Bundle Trust Board Meeting in Public Session 4 October 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 6 September 2022

Chair

Item 5.1 Public Board Minutes September 2022.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log September 2022.docx

6 Chief Executive Horizon Scan Including STP

Chief Executive

Item 6 CEO Trust Board report, 041022.docx

7 Patient/Staff Story

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

7.1 BREAK

8 Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities

8.1 Assurance and Risk Report from the Quality Governance Committee

Item 8.1 QGC Upward report September 2022.doc

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

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

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

9.2 Final Draft / ULHT Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) Action Plan 2022/23

Item 9.2 TB_WRES_OCT22.docx

Item 9.2 TB_WDES_OCT22.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

Item 10.1 FPEC Upward Report September 2022.docx

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

11.1 Nuclear Medicine

Chief Operating Officer

Item 11.1 Nuclear medicine Public Board paper draft 041022 SE.docx

Item 11.1 appendix 1 - Survey results.pdf

Item 11.1 Appendix 2 - QIA Option 1.pdf

Item 11.1 Appendix 2 - QIA Option 2.pdf

Item 11.1 Appendix 3 - Consultation document.docx

12 Integrated Performance Report

Item 12 IPR Trust Board - Front page.docx

Item 12 IPR Trust Board September 2022 v2.docx

13 Risk and Assurance

13.1 Risk Management Report

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

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

13.2 Board Assurance Framework

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

Item 13.2 BAF 2022-2023 27.09.2022.xlsx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 1 November 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 6 September 2022

Via MS Teams Live Stream

Present

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

Non-Voting Members:
Sarah Buik, Associate Non-Executive Director

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mr Paul Dunning, Deputy Medical Director
Ms Julie Record, Matron, Surgery Division
Ms Sarah Addlesee, Associate Director of Nursing

Apologies
Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration
Dr Colin Farquharson, Medical Director
Dr Maria Prior, Healthwatch Representative
Mrs Vicki Wells, Associate Non-Executive Director

1482/22	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. The Trust Board continue to hold meetings open to the public through the use of MS Teams Live 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. The Chair welcomed those members of the public who had joined the meeting virtually along with the new Non-Executive Director members who had joined the Trust Board.
1483/22	The Chair moved to questions from members of the public. **Item 2 Public Questions**
1484/22	**Q1 from Vi King** **Please can I ask what the Trust's plans are to stop patients having to wait and sleep in chair's whilst waiting for a bed at Lincoln.** **I am sure the Trustboard will agree that it's not acceptable that patients are having to sit and even sleep in chairs for many hours.** **Also, what support are you giving the staff who are having to deal with these difficult situations.** The Chief Operating Officer responded:
1485/22	The experience described was not accepted by the Trust or the Board and there were a number of responses to be offered in respect of this which were important and were believed would change the experience.
1486/22	Like many Trusts with busy emergency pathways, experiencing overcrowding and delays in accessing beds and services, the Trust was determined to improve this.
1487/22	The Chief Operating Officer noted that it was recognised even if flow was to be perfect and people admitted and discharged in the time wanted, the departments within the Trust were not big enough. There was currently substantial building work underway at Lincoln to expand the size of the Accident and Emergency department in preparation for winter and to address the size issue.
1488/22	There was a new Accident and Emergency build due to take place at Pilgrim and this was one of the largest ever capital programmes for the Trust. This would physically expand the department.
1489/22	There were also a number of schemes in place, described to an extent, through the Finance, Performance and Estates Committee upward report within the Board papers.
1490/22	Three major pieces of work were being undertaken with the first focusing on reducing the number of people who had to stay in hospital who did not require hospital care. This was being done with system partners in community services, third sector and

	the local authority to increase the amount of care being delivered in people's homes that no longer required hospital care. This would provide space for those requiring care.
1491/22	Secondly the Trust was working to reduce delays to diagnostics and internal delays with work taking place with NHS England specialists and specialist consultants in order to make improvements.
1492/22	Thirdly would be an improvement in the number of people being treated the same day, this was referred to as Same Day Emergency Care. Whilst progress was being made in this regard it was hoped that further progress could be made.
1493/22	The examples offered were just some of the schemes in place to realise improvements.
1494/22	The wellbeing of staff was also taken very seriously by the Trust with wellbeing rounds being undertaken by Executive Directors and a suite of wellbeing offers in place. These ranged from wellbeing contracts with leadership teams and others in the Trust up to professional counselling services should staff wish to access these and felt the need for that level of support.
1495/22	The Chair noted the importance of the question that had been asked hoping that the response had offered the seriousness and range of actions being described to attend to and alleviate the situation described, along with the support in place for staff.
1496/22	**Item 3 Apologies for Absence** Apologies were received from Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration, Dr Colin Farquharson, Medical Director, Dr Maria Prior, Healthwatch Representative, Mrs Vicki Wells, Associate Non-Executive Director.
1497/22	**Item 4 Declarations of Interest** There were no new declarations of interest with the new Non-Executive Directors having made the relevant declarations which would be published on the Trust website.
1498/22	**Item 5.1 Minutes of the meeting held on 2 August 2022 for accuracy** The minutes of the meeting held on 2 August 2022 were agreed as a true and accurate record.
1499/22	**Item 5.2 Matters arising from the previous meeting/action log** 1265/22 – Integrated Performance Report – The Trust Secretary noted that this would be considered in the Private Board Session and would then come forward to the public Board meeting as part of the winter plan.
1500/22	The metrics discussed and scorecard would be brought forward as part of the discussion which would be received to the public Board in October.

1501/22	The Chair was keen that there were a clear set of metrics which would be taken in public session in order to understand the position as the Trust moved through the winter period.
1502/22	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board noting that the first item of the report highlighted the pertinence of the public question raised and also the action log item regarding the issue of system plans for the winter.
1503/22	There was a need to ensure the right capacity and operational resilience was in place with the NHS letter setting out expectations for the coming winter having now been issued. The summary of the letter was offered in the paper including the objectives that had been set along with 6 key metrics identified. The Trust would build a report on progress and performance around the 6 metrics going forward.
1504/22	To support system with the arrangements, a new Board Assurance Framework had been recommended that would, through the Integrated Care Board (ICB) to provide appropriate assurance on whether all parts of the system had the right capacity and resilience in place. This was an important topic and one that the Board would consider monthly.
1505/22	The Chief Executive noted the system outage for the e-financial system noting that the provider had had a cyber issue. This was now back in place and thanks extended to finance colleagues for efforts with business continuity plans and processes in place. The Board noted that the Trust hosted the service on behalf of all providers, although the system was provided by ADVANCE.
1506/22	The Board noted that the stocktake report and review into the operation of the Lincolnshire Health and Care Collaborative (LHCC) had been received and was being worked through. This included recommendations for the Leaders Group as well as LHCC.
1507/22	The Chief Executive noted the cost-of-living pressures and was aware of the implications to both the Trust as a provider but also implications for patients and staff which could be both physical and mental. All parts of the system were working on this.
1508/22	ICB colleagues had been asked to work with NHS England to confirm the revised ratings for providers in the NHS Oversight Framework, known as SOF. This was due to be done on 8 September. The Trust had moved from SOF level 4 to 3, following exit from special measures and it was not anticipated that the ICB would want to change the rating.
1509/22	The Chief Executive offered the Trust overview noting that the month 4 financial position would be offered through the Finance, Performance and Estates Committees assurance report. It was noted that the Trust had work to do in order to recover and stop the continued overspend but then also to recover the position in order to come in on plan at the end of the year with a breakeven position.

1510/22	The Chief Executive noted that the outcome of the nuclear medicine public consultation would be presented to the public Board in October.
1511/22	Covid-19 remained with the Trust and the vaccination season for Covid-19 and flu was about to commence. The Trust was also working on changes in the testing arrangements and further national guidance on mask wearing. This would not change the position of the Trust.
1512/22	Visiting arrangements were being considered with a view to restoring public access to the Trust restaurants over the coming weeks. Alongside this it was also felt to be timely to review, with staff side, the Trust working from home arrangements, this would be done over the coming months.
1513/22	The Chief Executive noted an additional item which had not been appropriate for inclusion within the report noting the Dr Farquharson, Medical Director had offered apologies to the meeting and was unwell so would not be with the Trust for the coming few months.
1514/22	Cover arrangements were being worked through and the Chief Executive was delighted that Mr Dunning, Deputy Medical Director, had been able to join the meeting.
1515/22	The Trust Board wished Dr Farquharson well for both treatment and recovery and would look forward to welcoming him back.
1516/22	Mrs Brown noted the national requirements going into winter and asked if the national teams had identified additional support, both resource and pastoral for teams going in to winter.
1517/22	The Chief Executive noted that through the ICB, as reporting of assurance was at a system level, additional resources had been made available to the system to manage the winter period. Proposals had been put forward by the Lincolnshire system with many of those being about the out of hospital sector so that demand was managed appropriately in the system. This would manage some of the issues discussed in terms of appropriate flow across the system.
1518/22	The Chief Operating Officer noted that in addition, there had been some time spent recently with regional and national colleagues for winter preparedness events that had enabled the Trust to access some extra support such as clinical and non-clinical expertise. This would enable the Trust access to wellbeing strategies for staff that had been tested.
1519/22	The Chair noted as a Board there was a need to be clear how the oversight and assurance function was exercised over the course of the winter and to ensure those elements which the Trust could deliver, along with high quality service aspired to were delivered. Recognising that the Trust was part of a system and system colleagues also needed to support.

1520/22	There would be some complexities, but the Board would need clear oversight during what was anticipated to be a challenging time for the Trust. The Trust Board: • **Received the report and significant assurance provided**
1521/22	**Item 7 Patient Story** The Director of Nursing introduced the patient story relating to a lady called Nicky who was a patient on Ward 1 at Pilgrim Hospital in 2021.
1522/22	Nicky had been very unwell with Covid-19 and with the help and support of the team got a lot better and was able to go home. Initially Nicky had written a letter to the Chief Executive to express how amazed she had been by the teams and the care that had been provided, alongside those in the emergency department. Nicky had been left with some long-term issues and as part of the recovery process wanted to share her story. Nicky was planning to come back into the organisation to visit the teams who had cared for her and also had some great ideas as to how she would like to offer thanks back to the staff.
1523/22	The Board, via the video, watched Nicky's story understanding the impact Covid-19 had had and the care received by the teams in both the emergency department and whilst on Ward 1 at Pilgrim Hospital.
1524/22	The Chair thanked Nicky for sharing her story which was very moving and referenced the comment offered in the MS Teams chat from Professor Baker which stated this was a very moving story, we all owe a debt of graduate to staff who worked on the Covid-19 frontline across the Trust and indeed across the country.
1525/22	The Chief Executive noted that it was nice to be able to put a face to correspondence received and that the story was a timely reminder as Covid-19 had impacted the Trust 2 and a half year ago. It was easy to forget some of the trauma and distress that was around at the time, and for some considerable time.
1526/22	Those who were on site most days saw the reality of Covid-19 and the story offered a moving description of what it was like for individuals who were afraid. It was positive to hear that staff were both living the values of the organisation and deliver the technical elements of the role. There had been a number of new skills that staff had needed to learn however from the story the standout message was the compassion that was shown for people and their loved ones. The compassion shown by staff was testament to the type of people employed by the Trust and the Chief Executive was proud to be associated with them.
1527/22	The Director of Nursing offered thanks to Nicky for offering the story noting that a letter of thanks would be sent. The story demonstrated what the NHS and the Trust was capable of and linked nicely into the accreditation agenda item.
1528/22	It was important to note that Ward 1 was not a ward pre-Covid-19 and the ability to bring a disparate group of staff together in to one area, to deliver the care described,

	was a testament to the individuals in the team and the leadership of the team. This was also seen on the Neustadt-Welton Ward on the Lincoln site.
1529/22	The Director of Nursing noted that what stood out was the little things that had made the difference and how it was understood what this meant for the patients and relatives. From a staff perspective permission was not sought but the right action taken.
1530/22	The Director of Nursing expressed pride for all those involved in the care during Covid-19 and to the staff mentioned in the story. Thanks were offered to Nicky and everyone who had worked throughout the pandemic both within the Trust and the NHS.
1531/22	Dr Gibson noted that most people were hidden away during Covid-19 and noted that staff were not only caring in a compassionate way but also exposed themselves to a high risk. The NHS had been awarded the St George's cross which was an award for courage and compassion demonstrated by those staff.
1532/22	The Chair, as a Trust Board and wider nation owed a great debt of gratitude to the frontline NHS workers who worked tirelessly to do things for people which had been brought alive by the very moving tribute from Nicky.
1533/22	Congratulations were offered to all of the staff who had made Nicky's stay and the patient experience as positive as reported and for the continued compassion and responsibility of care to patients. The Trust Board: • **Received the patient story**
1534/22	**Item 7.1 Ward Accreditation Presentation** The Director of Nursing noted that Ms Sarah Addlesee, Associate Director of Nursing and Ms Julie Record, Matron Surgical Division Grantham had joined the Board in order that the Surgical Unit at Grantham would be awarded accreditation.
1535/22	The aim of the accreditation programme, for which regular updates had been offered to the Quality Governance Committee, had been set up a year ago for all wards and departments to work towards accreditation to strengthen leadership, standardise care, define and track quality of care delivered, recognise and incentivise high standards or care, provide assurance that regulatory requirements were being met, identify areas of good practice and where improvements were required, plus a strong focus on the leadership team.
1536/22	The Director of Nursing noted that the Board would be awarding the first bronze diamond award to the Surgical Unit at Grantham Hospital who had shared some achievements and successes in the application for quality accreditation that had been heard at a panel on 27 July.
1537/22	The achievement of the bronze diamond award was the first step on the diamond award followed by silver and gold.

1538/22	In order to achieve this the team was required to achieve 26 weeks of green awards in weekly spot checks, 6 months of green awards in monthly matron audits, which were scrutinised by the Director of Nursing. Achieve a green rating in ward reviews which was a full comprehensive review with colleagues both lay people, Non-Executive Directors and colleagues from other areas visit the wards.
1539/22	A minimum of bronze harm free care certificates for no falls, pressure ulcers, healthcare acquired infection prevention and control (IPC), 6 months of green across frontline ownership IPC audits both for submission and compliance and 6 months of at least green indicators around sepsis screening and the deteriorating patient.
1540/22	For all the elements described the Director of Nursing stated that the programme gave high levels of confidence that the aims of the programme were being realised and benefits of accreditation delivered in practice.
1541/22	Following the Board meeting the Chair, Director of Nursing and Chief Executive would visit the ward to formally offer individual certificates and formal award for the accreditation.
1542/22	The Associate Director of Nursing was delighted to be able to introduce the Matron for the service and team that had been successful in achieving the very first bronze diamond award. There had been significant core requirements that the team had been required to achieve and it was noted that that application for the award had been for a 12-month rolling programme from June 2021 to May 2022.
1543/22	The Board was advised that the team had achieved in excess of the minimum requirements in order to apply for and achieved the bronze diamond award. In addition, preparation for attending the quality accreditation panel required a portfolio of evidence against 6 parameters to be offered.
1544/22	The parameters included evidence of improvement work, learning from incidents, patient and carer feedback, staff feedback, learner feedback and harm free care data and how this had been used to action improvements. The presentation of evidence to the panel offered a level of confidence that demonstrated how the team had achieved quality and safety indicators in the area.
1545/22	The Matron noted that following 3 falls in July 2021, which was unusual for a surgical ward where patients were not high risk of falls, work was undertaken to identify the reason and cause. As a result of this the ward rolled out the ‘Call don’t Fall’ campaign with patients being provided with a prompt card to encourage the use of call bells to call for a nurse when mobilising for the first time following an operation. This had worked extremely well and resulted in only one fall since which was as a result of a patient overreaching.
1546/22	Quality improvement was also undertaken with a redesign project to reduce theatre delays and focused on cancelations, complaints and patients in recovery not being collected by the ward. The team worked with Four Eyes and put in place magnet boards to identify the stage of the patient on their journey. A megaphone was also

	purchased in order to communicate across a busy ward to advise staff when a theatre was ready for use.
1547/22	The Associate Director of Nursing noted that it had been positive to hear examples of work done based on patient and staff feedback and with the rolling programme the team was now in a position to prepare the application for the silver award.
1548/22	The Chief Executive noted that this was an uplifting item on the agenda and that this demonstrated outstanding care, personally delivered and hoped that the Matron felt proud of the achievement noting that a high bar needed to be met in order to achieve this.
1549/22	The Chair was proud to hear of the achievements and noted that this offered an evidence base to be proud and celebrate success. The Trust Board was not one to look for fault but looked to celebrate success and enable staff to do the best job possible and deliver outstanding care in a personal way as described in the Trust vision.
1550/22	The Chair offered thanks to the Director of Nursing for implementing the ward accreditation programme noting that the Trust did not previously have a great record of embedding high quality care and as such it was good to be able to support the programme to commence and work in the way described.
1551/22	Dr Gibson, through the MS Teams chat, offered thanks to the Director of Nursing for the vision and leadership with no apologies offered for setting high standards of care as this demonstrated what could be achieved when the standards were set.
1552/22	The Chair formally offered to the ward the bronze diamond award with the great thanks of the Trust Board.
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
1553/22	**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 23 August 2022 meeting and noted the welcoming of new Non-Executive Director members.
1554/22	Dr Gibson noted the receipt of the mortality report with the Committee noting a continued improvement in Hospital Standardised Mortality Ratios (HSMR) data and good benchmarking against the peer group.
1555/22	An update in respect of Duty of Candour had been received, in line with the regular reporting that had been put in place, with the Committee noting 100% achievement in both written and verbal duty of candour. This demonstrated the impact of the response to earlier issues and if the compliance continued at a high level the Committee would revert to usual reporting.

1556/22	Dr Gibson noted the Infection, Prevention and Control (IPC) update noting that there had been no new cases of Methicillin-resistant Staphylococcus aureus (MRSA) however the Committee had noted the update in respect of the previously reported Carbapenemase Producing Enterobacteriaceae (CPE). Work was being undertaken with estates and facilities which would eliminate the CPE by replacing wash hand basins.
1557/22	The Committee was pleased to receive the regional letter from the IPC Team confirming the Trust achievement of a green rating. This was a great achievement and a tribute to the Director of Nursing as the Director of IPC, Deputy DIPC and Consultant Microbiologist working in the area.
1558/22	Dr Gibson noted the issues of concern noted through the Medicines Quality Group upward report with the Medicines Management annual report not yet received. In the following report from the Medicines Management Task and Finish Group long timescales were noted to address some of the actions in relation to medicines management. It was important that, in the absence of the Medical Director, momentum around addressing these issues was not lost.
1559/22	The Children and Young People group upward report was received offering a considerable level of assurance on actions outstanding from previous Care Quality Commission (CQC) actions. It was noted that the paediatric model at Pilgrim Hospital was interim, and work was underway to review and assess the suitability of the model in the long term.
1560/22	Dr Gibson noted the potential for training of staff understanding the important of patient experience which had been raised through the Patient Experience Group and noted that there was not a consistent approach being taken across all staff groups.
1561/22	As a result, the Committee had referred this to the People and Organisational Development Committee for consideration.
1562/22	The Committee receive a number of patient survey reports throughout the year and welcomed the intention for all reports to be divided in to 10 consistent domains so that the Trust could see how it was performing and to triangulate across a number of surveys and offer a coherent approach.
1563/22	Dr Gibson was pleased to note that the complaints report had inclusions, for the first time, of health inequality data and future reporting of this was welcomed.
1564/22	The Committee noted that CQUINs (Commissioning for Quality and Innovation) had returned and reporting for 2022/23 would take place from quarter 2 onwards and would be monitored and reported to the Board.
1565/22	The Savile action plan had been updated and offered to the Committee with some actions remaining incomplete, mostly due to human resources and therefore a further referral would be made to the People and Organisational Development Committee.
1566/22	The Chair noted the achievement with Duty of Candour and congratulated all involved noting the need now to sustain the position. The green rating from NHSE

	regarding IPC was celebrated and it was noted that recently the Trust had been rated red. This demonstrated the effort that had been made in relation to the improvements made.
1567/22	Concern continued to be noted in respect of medicines management and as stated by Dr Gibson there was a need for the annual report to be received and for continued improvements to be seen.
1568/22	Mrs Brown reflected on the Quality Governance Committee noting that this was the first meeting of the Committee that she had attended and commended the candour during the meeting, the standard of papers, use of benchmarking and external assurance.
1569/22	The Chair thanked Mrs Brown for the initial observations of the Committee was pleased that Mrs Brown would be about to continue the work as Chair.
1570/22	The escalations to the People and Organisational Development Committee in respect of the Savile action plan and patient experience training were noted. • **Received the assurance report**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1571/22	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee – No meeting held**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1572/22	**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 25 August 2022 meeting.
1573/22	Ms Cecchini noted that limited assurance continued to be received in relation to estates however it was noted that positive feedback had been received on the planning for the recent heatwaves. This had also supported the resolution of some long-standing issues within the Trust.
1574/22	Good progress had been made in respect of Health and Safety with the British Safety Council having written a letter of commendation to the Trust, mirroring the green IPC rating, and was good secondary assurance on arrangements in place.
1575/22	Ms Cecchini noted that the Trust would commence Patient-Led Assessments of the Care Environment (PLACE) following PLACE Lite which had operated during Covid-19 and would offer further assurance to the Committee.

1576/22	The Estates Team were preparing the Premises Assurance Model which was a detailed return to NHS England and would offer assurance on many aspects of the Trust estate. This was currently being taken through an independent review and would then be submitted with the outcome and actions from this support the Board Assurance Framework (BAF) rating.
1577/22	Ms Cecchini noted that the Green Plan had been received and would be discussed by the Board. This had been reviewed and the Committee had observed some ambitious targets to 2040. The plans for 2022/23 would be scrutinised and it was noted that there were some concerns on the ambitions however there was optimise that the Trust would deliver.
1578/22	The Committee was pleased to note that all Low Surface Temperature (LST) works had been completed at Louth Hospital with some underspend achieved and there was now negotiation taking place with the finance team to understand how the underspend could be carried forward to support the third-party remedial works.
1579/22	As detailed in the Chief Executive's update the financial position was £6.5m off plan and the Committee was advised that without further action this could result in a £26m forecast outturn deficit. The Trust continued to report to NHS England that the Trust would deliver plan and the Committee noted the actions being undertaken to bring the Trust back in line with plan.
1580/22	The Committee noted slippage on capital spend at month 4 however noted that this was not a cause for concern however this would be scrutinised in order to avoid a large overspend at the end of the year. The Trust had a significant capital programme that the team were managing.
1581/22	Ms Cecchini noted some concerns regarding contracting and the risk and gain share element of the contract with Commissioners which was not yet finalised. The concern was due to the system being so far behind on the initiative to close beds on the back of system transformation.
1582/22	The Committee continued to receive assurance with regard to Data Security and received the action plan for the Data Security and Protection Toolkit with one major outstanding item being the compliance against training. If the Trust could achieve 95% then the toolkit could be turned green.
1583/22	The Digital Hospital Group had reported that there was no further national funding for the maternity electronic patient record so the Trust would need to consider this as part of the Electronic Patient Record business case and Digital Strategy.
1584/22	Ms Cecchini noted that operational performance continued to report a general deterioration in most performance areas and limited assurance continued to be received. Challenges remained ongoing in urgent care and the Trust were expecting community capacity to commence, for pathway 1, in September.
1585/22	The Trust continued to seek mutual aid for cancer services with concern noted in a number of deteriorating metrics, largely around colorectal pathways. A deep dive was being undertaken and would be reported to the Committee in September.

1586/22	The Committee continued to raise concern that metrics within the Committee Performance Dashboard remained incomplete and unclear however it was understood that these were being addressed by the Executive team.
1587/22	Ms Cecchini noted that the Committee had agreed the RAG ratings for the BAF objectives 3d cancer services and 3f urgent care as red. A conversation was also held regarding the risk around capacity and the ability for clinical teams and management teams to support improvement programmes whilst trying to address operational pressures.
1588/22	The Chair noted the broad agenda of the Committee however noted that there was some real risk emerging across some of the constituent parts of the agenda that would need to be focused on.
1589/22	The Director of Nursing was pleased to note the completion of the LST radiators and hot pipes, particularly at Louth and noted that evidence would be collected and held should this be required in the future.
1590/22	The Chair noted the need to discuss the maternity electronic patient record as this had been discussed on a number of occasions by the Board. The issue of the deficit and performance was related to the open beds and the impact on agency. As a Board there was a need to have a deep dive in to the understanding of the interdependency on the component parts of this.
1591/22	The Board needed to ensure that all actions required by the Trust were being undertaken with clarity needed on the support required from the system in order to ensure the information allowed an assessment of assurance.
1592/22	The Chair noted with regard to the question about capacity to support improvement programmes that there was a need to improve productivity and patient care and flow to allow this to progress. Without these elements of progress, it would be difficult to achieve long term recovery. The Trust Board: • **Received the assurance report**
1593/22	**Item 10.2 Green Plan** The Chief Operating Officer presented the Green Plan to the Board noting that this was the second published version and set out the aspirations of the Trust in terms of the carbon agenda and the part of the Trust in the net zero 2040 ambition as part of the wider NHS.
1594/22	The Chief Operating Office acknowledged the length of the document and detail included. This would help the Trust to understand the carbon footprint and activities undertaken by the organisation and it was noted that progress had been made by the Trust.

1595/22	This was an area that the Estates Team had previously won awards for particularly around how the Trust looks to better manage energy consumption and how energy was used but also how this formed part of future provision for estates and facilities.
1596/22	As part of understanding the carbon footprint work had been undertaken with specialist advisors to consider procurement costs, whilst not generating carbon from purchases, buying the right type of products and services that have a substantial impact on the carbon footprint.
1597/22	The Chief Operating Officer reflected on the timescales and the ambition of these in the coming 2 years noting that timescales could be prohibitive due to the availability of funding, either directly within the Trust or regionally and nationally. It was believed that the ambition within the plan should be set as it was.
1598/22	The Green Plan was intertwined with many other approaches in the organisation including the procurement and estates strategies and this formed part of a suite of things that offered a framework of decision making over the coming 2-3 years. This would guide the Trust in the next decisions on how to build, areas to replace, management of core infrastructure and how to manage energy.
1599/22	Professor Baker noted that the plan was comprehensive and noted the need for a scale of behavioural change due to the need for younger generations to generate significantly less amounts of carbon in order to achieve what was within the plan.
1600/22	It was noted that most elements within the plan were not cost neutral either to individuals of the organisations and whilst there was a significant amount within the plan it was felt that this did not emphasise the need for behavioural change sufficiently.
1601/22	The Chief Operating Officer noted that it was believed different groups of stakeholders, both within the organisation and patients would have a different perspective about what they should do and what the Trust should do for them. This would all start with the plan which would commence conversations and as papers were presented to the Finance, Performance and Estates Committee in relation to construction and estates and facilities there would be consistent reference to the plan and ambitions described.
1602/22	The Trust was not shying away from the ambition set as there was a need for this to progress and set a clear direction of travel. Currently there was a global energy crisis which was changing the dynamics of economics in a specific way and meant that energy consumption was becoming an issue along with energy efficiency. This would, as a result, drive some of the things previously described as unaffordable in the plan and may now, due to the change in energy prices and manufacturing enable the Trust to implement some of these.
1603/22	Dr Gibson noted the emphasis on staff engagement which had been included and noted that some of the current significant energy use was related to the structure of the old estate. Dr Gibson noted that a number of staff travelled between sites and that the use of electric cars for this would be perfect due to the distances and asked if the plan could be more positive thinking in relation to electric cars.

1604/22	Dr Gibson also noted the relative amounts of gas and electric used on the different sites with Pilgrim 50/50 and Lincoln 90% gas and asked if there was a reason for this and would altering of the ratio be considered going forward.
1605/22	The Chief Operating Officer noted that energy consumption was stark when compared to household users and noted that this was due to the use of some specialist equipment, diagnostics and treatment with equipment such as CT and MRI scanners.
1606/22	It was noted that over time those devices would become more efficient and use less but for the time being there was a need to maintain this, and it was important how the Trust obtained energy to make sure this was done in the most carbon efficient way.
1607/22	The Chief Operating Officer advised that there were green fleets and that many colleagues were utilising these and the use of NHS Fleet there was a push with staff to use electric cars. There was a lot to do to support staff to do this and to switch the fleet.
1608/22	Within the report this included own vehicles and how to switch to greener vehicles and also the influence of more electric vehicles in public transport and between the hospital sites. This would be a key stone on the strategy going forward.
1609/22	It was noted, for oil and gas usage and powerplant, the Trust had an energy contract for which specialist advice was taken in order for the Trust to be guided in the best use of different sources of energy. This would see change as the Trust used different types of energy. Some conversations for solar energy had commenced, particularly where there was access to larger land areas. Over the next 2 years if was expected that a real change in the type of energy used by the Trust would be seen to make the Trust more energy and cost efficient.
1610/22	The Chief Executive welcomed the paper noting that it was an important topic that needed to be addressed and that this positioned well in terms of the Integrated Care System (ICS) and the need to focus on part of this in the social and economic green agenda and how this aligned to individual organisations. It was noted that it was as yet unclear if there would be a change in the green agenda following the appointment of the new Prime Minister.
1611/22	The Chief Executive also noted that staff were interested in the topic and there was a need to make the most of this, some form the travel aspect and waste issues of things that could be more reusable. Whilst the plan was ambitious it was welcomed and supported.
1612/22	Mrs Dunnett, through the MS Teams chat asked if the plan was aligned with the system.
1613/22	The Chief Operating Officer noted that this had been done in collaboration with system partners, including local authority and local government, with some specialist advisors being shared.

1614/22	The Chair noted that the travel and transport strategy for the county had always been important, whether this was looking at the green plan or service reform the transportation issues was becoming a key priority.
1615/22	Whilst the Trust Board needed to own the Green Plan it was noted that a number of actions were the responsibility of the Board with the Chair asking how it was intended that the responsibility be discharged.
1616/22	The Chief Operating Officer proposed that this would be updated through the Finance, Performance and Estates Committee and onward to the Board with the Green Plan manifesting in other reports. Updates on the timescales would also be through finance and estates reporting.
1617/22	The Chair noted the need to be clear of the accountability through the route described. The Trust Board: • **Received the report** • **Approved the Green Plan**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1618/22	No items
1619/22	**Item 12 Integrated Performance Report** The Chair noted the limited assurance offered and noted the updates received from the Committees regarding the performance for which each was responsible.
1620/22	The Director of Finance and Digital highlighted that the core items had been highlighted by the relevant Committees.
1621/22	The Chair noted, as a Board there was a need to be mindful that there were new colleagues who had joined along with an action point to ensure that assurance was gained on performance through the winter. There was a need to understand reporting through the SPC process and scorecard and to refresh the understanding of all Board members. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
1622/22	**Item 13.1 Risk Management Report** The Director of Nursing presented the monthly report to the Board noting that there were 10 very high risks for quality and safety relating to delays in planned care, non-admitted cancer, ambulance handovers and echocardiogram results. Along with

	concerns around learning lessons from patient safety incidents, potential serious harms from falls, medication errors and hard copy record keeping.
1623/22	The Quality Governance Committee had also considered a very high risks regarding dosage rate units in radiotherapy and following the Committee there had been a risk register confirm and challenge group. The group had agreed that a mitigation plan was in place for an equipment replacement project to reduce the risk to a moderate to low risk. The change had been offered to the Chair of the Committee following the discussion.
1624/22	The Director of Nursing noted 12 quality and safety risks that were rated high, and all had been discussed and reviewed by the Quality Governance Committee. It was pleasing to have received feedback from MRs Brown on candour and the standard of papers.
1625/22	The Board noted 2 very high workforce risks regarding recruitment and retention of the workforce and workforce culture, which may also impact on quality and safety. There had been reviewed at the People and Organisational Development Committee along with 3 high rated risks.
1626/22	The Director of Nursing advised of 3 very high risks relating to the Finance, Performance and Estates Committee noting that these had been increased in month in terms of the risk rating. These were in line with the cost and reliance on temporary clinical staff, potential of a major fire safety incident and compliance with fire safety standards. These had all been reviewed through the Committee.
1627/22	There were clear mitigations in place for each of the risks mentioned and the process for executive confirm and challenge of the risk register items continued. This also took place with divisions and corporate directorates with the full range of risks offered within the appendix to the report.
1628/22	Mrs Brown noted reflections throughout the course of the meeting and the review date being delayed in respect of ambulance handovers. Throughout the meeting there had been discussions regarding emergency care with actions being taken detailed, there was confidence that the right actions were being taken.
1629/22	It was reflected that there was a patient safety risk with overcrowding and ambulance handovers and Mrs Brown asked if the Quality Governance Committee should receive a deep dive into patient safety mechanism in place for this over the coming winter in order to receive assurance.
1630/22	The Director of Nursing noted that this was a significant risk for the Trust, and it was intended that this work would be undertaken in line with winter planning. It would be possible to pull the work forward in terms of the Quality Governance Committee schedule so that this could take place sooner than planned.
1631/22	The Chair noted that this tied in to wanting to understand, how as a Trust Board, members would remain sighted on service and quality.

1632/22	The Chief Operating Officer noted that the Clinical Harm Oversight Group reported into the Quality Governance Committee with one area considering ambulance handover and delays which may lead to harm in the emergency departments. Consideration would be given to this to ensure it was appropriate given the level of risk being spoken about.
1633/22	Reporting also goes into the Finance, Performance and Estates Committee however there may be a need to pull this into a single deep dive. Work as a system discussed 4 harms, patients waiting, patients in the department, patients waiting to go home and then the highest risk, harm of patients yet to be seen by and ambulance or any professional.
1634/22	This was all considered by the Urgent and Emergency Care Partnership Board across all of Lincolnshire with the Chief Operating Officer advising that harm reviews from the system could be distilled into those of the Trust. From a public Board viewpoint this would be presented through the governance route to the Board to be sighted.
1635/22	The Chair noted that this would be left to the Executive Directors to determine how this would be brought forward in order to offer a level of information. **Action – Chief Operating Officer, 1 November 2022**
1636/22	The Chair noted risk 4780 in relation to stroke and asked about the position of the Acute Services Review and implementation and the ability for an update to be offered to the Board. It was noted that it was right for the risk to be presented however an update would be beneficial. **Action – Director of Improvement and Integration, 4 October 2022** The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the significant assurance**
1637/22	**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 August with the exception of the People and Organisational Development Committee which had not met.
1638/22	There were no movements in the ratings previously considered by the Board however the Trust Secretary noted the new assurance ratings offered by the Finance, Performance and Estates Committee for objectives 3d, 3d and 3f which were new objectives for 2022/23.
1639/22	The Chair offered thanks for the due diligence being offered to the BAF noting the conversations which were being stimulated by this, particularly around risk.
1640/22	The changes identified were noted, particularly the newly rated objectives which were

	confirmed by the Board as representative of the current position of achievement against the strategic objectives. The Trust Board: • **Received the report noting the moderate assurance**
1641/22 1642/22 1643/22 1644/22 1645/22	**Item 14 Any Other Notified Items of Urgent Business** The Chair paid tribute to Mrs Dunnett for her long service to the Trust noting that Mrs Dunnett would be standing down with the Trust as a Non-Executive Director at the end of the month. Thanks were offered to Mrs Dunnett for the sterling work undertaken over the past 6 years. Mrs Dunnett had joined the Trust when it was in a difficult place and had shown faith, determinism and professionalism over that time. Mrs Dunnett had made a genuine contribution across a range of Board business and always done so from a place of great intent with the patient at the heart of intentions. As Maternity and Neonatal Safety Champion, Mrs Dunnett had supported the Trust in being in a much better place which was demonstrated by recent national inspections. Best wishes were offered to Mrs Dunnett for the future and expressed by members of the Board through the MS Teams chat.
1646/22	The next scheduled meeting will be held on Tuesday 4 October 2022, arrangements to be confirmed taking account of national guidance.

Voting Members	**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**	**2 Aug 2022**	**6 Sept 2022**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	A	X	A	X	X	A	X	X	X	X	X
Sarah Dunnett	X	X	X	X	X	X	X	A	X	A	X	A	A
Elizabeth Libiszewski	X	X	X	X	X								
Paul Matthew	X	X	X	X	X	X	A	X	X	X	X	A	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	A	A	X	X
Mark Brassington	X												
Simon Evans		X	X	X	X	X	X	X	X	X	X	A	X
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X	X
David Woodward	A	X	X	X	X								
Philip Baker	X	X	X	X	X	X	X	X	X	X	X	X	X
Colin Farquharson	X	X	X	X	X	X	X	X	X	X	X	X	A

Gail Shadlock						X	X	X	X	X	X		
Dani Cecchini						X	X	X	X	X	X	X	X
Rebecca Brown													X
Neil Herbert													X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
7 December 2021	1914/21	Action Log	Establishment reviews for endoscopy and ED would be received once considered at Committee in Jan/Feb 2022 Endoscopy review to be received in July	Director of Nursing	~~01/03/2022~~ ~~05/07/2022~~ ~~02/08/2022~~ 04/10/200	Deferred to October
5 July 2022	1265/22	Integrated Performance Report	Board to review performance report through IPR ahead of the winter pressures, with focus to be afforded to the scorecard performance and position of a range of metrics.	Trust Secretary	~~06/09/2022~~ 04/10/2022	To be considered in private Board session before being offered to public Board as part of the winter plan in October
6 September 2022	1635/22	Risk Management Report	Detailed reporting of ambulance handover delays and patient harm to be considered to Quality Governance Committee	Chief Operating Officer	01/11/2022	Agenda item for October QGC
6 September 2022	1636/22	Risk Management Report	ASR Stroke service implementation update to be offered to the Board	Director of Improvement and Integration	04/10/2022	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*4 October 2022*
Item Number	*Item number 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to be under significant pressure as winter approaches. Further refinement is taking place on the system winter plan in order to ensure that the right amount of capacity is in place. This plan will take account of the national guidance that was issued last month and it will also need to factor in the potential impact of flu and COVID outbreaks.
b) The new Secretary of State for Health and Social Care, Dr Therese Coffey, has issued a new document setting out her priorities. 'Our Plan for Patients' provides details of the expectations around ambulances, backlogs, care and doctors and dentists. This is colloquially known as the A B C D plan.
c) Dr Caroline Johnson, the MP for Sleaford and North Hykeham, has been appointed as a Parliamentary Under-Secretary of State in the Department of Health and Social Care.
d) Following the conclusion of the public consultation into four NHS services in Lincolnshire (often referred to as the Acute Services Review) and in the absence of any legal challenges, the NHS Lincolnshire Integrated Care Board is now working through the implementation of the proposals. In this regard, an ASR Implementation Oversight Group has been established.
e) A recruitment process is underway to appoint a replacement System Improvement Director for Lincolnshire. Having such a post is a requirement for systems that are in the Recovery Support Programme. The current incumbent, Keith Spencer, finishes his fixed term contract at the end of October and is moving on to a new role in another part of the country.
f) The first meeting of the Lincolnshire Integrated Care Partnership took place on 27th September. The ICP is a statutory committee as part of the ICS arrangements. One of its key roles is to prepare an integrated care strategy.
g) The latest Quarterly System Review Meeting (QSRM) took place with NHS Midlands on 15th September. This was a positive meeting with lots of good work highlighted and commended. As expected, a lot of the focus was on how to improve the position relating to urgent and emergency care, 78 week waits, cancer, finance and workforce.

Trust Overview

a) At month 5, the Trust reported a year to date deficit of £9.0m against a year to date plan of break-even. After adjustments, this equates to a deficit of £9,1m in relation to the system financial plan.
b) The Trust has returned its visiting arrangements back to those that were in place prior to the COVID pandemic. This means that visitors no longer need to book an appointment to see their loved ones and two visitors may be at a bedside at a time during the ward's usual visiting times. Outpatient services, the emergency departments and maternity services have also returned to their pre-COVID arrangements. Infection prevention and control measures remain in place.
c) The Trust has also reopened its restaurants to the public. Work is also underway to improve the café and shop arrangements at Trust sites and to extend the hours at which refreshments are available.
d) The trust's Medical Director Dr Colin Farquharson is off on long-term sickness. In his absence Paul Dunning, one of the current Deputy Medical Directors, will take on the Medical Director title and responsibilities. This will be until at least 31st December. Paul will be supported by Andrew Simpson, one of the other Deputy Medical Directors. They will work in partnership to ensure that appropriate Medical Director

cover is provided during Colin's absence. Paul and Andrew will have additional support to call on as Ciro Rinaldi has been appointed as a Deputy Medical Director. Ciro will be vacating his Divisional Clinical Director roles in both Medicine and Clinical Support Services.

e) Claire Low will be taking up the post of Director of People and OD with effect from 1st October. Claire will be taking on the role until further notice, after previously being the Trust's Deputy Director of People and OD. Paul Matthew has temporarily led the directorate for the past year. I would like to thank Paul for his stewardship of the role, which he took on alongside his usual role as Director of Finance and Digital.

f) The Trust's Annual Staff Awards ceremony takes place on the evening of 13th October at the Lincolnshire Showground.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	29 September 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 received the report noting the ongoing work on the admitted waiting list to ensure appropriate prioritisation in risk groups. Use of the C2AI tool continued and it was noted that weekly cell meetings continued to ensure highest areas of risk and listing were appropriate. Overall, there was an improved utilisation of the list fill. The Committee considered in detail the recommendations put forward by the group including discontinuation of reporting of A&E 12-hour breaches on Datix, exclusion of specific RTT codes triggering the requirement for a clinical harm review, approval of recommendations for the 52-week clinical harm review process and approval of recommendations on the Cancer 52/104 day clinical harm review process. The aim of these recommendations is to avoid duplication of processes which require significant clinical input. The Committee supported the first three recommendations however, in line with reporting from the group noted that further work was required before the recommendations on Cancer 52/104 day clinical harm review process could be approved. **Patient Safety Group Upward Report** The Committee received the report noting that most items discussed by the group featured on the Committee agenda for detailed discussion. It was noted that the Trust had appointed a Deteriorating Patient Lead

	which would enable a reinvigoration of the Deteriorating Patient Group from October. The group had introduced divisional reporting and noted that the level of information being provided demonstrated a grip by the divisions of governance issues with actions in place where required. **Patient Safety Alerts Quarterly Report** The Committee received the quarterly report noting that there were 3 open Central Alert System notices and 55 open Field Safety Notices, down from 71 in previous reports. Work continued to identify timeframes for the closure of FSNs which would be reported to the Patient Safety Group. This would enable identification of those still overdue. **Serious Incident Summary Report** The Committee received the report noting the position presented. **Patient Safety Incident Response Framework (PSIRF)** The Committee were pleased to have the opportunity to view the PSIRF video explaining how this was being introduced and the purpose. The Committee noted the work that was underway to ensure preparations were in place with a development plan being devised for the coming 9 months. It was anticipated that PSIRF would be fully in place in the next 12 months. The Committee supported the suggestion of formal quarterly reporting of progress on implementation of PSIRF direct to the Committee, with upward reporting through the Patient Safety Group. **High Profile Cases** The Committee received the report noting the content. **Complaints, Legal Claims and Inquest, Incidents and Patient Advice and Liaison Service (PALS) Report** The Committee received the report noting the themes being identified of communication, attitude and behaviours of staff. It was noted that this did not align with external reviews which saw the Trust score well on caring domains. The work being undertaken in this area would support the Trust with the development of PSIRF and it was noted that in future the CLIPs report may be superseded by PSIRF reporting. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report noting that there continued to be no cases of MRSA however C.difficile was now 9 cases above trajectory. This was an unusual position for the Trust however immediate actions had been taken to strengthen oversight arrangements.

