jun-22
123
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Number of cancer patients waiting over 104 days.

What the chart tells us:

As of 13th July the 104 Day backlog was at 123 patients. The agreed target is <10.

There are four tumour sites of concern
Colorectal 78 (majority awaiting diagnostics, outpatients and clinical review)
Upper GI 19
Urology 12

Issues:

The impact of critical and major incidents on Trust activity and patient pathways.
Pressure on diagnostic services following the fire in Radiology at LCH.
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 and Lung.
Approximately 20% 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 locums or substantive posts. 2 posts have recently been offered and start dates are TBC. There is a significant lack of consultants nationally and very few available from agency.
For Colorectal, a Deep Dive and pathway analysis is underway, supported by CCG colleagues.

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.
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	Apr-22	May-22	Jun-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%	89.27%	90.26%	89.76%	89.76%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	10.55%	10.31%	12.08%	10.98%		F		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.21%	5.26%	5.28%	5.25%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	14.67%	14.58%	14.82%	14.69%		F	H	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	54.06%	57.62%	59.14%	56.94%		F	B	

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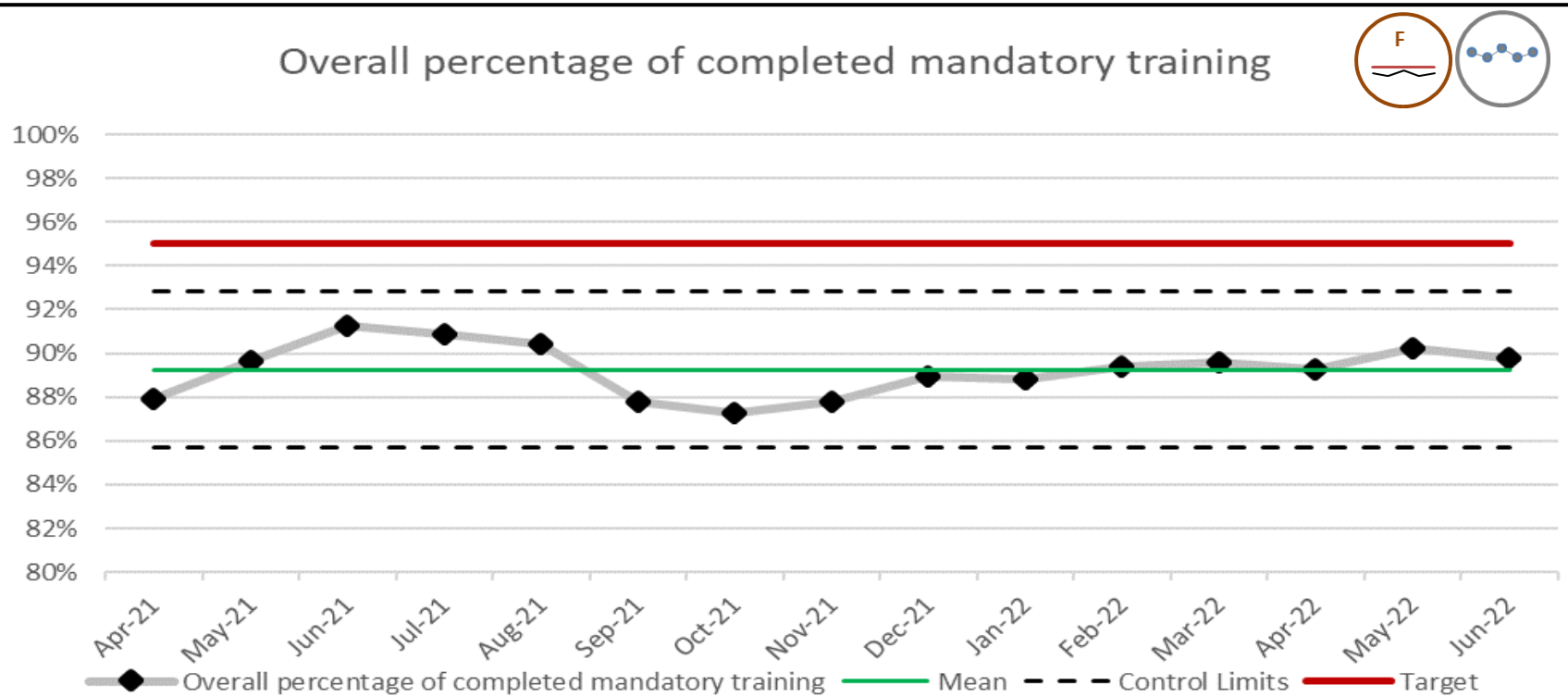

Jun-22
89.76%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Mandatory training shows no increase over the past month however the overall rate can mask poor compliance in some areas.

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 proper 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.
- 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:
Messages from The Director of Finance and Digital in April and May has helped in reinforcing protected time off for completion of core learning. These messages need to be repeated over the next month. Issues of access and recording of learning to be addressed by digital team.

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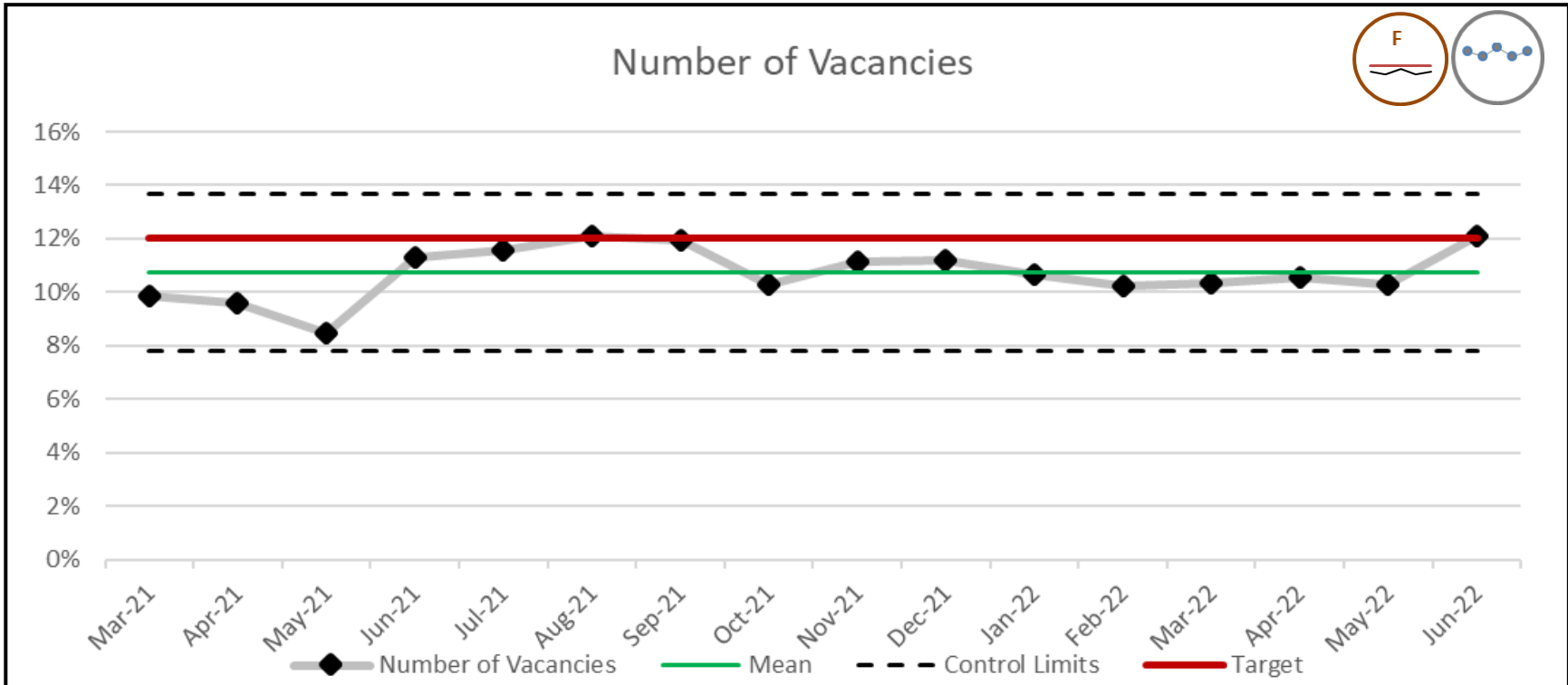

Jun-22
12.08%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
12%
Target Achievement
Metric is failing to target
Executive Lead
Director of HR & OD

Background:
Percentage of Vacancies

What the chart tells us:
There has been a 1.7 % increase in vacancy factor from last month.

Issues:

We have seen an increase due to having a gap in updated establishment report from Finance, the gap between March & June 2022.

We are now financed for significantly more staff in Nursing & Midwifery and AHPs; hence the vacancy factor has increased.

Actions:

We have increased our International Nurse Recruitment by bringing in a further recruitment agency to support us.

In Medicine, we are running a project looking at increasing nurse recruitment.

AHPs we have a bid in with NHSEI to increase our numbers by an additional 28 over the next few months.