	The Committee noted the progress that had been made in respect of the Covid-19 BAF and with the lifting of visiting restrictions it was noted that the Covid-19 BAF would be closed with remaining actions moved to the trust wide IPC BAF, which would support statutory requirements. **Medicines Management Task and Finish Group Upward Report** The Committee received the report noting the update offered and that actions relating to the CQC and internal audit recommendations would be drawn together in order for there to be a clear line of responsibility and oversight. The Committee was pleased to note the recent medicines ambassador day which had raised the profile of medication safety and improved the process for handling medication incidents. The Committee noted the need for clear timescales against actions and a clear structure for reporting of assurances. **Medicines Management Annual Report** The Committee welcomed the Chief Pharmacist to present the report noting the key achievements in 2021/22 which had focused on the establishment of the aseptic unit, Covid-19 vaccinations, and the provision of 7 day pharmacy services for ICU. The team had supported and delivered close to 1.5m doses of the Covid-19 vaccine across Lincolnshire in addition to supporting the flu vaccination programme. The Committee suggested that future reports would benefit from the inclusion of patient feedback/experience and benchmarking data. The forward plans for the service were commended together with the need to address outstanding internal audit and CQC recommendations. **Safeguarding and Vulnerabilities Oversight Group Upward Report** The Committee received the report and update in respect of the "Out of Sight Who Cares" report noting that this related to long term mental health placements with learning disabilities. Whilst this did not predominantly apply to the Trust there were some elements, such as restraint, which should be considered and as such the gap analysis had been conducted which confirmed that all aspects were in place. The Committee noted the proposed introduction of the "Oliver McGowan" training for learning disability and autism, with this now being a statutory requirement for tier 1 and tier 2 staff. It was noted that this would be a significant training programme to be completed both for ULHT and across the region. **Maternity and Neonatal Oversight Group Upward Report**

	The Committee received the report noting that the memorandum of understanding had been agreed between the Trust and Nottingham University Hospitals NHS Trust. This would enable mutual aid to be offered/received and for learning to be shared. Good progress was being made in respect of Ockenden reporting and it was noted that further national guidance was awaited for the interpretation of some recommendations. It was noted that some recommendations had been retracted and further information would be offered to the Committee in October. The Trust continued to progress with CNST Maternity however the Committee noted concern with regarding to 3 actions being at risk relating to training compliance, software limitations and staffing. The group received the Maternity and Neonatal Safety Champion Non-Executive Director, and it was noted that this was the final report for the outgoing Non-Executive Director. The Committee offered formal thanks to Mrs Dunnett for undertaking the role.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report and was delighted to be advised of the success for the Patient Experience Team at the Patient Experience Network National Awards 2022 with a first prize for the Patient Experience Dashboard and second prize for the Patient Panel. The Committee noted the continued diverse and wide-ranging conversations held by the group and noted that themes continued to be raised with regard to communication, and attitudes and behaviours. Further work would be undertaken to identify more specific themes from the broad areas to be addressed. **Duty of Candour** The Committee received the report noting that this was presented on a monthly basis to ensure continued oversight with compliance for both written and verbal duty of candour. It was noted that 100% compliance had not been achieved in the most recent month and whilst figures continued to be validated the Committee agreed that this would continue to be reported monthly until there was clarity on the embedding of the culture of duty of candour.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the benchmarking data that

	had been included and offered assurance to the Committee. Concern was noted in respect of VTE with the Committee being advised of the need to refocus support on VTE assessment compliance. Work was taking place in order to put forward a proposal to the Trust Leadership Team for a joint venture between divisions to appoint a member of staff to support VTE assessment.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report noting the limited assurance that was offered. Steady progress was being made across all areas with continued improvement seen in SHMI and the IPC BAF. The Committee considered the continued inclusion of the Ockenden recommendations and action plans within the wider IIP objective of enhancing patient safety by learning from incidents. The Committee supported the removal of the Ockenden actions from the IIP programme structure due to the detailed and continued reporting of Ockenden and maternity performance directly to the Committee. This would remove duplication. **Topical, Legal and Regulatory Update** The Committee received the report for information noting the People First initiative from the CQC. This followed on from the CQC initiative during the pandemic known as Patients First. A review of the document was being undertaken with emergency department staff, where People First is focused initially, and an update will be offered to the Committee. **CQC Action Plan** The Committee received the action plan relevant to the Committee and also the overall action plan. The Committee was pleased to note significant progress which had been supported by the Executive Led CQC Assurance Meeting during September and noted that this was the biggest step change in achieving "must-do" actions within any month to date. **Committee Performance Dashboard** The Committee noted that items had been considered through agenda items discussed however also noted the Sepsis indicator for children. Due to the deterioration in the metric, actions were in place to understand the position with the emergency departments and family health. All cases had been reviewed as part of the harm review process which had identified that there was currently no harm.
Issues where assurance	None

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	13 September 2022
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2022/23 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Lack of Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Safer Staffing** The Committee received the report noting the slightly improved position due to recruitment. There had been improvement seen in fill rates due to temporary workforce and agency. The Committee noted that there had been an increase in category 2 pressure ulcers being reported however noted that this was due to earlier identification. A root cause analysis for skin integrity had been conducted and it was noted that staffing was not a contributory factor. The Committee received moderate assurance and would welcome the in-year review of nursing recruitment and pipeline at the next meeting. **Workforce Strategy and Organisational Development (WSOD) Group Upward Report** The Committee received the upward report noting that this remained an evolving process, but that reporting continued to develop The Committee considered the metrics that were presented and noted the intention for these to be presented to the group and upwardly reported to the Committee. This would offer exception reporting to flag those metrics which were not on track. **Committee Performance Dashboard** The Committee noted the dashboard and received which had been considered as part of the WSOD Group upward report. **Medical Engagement Development Plan** The Committee received the plan noting that Junior Doctor Support Manager position now in place and offering support.

	The embedding of the Medical Leadership Development Programme was noted with 20 places available to staff for a series of workshops with a reasonable level of uptake noted. **Responsible Officer Revalidation Annual Report** The Committee received the annual report noting the medical revalidation and maintaining higher professional standard policies had been revised. The Committee was assured by the high level of appraisals and the deployment of an audit tool to assess the content and quality of appraisals.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **EDI Group Upward Report** The Committee received the upward report noting the discussions held in respect of the WRES and WDES action plans. The group had considered the next 'United against' campaign and supported the focus being on abuse, violence and aggression. The Committee was pleased to note the appointment of the BAME staff network chair which was approved by the group. **Workforce Race Equality Standard and Workforce Disability Equality Standard Action plans** The Committee received the WRES and WDES action plans noting that these had been discussed by the EDI Group and the requirement for publication by the end of October. The actions had been agreed with the relevant staff networks with staff engagement to continue following approval. The Committee approved and supported the actions plans being presented to the October Board meeting. **Culture and Leadership Group Upward Report** The Committee received the report noting the progress being made and recognised the work that would be undertaken in respect of the organisation values and behaviours. The Committee noted the need to baseline data that was already available which would link into the Committee scorecard in order to report outcome measures.

	Guardians of Safe Working Quarterly 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 which continued to be raised in respect of provision of hot food and culture and behaviour in some areas. The Committee was pleased to note that actions were in place to address the concerns although noted that these would take time to resolve and would potentially impact on recruitment to the Trust.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Medical School Update** The Committee noted the report and the current number of students in the Trust and reflected the upward pressure within the Trust as the number of medical students increased. **University Teaching Hospital Group Upward Report** The Committee received the report noting that the group had undertaken a refresh of the overall plan and noted the key focus of the development of the Rural Healthcare Strategy. Work was underway with the University of Lincoln regarding research and innovation with key stakeholders currently being identified. The Committee was pleased to note the progress with recruitment for clinical academics and the work taking place with the University to advertise for 2 Respiratory Clinical Academics.
	Assurance in respect of other areas: **Topical, legal and regulatory update** The Committee received the update for information noting the content of the report. **Integrated Improvement Plan** The Committee received the report noting that limited assurance was offered in respect of the month 5 update. Good progress had been made on vacancy rates however it was noted that further progress was required to improve the upward trajectory for appraisal. The Committee noted the focus for the coming quarter on the development of the Rural Healthcare Strategy.

	CQC Action Plan The Committee received the report noting that this outline the CQC assurance process which had been revised at the beginning of the year. The Committee was assured of the progress being made with a number of movements within the actions rated as red as these were either closed as assurance was received or evidence had been provided. **Audit Recommendations** The Committee received the report noting the audit recommendations which were overdue and noted the need for review and update for a number of recommendations to be closed. **Committee referrals** The Committee received updates in respect of a number of referrals made by the Quality Governance Committee noting that in order to offer assurance to the referring Committee papers would be offered to provide updates.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to escalate to the Board concerns raised by the Guardian of Safe Working in respect of culture and behaviour
Items referred to other Committees for Assurance	
Committee Review of corporate risk register	The committee received the risk register noting the current risks presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. The Committee agreed that Objective 2a A modern and progressive workforce should be uprated to Amber.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

Voting Members	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**
Geoff Hayward	Meeting not held										Meeti		Meeting	
Philip Baker (Chair)			X	X	X	X	X	X	X	X		X		X
Sarah Dunnett			X	X	X	X								

Gail Shadlock						X	X	X	A		A		
Karen Dunderdale		X	X	X	X	X	X	D	X		X		X
Paul Matthew		X	X	X	X	X	X	X	X		X		X
Martin Rayson													
Colin Farquharson		X	X	X	X	X	X	A	X		X		D
Chris Gibson													X
Vicki Wells													A

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

Meeting	Trust Board
Date of Meeting	4 October 2022
Item Number	Item 9.2
Final Draft / ULHT Workforce Race Equality Standard (WRES) Action Plan 2022/23	
Accountable Director	Claire Low, Executive Director for People & OD
Presented by	
Author(s)	Sarah Akhtar, Associate Director for OD, Wellbeing and Inclusion and Alison Marriot, EDI Project Manager
Report previously considered at	People and OD Committee – 9 September 2022

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

Risk Assessment	*To be confirmed*
Financial Impact Assessment	*Costs to be confirmed*
Quality Impact Assessment	*Individual actions subject to assessment*
Equality Impact Assessment	*Individual actions subject to assessment*
Assurance Level Assessment	*Insert assurance level* ▪ *Moderate*
Recommendations/ Decision Required	Trust Board are requested to: 1. Review the attached final draft action plan 2. Consider the proposed WRES actions 3. Confirm and share any further insights 4. Support the approach proposed 5. Support publication of ULHT WRES Action Plan 2022/23

Executive Summary
As detailed below

United Lincolnshire Hospitals NHS Trust

TRUST BOARD
4 October 2022

FINAL DRAFT
ULHT Workforce Race Equality Standard (WRES) Action Plan 2022/23

INTRODUCTION

- Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

- Equal access to career opportunities and fair treatment in the workplace for employees from black and minority ethnic (BME) backgrounds is important because studies shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

- Workforce Race Equality Standard (WRES) consists of nine indicators. NHS providers are required to collate data against each indicator. This data enables NHS organisations to compare the career and workplace experiences of BME* (Black & Minority Ethnic) and white staff and assess year on year progress.

ULHT WRES ACTION PLAN 2022/23 (see attached)

1. Action plan is informed by NHS Staff Survey results, regional/system and national priorities. The plan aims to address important and identified challenges for ULHT i.e. inappropriate banter; and provision of EDI/Inclusion education and training.

2. The Trust's aim is to move from compliance to good practice.

3. The plan highlights inclusive recruitment practices, robust HR processes and the prominence of the People Promise as important elements of the Trust's WRES action plan. Recent campaigns, such as the Trust's United Against campaign also feature as being pivotal to the Trust's performance and progress

4. Trust WRES actions are aligned to the Belonging element of the Lincolnshire System People Plan and brings greater momentum to the agenda and to the priorities.

5. Stakeholder engagement with individuals and groups served to raise awareness of the Trust's EDI agenda and the employee experience of BME staff. Focus groups and discussions were used to agree actions and informed the development of the action.

See also appendix one: WRES Data for Indicators 1 and 9

PROGRESS AND NEXT STEPS

1. WRES Action Plan 2022/23 ratified by EDI Group and People and OD Committee
2. Publication WRES Action Plan 2022/23 (by 31 October 2022)
3. Update to CCG Senior Equality & Human Rights Manager - October 2022 (contractual requirement under Section 6)
4. Communication to all stakeholders (all staff; system partners; participants of WRES workshops)

Workforce Race Equality Standard (WRES) Action Plan 2022/23				
WRES Indicator	**Current WRES Performance**	**Lead**	**Actions**	**Timescale**
1. Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.		**Director People & OD** Supported by: People & OD VSM Team EDI Project Manager	Set and approve "NHS: A Model Employer" targets to increase BME representation at senior levels in line with the overall workforce percentage of BME colleagues (16.76%) NHS: A Model Employer wres-leadership-strategy.pdf (england.nhs.uk) Further work required to determine further specific targets for AfC Bands 8a and above from 2023 to 2028 **Measurable outcome:** the Trust has agreed targets and action plan, which support positive action in recruitment (which is underpinned legally by the Equality Act 2010)	**Urgent:** December 2022
2. Relative likelihood of staff being appointed from shortlisting across all posts.		**Head of Recruitment** Supported by: Associate Director of Workforce System working group: "Overhauling	**Inclusive recruitment review** (existing action in NHS Lincolnshire "Belonging" Strategy) – attraction, recruitment and selection methods; job descriptions; training recruiting managers Reporting is on a whole-Trust basis. The Trust will seek to understand the data for each professional group & by division for further assurance. Consider if TRAC data better than ESR data for metric	In progress Target completion date: June 2023 February 2023

		Recruitment" (Lincs People Plan) EDI Team	**Measurable outcome** – achieve parity (1.0)	January 2023
3. Relative likelihood of staff entering the formal disciplinary procedure, as measured by entry into formal investigation.		**Associate Director of Workforce** Supported by: System working group: "Reducing the Disciplinary Gap" (Lincs People Plan) Strategic HR Business Partners	**Actions from the Lincolnshire People Plan - Belonging Strategy (Reducing the disciplinary gap)** - Equip line managers with skills/confidence in giving feedback effectively; having "difficult conversations" particularly around behaviours which do not align ULHT values - Design a "roadmap" around values & behaviours which outlines the impact of positive & negative behaviours - Review disciplinary, grievance and bullying & harassment policies **Measurable outcome:** reduce gap further from 1.13 to parity (1.0) i.e. BME colleagues are no longer more likely than white colleagues to enter a formal disciplinary procedure	In progress Target completion date: June 2023
4. Relative likelihood of accessing non-mandatory training & CPD		**EDI team**	Whilst progress is positive, it is important to understand the reasons behind the improvement in this ratio and to use this information to help maintain this performance **Measurable outcome:** understand factors/conditions in which this improvement has been achieved	February 2023
5. Percentage of staff experiencing harassment, bullying		**Associate Director - OD, Wellbeing & Inclusion**	**Continue implementation of United Against programme:** actions embedded in Lincolnshire System Belonging Strategy ("Bullying & Harassment"	In progress

or abuse from patients, relatives or the public in last 12 months.		Supported by: People & OD VSM team EDI team United Against working group Staffside Staff Networks	work stream); and delivery plans for EDI Objectives and the People Promise **Summary of key actions:** - Improve reporting mechanisms to ensure ease of access for all staff as well as an anonymised option - Comprehensive support for staff experiencing discriminatory behaviours - Ensuring individuals reporting incidents are kept in the loop and made aware action underway and outcomes - Support, guidance and advice for staff members responsible for managing incidents - Robust monitoring and reporting of incidents - Support and guidance for bystanders - Staff training **Measurable outcome:** Incremental improvement in NHS Staff Survey results from 2022/23 onwards 1. Achieve upward scores and a positive trajectory for NSS results for this indicator. 2. Achieve 'national average score' for Acute Trusts in all indicators 3. Achieve above average scores and position ULHT in upper quartile for NSS results for all	Target completion date: December 2023
6. Percentage of staff experiencing harassment, bullying		**Associate Director - OD, Wellbeing & Inclusion**	**Continue implementation of United Against programme** (see actions detailed in indicator 5)	In progress. Target completion date: December 2023

or abuse from staff in last 12 months.		Supported by: People & OD VSM team EDI team United Against working group Staffside Staff Networks	Actions embedded within delivery plans for ULHT EDI Objectives and People Promise Actions embedded within Culture and Leadership programme Civility actions embedded in Lincolnshire Belonging Strategy and part of the 'Bullying & Harassment' work-stream CQ Leading Inclusively with Cultural Intelligence programme (system and Trust level) **Measurable outcome:** Incremental improvement in NHS Staff Survey results from 2022/23 onwards 1. Achieve upward scores and a positive trajectory for NSS results for this indicator. 2. Achieve 'national average score' for Acute Trusts in all indicators 3. Achieve above average scores and position ULHT in upper quartile for NSS results for all	EDI objectives cover 2023-2025 June 2023 June 2023

7. Percentage believing that trust provides equal opportunities for career progression or promotion		**Head of Recruitment** Supporting colleagues: People & OD VSM team EDI team	**Inclusive recruitment review** (existing action in NHS Lincolnshire "Belonging" Strategy) – as per Indicator 2. **Measurable outcome:** Incremental improvement in NHS Staff Survey results from 2022/23 onwards 1. Achieve upward scores and a positive trajectory for NSS results for this indicator. 2. Achieve 'national average score' for Acute Trusts in all indicators 3. Achieve above average scores and position ULHT in upper quartile for NSS results for all	June 2023
8. Percentage of staff who personally experienced discrimination at work from a manager, team leader or other colleagues		**Associate Director - OD, Wellbeing & Inclusion** Supported by: People & OD VSM team EDI team United Against working group Staffside Staff Networks	Please see details for indicators 5 and 6 above	As for indicators 5 & 6

9. Percentage difference between the organisation's Board voting membership and its overall workforce BME representation.		**Trust Board** Supporting colleagues: Trust Board Secretary AD – OD, Wellbeing & Inclusion. EDI team External recruitment & selection partners	No substantive* BME representation on ULHT Board. BME colleagues represent 16.76% of the overall workforce; 69% of the medical workforce; 14% of the Agenda for Change clinical workforce. **Prepare now for future/pending vacancies on ULHT Board – actions required:** ensure recruitment and selection processes/methods are inclusive (action included in WDES action plan to support better Board representation) **Measurable outcomes**: 1. Inclusive Board recruitment & selection process established 2. Increased representation at senior level *Board includes seconded BME staff member	April 2023
Medical workforce - Supporting actions pending launch of local Medical Workforce Race Equality Standards (MWRES) by national WRES team.		**EDI Team** Supported by: Medical Director's Office Associate Director - OD, Wellbeing & Inclusion Medical Staffing Team	Following actions proposed to support BME medical colleagues 1. Establish working group to launch "Welcoming & Valuing International Medical Graduates" standards. Group will apply best induction practice for all professional groups. Ensure actions embedded to achieve following outcomes: increased support for international new starters; development of future Consultant pipeline 2. Engage with Speciality/Locally-Employed Doctors* to understand this group's employee experience and use the intelligence gathered to inform MWRES actions	December 2022 - April 2023

		Divisional Tri-umvirate Teams	3. Recognition for BME colleagues in senior divisional leadership roles *collectively referred to as *non-consultant grades* in WRES	

APPENDIX ONE:

WRES Indicator 1:
Percentage of staff in NHS Agenda for Change (AfC) pay bands or medical and dental subgroups and very senior managers (VSM), including executive board members, compared with the percentage of staff in the overall workforce.

Total number of staff employed within the Trust on 31 March 2022: 8513

Percentage of BME staff:	16.76%	(n=1427)
Percentage of white staff:	81.35%	(n=6925)
Percentage not declared/unknown:	1.89%	(n=161)

NB: Bank staff not included and WRES for Bank pending

TABLE 1: Non-Clinical: Percentage of staff by AfC Band (previous year figure)

	BME	**White**	**Unknown/Undeclared**
Under Band 1	10%	90%	0
Band 1	0% (3.27%)	90% (94.12%)	10% (2.61%)
Band 2	3.4% (2.84%)	95.6% (96.45%)	0.96% (0.71%)
Band 3	2.2% (1.4%)	97% (97.8%)	0.6% (0.8%)
Band 4	2.5% (2.5%)	97.1% (97.48%)	0.32% (0)
Band 5	1.7% (2.26%)	97.7% (97.18%)	0.6% (0.56%)
Band 6	5% (3.39%)	93.6% (94.07%)	1.4% (2.54%)
Band 7	2.1% (3.41%)	95.8% (96.59%)	2.1% (0)
Band 8a	1.85% (3.85%)	94.4% (92.31%)	3.7% (3.85%)
Band 8b	15.4% (9.38%)	84.6% (90.63%)	0% (0)
Band 8c	0% (6.25%)	100% (93.75%)	0% (0)
Band 8d	12.5% (0)	87.5% (100%)	0% (0)
Band 9	16.7% (14.29%)	83.3% (85.71%)	0% (0)
VSM	0% (0)	100% (100%)	0% (0)
Total: AfC Non-Clinical Workforce	**3.1%** (2.69%) **BME**	**96%** (96.47%) **White**	**0.9%** (0.84%) **Unknown**

TABLE 2: Clinical: Percentage of staff by AfC Band (previous year figure)

	BME	**White**	**Unknown/Undeclared**
Under Band 1	0% (0%)	100% (100%)	0 (0%)
Band 1	0 0	0 0	0 0
Band 2	8.6% (7.04%)	90.5% (92.15%)	0.79% (0.81%)
Band 3	23.7% (17.69%)	75.6% (81.54%)	0.75% (0.77%)
Band 4	7.9% (3.26%)	92.1% (96.74%)	0 (0)
Band 5	25.5% (14.34%)	71.5% (84.42%)	3.0% (1.24%)
Band 6	8.8% (7.57%)	90.8% (92.22%)	0.4% (0.21%)
Band 7	4.9% (4.44%)	5% (94.71%)	0.6% (0.85%)
Band 8a	9.8% (9.41%)	89.2% (88.82%)	0.99% (1.76%)
Band 8b	7.5% (8.33%)	90% (88.89%)	2.5% (2.78%)
Band 8c	26.7% (17.65%)	73.3% (82.35%)	0 (0)
Band 8d	0 (0)	100% (100%)	0 (0)
Band 9	0 (0)	100% (83.33%)	0 (16.67%)
VSM	0 (0)	100%	0 (0)
Total: AfC Clinical Workforce	**14.2%** (9.55%) **BME**	**84.3%** (89.6%) **White**	**1.4%** (0.85%) **Unknown**

Table 3: Medical and Dental: Percentage of staff by AfC Band (previous year figure)

	BME	**White**	**Unknown/Undeclared**
Consultants	60.5% (60.12%)	34% (34.68%)	5.5% (5.2%)
Of which senior medical managers	0 (0)	0 (0)	0 (0)
Non-Consultant Career Grade	80.7% (78.7%)	10.5% (14.7%)	8.8% (6.6%)
Trainee Grades	69.39% (66.26)	23.2% (24.12%)	7.4% (9.62%)
Other	0 (0)	0 (0)	0 (0)

Total: Medical & Dental Workforce	**68.8%** (66.74%) **BME**	**24.3%** (25.63%) **White**	**6.9%** (7.63%) **Unknown**

WRES Indicator 9:

Percentage difference between the Trust Board's voting membership and its overall workforce / executive membership and the overall workforce (previous year figure):

	BME* (Number)	**White (Number)**	**Unknown (Number)**
Total Board Members	0 (0) *1 board member on secondment to ULHT	11 (12)	2 (0)
Voting Board Members	0 (0)	10 (10)	1 (0)
Non-Voting Board Members	0 (0) *1 board member on secondment to ULHT	1 (2)	1 (0)
Executive Board Members	0 (0)	6 (6)	1 (0)
Non-Executive Board Members	0 (0)	5 (6)	1 (0)
% difference between Voting Board members & overall workforce	**-16.8%** (-13.3%)	**+3.3%** (+14.9%)	**+13.5%** (-1.6%)

Meeting	Trust Board
Date of Meeting	4 October 2022
Item Number	Item 9.2
Final Draft / ULHT Workforce Disability Equality Standard (WDES) Action Plan 2022/23	
Accountable Director	Claire Low, Executive Director for People & OD
Presented by	
Author(s)	Sarah Akhtar, Associate Director for OD, Wellbeing and Inclusion and Alison Marriot, EDI Project Manager
Report previously considered at	People and OD Committee – 9 September 2022

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

Risk Assessment	*To be confirmed*
Financial Impact Assessment	*Costs to be confirmed*
Quality Impact Assessment	*Individual actions subject to assessment*
Equality Impact Assessment	*Individual actions subject to assessment*
Assurance Level Assessment	*Insert assurance level* ▪ *Moderate*
Recommendations/ Decision Required	Trust Board are requested to: 1. Review the attached final draft action plan 2. Consider the proposed WDES actions 3. Confirm and share any further insights 4. Support the approach proposed 5. Support publication of ULHT WDES Action Plan 2022/23

Executive Summary
As detailed below

United Lincolnshire Hospitals NHS Trust

PEOPLE AND OD COMMITTEE (PODC)
4 October 2022

FINAL DRAFT
ULHT Workforce Disability Equality Standard (WDES) Action Plan 2022/23

INTRODUCTION

- Implementing the Workforce Disability Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

- Equal access to career opportunities and fair treatment in the workplace for disabled employees is important because studies shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

- The Workforce Disability Equality Standard (WDES) consists of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

- NHS organisations use the metrics data to develop and publish an action plan (see attached). Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality.

- The WDES enables NHS organisations to better understand the experiences of their disabled staff and supports positive change for all staff by creating a more inclusive environment for Disabled people working and seeking employment in the NHS.

ULHT WDES ACTION PLAN 2022/23

1. The action plan is informed by the results of the NHS Staff Survey, regional/system and national priorities. The plan aims to address important challenges for ULHT such as abusive behaviour and a significant disparity in how valued Disabled colleagues feel compared to non-Disabled colleagues.

2. The area of Workplace / Reasonable Adjustments is highlighted as an area in need of greater focus as is supporting Disabled staff to ‘disclose’ their disability status and relates to the Trust’s ambition to create a culture which fosters belonging and where individuals can feel confident, respected and safe at work.

3. The Trust’s aim is to move from compliance to good practice.

4. Trust WDES actions are aligned to the Belonging element of the Lincolnshire System People Plan and brings greater momentum to the agenda and to the priorities.

5. Stakeholder engagement with individuals and groups served to raise awareness of the Trust's EDI agenda and the employee experience of Disabled staff. Focus groups and discussions were used to agree actions and informed the development of the action.

PROGRESS AND NEXT STEPS

1. WDES Action Plan 2022/23 ratified by EDI Group and People and OD Committee
2. Publication WDES Action Plan 2022/23 (by 31 October 2022)
3. Update to CCG Senior Equality & Human Rights Manager - October 2022 (contractual requirement under Section 6)
4. Communication to all stakeholders (all staff; system partners; participants of WDES workshops)

OUTSTANDING CARE personally DELIVERED

Workforce Disability Equality Standard (WDES) Action Plan 2022/23				
WDES Measure	**Current WDES performance**	**Lead**	**Actions**	**Timescale**
1. Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce		**Director of Finance & Digital/People & OD** Supporting colleagues: EDI Team Chief Executive's Office Medical Staffing/ Medical Director's Office Communications Team MAPLE Staff Network Head of Recruitment OD Team	**Awareness Campaign** Staff guidance for updating EDI information (ESR) i.e. why it is important; definition of Disability including long-term conditions that might not be understood as a 'Disability' Medical Workforce Engagement: address level of comfort/safety in disclosing a disability in ESR ULHT Board Engagement/senior level engagement (Cluster 4 in WDES data): encourage/raise awareness around disclosure of a Disability via ESR; increase awareness lived experiences of Disabled colleagues and long-term conditions (link to WDES Innovation Fund Bid) Ensure recruitment processes continue to capture equalities information efficiently via application stage and upon appointment (via ESR) Ensure new starters given opportunity to review & update equalities information during Corporate Induction **Measurable Outcome** – increase Disability declaration rate to 5% by 2023-24	October-December 2022 Immediate & ongoing December 2022

2. Relative likelihood of staff being appointed from shortlisting across all posts.	 Disabled candidates slightly more likely to be appointed	**Head of Recruitment** Supporting colleagues: "Overhauling Recruitment" Working Group (Lincs ICB) EDI team MAPLE Staff Network	**Inclusive Recruitment Review –** end to end review of process (application of reasonable adjustments; attraction and selection methods; recruitment training for appointing line managers) Assessment of benefits - TRAC vs. ESR metric data Review Trust performance against Mindful Employer and Disability Confident Employer schemes (ensure Trust is achieving/sustaining standards) Improve quality and access to intranet information for Disabled colleagues and line managers to ensure awareness of scheme including support available and recruiting managers' responsibilities. **Measurable Outcome** – disabled colleagues are currently slightly more likely to be appointed from shortlisting (0.94). Maintain current performance (1.0)	In progress – current work plan concludes June 2023 End January 2023
3. Relative likelihood of staff entering the formal capability procedure, for performance-related reasons.		**Associate Director - Workforce** Supporting colleagues: ER team/HRBPS EDI team MAPLE Staff Network	**Review Capability Policy and Procedure -** from Disability perspective (including support for Disabled colleagues) For note: action included in Lincolnshire Belonging Strategy **Detailed case analysis –** independent/in strictest confidence review of formal cases reported in this year's WDES data in order to understand disparity **Measurable Outcome:** reduce disparity ratio between Disabled and non-Disabled staff from 9.4 to 4.5 (or lower)	In progress – current work plan concludes June 2023 End March 2023

4a. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months Percentage of staff experiencing bullying, harassment or abuse from managers in the last 12 months Percentage of staff experiencing bullying, harassment or abuse from other colleagues in the last 12 months	  	**Associate Director for OD, Wellbeing & Inclusion** Supporting colleagues: EDI Team United Against - working group Staffside Programme Manager for CQ MAPLE staff network Lincs ICS Belonging Strategy – Bullying & Harassment workstream members	**Continue with implementation of 'United Against' actions** (guided by the anti-racism strategy). For note: action also included in Lincolnshire Belonging Strategy (Bullying & Harassment work stream) and People Promise Delivery Plan for ULHT **Key actions as follows:** - Improve reporting mechanisms for colleagues and by-standers (accessible, simple and an anonymised option) - Improved support for colleagues experiencing abuse i.e. via EAP - Better feedback on action taken and outcomes - Accessible resources for staff involved with managing incidents, supporting witnesses etc - Fostering 'allyship' and delivering support for bystanders (via Culture and Leadership and values project) - Continued implementation of CQ Leading Inclusively with Cultural Intelligence Programme (Trust and system level) **Measurable Outcomes**: incremental improvement in NHS Staff Survey results from 2022/23 onwards 1. Achieve upward scores and a positive trajectory for indicators (4a) 2. Achieve 'national average score' for Acute Trusts in all indicators 3. Achieve above average scores and position ULHT in upper quartile for NSS results for all	In progress, current workplans conclude April 2023

4b. Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	 Disabled colleagues slightly more likely to report For note: overall confidence to report has decreased for all groups 	**EDI team** Supporting colleagues: Freedom to Speak Up Guardian People Promise Manager MAPLE Staff Network Lincs Belonging Strategy (Bullying & Harassment working group)	See above actions and detail for Indicator 4a. **Measurable Outcomes:** 1. Increased confidence to report concerns amongst colleagues directly affected by abuse, discrimination etc. 2. Increased confidence to report concerns amongst colleagues indirectly affected (bystanders) by abuse, discrimination etc.	In progress, current work plans conclude April 2023.
5. Percentage believing that trust provides equal opportunities for career progression or promotion		**Head of Recruitment** Supporting colleagues: EDI team MAPLE Staff Network	See above actions and detail for indicators 2 (Inclusive Recruitment) and 4a **Measurable Outcomes:** 1. Improved NSS scores (as detailed in 4a) 2. Disparity ratio (gap between disabled and non-disabled staff) improved by at least 1% point and is above the national NHS average	In progress, current work plans conclude April and June 2023

6. Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.		**EDI team** Supporting colleagues: HR Policy Manager MAPLE Staff Network Staff-side Occupational Health team OD Team	**Review Absence Management Policy:** from a Disability perspective and put forward recommendations, including support for reasonable adjustments when attending medical appointments relating to a disability **Review of Flexible Working Requests –** by protected characteristics. **Measurable Outcomes:** 1. Improved NSS scores (as detailed in 4a) 2. Accurate understanding if any barriers for disabled colleagues' access to flexible working arrangements, and establish any actions required.	March 2023 February 2023
7. Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work		**EDI team**	**Engage MAPLE Staff Network and ULHT colleagues -** to establish reasons for disabled colleagues being more likely (+10%) to feel that the Trust does not value their work, when compared with non-disabled colleagues **Measurable outcome**: - 1. Improved NSS scores (as detailed in 4a)	December 2022 (link to Disability History Month)

8. Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work		**EDI team** Supporting colleagues: HR Policy Manager Occupational Health team Strategic HRBPs MAPLE Staff Network OD team	Latest NSS 2021 results highlight following staff groups reporting lower scores when requesting adequate adjustments – when compared with colleagues in other staff groups: • Medical & Dental – 55.6% • Estates & Ancillary – 63.6% • Nursing & Midwifery Registered – 63.6% Actions required: 1. Identify gaps in provision of adequate adjustments – with particular attention to the staff groups listed above 2. Raise awareness and share information about the Access to Work Scheme. 3. Reasonable/Workplace Adjustments Policy & communications to raise awareness of responsibilities 4. Research and identify good practice amongst NHS Trusts to confirm management of reasonable adjustments **Measurable outcome:** 1. Improved NSS results, including reduction by at least 1% point in gap between experience of disabled and non-disabled colleagues by 2023 NSS results 2. Improved NSS results for the three areas of the workforce identified above, by at least 1% in 2023 NSS results.	March 2023

9a. The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. 9b. Have you taken action to facilitate the voices of disabled staff to be heard in your Trust?	 	**EDI team** Supporting colleagues: Council of Staff Networks MAPLE Staff Network & Executive Sponsor Communications Team Strategic HR Business Partners	**Continue with Engagement with Disabled Colleagues** assisted by supporting colleagues For note, actions/outcomes detailed in 4a and 7 above will support this indicator **Measurable Outcome:** 1. Improved NSS score as detailed in 4a, to reduce gap between disabled and non-disabled colleagues. Continue support the MAPLE Staff Network. To continue to actively support Lincolnshire ICB system-working with all staff networks, with which ULHT is taking the lead role (Chair – ULHT Women's Network) To continue to meet on a monthly basis with colleagues across the system, with the support of the "Every-One" organisation, to establish a support network for NHS staff who are also unpaid carers outside of work. **Measurable outcomes**: 1. MAPLE network membership increased by at least 10% 2. There is an identifiable NHS staff carers network in place, either on a system-basis or as a Trust	Ongoing End April 2023

10. Percentage difference between the organisation's Board voting membership and its overall workforce.		**Trust Board** Supporting colleagues include: Trust Board Secretary AD – OD, Wellbeing & Inclusion. EDI team External recruitment & selection partners	Please see indicator 1: improving disclosure rates (applicable to Trust Board members also) **Further action required:** Prepare for future Trust Board vacancies by reviewing recruitment and selection process from inclusion perspective (aligns with action for WRES/BME Board representation). **Measurable Outcomes**: 1. Each Trust Board member is aware of how to update their disability status in ESR (improving disclosure rates) 2. Inclusive Board recruitment & selection process established, and enacted when there is a vacancy 3. Increased representation at senior level	April 2023

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	22 September 2022
Chairperson:	Dani Cecchini, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Report** The Committee received the report noting the estates discussions held during the finance report and the current position with the level of investment required in the Trust's infrastructure. The Committee noted the escalation being made in respect of fire safety which was currently a high risk on the strategic risk register. Work was continuing in respect of the fire plan however it was noted that concerns were being identified. These would be considered in detail during October and reported to the Committee in due course. **Low Surface Temperature Report** The Committee received the report noting that significant assurance was offered and noted that some final remedial were being completed at Louth. The Committee noted that quotations were being received in respect of other locations.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contract and CRIG Upward Report** The Committee received the finance report which offered limited assurance with discussion undertaken on the approach taken to report the month 5 position due to unavailability of the ledger system with further assurance offered through the discussion. The Committee noted the month 5 position reported as £9.1m deficit year to date against a breakeven plan. The Committee discussed and would welcome sight of quantified risk and mitigations in order to

	provide more rigour around the risks relating to Covid-19 costs, open beds, CIP delivery and elective recovery fund. The Committee noted concern on the ERF however recognised the limited guidance which was currently available. It was noted however that the change in case mix may support the position. Work continued to update the ledger and it was noted that due to the outage time this would impact on the Trusts Better Payment Practice Code for which the Trust was monitored externally, there was an understanding of this position nationally. The Committee received the CIP report noting the limited assurance that was offered and the current identification of £22.7m CIP compared to the £33m target. It was noted that £17m was expected to be delivered against plan. The Committee noted the number of pipeline transactional cost saving schemes identified which required working up. The Capital Delivery Group Upward Reports were received by the Committee, and it was noted that moderate assurance was offered in respect of the delivery of capital. It was noted that whilst there had been some slippage on schemes these were on track for delivery in different quarters. An updated forecast for capital delivery would be offered to the Committee in order to consider those elements, such as estates infrastructure, which may need to be addressed sooner than the currently prioritised capital spend. The Committee received the CRIG upward report noting this offered moderate assurance and offered to the Committee information on the investments coming through. The Committee received the Contract report which again offered moderate assurance however it was noted that some provider-to-provider contracts remained unsigned. There was not thought to be a financial risk at this time as a result. **Procurement Strategy** The Committee welcomed the Deputy Director of Procurement who presented the Procurement strategy and noted that the strategy had been put in place 18 months previously and had resulted in positive changes in the service. The Committee was pleased to note the developments of the service which worked across the ICB for the three provider organisations and supported opportunities to achieve better value for money. The Committee accepted the strategy and noted that quarterly reporting would be offered to the Committee once confirmed through the

	development session. The Committee requested reporting on the progress against the strategy and an understanding of what was included within the workplace for the top 20 contracts in order to understand what would be coming through. The Committee was pleased to note and offered thanks for the support from the Procurement team in respect of the support and management for business continuity when the ledger system was unavailable.
	Assurance in respect of SO 3c Enhanced data and digital capability No reports due
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting the limited assurance and continued deterioration amongst most of the metrics. The deterioration was noted due to the lack of flow and discharge across the organisation due to the number of open beds, length of stay and pressures in the ability to receive patients. The Committee noted that there had been some improvements in cancer services however noted that there continued to be national concern and issues with colorectal cancer services which were also impacting the Trust. Work was underway to try to address some of the concerns however it was noted that this would impact on other areas. The Committee noted the continued work in respect of urgent care and care closer to home in order to improve flow through the hospitals however noted that the impact of this was not expected to be seen until December.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 3f Urgent Care **As reported at SO 3d**
	Assurance in respect of SO 4a Establish new evidence based models of care No reports due

	Assurance in respect of other areas: **Winter Plan** The Committee received a verbal update in respect of the winter plan and progress that had been made noting that the plan would be presented to the Committee in full in October and onward to the Board. The winter plan had been developed through a system approach recognising that there was a need to not add more pressure in to the acute services. The Committee noted the need for delivery of improvement programmes which would be bolstered by the winter plan. **Committee Performance Dashboard** The Committee noted the continued deterioration in performance metrics which had been discussed in detail through the operational performance report. **Topical, Legal and Regulatory Update** The Committee received the report for information noting that those items reported were, in the main, subject to discussion by the Committee. **Integrated Improvement Plan** The Committee received the report noting that limited assurance was offered in respect of the progress against delivery of the Trust's IIP. It was noted that all but 1 of the measures, IPC BAF (Green) were reported as red, not achieving ambition. 2 indicators remained outstanding in respect of DKA indicators and Health Inequalities and Core20Plus. Whilst 2 indicators remained outstanding the Committee noted the progress that had been made to include these. The Committee noted that it was not considering trajectories but wished to understand that there were underpinning arrangements in place for all schemes to support delivery. **Improvement Steering Group Upward Report** The Committee received the report noting that this offered oversight of the improvement programmes and that maturity of the programme continued to develop. It was noted that rigour and interventions were being put in place to ensure a clear understanding as to why progress was not being made with support then being offered to achieve delivery. Concern was noted with regard to the appropriate level of resource in place to support the programmes however the Committee undertook detailed discussion of those programmes of work relevant to it in order to understand the position. **CQC Action Plan**

	The Committee received the report taking this as read noting there had been no movement from the previous report.
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.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	*ULHT Trust Board*
Date of Meeting	*4 October 2022*
Item Number	*Item 11.1*
ULHT Nuclear Medicine Consultation	
Accountable Director	*Simon Evans Chief Operating officer.*
Presented by	*Simon Evans* *Ian Fulloway Diagnostics Lead* *Dr Laura White Head of Nuclear Medicine*
Author(s)	*Laura White, Head of Nuclear Medicine* *Anna Richards, Associate Director of Communications& Engagement* *Andrew Prydderch, Associate Director of Strategic Projects* *Helen Christie, Senior Finance Business Partner* *Paul Bulman, Associate Director of Finance*
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	
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	
4a Establish new evidence based models of care	*X*
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	*X*

Risk Assessment	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*2 QIAs approved on the 11th May* *Both had an overall risk score of 12.*
Equality Impact Assessment	EIA forms part of the new QIA model
Assurance Level Assessment	*Insert assurance level* • *Moderate*
Recommendations/ Decision Required	• Decision on the future configuration of Nuclear Medicine within ULHT. • *Recommendation that the Trust support the move to a single site model of care*

Nuclear medicine is a specialist imaging technique involving the administration of radioactive substances (called radiopharmaceuticals) in the diagnosis and treatment of disease. The technique enables assessment of the function of organs, whereas most conventional imaging modalities (e.g. X-ray) look at anatomy.

The majority of radiopharmaceuticals used for these tests are made daily in an aseptic facility known as a radiopharmacy.

There are over 20 different tests that nuclear medicine can perform and they look at conditions as diverse as Parkinson's disease to delayed gastric emptying. In United Lincolnshire Hospitals NHS Trust (ULHT) hospitals, the most common tests performed are bone scans and heart scans.

Nuclear medicine services in Lincolnshire are provided at Grantham and District Hospital (GDH), Lincoln County Hospital (LCH) and Pilgrim Hospital, Boston (PHB). The imaging is performed at all three sites using five gamma cameras.

There is a relatively new £1 million regional radiopharmacy based at Lincoln. This radiopharmacy provides radiopharmaceuticals for the whole county and transports to Grantham and Boston on a daily basis.

There are currently a range of issues facing the service, including shortage of staff, aging equipment, future proofing the service, aging workforce and a challenge around the move of the Boston service due to the building of the new Emergency Department on the site. This is why it was decided to review the future delivery of the service.

The options for the future of the nuclear medicine service have been subject to a 14 week public consultation which ran from Monday 28 February 2022 to Monday 6 June 2022.

The consultation presented two possible viable options for the future of the service:

- Option 1: Centralisation of the service at Lincoln
- Option 2: Centralisation of the service at two sites – Lincoln and Pilgrim

It was always the case that there were significant benefits to either model over business as usual. An economic appraisal of the benefits, risks and hypothetical costs was undertaken. (This economic appraisal excluded the high cost of providing a new service at PHB due to the demolition of the building)

The financial appraisal takes into account the real world costs of providing a new service at PHB due to the demolition of OX block where the service is currently. This shows that:

- Capital costs would be £3.1M for the single site option and £5.6M for the two site model;
- There are reductions in revenue costs by c. £200K for the single site model;

A summary of the findings from the consultation can be found later in this paper, along with an in-depth analysis of the potential future options and potential implications around cost, co-dependent services and staffing. The paper also discusses subsequent challenges now faced by the department since the original consultation options were considered.

Purpose

The purpose of this paper is to provide the Trust Board with an overview of the current configuration of the nuclear medicine service and to provide feedback from the public consultation recently held on the future of the service.

The paper illustrates how the two options proposed would impact on how the service is delivered with both the positive and negative impacts of different configurations.

Strategic Context

Because nuclear medicine is a specialised technique, the vast majority of patients will only attend for one specific test (which may require two separate visits). Due to the fact nuclear medicine involves radiation, the technique is highly regulated and all staff have to undergo extensive specialist training. This is to ensure the risk to the patient from the radiation is outweighed by the benefits of having the procedure.

After administration of the radiopharmaceutical, patients must wait for a specified time to allow the radiopharmaceutical to distribute in their bodies before the images are then taken on a specialist camera called a gamma camera. This camera detects the radiation emitted from the patient to enable the organ of interest to be investigated. A gamma camera is similar in size to a CT scanner.

A clinician is required to oversee the service and hold an ARSAC (Administration of radioactive substances advisory committee) licence (Practitioner Licence). This licence lists the different diagnostic tests that can be performed under that Practitioner. Only tests that

the clinician has proven training and experience in are listed on this licence to ensure the test is diagnostic and the impact on patient management is optimised. Departments with an ARSAC licence also require a certain number of Medical Physics Experts (MPE) to oversee the service at that site (site licence), this also lists the tests that can be performed at that site.

Nationally there are issues with the provision of nuclear medicine services. National technologist training schemes ceased a few years ago and the impact is now starting to be felt as the current workforce ages. A national survey in 2019 (*IPEM Workforce Report, No 55*) showed that 10% of staff working in the field are over the age of 55 and a further 39% are over the age of 40. Contrary to most modalities in medical imaging, there has been static demand for the service over the last 5 years as outlined in *Diagnostics: Recovery and Renewal, NHSE, October 2020*. It is likely that future demand will reduce or the types of investigations will change due to new developments in other diagnostics.

The Case for Change

Similar to the national picture, ULHT has struggled to recruit staff into the Nuclear Medicine service for a number of years. The age of current trained staff in the department is an issue, with 23% above the age of 55 - well above the national picture.

Equipment is also a problem, with all of the Gamma cameras in Lincolnshire being beyond the recommended replacement age (10 years reference: *Diagnostics: Recovery and Renewal, NHSE, October 2020*) and some contracts are now “end of life, best endeavours only” contracts. This means any fault requiring replacement parts could mean the camera will no longer work, if the part is no longer available.

The British Nuclear Medicine Society (BNMS) guidance states there should be one camera for every 1,500 referrals. If this is applied to patient numbers across Lincolnshire there would be a requirement for three cameras. There are currently five within the county.

There has been a desire to look at how the service is delivered at ULHT for a number of years due to the lack of demand and staffing challenges at some of the sites. Rationalising the service would mean an efficient, robust service with the capacity to train more staff, to help address the issues with the number of staff due to retire in the next few years. In addition, the opportunities for learning new skills is bigger if the service is centralised at one

or two sites, and therefore retention of staff should be higher. (A previous example of this approach succeeding is with the Lincolnshire Cardiac service.)

In addition to all of the above, the building that currently houses the nuclear medicine service at Boston is going to be knocked down to make way for the new Emergency Department (ED) next year. Before the Trust invests a substantial amount of money in building a replacement nuclear medicine department at Pilgrim, the feasibility of being able to run this department effectively for a number of years needs to be considered. It needs to be understood that any future service model agreed upon will result in no service at Pilgrim for a period of time (likely to be at least a year) as the ED build requires the building to be removed in February 2023. The procurement, build and commissioning of the new department means it is unlikely to be operational until financial year 2024/2025.

In view of the aging workforce, inability to recruit, and need to urgently replace out of date equipment the service undertook a review of future models of provision. Two options were developed and taken to public consultation, however this paper will also consider the business-as-usual scenario. The driver behind the options is the need to reduce current provision due to poor robustness of service and staff provision.

It is our opinion that the only way to ensure a robust, responsive, future-proof nuclear medicine service for Lincolnshire is to reduce the number of sites where it is provided.

Current Situation (Business as Usual)

Table 1 and table 2 show the services currently provided and staffing at each site. Table 3 shows the equipment at each site. The most common tests are provided at all three sites, with the exception of one gastro examination which is not provided at Pilgrim. This means currently patients must attend two appointments (separated by a week) at either Lincoln or Grantham hospital for this specific test.

Services available at each nuclear medicine site				
Sites	**Lincoln**	**Grantham**	**Pilgrim**	**Typical usage (patients per year 2019)**

Radiopharmacy	Yes	No	No	Daily (>90% of patient preps)
Bone studies	Yes	Yes	Yes	1234 (L:601, G:252, B:381)
Cardiac studies	Yes	Yes	Yes	775 (L:364, G:193, B:218)
Cardiac stressing	Yes	Yes	Provided by cardiology	772 (L:361, G:193, B:218)
Gastric studies	Yes	Yes	No	474 (L:384, G:90, B:0)
Breast SLN	Yes	Yes	Yes	379 (L:220, G:32, B:127)
Lung imaging	Yes	yes	Yes	226 (L:113, G:22, B:91)
Renal studies	Yes	Yes	Yes	209 (L:111, G:40, B:58)
Hybrid imaging (SPECT/CT)	Yes	No	No	>200 only available in L
Brain studies	Yes	Yes	Yes	153 (L:34,G:67,B:52)
Endocrine	Yes	Some	Some	129 (L:68, G:20, B:41)
Neuroendocrine	Yes	No	No	31 L only
White cell imaging	Yes	No	No	9 L only
Radium therapy	Yes	No	No	11(started sept 2019 only L)
Non-imaging tests	Yes	No	No	10 patients only available in L
Iodine therapy	Yes	No	Yes	8 (only L in 2019 but now in B too)
ULHT liaison to AML PET-CT	Yes	No	some	Service only at LCH
Clinical Scientist training	Yes	No	No	3 year training program
Apprentice technologist training	Yes*	No	No	Appointed in 2021, 3 year degree course.

*Table 1: Services and demand at each site * N.B. Patient numbers are different to number of studies as some tests require two visits. Using 2019 as GDH was a green site/reduced service since then. This provided sufficient capacity for the demand. Number in brackets are scans at each site L:Lincoln, G: Grantham, B: Boston)*

Base of current staffing (Whole time equivalents WTE)			
Sites	**Lincoln**	**Grantham**	**Pilgrim**
Technologists	5.65	1.6	2.8*
Clinical Scientists Provide support for the 3 sites.	2.8** (1.0 WTE MPE)	0	0
Clinical imaging assistants	2.8 (also helps admin)+ 1 apprentice	1 currently vacant	0
Nurses	2.0	0	0.6
Admin	0.8	0	1.06
Total	**14.05**	**2.6**	**4.86**
Number over age of 55 (not including admin)	2 (1 tech and 1 nurse)	1(tech)	1.6 (1 tech 0.6 nurse)

** 0.8 tech now is 50% at PHB and 50 % at one of the other sites.*
*** This is in the process of increasing to 3.8WTE following the recent IRMER CQC inspection. Currently out to advert for a MPE*
Table 2: Staffing in Nuclear Medicine

Equipment at each site			
Sites	**Lincoln**	**Grantham**	**Pilgrim**

Number of gamma cameras	2	1	2
Age of cameras (years)	10,12	16	11,11
Radiopharmacy on site (needed daily to produce drugs for the scan)	Yes (installed 2019)	No (from LCH)	No (from LCH)

Table 3: equipment at each site

Some specialist tests can only be performed at Lincoln due to equipment and licencing requirements. Because the service resources are spread thinly across the three sites there is limited capacity to put on additional ad-hoc sessions with any spikes in demand and little capacity for training.

The majority of tests in nuclear medicine are undertaken solely by nuclear medicine staff. There are two exceptions to this. Firstly, paediatric tests require a doctor from outside of the department to administer the drugs and site the cannula. The other one is myocardial stressing at Pilgrim. The stressing is undertaken by advanced cardiac practitioners from cardiology. This means we are dependent on the availability of these staff to perform the tests. At Pilgrim, the typical number of stress patients in a session is 3-4 whereas in Lincoln they will have 6-7 booked. This limits the responsiveness of the service to fluctuations in demand and the efficiency with both kits and staffing at this site.

Referrals are allocated appointments based on postcode. These are simply split as “LN” postcodes go to Lincoln County, “PE” postcodes to Pilgrim hospital and “NG” postcodes to Grantham However, the team change locations where patients may be seen sooner or if the patient requests a specific site.

When the split of referrals into the service is considered by postcode, 51% come from the LN postcode, 28% come from the PE postcode and 21% come from the NG postcode. This is one of the reasons that Grantham was not considered as the second site in option 2 of the public consultation, as it would involve more patients travelling further. The two sites picked were based on geographical coverage of the county and the demand at that site. A thorough discussion of the 2nd site can be seen in the consultation documents (see Appendix 3).

Examination lengths are very variable, with some studies taking just 10 minutes of camera time, others up to four hours. This makes analysis of capacity and demand difficult. It should also be noted that the second cameras at both Lincoln and Pilgrim hospitals are

currently dedicated cardiac cameras so cannot perform any other procedures. The workflow can therefore be very different when looking at the different sites. Diagram 1 shows a typical day in nuclear medicine at ULHT. This shows why the staffing at the different sites varies and it needs to be remembered that most radiopharmaceuticals have an expiry time of 8-10 hours once they are manufactured.

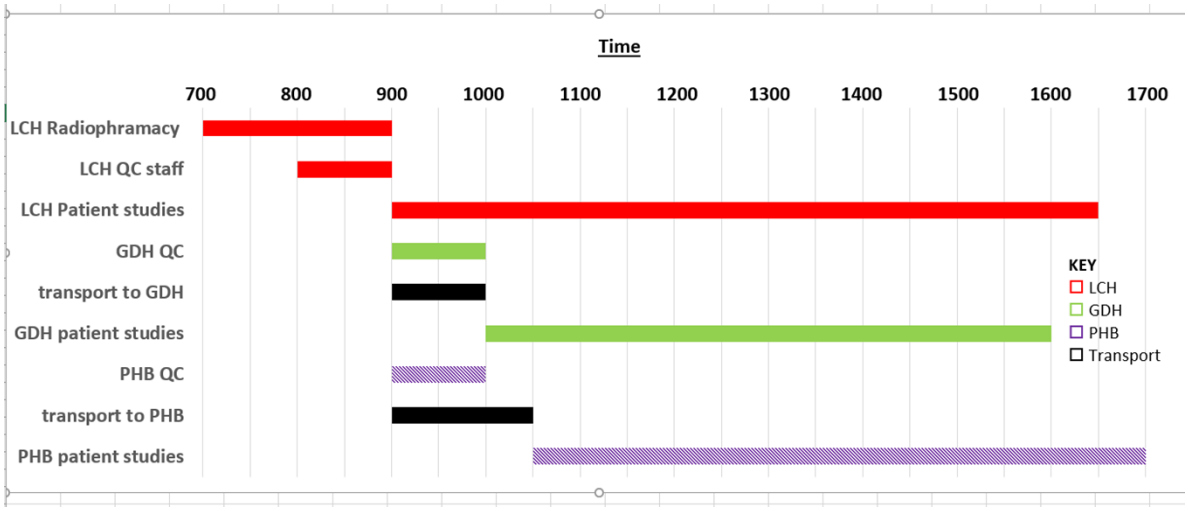


Diagram 1: Typical day in the ULHT nuclear medicine department

Typical duration of patient clinics:

Lincoln:	9:00-16:30	(7:30 hrs)
Grantham:	10:00- 16:00	(6:00 hrs)
Pilgrim:	10:30 – 17:00	(6:30 hrs)

Business Needs

The problems experienced by the service at ULHT mirrors that seen nationally by the field, namely a lack of trained staff, aged cameras and static demand. In addition there is a national problem with supply of isotopes due to reliance on reactors in Europe that are all aged and need regular maintenance and repair. This sometimes means patient studies need to be cancelled at short notice as a generator has not arrived from Europe or a kit has not arrived.

To ensure a quality and future-proofed provision for the population of Lincolnshire it is important that something is done expediently.

The tests performed by conventional nuclear medicine have a number of competitors including PET for bone scanning in urology patients and CT and MRI for cardiac imaging. Another advantage of making a change now is that future decisions around the need to replace cameras is also easier to make.

Current issues:

- Of the five cameras, two of the general purpose cameras have been served “end of life” meaning there is a potential that they could have a fatal fault and end the use of that camera. The third general purpose camera is no longer manufactured so the parts and skilled engineers on the systems are limited. In addition the cardiac cameras are the last two of their kind in the country and there are only two engineers trained to service them. This leads to a lack of resilience in the service.

- The cameras in Lincolnshire are not fully utilised due to a lack of staffing. For example in March 2022 of the potential 115 (23 days per camera) camera days available only 60 were utilised (52%);

- Staffing at all three sites is such that if staff are sick or on annual leave the workload of the department often needs to be altered. This leads to the service not being very robust;

- A lack of trained Technologist staffing means that there is a regular requirement for the Medical Physics Experts (MPEs) to cover radiopharmacy sessions (typically 45 minutes). For example in July 2022 MPE sessions will happen on 43% of the production days. This means the MPEs are not able to perform the jobs only they can do, and they are performing jobs a lower band could do;

- In addition, Clinical Scientists are occasionally required to perform quality control on the camera and pack the radioactive kits to send to the other sites;

- 23% of the trained workforce are within five years of retirement (30% of the clinical technologist workforce). The department has a technologist apprentice who will be fully trained in two years, but training more than one technologist at a time in the

departments is problematic with the current workforce distribution, due to the time required for supervision and staffing spread over three sites.

- In addition, development in the service is difficult due to the lack of capacity for the scientific staff to adopt new methods. There are also difficulties in undertaking the number of audits that would ideally be undertaken to ensure best practice.

Public Consultation summary

1) Introduction

A full public consultation on the future of the nuclear medicine service in Lincolnshire's hospitals was launched on Monday 28 February 2002, initially to run for 12 weeks.

This followed a review of the service, with the input of the ULHT Patient Panel, looking at the sustainability of the service going forward and possible future options.

Before the consultation was launched, the following pre-engagement took place:

- Review of patient experience data around the nuclear medicine service for the years 2018 and 2020.
- Presentation to Lincolnshire Health Scrutiny Committee 15/09/21
- Options development workshop with ULHT Patient Panel 19/10/21

At the beginning of the consultation we had planned four virtual engagement events for participants to attend, due to uncertainty around the safety of face-to-face events in the wake of the COVID-19 pandemic.

During the course of the consultation, there was a request from the Lincolnshire Health Scrutiny Committee that we consider putting on additional face-to-face consultation events, to maximise the opportunity for our public to contribute and given the waning risks around COVID-19.

We therefore added an additional three face-to-face events to our schedule, in the places where it was felt the most impact of any service change might be felt (based on postcode data).

As a result of these additional meetings, we extended the consultation period by an extra two weeks due to the Lincoln City Council local election purdah period, which ran from 21/03/22 to 05/05/22 and prevented us from holding face-to-face meetings for a period of time.

In total, the consultation ran for 14 weeks from Monday 28 February 2022 to Monday 6 June 2022.

2) Engagement activity and response rates

Staff engagement around this proposed service change has been undertaken outside of this public engagement process, with a series of staff meetings.

However, staff were also encouraged to fill in the survey and attend engagement events if they wished.

Public engagement around the future of this service has taken a number of different forms; to enable everyone who wishes to participate to give their views.

This has included public meetings held both virtually and in person, an online survey, paper copies of surveys, direct approaches to nuclear medicine patients and offers of attendance at any patient groups across Lincolnshire.

All engagement meetings have been held in a standard format, with a presentation about the challenges faced and potential options by Head of Nuclear Medicine Laura White, followed by an opportunity for members of the public to offer their views and ask follow-up questions.

In addition, we have carried out a public online survey (also available in paper copy), which was promoted in the local media, on social media, and shared with community groups.

We have held six engagement meetings- two in person and four virtually, which have attracted 10 attendees. The planned face-to-face engagement event planned in Spalding on 10/05/22 was cancelled on the day, due to no members of the public having booked in to attend, in spite of extensive advertising both on social media and in the local media.

We have also attended the Lincolnshire Health Scrutiny Committee, the ULHT Patient Panel, a Lincolnshire ICS meeting and one GP practice Patient Participation Group meeting.

In addition we have received 22 pieces of individual correspondence about the proposed change and options which have been individually logged. The survey has also attracted 919 responses.

Therefore, overall we have listened to over 990 people who have provided their views on this subject.

Meeting	**Detail**	**Numbers at event**
Virtual engagement meeting	08/03/22	0
ULHT Patient Panel	15/03/22	20
Lincolnshire HSC	16/03/22	Panel members
Virtual engagement meeting	28/03/22	1
Virtual engagement meeting	13/04/22	2
ICS meeting	14/04/22	9
Virtual engagement meeting	03/05/22	0
Sidings PPG meeting	03/05/22	7
Face to face engagement meeting	10/05/22 in Spalding	CANCELLED
Face to face engagement meeting	23/05/22 in Grantham	4
Face to face engagement meeting	31/05/22 in Skegness	3

3) Promotion

During the course of the consultation, we have carried out extensive communication with our staff, public, patients and stakeholders about the nuclear medicine service and opportunities to engage. This has included:

- Media press releases issued to all local media on 28/02/22 and 05/04/22 (eliciting a good level of local online, print and broadcast coverage)
- Regular ongoing social media messaging through ULHT corporate Facebook, Twitter and Instagram accounts. Including reminder messaging in advance of each public meeting
- Ongoing advertising on ULHT website
- Column across local publications The Lincolnite, Boston Standard series and Grantham Journal series w/b 25/03/22
- Stakeholder messages, asking for word to be spread to constituents, staff and on social media channels, on 28/02/22 and 05/04/22
- Posters and flyers displayed in hospital nuclear medicine departments
- Flyers distributed at Boston Asda roadshow event on 08/04/22
- ULHT staff-facing messaging including in Weekly Roundup, CEO blog, ULHT Bulletin, staff intranet and on closed staff Facebook group.

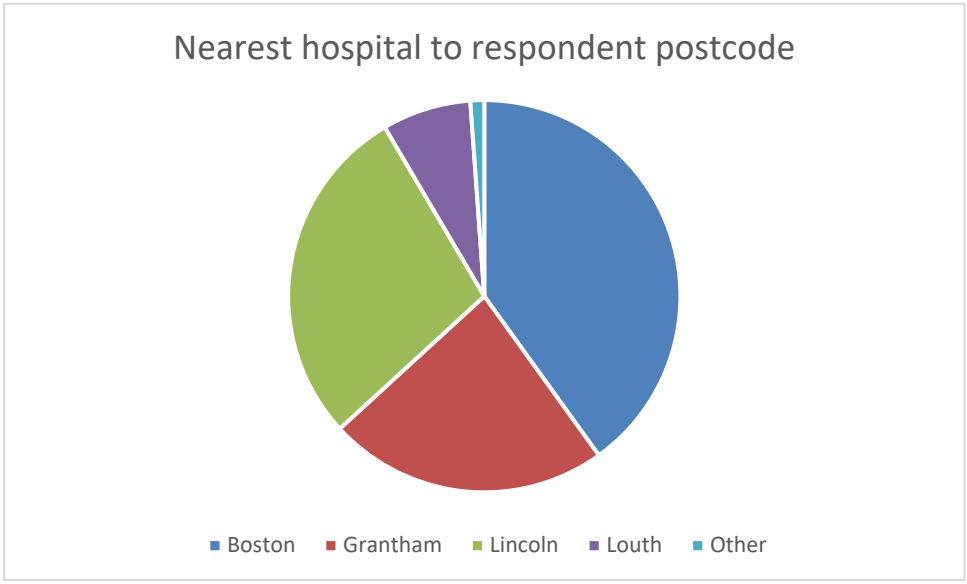
4) Findings

Survey

The survey was circulated using all of the channels described above and ran from Monday 28 February 2022 to Monday 6 June 2022. It attracted 919 individual responses.

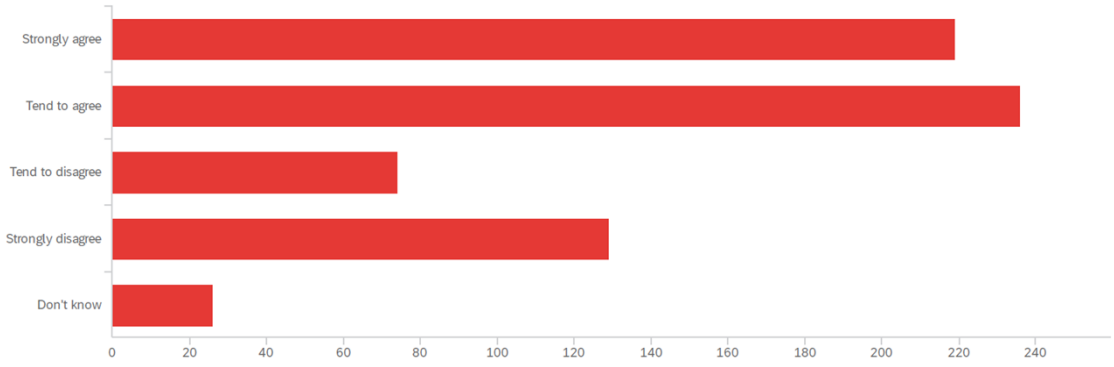
The full results of the survey can be found on our website and appendix 1.

For information on split of respondents based on the nearest hospital to their postcode, please see below. Other hospitals include those outside of Lincolnshire.



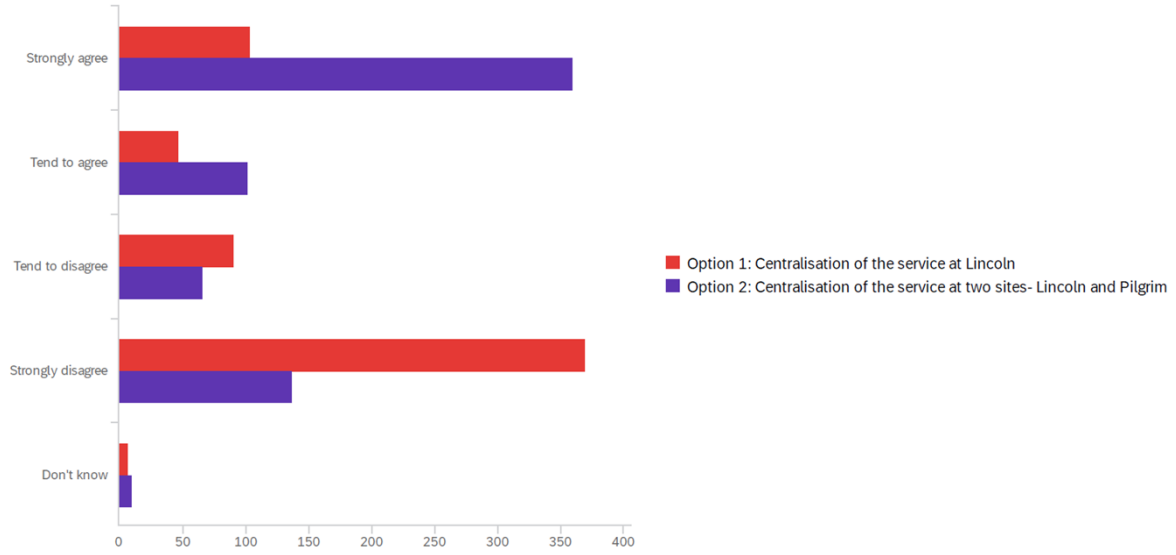
A summary of responses to the key questions asked is outlined below:

How much do you agree or disagree that the Nuclear Medicine service needs to change to ensure a safe and sustainable service to patients in Lincolnshire?



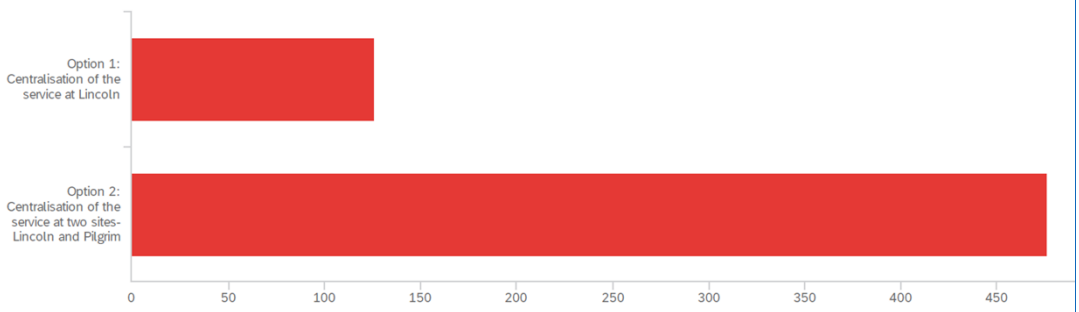
Of the respondents who answered this question, over 66% either tended to agree or strongly agreed. 30% either tended to disagree or strongly disagreed.

Please tell us how much you agree or disagree with proposed Option 1 or proposed Option 2



Overall, the trend of responses was to broadly agree with Option 2, rather than Option 1.

What is your preferred choice for changes to nuclear medicine services?



Overall, 79% of respondents said they preferred Option 2, and 21% of respondents preferred Option 1.

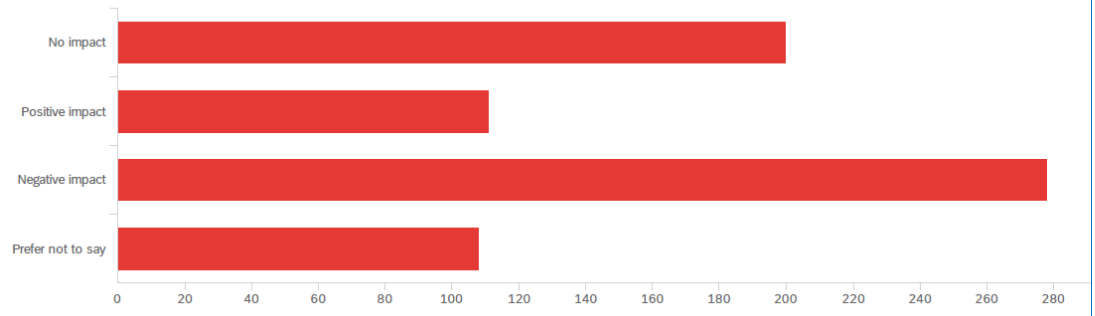
Please tell us why you chose your preferred option and if you have any other suggested proposals to address the identified challenges?

Key points included:

- The service needs to be at Pilgrim to save patients travelling so far and to efficiently serve all the areas to the east of the county and coastal areas

- Lincolnshire is a large county and so needs two centres to provide greater resilience and better patient access
- Better to have a robust service of excellence on one site, than poor practice on two sites
- Preferably keep all three sites open.
- It should be Lincoln and Grantham
- Transport cost and availability is a big consideration. The elderly population would find it more difficult to travel or to find transport.
- The ambulance service will not be able to support patient travel to one site because of increased distance for some patients
- Move the whole service to Louth
- Centralisation at Lincoln would be detrimental to breast services that require vital nuclear medicine support, particularly at Boston
- The radiopharmacy is already at Lincoln and it is the most central option.
- Low numbers of patients will be affected, all of whom only have to access the service very rarely.
- Moving nuclear medicine from Grantham will put undue pressure on the current echo appointments which can delay chemo starting.
- Centralise it to Grantham
- Provide mobile services to all ULHT sites
- Believe centralisation to one site will be more cost effective, however there needs to be an assurance that transport for people without their own cars/ access to public transport will be addressed
- COVID has shown the benefit of splitting resources to help minimise spread of infection. If you have just one centre it increases the risk and reduces options to manage the crisis.
- People have to travel for other specialised services, this is no different
- Spreading the appointments between hospitals will provide patients with more choice.
- Opposed to centralisation of services at Lincoln
- Would prefer to avoid all paediatric nephrology patients having to travel to Lincoln for imaging
- Fuel prices and the cost of living are increasing.

Please tell us about the impact the proposed changes to nuclear medicine services might have on you:



39% of respondents felt that any service change would have a negative impact on them, 29% said they felt it would have no impact and 16% said that they felt it could have a positive impact.

Please tell us the reason for your answer and what could be done to reduce any negative impacts.

Key points included:

- Don't want to travel further
- As I get older, travel becomes more difficult
- Lack of public transport in Lincolnshire
- Difficult to navigate an unfamiliar hospital
- Centralisation makes sense, to make best use of the staff you have
- Better to have a centre of excellence
- Having a better funded service will likely improve the quality of the service
- Worry about impact on breast surgery at Pilgrim if service removed from there
- Easier to recruit staff in Lincoln if centralised
- Should be aiming to make services available more locally and closer to home
- Travel can cause anxiety and worry
- Worry about availability of car parking at Lincoln
- Worry for the staff who will be affected by any change
- One site could lead to unnecessary delays for treatment
- Four hour round trip to Lincoln by bus for people from Skegness

- Want to see the service secure for the future
- Centralisation never works
- Newer equipment and a more efficient service would benefit me
- Having a service at Grantham should not be ruled out
- Worried I may not be well enough to travel long distances
- Patients may refuse treatment because of long travel times, leading to deterioration in their condition
- Negative impact in terms of travel for those living in South Lincolnshire and the East Coast
- Would like to have a choice of where I go
- Not practical to centralise
- Impact of travelling isn't just cost- time off work, carers for children etc.
- Have to travel for most things anyway
- Positive impact of having these services in Lincolnshire, not out of county
- Worried about population increases and the need for these services increasing
- Worried about resilience of just one site if equipment breaks down
- Concerned centralisation will result in long waiters on the cancer pathway
- Would like to see more modern equipment with lower dose imaging of patients- safer
- Discrimination against Grantham population

Suggestions to reduce negative impacts:

- Put on a free inter-hospital bus service
- Improve car parking facilities at Boston and Lincoln
- Develop more services in Peterborough and Kings Lynn
- Invest more
- Centralise management structure
- Retain current service
- Explore the possibility of mobile service
- Have one camera on each site
- Centralise at Grantham only- most central location
- Find the funding to increase the service, not decrease it
- Extend the volunteer driving scheme

Consultation meetings

Of seven public consultation meetings that were scheduled, three did not go ahead due to no attendees being present. The remaining four attracted a total of 10 attendees. A summary of the feedback from these meetings is below:

- Don't like either of the two options being put forward.
- From Grantham, Boston is impossible to get to on public transport.
- Should put any centralised facility in Grantham as it is in the middle of the county.
- We need to take into account that there are places in Lincolnshire that are far away on the coast.
- It would be wrong for people to have to travel 50-plus miles when they are obviously not well
- People in poorer communities would struggle to access the service.
- Could we put transport on?
- You can't put more pressure on the ambulance service, they are already stretched.
- Need to remember that sometimes patients need to go back two days in a row for tests, which is worse if you have to travel a long way.
- Transport is easier from Grantham to Lincoln than to anywhere else in the country- so Lincoln would be preferred option for centralisation
- Plans must take into account future population increases, especially in Grantham and Boston.
- Concerned about the practical implications of a nuclear medicine service change on the breast service.
- Could we explore mobile scanners as an option?
- Can understand the options given, due to staffing issues and pressures.

ULHT Patient Panel

A presentation was made to 20 members of the ULHT Patient Panel as part of the consultation exercise.

A summary of the feedback from the panel is below:

- Have we explored why so many referrals come from LN postcodes?
- The question of transport urgently needs to be answered
- With the issues around training of technicians, is there a possibility to link in with the University of Lincoln?
- You have known about the A&E plans at Pilgrim for years. If you are knocking down the nuclear medicine department doesn't it mean that you have already made the decision to close the Boston unit?
- The more sites you can deliver a service from the better for transport reasons.
- Need to remember that the LN postcode goes as far as the East Coast, so use of postcodes gives a misleading impression of locations.
- Need to consider people going elsewhere (out of county) when developing the options.
- Will need to improve waiting facilities at Lincoln, if more patients are seen there
- Need to look at the solution logically. Two sites are better for patient accessibility, but the service is split and staff have to share and it will hamper making this a service of excellence.
- If you do centralise at Lincoln and put on transport, you could make it a better and quicker service of excellence.
- Could consider taking an apprentice at Boston to secure staffing numbers in the next two years
- Need to compare patient experience and having a centre of excellence. Patients will use this kind of service only once, and therefore will experience any inconvenience only once- and in exchange they get the best facilities, equipment and staff. It has to be centralisation at Lincoln.

Lincolnshire Health Scrutiny Committee response

Lincolnshire Health Scrutiny Committee received a presentation on the challenges facing the nuclear medicine service in September 2021, and then another presentation asking them for their response to the public consultation in March 2022.

Both of these constructive meetings allowed councillors to ask questions of the service lead and determine their response to the changes being proposed.

The HSC provided a formal response to the consultation with outlined that they:

- Tend to disagree that the nuclear medicine service in Lincolnshire needs to change.
- Tend to disagree with Option 1
- Tend to disagree with Option 2

The committee's response included the following comments:

"The Health Scrutiny Committee for Lincolnshire cannot support either options 1 or 2. Option 1 - The Committee is very concerned that the consultation exercise pre-supposes a conclusion that the nuclear medicine service will be centralised at Lincoln County Hospital, so cannot support option 1."

The grounds of this response were multiple, but included:

(1) Impact on patients – Either option would displace thousands of patients per year

(2) Impact on staffing – Whilst the difficulties in recruiting, training and retaining staff have been explained, patient numbers over recent years have not reduced, and it is not clear how these difficulties would be addressed by a centralised service.

(3) Age of gamma cameras – If cameras are unreliable because of their age, the Trust should be seeking replacement of at least two cameras as soon as possible, irrespective of the service configuration.

(4) Car parking - On a practical level, centralising at either one or two sites will lead to more patients attending both Boston and Lincoln, putting more strain on the patient car park at these two hospitals.

The committee believes that any change to the service would have a negative impact on the population of Lincolnshire, on the grounds of travel and transport, patient car parking issues, and the potential need to transfer inpatients.

Clinicians' views

A number of ULHT clinicians formally responded to the consultation by email, raising concerns about various elements of the proposed service change and impact upon other

specialties and services that have not been addressed in consultation paperwork. This is specifically in relation to Option 1- Centralising the service at Lincoln hospital.

A summary of the concerns raised is below:

- Cardiology services use cardiac nuclear imaging as part of diagnosis as well as assessment of the extent of Myocardial Ischaemia. From a cardiology perspective there is a strong argument to keep the service running on the Pilgrim site to keep up with demand.
- Nuclear medicine is used regularly for orthopaedic revision patients, and displacing the services from Pilgrim would seriously hamper the work-up of these patients who already have mobility issues.
- For urology patients, there is a great advantage for nuclear medicine being continued at Pilgrim. Urology patients are elderly and accessing the services at Lincoln would be a challenge.
- Some pregnant ladies require VQ scans, and it would put a strain on them to have to travel to Lincoln form Boston.
- Concerned for patients with PD that need Datscans, as if they need to travel to Lincoln is going to be much more difficult for them. The same for elderly patients that need bone scans. Concern that any change will affect the most vulnerable population for whom it is difficult to travel.
- Endocrinology service receive patients from Spalding and beyond who would not be happy /able to travel further for investigations. This would compromise/delay management.
- Could have a significant impact on breast cancer surgery currently carried out at Pilgrim.
- Implication on paediatric renal outpatients.

Other responses

- One of the Pilgrim cameras was purchased through Pilgrim Heart and Lung Fund (PHLF) registered charity, and just recently software for gated assessment of myocardial function was purchased through the same charity, and is just about to start running.
- Suggestion that it was a biased consultation, considering a service at Grantham was not put forward as an option.

- Felt that the public were not able to comment as early as possible in the decision making process.
- **Boston MP Matt Warman**- no case for the centralisation of services at Lincoln.
- **Rotary club of Boston**- responded to say that the service must be retained at Boston, due to transport issues to other sites and also co-dependent services. It also raised the issue of equipment within the department that has been funded by charity, including the Rotary Club of Boston, and they would regard the removal of this equipment to be totally unacceptable and of dubious legality.
- **Sidings PPG-** Would like to see more efforts to recruit and retain staff. Concerns about transport infrastructure in Lincolnshire and the impact upon the East Coast population of any change. Believe that the two site model is the only feasible option.
- **Lincolnshire ICS-** Would strongly back the consolidation at LCH option – makes sense in terms of supporting the ambition for excellence in NHS care and best possible care for patients, and creating best service model for great staff to thrive in.

5) Themes

Collating all of the evidence from the above described consultation exercise, the below themes have emerged:

General comments:

- Majority of people recognised the need for change
- Recognition that centralisation to achieve a more robust and specialised service is preferable
- Travel and transport was the biggest area of concern
- Concerns raised about health inequalities across the county/ inequality of service
- Clinicians felt that co-dependent services had not been fully consulted or taken into account in options development
- Some felt that a ‘do nothing’ option should have been put on the table, others felt that centralisation at Grantham should have been considered
- No overall agreement on preferred way forward, due to the above
- Of the two options presented, Option 2 was preferred

- Issues raised around purchase of equipment at Pilgrim by charity, and issues around movement and disposal of that
- Consideration still needs to be made around the short-term future of the Pilgrim service due to the ongoing A&E redevelopment

Areas of concern around change:

- **Travel and transport**- Issues with access for people with no transport, lack of public transport provision, questions about possibility of putting on transport, concerns about car parking on Lincoln site if centralised there, possible negative impact upon ambulance service
- **Inequality**- Concerns around possible disadvantage to those who are elderly, disabled or on low incomes as a result of possible further distances to travel for treatment and cost of fuel
- **Co-dependent services**- Concerns that the full impact of any change on other co-dependent services has not been fully understood or addressed.
- **Other interests**- Charity donations of equipment to the Pilgrim service could pose an issue
- **Resilience**- Concern that a service at just one site is not very resilient in the face of issues such as fire, pandemic etc.
- **Choice**- Concerns that a one-site service provides no patient choice of location for treatment
- **Waiting lists**- Concerns about the impact any centralisation will have on waiting lists

Areas of support for change:

- **Cost effectiveness**- Recognition that service would operate more efficiently from fewer sites
- **Ability to specialise**- Recognition of benefits of a specialist service on one site
- **Patient impact**- Patient number affected would be low, compared to relative benefit
- **Staff**- Recognition that consolidation would result in best use of staffing resource and possible improved experience for staff
- **Co-located service**- Recognition that the radiopharmacy at Lincoln means Lincoln needs a service

Preferred outcome:

There was no overall consensus on the preferred outcome from the consultation findings. Support for Option 2 (a two-site model) was overwhelming from the patient survey, but less so from other engagement activities. Many suggestions were made about the need to look at a 'no change' option or to explore a continuation of service or centralisation of service at Grantham hospital.

Constructive suggestions:

- Put on a free inter-hospital bus service
- Improve car parking facilities at Boston and Lincoln
- Explore the possibility of mobile service
- Have one camera on each site
- Centralise at Grantham only- most central location
- Extend the volunteer driving scheme
- Work more closely with University of Lincoln on recruitment
- Focus on staff retention.