Mitigations:

See actions

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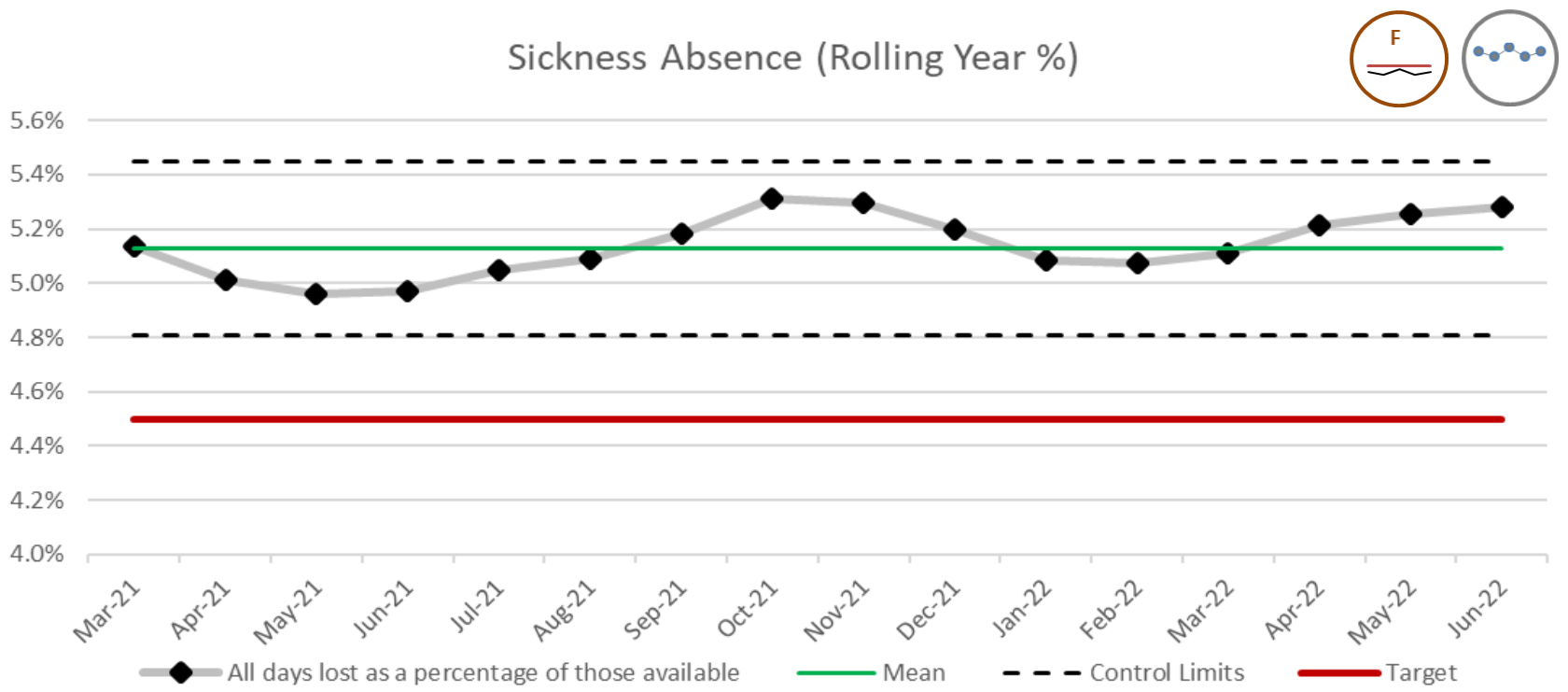

Jun-22

5.28%

Variance Type

Metric is currently experiencing Common Cause Variation

Target

4.5%

Target Achievement

Metric is consistently failing to target

Executive Lead

Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The trend has increased by 0.02% to 5.28% which is still above the target of 4.5%.

Issues:

- The COVID absences are slightly increased
- AMS system requires managers to be more stringent with the ab man process
- Capacity in the HR team to support case management sooner.

Actions:

- Extensive work is continuing to get full engagement of using Absence Management System (AMS) Trust wide.
- SHRBP's and ER Team continue to work with divisional leads to ensure that the system is being used to log absences correctly, support the wellbeing of employees and monitor attendance.
- All cases in Case Manager are being reviewed and all data is being cleansed in AMS.
- The introduction of LTS Absence meetings with HRBP's, ER Advisers, Divisional Leads and Occ Health have commenced.
- E&F and Medicine Divisions has start the learning journey through a People Management Essentials (PME) sessions. This covers a section on AMS and management responsibilities.

Mitigations:
Support from Empactis has been given to all Divisions.

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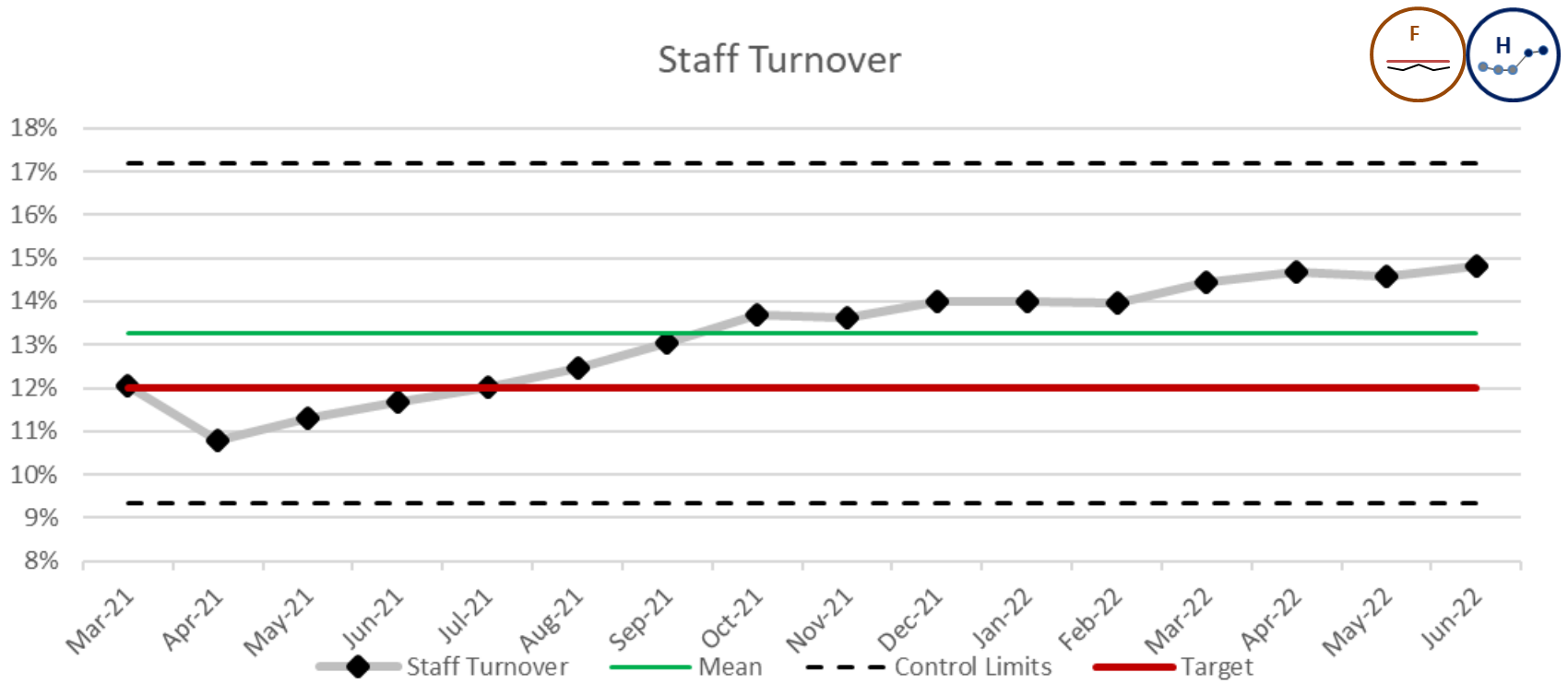

Jun-22
14.82%
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
12%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

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

What the chart tells us:
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:
Analysis of exit survey data shows (completion rate of has steadily dropped over the past 3 months):

- Lack of support from managers, development opportunities, flexible working opportunities and relocations, continues to be one of the main reasons for people leaving.

The reasons are the same month on month.

Actions:

- A Culture and leadership OD manager has been appointed started in July 22.
- A People Promise Manager started in May 22.
- A new suite of leadership and management training is being introduced in June 22. Flexible working clinics offered by OD to all managers.

Mitigations:
See actions

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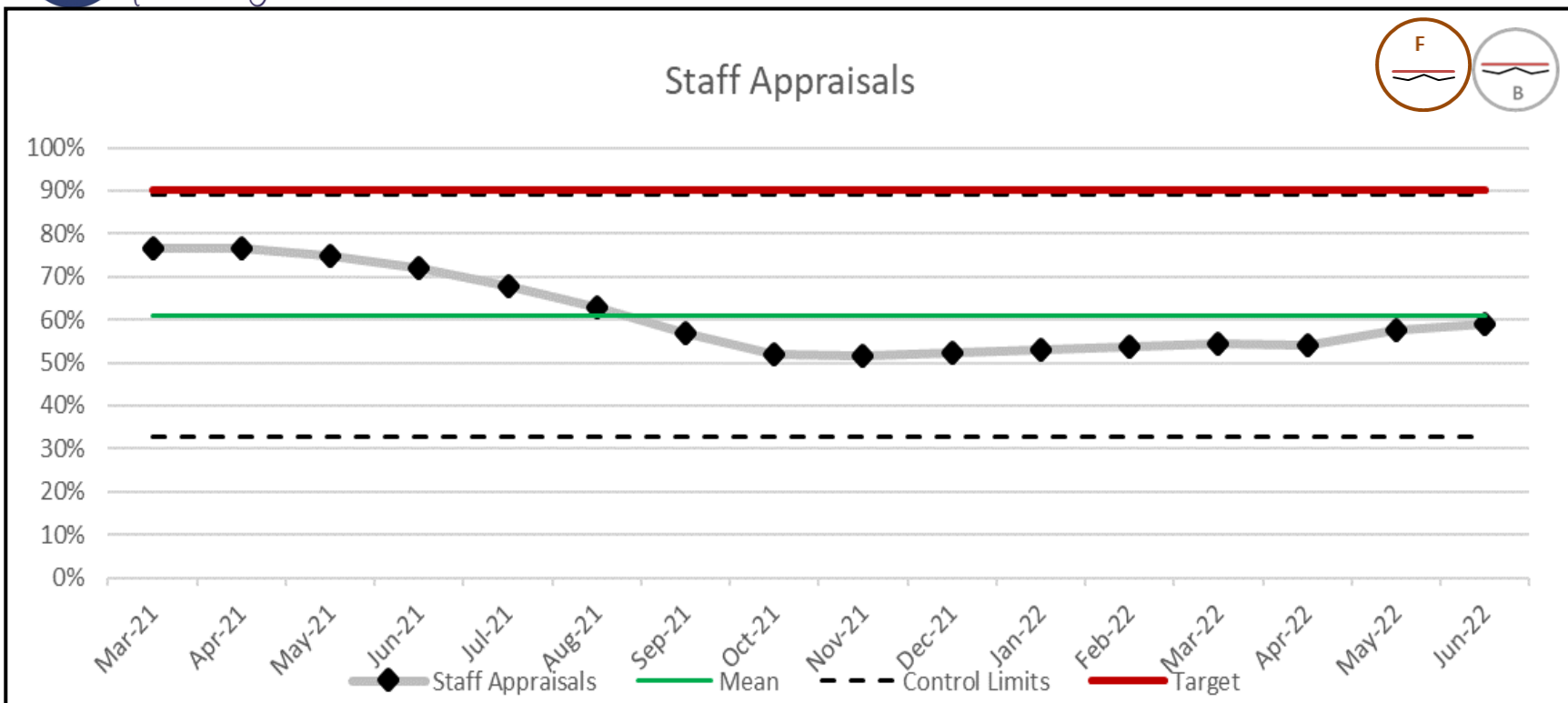

Jun-22
59.14%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 57.62%.

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

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

Actions:
- Appraisal completion to be focussed through the divisions regardless of operational pressures 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 to bring rates up in May 2022 will show in June 22.
- Managers training from June 2022 paused due to decommissioning of workpal and will resume once contingency process in place end of July 22.

Mitigations:
See actions

Financial Position Month 03 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

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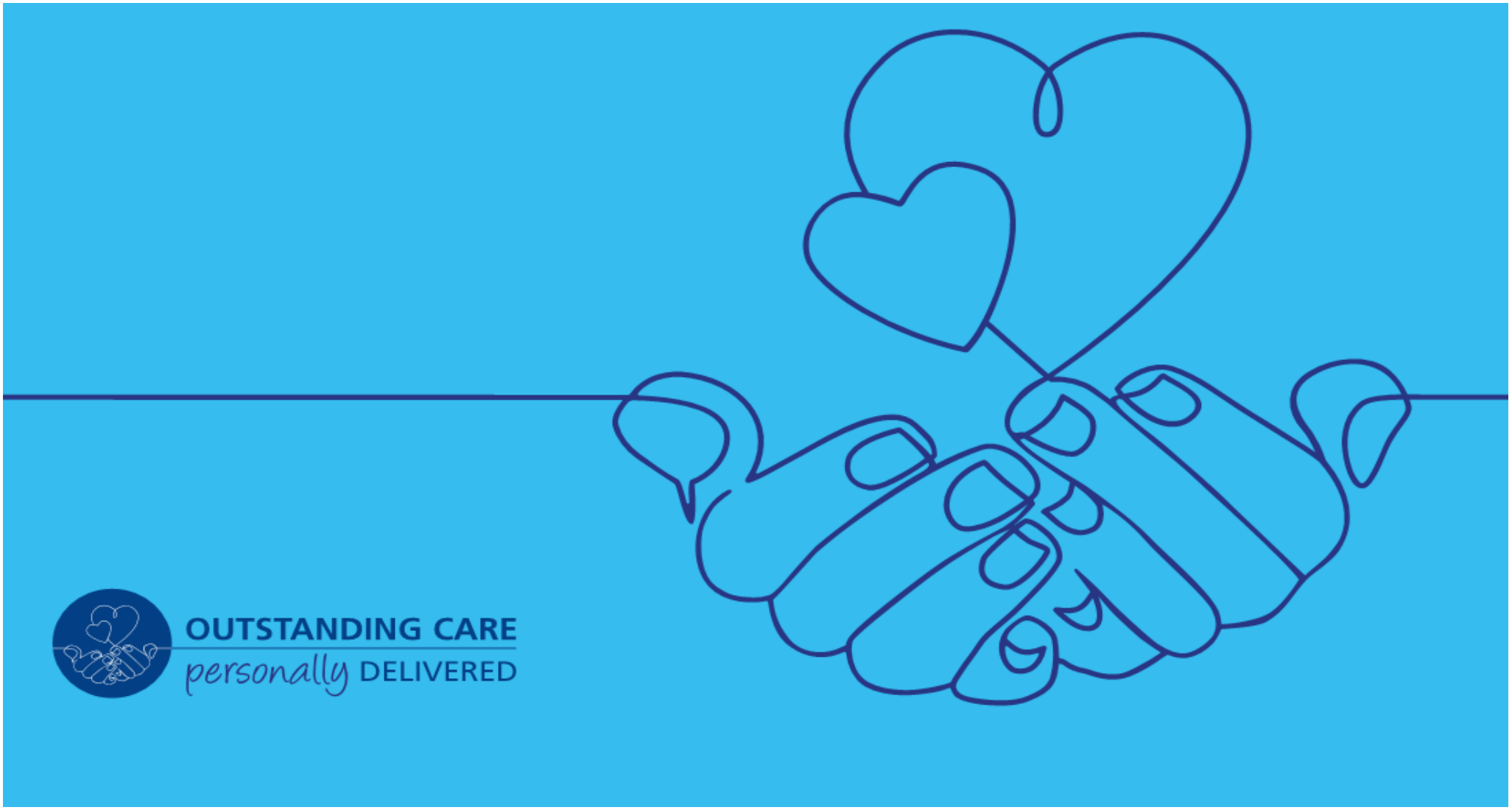
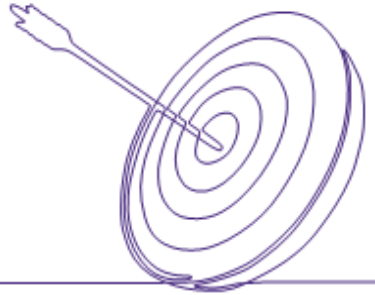


Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)



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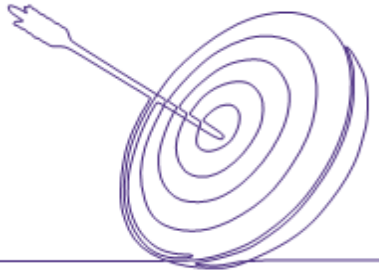
	Current Month			Year To Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Patient Care Activities Income	52,630	51,799	(831)	157,467	157,193	(274)
Other Operating Income	3,182	3,573	391	8,904	10,669	1,765
Substantive Staff	(30,144)	(29,608)	536	(90,632)	(89,852)	780
Agency Staff	(2,510)	(4,603)	(2,093)	(8,620)	(12,725)	(4,105)
Bank Staff	(2,920)	(3,799)	(879)	(8,794)	(11,700)	(2,906)
Apprentice Levy	(696)	(222)	474	(988)	(663)	325
Non Pay	(16,320)	(18,788)	(2,468)	(50,721)	(51,501)	(780)
Depreciation	(1,667)	(1,629)	38	(4,954)	(4,897)	57
Net Financing	(603)	(610)	(7)	(1,889)	(1,869)	20
Surplus/Deficit	**952**	**(3,888)**	**(4,840)**	**(227)**	**(5,344)**	**(5,117)**
Below Line Adjustments	170	54	(116)	227	161	(66)
Adjusted Surplus/Deficit	**1,122**	**(3,834)**	**(4,956)**	**0**	**(5,183)**	**(5,183)**

- The Trust was required to submit a revised plan in June to take account of additional national funding for 'excess' inflation and pressures; this funding came with the expectation that systems and organisations within them would improve their plan positions for 2022/23.

- The Trust has submitted a revised break even position for 2022/23. The above table shows that the Trust delivered a £3,834k deficit in June (£4,956k adverse to plan) and YTD has delivered a £5,183k deficit (£5,183k adverse to plan). Actual CIP savings of £2.7m have been delivered YTD, such that YTD CIP savings delivery is £1.3m (32.7%) adverse to plan.

Finance Spotlight Report (Key areas of focus - Income)



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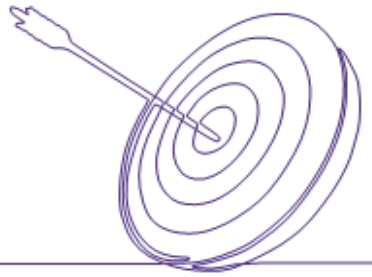
The Income position is £1.5m favourable to plan; this includes:

- **NHS Patient Care income contract - adverse variance of £(0.4)m**; this includes under performance of £0.1m in respect of diagnostic imaging & AQP (as a result of the radiology fire), and under performance of £0.3m in relation to pass-through expenditure (for which there will be an offset in Non Pay).
- **Radiology fire - favourable variance of £0.8m**; the financial plan did not include the I&E impact of the Radiology fire; this favourable income variance offsets an adverse variance of £0.8m in expenditure (mainly in Non Pay in relation to hire of clinical equipment).
- **Bad debt provisions - favourable variance of £0.2m**; this reflects a one off change in month 2 which is offset by an adverse variance of £0.2m in Non Pay.
- **Education & Training - favourable variance of £0.2m** (including notional income re the apprenticeship levy); the income variance offsets an adverse variance of £0.2m in Non Pay.
- **Non-Patient Care services - £0.2m favourable to plan.**
- **Pay Recharges - favourable variance of £0.1m**; this favourable income variance offsets an adverse variance of £0.1m in Pay.
- **Various income lines – favourable variance in total of £0.3m**; including more notably £75k on Injury Cost Recovery Unit, £69k on Research & Development, £37k on overseas patients and £27k on private patients.

Finance Spotlight Report (Key areas of focus - Pay)



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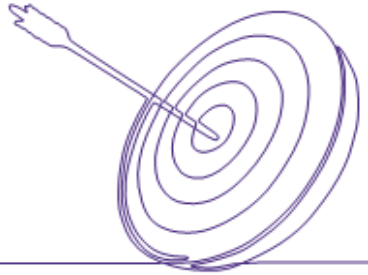
- **The YTD Pay position is £5.9m adverse to plan including under delivery on Pay CIP of £1.0m.**
- Actual Pay expenditure in June of £38.2m was £0.1m lower than £38.3m in May.
- The June Pay position includes £0.6m of non-recurrent technical CIP savings, without which Pay would have moved adversely by £0.5m in comparison to May (driven by higher expenditure on Agency staffing).
  - **Substantive pay is £0.5m favourable to plan**
    - Expenditure of £29.8m in June is £0.4m lower than expenditure of £30.2m in May: £0.6m of technical CIP savings were released in June but were partly offset by an increase £0.2m in A4C enhancements as a result of there being one more Bank Holiday in June than in May.
    - Excluding technical savings and bank holiday enhancements, substantive pay is overall unchanged.
  - **Agency pay is £4.1m adverse to plan**
    - Expenditure of £4.6m in June is £0.4m higher than expenditure of £4.2m in May.
    - The YTD efficiency plan assumed savings of £1.9m in Agency Pay, but only £0.2m of savings have been delivered (or £1.7m adverse to plan); the YTD position also reflects higher than planned bed numbers, sickness levels & vacancies.
  - **Bank Pay is £2.9m adverse to plan**
    - Expenditure of £3.8m in May is £0.1m lower than expenditure of £3.9m in May; Bank expenditure (like Agency Pay) reflects higher than planned bed numbers, sickness levels and vacancies.