Responses from to Public Consultation survey comments

It is clear from the survey and consultation feedback that there is a requirement for the Trust and wider system partners to see if a workable solution for patient transport can be achieved. It should be noted, however, that currently some patients already travel to appointments at Grantham, Pilgrim and Lincoln for nuclear medicine appointments, either due to the availability of appointments or the fact the scan is only undertaken at that site.

The tables below are responses to some of the concerns that were raised from the public consultation:

Health Scrutiny Committee concerns	
Concern	**Response**
Impact on patients will displace 1000s patients per year	Option 1 Impact on approximately 1500 patients Option 2:Impact on approximately 700 patients
Staffing: How will centralisation address this issue	This would be addressed as the staff would not be spread over three sites. This means number of staff per site would be higher, freeing up experienced staff to undertake the training. In addition there are more opportunities for skill development at LCH due to the radiopharmacy, so retention should be higher.
Age of gamma cameras	There has been funding allocated for 1 new SPECT/CT camera. There is a need to adopt up to date technology as there are lot of advantages over the current cameras and increases diagnostic power of the tests.
Car Parking strain on chosen site(s)	It is unlikely the number of patients that are being discussed here would cause a big problem. (based on a 50 week/ 5 day a week service): Option 1: 6 patients a day. Option 2: 3 patients a day

Clinicians' concerns	
Concern	**Response**
Cardiology services use cardiac nuclear imaging as part of diagnosis as well as assessment of the extent of Myocardial Ischaemia. From a cardiology perspective there is a strong argument to keep the service running on the Pilgrim site to keep up with demand.	The limiting factor for stressing of patients in Pilgrim is reliance on cardiology to undertake the stressing. The typical number is 3-4 patients a week. LCH and GDH have nuclear medicine staff who stress. Typical numbers per week in LCH (from 1 day of stress) is 7. The limit in LCH is the people to scan. Centralising staff to LCH would give greater capacity than we currently have.
Nuclear medicine is used regularly for orthopaedic revision patients, and displacing the services from Pilgrim would seriously hamper the work-up of these patients who already have mobility issues.	The numbers of these are low, with 5 patients performed a month.
For urology patients, there is a great advantage for nuclear medicine being continued at Pilgrim. Urology patients	The majority of bone scans are performed on urology patients (who have prostate cancer). These 2ww patients are already often offered

are elderly and accessing the services at Lincoln would be a challenge.	a scan at one of the other sites if they can be accommodated sooner than in PHB.
Some pregnant ladies require VQ scans, and it would put a strain on them to have to travel to Lincoln form Boston.	In 2022 there have only been 2 pregnant lung scans performed in PHB. Currently if PHB cannot accommodate the scan in a timely fashion the scan will be performed in LCH. In addition if a scan is required over the weekend the patient will be sent for a CTPA.
Concerned for patients with PD that need Datscans, as if they need to travel to Lincoln is going to be much more difficult for them. The same for elderly patients that need bone scans. Concern that any change will affect the most vulnerable population for whom it is difficult to travel.	DatScans are difficult to accommodate due to the scanning time required. They are already asked to go to GDH or LCH if their appointment is earlier than PHB. Datscans are a scan only occasionally performed, typical 3 patients a month.
Endocrinology service receive patients from Spalding and beyond who would not be happy /able to travel further for investigations. This would compromise/delay management.	Currently not all endocrine patients can be performed at PHB and they need to travel now. Again numbers of patients are low (2 per month).
Could have a significant impact on breast cancer surgery currently carried out at Pilgrim.	The number performed each month this year has been 6 (c.f. 19 at LCH).Currently in discussion with the breast team on the best way to proceed with these.
Implication on paediatric renal outpatients.	Again this number is very small with less than 5 performed at PHB this year.

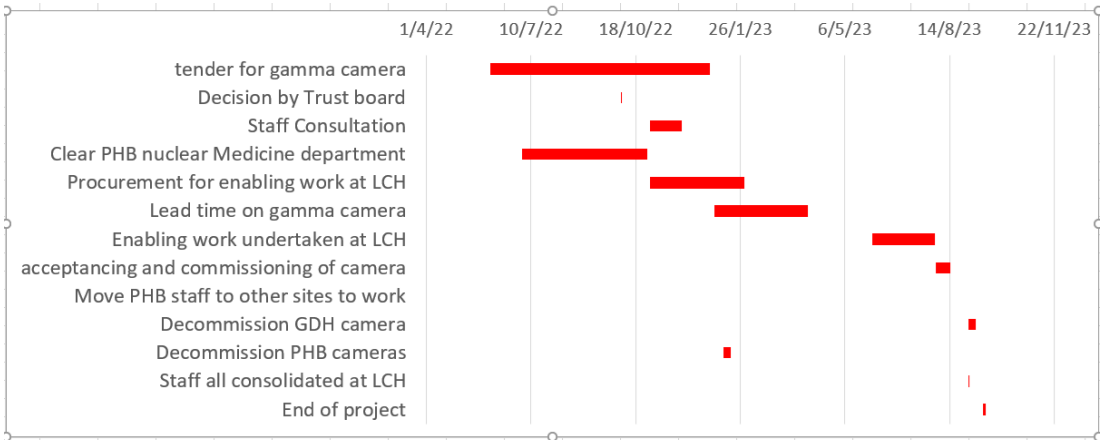
General area of concern around change.	
Concern	**Response**
Travel and transport- Issues with access for people with no transport, lack of public transport provision, questions about possibility of putting on transport, concerns about car parking on Lincoln site if centralised there, possible negative impact upon ambulance service	Transport is a concern within Lincolnshire and this needs to be reviewed with our partners to ensure patients are not disadvantaged. The number of patients that are being discussed is small and should not impact on car parking at the sites greatly. With regards to ambulances, the large majority of patients are outpatients and would not require ambulance transport.
Inequality- Concerns around possible disadvantage to those who are elderly, disabled or on low incomes as a result of possible further distances to travel for treatment and cost of fuel	The changes will impact more people each year than currently however those on low income are entitled to free hospital transport via non-emergency patient transport. In addition patients do not come

	regularly for these tests so the impact on each individual patient would be small.
Co-dependent services- Concerns that the full impact of any change on other co-dependent services has not been fully understood or addressed.	The only time-critical co-dependent service is breast surgery, and the team have engaged positively with nuclear medicine to ensure no impact to their service. All other services refer into nuclear medicine and the tests are performed as soon as possible at one of the sites.
Other interests- Charity donations of equipment to the Pilgrim service could pose an issue	The PHFL provided a cardiac camera to the department 12 years ago. This is now past its recommended replacement age of 10 years. Servicing of the camera has been paid by ULHT for the 12 years. In addition, PHFL have provided a floating licence for a cardiac software package which can be accessed on a cloud solution and will be of benefit to Pilgrim patients irrespective of the option chosen via the public consultation.
Resilience- Concern that a service at just one site is not very resilient in the face of issues such as fire, pandemic etc.	The service has this fragility currently due to the single radiopharmacy sited at Lincoln. Nuclear medicine working practices meant we did not need much adaption when COVID hit, which be similar for other incidents.
Choice- Concerns that a one-site service provides no patient choice of location for treatment	Current service does not allow much patient choice as patients can only be scanned at certain sites for a number of tests and may be moved sites to ensure prompt scanning for some tests.

Constructive suggestion	
Constructive suggestion	**Response**
Put on a free inter-hospital bus service	This is definitely something we would be willing to discuss. There could be a potential to “group” patients on a set day.
Improve car parking facilities at Boston and Lincoln	To be considered by the Trust.
Explore the possibility of mobile service	There are no commercially available mobiles gamma cameras in this country to the best of our knowledge. PET-CT services are provided this way but the whole service is provided by the company (including the scanning and reporting). In America there is a big drive towards mobile gamma cameras, but these are gamma cameras on wheels allowing flexibility within a site, not going between different sites.
Have one camera on each site	This would not match the demand of the services and would not remove any of the current problems the service has.
Centralise at Grantham only- most central location	The licencing requirements and space would be prohibitive. There would also be a requirement to buy at least two cameras to ensure enough capacity for the patients. There would also be a requirement to build a radiopharmacy at Grantham and obtain a licence. In addition, this would result in the most patients having to increase their travel time for their scan as Grantham have the lowest number of referrals in the county.(approximately 2500 patients)
Extend the volunteer driving scheme	Very good idea. We would want to ensure drivers were properly trained as our patients are radioactive after their test.
Work more closely with University of Lincoln on recruitment	University of Lincoln currently do not offer medical physics courses, but this is something keen to work with them to develop if we had capacity to do so.
Focus on staff retention.	Completely agree. Way to do this is to ensure staff are trained in a variety of skills and have a good team around them for support.

Option 1 Scenario Centralise at Lincoln

Approximate Timeline



Approximate Project time: November 2022-September 2023
(PHB service stop January 2023, GDH service stop September 2023) This relies on a turnkey solution or availability of estates to do the work.

Impact on patients

Short term impact (6months): The patients who are currently referred to Pilgrim (typically about 80 patients per month) will be asked to travel to Grantham or Lincoln for their study until the third camera is installed in Lincoln.

Long term impact: All patients will be investigated at Lincoln (typically 130 patients a month).

***Inpatients impact*:** There is very little demand for inpatient studies in nuclear medicine. The main acute test that is performed is a lung scan looking for pulmonary embolism. These are defined as “inpatients” but in most situations they are discharged with treatment and come back in for the test. They then go back to the ward to be given their follow up plan once the scan has been reported. This is due to the fact the department only operates Monday to Friday 9-5 and most of these patients do not require hospitalisation. In 2022 so far there have been 122 in-patients in the county 77% of these have been lung scans that the patients are ”well”. Most other tests can wait until the patient is discharged.

Impact on staff

Short term impact (six months): Staff would be transferred from Pilgrim to Lincoln. Grantham would be supported by transfer of staff weekly to Grantham. This is required to ensure capacity and robustness of service at both Grantham and Lincoln while the new camera is being installed at Lincoln.

Long term impact: All staff would be consulted to ensure the best plan for the individual and service is determined. The Lincoln based staff would have the potential to extend their roles with stress assistance, stress lead, non-imaging techniques, radium therapy and aseptic manufacture in the radiopharmacy. This will hopefully increase the retention of the staff due to interest in new skills and variety in their job.

In addition, this will free up MPE staff and other senior staff from performing tasks that should be undertaken by lower banded staffing. Freeing them to develop the service and audit practices.

The team morale and support will be good and there would be a potential to recruit another apprentice to train as the senior technologists will be required to do less work that could be covered by lower band staffing. This would be planned to counteract the staff who would be eligible to retire in the next five years.

Impact on clinical workload efficiency

The requirement to provide technology support for Grantham hospital from Lincoln would be stopped meaning that the number of patients investigated would be increased. The Grantham service would become 5 days a week (currently it is 3 days a week) and the Lincoln service could run 2 cameras 5 days a week. This would give 69 camera days when we look at the scenario of March 2022. In addition the scanning day would be longer for the majority of those (46) as they are in Lincoln.

In addition efficiency of kits would be increased as batch-booking of tests will be possible. There will also be more ability to respond to fluctuations in demand for urgent studies and 2wws as there are more staff each day not required in the radiopharmacy each day. In addition the workload of the radiopharmacy staff would go down as the number of kits made

each day would reduce. This also brings with it a reduction in finger doses for the manufacturers.

The additional advantage of this is the ability to extend the clinical working day, as there would be extra staff who could start their shift later and continue clinical scanning later in the day. Currently there is no opportunity for this as all staff are needed to cover the start of day tasks. This would not only mean more patients scanned per day, but a better service for patients as we could give them appointments later in the day.

Impact on the quality of the service

All of the service will be covered by the quality system ISO 9000:2015 certificate that the Lincoln site has held for a number of years meaning regular external audit of the service and the processes that are performed. There is a push from a number of professional bodies that all clinical services have a quality system.

Impact on other services

All clinical services refer into nuclear medicine and the location the scan is performed is determined by the nuclear medicine service. In addition patients are currently asked to travel if they can be accommodated at a different site sooner than there local site so there will be little impact on the majority of other services.

The main service affected is breast surgery at Pilgrim because the injection needs to be performed on the day or the day before surgery. The number of breast patients requiring nuclear medicine in Pilgrim is small, from January 2022 to May 2022 there were an average of six a month. This is compared to 19 per month in Lincoln.

In addition the nuclear medicine team is in discussion with the breast team to explore all the possibilities to ensure there will be no disruption in service. The possible options are to train their staff to inject (which happens in a number of trusts) or for the patient to be injected the day before at Lincoln hospital.

Five year situation

- It is likely that the Head Technologists at Pilgrim and Grantham would have likely retired and the radiopharmacy production manager who is based at Lincoln. Recruitment is problematic however as all the staff are based in Lincoln we may be able to identify somebody who could take over from the production manager. The current apprentice is already in a long standing vacancy and consolidating staff at one site should hopefully mean a second apprentice could be accommodated. HEE has just realised an expression of interest for funding for a technologist which hopefully we could be successful.

- It is hoped with the additional Clinical Scientist staff not supporting three sites there will be more capacity to optimise the current clinical procedures. In addition it is hoped to introduce new techniques to the region which currently patient have to travel out of the county for. An example is DPD scanning for amyloidosis that we have been working alongside cardiology to introduce to our patients. We have no capacity to do this properly at the moment, leading to it still not being in place long delays.

- Again freeing up the medical physics experts will mean that there is a potential to provide support for the PET-CT service bringing money into the hospital.

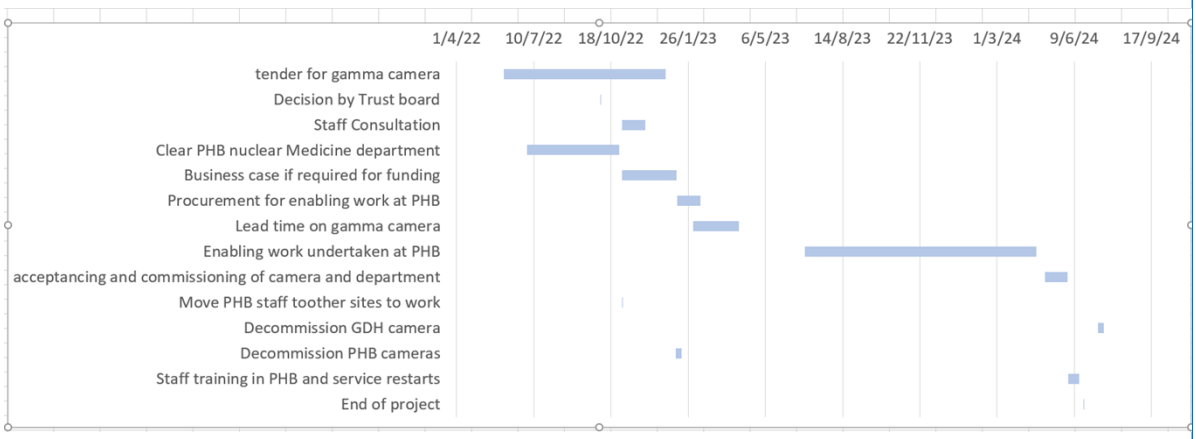
- We will be an established training centre for apprentice and clinical scientist ensuring robustness in future staffing.

- Further development of our associate technologist roles who are essential to freeing time up for senior staff to perform appropriate tasks for their role.

- Build relationships with the University of Lincoln to undertake research projects with them and hopeful start a technologist and medical physics course.

Option 2 Scenario Two site configuration Pilgrim and Lincoln

Best estimated Timeline



Approximate Project time: November 2022-July 2024 may be extended based on procurement (12 months) and assuming CRIG approval needed.
(no PHB service between January 2023 – July 2024 minimum)
Assumption: Money is allocated by CRIG and estates are available to project manage the project.

Impact on patients

Short term impact (likely to be 18 months): The patients who are currently referred to Pilgrim (typically about 80 patients per month) will be asked to travel to Grantham or Lincoln for their study until the department is built in Pilgrim and a camera is installed and commissioned.

Long term impact: Patients from the Boston area will go back to being scanned at Pilgrim and Grantham patients will travel to Lincoln (typically about 50 patients per month).

Impact on staff

Short term impact (likely to be 18 months): Staff would be transferred from Pilgrim to Lincoln. Grantham will be supported by transfer of staff weekly to Grantham. This is required to ensure capacity and robustness of service at both Grantham and Lincoln while department is built and commissioned in Pilgrim.

Long term impact: The 1 WTE post at Grantham will transfer to Pilgrim. The 0.6WTE will be moved to Lincoln. It would be good if the technical staff rotate around the two sites as this increases robustness of the service. This will be discussed in the staff consultation. It will also give the technologists experience on the modern hybrid camera that will be installed which is not just good for their development but the morale and team ethos.

Recruitment required: In reality, another MPE (Band 8A) should be employed as per the national guideline produced by IPEM (*policy statement medical physics expert support for nuclear medicine*). This will be difficult to recruit to given the national shortage of them.

Impact on clinical workload efficiency

There should be some improvement in this as the patients will be spread over two sites compared to three but the impact is likely to be small as the size of the team at both Pilgrim and Lincoln will be little changed from what the current configuration is.

Impact on the quality of the service

The will be less variability in service as there will be fewer sites however there will be work required by the MPEs/Clinical Scientists to ensure all standard operating procedures are written for the new department in Pilgrim and the new camera. In addition all of these procedures need to be added to the quality system and certification from ISO9000:2015 for Pilgrim needs to be obtained as per national guidance. It is likely to be at least two months' worth of work to get Pilgrim ISO9000:2015 accredited.

Impact on other services

There will be some disruption of the breast surgery but we are in discussion with the breast team how best to minimise this disruption. There will also be a disruptions to in-patients until the department is re-opened (this is as mentioned small).

Five year situation

- It is likely that the Head technologists at Pilgrim and Grantham would have retired and the radiopharmacy production manager who is based at Lincoln. Recruitment

is problematic however one post would be a management one. The current apprentice is already in a long standing vacancy and consolidating staff at one site should hopefully mean a second apprentice could be accommodated however spare capacity to train them would be difficult. HEE has just realised an expression of interest for funding for a technologist which hopefully we could be successful.

- Hopefully the trust would fund another MPE and we can recruit to it. (however the current advert has only attracted 5 applicants and only 1 from the EU). This post would only be needed if there was a second site.
- Hopefully both sites would be ISO9000:2015 accredited but this would be dependent on whether the additional MPE post is funded.
- Need to try to start some more services at Pilgrim (such as gastric studies, and radium therapies) to ensure parity between the two sites.

Review of spending - Financial and economic impact of the options

This section will review the spending objectives, economic evaluation and financial evaluation of the two options compared to business as usual.

Spending Objectives

Spending Objective SO1: to reduce service provision in line with service needs	
Specific	A reduction in service provision from 5 cameras to 3 in line with BNMS guidance
Measurable	In line with constitutional standards and numbers of patients needing to be seen within 6 weeks the service constantly monitors capacity and demand. The has been static for the last 5 years
Achievable	As some cameras are now out of recommended working life they can easily be decommissioned retaining equipment that is still operational
Relevant	Fits within local and national strategies at a time where demands on the service are static
Time Constrained	There is a need to act as soon as possible due to the age of the equipment

Spending Objective SO2: to ensure resilience in the service into the future	
Specific	A reduction in service provision to ensure that the remaining service is adequately and safely staffed

Measurable	The age of the workforce is increasing with several members of staff retiring. High cost staff are undertaking duties that could be undertaken by lower cost staff, freeing them up for other duties
Achievable	Recruitment of nuclear medicine technologies is difficult and especially so within Lincolnshire. A new service model needs to be developed to make the Trust more attractive in the marketplace
Relevant	Fits within local and national strategies at a time where recruitment into the service is at an all time low
Time Constrained	There is a need to act as soon as possible due to several members of staff retiring within the next few years

Options

In addition to maintaining business as usual two further options were developed:

1) Centralisation of the entire service at Lincoln County Hospital;
2) Centralisation of the service at two sites – Lincoln County Hospital and Pilgrim Hospital.

Benefits

The project team have identified the following benefits. They have been classed in terms of type (cash releasing, non cash releasing, quantifiable but not monetisable and unquantifiable) and beneficiary.

CRB1 relates to an increase in capacity by centralising the service at LCH. Currently PHB lists cannot start until 10:30 due to the manufacture of radiopharmaceuticals at LCH and subsequent transfer to PHB. Having all cameras at LCH means that all lists start at 09:00. The impact in terms of additional activity would equate to £43,500k (as current payment is block this would need to go through contract negotiations).

CRB2 relates to a reduction in staffing costs. By moving staff to a more consolidate model staffing can be reduced slightly with economy of scale. The results are small but moving to a 2 site model would mean a decrease of 1WTE band 7 offset by an increase in 1WTE B6. Moving to a single site model would result in a reduction of 0.6WTE B6:

	BAU	1 site	1 site var	2 site	2 site var
Band 8a tech	1	1	0	1	0
Band 7 tech	3.65	3.65	0	2.65	1
Band 6 tech	5.4	5.4	0	6.4	-1
Band 6 nurse	1.6	1	0.6	1.6	0
Band 5 nurse	1	1	0	1	0
Band 3	3.8	3.8	0	3.8	0

CRB3 relates to inefficiencies in the production of isotope kits which a procured in set volumes. For some tests the production volume for a single kit can be for c. 20 patients. There may only be around 3 or 4 patients booked on lists at GDH and PHB and as the kits have a short half-life they cannot be saved for later lists. By

consolidating on one or two sites there would be an efficiency saving by creating lists that can use more of each kit. Savings have been calculated on an audit of recent usage by number of patients seen on each site.

CRB4, 5 and 6 relate to savings from not having to transport radiopharmaceuticals across the county. By moving from a 3 site model to a 2 site and to a single site proportionate savings are made by a reduction in staffing, vehicle rental, fuel and insurance.

All the above are cash releasing benefits direct to ULHT (direct public sector).

NCRB1 is a non cash releasing direct public sector benefit brought about by the increased ability to train staff by increasing resilience through the reduction in sites. This has been calculated using the social value engine with the proxy "Improved wellbeing resulting from participation in employment training (provided through workplace or Job Centre scheme) and relates to WTE working at the LCH site.

SB1 is a societal benefit related to a reduction in patient harms. This calculation is based on an assumption that harms will reduce with increased resilience in staffing numbers. The calculation is based on an average litigation cost of £50k that would affect an assumption of 5 patients per annum with a likelihood of that occurring of 10% with a three site model, 5% with a 2 site model and 2% with a one site model/

The unquantifiable benefits are all direct to the public sector and include:

- Reduced radiation to the hands of operators making up the pharmaceutical kits from the outcome of being more efficient with less sites to supply. This also reduces RSI wrist injuries;
- An ability to perform service audits through having increased staffing / resilience on the LCH site;
- A reduction in service contract costs. Whilst cash releasing this benefit will vary over time due to the phasing of decommissioning old scanners and installing new. For ease this benefit is reflected in the revenue costs within the economic model;
- Similarly, there is a requirement for each site performing gamma camera studies to have a medical physics expert. The likelihood of appointing is low but it would require LCH, PHB and GDH to have 1 WTE MPE. Moving to a 1 or 2 site model provides a non cash releasing / cost avoidance benefit that, for the purposes of phasing is built into the revenue lines of each of the options within the model.

Type	Beneficiary	Description	BAU	Option 1	Option 2
CRB1	Direct Public Sector	Increase in activity	£0	£43,597	£0
CRB2	Direct Public Sector	Reduction in staffing costs	£0	£29,000	£8,700
CRB3	Direct Public Sector	Reduction in wasted isotope kits	£0	£21,852	£13,468
CRB4	Direct Public Sector	Reduction in logistical costs - drivers	£0	£27,610	£11,833
CRB5	Direct Public Sector	Reduction in logistical costs - van rental	£0	£5,054	£2,527

CRB6	Direct Public Sector	Reduction in logistical costs - fuel and insurance	£0	£7,045	£3,522
NCRB1	Direct Public Sector	Improved training resulting in more effective, motivated staff	£0	£11,042	£7,591
SB1	Societal Benefit	A reduction in patient harms by having a service that was properly staffed providing a safe environment	£0	20,000	12,500
U1	Direct Public Sector	Reduced radiation dose & RSI to staff			
U2	Direct Public Sector	Lincoln site is already IS09000:2015 accredited. Reducing to two sites or centralising means there would be more time to perform audits as the service at Lincoln will have more capacity			
U3	Direct Public Sector	Reduction in service contract costs from 5 contracts to 3. This saving has not been calculated as it is included within the revenue costs for each of the options.			
U4	Direct Public Sector	Reduction in the statutory requirement to appoint a medical physics expert for every "site" that provides the service. This saving has not been calculated as it is included within the revenue costs for each of the options.			

Risks

Risk	Mitigation	Post Mitigation Risk Score
If we move to a single or two site model there may be an impact on services on those sites	Numbers are small and can be managed through patient transport services	9
If we move to a single or two site model there will not be a service for In Patients	Numbers are very small and can be managed through alternative imaging or patient transport services	4
If we move to a single or two site model there will be a requirement for some patients to travel for their scans, causing a greater inconvenience and may lead to some patients going out of county for tests	Some patients already travel out of county and other patients are already travelling for other nuclear medicine tests such as PET-CT. There is also already a degree of travel due to the inability to staff some lists. Patient transport services will also assist, impact very low	3

Constraints

The actual costs are detailed within the financial case. If the service remains at Pilgrim there will be a significant cost to set up the service in the new area. Capital may need to be found elsewhere to fund this.

Timelines are also a constraint again based on the ED project. However, as we have an excess number of cameras to demand the service can continue for a short time without the PHB service.

Dependencies

The Pilgrim ED project is the main dependency. If this project is approved (as is expected) then the Trust must take action over the gamma camera provision.

Clinical services are dependent on the provision of gamma camera tests and any change must be thought through with them in mind to continue to be able to provide for their patients.

Economic Appraisal

The economic appraisal uses business as usual as the benchmark for comparison of the two options. Option 2, a service at Lincoln and Pilgrim, compares capital costs based on replacing the cameras at the two sites. It does not take into account the cost of moving the Pilgrim service as this decision is not based on the ED project – the service review was taking place irrespective of this. This provides for a fairer comparison of the two options without negatively biasing the benefit to cost ratio at Pilgrim. The financial case details the real world cost of replacing the Pilgrim service.

Costs for the single site model in the economic appraisal are greater because work would need to be done on the Lincoln site to develop a new scan room. This work is relatively minor but adds £318,962 onto the cost of the additional scanner. The two site option only considers replacement cameras at Lincoln and Pilgrim.

The benefits for the single site service are greater for the single site model as they allow for greater rationalisation and improved efficiency:

Summary (Discounted) - £'000	Option 0 - Business as Usual	Option 1 - 1 Site Model	Option 2- 2 Site Model
Cash releasing benefits	£0.00	£967.04	£277.89
Non-cash releasing benefits	£0.00	£84.00	£57.75
Societal benefits	£0.00	£167.21	£104.51
Total benefits	**£0.00**	**£1,218.25**	**£440.15**

In summary for every £1 spent on each option the return on investment equals:

Option 1 - £2.89
Option 2 - £1.85

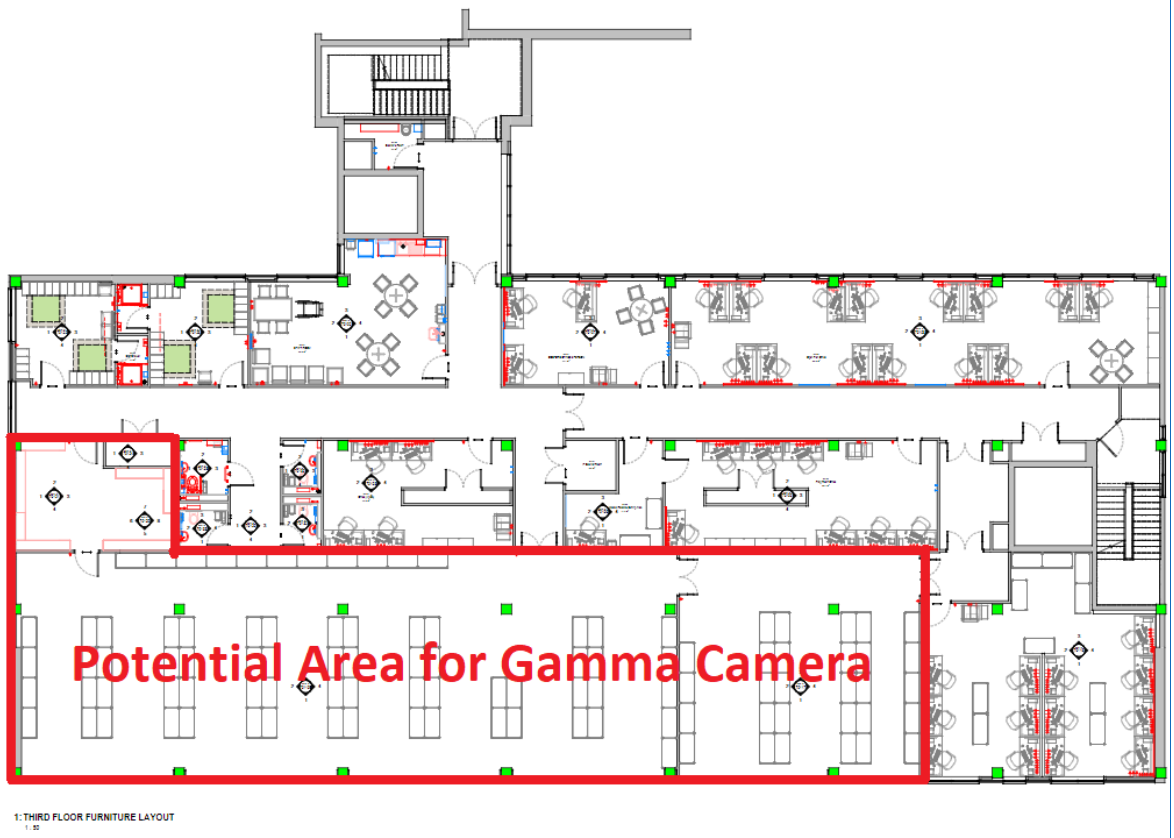
Economic Summary (Discounted) - £'000			
	Option 0 - Business as Usual	Option 1 - 1 Site Model	Option 2 -
Incremental costs - total	£0.00	-£1,063.79	
Incremental benefits - total	£0.00	£3,074.75	
Risk-adjusted Net Present Social Value (NPSV)	£0.00	£2,010.96	
Benefit-cost ratio		2.89	

This makes the single site model, option 1, the best model from an economic perspective.

Financial Appraisal

The financial appraisal deals with the reality of the different options rather than the hypothetical situation in the economic appraisal. The economic appraisal considered a two site model where the service continued as is at PHB, albeit with timely camera replacements and changes in staffing models identified by the service. The reality is, with the forthcoming demolition of the building in which the camera is located for the ED expansion project, a new Gamma Camera Department needs to be found.

The decant plan for the building is to use the nearby maternity block which is being refurbished. The plan took into account the need to provide all clinical and administrative services within the OX block, where the gamma camera is located. A provisional space for the camera is located on floor 3 as per the plan below.



However, the allocated space is not a clinical area currently and there is much more work to be done to create a new gamma camera department. The single site option is to put a camera into identified space at LCH, within the existing department with associated services already in place. Including camera replacements the capital cost for the two site model is £5.6M and for the single site option £3.1M.

As discussed in the benefits register there are improvements in staffing with the single site model reducing revenue costs by c. £200K. There is a small increase in direct non-pay expenditure due to higher service contract costs.

Two Site Option:

Type	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
Capital Investment	£ -	£ 3,763,269	£ 900,000	£ 900,000	£ -	£ -	£ -	£ -	£ -	£ -
Capital Charges	£ -	£ 304,922	£ 456,573	£ 603,724	£ 588,554	£ 573,384	£ 558,214	£ 543,043	£ 401,552	£ 264,560
Direct Pay Expenditure	£ 1,171,400	£ 1,171,400	£ 1,171,400	£ 1,171,400	£ 1,171,400	£ 1,171,400	£ 1,171,400	£ 1,171,400	£ 1,171,400	£ 1,171,400
Direct Non-pay expenditure	£ 757,600	£ 848,800	£ 858,800	£ 888,800	£ 918,800	£ 918,800	£ 918,800	£ 918,800	£ 918,800	£ 918,800
Total costs excluding cap charges	£ 1,929,000	£ 2,020,200	£ 2,030,200	£ 2,060,200	£ 2,090,200	£ 2,090,200	£ 2,090,200	£ 2,090,200	£ 2,090,200	£ 2,090,200
Total costs including cap charges	£ 1,929,000	£ 2,325,122	£ 2,486,773	£ 2,663,924	£ 2,678,754	£ 2,663,584	£ 2,648,414	£ 2,633,243	£ 2,491,752	£ 2,354,760
Cost Reductions	£ -	£ 124,500	£ 124,500	£ 124,500	£ 124,500	£ 124,500	£ 124,500	£ 124,500	£ 124,500	£ 124,500
Income	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Total Revenue (- Deficit / + Surplus) Before Overheads (inc CC)	-£ 1,929,000	-£ 2,200,622	-£ 2,362,273	-£ 2,539,424	-£ 2,554,254	-£ 2,539,084	-£ 2,523,914	-£ 2,508,743	-£ 2,367,252	-£ 2,230,260

One Site Option:

Type	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
Capital Investment	£ -	£ 1,302,272	£ 900,000	£ 900,000	£ -	£ -	£ -	£ -	£ -	£ -
Capital Charges	£ -	£ 185,075	£ 337,927	£ 486,280	£ 472,310	£ 458,341	£ 444,372	£ 430,402	£ 290,112	£ 154,321
Direct Pay Expenditure	£ 1,104,400	£ 1,104,400	£ 1,104,400	£ 1,104,400	£ 1,104,400	£ 1,104,400	£ 1,104,400	£ 1,104,400	£ 1,104,400	£ 1,104,400
Direct Non-pay expenditure	£ 757,600	£ 893,200	£ 923,200	£ 933,200	£ 963,200	£ 963,200	£ 963,200	£ 963,200	£ 963,200	£ 963,200
Total costs excluding cap charges	£ 1,862,000	£ 1,997,600	£ 2,027,600	£ 2,037,600	£ 2,067,600	£ 2,067,600	£ 2,067,600	£ 2,067,600	£ 2,067,600	£ 2,067,600
Total costs including cap charges	£ 1,862,000	£ 2,182,675	£ 2,365,527	£ 2,523,880	£ 2,539,910	£ 2,525,941	£ 2,511,972	£ 2,498,002	£ 2,357,712	£ 2,221,921
Cost Reductions	£ -	£ 236,400	£ 236,400	£ 236,400	£ 236,400	£ 236,400	£ 236,400	£ 236,400	£ 236,400	£ 236,400
Income	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Total Revenue (- Deficit / + Surplus) Before Overheads (inc CC)	-£ 1,862,000	-£ 1,946,275	-£ 2,129,127	-£ 2,287,480	-£ 2,303,510	-£ 2,289,541	-£ 2,275,572	-£ 2,261,602	-£ 2,121,312	-£ 1,985,521

Current Context

Following the public consultation, it was clear that the two site option was preferred by the majority of the public. However, as highlighted in the quality impact assessment (QIA) there is a positive impact on patient safety and governance by centralising at one site. In addition, the national guidance for non-emergency patient transport is such that a large proportion of patients with additional needs are entitled to free transport. The QIA scores for inequalities of care were similar when mitigations were considered reviewing the 2 options. Currently patients from the east coast with an LN postcode are already directed to Lincoln (including those from Mablethorpe, Louth and Alford) and accounts for 10% of the Lincoln site's patients.

In addition, the health inequalities were discussed in a meeting with the Lincolnshire ICS and they felt strongly that consolidation at Lincoln was the best option "in terms of supporting our collective Lincolnshire ambitions for excellence in NHS care and best possible care for patients, and creating best service model for great staff to thrive in too". They were not concerned with health inequality due to the small number of patients that would require additional transport and felt the improvement to the overall service outweighed the inconvenience of a small number of patients who are likely to only require 1 of these tests in their lives

These proposals have been in discussion since July 2021, and have been delayed due to a number of outside factors.

Unfortunately, operational changes have occurred since this date which makes the two site model less viable. These include the sign off by Medicines and Healthcare products Regulatory Agency (MHRA) to use the new radiopharmacy. The new legislation covering aseptic techniques are now more labour intensive than were previously allowed. This has meant at Lincoln radiopharmacy more staff required at the start of the day and the production of the injections for the patients is more time consuming. Old facilities are exempt from these legislative changes but Boston will need to adopt this technique if a new department is built which has delayed the start of the clinic in Lincoln by approximately 30 minutes a day.

In addition, the staffing situation within the service has unfortunately deteriorated since the consultation was started, with little prospect of improvement due to national recruitment issues. In addition there are several senior staff needing protracted time away from the

department meaning project management of the more complex two site model would be problematic.

Another consideration is the recent changes to the main legislation that covers the practices in nuclear medicine. They now state suitably qualified Clinical Scientist defined as Medical Physics Experts (MPEs) must be involved in a number of practices undertaken in the department. A recent CQC inspection criticised the number of MPEs ULHT had which resulted in nuclear medicine receiving funding for an additional 1 WTE medical Physics expert. This addition staffing was based on based on the “lowest required” assuming a 1 site model. There is a requirement for at least 1 more WTE MPE if the 2 site model is adopted. It should be noted that there is a national shortage of MPEs and the likelihood of recruiting to this additional post is small. Other local trusts have a shortage of MPEs and cannot recruit.

In discussion with a number of project members within the ED build team at Pilgrim, the current nuclear medicine department will need to close in the next few months. The Trust will need to find at least £2.5 million (which is a high level estimate) to re-provide the department in Pilgrim and there is no definitive project plan timeline for this. The project is likely to take 18 months to complete, however the start date needs to be confirmed. Some discussions state this start date may not be until 2024-2025 financial year.

There is little confidence that any current staff vacancies will be filled, due to experience of struggling to recruit in the past, and a recent IPEM survey indicated that 57% of nuclear medicine centres staffing provision is not sufficient. Both Clinical Scientists and Clinical Technologists are on the national shortage list and local trusts (including Nottingham, Leicester and Derby) have not been able to recruit trained staff to their vacant posts.

Without recruitment of at least 1 medical Physics Expert (Clinical Scientist with at least 3-5 year’s experience) and at least 1 experienced clinical technologist, running 2 sites robustly would be very difficult. In addition, within the next 4 years this will be another 3 technologist required (due to retirement). If the department in PHB is not open until 2024 this would mean it would be open for a year before there would be no staff to run it. The investment discussed above is a large one and it would be expected to have a department run at PHB robustly for at least 10 years, and this is not going to be possible. These considerations mean that it is felt hat the two site model is no longer feasible.

It is felt that the impact of centralisation on the Lincoln County Hospital site would be minimal, with approximately 5-7 additional patients being seen there per day. This should not put undue pressure on the site in terms of capacity, parking and transport.

It is important to note that the nature of the service means that the majority of nuclear medicine patients would attend for 1 or 2 appointment and not be required to be investigated again.

Key messages

- ULHT nuclear medicine service is facing the same problems that the national governing body of nuclear medicine (BNMS) have highlighted the wider nuclear medicine community is facing.
- Continuing the 3 site model is a static situation which is not sustainable and there is no scope for developing the service and increasing, linked with the new medical school at University of Lincoln.
- Making a decision to rationalise the service now could help mitigate some of the reduction in capacity due to staff retirement in the next five years.
- The staff are currently spread too thinly throughout the region meaning that capacity for scanning is low and equipment is not properly utilised.
- A number of staff are due to retire in the next 5 years and there is currently no capacity to train staff to fill the gaps that will be made.
- The robustness of the service as it stands is poor and chances of cancellation of studies is high.
- Currently there are a number of skilled staff being required to undertake tasks that can be undertaken by lower bands, but there are not the correct trained staff at the correct sites.

- There will be a period of time (likely to be over 16-18 months but there is no guarantee of when the build project could start so it may be longer) where no/minimal service will be undertaken in Pilgrim irrespective of the future model due to the emergency Department build requiring the building housing Pilgrim nuclear medicine to be knocked down.

- Currently work is being duplicated on three sites meaning there is little capacity to audit the practices against national guidelines and develop and introduce new techniques that currently patients have to travel out of the region for.

Conclusions/Recommendations

The Clinical Support Services Division of ULHT wish to recommend the centralisation of the nuclear medicine service to Lincoln (Option 1). There would be an agreement with the breast team to ensure that the breast surgery was supported via training of their staff or injections by our team in Lincoln.

The justification for this recommendation is as follows:

- Increased robustness and responsiveness of the service, ensuring patients can be seen in a timely fashion and flexibility to alter clinic times when required to ensure 2 week wait patients are all performed in the required time. This will also minimise the chances of short notice cancellations due to staff sickness.

- Patients are not required to attend our department regularly and currently patients have to travel for certain tests due to availability of slots.

- Ensure a quality service to all patients of Lincolnshire by having capacity to regular audit all practices against guidance and ensure the patients of Lincolnshire are getting the best service that can be provided.

- Ensure an efficient department with both equipment and staff as currently the staff are spread too thinly to use any of the equipment to its capacity.

- Increased capacity to train staff to ensure a future workforce to cope with the retirement due in the next few years.

- Develop staff to increase their skill mix within the field of nuclear medicine and ensure robustness in the service.

- Increase capacity to develop new services that patients now have to travel out of the region to have performed.

- Develop a skill mix within the team to ensure staff are doing work at their grading and not having to fill in for lack of skilled staffing.

- Enable the service to adapt to the requirements of future nuclear medicine demands (for e.g. equipment requirements) which is not possible when running the service on three sites.

- Right size the department for the number of Medical Physics Experts required and enable them to train to support the PET-CT service.

- There has not be a national review of the best configuration of nuclear medicine services within a county or region however one recent scheme there has been to compare the a “reasonable” model for nuclear medicine service delivery is with PET-CT(a nuclear medicine diagnostic test). The national contract established by NHSE in 2015 looked at “optimising equality in patient access” to PET-CT. The national contract sited a PET-CT scanner in Lincoln to provide a service for Lincolnshire NOT at 3 sites covering the county. The reason being it is a specialised, expensive service. This is the model CSS is suggesting for the same reasons.