Finance Spotlight Report (Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

Non Pay

- Non Pay expenditure in June of £20.4m was £2.1m higher than £18.3m in May; this increase reflects both increased activity volumes and the fact that in May £0.7m of non recurrent technical CIP savings were released in Non Pay.
- The YTD Non-Pay position is £0.7m adverse to plan including under delivery on CIP of £0.3m.
- The YTD position reflects lower than planned activity levels (including pass-through expenditure), but this under spend has been more than offset by c£1.4m of unplanned expenditure/higher than planned expenditure for which there is an offset within income e.g. £0.8m in relation to the radiology fire, £0.1m re training course fees and £0.1m re notional apprenticeship levy expenditure.

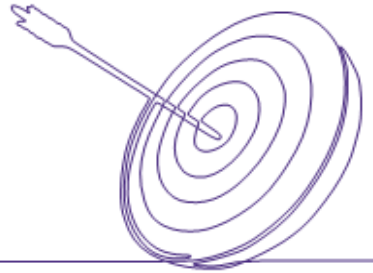
CIP

- 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 £4.0m by the end of Month 3; actual savings of £2.7m (67.3%) have been delivered, such that YTD delivery is £1.3m (32.7%) 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£2.2m.

Finance Spotlight Report (Key areas of focus – Other cntd)



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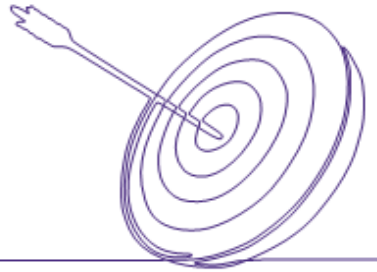
Cash

- The June 2022 cash balance is £67.2m which is a decrease of £21.1m against the March year- end cash balance of £88.3m. This is driven by multiple factors, the most significant being the reduction in year end capital creditors from £22.6m to £8.8m and an increase in receivables from £15.5m to £25.7m.

BPPC

- BPPC performance is 67% / 71% by value / volume of invoices paid for June 2022. The YTD performance is 77% / 74%, this compares to the full year in 2021/22 of 89% / 83%. While performance has started to improve following the introduction of the new finance system in December 2021, a backlog remains and can be seen in the heightened level of trade creditors and has manifested through the reduced performance against the BPPC target.

Finance Dashboard



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

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

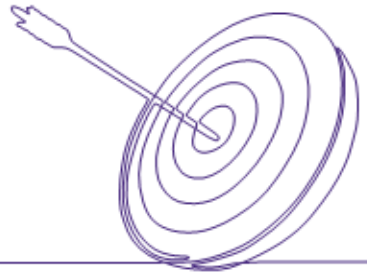
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last two full financial years and the current 2021/22 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	JUN 2022
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	0.60
Capital service cover rating	4	4	4	1	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	1.09
Liquidity rating	4	4	1	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(3.10%)
I&E margin rating	4	4	2	2	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]
Agency rating	4	4	4	4	[illegible]
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(3.10%)
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 has not yet been released in 2022/23

Balance Sheet



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	31-Mar-22	30-Jun-22	
	£000	Plan £000	Actual £000
Intangible assets	7,675	7,141	7,141
Property, plant and equipment	267,753	270,787	266,119
Right of use assets	12,751	12,431	12,252
Receivables	1,848	1,848	1,857
Total non-current assets	**290,027**	**292,207**	**287,369**
Inventories	6,006	6,006	6,033
Receivables	15,520	23,456	25,897
Cash and cash equivalents	88,297	57,943	67,186
Total current assets	**109,823**	**87,405**	**99,117**
Trade and other payables	(89,017)	(69,341)	(79,032)
Borrowings	(2,381)	(3,218)	(2,585)
Provisions	(8,774)	(8,895)	(5,596)
Other liabilities	(1,130)	(1,130)	(3,876)
Total current liabilities	**(101,302)**	**(82,584)**	**(91,089)**
Total assets less current liabilities	**298,548**	**297,028**	**295,397**
Borrowings	(14,264)	(13,126)	(13,583)
Provisions	(3,182)	(3,153)	(6,180)
Other liabilities	(11,572)	(11,446)	(11,446)
Total non-current liabilities	**(29,018)**	**(27,725)**	**(31,209)**
Total assets employed	**269,530**	**269,303**	**264,188**
Financed by			
Public dividend capital	704,178	704,180	704,180
Revaluation reserve	29,294	29,120	29,116
Other reserves	190	190	190
Income and expenditure reserve	(464,131)	(464,187)	(469,298)
Total taxpayers' equity	**269,530**	**269,303**	**264,188**

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: Payables, Receivables and Cash have each been impacted by the migration to the new finance system and disruption to BAU processing. Whilst now operating at close to normal levels, these elements of working capital are expected to return to 'normal' business levels in the next few months.

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

Note 4: Trade Payables and other payables remain circa £10m higher than would be normally be expected. This being driven by the heightened level of capital creditors associated with the 2021/22 programme and also the remaining finance system 'backlog.'

The payables balance of £79m is broadly split between:
Staff related creditors £5m, Trade Payables / accruals £42m, Capital creditors £9m and Tax / Superannuation £10m.

Cashflow reconciliation – April 2022– March 2023

United Lincolnshire Hospitals NHS Trust

	31-Mar-22	30-Jun-22	
	£000	Plan £000	Actual £000
Operating surplus / (deficit)	549	1,662	(3,475)
Depreciation and amortisation	15,736	4,954	4,897
Impairments and reversals	7,340	-	-
Income recognised in respect of capital donations	(27)	-	-
Amortisation of PFI deferred credit	(503)	(126)	(126)
(Increase) / decrease in receivables and other assets	11,261	(7,936)	(10,501)
(Increase) / decrease in inventories	504	-	(27)
Increase/(decrease) in trade and other payables	9,745	(3,121)	2,027
Increase/(decrease) in other liabilities	(457)	-	2,746
Increase / (decrease) in provisions	5,860	122	(141)
Net cash flows from / (used in) operating activities	**50,008**	**(4,445)**	**(4,600)**
Interest received	34	60	159
Purchase of intangible assets	(994)	-	-
Purchase of property, plant and equipment	(35,132)	(25,391)	(16,099)
Proceeds from sales of property, plant and equipment	148	-	-
Net cash flows from / (used in) investing activities	(35,944)	(25,331)	(15,940)
Public dividend capital received	26,610	-	-
Capital element of finance lease rental payments	-	(550)	(542)
Interest paid	(1)	-	-
Interest element of finance lease	-	(28)	(29)
PDC dividend (paid)/refunded	(6,418)	-	-
Net cash flows from / (used in) financing activities	20,191	(578)	(571)
Increase / (decrease) in cash and cash equivalents	**34,255**	**(30,354)**	**(21,111)**
Cash and cash equivalents at 1 April - brought forward	54,042	88,297	88,297
Cash and cash equivalents at period end	**88,297**	**57,943**	**67,186**

Note 1: Cash held at 30 Jun was £67.2m against a plan of £57.9m.

Note 2: Principle reasons for the cash variance to plan of £9.2m are:

- An increase in NHS deferred income associated with quarter 1 payments from Health Education England income and also block payments made by NHS England.
- The backlog of trade payables associated with the ledger implementation not being reduced as anticipated.

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

- The continued block payment regime
- The remaining backlog associated with the implementation of the new finance system.
- Receipt in March 21 of £7.1m to cover future outgoings associated with accrued annual leave.
- Increased levels of capital creditors.
- Increased levels of provisions to offset risks associated with current litigation and contractual obligations.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 July 2022*
Item Number	*Item number allocated by admin*
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	*Separate risk reports to lead committees*

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

Risk Assessment	*Not Applicable*
Financial Impact Assessment	*Not Applicable*
Quality Impact Assessment	*Not Applicable*
Equality Impact Assessment	*Not Applicable*
Assurance Level Assessment	*Significant, with some improvement required (based on Internal Audit Report – March 2022)*

Recommendations/ Decision Required	*The Trust Board is invited to review the content of the report.*

Executive Summary

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

There are 9 quality and safety risks currently rated Very high (20), which cover:

- Delays to planned care pathways for admitted, non-admitted and cancer patients
- Delays to handover from ambulances to A&E
- Potential serious harm from patent falls
- Provision of echocardiograms
- Learning from patient safety events
- Use of hard copy documents for patient records and medication details

There are also 8 quality and safety risks with a current rating of High (15-16).

There are 3 Very high workforce risks (scoring 20-25) at present:

- Recruitment and retention of registered nurses
- Recruitment and retention of consultants and middle grade doctors
- Low morale amongst the workforce

There are also 3 workforce risks with a current rating of High (15-16).

A complete review and refresh of the People and OD directorate risk register has been undertaken and an initial draft was presented for discussion at the Risk Register Confirm & Challenge Group (RRC&CG) in May. Due to cancellation of the June People & OD Committee these changes have yet to be approved and updated on the risk register.

There are 2 active finance, performance and estates risks that are rated Very high (20-25) at present (all have been increased in rating since last month):

- Cost of reliance upon temporary clinical staff
- Potential for a major fire safety incident

There are also 3 finance, performance & estates 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 Leadership Team (TLT) 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 248 active risks currently recorded on the Trust risk register. There are 12 risks with a current rating of Very high (20-25) and 13 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)
3 (1%)	**40** (16%)	**175** (70%)	**17** (7%)	**14** (6%)

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

2.3 There are currently 7 Very high risks and 5 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	22/06/22
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	22/06/22
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	22/06/22
4803	If there are substantial delays to patient handovers from ambulances then it could lead to patients being treated in an area that is not appropriate for patient care, resulting in failure to meet the national standard for ambulance handovers which impacts on the wider system and may lead to regulatory action, also potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	- Early intelligence of increasing EMAS demand to allow for planning and preparedness to receive and escalate. - Contact points throughout the day and night with the Clinical Site Manager and Tactical Lead (in and out of hours) to appreciate EMAS on scene (active calls) and calls waiting by district and potential conveyance by site.	23/03/22
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	13/06/22

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	25/05/2022
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.	13/06/2022

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

2.4 There are currently no Very high risks and 2 High risks to this objective.

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

2.5 There are currently 2 Very high risks and 1 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
4828	If information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a reduced likelihood of a positive clinical outcome and possibly causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust.	21/06/2022
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.	15/06/2022

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

2.6 There are 2 Very high risks and 3 High risks to this objective. A refreshed version of the workforce risk register has been drafted by the People & OD Directorate for presentation to the committee in June, however the meeting was cancelled and an approved new risk register has not yet been added to Datix, therefore a summary of current Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4669	If the Trust is unable to recruit and retain sufficient numbers of registered nurses then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	Very high risk (20)	Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding.	23/05/2022 (included in full refresh of People & OD risk register)
4670	If the Trust is unable to recruit and retain sufficient numbers of consultants & middle grade doctors then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	Very high risk (20)	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	23/05/2022 (included in full refresh of People & OD risk register)

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

2.7 There is 1 Very high risk to this objective, a summary of which is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4667	If issues such as workload; work-life balance; organisational change; and cost reduction; are not managed effectively then it could have a significant negative impact on the morale of a substantial proportion of the workforce, resulting in increased turnover / increased absence / reduced productivity / reduced quality.	Very high risk (20)	Decision taken not to have a separate People Strategy. Will focus on the "People" Strategic Objective in the IIP. This focuses on "modern and progressive workforce" and being the "best place to work". Series of projects and programmes being worked up to deliver agreed outcomes.	23/05/2022 (included in full refresh of People & OD risk register)

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 is currently 1 Very high risk and 1 High risk 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
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)	Statutory Fire Safety Improvement and Capital Investment Programme based upon risk. Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. Planned preventative maintenance programme by Estates	20/06/2022

Strategic objective 3b: Efficient use of our resources
Assurance lead: Finance, Performance & Estates Committee

2.10 There is currently 1 Very high risk and 3 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 2 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 or 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 most significant risks within the Trust at present relate to:

- the recovery of planned care pathways;
- ambulance handover delays;
- the availability of accurate patient information;
- patient harm from falls;
- the provision of echocardiograms;
- the ability to learn lessons from previous patient safety incidents.
- fire safety
- the cost of reliance on temporary clinical staff
- the recruitment of medical and nursing staff; and
- staff morale

3.2 The Trust Board is invited to review the content of the report, no further escalations at this time.

Appendix A - Quality and Safety 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**																			
4879	Physical or psychological harm	Evans, Simon	Rimmer, Lucy		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Cancer Centre		If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	22/06/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	29/07/2022
4877	Physical or psychological harm	Evans, Simon	Carter, Mr Damian		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 (non-admitted / outpatients) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	31/07/2022
4878	Physical or psychological harm	Evans, Simon	Carter, Mr Damian		28/03/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU		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	22/06/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	21/07/2022
4803	Physical or psychological harm	Evans, Simon	Skinner, Maxine	Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there are substantial delays to patient handovers from ambulances then it could lead to patients being treated in an area that is not appropriate for patient care, resulting in failure to meet the national standard for ambulance handovers which impacts on the wider system and may lead to regulatory action, also potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	ULHT policy & procedure: - All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager and the in hours Tactical Lead to secure a resolution and plans to resolve are fed back to the DOM. - Out of hours, the responsibility lies with the Tactical On Call Manager. - Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting. - Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond. - The rapid handover protocol has now been revisited and agreed. Designated escalation areas are being identified/confirmed to assist in reducing delays in handover.	- Ambulance handover times: increase of >2hrs in January 2022 (261 in January vs 238 in December) and decrease in >4hr delays (35 in January compared to 39 in December) - Clinical harm reviews / incidents linked to ambulance handover delays: 3 serious harm incidents reported this quarter (under investigation)	23/03/2022	Extremely likely	High	Very high risk	20	- Early intelligence of increasing EMAS demand to allow for planning and preparedness to receive and escalate. - Contact points throughout the day and night with the Clinical Site Manager and Tactical Lead (in and out of hours) to appreciate EMAS on scene (active calls) and calls waiting by district and potential conveyance by site.	January saw formal requests from EMAS to enact the rapid handover protocol. Risk discussed at Risk Register Confirm & Challenge Group 23 March 2022, current rating increased from 16 to 20.	Low risk	30/09/2022	30/06/2022	30/04/2022

Appendix A - Quality and Safety 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
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	13/06/2022	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.	Initial business case for a dedicated falls team resource to be presented to CRIG in June 2022. 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. Falls Prevention Steering Group time out session planned 23/06/22 which will provide an opportunity to review the work programme of the group to ensure all the of the right questions are being asked and the right areas of focus are being looked at effectively.	Low risk	31/12/2021	31/03/2023	31/07/2022
4789	Physical or psychological harm	Evans, Simon	Ratcliff, Carl	Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, 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	25/05/2022	Extremely likely	High	Very high risk	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	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.	Low risk	31/03/2022	31/03/2023	30/06/2022
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 patient safety incidents occur, so that changes can be made to policies and procedures, there is an increased likelihood of similar incidents occurring in future which could result in serious harm affecting a large number of patients.	National Policy: - NHS National Patient Safety Strategy - NHS National Reporting and Learning System (NRLS) ULHT Policy: - Analysing and Learning from Patient Safety Incidents, Complaints, Claims and Coroners Inquests Policy (approved April 2019, due for review April 2022) ULHT governance: - Trust Board assurance through Quality Governance Committee (QGC) and sub-groups"	- Recurring themes in patient safety incidents, complaints, PALS & claims (e.g. patient falls SIs; pressure ulcer incidents; DKA incidents) - Recurring themes in audits / reviews of risk / incident / complaints / claims management"	13/06/2022	Extremely likely	High	Very high risk	20	- Establishment of Patient Safety Improvement Team - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previoulsy called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ - Prepare for implementation of new Patient safety Incident Response Framework (PSIRF) in 2022 (replacement for Serious Incident Framework)	- Patient Safety Improvement Team now established within Clinical Governance - Datix CloudIQ has been approved for connection to the new national learning system - Case of need for Datix CloudIQ approved in principle; implementation to be planned Directorate review (May 2022) - agreed that this would remain Very high (20) subject to learning lessons work being completed and evidence that repeated incidents are reducing	Low risk	31/01/2019	31/03/2023	30/07/2022

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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
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	05/07/2022	Quite likely	High	High risk	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB scheduled from Feb / Mar 22. Risk discussed at Risk Register Confirm & Challenge Group on 23 March 2022. Still inconsistencies with timeliness against BTC standards, particularly at Lincoln, and inability to ring-fence beds. Agreed that risk remains high but has reduced. Recommendation for rating to change from 20 to 16.	Low risk	30/09/2022	30/09/2022	28/09/2022
4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors.	1. IV medicines ready to use (pre-prepared in clinical area) kept for 24 hours. 2. To minimise the risk of microbiological contamination and minimise the risk of infection, administration of injections and infusion prepared in a clinical area should be performed immediately after preparation and ideally within 30 minutes of preparation. 3. To minimise the risk of wrong dose/drug/patient errors, the identity of all injectable medicines must be assured. If the preparation (syringe or IV bag) leaves the hands of the person who prepared it and/or the entire injection or infusion process is not under the direct supervision of that person, the syringe or IV bag must be labelled. Infusion Labels must include as a minimum: - the name & dose or strength of the drug and diluent (including units of measurement) - the date and time of preparation - the name of the person who prepared it. Bolus Labels must include as a minimum: - the name & dose of the drug.	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	15/06/2022	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	Low risk	30/09/2022	30/09/2022	14/07/2022
4779	Physical or psychological harm	Evans, Simon	Ratcliff, Carl	Clinical Effectiveness Group	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	29/04/2022	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.	Low risk	31/03/2022	30/06/2022	30/05/2022
4790	Service disruption	Evans, Simon	Spendlove, Mrs Clare	Patient Safety Group	16/01/2022	15	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		Major risk to service delivery (cardiology diagnostic tests and reports) due to current system no longer being supported. Supplier only able to support on best endeavours basis. Frequent loss of service resulting in adverse impact on service provision. Urgent replacement of system required	Best endeavours agreement in place with supplier procurement process to be undertaken for replacement system	volume of system failures/ability to reinstate	29/07/2022	Quite likely	High	High risk	16	new system procurement to be expedited	System procurement completed .Implementation plan in place. Risk to be re-assessed once new system has been implemented. Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Agreed that the current level of risk is High and acceptable risk is Low (not Moderate).	Low risk	31/12/2022	31/12/2022	31/08/2022

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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
4935	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha	Patient Safety Group	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.	06/06/2022	Quite likely	High	High risk	16	Recruit to vacant posts.	Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review	Low risk	31/10/2022		30/06/2022
Strategic Objective						**1b. Improve patient experience**																			
4701	Reputation	Grooby, Mrs Libby	Upjohn, Emma		13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	13/04/2022	Reasonably likely	Extreme	High risk	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15	Low risk	31/03/2025	31/03/2025	30/09/2022
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, then once COVID funding ends it will leave 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.	22/03/2022	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.	Low risk	30/11/2021	31/03/2023	30/06/2022
Strategic Objective						**1c. Improve clinical outcomes**																			
4731	Physical or psychological harm	Evans, Simon	Parkin, Mr Lee	Medical Records Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	21/06/2022	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	Low risk	30/06/2018	31/03/2023	21/07/2022
4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	If information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	15/06/2022	Extremely likely	High	Very high risk	20	Planned introduction of an auditable electronic prescribing system across the Trust.	Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. 17/5/22 No change	Low risk	31/03/2022	30/09/2022	13/09/2022