- It is the option that the ICS support and they feel this matches best the “Lincolnshire ambitions for excellence in NHS care and best possible care for patients, and creating best service model for great staff to thrive in too”.

Appendix 1:Survey results

Appendix 2: QIA for both options.

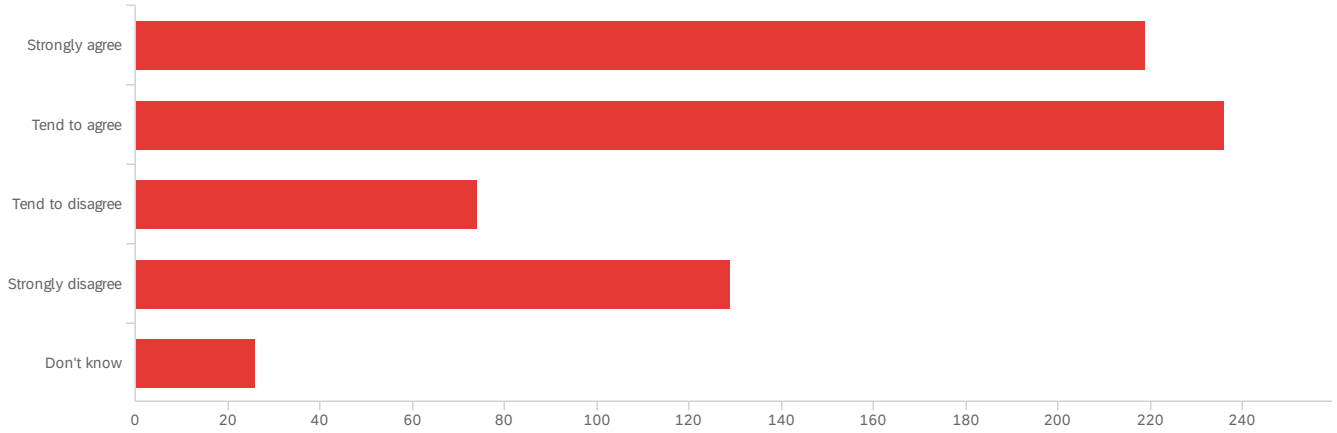
Appendix 3: Nuclear Medicine Consultation Documents.

Default Report

Nuclear Medicine Consultation Questionnaire_2022

June 8, 2022 3:16 AM MDT

Q1 - How much do you agree or disagree that the Nuclear Medicine service needs to change to ensure a safe and sustainable service to patients in Lincolnshire?

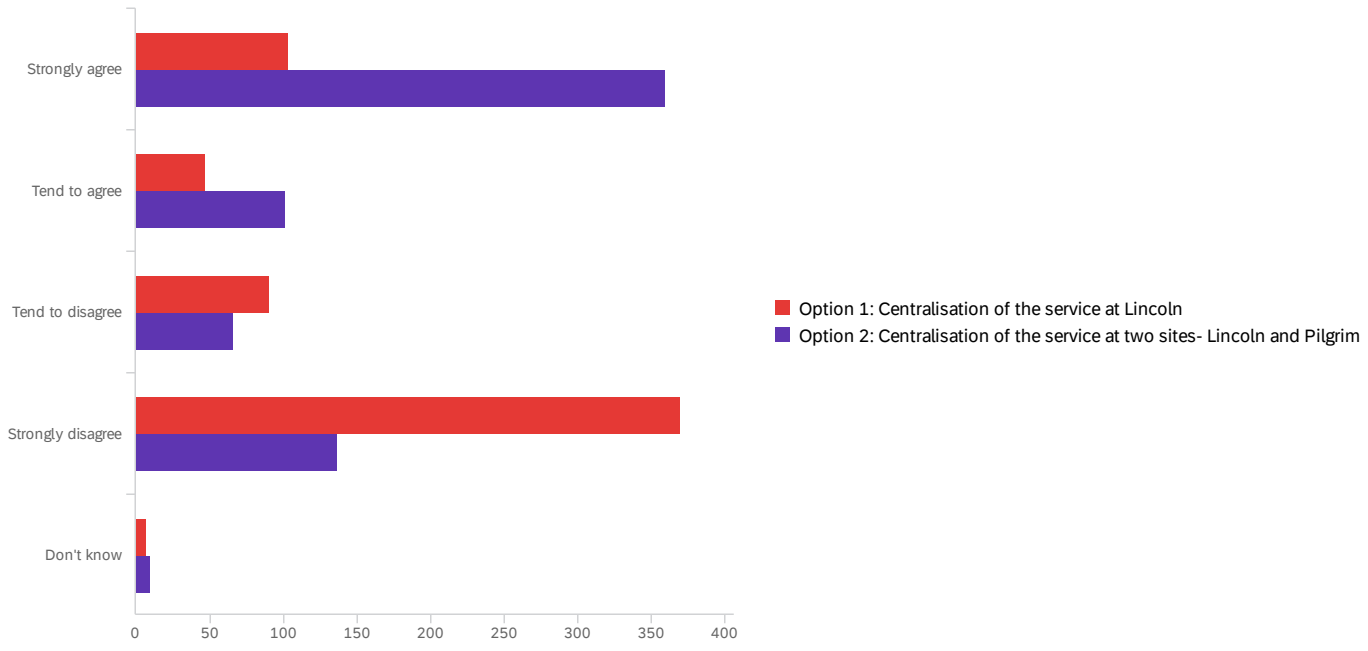


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	How much do you agree or disagree that the Nuclear Medicine service needs to change to ensure a safe and sustainable service to patients in Lincolnshire?	1.00	5.00	2.28	1.20	1.45	684

#	Field	Choice Count	
1	Strongly agree	32.02%	219
2	Tend to agree	34.50%	236
3	Tend to disagree	10.82%	74
4	Strongly disagree	18.86%	129
5	Don't know	3.80%	26
			684

Showing rows 1 - 6 of 6

Q2 - Please tell us how much you agree or disagree with the following options? Our clinicians, expert staff and patient representatives have looked at different ways that we could deliver these services in the future and they are explained in more detail in the consultation document. We believe that centralising the service to either one or two sites would ensure a robust service for the people of Lincolnshire. The radiopharmacy has recently been built at Lincoln County Hospital and this cannot be moved, therefore closing Lincoln was not considered as an option. As a result of our option appraisal work, this consultation is on the following two options. These are: Option 1- Centralisation of the service at Lincoln Option 2- Centralisation of the service at two sites- Lincoln and Pilgrim



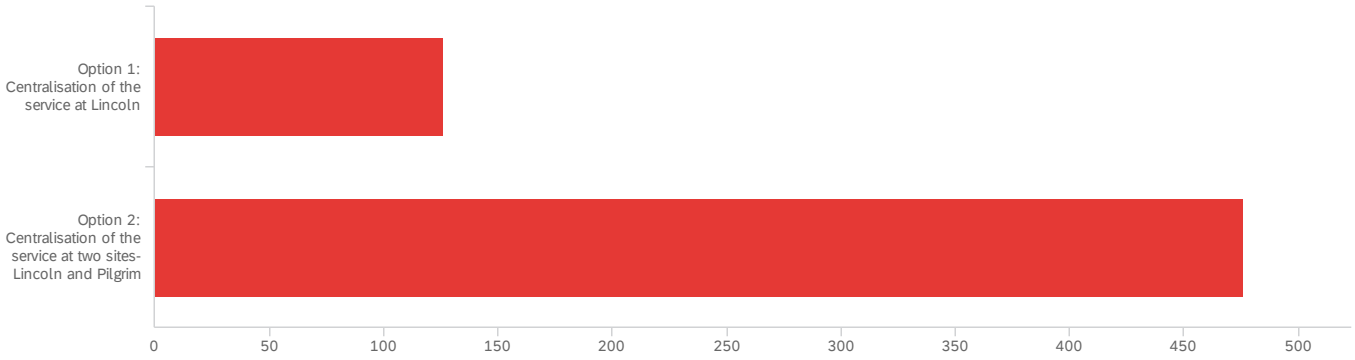
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Option 1: Centralisation of the service at Lincoln	1.00	5.00	3.21	1.16	1.35	619

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
2	Option 2: Centralisation of the service at two sites- Lincoln and Pilgrim	1.00	5.00	2.01	1.26	1.58	675

#	Field	Strongly agree		Tend to agree		Tend to disagree		Strongly disagree		Don't know		Total
1	Option 1: Centralisation of the service at Lincoln	16.80%	104	7.59%	47	14.70%	91	59.77%	370	1.13%	7	619
2	Option 2: Centralisation of the service at two sites- Lincoln and Pilgrim	53.33%	360	15.11%	102	9.78%	66	20.30%	137	1.48%	10	675

Showing rows 1 - 2 of 2

Q3 - What is your preferred choice for changes to nuclear medicine services? (please choose only 1 answer)



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	What is your preferred choice for changes to nuclear medicine services? (please choose only 1 answer)	1.00	2.00	1.79	0.41	0.17	602

#	Field	Choice Count	
1	Option 1: Centralisation of the service at Lincoln	20.93%	126
2	Option 2: Centralisation of the service at two sites- Lincoln and Pilgrim	79.07%	476
			602

Showing rows 1 - 3 of 3

Q4 - Please tell us why you chose your preferred option and if you have any other suggested proposals to address the identified challenges

Please tell us why you chose your preferred option and if you have any othe...
It needs to be in Pilgrim as well as - to save patients having to travel so far
Lincolnshire is a large county so it makes sense to have 2 centres.
Better to have a robust service on one site with excellent practice than poor practice due to low staff numbers
I agree that nuclear medicine is a specialised service and the funds are limited, so the best option is likely to centralise the service in Lincoln for the County.
Easy access by road, bus links. No access by train
As a patient that has used this service at both Lincoln and Boston I feel that as the time involved in the actual treatment it makes much more sense to use 2 hospitals rather than 1 . Lincoln hospital has had many dept moved to them and makes it more difficult for people to attend if travelling from the east of the county.
Its not always easy to get to lincoln
Because of the distance people have to travel. Especially in bad weather.
Preferably keep all 3 sites open.
It is not so easy for people in the south of the county to get to Lincoln
Pilgrim doe's have the space for it
Two sites offer more availability and, hopefully, shorter waiting lists. Travelling to sites offers options also
Neither of the above. It should be Lincoln & Grantham
Travel to Lincoln for patients can be difficult if relying on public transport
Would not opt for this high level radiation
Too far to travel
easier access for more residents
Community testing stations with two core fully equipped and staffed hospitals e centres of excellence
What is the matter with Gratham

Please tell us why you chose your preferred option and if you have any othe...

Due to the distances involved and the lack of public transport there should be centralisation at two hospitals so that patients aren't having to travel long distances

This will provide better access to the service for the people of Lincolnshire

I live in the Boston area, I am disabled and unable to travel

Using the Pilgrim Hospital will efficiently serve all the areas to the east of the county and coastal areas . Transport costs must be considered , the elderly population would find it more difficult to travel or to find transport.

It makes it more available for all areas and can still function with staff shortages

Develop grantham, not remove services, especially Boston because of transport difficulties. Lesser problem with Lincoln but still two buses and taxis 1.5 hours each way.

As Lincolnshire whether the historic county or the political county is still too large an area to concentrate all major NHS services in Lincoln so nuclear medicine should be based in a Lincoln covering the north & Boston covering the south of Lincs. Also the road to Lincoln is unfortunately not a dual carriageway from Sleaford to the City, with the hospital in the north of the City. Also, parking at Pilgrim is better than at the City Hospital. Have NHS Lincs. consulted the MPs & County/District Councillors too. Thank you, Peter Dorr

Obviously it is better to have more than one site, for numerous reasons: availability, ease of getting there, etc

Physical distance of centralising Nuclear Medicine on one site in Lincolnshire will mean difficult challenges to patients having to travel to Lincoln for tests. Not only will this be an ordeal for some patients and increased expense , I believe 1) One site will not cope with demand. 2) The ambulance service will not be able to support patient travel to one site because of increased distance for some patients. 3) In-patients at Pilgrim needing Nuclear Medicine scans wiĺ have to travel to Lincoln. This is far from ideal for an acute hospital.

If there was a fire at either site and there was only one site we would be stuck

serving 2 large areas in this huge county

Access to services from the east of Lincolnshire is difficult and maintaining services at Boston is the best option for people in the Skegness Boston Holland area

This provides greater resilience and better patient access

One site would secure the best possible service from all associated staff

For travel as lots of Lincolnshire villages are in the country

With a large county, travelling to Lincoln is not always an easy option

Too many patients if at one location - car parking and ability to access.

so they can pump resources into one building

Lincolnshire is a very large county therefore the services should be split.

Lincolnshire is big county and roads not good enough for emergencies especially through holiday months.

Please tell us why you chose your preferred option and if you have any othe...

Currently following the fire at Lincoln county hospital, there has been some delay in providing the service.if the service is centralised to Lincoln, what happens if we have a similar event? Patients would have to then travel out of the county? Secondly majority of the people that would be require the service would be patients who have recently be diagnosed with cancer, Boston and Skegness area have a higher burden of elderly patients who may require the service. A 2 hour commute with extended wait times between would be very challenging for these group of patients. Just wonder why the Lincoln patients are unable to travel to Boston and why it is almost always Boston patients travelling to Lincoln ! Everything the management seems to be focused on is moving more and more services to Lincoln ! I note for example, there is currently no urology service in Boston and patients have to be transferred by ambulance to Lincoln to see a urologist, with not ambulance wait times!

To far to travel. Lots of complaints regarding care at Lincoln. More resilient to have 2 sites

Some patients would find it very difficult/expensive to get to Lincoln so having another site south of the county would be very helpful to them

Move all of this to Louth, it's a big site that's not being used to its full potential.

Reduce waiting time and travel distance for patients.

Lincolnshire a large county with poor transport so drive to centralising services in Lincoln a mistake

County & Pilgrim are the two major hospitals in the LCC & should remain so.

Should be left as it is to include Grantham

Prefer 2 sites so that patients do not need to travel too far for service and for resilience for such a large geographic area. Unsure why Grantham was not mentioned as a potential site.

It would allow a specialist resource and specific staff to be focused and allow excellence which then could be expanded when circumstances later allow.

The impact of moving everything to Lincoln has a detrimental affect on people in rural areas that don't have access to their own transport . There is also the matter of time it takes to travel from coastal areas to Lincoln with no decent roads or public transport . We seem to have money thrown at Pilgrim , but with lessoning services

Traveling distances

There are lots of people that have transportation issues. Public transport in Lincolnshire is sporadic. Multiple locations are essential

Better to split facilities between 2 sites - not all your eggs in one basket

I haven't because I believe Grantham hospital should play a part

The size of the county, rurality and wrong to have one site which would mean between 90 and 100 mile round trip for those in the South f the County. My husband has used this service at Boston.

MORE CENTRALLY LOCATED

Public transport is difficult innLincolnshire and even a 2 centre option creates difficulties for patients

Enough services are being moved to lincoln only. We need to remember there are more people outside lincoln than in.

If there are difficulties in providing this service better to centralise in onenplace.

Please tell us why you chose your preferred option and if you have any othe...

In the case of patients living in the Boston area or further south at a time of stress and worry then Lincoln is rather a distant site and being possibly 40 miles closer to home territory could be a great soothing factor.

Lack of public transport in county.

Lincoln is very far from many places in the county.

Difficulty of travel for many people into Lincoln; no direct train service etc

If staffing is already difficult centralisation to one site makes sense, but public transport links need to be improved to avoid the costly options available in some areas.

I am used to going to Lincoln for various clinical services, Boston is much further away

Central in the County. Better access by car

One central site will provide a far better sustainable service. Patients will be willing to travel to Lincoln from North, South, East and West Lincolnshire knowing they will be receiving a top grade testing/diagnostic service.

Why is it Grantham population are the ones that have to travel for everything

Centralisation at Lincoln would be detrimental to breast services that require vital nuclear medicine support particularly at PHB which would mean patients would need to go to Lincoln for surgery which could lead to delays within cancer surgery

Having two sites, geographically spaced apart will cause less problems to Lincoln's infrastructure and mean less travelling for a significant number of patients this lessening the environmental impact of longer journeys in cars.

Public transport is inadequate in Lincolnshire, and to put all these services in one site in Lincoln would involve unacceptable amount of transport fromn the south of the county. In addition the recent catastrophic fire at Lincoln showed how difficult it was to find suitable alternative centres for treatment. Lincolnshire is not just Lincoln, and those of us who live in the south of the county deserve a local centre for these services.

Personal impact as a carer providing transport

Ease of access and availability of service

Lincoln has poor transportation links so needs 2 locations

The pharmacy is already there and Lincoln is the most central option. it makes no sense to duplicate the machinery in two locations when resources are low. The increased travel distance is a minor inconvenience for the low numbers of patients that it will affect and the few number of visits any individual will need.

Lincoln easier to get to than Boston Pilgrim.Would prefer Grantham but expect that one will close .

Keep it at grantham

Transport problems - how do people in South of the region such as Bourne get to these sites? I regular public transport. You have to have access to a car but not everyone has. At least at Peterborough there’s a regular bus service.

Better to put all resourses in one place therefore only needing one set of staff

Please tell us why you chose your preferred option and if you have any othe...

It will not be viable unless centralised and will provide huger quality more cost effective services if centralised. But need to deal with the transportation challenges and patient vented appointments for those who live further away

To allow more patients availability of this facility in all areas of the county.

Lincoln is the best run!

LINCOLNSHIRE is the second largest county in England and 100 miles by 60. People need a service serving all Lincolnshire. This is not about quality but failure to recruit skilled staff

I am aware of quite a few people locally who have received excellent service at Pilgrim in this department. Lincolnshire is the largest county. Two sites offers scope to minimise disruption to services i.e. recent fire at Lincoln etc.

Lincolnshire is a very big country and why should every thing go to Lincoln,pilgrim is a very good hospital

The road infrastructure in Lincolnshire is as best poor and Lincoln not central, but on the west of the county. Having one centre for nuclear medicine services would reduce the effectiveness of the service and increase the travel time to the hospital significantly which could, in some cases, put lives at risk.

It is wrong for people who leave either of the 2 main hospitals in the county to have to travel half way around the county for treatment. Especially at a time when they need these services

It is wrong for people who live close to the 2 main hospitals in the county to have to travel miles to access these services

With 2 sites there would be one to the north and one south

Service involves ageing population travelling from south of county a nightmare all the way to Lincoln

Travelling to Lincoln involves over an hour's journey each way. Not easy for ill eople.

travelling issues for Lincs residents to one centralized location, lincs is one of the biggest geographical CC areas, its not fair or reasonable to expect patients from the peripheral areas to travel such long distances. Also there is no back up or continuity if a problem occurs at one centralised location, ie fire, flood, power outage or other disaster

It's central to all

Whilst I have an interest in centralising the service to Lincoln County Hospital (I live in Lincoln), I am also aware of recent circumstances in Lincoln where a fire shut down A & E and adjoining services for some time. I therefore feel that some provision, however costly, should exist for this service to be able to function at a different site, however inconvenient, in order to ensure that some service is still available.

Lincoln is more commutable and has traffic links

ease of access from all parts of the county

Its too far to travel to Lincoln,too expensive by taxi and hospital transport and the bus service is none existent from here

Better to have one large facility with one set of clerical staff etc instead of two sites with duplicated support staff

One site is not enough for such a large catchment area, so needs two minimum

Please tell us why you chose your preferred option and if you have any othe...

covers more patients

Having had to use another service that is only available at Lincoln Hospitali for the whole of Lincolnshire which is one of the biggest spread out counties in the country and seen at first hand what patients have to go through to travel there I strongly believe there should be 2 sites. The cost in transport alone getting alone and vunerble patients to one hospital must be in the millions and if there were 2 sites this cost would be offset against the staff etc at a 2nd site.

Having one Centre would provide an efficient service

The growing population of Boston Skegness and other surrounding areas are mostly elderly and vulnerable. Their ability to travel to Lincoln to receive treatment is very limited and in some cases not possible at all.

Dont know what future demand is likely to be for this service

Transport can be challenging so there should be two options

As a retired nurse I understand the cost and complex nature of the service. The cost and availability of isotopes leads me to think centrally is the obvious way ahead

Lincoln is hard to get to from South Lincolnshire

The recent fire at Lincoln county should show the trust the folly of centralizing everything at at Lincoln County, The trust cannot and must not centralize everything at Lincoln county, Lincoln is NOT the entirety of Lincolnshire

Lincolnshire is a big county and the south east is already poorly served. Let’s not make it worse.

accessibility

As a minimum the two main hospitals in the county providing 24/7 ED must have access to these diagnostic services either for emergencies or planned follow up without having to travel.

I am able to get to Lincoln with ease. It is incredibly difficult to get to Pilgrim

Lincolnshire is a large county and to enable people to access services two centres are needed Services at Lincoln cannot cope with the number of clients now so why on earth would we increase the number of people trying to get onto the site for whatever reason at Lincoln

Why are ulht discriminating people who don’t live in Lincoln with all services appear to be centralising to Lincoln now. The hospital at Lincoln can’t cope with the pressures it currently has so centralising more to that site is unsustainable.

Gives greater flexability .

Would provide a financially efficient service

Lincoln is more central to the county.

More options for patients

Two sites more options forv patients

Please tell us why you chose your preferred option and if you have any othe...

Centralising services at Lincoln would have a detrimental effect on patients that live in the south of the county, not everyone can travel, removing services from Boston would have a negative impact on staff & patients alike

Moving nuclear medicine from Grantham will put undue pressure on the current echo appointments which can delay chemo starting. Also moving from Grantham means nearly all breast cancer surgery will need to stop as they need their nuclear medicine injection the day before or on the day of surgery and shouldn't have to be forced to travel to Lincoln or Boston on the morning of surgery to have this injection. Was these cancer groups of patients even considered?

Lincoln is 1 hour 30 minutes away from my home.

Many services are due to be transferred to Lincoln only, reducing choice of access for patients

The centralisation of the service is not reasonable because of the distance, typ of roads and also weather at the winter time. Not forgetting arrest time when farm vehicles necessarily slow the movement of traffic. Patients who Ed this type of investigation wil be very sick almost by definition. Travel May May be in the patients best interests.

Lincolnshire is a large area to cover. Centralisation at one site would not only put a lot of pressure on the staff at that site, but also delay the procedure for many patients, increase travel and cause inconvinience. Having at least two different sites, helps in distributing the workload and allows patients to travel to a closer option. Having a mobile unit for patients with mobility issues and extreme distances to travel may also be helpful.

None of the sites are big enough for the capacity of Lincolnshire anymore. But we should not expect people to travel further when unwell. All sites need to be made bigger. We cannot just keep moving the problem around.

It is central to the county and good public transport for those who do not drive.

Poor and expensive public transport availability between Boston and lincoln

Transport especially for those around the Grantham area who are elderly, unable to drive, etc

Lincolnshire is a large county and whilst restricting the service to 1 hospital may be a money saver for the trust it is a costly inconvenience on the patient and in time will place strains on Lincoln hospital services because of increased workload and its facilities as well as the local area.

Access to Clinical care is already difficult, expecially for people who rely on public transport. I live in Holbeach and a vist to Pilgrim for a 20 minute consultation takes over 5 hours with travelling by bus. Lincoln is almost impossible to get to and back in a day.

Large population that use Pilgrim, which is currently due to expand by around 10%, poor transport between the 2 centers, busses are poor trains poor and involve a change, Lincoln hospital is slow compared to Boston who already have poor services.

For ease of travelling.

It is over an hour to travel to Lincoln if you are lucky enough to own a car and are well. It is a nightmare journey by bus and if you have bladder problems is almost impossible.

2 sites are best for local people

Cost/service delivery benefits are obvious if centralised - resources are scarce - service is highly specialised

As Lincoln is now joined forces with Nottingham University I think Lincoln is moving forward too being a teaching hospital

Both as more options for pstients

Please tell us why you chose your preferred option and if you have any othe...
This makes the most economic sense
Waiting lists will increase if only one site is available
Aged population and poor public transport between sites.
I do not agree that the services should be provided in less locations. The population of Lincolnshire, particularly in the south of the county is growing and you should be expanding services but making it more efficient. I do not agree that the proposal of one or two sites is sufficient.
To best meet patient need over a very large geographic area and to avoid overloading the service at one site and to provide back up in case of problems or breakdown at one site.
Geography, creating two centres gives more scope and flexibility
If it must be at 2 sites then it should be Lincoln and Grantham
Retain services at a grantham. It's time to provide services locally to people. The trust board is obsessed with centralised services and provides unsafe,inaccessible poor quality services .
I have no preferred option. My preferred option like everyone else's is to keep the services over 3 sites, including Grantham and have the Government properly fund it
Grantham is not allowed
People have to travel and cannot afford to travel to lincoln if boston area
Poor transport links and costs from south of the county
Centralization at Lincoln will impact in patients and capacity, delays in diagnosis. Lincoln clearly cannot cope with the already centralized specialties
Lincolnshire is second largest County in UK and the south of the County deserves decent medical facilities. Lincoln has no decent public transport links and it takes one hour plus to travel by road
It is still difficult to get to Pilgrimas buses have been cut on many routes . It is impossible to get to or from Pilgrimin many Boston areas . The loss of any service is not best practice .
Really?
It will be a good options for patients that struggle to find transport to Lincoln
The 2 sites have services that require nuclear medicine support to ensure the clinical standards are met and also patients access to services.
So that the health inequalities are not made any worse in the Boston area
this option allows for access re travelling easier for more people
Lincolnshire is a large county and people in the south and east of the county always have to travel a distance
Centralisation at Lincoln only would render breast cancer services in the Trust potentially unsustainable

Please tell us why you chose your preferred option and if you have any othe...

Travel difficulties for residents who do not live near Lincoln

It's unrealistic to expect this underfunded trust to be able to offer costly services like these across all three sites.

Skegness Town Council is against any loss of services at their nearest hospital - Pilgrim.

because it is closer to me and Boston is expanding its population all of the time

Lincolnshire provides enough challenges due to ruraluty and poor public transport having the service only at Lincoln would be discriminatory and challenging for numerous patients in the south and east of the co7nty

I have no preference as at Grantham where is closest to us would be best as we are 1 hour and 20 minutes from Lincoln and 70 minutes from Boston so my choice would be in any event not to use UHLT but Peterborough hospital as this is 30 minutes from me albeit I am actually in Lincolnshire and my GP is based in Lincolnshire

The optimum way to achieve savings AND continue the service . I guess the service is used more by older people who might find travelling difficult

Neither. Centralise it to Grantham!

I chose neither as I believe that the service should be at Grantham. One area mentioned is the distance patients have to travel,Grantham would be more central than the two options given. Grantham site has many building that could be utilised or demolished and a new unit built.

No change. Fund all 3 sites properly.

More sites the better

It is a bad idea to central the nuclear medicine services and other services in one central location. You are NOT considering the whole population of Lincolnshire. Lincoln has limited parking and public transport is NOT easy to get to Lincoln. Centralisation is NOT the answer!!!!

Best chance of atrracting and retaining staff, best use of equipment, avoids downgrading of Boston by loss of services

Better for patients geographically in a county with an ageing population

Not everyone can travel. Public transport is erratic and often cancelled. Services cannot be relied upon for an appointment that could have been several months waiting.

Two sites give more options for the public, more options for operators and doesleave a spare unit if forsome reason one is not usable

Rebuild the unit at Pilgrim, move service from Lincoln and Grantham to Boston. Make that your centre of excellence.

Transport and access. Rural living people will yet again pay for something they are not able to use

Lincoln is about an hours drive and i could also travel by bus, although i am not sure how that would align with appt times. I do realise that it may make travelling more difficult for those living in the south of the County , however if Lincoln cannot be moved, then it probably makes sense to centralise at Lincoln..

Contingency e.g. if one hospital is not operating fully (as it was in the pademic, operations, consultations etc from Lincoln have been cancelled, the service can be provided from the second hospital), huge county with lack of good transport links,

Two sites are better for patients. Would over load service if just in one place. Also would help with patient access / travel.

Please tell us why you chose your preferred option and if you have any othe...

No other choices. A total fix

Centralisation only at Lincoln might possibly render breast cancer services unsustainable in the long run due to complex issues related to unavailability of same day injecting at Pilgrim

Provide Mobile Services to all ULHT sites

In view of the issues (staffing, economies of scale, population distribution) and fairly small number of patients ,points to1 site which in view of presence of radio pharmacy at Lincoln means it being in Lincoln

Neither. You're forgetting Grantham we already have lost 24 hour A&E among other vital aspects.

Believe this will be more cost effective however there needs to be an assurance that transport for people without there own cars /access to public transport will be addressed

Easier access for patients across the county. Stopping one place being too busy and creating difficulties parking in Lincoln if all services are there.

Travel distance as county is large. Also patients likely to be older and unwell. Cost of fuel and time.

By having two sites it allows patients to be seen at their nearest hospital reducing their travel time potentially at a point when they are feeling unwell.

Due to distance people have to travel and capacity

Lincoln hospital is easy to access and plenty car parking no

To reduce average travel distance for patients.

Less distance for people to travel

Having used the service a 90 mile round trip every day for 24 days added more stress to my treatment.

Once again the residents of the Grantham area are to be denied an essential facility. You produce no facts on numbers, the costs now and proposed, no evidence of non availability of spsecialists. In essence a poor resume of an essential need. The trust has obviously allowed existing equipment to become outdated, this displays a complete lack of foresight and planning. The latter a task not uncommon when Grantham is considered. Thus a poor presentation for the public to have any in-depth understanding if the needs.

Centralisation in a county of this size is not beneficial to patients, by cutting the services if anything goes wrong with the staffing or equipment if it is only at the one site it means that the service is either affected or unable to be offered. With affiliation with the University of Lincoln we should be able to attract staff however if the services continue to be cut what incentive is there to work in a hospital with skeleton services.

Neither are a good option for people living in the southwest of the county. We are closer to Leicester, Peterborough and Nottingham than Lincoln or Boston.

There wasn't an option for Grantham. Personally, couldn't get to Lincoln or Pilgrim! Can get to Grantham!

The populations of all three hospital areas are increasing, and the population is living longer. If the services to close at Pilgrim and Granthem there would be dying as a result of haveing to travel to fare.

Please tell us why you chose your preferred option and if you have any othe...

1. With covid it has shown the benefit of splitting resources to help minimise spread of infection. If you have just one centre it increases the risk and reduces options to manage the crisis. 2. I live near boston. I dont drive, limited public transport. If linciln was the only centre then it would disadvantage a lot of people and i think there would be a lot of missed appointments stills because of the difficulties getting to one centre.

Transport , scatter of people across Lincolnshire

It's a big county and those living further distances will have too far to travel. It's descriminatory!

Centralisation does Not work! Why compromise the other hospitals to place the nuclear services and possible other services in Lincoln?? The nuclear services on three different sites has worked and relieved the situation during the pandemic! Please consider the people of Lincolnshire, rurality, which includes varying transport problems. People prefer a smaller hospital for somethings. If have to alter the nuclear services, then go for a to centre option, Boston & Lincoln. Do NOT make it a 'fait de complie!'.

Keep all 3 sites including Grantham

Grantham should have been in the mix why was it not ? You will never get your hand on the land that the hospital stands on no matter how hard you try.

Limitation of the resources and infrastructure in the area of, and surrounding Lincoln County Hospital.

People have to travel for other specialised services, this is no different

Unable to choose

A lot of people do not want to, or be able to afford to travel to Lincoln. There are a lot of people rely on local treatment and closing down Pilgrim and Grantham will not be any more efficient. Patients will suffer.

Spreading the appointments between hospitals will provide the county with more choice. Waiting lists are long enough at Lincoln hospital... Why do you want to add MORE patients to the list!!

Might actually get an appointment in foreseeable future. If only one site available and problems arise there is no alternative

Unable to get to either

We live near Spalding, travel to Lincoln currently is unaffordable and there is very poor parking at Lincoln

Best of two evils..why not Grantham

The area of residents which Boston Pilgrim serves is much greater than other sites. The distance for these residents to travel to Lincoln is extortionate, given that many who require the service are unwell already. Travel from Boston to Lincoln can take in excess of 1hour one way, there is no train service to Lincoln, and the bus route is questionable. The cost of travelling to Lincoln, and then parking as well, is far more unsustainable for residents of surrounding Lincolnshire than it is to maintain the two locations of Lincoln and Boston.

Lincoln is not easy to get to for everyone

Lack of decent roads over a large geographical area add difficulties and costs to the burden of people already unwell

Lincolnshire is big area. Public transport poor. And travel is not easy for all.

Fixed choice no other options

Please tell us why you chose your preferred option and if you have any othe...

Centralisation at Lincoln and Grantham

Due to the lack of infrastructure in Lincolnshire with regards to travel

People ie patients also need to be considered in getting to their appointment

Neither are acceptable if you live in Grantham

Would prefer to keep all 3 sites as at present and invest the money in training the extra people required , people travelling from my area is totally unacceptable .

Grantham musses out yet again...

Impossible for ill and disabled to travel to Lincoln from South lincs.

Lincoln and grantham

Should be available at each hospital. It is difficult for patients to travel long distances. Lincolnshire doesn't have enough hospitals as it is and large distances between them all. Public transport is not the best in Lincolnshire

What about Grantham.

To be fairer to those living in the North and the South of the county but also to ensure a suitable back up facility if something goes wrong with one facility.

Grantham should not be denied these services so why have Grantham not been included in the options

Difficulty of travelling to Lincoln.

My thoughts are that if this service was based in only one site, there woud long waiting lists.

As pensioners who live in Boston the last thing we want is to have the stressful journey to Lincoln.

Easier for the elderly who are often no longer driving and who more commonly use nuclear medicine services to get there if there are two sites. services

My option would be to retain services at Grantham

Lincoln more likely to attract quality staff

Use Grantham to make using the service greener. people don't want to travell miles.

Rationalisation while retaining access across the county

all three inc grantham . distance to travel to hospital is too difficult given the rural areas

Many elderly people in the area around Boston who find it difficult to travel. Public Transport is out of the question

Travelling from the south if the County is extremely difficult for many patients

Please tell us why you chose your preferred option and if you have any othe...

Boston & lincoln are too far from Grantham. When I live a mile from Grantham hospital why should I need to drive 30+ miles to satisfy ULHT ideology

Neither option! Grantham needs this service

I live in Boston therefore I would resent having to travel to Lincoln

Neither is my preferred choice. As a Grantham resident I would like to see Grantham as a preferred option.

Patients need a "centre of excellence". Such a specialised field needs to be in one place. Patients don't tend to attend more than once and some will, in any case, need to go Lincoln. Probably best, therefore, to to concentrate expertise and equipment in one location.

So many services are Lincoln with poor parking, no buses and too far for travel

Pilgrim is nearest

A better choice of locations, and if there is an issue at one site, there would be a 2nd site to fall back on

keep all three centres open, Lincolnshire geography, roads and transport are not supportive of reducing the number of sites to best serve the patients

Having two sites helps patients in a large rural county reduce travel times, and two sites ensures continuity of service in case there are issues at one site

should improve recruitment & retention of staff and optimise use of newer equipment and safe practice

Once injected pts are told to ‘go home’ or similar. The further away you live, the more difficult this becomes.

The location of the radiopharmacy

There are still loads of people thats go to Pilgrim for nuclear medicine and its there nearest hospital there is also alot of inpatient that neef the service .

Better to keep the staff in one place so they dont have to try and cover two sites.

Treating patients in a timely manner, reducing the extra anxiety and stress at an already worrying time. Being able to offer a diverse service without the population having to travel which increases to the carbon footprint and footfall at one site. The cost implications to the patient having to have extra time to travel, cost of travelling, accessing support if not able to attend appointment independently. Reduction in staff roles at one site if it was to reduce.

Greatest efficiency by being on one site

We were told that after Stroke servcies no other services would be centralised to Linocln yet here is another proposal to do just that. Why cant the service be centralised to Pilgrim?

As a 35 year nuclear medicine veteran i am fully aware of the efficiencies of having all cameras and radiopharmayservices at one site. This maximises the camera usage with the smallest number of specialist staff required.

Yet again Grantham is not a choise. Why should you close Grantham as apposed to Boston. For once why can't other people travel here.

I would prefer for Grantham to be an option

Please tell us why you chose your preferred option and if you have any othe...

Travel is not always easy for some patients.

Leave it in Grantham. People cannot always travel to either of these other hospitals. And aren't always allowed hospital transport. Public transport is a definite no go.

Lincoln hospital is the most central and accessible location (roads/public transport connections) . The hospital already has all the facilities including pharmacy

Both Lincoln and Grantham involve long journeys for people in the Grantham area Grantham hospital , has been able to provide a vital service during the Covid pandemic. Grantham also has better transport road and rail links than either Lincoln or Boston .in case of major incidents on A1 or main North South rail network.

There are not enough staff to safely cover both sites and it will also mean better availability of isotopes

Value for money -cost effectiveness, doesn't need so many staff.

Lincolnshire is a big area and one site in the north will be a disservice to the people living away. Long travel times and poor service.

Preferred option is adequate funding of statue quo

You should always have the option of 2 places, rather than putting everything in one place. This is the best option for the patients

This way the shortage of staff may not be felt so much. The concentration of one hospital strengthens the work until results are achieved.

Like it or not the travelling cost and distance from the furthest areas within Lincolns catchment area will put people off attending thereby lessening patient care opportunities, this and the unmitigable risks associated with reliance on a single unit make this option obviously less favourable.

As this seems to be primarily a diagnostics service, I feel that this should be available closer to home prior to any necessary treatment.

having to travel to access this service could be difficult for some patients.

accessible service to those across the county and in particular those on the fringes of the county east, and south Holland etc

Rural county with poor public transport makes it difficult for patients to get to Only one site if they don’t have their own transport

Getting to Lincoln can be challenging for elderly and unwell patients.

Dont have to travel so far

For a more efficient world class service. 2 options runs a risk of fragmenting the service.

Centralisation of diagnostic services is a poor option for patients living in such a wide geographical area. This also tends to make choices political rather than clinical and also tend to favour the bigger and better financed centres.

Retain service at Grantham by rotating staff and retaining equipment at all 3 sites.

Lincolnshire so spread need 2 sites to give best service

Expanding community, estate expansion, supporting acute services at pilgrim. Golden hour.

Please tell us why you chose your preferred option and if you have any othe...

Leaving it solely at Lincoln will require patients having to travel unacceptable distances especially in be coastal areas

Pilgrim Hospital serves an enormous area and many many patients

If you are short staffed at Lincoln? How would you cope with Boston people also?? The waiting lists will grow and Boston would be left behaving as usual!

It is an expensive service. Better to centralised at Lincoln and offer patients an excellent service.

Living in Skegness makes a journey to Lincoln a really long trek.

So that patients in the Boston area and further afield are not disadvantaged by there only being one site.

These extremely important services are needed by many poorly patients living nearer to Boston. They cannot travel to Lincoln for tests without it hugely impacting many many individuals in various ways. Patients would have to pay to travel, take extra time out of their day. Causing conditions to worsen and be in pain whilst having to travel many miles from home. Services need to stay local for hospital staff and equipment as well as for patients. We cannot lose more services to another hospital.

Too much going to Lincoln only making services inaccessible for those in the south of the county. Public transport is deficient and roads are choked. We CANNOT get there.

It is the nearest to me therefore easier to get too though at over 75 no where is easy

Travel times parking ., emergency , nothing is less than 20 minutes

I live in Boston and would face a sixty mile round trip to access the service if needed. Tends to be older people who need the service and consideration should be given to the patient, not convenience for admin. of the NHS.

Lincolnshire is a large county, with very varying levels of transport access. By centralising the service to just Lincoln County Hospital rather than offering it at Pilgrim too, I feel the service risks alienating, frustrating, and putting-off patients who may have to travel very long distances to access the service otherwise.

Lincoln is right at the north of a large county and public transport is virtually non-existant over long distances.

No option for grantham?

Distances for south Holland patients , hopeless public transport options. Recruitment has to be improved for our patients sakes

For people living in Skegness and coastal areas, having 2 places would ease travel and discomfort with travelling longer distances. Also having a choice of places is preferable to just one. It will also ease waiting times / lists if both places are running simultaneously.

Keep nuclear medicine across all three sites

Due to patients travelling and a good service and team at phb already

Lincolnshire is a huge county and having 2 centres at the main hospitals would be better for the residents of the county

Travel challenges

Centralise at two sites to cover North and South areas, keep waiting lists down

Please tell us why you chose your preferred option and if you have any othe...

Not having a nuclear medicine service at pilgrim hospital will affect the ability to scan inpatients, and have an impact on the skin service for breast surgery. Patients will also have to travel significant distances to attend Lincoln. Some nuclear medicine tests can take a long time, and the travel can add significantly to a patient's day.

i prefer none of these choices, living in Grantham i had to go to Boston for an eye appt at 12,i hvae no access to a vehicle and there were trains at 8.30 or 11.30, niether of which were convenient and then hoe do i get to hospital but by expensive taxi fare? transport if you don't drive or have access to a vehicle is a massive problem and it can take 2+ hours to get to lincoln by bus which imho is totally unacceptable, the train service is rubbis and all this needs to be taken into account

Because not everyone drives and the county is so big it would be unfair to those living further south

2 sites are better than 1, choice of location is important for patients

Traveling to Lincoln is very difficult without transport and south Lincolnshire seems to be losing all its services leaving us to have to travel to Lincoln and Nottingham for even basic treatment

I am disabled and have many health conditions. I don't travel long distances well at all, so looking for the closest facility to me

having only one centre will increase waiting times for patients

Lincoln is a long way for people south of the County plus the problems with public or private transport. I am not sure about distances from Grantham plus surrounding areas to Lincoln or Boston

Nearest to home location

You cannot expect cancer patients to travel excessive distances. Door to door S.Lincs. to Lincoln can be a 1 hr 15 trip along poor roads.

Sick of ulht trying to close Grantham, why not use Grantham and Louth

Lincoln is the best option and near to the Lincoln medical school. Moreover Pilgrim has a history of poor CQC reports!

Also Grantham pleaae its far too far for most patients to trave to Boston and Lincoln

Lincoln is a very long way away from South Lincolnshire. Pilgrims is much more accessible.

You are missing the point - services such as this should stay at Grantham Hospital to service the community there, taking them away just permits the eventual closure of Grantham Hospital

Because transport links to Lincoln can be quiet lengthy and expensive

We cannot keep loosing services at Grantham Hospital. This is not fair on the people of Grantham and surrounding areas having to travel.