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4905	Physical or psychological harm	Cooper, Mrs Anita	Bradley, Mrs Lesley		22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	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.	28/04/2022	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.		Moderate risk	30/06/2023		30/06/2022
Strategic Objective						**2a. A modern and progressive workforce**																			
4669	Service disruption	Paul Matthew	Karen Taylor	Workforce Strategy Group	12/01/2022	25	Workforce Metrics	Corporate	People and Organisational Development	Operational HR	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of registered nurses then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	ULHT policy: - Nursing workforce planning processes - Nursing recruitment framework & associated policies, training & guidance - Nursing rota management systems & processes - Nurse Bank & agency temporary staffing arrangements - Workforce management information ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Nursing vacancies & turnover rate. Nursing staff survey results relating to job satisfaction / retention.	23/05/2022	Quite likely	Extreme	Very high risk	20	Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding.	Workforce supply is a workstream in the Integrated Improvement Plan reflecting the priority within the NHS National People Plan. Programmes have been delayed by COVID. However vacancy rates have reduced over the last three months. The Director of Nursing has initiated a Nurse Transformation Programme to look at demand and supply issues around nursing.	Moderate risk	31/03/2022	31/01/2023	31/03/2022
4670	Service disruption	Paul Matthew	Karen Taylor	Workforce Strategy Group	12/01/2022	25	Workforce Metrics	Corporate	People and Organisational Development	Operational HR	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of consultants & middle grade doctors then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	ULHT policy: - Medical workforce planning processes - Medical recruitment framework & associated policies, training & guidance - Medical rota management systems & processes - Medical staff locum temporary staffing arrangements - Workforce management information ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Medical staff vacancies & turnover rate. Medical staff survey results relating to job satisfaction / retention.	23/05/2022	Quite likely	Extreme	Very high risk	20	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	Plan for every medical post in place. Pre-COVID was strong pipeline for medical recruitment. Focus of IIP. We are restoring recruitment processes and using Teams to run AAC panels. Vacancy rate for medical staff reducing.	Moderate risk	31/03/2022	31/03/2023	31/03/2022
4671	Service disruption	Paul Matthew	Claire Low	Workforce Strategy Group	12/01/2022	16	Workforce Metrics	Corporate	People and Organisational Development	Operational HR	Trust-wide	If a substantial proportion of the Trust's workforce tests positive for Covid-19, or are required to self-isolate in accordance with government guidelines, then it may not be possible to maintain some services resulting in significant short-term disruption affecting the care of a large number of patients	National policy: - Government policy / guidelines on Covid testing and isolation ULHT policy: - Working Safely - Covid-19 Policy (Health & Safety Policy), approved July 2021 - Temporary staffing processes (bank / agency / locum) - Emergency planning processes and workforce contingency arrangements for Major, Critical and Business Continuity Incidents ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group; Health & Safety Group - Operational workforce governance arrangements	Frequency of workforce-related Major / Critical / Business Continuity incidents. Staff absence rates (Covid-related). Temporary staff usage rates.	23/05/2022	Quite likely	High	High risk	16	Occupational Health staff health checks & testing regime; Health and well-being offer to staff; Implementation of new Absence Management System (Empactis); use of bank / agency staff to fill rota vacancies; & operational command structure for Covid response.	Re-launch of staff health and well-being offer. Empactis launched with corporate staff in August and rolled out through to February 2020. Sick leave cover due to Covid is currently one of the top 4 reasons for use of temporary staff.	Moderate risk	31/03/2022	31/03/2023	31/03/2022
4741	Service disruption	Colin Farquharson	Aurora A Sanz Torres	Patient Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung Clinical oncology - head and neck, skin, upper GI (RT only)	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements	Monitoring tumour site performance data	22/06/2022	Quite likely	High	High risk	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements.	Low risk	31/03/2022	30/09/2022	31/03/2022

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4780	Service disruption	Simon Evans	Anita Parmar	Workforce Strategy Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Risk of not being able to maintain effective stroke provision across ULHT due to the significant deficit in stroke consultant staffing and nurse staffing. 1 in 4 consultant on-call rota is unsustainable with current staffing levels. Stroke risk summit undertaken 2019. Designated TRUST FRAGILE SERVICE	Ongoing recruitment activity to attract perm and locum resources. No success with overseas or local tertiary centre recruitment Temporary Service change during COVID has consolidated to a single site hyper-acute service- approved by Executives in December 2019 Protocol in place for access to Thrombolysis Trolley on each site. Acute Care Practitioners (ACP's) appointed and undergoing Masters Level Education and Training currently. Integrated into Cardiology ACP Workforce to ensure supported management & education. Business case being developed to secure funding for ACP workforce	monthly service review in place primarily assessed on rota gaps / ability to maintian services across both sites	25/05/2022	Quite likely	High	High risk	16	Monthly review of provision in place ongoing recruitment campaigns for vacancies expansion of ACP workforce (business case beig developed) to increase medical capacity to support consultant workforce	ongoing deficit in Stroke Consultant staffing. Recruitment to substantive posts unsuccessful. Only 2 substantive consultants out of 6 in post. National Market shortage .Increased reliance on agency locums with significant financial impact Increased pressure on current workforce as service demands have not reduced ASR consultation adding pressure due to lack of uncertainty on outcome. Increase in staff turnover due to service instability daily ward round commitments amended to every other day to create capacity	Moderate risk	31/03/2022	30/09/2022	31/03/2022
Strategic Objective						**2b. Making ULHT the best place to work**																			
4667	Service disruption	Paul Matthew	Claire Low		11/01/2022	25	Risk assessments	Corporate	People and Organisational Development	Operational HR	Trust-wide	If issues such as workload; work-life balance; organisational change; and cost reduction; are not managed effectively then it could have a significant negative impact on the morale of a substantial proportion of the workforce, resulting in increased turnover / increased absence / reduced productivity / reduced quality.	Staff Charter & Personal Responsibility Framework Staff engagement strategies & plans. Internal communications platforms (intranet; bulletins; forums). Staff survey process and response planning. People management & appraisal policies, processes, systems (e.g. ESR) training & monitoring. Core learning programmes. Leadership development and succession planning processes. Management of change policies, guidelines, support and training. Partnership agreement with staff side representatives. Occupational health & wellbeing arrangements for staff.	Staff survey results. Staff 'pulse check' results. Staff absence rates. Staff turnover rates. Complaints received regarding staff attitude / behaviour.	23/05/2022	Quite likely	Extreme	Very high risk	20	Focus on the "People" Strategic Objective in the IIP. This focuses on "modern and progressive workforce" and being the "best place to work". Series of projects and programmes being worked up to deliver agreed outcomes.	Some improvement in the results of the staff survey. Still below average for acute trusts. Less than 50% of staff would recommend ULHT as a place to work. Considerable work still to be done on morale, but this is the thrust of the Integrated Improvement Plan and a number of workstreams within it. Progress on projects delayed owing to COVID, but as part of managing the incident we have introduced new approaches to interacting with staff and feedback has been positive.	Low risk	31/03/2022	31/03/2022	31/03/2022
Strategic Objective						**3a. A modern, clean and fit for purpose environment**																			
4648	Physical or psychological harm	Evans, Simon	Davey, Keiron	Fire Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	20/06/2022	Quite likely	Extreme	Very high risk	20	- Statutory Fire Safety Improvement Programme based upon risk. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Capital investment programme for Fire Safety being implemented on the basis of risk. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	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.	Moderate risk	31/03/2022	31/12/2022	31/07/2022
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
Strategic Objective						**3b. 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.	Moderate risk	31/03/2022	31/03/2023	31/03/2022
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.	Low risk	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.	Moderate risk	31/03/2023	31/03/2023	30/09/2022

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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.	Moderate risk	31/03/2023	31/03/2023	31/12/2021
Strategic Objective						**3c. Enhanced data and digital capability**																			
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.	Low risk	31/03/2023	31/03/2023	18/08/2022
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the required data protection / privacy impact assessment process is not followed consistently at the start of a system change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	National policy: - Data Protection Act 2018 - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy (approved May 2018, due for review May 2021) & supporting appendices ULHT governance: - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group - Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles	Internal audit review of data protection / PIA processes	24/03/2022	Quite likely	High	High risk	16	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process.	Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues. Reference to DPIAs in Data Security and Awareness mandatory training. Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required. Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data.	Low risk	31/03/2022	31/01/2023	30/06/2022

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 August 2022*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2022/23	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure* • *Confirm the proposed RED rating of objective 3b – efficient use of resources* • *Confirm the proposed GREEN 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 June and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives with the exception of the new 2022/23 objectives 3d, 3e and 3f. Assurance ratings provided have been confirmed by the Committees.

Following a request for a detailed review of the BAF by the Committees this had been undertaken with the updates offered to the Board in green text, as received by the Committees.

The Board are asked to note that further review of objectives 3d, 3e and 3f will be finalised and presented to the Finance, Performance and Estates Committee in August and upwardly presented to the Board in September.

Red text has been presented in the Board Assurance Framework to demonstrate items proposed for removal, which no longer feature as a project/priority within the year 3 IIP. Through the detailed review process the changes will be confirmed.

The following assurance ratings have been identified:

Objective		Rating at start of 2022/23	Previous month (June)	Assurance Rating (July)
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**	**Red**	**Red**
2b	Making ULHT the best place to work	**Red**	**Red**	**Red**
2c	Well led services	**Amber**	**Amber**	**Amber**
3a	A modern, clean and fit for purpose environment	**Amber**	**Amber**	**Amber**

3b	Efficient use of resources	**Amber**	**Amber**	**Red**
3c	Enhanced data and digital capability	**Amber**	**Amber**	**Amber**
3d	Improving cancer services access			
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards			
3f	Urgent Care			
4a	Establish new evidence based models of care	**Amber**	**Amber**	**Amber**
4b	To become a University Hospitals Teaching Trust	**Red**	**Red**	**Red**
4c	Successful delivery of the Acute Services Review and Recovery Support plans			**Green**

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2022/23 - July 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.	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.	Other divisions due to commence upward reporting to PSG from July 2022.	Where possible, safety conversations have been taking place with staff.		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	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		

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						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.		