Fewer people would have to travel to Lincoln

Whilst I understand the reasoning to centralise the Nuclear Medicine service, the issue for me is transport of patients and this is why I would prefer centralisation of two sites. I have elderly parents who do not drive and struggle to attend appointments at Lincoln. Whereas they would be able to attend Boston. Obviously another deciding factor is demand and capacity. I am not aware of how many patients are referred and seen in Boston or would be redirected to Boston. -v- cost of gamma camera and precious clinical space.

Please tell us why you chose your preferred option and if you have any othe...

There is an option for patients living north and south of the county. This mean that patients are not travelling for potentially long periods of time for treatment/assessment when unwell.This may have significant impact on the elderly or patients that require ambulance transport. It also means if there are issues with equipment at one site then another is available

Because poorly, frail people cannot travel so far to Lincoln it has coats and a long journey not all people drive . Petrol and parking costs are way to much and long journeys from Spalding area.

travelling can be a problem

a single place has a big impact on primarily older patients needing to travel much larger distances

I am a wheelchair user, access to Lincoln hospital and parking make appointments very challenging, I should be able to attend on my own ,but can't because of these problems. The needs if the mobility challenged are completely ignored at Lincoln hospital

More options less waiting

Greater choice in such a large county

T

Nearest hospital Boston is too far for me

This is a relatively large county. It would be poor patient experience to ask some on the edge of the county to travel over 2 hours (return) to access an outpatient service as this if the services were centralised to one site.

Excellent service /staff

Just one site makes more sense, make Lincoln the home for it

2 locations are better than one, more opportunity for patients

This maintains a greater department size and therefore cross county specialisation and rotation to maintain staffing levels. A smaller department potentially can reduce attraction to staffing inadvertently

Need to have the images to be done as early and as reable as possible

Any centralisation of a service at Lincoln only means a disadvantage to the patients in Pilgrim. We often have to wait for extended times for appointments for the scans and then there is the added difficulty of transport which often never turns up and the patient misses their appointment. Pilgrim serves a large population of patients and restricting its access to services should not be an option

Centralisation of services in a county like Lincolnshire only promote inequality and reduces access to services that are required. Roads and transport infrastructure are not good enough and will reduce patient choice and care

Grantham is much closer than Pilgrim so should be retained, to ensure viability of the daily dose samples.

.

more patients can be seen in two hospitals sites rarer than just one site. therefore doubling appointments

why not centralise at Grantham

Please tell us why you chose your preferred option and if you have any othe...

Access for more people.

Because it is absolutely clear that this is a very specialist area of diagnosis and treatment requiring increasingly specialist resources and expertise in the staff involved and it makes absolute sense for this facility to be centralised so that in Lincolnshire we can look forward to the very best service in this specialist but important area

A nightmare to get to Lincoln which is already busy enough

Better location and easier accessibility for the majority of the county.

Ulht services a large area of Lincolnshire and Lincoln county hospital is not solely accessible to the whole county in a reasonable way thus it logistically makes sense to have both lincoln and pilgrim offering the service to enable better patient access and remain inline with the trust values of patient centred and providing excellent services.

1) impact on breast surgery - nuclear medicine is essential to this and if nuclear medicine goes, breast surgery will be significantly affected (see point 3) for impact of reducing or losing breast surgery at Pilgrim) 2) comment re pts going out of county for tests if no service at Pilgrim - Peterborough is further than Lincoln for most Pilgrim patients so not really an issue 3) services are seeping out of Pilgrim and the effect on wider staff morale and recruitment should not be ignored 4) increased resilience in case of scanner failure at one site

Lincolnshire is one of the larger counties in England but with a poor communications structure ie major roads. Travel to Lincoln is often over a 2 hour journey from the coastal towns and villages so there is a requirement for closer sites that can be attended by patients without personal transport.

Centralising this service in one location impacts on all users/future users by always having to travel to Lincoln and not everyone has a car and will have to rely on other modes of transport which in Lincolnshire are dire. Therefore Boston Pilgrim and Lincoln a much better proposition.

Service at Boston needs support from cardiology to do heart tests, this is a burden on cardiology which will be relieved if service only in lincoln site.

why dont you move to louth

There are many children requiring especially renal imaging at Pilgrim and surrounds. To not have facility at Pilgrim with the travel distances and population type is a complete nonsense

Centralise Lincoln and Grantham. You are trying yet again to reduce facilities in Grantham. Good excuse then to close it.

Lincolnshire is a vast county and public transport is in short supply, hence making it difficult to access these services. Given a choice, and, whilst not understanding the complexities of the provision of this service, I would suggest a mobile provision to enable maximum service whilst addressing any staffing issues you currently have.

Boston is a very over populated area abd needs these precious services every thing goes to lincoln making us a poor area not on

Far better to have one unit for the whole county

Needs to be boston

The distance

preferred option to put routine nuclear medicine services in Grantham and complicated at LCH or PBH. parking already stretched at LCH & PBH

So patients from the boston area do not need travel further afield for treatment, there health & wellness is most important.

Spread services across county.

Please tell us why you chose your preferred option and if you have any othe...

It needs to be accessible to people and not everyone can get to one site

The centralisation of services to Lincoln has to stop. The transport infrastructure in Lincolnshire does not support this as the journey times from the south and east of the county are untenable.

Lincolnshire is a rural county and not everyone has transport .

Travel from the east coast is difficult and getting hospital transport virtually imposdible

The county is too big and spread out with poor bus services to have it only at lincoln

Once again it is suggested that a service be moved to Lincoln.Lincolnshire is a large county and everyone deserves to be able to access a service not just convenient to the residents of Lincoln. It amazes me that you expect patients to travel to Lincoln for this service. When will common sense start to prevail not just with this device, but with everything else!!

Lincolnshire is a large county with a lot of bad roads. One point of centralisation is a good option in theory but means lomg travelling distances for many. If you have 5 Gamma Cameras at present but a workload only for 3, is there not a market for second hand medical equipment? Could the five not be sold to provide some funding for three new cameras, one to be placed at each of the existing hospitals, thus covering a larger area of the county.

For the people of Lincolnshire it is better at more than one site for ease and safety of travel and attendance for appointments. For the people of Grantham it would better to have this also on the Grantham site.

I chose this option so that emergency care can be developed at Boston

Too many services being removed from Pilgrim to Lincoln There is no thought how the people of South Lincolnshire will get to Lincoln . There is no direct road or train service from Boston Skegness or Spalding. A lot of people that will use the service may not be able to drive or have access to a lift , they also may not be eligible for transport help. Do the powers that be think we all have a magic wand to whisk us there. It is short sighted and dangerous to centralise everything. We need accessible services in the south of this very large county. I know from having worked at Pilgrim how demoralising it is when the excellent service we provided prior to ULHT was taken from us . Each hospital has its part to play and the citizens have a right to local care

Makes sense to see all patients in one play rather than spreading over 2 sites and trying to maintain staff and equipment at 2 sites

Pilgrim

Pilgrim

Pgrim

transportation to Lincoln is difficult from the Boston, Skegness side of the county.

Centralising on just one site could lead to patients waiting longer for diagnosis. Also, for someone in the south of the area, it's a long way to go.

Too far for people to travel especially will be busy in summer season so what would waiting time be for treatment overflow of new buildings already pushing services to overflowing capacity need more attention to vast influx of Eastern European’s and for local people that do not have to pay out for transport not fair on old age pensioners they have more expense than ever now at least try and accommodate health treatment

Inclusive availability for surrounding areas and elderly population

Not everyone has transport to get to Lincoln , Lincolnshire is a large area and some people don’t have ability to travel all the way to Lincoln where by Boston is easier to access

Please tell us why you chose your preferred option and if you have any othe...

Lincoln will soon have all services , the journey is poor and will significantly reduce care locally, will push costs elsewhere . Postcode lottery health in Lincolnshire, the public deserves better

no changes

Surly if there are 2 sites twice as many people can be seen

Lincolnshire being the rural area it is and limited public transport having 2 sites would make the service more accessible to all. Also the breast list currently run at Pilgrim may not happen if services are centralised to 1 site, some patients need nuclear medicine injections in the day of surgery.

Ready made site

Closest to me

Better to have one fully operational service in Lincoln than end up with none at all.

Efficiency of service

It's important that Boston retains some services rather than moving all the big services to Lincoln. In terms of patients traveling you need to maintain 2 sites for nuclear medicine

Everything centralised in one place. Dividing it in two isn't staff efficient. If all in one place then all information would always be at hand.

ease of access for patients, travelling to lincoln is too far for a lot of patients especially elderly who are not able to get transport.

It is closer to me and the county town

Ease of access

It will be too far for people to travel especially older people who don't drive

Large rural county does not suit centralisation

Both sites should have the service in order to provide a service for patients in both areas. Transport costs are increasing, elderly people struggle with transport, these patients are often sick and travelling miles is not always comfortable for them. Transport delays, weather, cost, staffing, all 8A October negatively when patients travel a long way

Always the best for patients

Because it is quite clear that Lincoln is aleays getting funding fir various projects whilst the restvof the countyvreceivrs thevsvmcraps from the table. That looks good for the MP and Martin Hill. It is not good firvthe residents of the rest of Lincs

Access to the service not everything should move to Lincoln, due to the geography of the county

Lincoln has a more comprehensive NHS facility for most applications

Lincolnshire is one the largest counties and patients should be able yo access services closer to.home

Patients are already traveling long distances for diagnostics and treatment. The hospital transport is truly awful and not at all patient centred costing time and appointments to be lost over and over which will worsen by centralising another service. .

Please tell us why you chose your preferred option and if you have any othe...
it is difficult to get to Lincoln from all areas of south Lincolnshire
Lincoln Hospital not the most convenient place to get to
Boston is more accessible to me.
Both sites require nuclear medicine services
Lincoln is too far from the East Coast ti travel
Travelling time and risk of road closure due to accident meaning missed appointment
Typically of ULHT you want to move everything away from Grantham. You must for some inexplicable reason hate Grantham
2500 tests a year at one hospital is not safe surely but 2 sites spaced to deal with each half of the county would be the better option.
The area of Lincolnshire is widely spread out a d would be better covered by more than one site. Also a 2nd site gives a backup if one site has issues.
Very easy to get to, and staff are excellent
Centralising staffing expertise and resources in one place makes more sense with savings in not having to buy and service so many excess pieces of equipment
There is a long enough wait for services already in this area we cannot lose the one @ pilgrim as some people cannot travel to Lincoln for this important test
Training is a big problem &we need staff on 1 site to give both support to junior staff. This will also increase retention as lincoln do all the tests &have radiopharmacy meaning staff can gain experience in all skills associated with nuclear medicine
Travelling g to Lincoln for staff and patients unsustainable
Grantham as the third site
Neither. Use Grantham over Pilgrim
At least this option provides two locations rather than yet again seeing services centralised to Lincoln
We need reasonable equitable access to care for patients spread across this large area of Lincolnshire. Deprivation in many areas and poor public transport means that many people are unable to travel to one site across the county
For those who find travelling difficult, Lincoln is such a long journey, particularly those from the Boston and Skegness area of the county. Lincoln hospital already have several centralised services such as the cardiac catheter lab and stroke. Please don’t deplete the services at Pilgrim any further.
Lincoln is easier for patients to get too. Better roads and infrastructure
Lincolnshire is a large county and the logistics of all patients being able to access Lincoln is unrealistic.
Makes sense centralise services and expertise on one site.

Please tell us why you chose your preferred option and if you have any othe...
Fairley central in the county
Give people option if cannot get to lincoln easy
Lincoln is too far to travel for huge numbers of people in the county and is already where most services are. It is Lincolnshire hospitals trust not Lincoln.
Due to large county and poor transport links better to have two sites
It gives more choice to people
Area and accessibility to patients
Not everyone can travel to lincoln elderly people etc
Because I live in South Lincolnshire.
One service would not support those of use who live in the south of the county
A robust service on one site enables greater flexibility for patients. It utilises resources more effectively including staff time and radiopharmaceuticals
Lincolnshire is a massive county & travelling to the Lincoln site will be difficult for those living in the south of the county
As someone who lives in Lincolnshire this is a large county with lots of people so it makes sense to have two sights so people are given the choice
If the service is central to Lincoln only many patients in the south of the county will be geographical nearer to NUH, this would then have additional cost treating them outside of ULHT. Additional costs moving patients within the hospital setting ie from Boston to Lincoln would also be occurred.
I selfishly chose Lincoln as my preferred option not only because of convenience, being 30 miles from home, but because as a cancer patient 12 years ago it was necessary for a bone scan during treatment, at Lincoln. I was very well looked after there.
It is needed at both sites
I only answered because it would not give an option to enable better coverage.
The distances involved for patients just coming to Lincoln would not be beneficial. In addition I am not sure Lincoln has the capacity to cope with the increased footfall from absorbing two other locations.
opposed to centralisation of services at Lincoln
Convenience and age consideration. At 80 years of age I would not be comfortable having to travel to Lincoln from Boston
Transportation to Lincoln difficult also opposed to centralisation of services in Lincoln.
would request service at boston for my patients. can trust provide transport facility for patients who cant afford to travel?
It seems like the most cost effective solution
I look after paediatric nephrology patients and I would prefer to avoid all of my Boston based patients having to travel to Lincoln for imaging.

Please tell us why you chose your preferred option and if you have any othe...

Covering two hospital sites covers a larger area cutting waiting list time.

Shorter distance to travel keeping costs down

If only one centralised site available this will impact on the amount of travelling required when fuel poverty is at its highest, more problems with parking issues, bus transportation not very good and in many areas non existent meaning the patient has to rely on others for transport. Only having one site will also impact on waiting times becoming longer, my husband had to attend Grantham for a specialist nuclear test which DVLA insisted he had and was paid for by them so HGV/PCV drivers employment is put on hold. There is also a possibility of deaths occurring whilst waiting.

I feel the service should remain at all 3 sites given the difficulty due to lack of transport infrastructure within Lincolnshire also The Lincoln site is no longer fit for purpose and require a new Hospital on the new ring road. I feel better use of Finances would allow all 3 sites to stay open plus making Lincolnshire hospitals a place that people wanted to work not as they are currently

I feel the services on all three sites should stay open especially those at Boston. Access for the east if the county is essential for good patient access.

East Lincolnshire populations needs access to important services

Grantham?

Because ever since we became a united trust lincoln are taking everything. These specialist services need to continue at pilgrim too for the sake of the patients.

Elderly population and unreliable poor public transport

I work within cardiology at ULH. I refer patients into the nuclear medicine service. The usual demographic of patient I refer is >70 with increased frailty. Given the size of our county asking these patients to travel from South Lincolnshire to Lincoln county (sometimes on public transport) can and will be detrimental for these pts. Moving a diagnostic service to a single site is short sighted and shouldn't be called to centralising as Lincoln is far from central for the people of Lincolnshire.

Improved service levels

Lincolnshire is a vast county and having a centralised unit only in Lincoln will leave many patients in surrounding areas without appropriate diagnostic and treatment at an adequate time

You are basically trying to shut down all services at pilgrim and increase mortality and morbidity rates in rural areas. You are taking away health care needs from a large area!!

Difficult to travel to Lincoln when living in Boston and services are in Boston. Almost all services being moved to Lincoln and Boston people being discriminated.

Getting to Boston is even worse than getting to Lincoln

I have significant concerns around car parking provision if the service is centralised, this can be challenging at the best of time, also increased travel if Grantham facility is closed

We need ongoing service at boston

Centralising all services to Lincoln leaves other sites unsafe and it becomes a post code lottery. Lincoln can’t cope with most of the services there already

The team at pilgrim do a fantastic job and easier for local patients to attend

Please tell us why you chose your preferred option and if you have any othe...

If it’s about saving money and staff for the better of the service then it’s better to just have one site.

To stop erosion of services to South & East Lincolnshire. There seems to be a gradual decline of services provided at Pilgrim.

Find the funding, stop cutting services. National insurance increases should pay to increase and not decrease services

Due to large area of Lincolnshire, gives people more choice

travel in lincolnshire is terrible so 2 sites is more appropriate given the distances and poor road network

Personally more available.

Public transport options from Boston to Lincoln are limited at best and not likely to be suitable for many users of this service in my opinion

More efficient use of resources and reinvestment of funding at Boston for any financial efficiencies

Location of the recently installed state of the art Radiopharmacy at Lincoln fits with better with the centralisation of service. Otherwise, radionuclides will either need to be prepared at Lincoln and transported and transferred on a daily basis to Pilgrim Hospital, at a continued further expense. Or, a new radiopharmacy will also need to installed at Boston.

Its ridiculous to have everything at just one sight, if that breaks your jiggered, plus lincolnshire is a vast county with an ageing population, so need to maintain two sites at least.

Using both sites ensures availablity to most people in Licolnshire

Transport issues - the more sites available, the better access for patients

Lincoln can be too far to travel to from certain areas, especially as this service can require a few hours stay at the hospital.It needs to be accesible for everyone that lives nearer to the Boston area.

Travel to Lincoln is difficult for many. Having services at PH will make it easier for those living on the East Coast. Very disappointing that yet fro services being removed from Grantham.

I don't believe having one central site will allow patients to be seen as quickly as they would in the past. I understand the need for it to be streamlined but over two sites would reduce the pressure on Lincoln

Lincoln is an impossible, expensive and painful journey from South Lincolnshire - Pilgrim is bad enough.

Available to costal Lincolnshire

As we have an elderly population it is easier for patients to have the option of two sites.

Grab l time from o ton and l k of car parking at Lincoln Hospital which is already overloaded

because of the need to biuld a new department in pilgrim due to the redevelopment of the A&E which would make the 2 site option using pilgrim very economically challenging.

Patients are then able to be given a choice also less travelling for those in the south of County

Lincoln because it is more central to the County AND IT'S THE CAPITAL CITY.

Please tell us why you chose your preferred option and if you have any othe...

Numbers of diagnostic procedures undertaken at Boston and Grantham do not warrant a huge spend on expensive cametas due to low use

Travel distances are big and all services centralised at lincoln will not serve the lincolnshire people as other services will be impacted at boston and the next consultation will be to close down and degrade the services at boston and poor services for people living in boston and skegness region.

I know many of my patients depend on public transport services to get to their appointments and for those living on the East Coast/Mablethorpe area they often require 2 buses (or an expensive Taxi) to get to Pilgrim as it is...getting to Lincoln Hospital for them would impossible to arrive in time, especially for early morning appointments and face a long wait for their journey home afterwards. For our elderly patients this can be a whole day out often without their medications/diuretics or food & drink due to the inconvenience of needing the toilet. The increase cost for their transport would also be a factor and may lead to cancelling their test and not reaching a confirmed diagnosis for their chest pain or other conditions. In the past when I have offered cardiac investigations at Lincoln patients have preferred an alternative test such as an MPI scan at Pilgrim Hospital to avoid the travelling.

I believe that as Lincolnshire has such poor transportation that this will affect many patients who don't drive or cant rely on others to take them to appointments.

Co-located with radiopharmacy

Too much centralisation of services at Lincoln not convenient for the people of East Lincolnshire

More sustainable

Easy road access and ability to deal with outcomes from results.

Waiting lists will go up if just at one site

Better patient care

You cant have everything centralised in Lincoln.

Distance of travel from the whole area to Lincoln. Could be difficult to get from Boston if ill and or vunerable

As a very specialised service I would be happy to travel to Lincoln. HOWEVER as many services are transferred to Lincoln I would like to see much better parking and maybe a free bus service between The hospitals

Lincoln is not easy to access for people in coastal areas especially with the lack of public transport and the time taken to get there

like many people you do not seem to understand Lincolnshire is the second largest county in England. NOT EVERY PERSON LIVES IN BOSTON OR LINCOLN. This covers up for shortage of staff . PROVIDE SERVICES FOR THE WHOLE OF THE COUNTY INCLUDING GRANTHAM HOSPITAL which is so run down and has been your aim to close for years.

If staffing is an issue, then consolidating the three sites to one would be the most appropriate option. This would offer a safer more robust service if the staff from Boston and Grantham are transferred across to Lincoln.

How about centralisation at Grantham

Split the load in this huge county

By offering two sites, we can effect mange the waiting time for service delivery and by keeping two sites , services users get a chance to choose a preferred locatio.

Please tell us why you chose your preferred option and if you have any othe...

Needs to be on 2 sites so if problem at one back up option automatically there

If it's at two sites it will take the pressure off the service at Lincoln it can't take much more before it collapses all together the waiting times for appointments is gey

More accessible for more people

There are many reasons for keeping the services centralised at both sites, such as...1. Boston serves a huge geographical area, because of which for people living in Skegness and further areas Boston is a much more convenient and manageable option for travelling purpose. 2. Population of Boston and surrounding area has been growing really fast in recent years. There is also a huge percentage of elderly population in and around Boston, who are likely to require these services most. Centralising these services at only one place in the whole county will put huge pressure on Lincoln site and patients will face further delays due to lack of appointment slots.

Lincoln is not as easily accessible for some people. Many changes where services have been sent to Lincoln already. It impacts On people more than you realise when services are sent further afield. Such as people from Skegness/mablethorpe direction, public transport is not reliable for people, lengthy journeys not to mention the cost implications to people. I think there would be more DNA and wasted appointments by centralising it to only one site

Access to and parking at Lincoln is poor.

Distance from home to Hospital

Serves both purposes of reducing the number of sites and providing equitable services to the people of Lincolnshire

Easy access to local populations at both Boston and Lincoln

The geography of Lincolnshire and poor public transport provision.

Pilgrim has already lost several services and patients are having to travel significant distance to obtain tests and treatment interventions. Boston is already deprived and these moves are making life harder for patients in this part of the county.

Choice

Lincolnshire is a big county and so it needs to be at two sites for the geographic size. Patients on the East Coast will not have to travel into Lincoln. And people from N.Lincs and Central Lincs will be able to use Lincoln. It will share the load so that patients are not all going to one place and having longer waiting times for their important life saving in some circumstances appointments.

All services moving to Lincoln would put population at Boston at unfair disadvantage

As usual survey is biased towards Lincoln. We need services in Boston area as well. Certainly not fun traing when ill. I should know just had to go to Peterboro for operation you are not kept in long then expected to travel sith all the extra costs that brings

Lincoln not able to cope with existing services & parking

Bigger hospital, more central to county

My preference is to keep Grantham open. It is a poor consultation when it is already decided that the Grantham unit is not even an option.

Breast cancer surgery can not be carried out without nuclear medicine support on site.

The geographic location of the two hospitals and that acute services are being run at these two sites

Please tell us why you chose your preferred option and if you have any othe...
Boston should be choice for elective imaging if one hospital is required in trust to choose
Please don't take everything away from Pilgrim. It was built up over many years, don't destroy it.
2 sites improves patient choice
I choose neither option
To keep Pilgrim services viable
Staffing and expertise there.
We are such a large county. Travel becoming an increased problem
Issues with transport and the road infrastructure in Ali Colin mean I would favour retaining two sites if possible
Difficulty for people to access one site only
Pilgrim hospital covers a vast area and if the department is moved from pilgrim patients will have to travel miles for the service which lots of them are unable or not willing to do !!!
Both options are ridiculous. Both sites under immense pressures grantham has no services due to all being pulled why not make this site xentrr of excellenxe dor imagaing and inveatigations
Travelling to and from the furthest boundaries of Lincolnshire to Lincoln for many ill infirm people will take hours and transport links are pitiful. Having two locations is not ideal three on the map looks better!
It will allow easier access to people living both sides of Lincoln and Boston
Everything going to Lincoln and too far for those in south of county
Don't choose either of the above Why is Grantham not a choice?
The county is large geographically and with poor transport links and so it is essential that that Pilgrim is kept to serve the southern part of the county
To allow those patients who cannot travel to lincoln to still be able to access the care needed. This allows the worklad to be spread across both sites too
Grantham has been promoted going forward as being a diagnostic hub. Surely this is a diagnostic service? I can appreciate that the cardiac investigations should be based at Lincoln, but others could as easily be based at Grantham where there is space available as you seem to be removing other services
Better choice for more patients both coastal and inland Lincolnshire. We are on the coast happy to travel either hospital.
I prefer option 2 because it gives more access to all people in Lincolnshire being such a large county we already struggle to get access to servuces
Lincolnshire is a huge county and public transport sparse so for ease of patients getting there maybe 2 sites is best. Even though Lincoln is nearer for me, I feel other patients need consideration.
More effective service in one place

Please tell us why you chose your preferred option and if you have any othe...
They already have equipment and staff at Lincoln to centralise it would cut down on further costs and staffing issues
Only chose this so at least some people in Lincolnshire will have the servuce nearby.
Retain the service at Grantham which serves a greater population area than Boston
Some people in lincolnshire are too ill to travel to lincoln if they live in boston or skegness and local villages
Lincolnshire is a large county. Travelling to Lincoln from the east coast is difficult
Because the other option isn't available
Why cant the other dite be Grantham?
It already appears to have purpose-built unit.
Leave at Grantham and relieve pressure on Lincoln
Better choice in a large rural county
Health is under pressure, and services must be efficient. One of the ways people can support this beyond increases to NI and taxes is to be willing to travel
I agree with the need to consolidate the service. Patients from the Boston area would need to travel to Lincoln if Boston closes. This would be inconvenient for some scans, especially those with repeat attendances. If it is viable to send radiopharmaceuticals to Boston daily this should be done.
Ensure better staffing and less money needed to purchase new equipment making the service more cost effective.
This is a large County and requires a choice as well as providing a back up during problems
As Radiopharmacy is established at LCH and cannot be moved, considering workforce and cost, there appear to be no other options.
Neither. I strongly object to South Lincolnshire patients having to be treated in either of the north/east hospitals. Why can't this service be provided at Grantham as in the past.
Travelling for many people increases stress at times when you need it less. Also the cost for patients should be taken into account. Patients in rural areas are always at a disadvantage.
It will allow the best service to be available to all residents.
if we cnt have it at grantham then \\Lincoln is my preferred option
Transport is a difficult issue in the county and so the more sites available the better
I believe services should never be centralised to one site as this introduces issues for patient transport, more issues if one site goes down for any reason and more strain on the one site and is a poor cost cutting method.
I have chosen Lincoln as there is no option for Grantham. We have anew MRI machine and you are yet again taking away a service that we desperately need.

Please tell us why you chose your preferred option and if you have any othe...
As there are patients requiring treatment on both sites
easy access on public transport
Travel, use the service myself ,too much emphasis on relocating all services to Lincolnthe rest of Lincolnshire doesn't matter
Grantham needs to be kept open lincoln is too far and boston is even furtherv
Travel could be restricted if only at the Lincoln site as there is no public transport artage of voluntary drivers for the voluntary car service to be sufficient. It is also infare for those in the south of the county to incur additional transport costs to get to Lincoln.
logistics for patients
Need this at Grantham
should have more available appointments at two sites
to give south lincolnshire patients less travelling
more accessibility
Bus service is frequent to lincoln so we can get there if no car is available
The distances to Lincoln from large parts of the county.many more people wil go outside ULHT to other trusts
patients need availability of two sites to reduce transport problems and ability to travel
Boston is closer than Lincoln to where I live.
south ad east lincs is a large population, with a high proportion of elderly for whom the excess travelling to lincoln would add further stress to them.
As long as Lincoln can accept and accommodate the increased numbers it seems reasonable to centralise at this location
There may be patients who cannot get to Lincoln County, also this will even out staffing requirements to provide this service at either site
Lincolnshire is a large and rural county and therefore Lincoln is not within easy distance for everyone
I live in Louth, Boston is far easier to get to than Lincoln. Also, with 2 sites there's the ability for continuation of services if something were to happen to 1 of the sites. Seems ridiculous put all of the eggs into one basket! l
My preferred option would be for services to be continued & updated at Grantham
Don't reduce sites or machinery. Staff needs to increase to provide these services to an increased number of patients
Travel difficult for many patients, poor public transport
Travel distance

Please tell us why you chose your preferred option and if you have any othe...

More accessible than one single site

Again, Grantham losses. It is the most central hospital for the WHOLE of Linc. Also there is plenty of space there that is unused.

Distance for a wide area of Patients. Their needs and quality of care and efficiency. Not all can travel to Lincoln.

The service will be more accesible to patients if it is available at 2 sites in the County

Central to Lincolnshire

Stop stripping services from Grantham!!!!!

To maintain a degree of accesability to the service i.e. no direct public transport to Lincoln from many areas in the south east of the county.

Travel costs

Due to area covered by hospitals. Choice helps distance and travel issues.

Too many "centres of excellence" are based at Lincoln which is NOT the centre of the county. Travelling times to Lincoln from the coastal areas are extensive. Even Pilgrim is more than an hour away from many towns, Lincoln can be more than two hours away.

The Cancer Services Department will have more patients waiting longer for treatment at their preferred site.

Impractical for people in the East of the county that are unable to drive to travel all the way to Lincoln.

Common sense

Stops people complaining that everything ends up at Lincoln

Because Lincoln is often too far for patients who live in Boston to travel

It's a big county and patients would have to travel too far if it was only Lincoln.

Please reduce inverse care law in rural and coastal Linc's. Central government need to provide more funding and CEOs and MPs should be lobbying for it.

Personal choice as live in Lincoln

Distances to travel are reduced with two sites with one to the South and one in the North. As their is a dire lack of public transportation

It is difficult for patients not to have services at their nearest hospital but in todays challenging times things need to be cost effective for all. I do feel that to put services between Boston & Lincoln and cut out Grantham, whilst not idea for Grantham based patients iit is better than only having services at one of the other 2 sites. Transport and other help is always available to the vulnerable and needy. Better that than lose the service altogether to just Boston or to just Lincoln

Simple - transport to Boston is awful. Not good to Lincoln but better than Boston.

Because it's closer to my home.

Please tell us why you chose your preferred option and if you have any othe...

It covers two key sites that are easily accessible.

NM scans are integral to the cancer pathway - patients are often unable to or unwilling to travel between sites for investigations/procedures and limited the number of sites that these scans can be done will only have a negative impact on the patients. It will increase work load for CNS teams, including the PD CNS team, as a lot of their time is already taken up trying to convince patients that these investigations are necessary and they need to attend a certain site. It's sad that patient's will refuse optimum care based on location, and sometimes it can be difficult to understand because it seems illogical that patient will decline something that would help them based on location, but sick people are scared and that should always be taken into account as scared people don't always make the best decisions. We are also a nation of self depreciation...we'd give our all to our families but you don't matter because it's just you so as long as everyone else is okay, it's fine...but that isn't the case!!! By removing sites and limiting the options available, these patients are putting themselves at risk because they don't want the hassle/fuss of having to make the arrangements to travel further

delivery of radionuclide to one site will be best

i live and work in Boston

More effective leadership and adminstration structure in place at LCH. PHB patient throughput limited by geographic location with prep delivery.

another service taken from Grantham

People living in the Fens area, and therefore served by Pilgrim, will have a long journey (whilst presumably being unwell) if the service is centralised at LCH. Another option may be to contract with another DGH in the area, e.g. Peterborough to provide services to patients in Boston and South Holland.

Not having to go to a different site at short notice for treatment

Lincolnshire has bad public tranport and aging population - its hard for patients to travel

A lot of patients cannot access centralised services - Boston and surrounding areas have some of the worst transport links in the country. Buses do not run every day and medical physics is a 7 day service, not everyone has family/friends to drive them. The trust is constantly depriving patients of essential care by centralising services instead of investing and improving services at a local level.

The service could continue to run even if one site had technical issues preventing use of machines.

Such a specialised service does not need to be run at two sites- too costly for the trust.

Why can services not be provided at Grantham/Lincoln and Grantham? Grantham is more central and easily accessible than Pilgrim. Nuclear Medicine department already exists and would just need equipment updating.

Services need to be maintained at Pilgrim Hospital. Lincoln is too big already. There is not enough estate or car parking and patients cannot or will not keep travelling to Lincoln. Local services need to be offered to patients from Boston/Skegness etc.

Pilgrim hospital will only attract locums

Too many services are being centralised at Lincoln which is detrimental to the patients in the south of the county.

to cover the county it is unfair to expect everyone to travel to Lincoln. Boston areas are just as important and the Trust should not be discriminatory to individuals living closer to Boston. many of the patients requiring nuclear medicine are elderly and should not be expected to travel over 30 miles for these tests

Everything is being centralised at Lincoln, this cannot be sustained and should be shared across multiple hospitals for a county of our size.

Please tell us why you chose your preferred option and if you have any othe...

This is just a case of moving everything to Lincoln forgetting that people in Boston and the south of the country exist or matter

why does everything have to be Lincoln or pilgrim. I thought they wanted an elective site at GRANTHAM so why not at Grantham

The size of the county would mean unacceptable patient journeys if Boston was not available as an option

Patients travel now a long way for many NHS procedures. Fuel prices and the cost of living are increasing. Patients from the sound of the county, using ULHT services should be able to access them at the site closet too them offering this service. Hence keeping nulclear medicine at Lincoln and pilgrim would mean patients south of Boston would not have a lengthy drive to Lincoln . This reduces stress and risk to the patient

At some point, all medical services will need to be centralised - the county cannot afford to rub three hospitals. Rather than salami slice service, bite the bullet and build a new hospital centrally, suggest sleaford for its transport lincs.

I work with Cancer patient and they often are too poorly to travel great distances and Boston is a nearer option to many

As a former cancer patient I know how exhausting the travel can be on top of what is already a difficult treatment. Even two sites over as large an area as Lincolnshire will mean travel fro a lot of people, having only one centre would increase the stress on vulnerable unwell patients.

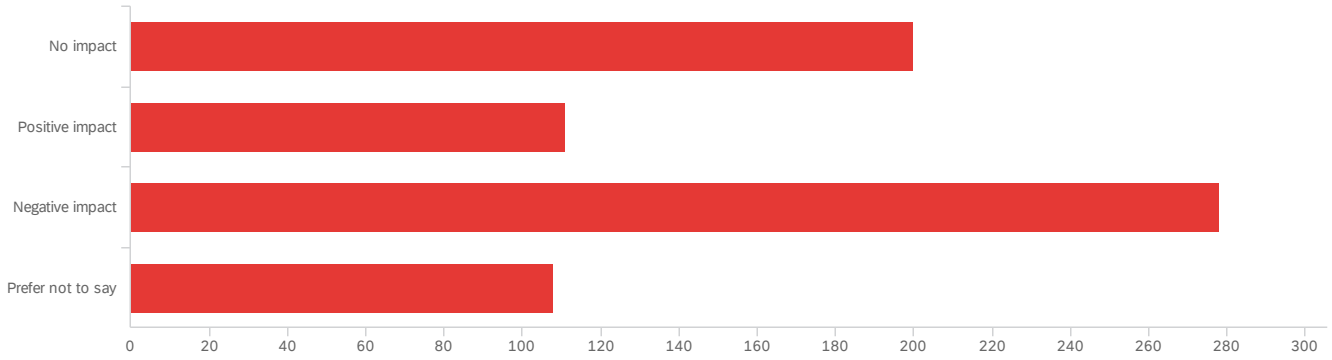
volume = competency = better diagnostics and enhanced patient experience

There is enough services at Lincoln. More elderly pilgrim side of the county who will find it very hard to travel for appointment

Some of our patients come from the east coast and are elderly, they should have an option of Lincoln & Boston. If it is only one centre then i would opt for Lincoln

The service needs to be at both sites for coverage and uptake, Pilgrim has lost a lot of important services which means lengthy trips for patients or may decline based on this.

Q5 - Please tell us about the impact the proposed changes to nuclear medicine services might have on you:



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Please tell us about the impact the proposed changes to nuclear medicine services might have on you:	1.00	4.00	2.42	1.06	1.13	697

#	Field		Choice Count
1	No impact	28.69%	200
2	Positive impact	15.93%	111
3	Negative impact	39.89%	278
4	Prefer not to say	15.49%	108
			697

Showing rows 1 - 5 of 5

Q6 - Please tell us the reason for your answer and what could be done to reduce any negative impacts:

Please tell us the reason for your answer and what could be done to reduce...
As I get older having to travel for diagnostic examinations will be one harder
Further to travel but have to travel for other clinically excellent services
Having a better and more funded service in one place will likely improve the quality of the service that can be provided to patients.
Easier to recruit in Lincoln
Use two locations
Whilsy I'm not currently a user i can't say there is no impact as i provide transport for others and it may impact me in the future. Travelling to lincoln would definitely be a negative impact
Because of travelling too far especially for the elderly.
It will help a lot of people so shouldn't be at just at one hospital
Because although I have had no need of the service, I might do. And if changes means we keep the service in our county then we must accept proposed changes
Having Lincoln & Grantham would be closer for those living in Boston. Grantham have already lost their A&E dept after 6pm so why should they lose more
If needed able to travel as required
Expensive treatment -prevention is the answer
Too far to travel
increase access not reduce it
No idea how it effects us
If the distance is too far from a patients home they may be very reluctant to attend for essential tests etc
This service is important for accurate cancer screening, diagnosis and detection of recurrence. It is important to have a service as close to 'home' as possible.
leave the services in boston
Better and more modern , efficient equipments, faster more efficient service , diagnoses and treatment , better staffed centres ,

Please tell us the reason for your answer and what could be done to reduce...

In the long-run both can be used with reduced time as different days

Develop Grantham as an option, space available and most central. Larger population in Grantham than Boston.

Please see above.

One site will mean longer way outing times and could lead to unnecessary deatgs

This question is not a fair one as anyones's need for a service can change at any point in the future. Anyone's personal circumstances can change without warning. The one constant is that we will all become ill and die at some point.

reduction of services is seen all around us. Lincolnshire's infra structure/NHS should be brought into line with neighbouring counties, not reduced further

Centralising services in Lincoln would mean a 4 hour round trip by bus for people in Skegness. A 3 hour round trip from Holland and Boston.Further discriminating against the old and the poor and the less healthy who live in greater numbers in Skegness Mablethorpe and Boston

Reducing the number of sites increases demand on the remaining sites. This should be countered by an increase in staffing and improved parking facilities at Boston and Lincoln

Inter hospital bus service

I am fortunate enough to have transportation for venues

Not currently requiring treatment. Two centre's are better than one as proved following the recent fire

Would need to increase car park facilities further, distance and difficulty to travel for many if at one site.

more resources for one department

Louth did have a great hospital while I can understand budgeting for all a balance is required to aid patients getting to locations

As stated above

As Lincoln is remaining, I would not experience a negative impact as I live close to Lincoln and have my own transport, thankfully!

I have no personal need for this service - yet, but am putting myself in the shoes of someone who does.

We cannot answer this question as if nuclear medicine is at Lincoln & Boston: Agree. If at Lincoln Disagree. Travelling to Lincoln from Boston is not easy & poor by rail.

Too much centralisation in a large county making it difficult for people to access treatment.

Should my cancer re-occur I would feel safer knowing past mistakes leading me to be treated out of a county previously

As pensioners traveling to Lincoln for treatment is not easy . Lack of public transport , time traveled , difficulty navigating an unfamiliar hospital .

There are lots of people that have transportation issues. Public transport in Lincolnshire is sporadic. Multiple locations are essential

Please tell us the reason for your answer and what could be done to reduce...

Again grantham being black sheeps... the area has patients who require service too but would have to travel

Older people do not like wasting NHS resources and would drive to Lincoln or seek help from a neighbour. I have taken neighbours to Pilgrim Hospital rather than wait for an ambulance or hospital transport. I find it unreasonable to expect those in the South of the County to make this journey.

MORE LOCAL TO WHERE I LIVE REDUCE WAITING LISTS

I am currently not receiving any form of treatment

Centralising services is negative to those awsy from thise centers

I am a stroke patient so have required these tests. Make sure equipment, staffing make more appts available.

The service will presumably be updated and my other reasons are as in my previous comment about choosing the two- site approach.

I don't have use for services but that could easily change, and I would not be near a site if centralised to Lincoln only.

Provide transport for people unable to travel. Join with councillors MPs etc to push government for more equitable share of gdp spend and investment to improve Lincolnshire infra structure

If staffing is already difficult centralisation to one site makes sense. Public transport links need to be improved in many areas as the other options are costly.

No negative impact

Centralised, better and quicker diagnosis. Lack of communication via too many different sites

My husband and i both suffer with ongoing degenerative illnesses so knkwing one site will be of excellence is very reasduring.

Patients having to travel miles and hours after treatment

it would be negative if breast patients were not supported to have surgery at PHB

I am not currently needing to ise the service.however increasing age will undoubtedly mean i need access within the next ten years and I will mot want to drive a round trip of over 100 miles due to cost, environmental impact and lack of public transport

Keep the services in places they are

At present I do not have need of these services, but should I, I do not think a journey of more than 1 and a half hours each way is acceptable.

An improved service by consolidating with no change in travel time

I would have no problem travelling to Lincoln and would prefer the department was fully up to date.

Lincoln is easier to get to 45 mins Boston similar time but roads more difficult.

Grantham is losing to many services. People dont want to travel long distances to have treatment

Please tell us the reason for your answer and what could be done to reduce...

Negative impact is that I wouldn't be able to get to Lincoln or Boston easily.

Travel from both ends of the county should be taken into account when making such a momentous decision.

Heartily sick of appointments being cancelled.

services for the whole population in Lincolnshire

Further to travel

You decided anyway what you are doing just going through the motions

It would have a negative impact because I live in the south east of the county and getting to Lincoln Hospital is over an hours drive away on a good day and anywhere up to two hours if travelling in the "rush hour" time period. The only way to mitigate this would be to have a two centre system, or radically change the whole of the health service in the county by building a CENTRAL hospital in Horncastle.

At present it would not affect me or my family but that is not to say I would not need it in the future

At present I do not need these services but that is not to say I won't need them in the future

Moving to Lincoln further downgrades thge services available at Boston.

poor or no service to deal with my health issues!

I have recently had to attend nuclear medicine services and was very impressed with the staff and facilities, and in particular how they handled a crisis when the camera function failed. They did a splendid job in restoring services which must have been difficult but demonstrates the difficult circumstances under which they operate.

If option one is chosen then any treatment would be negated in some way by the stress and discomfort of travelling plus the cost.Better transport infrastructure would help t of having to travel so far. The only way to be better would be beter transport

If I require this service in future I will have to travel no matter which option is chosen

There would be no impact on not being able to go to Grantham, but would prefer more than one option

have in the last 6 months gained from a heart scan, 2 sites would service more patients

I am lucky that I have transport and can travel to Boston and Skegness, please think about the patients.

If needed to use a facility I would happily travel to access it. Negative impacts are often in oriole's minds only as they would like to have all medical facilities close their residences regardless of the efficiency and expertise of specialist practitioners- it is all about educating the public to understand that first class services need to be centralised

Having had cause to use the services on numerous occasions in the last 5 years year including having a stroke which if I had needed to travel to Lincoln would have almost certainly killed me . If money is a factor in the decision maybe consider centralising a few middle managers posts would no doubt cover the necessary funds.

At present dont require this service but you never know what the future will bring!!!

No impact because I can drive but there would be a negative impact if I had to rely on public transport

Please tell us the reason for your answer and what could be done to reduce...

Travel would be an issue

If services are centralised to lincoln it will impact negatively because it is 50 mes away

It would be out of my way and an inconvenience to have to travel to Lincoln County when Pilgrim is much closer and much more accessible

I live near Lincoln County Hospital

If services continue to be centralised at Lincoln please can the CCG grow services at Peterborough and Kings Lynn for Lincolnshire residents.

Because there might be a chance that i would be required to go to Pilgrim for an appropriate, which would be detremental to my health to travel that far

At the moment there is no impact on me as I am not currently using this service As an aging member of society I would find future access of any service in Lincoln very difficult

I live in Woodhall Spa and am between both sites.

Live in Lincoln

I am having to go out of the county to Leicestershire for an operation that includes a nuclear iv thingy. It means an overnight stay for my husband or driving 2 1/2 hours there, hanging around for 15 hours then driving 2 1/2 hours home at night.

I am aged 80 and may well need this excellent support sooner than later . no neg impacts

I am 80 yrs old and will possible need this valuable service . No negative impacts as far as I can see

Having to travel an hour each way to Lincoln & back is difficult& causes a lot of anxiety & worry

Provide a smaller sustainable service at all 3 sites and respect the fact that Lincolnshire is a large county and cancer patients deserve to have care provided locally...isn't this one of our trust objectives?

Longer journeys, would increase timt needed to attend appointments.

Give patients the opportunity to select which hospital they prefer to attend

Positive because it keeps cutting edge treatment available in Boston. As a person who has been grateful for such investigation I feel that Lincoln is too far away from Boston at times of need. The way to reduce negativity is to have the service available at two sites so that over centralising will not be the cause of lower standards of treatment.

Never used the nuclear medicine services. However, have worked with various patients who have.

I feel sorry for the staff that any changes will affect.

To know the service is available if needed; is effectively and efficiently resourced - clinicians and equipment.

Better parking facilities especially Lincoln site so that people don't feel pressured. Transport issues especially with current economy situation. Distance to get to either site and taking away more of Grantham's facilities.

Please tell us the reason for your answer and what could be done to reduce...

My wife is disabled and has multiple outpatient treatments on an ongoing basis, and I am in my mid 60's and may be needing more treatment in the next decades

I use the service, don't drive, staff at Boston are excellent, a 1 hot appointment will take minimum 5 to go to lincoln

Dont use it at present, but nay have to at some point.

It is over an hour to travel to Lincoln if you are lucky enough to own a car and are well. It is a nightmare journey by bus and if you have bladder problems is almost impossible.

Leave well alone

No obvious personal impact

Too have it based in Lincoln is an asset too the hospital

I am 80 and may well need these valuable services more option the better for me

I live locally to the Lincoln area

Keep two sites open if at all possible as the population of Lincolnshire has grown greatly because of the pandemic and people are relocating to Lincs away from large conglomerations because of covid

The poor transport links in the county is a big issue when it comes to the centralisation of any services. You are expecting users of these services to be able to travel and this can be difficult if not impossible. You should be investing in Grantham hospital and not cutting services

I don't need the service now but may in the future so cannot evaluate the impact

Security of service if needed

Difficult to travel to Lincoln or Boston

Retain services at Grantham hospital and stop making excuses to downgrade the site. It is no acceptable to expect people to travel to lincoln or Boston for everything.

I live in Grantham and yet again local services are taken away from me despite the huge increase of houses built and the need for local services, we are all sick of it

I live 12 miles south of Grantham and therefore I am 70 minutes from Boston and 80 minutes from Lincoln so negative impact

As above

Maintain services at Pilgrim

I am in remission from cancer but family member currently using service at Boston. Many people do not wish to face two hours it more round trip to Lincoln.

Loss of the service . Difficult to access Pilgrim . Lincoln is impossible with out a car to the detriment of patients .

Invest more. Dont find excuses and play with peoples lives, the govenment has the money

Please tell us the reason for your answer and what could be done to reduce...

To have a 2 site model so that services can deliver safe care to patients and recruit workforce to the 2 sites.

as travel to any of these sites is problematic for me, I have chosen the two nearest, although they are still minimum1 hour travel away.

It will take me an hour either way to Boston or Lincoln but others will have problems with time and transport

Centralisation of nuclear medicine only at Lincoln without also maintaining services at Pilgrim would have a potentially devastating impact on local population's access to breast cancer surgical treatment with likely secondary implications for the whole population of Lincolnshire. Boston Breast Unit carries out at least 1/3 of all breast surgeries in the Trust, including the whole gamut of cancer and oncoplastic operations for breast cancer. Sentinel node biopsy has a pivotal role in surgical treatment of breast cancer. Losing or reducing access to same day isotope injecting at Boston would result in unmanageable pressure on the whole ULHT breast services, because this activity cannot simply be replaced. Owing to the nature of breast operations (specialised radiology support, same-day localisation techniques etc. = unavailable in Grantham) the range of surgeries that can be safely done in Grantham are already quite limited. Pilgrim, on the other hand must carry on delivering full breast cancer treatment and have easy access to sentinel node procedure. Currently there are 2 days a week of breast operating at Pilgrim. Due to the fact that breast activity is dependent on radiology support (provided by Radiology based at LCH which already has staffing issues), all Breast Unit activity – crucially, 2 week wait clinics - cannot be freely moved around the week, and therefore theatre sessions cannot be moved to a different day for same reasons. Removing nuclear medicine from Pilgrim will result in being unable to accommodate 70% of cancer patients (requiring SLNB) on the Monday list and reduce flexibility of the second full day list. 1) Nuclear medicine unable to produce isotope and inject patients on a Sunday afternoon. 2) Patients cannot travel to nuclear medicine at Lincoln on the day of their surgery and back to Pilgrim to have surgery. Apart from direct impact on patients this would prevent their timely assessment by anaesthetics prior to being injected. Some patients might be found unfit for surgery AFTER being injected with radioisotope – resulting in patient harm. 3) Rendering one full day list unsuitable for major part of routine cancer surgeries would have a knock-on effect on waiting list and cancer targets of the PanTrust service and would not be sustainable. 4) Only maximum of 2 patients on the second weekly breast list can be injected the day before due to strictly defined 24 h window between injection and procedure. This will limit the number of SLNB patients on that list and affect flexibility, theatre flow and utilisation.

Vulnerable residents will have difficulty getting to Lincoln on public transport.

because it is too far to travel to Lincoln

Not close enough. They are downgrading Grantham and in my experience this is because of Beverley allitt the child killer

Within tne financial constraints, the broader geographical the base the more beneficial for users

It's yet another service I would have to travel over an hour for.

Reduced service in my location. Fund the service properly.

I frequently have to have nuclear medicine scans and living near Grantham it is quick and timely at Grantham hospital.

Accessibility to Lincoln. Please use all the hospitals in Lincolnshire. Do NOT compromise them for one Central hub. Never Works!!!

Have not used service, if needed in the future would like the service to be as robust as possible

Do not require this service

You say staff shortage, and that you have 5 cameras when you only need 3. So have 1 at grantham, 1 at boston and 1 at lincoln. Reallocate the staff down to the requirements for 3 working cameras. You inflate the cost to a 0.5 million, when really 500k is a small amount compared to the costs of redevelopment of boston A&E and other departments. 500k per hospital should be easily manageable after national insurance increases. Maybe look at the pay structure of executive management and how many are actually needed. Centralise your management structure first.

The only objection is the travelling distance for these tests

If i need it as you provide no fre transport. I would not be able to attend an appointment in a day at Lincoln

Please tell us the reason for your answer and what could be done to reduce...

I have Fibromyalgia and i also work for a local charity

Cancer patient

Answers given are what I would consider relevant to anyone , anywhere, requiring this service

No one can forecast health problems

Centralisation at both Lincoln and Pilgrim sites would have no impact. Centralisation only at Lincoln would have a significant negative impact on breast cancer services delivered to the population of Lincolnshire

Fund services at all 3 sites

Currently not needing such investigations

It's important that Grantham hospital isn't lost. Not everyone can travel to Lincoln or Boston, Grantham is growing in numbers and it's vital we have a fully working hospital.

i have previously had to travel to grantham for these services

I currently attend Grantham for this clinic and I will have to travel further.

Make sure waiting areas are friendly, welcoming, place for carers/relatives to wait. Refreshments easily available. Modest car park charges.

At the moment I do not need the service but who knows I may do in the future. I currently live equal distance between the two sites so either hospital would work for me. Transport is always a big concern for people having to go to hospital, the car park at pilgrim certainly needs redoing - first impressions count!!!

If have to travel

A reduction in nearby facilities is always adverse to a patient.

Newer equipment and a more efficient service would benefit me when I need the service

I am not sure I would be able to do the journeys again to Lincoln. At least with Pilgrim available it would cut the time and stress.

Fortunately I have not had the need for such services, however I am aware of friends and others that rely on such help

The impact affects service users who are supposed to be at the core of the trust values therefore it should be put out to the public what they would like to happen

Too far to travel and very poor public transport. If you do not have a car you cannot get to Lincoln or Boston easily.

Cannot get to Lincoln or Boston, can only get to Grantham, which has been the better hospital overall

Keep the units open in all three places.

Increased costs to trav and woud probably mean I wouldnt be able to attend. Keeping services at least at 2 centres improves access

Please tell us the reason for your answer and what could be done to reduce...

Keep services close to all county residents. To reduce negative impact all sites should be funded!

Decreased appointments & delays. Lack of parking, especially at Lincoln.

Grantham hospital needs to be developed not closed by stealth

more difficulty in travelling to hospital appointments

Don't use it (fortunately)

With only 2 equally defective alternatives I can't form a preferred solution

Keep Pilgrim, as it covers a very large area and the Staff are a very valuable part of the hospital. Lack of parking at Lincoln and cost of travelling makes it impossible for patients who cannot afford to travel far.

Spreading the appointments between hospitals will provide the county with more choice. Waiting lists are long enough at Lincoln hospital... Why do you want to add MORE patients to the list!!

Depends on husband's and my health.

Unable to get to either hospital

If centralised to Lincoln everyone in south holland etc eho has to access these services will be disadvantaged

Need to travel. Close Boston and keep open Grantham

If I require the scans performed by these services, I would likely have to take a full day off work, as I would be required to travel over an hour to go to Lincoln, then wait for my appointment, then have over an hour to travel back. Plus the increased cost of travelling in a time of increased costs of living and fuel - the loss of income is not practical.

Travel to and from Lincoln by public transport is an all day and very expensive event event

Family and friends and the wider community deserve the best local services, level up not down!

I may possibly have a heart condition. work in spalding. Live in Boston travel is disruptive

No one can predict the type of future health prblems

Specialist scans should be carried put at Grantham

Distance traveled to both locations us the same for us but not for others

Currently, i have no need of these services but am afraid that more of health services becomes unavailable because they are too far away

The difficulties and expense if travelling to Lincoln is bad enough. Travelling to Boston is a non starter from Grantham - expensive, difficult, traffic and roads awful, public transport dire. Transport to Lincoln is awful too from Grantham

Travelling expenses and added stress having to travel to unknown areas rather than staying locally ...downgrading grantham instead of investing is unacceptable as most locals have been fighting for ...

Please tell us the reason for your answer and what could be done to reduce...

Too far, too expensive, no transport.

Lincolnshire is too big to centralise.

Keep Grantham open

I live in Lincoln

Less choice

I live closer to Lincoln than I do to Boston but not fair to those traveling all the way to Lincoln from the South of the county.

Travel from Grantham to either Lincoln or Boston is difficult if you are not a car owner. Cost of travel and parking are restrictive which could lead to non attendance and/or hardship

If needed it would be difficult to go to lincoln because of age.

Possible negative impact, due to poor travel systems in the County.

We need to keep services local - stressful journeys for the vast majority of people cause many problems

I'm old, don't drive, live rurally and will probably need the services. I could just about afford to get to Boston. I couldn't afford to get to Lincoln.

Travelling difficulties. Reduce negative impact by retaining service at Grantham

Ilive 4 miles from Grantham hospital yet everything seems to be going to Lincoln.

80 years old, living alone, driving to Lincoln would be an ordeal

Travelling difficulties

Leave Grantham with nuclear medicine facilities, reduce pay of ULHT board members to help invest in Grantham hospital.

Having to choose between eating or travelling to an appointment over 30 miles away.

I am 76 and would have to get someone to drive me to Lincoln if Pilgrim ceased the service.

I would have to travel to either site. Might as well be Lincoln.

Further to travel

I live on the coast so have to travel wherever an appointment is located

provide services across the country, not a postcode lottery

I live near Lincoln and would normally go to Lincoln hospital so I would not be affected by this change.

a higher quality service would be available in Lincolnshire so less likely to go out of county

Please tell us the reason for your answer and what could be done to reduce...

I already live relatively close to LCH - I would think very differently if I lived further away.

No impact on me as I live in Lincoln so will be near to a service.

Working within primary care we get the backlash from patients that are requiring the services that you are continuously trying to move to Lincoln. This impact is negative to patients as some patients refuse to travel/ dont have the ability to travel meaning they push their health needs to one side.

if option 1 it is a negative impact becuase patients from Boston will have to travel a far greater distance. If option 2 this will be a positive impact. However, why is there no option 3 - Centralise to Pilgrim

Reduce waiting times for scans and ensure that specialists are on site to perform all investigations required, not just more routine ones.

Why are these questions loaded? I thought this was to be a consultation not partly decided already.

The negative impact would be that if I needed any investigations or treatment I would have to make a journey which I might not be well enough to do. Who would want at least another 1.5hrs added to having treatment when you do not feel well when if available locally it would only be 20 minutes. The cost of travel or getting to a hospital if unable to drive yourself would also be a negative impact. If the Trust provided the transport why would they want to waste money in such a way & would I really want to be sitting around waiting for transport.

Grantham should not be ruled out as an option travel for vulnerable people is difficult and should not have to have extra expenses when needing important care, this is what elderly patients have paid in for all their lives..

Impact on myself no. But other people I know it definitely would.

my nearest hospital is Lincoln and as the facility is likely to remain at Lincoln I will not be adversely affected.

Modernisation of Grantham site! Recruitment of suitable staff for Grantham .improved road to Boston/ free twice daily shuttle to chosen site from Grantham.

May have negative impact on inpatients at Pilgrim but improve experience at Lincoln so overall neutral

Haven't need to use this service

Mobile services and local availability

Retain current service

It is not a service I need right now but I feel strongly that is should be available in at least 2 places

Regular updates of the work being undertaken.

Additional travelling time and costs in combination to increased risk of a single site incident stopping services produce an overall negative impact. Running two sites reduces but not entirely removes this negativity when three sites were previously available.

I have retired parents and family that all live in Lincoln so would not be affected by the proposed changes. However, mindful that Lincolnshire is a large rural county with a high demographic of retired elderly, it is important that we are able to provide care closer to home where we can in a safe and effective way.

I live in Lincoln so have accessed the nuclear medicine appointments at Lincoln country hosptial.

Please tell us the reason for your answer and what could be done to reduce...

ensuring services are accessible to those who need them

Who knows when anyone may need this service. If 3 cameras are needed why not one at each site?

It would have no impact on me.

No impact if option2

I said no impact because I do not require this service. But if I required the service in the future I would see it as a positive impact. The thing I would hope the Trust will take note and that is transport for patients as Lincolnshire is a large county.

I am responding as Chair SOS Grantham Hospital and basing my comments on the impact of local service loss when all scans etc were halted at Grantham in June 2020. Our most vulnerable cancer patients with deteriorating conditions were required to travel long distances. I am aware of one elderly gent who could not face the long journey any more and refused further treatment. The service should be available to all and Grantham patients not treated yet again as an after thought.

Reassurance for vulnerable patients, keep 2 sites

Stop trying to reduce services at pilgrim and which ultimately makes it less attractive for consultants

It would possibly have an impact on me if just localised to one area

Many vulnerable patients would not be able to easily get to appointments as transport in Lincolnshire is difficult. Methods of transporting patients would have to be provided and made accessible

Stop taking everything to Lincoln. Boston was built to be a hospital for surrounding areas and you are just running it down.

Excellence within the county. The same as radiotherapy.

I am able to drive to either site

Keep these services at pilgrim hospital to reduce the negative impact on people like me who may need to access them without having to pay out and spend time travelling causing inconvenience.

Keep services in more areas than Lincoln. It is NOT central.

I have to use Lincoln now so there is really no impact except travel

Louth was a great local hospital. Travel time 10 mins. Also really clean and good standards

I have osteoporosis and neck pain and it may well be that my condition could require nuclear imaging in the future. As previously stated, it would be extremely difficult to face a 60 mile round journey. I do not drive, and Pilgrim is within walking distance, so another negative impacts to consider is environmental i.e. unnecessary journeys!

Distance and transport will always be a problem especially if all services are set in Lincoln.

Currently I have no health needs thankfully . Professionally I come across lots of patients where the distance and access to appointments impact on their decision to accept treatments /investigations and so it is having a detrimental effect on their health . This is even more so whilst ther is redu ced access for a family member to accompany them

Please tell us the reason for your answer and what could be done to reduce...

It's always better to have specialist healthcare in more than one place.

Too far to travel - especially people other side of Grantham and surrounding villages. Elderly people struggle with transport as it is so how can you expect them to travel miles for each test, especially if they are performed over 2 days? The fuel and car costs, the time for travelling and the parking is not up to scratch at neither Boston or Lincoln sites.

Would not want to travel to Lincoln if i needed to use this service and neither would friends and relatives who live in the Boston area

Less accessibility if Grantham is removed. Keep the facility there in preference to Boston.

see answer above.... massive issues with long, often non existant, expensive public transport

I can drive

Living on the coast means i have to travel to any appointments

As above.

at present have no need of this service.

For me personally at the moment I do not have any need for nuclear medicine but of course that could change in the future. Of course there will be an impact on those that need the Service.

unable to answer

Excessive travel distances when ill.

Can't travel easily to other sites

I can get there by public transport.

South Lincs Dwellers cant travel those distances

Not needing any treatment using this service at this time

Travel to Pilgrim and Lincoln is impossible for some people, and difficult, expensive, and time-consuming for others. You are expecting an already busy service to take on over at least 1/3 more work.

people have to travel when the cost of living is rising, this is not fair and equitable

Keep the services at Grantham

It would impact me should my parents need to utilise the service as above, otherwise no impact.

If o we two sites would be positive and manageable

offer the service at more than one hospital

Please tell us the reason for your answer and what could be done to reduce...

patients has to travel a long distance- its against the principle of care closer to home - this also doesn't guarantee improvement in the quality of services (no evidence available to support the decision being a rural hospital catering a vast area)

Both hospitals equal distance , but Pilgrim far more accessible than Lincoln. I should not be forced to have a carer with me

Nuclear service across Lincolnshire

I live in Lincoln so would be quite near

Distance to travel to be able to use this service.

Provide trasport

I am able to travel

N/a

Our local hospital is Grantham

as above. If there is no service at Pilgrim this negatively impacts my patients which makes my job as a doctor harder and their hospital stays are often lengthier. This then puts them at risk of further deterioration

Delays in accessing treatment as too far to travel

I have an NG postcode so would be negatively impacted.

if in need of this service then there will be a choice of site to go to for treatment

has no impact for me at the moment but will have for some people i care for

Only have to travel for 45 minutes instead of 1.5 hours

A reduction in choice is always a step backwards for the patient

Have not used the service to date.

As a staff member i recognise the impact this could have on our patients and the logistics of the county which it appears is often not taken into consideration when trying to centralise everything to lincoln. This simply is not practical

Have both sites offering this service

Everyone wants to have all services close to where they live but they're is no funding for service by area not population.

Lincoln site only is the problem for my patients

Given my location, by providing a mobile service, this would reduce any negative impact to me and my local neighbours.

We all may need these services why take everything away from pilgrim yet again !!!!!

Please tell us the reason for your answer and what could be done to reduce...

To maintain correct amount of staff. Specialise the service

Transport and time

At certain age may need it

will have to travel for tests, reduce impact be putting 1 site in Grantham, there is plenty of space there due to the service reduction at Grantham

Travel. Split between Boston and Lincoln would be best.

Accessibility

Negative affects on the communities in all parts of The county other than Lincoln itself. The tax payers of Lincolnshire a not in agreement with this constant development at Lincoln at the expense of the rest of the county.

Too far to travel to lincoln

Lincoln is just too far to travel especially when you are ill

If you moved away from pilgrim, it would have a major impact if I required the service

My Husband and Brother In Law both use this service. It is not at all convenient if the service is centralised at Lincoln considering the distance and cost of travel presently. Lincoln

Lincoln County Hospital and Diana Princess of Wales Hospital are both much the same distance from my home and both my late father and mother have been treated at both. I don't expect anything to be different for myself if I require such treatment I would go to either trust.

Further to travel

Keep it at Grantham for ease of attending appointments

Ideally Grantham , Pilgrim and Lincoln should retain these services but considering Grantham has a train service and a direct road to Lincoln where as Boston doesn't . Boston should be retained. Our stroke unit has been removed without any consultation with us in the south it is not fair or just to be tossed aside. Parking at Lincoln is inadequate for all these extra services. How can it best serve the community if only at one site only half the amount of people will have access. If the NHS stopped wasting money on unnecessary jobs and fine tuned there ordering services there would be more money to go around. Get out there to schools and colleges and promote health as a way forward to a career but don't make a job for someone use the resources you already have the people on the ground who would be honoured to promote their job .

As a family we've only used the service twice, both times at Lincoln

Dads cancer

Cancer

definitely need at least two sites

I live close to Lincoln, so the only impact will be longer waiting lists.

Getting older who knows what health problems are around the cornet

Please tell us the reason for your answer and what could be done to reduce...

My mother uses the Boston NM suite and can get by bus. Not so for Lincoln.

Travel times for some or the remoter areas of Lincolnshire

Cannot travel to Lincoln

are we to lose all services in Grantham?

It will give 2 site, 1 each in the north and south of the county

Keep the service on 2 sites. Pilgrim and Lincoln.

Wouldn't matter where i had to travel to

As I live in Boston and work at Pilgrim Hospital why would I want to travel over an hour (and potentially take time off work) to have a common scan done?

I live in Lincoln. However my choice isn't for that reason.

Difficulty accessing services

I expect i am being selfish but i live in Boston

Ensure availability across the area

If I need to go to Lincoln for this service wits negative was I live 5 minutes from pilgrim. I am very unfamiliar with travel to Lincoln and the hospital

Always the best for patients

Not had a need for service as yet but if i do travelling to Lincoln would be extreamly difficult due to lack of public transport.

Travelling time to Lincoln

I have the use of a motorcycle so expensive parking charges can be eliminated

If reducing current provision to one site, triggers reduced access for patients from rural villages who are unable to drive

As of now, i dont not use thus service.

better services and more up to date equipment

Distance to Lincoln Hospital

I have personally needed this service at Pilgrim; travel isn't always an option

Two centres to run services

Dont require at this time .negative impact reduced by having at boston too as will not be able to access lincoln without difficulties

Please tell us the reason for your answer and what could be done to reduce...

Requires a car journey
Currently fit as a fiddle so wouldn't need the service in the near future
Further to travel if taken out of lincolnshire
Specialist services would mean staff could learn new techniques clinics would not be cancelled with staff leave or time off which happens at present.
Keep this at pilgrim please
Better control of governance of service.
As mentioned above, service inaccessible for cancer patients/family members
I would not be able to afford travelling to Boston or Lincoln
Not remove the facility from Boston
Availability of options at two sites would reduce the negative impact.
As someone who lives in the Boston area and has previously been under cardiology (who use MPI scanning), it concerns me that I would potentially have to travel to Lincoln for services and take more time off work if I had to be further investigated.
No negative impacts it's all positive
I am moving out of the county to somewhere that has better facilities and easier access to services.
Not currently using this service and live close to Lincoln
Have to go to Lincoln for most things anyway
I can't get to Lincoln
I can currently travel to either hospital as drive and live between the two.
Pilgrims is our nearest hospital.
I live in Lincoln
Pilgrim needs this service too
There are no negative impacts, in my opinion. The positive impact would be that, should I need one of the 20 identified treatments for which the equipment is used, modern equipment would be available locally. Otherwise, abandon the requirement altogether and outsource to Nottingham or Leicester.
Further to travel from rural area. Improve not close services for Grantham area
The distance between the sites will negatively impact travel times for staff whose base site will change. Long days may be preferable in order to reduce travel time

Please tell us the reason for your answer and what could be done to reduce...

I live central to the county so travelling for me is currently not an issue

I live near Lincoln.

As my cancer was stage 3, I am aware of a possible return of the disease despite keeping scans up to date. Now being an octagenarian, the shorter the journey for treatment, the better.

A need for outstanding services for the vast amount of people who will enhabit all the new properties being built.

I live in Lincoln which would mean I am travelling the least as both options include that location.

if services are moved to Lincoln they become almost impossible to access without a car

Keep the service available at Pilgrim

Please see answer to question 4

not fair for my patients in boston area to travel all the way to lincoln.

I don't think it will affect me

As above -maintaining services on more sites will be more convenient for patients, many of whom struggle to travel significant distances

If I have to travel to Lincoln I need transportation which is not always available to me. My treatment is dependent on someone bringing me to hospital

Covered in the question above. Reduce the impacts by keeping at least 2 sites mentioned.

I live in Lincoln

Patients would have to travel a great distance for this service many are old and unable to access transport and can not afford the transport.

If services moved to Lincoln Negative impact on Pilgrim population

My local hospital services reduced still further. Not even included as a choice.

Waiting times will become longer for patients if only at 1 site. The service should remain at pilgrim too.

Service should be local

Keep Nuclear medicine across two sites.

As above

Bring back all services to Pilgrim as it serves most parts of east and south Lincolnshire. Patients decline travelling to Lincoln for diagnostics, clinics, and even Paediatrics!! This is not sustainable- you are depriving patients of accessibility to health care that they are entitled to!

To keep the services in Boston and also restore the other services taken away from Boston such as urology services, ENT oncall services.

Please tell us the reason for your answer and what could be done to reduce...

Having to travel a long distance for treatment in an area with poor transport links

I require annual cardiac MRI scans, all have been at Grantham. This is the easiest hospital for me to access and I have always felt comfortable with the staff there.

Family might need it in the future

Don't move service from boston

It will become a postcode lottery with patients having to travel longer and wait longer

I was a patient at lincoln nuclear sciences, so the service change wouldn't effect me.

Keep services at 2 sites to reduce inequity to the population in the East, especially the elderly.

Find the funding, stop cutting services. National insurance increases should pay to increase and not decrease services

Have transport. No need of the service at this time

I live close to Lincoln but have a car If Lincoln only more hospital transport will be required so more expense to ULHT and inconvenience for patients

Not sure of the impact but having benefited from this service when i lived in Berkshire i feel it is imperative it is easily available to others.

More travel, cost and time

Not accessing services

A common sense and a past vested interest rationale in a service that at one time was run on 3 hospital sites - Lincoln, Grantham, Boston with a variety of logistical, staffing, and budgetary issues that impacted the Trust financially. This was addressed many times over 15-20 years ago but still the debate continues.!!

Maintain them at two or three sites

Became Grantham Hospital is my local hospital and its always us that lose services and are required to travel. You could ask public to help raise funds to replace local equipment and expand training opportunities in house to train the next cohort needed to run the services

Free travel

Having the changes over 2 sites as opposed to 1

With mobility issues and lack of public transport, long distances across the county are ridiculously difficult. There should be more locations, not less.

Within 45 minutes of Lincoln

At this moment in time I have no need for the nuclear medicine services personally.

I live at Lincoln!

I HAVE NO NEED FOR THE SERVICE PROVIDED TO THOSE THAT DO.

Please tell us the reason for your answer and what could be done to reduce...

provide the services locally.

It will have a negative impact on my patients if they decline travelling long distances to Lincoln to have their investigation as it may delay giving effective and appropriate management of their condition

I work at Pilgrim hospital and i have applied for the apprenticeship role last year but was unsuccessful. I live and work in boston and if there was more investment made for these 2 sites primarily then there will be more investment to improve and hopefully i will be a more successful candidate.

Central

I have several issues and so does my wife that are dealt with by Lincoln/Grantham. Our ability to travel to Lincoln is far easier than travelling to Boston when our health is not good.

I am not a patos g but family have used this service

Service should be readily available when needed

Leave it in Pilgrim

I live close to Lincoln so makes no difference to me

Better equipment. Better staffing. Quicker results. Hopefully a better personal experience.

Leave a service at Boston

Provide services across Lincolnshire, taking into account very poor bus services and isolated communities. Include Skegness

Always have to travel away from Grantham. Need more services

I might need it!

Moving this unit to Lincoln means people from Boston needs to travel to Lincoln. And there might have long waiting for service delivery due to limited resources

future need

I have had diagnostic test at Grantham which greatly helped me with not having to travel for these tests as the are quite stressful for anyone in my spittoon

fortunately not being treated

Lincoln would be far away for me to travel every time, especially during winter months. Keeping the services at both sites is the best option in my opinion.

Knowing I have to travel further afield and anxiety that brings such as attending appointments on time/the distance et

Two site option as the preferred option. Avoid centralisation to one side of the county

Na

Please tell us the reason for your answer and what could be done to reduce...

If the service was centralised this would means hours of travelling across Lincolnshire for these vital tests

Patients having to travel

Choose option 2

If it is at Lincoln as well as Boston, then I would use Lincoln and would hope that the waiting times would reduce through the sharing of appointment slots between the two areas.

Maintain services at both sites and try not to centralise services to as a solution to addresses recruitment problems.

The thought of having to travel when ill and worried

I currently am not a user of this service

It is not solely nuclear medicine which will have negative impacts, it is the piecemeal withdrawal of services from Grantham and ULHT's incompetence. As tge government wiped NHS Trust debts at the start of the pandemic, what is the Trust's financial position now? And if it is poor, what is their excuse this time?

Need to provide nuclear medicine support for sentinel lymph node biopsy at all sites to continue breast cancer surgery.

All services being centralised at lincoln has a negative impact on the healthcare and the patients have to face the traumatic travel and endless wait for appointments and bed availability

Don't want to drive to Lincoln for everything

I cannot predict future personal needs but I prefer to stay local.

I live in Lincoln so wouldn't have to travel

I feel this service should remain at Grantham. It is becoming increasingly difficult for patients to be seen due to travelling limitations.

Rarely use it

Happy to attend a centre of excellence.

I am able to travel still.

Currently this is not a service I access. I also live near Lincoln which is not proposed for closure

Long distance to travel to access facilities. Improve infrastructure in Lincolnshire.

No services once again for the public of grantham

As said above three locations would be better for transport requirements

I have had cancer and have dugs that affect my bones so may need referrals to nuclear medicine in the future but so do other people in my community

Please tell us the reason for your answer and what could be done to reduce...

Personally don’t use the service at present but who knows about the future

Downgrading grantham hospital AGAIN!!

I currently do not need this service but who knows in the future

Currently I have no need of this service. I don’t know what the future needs might be.

Central to both and happy knowing we are reasonably distanced from each.

Can’t already get referred by a doctor as unable to get access to a doctor never mind a referral to a hispital

As I am well its no issue at the moment but that coukd change in the future

If I needed this treatment I would be able to travel to other sites as would others but this seems more efficient and cost effective

I have used the dept a few times as i had cancer. Yet again people.thqt are seriously ill in our area of Lincs need to travel so far to get diagnosis and treatment. We just feel.like no one gives a toss about us

The impact of travelling 2 hours+ return for these appointments especially for those non drivers. Public transport to the Boston/Lincoln sites is abysmal and further lengthens the journey

Same as q 5

It is further to travel to Lincoln for me and I live in the middle of the county. Worse still for those who live on the coast

I live near Lincoln, retain three sites, that's the environmental solution.

This us another service being taken away from Grantham. Boston and Lincoln are not easy to get to unless you have you own transport and even then the journey is long.

I do not go to Lincoln for treatment. Stamford patients are sent to either Peterborough/Addenbrookes. As usual, the south of the county is never thought about.

Need regular MRI and non driver

I would drive myself wherever I need to go. Plus I would prefer to go to Lincoln even though Pilgrim is nearer

I am lucky living near Lincoln hospital, but patients who are in the south would find travel hard, eg for elderly patients for Bone scans.. I don't know the cross section of Scans available between the 2 sites. EG are heart scans done on a specific site?

Provide hospital transport for patients living long distances without the normal restrictions.

As I live in Boston, should my family or I require nuclear medicine services we will have to travel to Lincoln.

Once again it is proposed that services be taken away from Grantham hospital, without any thought for the considerable derogatory effect on patients, such as miles to travel and no public transport

Fortunately have not needed this service

Please tell us the reason for your answer and what could be done to reduce...

Extending the volunteer driving scheme

feel grantham hospital is being neglected and leading to closure

Lincoln Hospital is not far from my address so would not effect me personally, thus making it a positive. But I would also like to think of people whom live in North Lincolnshire, who this would have negative impact.

Whatever you choose would not affect me as Lincoln is my nearest hospital location.

I have yet to use the service but do not believe in centralisation of any form as it limits access for patients in more rural and vunerable positions

I live in Grantham. I am disabled. I do not drive and need wheelchair assistance as do so many people. My family either have to take a day off work to take me or I have to pay someone to get me there and back. Its disgusting the way Grantham are treated

to run a 2 site model

To far to travel , travel costs, having to arrange transport , All Lincolnshire people deserve to treated the same and should not have to go to Lincoln for everything Health related

If i need this as have gastric issues i will struggle to get to boston and lincoln

Having ongoing chjecks for my condition and the difficulty of accessing treatment if only based in Lincoln.

no personal impact but there will be impacts on patients

Have the service at Grantham

I live in lincoln so can access both sites

consider the travelling problems for people living in more remote parts of lincolnshire

less access

If we had one site then what happens when it breakdown as occured with myself 2 weeks ago in Lincoln

if centralised at Lincoln will have a negative impact for patients and diagnostic pathways

Grantham is our closest option, so closing it would be inconvenient. Keep it as an option for our area.

At the moment I do not see myself needing to use the service, but as I grow older it may well come to pass

None

.

Keep these services available in Grantham

Increase staff not reduce cameras, equipment

Please tell us the reason for your answer and what could be done to reduce...

Travel dustance

Same reply as Q5.

My Job. I love working at Pilgrim Hospital Nuclear Medicine Department. Patients will not benefit from closure.

Neither I nor my Family are currently in need of this service

I would travel anyway

Travelling to Lincoln is hard work and expensive

Two centres would give a better choice in respect of travel arrangements.

Too far to travel for many if only one site.

Awaiting a bone scan.

Hopefully I will not need nuclear medicine but similar situations with radio therapy make me nervous of too much being moved to the fringe of the county.

It doesn't seem fair for poorly Cancer patients to have to travel further for their treatment, so keeping open as many sites as possible is the best option, to reduce waiting times for current patients, which will definitely increase if the service is centralised.

If the service is removed from Boston I would have difficulty attending an appt

Common sense

Means if I ever need to access it I'll have access to better services

I live in Boston so if it was centralised in Lincoln it would have a negative impact.

No need for that service at present

Reducing sites is about cost cutting - please state it as so. If people can't get to these reduced cites you are creating an health inequalitu

Lincoln is one of the main hospitals and can serve a large area

I feel it is more cost effective to the NHS and therefore preserving vital services for the future

If I needed it, I wouldn't be accessing it at Boston as it's so difficult to get there

I don't need this service at the moment, but it'd be nice to have more services here in Lincoln, as we don't have much stuff and not all people have cars to travel to other cities to get treatment.

It will result in an increase in long waiters on the cancer pathway

patients may refuse scan due to traveling

Please tell us the reason for your answer and what could be done to reduce...

I work in Nuclear Medicine at Boston

Use of modern more modern equipment which allows faster lower dose imaging of patients allowing for more patient throughput

Grantham still needs this service too

Length of journey, but only if I need the service.

Unless ULHT is going to pay to transport patients who do no live in Lincoln centralising has a negative impact on the whole community because family and friends cannot access services when needed.

I can travel to any of the sites so there would no difference in my ability to access services

So many services have been removed from Grantham with patients from this area constantly discriminated against in terms of accessibility to health care. Retain services at Grantham Hospital instead of taking the easy option and cutting yet more.

Patients want local services. It is about time more emphasis was put on sites other than Lincoln.

I would prefer not to travel to Lincoln when Pilgrim is nearer especially nowadays with the cost of fuel, I have unfortunately experienced this before having to have radiotherapy there and it is disruptive to life. To reduce the impact would be to keep the service at Pilgrim.

negative if services moved only to Lincoln. LCH is not the superpower centre of health care and in fact Boston frequently delivers higher quality, patient focussed , individualised care

See preview answers

Again forced to travel across county. NO TREATMENT AT GRANTHAM AGAIN

Not currently a service user

I live equi-distant from all four ULHT site - LCH; PHB; GDH and Louth

Please please think of the patients they are people and not numbers. I am the person on the end of the phone that will get the negative reports from the patients. I just have to listen and try to support the patient. So the managers and the higher people do not see this or hear this,

I hope never to need this treatment again. But if I do, both Lincoln and Boston are over 35 miles away. Because of the specialist nature of this, it is impossible to avoid some travel, but keeping it to a minimum always helps.

better diagnostics = better care

Multiple options for our patients

Keep services at both sites.

Q7 - Protected characteristics are specific aspects of a person’s identity defined by the Equality Act 2010. It is against the law to discriminate against someone because of the nine protected characteristics which are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Are there any positive or negative impacts that you believe we should take into account in relation to equalities or human rights? If so, are you able to provide any supporting evidence and suggest any ways in which the organisations could reduce or remove any potential negative impacts and increase any positive impacts?

Protected characteristics are specific aspects of a person’s identity defin...
Old people retiring to the coast should have thought about services available and travelling for health related appointments.
Lincoln is well positioned in the centre of the county, so the distance for patients that need the service will in the worst case be equidistant to the nuclear medicine department in Lincoln.
Irrelevant
No.
Just remembered we are people not just a number
At present I would only be affected by my older age so I have no evidence to show
Possible issues in using public transport/location of bus stops etc.
Medical choices !!!
negative impacts
Positive as at no.6 Negative is reduced as at no.6
Transport

Protected characteristics are specific aspects of a person's identity defin...

Yes, I do believe it is particularly discrimatory against the older and disabled population because of their challenges in travelling to Lincoln for a test. Even if they use their own transport, many people will worry about getting there, finding parking and finding the department in time for their appointment. Some people attending are carers for people having to be left at home.

age discrimination is ongoing in Lincolnshire through technology, transport isolation. The people who have paid the most NI contributions over the longest periods deserve to access good quality NHS services near to their community

A greater proportion of the old and disabled live in the east and south east a long way from Lincoln. The proposal to centralise services in Lincoln discriminates against the old and disabled as it reduces access to services.

N/A

If located at only one site, likely to cause great difficulties for many older and disabled patients.

no

A patient is just that regardless of ethnicity ,gender ,relationship status, or sexual orientation some forms now are ridiculous

As stated above! I wonder why moving the service to Boston is not an option too.

Please remember that not all disabilities are visible. Consider a patient's mental health, choices, preferences and wishes at all times and allow their designated carer to advocate/accompany the patient as and when necessary as the carer quite often is a person with 'expert experience' on the patient - please respect them and the information they hold!

No, we are all equal

Possibly age and disability as moving services away from where people live with no increase in accessibility given poor transport network

Yes: regarding physical & mental disability having to travel to Lincoln from Boston. Good parking at Pilgrim, poor parking at County.

Disability, age and race could all be reasons why people could struggle to afford transportation to Lincoln and or Boston for treatment and a specifi transport arrangement should be put into place to ensure everyone has easy access to treatment.

By moving all nuclear services to Lincoln it discriminates against the elderly and disabled . Even younger people who are carers

None that I know of

There are lots of people that have transportation issues. Public transport in Lincolnshire is sporadic. Multiple locations are essential

I accept that the county cannot provide all medical services. However, I consider this issue to be a service provided at two sites in the county. No doubt Grantham will want to maintain its service but the distance from Grantham to Lincoln is manageable. I hate to read that there are insufficient staff and that equipment needs replacing. However, that is a management issue and not one that users of the service should be burdened with. We do pay Trust CEO's and other senior staff large salaries to manage such issues. Reducing bank staff, better procurement etc would alleviate many problems.

NONE

The level of service will severely impact those people who find travel difficult

Increase number of appts. Quick turn around.

Protected characteristics are specific aspects of a person's identity defin...

I am of the opinion that closeness to one's home base would help stress relief of both patients and of relatives.

Lincolnshire has a senior management bias towards Lincoln and other areas. Places such as Boston are heavily discriminated against in terms of oppressive attitudes and service spend

None known

No e

Age and disabilities often impact how easy or difficult it is for patients to drive long distances to appointments. Cost savings could be put towards a patient transport system. This could be a service that us patients pay for but at a reduced rate that is an aporoximate cost of the fuel it would take for us to travel in our own vehicles.

I feel the Equality Act doesn't consider Grantham patients at all

Potential to advertently discriminate against women who need vital breast surgery locally and timely, understandably there may be a small proportion of men affected.

Mo

No

Travel arrangements for elderly or those unable to drive after treatment

No

Older people experience discrimination as they are not generally as mobile as young people, making long journeys for treatment very difficult or impossible.

None

No

isolated communities who require a service

I have autism and find Lincoln hospital a challenge for me due to anxiety and unfamiliar surroundings

No

Lincolnshire is a large county and has significant elderly population on the east coast. Moving services currently available in the South East of the county to the Far West of the county could have a serious impact on their ability to access the service, especially given the lack of public transport.