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1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG. 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	Local data sources are used where possible. Gaps in learning mitigated by ME process and escalation of concerns via incident management processes.	Quality Governance Committee	**Green**
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG)	Clinical harm review processes not all documented & aligned with incident reporting Recognition of a skills gap for investigations at different levels of the organisation	Implementation of a Clinical Harm Delivery Group reporting into the Clinical Harm Oversight Group which is a sub-group of QGC. Appointment of a Clinical Harm and Mortality Manager Investigation training will be addressed as part of the implementation of the PSIRF and National Patient Safety Strategy. Plan to refocus PRM with a specific focus on quality and safety.	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports Strong divisional reporting to MORALs	Divisional reporting to PSG has commenced although this is not yet embedded.	Divisions present focussed pieces of work to PSG on issues that arise based on the data received. There is strong Divisional representation at PSG each month.		
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust although progress is now being made within all four Divisions. Operational pressures continues to impact on delivery.	Individual Divisional meetings now in place; quarterly reporting to PSG Additional support provided to medicine from the Patient Safety Improvement Team	Audit of compliance	Audit of compliance not currently in place - under development at present.	Review will occur through the Divisional meetings with quarterly reporting to PSG. Links now in place with the Clinical Audit team to progress.		
						Medicines Quality Group in place with a focus on reducing medication errors Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit 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		

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						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. MNOG will retain oversight of the implemention 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.		
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA (Ensuring early detection and treatment of deteriorating patients) (PSG)	Number of incidents occurring regarding lack of recognition of the deteriorating patient Maturity of some of the sub-groups of DPG not yet realised Observation policy has now been reviewed and is out for approval.	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	Identified at PSG that further work is required to breakdown incident categories pertaining to the deteriorating patient.	Deep dive commissioned at PSG for presentation to the April meeting.		
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	New funding needed to continue restraint training delivery. Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months. Further work has taken place with LPFT to consider a joint approach to training - awaiting options paper from LPFT	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting from Mental Health/ Learning Disability and Autism Oversight Group	No active Restraint training available within the trust	Small business case paper being submitted for funding decision at the end of March 2022 - if successful plan to start training delivering in July 2022. Adhoc session being delivered to Security providers to ensure appropriately trained Datix being monitored by safeguarding team to ensure review of any restraint incidents		

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						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG)	Gap in current policy identified meaning that not all responses from divisions are received / recorded. Improvement demonstrated in the number of overdue alerts	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads(CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				
						Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity Meeting stood down due to operational pressures. The group meets monthly, has developed a work reporting plan Papers reviewed and Chair's report provided. Any risks to quality and safety are discussed at the relevant cell meeting, e.g., quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.		Upward reports to QGC monthly and responds to feedback Review of ToR in July 2021. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Divisional assurance reports to PEG providing limited assurance; further work needed to improve this. Will be monitored through PEG.	Head of Pt Experience revising divisional assurance report template and have discussions with divisional clinical leads re: requirements for the reports. Template approved through PEG Nov 21		

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience & Carer plan 2019-2023 (PEG)	Number of objectives in the plan paused due to Covid Pandemic; this means the plan need a full review.	Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level. Patient & Carers Experience Plan to be reviewed by end Sept 21 and present to Oct PEG	Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports.	Limited assurance until the plan is reviewed.	Plan is being reviewed with a draft final date of end of January 22.	Quality Governance Committee	**Amber**
						Quality Accreditation and assurance programme which includes section on patient experience. (PEG)	Lack of alignment of findings in accreditation data to patient experience plans. Ward / Dept review visits paused due to operational pressures	Head of pt experience to have access to accreditation data. Deep dives into areas of concern as identified in quality meetings and accreditation reports. Update reports to PEG and QGC as required. Matrons audits continue to take place. Any risks to quality and safety identified are discussed at the quality cell and issues escalated to gold as appropriate.	Reports to PEG and upwardly to QGC	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support.		
						Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging Sensory Loss group upwardly reports to Patient Panel.	Upward reports and minutes to the Patient Experience Group IIP reporting to Support & Challenge group.	Diversity of patient engagement and involvement.	CCG exploring dev of a Health Inequalities cell to combine efforts in reaching out. Date not yet secured. ULHT Experts by Experience project progressing with Mastalgia Expert ref group (ERG)established, Cancer Board recruiting 2022 discussions continue with Gastro & CYP (Expert Families).		
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Inconsistency in applying end of life visiting exceptions.	Exceptions guidance re-issued. Monitor through complaints & PALs.	Report to PEG through complaints & PALs reports; upward reports from Visiting Review working group. Visiting experience section within complaints & PALs reports.		Complaints/PALs reports to include visiting concerns; div ass reports to include visiting related issues. Visiting review indicates inconsistency in EoL visiting; criteria and process being strengthened. Request to ME's to ask relatives about visiting experience at EoL.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports not being received by PEG	Head of Pt Experience to discuss with EDI lead to agree a way forward. Head of Pt Experience & EDI lead meeting to agree a way forward. Links to Reaching Out IIP project.		

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						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 including the embedding of the SAFER bundle.							
1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust.	Issued identified with ensuring appropriate clinical engagement at the meetings.	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.	Divisional reports still in their infancy.	Verbal updates provided by divisional representatives at the group.	Quality Governance Committee	**Green**
						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.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Current reporting has tended to focus on process rather than improved outcomes.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (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.		
						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		

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						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 during COVID-19	National reports to be presented at Governance Meetings once produced		
						Process in place for implementing requirements of the CQUIN scheme.	Plans not fully formed for implementation of 2022/23 CQUINs	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		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidnce of newsletters shared is available.				
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)	Awaiting sign off of system people plan (delivery plan reviewed and objectives agreed annually in Q4)	System People Team System Workforce Cell	System PP - Each 'pillar assigned system lead Progress/assurance reported to People Board (quarterly) Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan Setting priorities 22-23 - away day (18/03)		Presentation of system progression and oversight being delivered to PODC on 15th March 2022. A day planning session has been held for the 22/23 priorities which are being presented at the next People Board for signoff in April 2022. The proposals and objectives for 22/23 were approved by People Board in April and a further time out is planned with the system leads to agree next steps/KPI's etc. A further time out was held with agreement made on top 3 priorities and how the delivery against these will be measured.		
						Workforce planning and workforce plans	Overall vacancy rate declining but increasing for clinical roles.	IIP Project - Embed robust workforce planning and development of new roles	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division.	Some areas remain hard to fill and therefore difficult to fully mitigate risk. Challenges in obtaining meaningful information from Trac, due to Recruitment team capacity issues.	Regular reviews take place with Divisions through workforce analyses and a plan for every post; alternatives and workforce mix are considered and where national workforce shortages identified then focus is on overseas recruitment. Current workforce planning being undertaken in conjunction with our SHRBP and finance colleagues. Draft narrative have been prepared to support the workforce requirements for the Trust, further work is required to align to activity demand and capacity before the final submission date. We continue to work closely with Strategy & Planning team and discussions with services, via service leads and Managing Directors. Working towards triangulation between workforce, finance and activity and weekly technical meetings have been established to bring teams together to interrogate		

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											teams together to interrogate the data. Deep dive into plan for every position with the Divisions, particularly for medical recruitment, which will be built into the plan. First draft to be prepared for Tuesday 7th June, for a 13th June submission. The workforce plan was submitted as per the above deadline and work now begins in terms of how we as a Trust measure the deliverables set against the plan with HR/Finance and Planning.		
						Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up Performance Dashboard developed offering accurate and timely information to all appropriate managers and staff		Recruitment deep dive continues with the support of the new Head of Recruitment. Additional resource has also been brought into the recruitment team with NLAG providing additional training support. Support is being received from NHSI/E and additional capacity has now been recruited to support the cohort recruitment of HCSW. A review of the process around how we recruit consultants to the Trust has also commenced. Additional training has been provided for the Recruitment team from NLAG and training from TRAC is due to take place in April. Additional training has been completed by the Recruitment team with support from NLAG. Work continues to 'relaunch' recruitment processes with a dedicated recruitment calendar of activity being produced alongside the launch of new recruitment standards and processes to improve the employment journey with a new recruitment landing page currently being created.		
			Vacancy rates rises Turnover increases										

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2a	A modern and progressive workforce	Director of People and Organisational Development	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 intergration 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 Appraisal - deep dive - Dec21 Mandatory training - currently in scope for reset Talent management - on hold	Regional Midlands Talent Board Model Employer ambition appraisal/mandatory training compliance	Appraisal and training compliance levels not at expected level		People and Organisational Development Committee	**Red**

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						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff - To be discussed following review of development offer (on hold)					
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	The reports are run daily and any abnormalities are considered in the context of the national and regional position. The pandemic and the critical incidents the Trust is in has impacted on usual trends. AMS data is reviewed regularly and reported into Divisions on accuracy. Data currently for absence is inline with national reporting. AMS Project is being relaunched with a training roll-out plan and SHRBP support. The AMS project has been relaunched and additional capacity identified. Training has started to be rolled out with divisions and a position paper is currently being prepared. Reporting will start to feature as part of the Workforce Cell meetings and monthly one to ones with key HR staff. Work continues 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.		
						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)				

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						Creation of robust Workforce Plan • Values based recruitment and retention • Maximising talent management opportunities • Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn'			Improved vacancy rates				
						Improve the consistency and quality of leadership through:- • Improved mandatory training compliance • Improved appraisals rates using the WorkPal system • Developing clear communication mechanisms within teams and departments			Appraisal rates and training development				
						Providing a stable and sustainable workforce by:- • Ensuring we have the right roles in the right place through strong workforce planning • Reducing vacancy rates and ensuring that posts are filled through a positive and values recruitment approach • Reducing our agency staffing levels/spend • Strengthening the Medical Workforce Job Planning processes							
						NHS People Plan & System People Plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future	Awaiting sign off of system people plan Delivery of IIP projects in early stage of delivery	People Plan - in draft System EDI Strategy underway 5 pillar -leads confirmed (ULHT Lead for leadership and lifelong learning)			Linked to delivery of the system People Plan agenda as above.		
						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 Programme Group upward report	Delivery of agreed output	Improved function of group and reporting to be in place for November report		

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand 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	Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work			People and Organisational Development Committee	**Red**
						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	Pulse surveys - " Have your say" Number of staff attending leadership courses		Proposal to be shared with ELT (Dec'21): gradual introduction of L&M activities NB. L&M apprenticeship on going		
						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	WRES/ WDES	WRES action plan WDES action plan 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 enrole. Work continues for the creation of a dedicated intranet website and members page.		
						Staff networks	Some staff networks stronger than others	Continued work to embed the networks and provide them with effective support Following recruitment of new SN Chairs - agree Universal Terms of Reference Support groups in developing strategic objectives for the next 12 months	Protect our staff from bullying, violence and harassment - measure through National Staff Survey		Governance for EDI Recruitment process for SN Chair/VC - Feb'22		

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						Demonstrate that we care and are concerned about staff health and wellbeing		EAP implementation from May'22	System Health & Wellbeing Board Linc People Board	OH KPIS to be agreed (for reporting to PODC) System Hub activity Wellbeing activity (upward report to PODC)	Commence reporting from 2022		
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian		Junior doctor forum	Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee		Junior Dr Survey results (alignment with NNSS21 findings)		
						Embed a compassionate leadership approach through our Culture & Leadership Programme			Improved Pulse survey results				
2c	Well led services	Chief Executive	Current risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes 4 sessions during Oct / Nov 21 Risk Register Confirm and Challenge Group ToRs Upgrade to datix system Full Risk Register review	Updated Policy and Strategy document for approval at December 21 Risk Register Confirm and Challenge meeting - Meeting Cancelled Covid pressures	Consider at January meeting	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**
						Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6			

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						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy management reviewed and updated	Move of policies in to SharePoint reliant on progress with Trust intranet. Timeline delayed through Covid Review of Divisional policy status reports not progressed due to covid pressures	Review of document management processes New document management system - SharePoint Reports generated form existing system All policies aligned to division and directorates Single process for all polices clinical and corporate	Fortnightly ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
						Ensure system alignment with improvement activity							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Interim case for £9.6M of CIR continues in to 2021/22. Will reflect priority areas in the Estates Strategy Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy.	Infrastructure case has tackled £9.6M of the overall £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP Delivery of 2021/22 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance.	Finance, Performance and Estates Committee	**Amber**
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response.		
						Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID		MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating. 6 facet survey review commencing in Jan 22. Specification drafted for full 6 facet survey with tender process to start in Jan 22	IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not. The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill. Review of 6 Facet Surveys will commence as part of HIP Bid (Referral in Estates Strategy)		

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						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report				
						Implement Year 1 of our Estates Strategy							
			Not identifying and then delivering the required £29m CIP of schemes The Trust is overly reliant upon a large number of temporary	4382 (CIP) - Risk rating 16		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.		
						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		

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3b	Efficient use of our resources	Director of Finance and Digital	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	rating 16 4383 (Reliance on agency) - Risk rating 20 TBC (Inflation impact) - Risk rating 6 4384 (ERF Clawback) - Risk rating 16 TBC (COVID costs) - Risk rating 16	CQC Well Led CQC Use of Resources	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	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans. Rotal 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	Finance, Performance and Estates Committee	Red
						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%.	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.	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.	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		
						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. 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.	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.		

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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	Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal		EMAS, GPs, mental health, community, social care and care homes data now also available within the Care Portal.	Finance, Performance and Estates Committee	**Amber**
						Commence implementation of the electronic health record Development and approval of OBC		Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of OBC		EPR OBC to be approved by NHSE/I OBC requirements being worked through with NHSE/I		
						Undertake review of business intelligence platform to better support decision making			Delivering improved information and reports Implement a refreshed IPR	IPR refresh for 22/23. Completed for Jan 2022	Steady implementation of PowerBI through specific bespoke dashboards and requests.		
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues						
						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.		

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3d	Improving cancer services access	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Cancer Care	Recovery post COVID and risk of further waves Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Cancer Improvement Board	Percentage of patients waiting 52 weeks or more 28 Day Faster Diagnostics			Finance, Performance and Estates Committee	
						Recovery Support Plans							
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Planned Care	Recovery post COVID and risk of further waves Specialty strategies not in place 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	Percentage of patients waiting 52 weeks or more 28 Day Faster Diagnostics		Reporting via FPEC/Improvement Steering Group (ISG) which commences on 20/06/22. Programme Manager recruited and due to start in June 2022.	Finance, Performance and Estates Committee	
						Recovery Support Plans			Delivery against 62 day combined standard Urgent Treatment (P2) turnaround time Deliver outpatient activity non face to face		Reporting via FPEC/Improvement Steering Group (ISG) which commences on 20/06/22. Programme Manager recruited and due to start in June 2022.		
						Pre op Assessment Modernisation	Engagement exercise required to seek further views regarding the proposed revised model	Pre assessment project group	IIP report to FPEC - monthly				
3f	Urgent Care	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Urgent Care	Recovery post COVID and risk of further waves Specialty strategies not in place	Urgent and Emergency Care Board.	Improvement against strategic metrics % of patients in Emergency Department >12 hrs (Total Time)		Reporting via FPEC/Improvement Steering Group (ISG) which commences on 20/06/22. Programme Manager recruited and due to start in June 2022.	Finance, Performance and Estates Committee	
						Recovery Support Plans							

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SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and 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	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.	Finance, Performance and Estates Committee	**Amber**
						Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans.	Engagement exercise required to seek further views regarding the proposed revised model	CYP Group re-established	Board report July 2021				
						Urology Transformational change programme - complete reconfiguration is complete and new models of care implemented but financial benefits outstanding	CIP Benefit is not fully realised	CIP progress being managed within BAU within the Surgical Division	Board report July 2021	CIP Benefits realisation	Being reported through Surgery FPAM and FPEC		
						Support Creation of ICS - Lincolnshire designation July 2022	Delay to review and adoption of legislation Clarity of roles and responsibilities as part of the ICS	Weekly ICS meetings Provider Collaborative Steering Group	SLB reports and upward reports by CEO / Chair	Impact of ICS and our role within it	key role as part of the provider collaborative steering group. Active stakeholder management of key roles.		
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress	Disruption due to COVID has resulted in a less mature approach to strategy deployment, broad understanding across the organisation, progress on building capacity and capability.	ELT/TLT oversight Board / system reporting	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		
						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	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators 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		

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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	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	People and Organisational Development Committee	Red
						Shared understanding and implications of the UHA guidance and identify realtionship 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 Furher 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 acandemic posts Increase in numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position		
						Improve the training environment for students	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 equipemtnto be able to perform their role. This will be aligned to the UHA Guidance, and will incldue those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unkown timescales of completion	Universtity Teaching Hospital Status working group has been renewed with more drive, ensuring representation from key stakeholders and clear milestones for delivery		
						Developing a joint ressearch 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	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 liase 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	Discussions being held to clearly identify opportunity for movement within guidance and steps being taken for a name change application		

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						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 Scientistis/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 Acadmic 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.		
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, Provide feedback on Public Consultation of ASR and develop implementation plans with clinical divisions	Clinical service strategy and heat map currently being developed 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. Programme management support being identified via Provider Collaborative to help deliver ASR phase 1	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning Publish ULHT clinical service strategy end of 2022/23 Working with Divisions to identify ASR implementation requirements	Finance, Performance and Estates Committee	**Green**
						Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team	Awaiting outcome of themes from consultation	Attendance at Consultation Steering Group by Deputy Director of Strategy and Planning, leading the ASR work on behalf of ULHT	SLB reports and upward reports by CEO / Chair	Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).	Flexible engagement approach from Strategy & Planning Team to allow for detail to be captured around operational demands at times when Divisional Teams are available on an ad hoc basis. This is to ensure delivery of the ask with regards to collation of ASR public consultation feedback.		

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The Trust Board has assigned each strategic objective of the 2021/22 Strategy to a lead assurance Committee. Outcomes under each strategic objective are aligned to a lead Committee or reserved for review by the Trust Board.

The process for routine reviews and update of the BAF is as follows:

- The corporate risk register is maintained by the Lead Executive, in accordance with the Risk Management Policy
- The BAF is updated with any changes to those corporate risks recorded within it; the Trust Board decides which corporate risks are significant enough to warrant inclusion on the BAF, based on recommendations from Committees
- The lead assurance Committee (or Trust Board, where applicable) reviews the management of risks to each required outcome (as part of their regular work programme), through evaluation of reports and risk assessments provided at Committee by Executive Leads
- The lead Committee identifies any gaps in controls or assurance and ensures there are appropriate plans in place to address them
- The lead Committee decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

To facilitate this process, each Committee will receive regular reports from specialist groups, Executive leads and other sources which provide management information and analysis of relevant key risk, to enable the Committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to the Committees should first have been reviewed and approved by the Executive Lead.

When deciding on the assurance rating for each outcome the following key should be used:

Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 August 2022*
Item Number	*Item 13.3*
Audit Committee Upward Report	
Accountable Director	*Sarah Dunnett, Audit Committee Chair*
Presented by	*Sarah Dunnett, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report and the actions being taken by the Audit Committee to provide assurance to the Board on strategic objective 2c.*

Executive Summary

The Audit Committee met via MS Teams on the 11th July 2022. The Committee considered the following items:

External Audit

The Committee noted the successful conclusion of the year end audit, recognising the challenges which would be reflected on when planning commenced for 2022/23.

Internal Audit

The Committee received a progress report from the Trust's Internal Audit providers noting delivery of 11 days against a total of 350 days in the agreed audit plan.

Whilst only a small number of days the Trust Internal Audit Provider confirmed that 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 were presented with proposed KPI's to monitor delivery and quality of the Internal Audit Plan for 2022/23. Feedback was provided and these would be updated and reported on at future meetings in line with best practice.

In reviewing follow up of audit recommendations the Committee noted that there were 36 live actions with 20 overdue, of these 3 high risk, 13 medium risk and 4 low risk. This was a significantly improved position from the last quarter which was recognised by the Committee whilst acknowledging that it needed to continue to emphasise the importance of acting on recommendations. There could be no acceptance that actions would not be progressed. 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.

Counter Fraud

The Committee reviewed and approved the Local Counter Fraud Specialists Progress report.

Action on areas of the Counter Fraud Functional Standard Return that were rated red (1) and amber (2) continued to progress and the Committee noted that an overall green rating had been submitted on 1 June for 2021/22.

The Committee received the Local Counter Fraud Specialist Annual Report 2021/22 which was consistent with the reporting which had been considered by the Committee through the year.

Compliance Report

The Committee received the regular report on compliance noting that this covered the period from April 2022 to June 2022. Oversight of regulatory notices and enforcement actions was noted including the S31 notices and improvement notices.

The Committee noted that the Trust had made the annual Data Security and Protection Toolkit submission in June 2022 with a rating of "approaching standards". The Trust had met all standards with the exception of achieving 95% compliance with Information Governance core training. Actions had been put in place to recover this standard and assurance on delivery would be received through the Finance, Performance and Estates Committee.

The Committee noted update reports in respect of Cyber security and speaking up acknowledging that these areas were considered in greater depth delegated from the Audit Committee at the Finance, Performance and Estates Committee and the People and OD Committee.

Standards of Business Conduct and Declarations of Interest Policy and Comms Plan

The Committee approved the refresh of the policy and noted the plan in place to begin communication and awareness activity in the organisation over the next quarter. Progress would be monitored through the routine compliance reporting.

Risk management and revision of risk register

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 continued fortnightly scrutiny by the Executive Leadership Team and the ongoing review of documentation management and control, along with policy approval processes. Work continued on the alignment and divisional review of documents.

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 rating.

Objective 2c – Well Led Services was the remit of the Audit Committee and the amber rating for the objective was confirmed.

Audit Committee Annual Report

The draft annual report for the Committee for 2021/22 was presented in line with best practice. Comments were noted from Committee members.