No

yes , all of those mentioned, age and disability in particular

Nothing really to comment on here - all persons concerned have the right to be dealt with respectfully and individually which I believe they are at present.

ability to travel distance due to infirmity of any sort plus cost of getting to treatment if not able to access free transport due to not being on the benefits you have deemed appropriate

Apply common sense

no

No. You already abide by the Equal Equality Act of 2010

It has to be made to work no changes may lead to a dangerous service

Boston serves more ethnic minorities and elderly patients, there is also a higher deprivation index to the south and east of Lincolnshire. Centralising the service in Lincoln alone would disadvantage these groups. A reduced but still active service at Boston could see those patient least able to get to Lincoln, while the majority who are freely mobile could probably still get to Lincoln.

This proposal impacts on travel for older people and could be seen as discriminatory

We are an ageing population, so you heed to consider that in planning, because its incredibly difficult to travel between Lincoln abd Boston.

Lincolnshire has poor public transport services and not everyone has friends or relatives or their own transport to enable access to essential services

Negative impact for people not in the Lincoln area.

N/A

Ability for people to travel to access service

No

Many of my friends in my age group 70 plus often feel our equal rights are completely ignored. Webse not grown up

Many of my friends in my age range (70 plus) often feel our equal opportunity is not recognised as we don't all have access to computers and are not familiar with howcto

no

No

Concessionary transport should be available where appropriate to take account of the move from Grantham hospital

No. A human is a human. All should be treated equally without favour . Anything less is by extension discrimination against 1 group or another. None should have preference over another. Particular worry is that older people will be pushed aside for younger....this in itself is wrong on many fronts. As would be giving preference to another group. Treatment on need basis as decided by Doctors not managers.

patients with certain disabilities cannot always manage travelling 1-2 hrs just to receive medical care at a centralised hospital. centralisation poses a risk for this vulnerable group.

None I am aware of.

Help those who need transport to get to their appointments in a timely fashion. Provide better car parking.

Protected characteristics are specific aspects of a person's identity defin...

Centralisation tends to discriminate the poor

None

Lincolnshire has an aging/aged population, some of whom will experience travelling difficulties; centralisation may therefore impact unfairly on the elderly

Manfully people in my age group 70+ frequently do not have equal rights as not computer literate and can not access valuable necessary information

None

age because people have further to travel is a negative. It is difficult for disabled to travel long distances and to have longer waiting lists.

The questions provided to not consider enough options, namely most Nuclear tests are completed on hybrid scanners therefore to negate the issues around staffing mover the nuclear scanner into radiology and train the radiographers to scan.

Your proposed changes will have a disproportionate impact on those with a disability and older people

None that I am aware of from reading this survey.

You are Health service, equalities and human rights is for politicians

There's always negative impacts when removing services. People cannot access them. The proposed sites are to far away .

Not for everyone not all are able to travel or have family that can take them and have to rely on outdated rail and bus timetables

No

Negative discrimination against Boston population which is majority immigrants and elderly

Loss of a hospital service .

How about discrimination on the poor and vulnerable

Age: elderly patients can have a second option closer to their homes

There will health inequality for patients on the East coast if Nuclear Medicine is centralised to Lincoln

no

Age and disability are definite negative impacts for anyone living in the south or on the east coast. Travel is very difficult without a car or money to get there.

no

The proposed changes are unfair to people who are unable to travel to Lincoln or Boston.

Long term negative impacts on long term patients

Protected characteristics are specific aspects of a person's identity defin...

None

Health-care us Health-care. Nobody should be treated differently in any capacity. At the end of the day you are a human nade up of more or less the same organs and tissues. This shouldnt even be a question, everyone should just be called a patient. You create the divides by classifying everyone and everything into separate categories.

Homeless and old.

None

Negative age, disability, socioeconomic factors, - additionally the specialist service is provided to already vulnerable people, centralisation i one hospital will cause that the waiting times become longer, people will need to travel more with additional costs. Potential mitigation ensure that are all identified for using the service as well those who have already used it are consulted, additional transport arrangements that would accommodate both disability and socio economic factors and make sure that any contongency plans are in place in case the service is unavailable (w.g. temporary due to pandemic/critical incidents) in Lincolnshire and patiencnts are provided with the service in a timely manner

None

No

You need to think about those who do not have transport. Journeys can be expensive from rural areas.

Religious beliefs are sensitively treated. Eg female clinicians for those that their religion dictates.

No

No

I cannot get to Lincoln or Boston. I've been to Lincoln, it was a horrible experience, it was dirty, someone cleaning the floor then came to try and take blood without Gloves and used the same swab the 3 times she missed, is just one negative of Lincoln.

Limiting the travelling distance has to be addressed.

Negative effect those that are vulnerable the elderly, young, learning disabilities, physically impaired and those of limited social and economic backgrounds.e with learning disabilities

This question is not pertinent unless you want a desired response to swing the votes in the favour of an already made decision

The many Disabled people & rurality, lack of transportation and Covid is still prevalent, so should offer the different sites!! Welcomed at Grantham & Boston Pilgrim hospital. Lincoln is variable.

I don't know how you sleep at night I really don't putting lives at risk

Age/Disability/Sexual orientation all historic negative impacting. All present mental or physical difficulties in travel, to and manoeuvring round the hospital sites and accessing services. Large and complex sites, buildings and services can become barriers to interaction or accessing services by increasing fears, confusion, and ability to get to or take part in appointments. Several times attending appointments at Lincoln County I have become tired and in pain due to getting round the hospital with a massive increase in anxiety and stress. I was medically retired from HM Forces on physical and mental grounds and have necessary recourse to hospital medical services.

Since the survey is restricted to two equally deficient alternatives I am unable to form any comment

Protected characteristics are specific aspects of a person's identity defin...

Lincoln chief Laura White attitude is clearly stating that Lincoln will be able to cope if pilgrim and grantham close down and appears to have a pompous attitude towards the other sites.

The waiting lists at Lincoln hospital are long enough!

No

Being treated as 2nd class despite paying the same Tax and NI to those who live near to your proposals.

No I didn't consider this relevant

These changes would have negative impacts on the elderly and disabled. Potentially vulnerable users of the service would be expected to arrange transport that would need to take them on over a 3 hour round trip, with significant costs incurred - sometimes multiple times for several scans.

The Pilgrim has a lot of older persons in its catchment

Discrimination to people of all the above characterisations by reducing their access to equaly good healthcare wherever they reside

People that are disabled wil struggle to travel distances without support.if hospital is local far easier to attend even if impaired

Total woke nonsense we are what we are

It seems the human rights of the people of Grantham are always at the back of the queue and services should be equally distributed throughout the Trust.

Don't know

I have to take my mother to hospital appointments. She is physically frail and not very mobile, plus she has dementia. Taking her to Lincoln or Boston would be a nightmare. The distance she would hsve to walk is too far. The journey alone would exhaust her before she got to have the tests required. Definitely a negative impact.

Definite discrimination against older generations and families on low incomes

The right to be able to afford to access tests and treatment

This discriminates against disabled people, I am personally not capable of travelling to Lincoln from South lincs

Disabilities and the difficulty in getting to a hospital using public transport. I live in Lincoln and that's hard enough. How long would it take someone with a disability to get from Boston to Lincoln and back again using public transport

If you provided adequate and efficient free transport to those requiring the service it would help because of cost to individuals trying to attend appointments under their own steam and lack of car parking spaces at Lincoln county hospital. Most people have enough anxiety about attending those appointments without having the additional fear of having to travel to a strange and busy city and then locate the hospital and try to find a parking space as well as the cost of getting there.

Transport arrangements are restrictive would a dedicated service bus from Grantham to either hospital be put in place with subsided fares?

No

The negative impacts could affect any of those groups. In particular the elderly who may not have access to travel.

Protected characteristics are specific aspects of a person's identity defin...

It should be realised that older people are not comfortable driving for any distance, particularly into busy high traffic areas

None

ulht need to seriously review their services

If it ain't broke, why fix it?

The excessive costs and difficulties due to travelling from the south of the county to Lincoln discriminates against the sick, aged, pensioners, any person on minimum income

The people in Grantham and the surrounding areas will have to choose between going to an appointment or eating if the service is removed from being local at Grantham

The cost of travel and stress it entails is a negative for me.

It concerns me greatly that having to travel a long way for treatments will be very difficult for the elderly and disabled amongst the community. The people needing these treatments are already going through so much and we shouldn't be adding to that burden by inflicting a 60+ mile round trip into the equation.

None

Bus from hospital to hospital would help

the availability of public transport for disabled and elderly to attend centres further away

no

No

Continuously trying to reduce a service or centralise it only has a negative impact. Perhaps encouraging a timely more effective service close to patients is more beneficial, increasing staff morale instead of setting them into a panic about their jobs/ future. Something the higher management rarely take into account

No

I feel that when someone is severely ill and have to travel outside the area they live in that ,this is being discriminated against as they have paid in for health care through national insurance the same as anyone else.

This is just another to close Grantham. Issues also include parking at Boston or lincoln

No

Yes elderly people would find the journey arduous and expensive, the journey to Boston from Grantham is particularly difficult during the winter.

No

No

No

Protected characteristics are specific aspects of a person's identity defin...

No

No, other than the obvious transport difficulties attaching to disability in a county with poor public and assisted travel capabilities.

There are potential negative impacts for elderly and disabled patients who may have further to travel with limited access to suitable transport.

What is the point of this question?

I think the word equitable fulfills the above question ie; to be fair, just and impartial.

Those in the Grantham area on low income, disabled or blind or single parents or children all need access to local scans. The loss of the service will impact on their ability to access scans/care. Other residents in villaves to the west of Grantham will also be affected. This consultation does not provide an option to retain services in Grantham which indicates predetermined to stop Grantham s services.

Age, disability and pregnancy

Higher elderly population.rurality and lack of transport links East coast Poverty

The above statement is not clear or concise and appears to be full of management speak !

If you reduce the accessibility by limiting provision you will negatively effect older and disabled patients

Yes. Talk in English and just ask the question. These questions are written in a way to baffle people.

No

Negative impact on services being continuously moved away from Grantham and Boston - need to ensure patients in these areas are not disadvantaged by the reduction in services in their area

everyone should be allowed to use them, we all live here

Not relevant!

n/a

As stated previously, elderly find travel difficult, expenses of travel are rising, expecting people to travel miles for their appointments when they could be performed closer to them is not acceptable

No

Travel from rural areas

if you live in grantham and are disabled or elderly getting to lincoln or boston on public transport is horrific, lengthy and expensive

Age and disability impact

no

As said all should be given the same opportunity or treatment

Disability, access to transport, transport of carers are negatives. I see no positives.

Discrimination against people who can't afford private transport

No

Older people of working age tend to be treated as if theure rerired

Having to travel

None

Disability's financial care closer to home patient choice

none

not forcing elderly patients to have to undertake long uncomfortable journeys (often on their own) when attending for treatment

people with limited resources will not be able to access the services appropriately

Disability, bins in disabled toilets are ,mostly, operated with a foot pedal. How can a wheelchair user do this? I am forced to open bins by forcing top up , this often unclean. This makes me more open to germs and infection. This is such a simple issue to resolve, I have mentioned it countless times but still no change

I believe disability is a consideration as clients will have have huge journeys to travel.

Centralising services to one location in the county which is not central promotes inequality. Is it really acceptable to expect vulnerable patients with chronic conditions to travel between 50-90 miles (round trip) for a scan. Would mobile units be an option or utilising community hospital space and staff?

everyone should be treated the same regardless of their persuasion other than that I can not answer any more to this question.

Easy travel arrangements for those without transport or disabilities / on low income.

By reducing the number of locations you are making it harder for the physically infirm or challenged (including older people who need these very facilities) to get to a centre.

None

N/A

None

age and disability

Negative

8

Continue at both sites to allow everyone to have a chance to access it

Increased journeys on already congested roads

?

A Lincoln based service would affect many under the above in the east and south of the county

No comment

See answer to question Q4 in relation to 'age' and 'disability' characteristics. If you were only to have one department based at Lincoln County Hospital you would need to provide good/effective transport from outlying areas for those unable to drive themselves or get someone to bring them to an appointment. Having a designated minibus to take all patients coming in from one area for appointments on a certain day may be cost effective.

No

I think moving services away from the Grantham site to the other site discriminates against the Grantham community. Leaving Grantham as a town very vunerable.

Equality of human rights to have a local service that fits their needs for whoever they may be

age discrimination a lot of the elderly population no longer drive.

No

Discrimation against: Age and disability. Older generation being unable to get reliable affordable transport

Rural living, poor travel infrastructure means , low incomes will be excluded from this service

As mentioned before breast surgery implications. Travel difficulties with our rural area and poor transportation links.

No

Disability, could be that people would struggle to attend Nuclear Medicine if it was based on one site only

No

Don't know

No. It would be benificial if linconshire actuallu complied with the act because i have been discrimnated by LCC for six years or more for having the audacity to stand up to them this actvjs a farce and protects a minority of individuals

No comments beyond those already accounted for

Yes, old age and physical disability that impact on access to services

The residents of Grantham are being treated as second class citizens with your Lincoln or Boston centric plans! You have a site at Grantham that has been treated disgracefully compared to Lincoln and Boston!

Protected characteristics are specific aspects of a person's identity defin...

N/A

Do not take this away from pilgrim we need this

No

Disability - difficult for some patients to travel countywide and this will be discriminatory to patients living in the Boston srea

You keep taking everything away from Grantham, how is that not discrimination against one town

None

No, everyone should be catered for

No

No

I am not aware of any equality or human rights issues at either Lincoln or Boston hospitals so cannot comment. Sorry.

Everyone needs a good health provision no matter what their protected characteristics.

The impact on the elderly, disabled and those in poverty who have the same rights but would have to travel further.

No

Age and ability

No

No

N/a

Don't know.

increase junior staff participation into decision making and investigate why staff are leaving the trust plus reduce management by 50%

Decisions presented as a consultation are a very negative effect on the aging and vulnerable population of the Grantham area. Now a need to consider moving nearer to health service provision.

Not sure what that has to do with whether a service remains or not. If the demand for a service is there it should remain regardless.

Please bring back services to Pilgrim as this would be discriminating and preventing equal, and accessible health needs if you centralise for Lincoln, which is inaccessible to individuals living near Boston and the coastal areas. This is depriving people from basic health needs and urgent care responses

Have mentioned before almost all services from Boston being taken away and Boston people being disadvantaged by having to travel, waste time for appointments at Lincoln despite having a hospital in Boston which is being gradually crippled

Protected characteristics are specific aspects of a person's identity defin...

This will negatively affect the elderly and disabled who find it harder to travel

Age in particular- need to travel further could be problematic

No

None

none no-one should get preference

No

Lincolnshire is full of ageing and disabled folk, you will be disadvantaging them too much expecting them to travel, keep at least two sites open

Many disabilities struggle with large hospital environments (Dementia, autism etc) and communication needs to be better - explain what nuclear medicine is in simpler terms and promote engagement in the survey

N/a

Negative impacts for the disabled, elderly, those without a car etc. Also severe financial implications in a world where everything costs so much.

None

due to the need for increased travel by patients this could effect age and disability particularly; so improved patient transport options may be needed

NO

none

I feel transferring NM investigations to Lincoln only will discriminate against my elderly frail patients who do not drive or those that have poor health or hidden disabilities who may not be eligible for Hospital transport.

No

Good service for people with transportation problems

As long as all people who need the service have access to the service regardless of sexuality/race/ethinicity

The population in the south of lincolnshire has grown as I'm sure it has in the North. More than one site is needed to meet demands

Nuclear medicine should stay in pilgrim

Leave it in Pilgrim

Some discrimination (eg age, financial, disability etc) could be addressed by providing a shuttle bus twice a day, morning and afternoon.

Moving everything to Lincoln impacts negatively on disabled , people with small children and the elderly . Many who don't have their own transportation

it would be great to see services and staff actually complying with the Equality Act 2010

Making a service safer for patients should have no bearing on the Equality Act. There is nothing discriminatory in making sure a service is still offered to all regardless of age, disability, gender, race, etc....

No

The fact that Boston and surrounding area has more elderly population would mean they will be put to much more inconvenience if the services are centralised at Lincoln. Keeping the services at both sites is much better option.

not evyerthing needs to be centralised at Lincoln County - We need to keep services at Pilgrim for our democratic population

There is no discrimination based on the parameters provided however centralising it to Lincoln would act as a post code lottery to the population of east Lincolnshire which is the most underprivileged side

NA

Boston has become multicultural with more overseas health care workers among others coming in. It would be a further disadvantage to ethnic minorities coming to work here. We are already struggling to attract staff to Boston.Moving services away would make the recruitment crisis worse.

No

Cant think of any

Most of the acute services are moved to Lincoln . This already has a negative impact on health of local population and increasing the ambulance wait time . The Population of Boston is being deprived of essential services . There is a huge population which are elderly or from minority who don't have access to own transport. So moving or centralising services to Lincoln would invariably have a negative impact

People with disabilities may find having to travel further a barrier to getting treatment

Sod the equalities, stop shutting down my local hospital

No

It will have a negative impact on people being able to utilise this service and it should be provided at all sites!

no

Not aware of any

No

No

Travelling long journeys for older and disabled patients in Grantham

Most people prefer a smaller more condense building to be less intimidating. More personal. More accessible building. Grantham supplies this

No impact on me be disabled as know we have to travel. Parking our worry and transport.

Protected characteristics are specific aspects of a person's identity defin...

No

Not sure

Me and my husband are both disabled rely on family to take us to appts. Daughter lives in Newark, son other side of lincoln and we are in Grantham. Thats alot of miles to take us to different appointments. Its ridiculous so do.feel discriminated against yes. maybe people making decisions should live the life of a disabled person for a while. On little money and expected to travel miles

The impact on an increasingly elderly Grantham population will be discriminatory. Not pursuing the changes would be the non discriminatory option

Those living on the coast are often from deprived backgrounds work limitations to travel and no public, very limited access to public transport

Yes, you ignore the time and risk posed by patient having to make more journeys, never mind the environmental impact of such.

Not having this service in Grantham discriminates against the old and disabled who rely on public transport

No. disabled/elderly people already find it difficult to get to hospital appointments.

Grantham residents have no human rights regarding health services.

No

None

Having 1 site for nuclear medicine services makes workforce and economic sense, older people may find the journey to Lincoln rather difficult from other corners of the county.

These proposals negatively impact on elderly and disabled people who you expect to find a way of travelling miles with all the physical and mental stress incurred

many of us can not travel far because of old age and bone problems

I would consider the financial impact this could have, as some people would have to travel further, thus costing some people further hardship

Yes stop taking away services from disabled people that are so badly needed in Grantham. We have a very large disabled population and we are disregarded a lot of the time. If you want to take these services away why are you not providing a reliable transportation service for disabled persons only. They need a dedicated one. TASL is awful

Patients on the East coast will be disadvantaged if service is centralised.

no

I am a carer 2 3 dusabled people and i feel you are making it harder onp eople as fuel is going up fuel at home is food is some sick people on benefits do not get enough money to travel that far

Check if people have any reading or writing or cognitive difficulties when being given written information of any kind.

increased challenges for those with disabilities, extreme age, economically challenged (negative impacts) if required to travel further

People can't afford to travel

Protected characteristics are specific aspects of a person's identity defin...

age definitely

No

Look at the recent budgeting for staffing at both sites, against the value that this service provides

None

no

No

Yes: travel is difficult for the elderly

Ensure sufficient disabled parking facilities are maintained at both of the centres proposed

No

Travel costs and difficulties. Time involved and frailty of some to have energy to manage difficulties

I have some mobility issues - especially re walking

Poorly Cancer patients should not have to travel to receive treatment, so keeping open as many sites as possible will mean a reduction in waiting times, and better patient journey through the cancer pathway.

Fulfil the rules of the Equalities Act 2010

Equality and human rights should always be considered

Please with disabilities have already have welfare cuts and universal credit has also been reduced. This will make accessing healthcare more difficult whereby people don't have cars to travel. Who well will these units units beresoutce for meeting duties under the act is partly down to training. From personal experience bullying and disability discrimination has not been addressed by management in the NHS and is therefore likely to continue

We cannot provide every medical service at every hospital within the NHS there simply is not enough money or resources to do that. This si a much better solution and whilst people will still feel aggrieved they will have to travel if they live in the Grantham area if the service is either at Boston or Lincoln they will still have a choiceh

no

patients refusing scan due to travel time. patients with no transport may struggle

No

I think people with a disability that impacts on their ability to travel long distances will be disproportionately impacted if services are centralised.

Greater travelling distances to Lincoln or Boston may be difficult for patients who are disabled

NO

Protected characteristics are specific aspects of a person's identity defin...

no

Age and disability will make it difficult for people to travel the distance to Lincoln. The only way you could remove the negative impact of this would be to provide free transport for these people, picking them up from their homes, I don't think you would stretch to that.

ageist and discriminatory towards individuals / elderly who will find it a problem to travel longer distances as a result of these proposed changes

Access to those in the south of the county, another Lincoln centric move

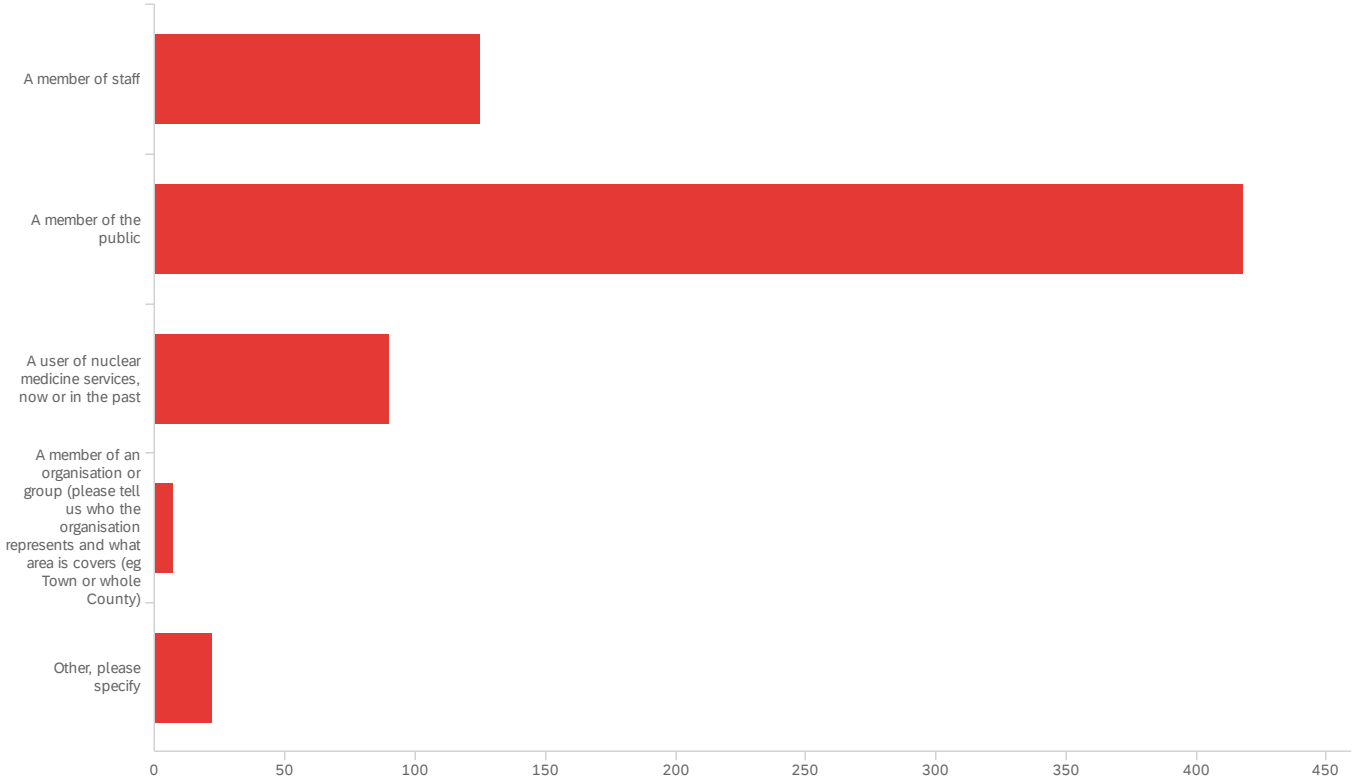
Unsure

The pros for this are service improvement, the cons will be distance to travel to access service; this is not a protected characteristic.

At the moment they have the right to choice of being treated in certain hospitals - this choice could be changed to just one location. I know there are dangers and you are trying to remove dangers but moving all to one central place is not ideal for our patients

none

Q8 - Please tell us if you are responding as:



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Please tell us if you are responding as: - Selected Choice	1.00	5.00	2.07	0.81	0.66	662

#	Field		Choice Count
1	A member of staff	18.88%	125
2	A member of the public	63.14%	418
3	A user of nuclear medicine services, now or in the past	13.60%	90
4	A member of an organisation or group (please tell us who the organisation represents and what area is covers (eg Town or whole County)	1.06%	7
5	Other, please specify	3.32%	22
			662

Showing rows 1 - 6 of 6

Q8_5_TEXT - Other, please specify

Other, please specify
AgeingWithoutChildren Lincolnshire group
Also ex NHS Elected Public Governor LPFT
PPG in Woodhall Spa
I am a member of the public who has benefitted from nuclear medicine.
Also, as well as a member of the public, I am a Carer and a relative had access to nuclear services at Grantham and the service was efficient.
Family member attended Pilgrim and we were very grateful for such care and professional service from Pilgrim Hospital.
Wellbeing Lincs whole County
Chair SOS Grantham Hospital and South Kesteven District Councillor Grantham St Vincent's Ward
Carer
adult social care Grantham
I used to work in nuclear medicine at Lincoln
A member of public whose parents used the service
Also a family member user of nuclear medicine service at Boston
Resident of Grantham since 1976
Boston
Spouse of someone who has used nuclear medicine dept
General practitioner
Retired Nuclear Medicine Manager.
A member of staff and a member of the public
I am a member of staff but family have used the services

Q9 - What is your full postcode? This will help us understand views in different areas.

What is your full postcode? This will help us understand views in differen...
LN2 5QY
LN2 4RT
Ln2
LN12 2GG
PE20 3LJ
PE23 4JN
PE22 9DW
PE21 9JB
LN11 0YJ
LN11 8LU
ln9 5sw
LN60UP
Pe24 5ag
Dn211GE
Pe227eq
NG340HY
Ln130bx
Ng317nd
DN21 3AH
PE20 1SF
PE203EH
LN6 9TP

What is your full postcode? This will help us understand views in differen...

NG318FJ
PE22 0JU
LN11 9DZ
dn21 3ps
PE253DQ
LN6 0JQ
PE21 7HG
Ng323ba
LN4 4QX
LN4 4RP
LN6 7JX
LN4 1RX
LN11 8QH
Pe22 8aa
PE21 9DP
LN8 3AL
Ln110fe
NG32 1BB
LN11 7ud
PE21
NG31 9SX
NG340NA
LN2 4EE
PE22 0BG

What is your full postcode? This will help us understand views in differen...

PE11 3HF
PE22 8JH
LN10 5EX
LN2 4WS
NG319DS
PE12 7QU
LN6 5SL
PE20 1QZ
Pe21 0nt
Ln25na
PE20 1SY
NG34 8RR
PE12 7AP
PE25 1DQ
PA22 7AQ
LN110EN
LN50SE
LN8 3NW
LN118TF
NG31 8LP
PE21
PE12 8BL
LN2 2UZ
Pe10 9jr

What is your full postcode? This will help us understand views in differen...

LN6 3LU
NG334ES
NG318NQ
Ng322jz
PE109DB
PE24 5YZ
LN6
LN119XX
Pe
PE22 9RF
Ng34 8wf
PE21 9LX
PE22 0JT
PE22 0JT
PE20 2hj
Pe22 0jt
PE21 9HT
LN11 8SB
LN13 0DL
LN6 8SZ
LN96RZ
ln121qt
PE24 5XS
LN11 7SN

What is your full postcode? This will help us understand views in differen...

LN9 5PS
LN9 5AH
ln11 8nh
LN11 0BF
Pe22 8PA
LN10 6TL
LN10 6RB
LN44tj
Ln24fp
PE11 3BE
PE22 9HS
LN/1BB
LN4 3PJ
PE10
LN1 3JT
pe220qz
LN9 6ry
ln10 6sx
LN6 0 JA
Pe21 8pr
NG31 9DG
PE11 2EQ
PE21 7PZ
LN2 5LR

What is your full postcode? This will help us understand views in differen...

LN2
LN35AA
LN6 9BE
Pe220bz
NG32 3RR
Pe126bx
PE12 8BZ
PE12 7ES
Pe201lj
LN69TE
PE25 2JB
PE229EP
LN10 6GA
LN67LJ
LN10 6yd
LN2 2JS
LN4 4DT
TF2 8JL
PE10 0EW
NG32 3PS
DN21 5RF
LN6 0XF
NG23 5JF
NG33 5SF

What is your full postcode? This will help us understand views in differen...

Pe21 7an
Pe12 7hq
PE21 9QY
PE21 9RA
Pe203dd
Pe21 9ns
PE20 2QD
LN12 2FB
LN12 2UU
LN6 8AD
Skegness Town Council PE25 2AX
PE21 7PG
PE245BN
NG33 5SF
PE22 9JD
NG33 4HB
NG31 7JP
NG319FR
Ng32 3pw
LN6 0XF
LN95QF
NG34 0NA
Pe21. 8dx
Pe127pg

What is your full postcode? This will help us understand views in differen...
LN11 9EE
Ln4
PE21 9NX
PE21 9HD
LN3 4BD
LN1 3UP
NG34 7WG
LN4 1EH
NG34 9FF
Ng34
LN1 2NU
PE6 8EW
Dn365ru
PE12 7HL
NG34 9AD
LN2 3QU
NG335NT
NG32 1PY
PE20 1BP
PE22 7BS
NG349pH
NG34 9PH
LN44JL
NG31 8HW

What is your full postcode? This will help us understand views in differen...

Ln11pu
Ng319ra
NG316DN
LN8 3RA
Ln6 9sw
LN1 1RT
PE21 0LF
LN63RD
LN11 8HL
NG31 7FJ
NG31 9JB
NG31 7PD
PE11 4DJ
LN6 7RS
PE22 0UB
PE20 1LN
Pe217ps
Pe21 9an
Pe21 7rz
PE253BU
NG34
Ln130pw
Ln11 0az
NG31 9GA

What is your full postcode? This will help us understand views in differen...

NG31 9UE
NG34 7QP
Pe129fa
Ng32 2pw
PE21
LN6 8JB
LN6 9AE
DN21 1QH
NG31 7EE
PE23 5JE
PE21 8HT
PE23 4BY
NG347GT
LN4
LN4 1JS
LN2
pe6
PE22 9AL
PE111QX
Ng328hn
NG318SX
PE217JN
NG31 8AF
NG34 9RJ

What is your full postcode? This will help us understand views in differen...

Ln4 3an
NG17 2EA
LN6 9SP
ng31 8bn
LN50ER
LN2 2JS
Pe21 7dr
LN6 5AX
PE203JE
PE20 1RD
PE20 3JE
LN23UH
LN63NW
NG31 7DR
NG31
NG31 8LJ
Ng316px
LN8 3PE
NG317BH
NG24 4FG
NG34 8PN
PE21 9QQ
LN2 3QL
PE21 7PN

What is your full postcode? This will help us understand views in differen...

DN21 2NA
PE22 0SU
LN6 0JG
Ln5 9fw
PE11 4YE
Pe245tq
LN1 2ZG
PE21 0SW
NG31 9ED
PE253EW
PE21 7bf
Ng34 9sb
Pe20 1ax
Ln1 3ne
PE25 2SF
LN2 4WE
PE20 1HG
PE218PR
Ln11 8QH
Pe217PR
LN2 2AB
PE11 4ND
PE11 1NH
PE25 3PN

What is your full postcode? This will help us understand views in differen...

LE14 2ad
pe22 8ba
NG349JJ
PE12 6HX
NG34 7HE
NG31 6RG
NG34 0NZ
LN12 2JX
Ng319hg
LN12 2NB
LN6 0XT
PE11 1GD
LN122GG
PE11 1XZ
NG31 6HQ
LN6 9BX
PE10 9DE
PE12 6TG
NG31 7JY
Ln9 6EG
NG31 9TJ
LN4 1FX
DN10 4AW
PE11

What is your full postcode? This will help us understand views in differen...

PE22 0SR
PE24 5AH
Ln12 1pe
PE21 9QS
NG31 8LR
NG31 7PQ
LE14 3AB
PE219QQ
PE217NG
LN6 9FJ
NG31 9HZ
Pe219pn
PE21 9QS
LN9 5SU
NG31 7AP
LN12 2BJ
NG31 7HT
NG34 9LJ
LN2 2HS
PE21 9JA
LN4 2BA
PE20 1LR
PE20
NG23

What is your full postcode? This will help us understand views in differen...

PE21 9QY
NG31 6NR
Ln12 2ul
PE219JB
LN68NL
Pe21 obz
NG31 9TB
Pe21
PE10 9TP
PE22 7PY
PE20 1AJ
PE220AG
Pe25 2ew
Pe219hr
PE21 7RT
LN86JH
Pe24 4nd
NG23 5AL
ln11 8dl
PE 22 0BA
Ln6 9yx
Pe21 9hn
Pe21 9hn
Pe220sd

What is your full postcode? This will help us understand views in differen...
PE21 9hn
PE21 9HN
PE21 0JD
LN2 3BW
PE219BG
LN10 6pg
Pe21
PE112BY
NG31 8GT
DN21 5SA
Pe228sd
NG34 7HL
LN5 9JE
LN4 3EA
Dn12 3Jx
LN4 2TU
PE21 0BN
LN22HG
pe244hf
DN21 2PU
LE13 1RJ
PE219LQ
PE21 0JP
PE21

What is your full postcode? This will help us understand views in differen...

Pe219ar
prefer no to say
Pe219qs
LN50SE
DN212NX
I live in Lincoln
PE21 7BX
LN122DS
PE21 0bf
PE21 7RU
PE22 0YG
PE228HF
Ng31
PE228ET
Pe21
PE22 7AB
Ln2 5qy
PE201XQ
Ln2 4fa
PE21 0DP
NG31 7FP
NG34 8XU
PE21 7LP
PE21 9LP

What is your full postcode? This will help us understand views in differen...

PE228QB
LN6 7LD
PE20 3EL
LN6 9PJ
LN83BP
Pe23 4au
PE219BQ
Ng34 9er
LN4 4XL
LN6 8NL
Pe21 0be
PE11 4NE
NG34 0QS
Ln6
NG34 8hz
Pe245he
LN4 2FX
LN11 0TQ
NG32 3NU
LN5 9BQ
PE20 3DG
PE22 9AL
PE20 3DG
PE21 9QS

What is your full postcode? This will help us understand views in differen...
PE6 8BZ
PE22 0JG
pe219ra
PE20 1LQ
LN12 2HP
PE22 8AG
LN6 3LR
PE20 1 PN
PE20 1XA
NG318BW
PE20 2JP
Pe21 9rp
PE11 1PT
LN12FS
PE21 0BB
PE21 6PF
PE21 7LD
PE21 9QY
NG31 9NU
PE22 0NX
NG34 7GE
Pe20 1sy
PE20 2”1SB
PE219QY

What is your full postcode? This will help us understand views in differen...

PE217RT
Ln1 1ll
PE21 9QS
LN8 2AR
LN2 4QT
LN1 2NU
Pe24 5qz
PE201RD
Ln41ju
LN21RT
LN5 9RY
PE21 9QE
NG33 4DA
PE24 5RS
NG31 9GA
NG32 1lt
PE12 6UP
PE219QQ
PE234QE
PE21 0QU
LN6 3LR
LN4 1DW
PE20 1QZ
LN11 9TR

What is your full postcode? This will help us understand views in differen...
Ng23
pe21 9pn
PE21 9DU
PE22 0YF
NG31 8AE
PE227LU
LN119dr
LN6 4RN
PE220JT
PE25 3TD
PE219NZ
LN6 8TJ
PE21 7HG
PE22 0BG
PE10
LN2 2HG
NG31 8PL
NG34 9TE
PE21
Pe23 5pb
Ln122pt
Ng31 9ju
LN2 4SF
LN2 2NQ

What is your full postcode? This will help us understand views in differen...

LN6 9RJ
PE20 1XA
Pe113wd
LN8 5QZ
PE22 0BB
PE219QS
Pe220sn
PE210QR
PE21 9RA
PE21 9NX
DN21 2SY
Pe219ra
Pe21 0sq
PE219QS
NG34 7LW
NG33 5GP
LN2 2QJ
PE21 9PH
LN2
PE219QE
PE20 2JS
Ln2 2ab
Ng34
LN2 5QY

What is your full postcode? This will help us understand views in differen...

Ln2 5QY
LN11 9XG
LN4 2QS
NG33 4BE
Pe21 0rx
Ng31 9ft
PE22 7JU
LN 11 0dy
PE201SP
NG31 9TP
Pe20 3qu
LN4 4GN
LN12 2QP
PE25 2TJ
Ng318qa
DN21 5BP
Ln4 2lh
NG32 2JY
NG31 8SF
Pe228qq
LN44RJ
LN1 2WS
NG318RF
PE9 2RJ

What is your full postcode? This will help us understand views in differen...

LN1 2uj
Ng348bz
LN1 3UH
LN4 4EZ
LN4 1EQ
LN5 9QX
PE20 1HG
PE21 6DN
NG31 9JD
DN365RT
Ln22qn
NG31 8LG
DN21 1DD
LN4 1QW
LN25BY
NG31 9AD
PE21 9PN
LN5 7JZ
Pe22 7bd
Ng31 8lx
PE12 9RF
PE21 9QS
LN5 7LP
NG31 8DT

What is your full postcode? This will help us understand views in differen...
LN69SP
PE23 5PT
NG349RP
PE10 9BJ
pe25 1DD
PE9 4RN
LN5 7NF
LN4 1HL
LN11 0HE
NG31 7BZ
NG32
NG34 8RR
Pe111JR
PE25 1GH
NG31 7LT
PE21 9QS
PE22 7NN
DN211WE
NG33 5AU
PE22 7QU
LN8 3YL
PE11
PE21 7LJ
PE21 9AN

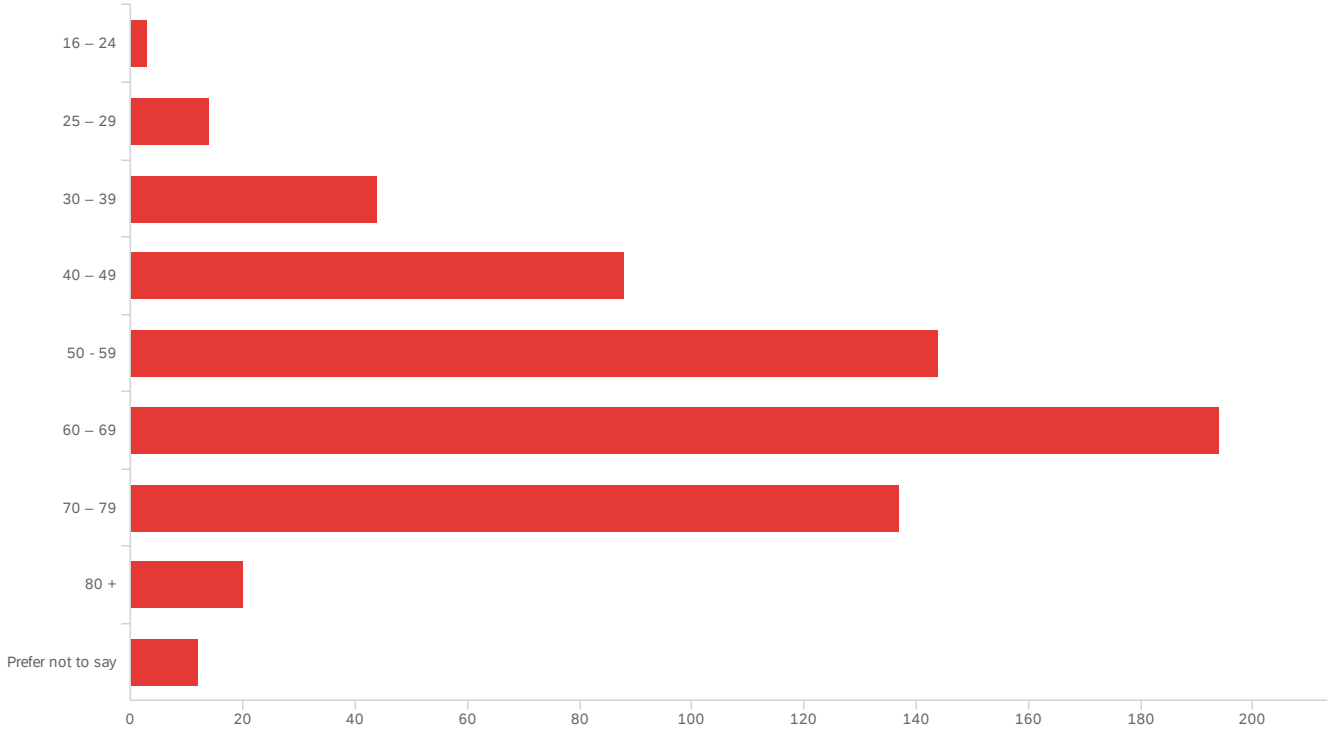
What is your full postcode? This will help us understand views in differen...

PE22 9JL
LN4 4TX
Ln42bd
PE21 7HP
DN21 3EZ
LN12XYZ
LN3 4DQ
LN117EL
LN3 4LU
NG34 7HE
LN67JA
LN4 1GP
LN6 7QZ
LN2 5QY
PE22 7BD
Ln41dw
NG340PQ
PE12 7JU
Ln1 3tj
pe21 8uj
PE21 7HS
LN6 9TY
LN2 4QY
NG31

What is your full postcode? This will help us understand views in differen...

PE228BD
ln2 2uz
PE22 9RF
pe210ae
PE220JX
PE22 0TP
NG31 9TB
LN2 1PX
ln3
PE21 7LR
LN10 6XS
PE22 0bd
DN36 5AE
ln22pr
PE21 7PG

Q10 - Age: What age group do you belong to?



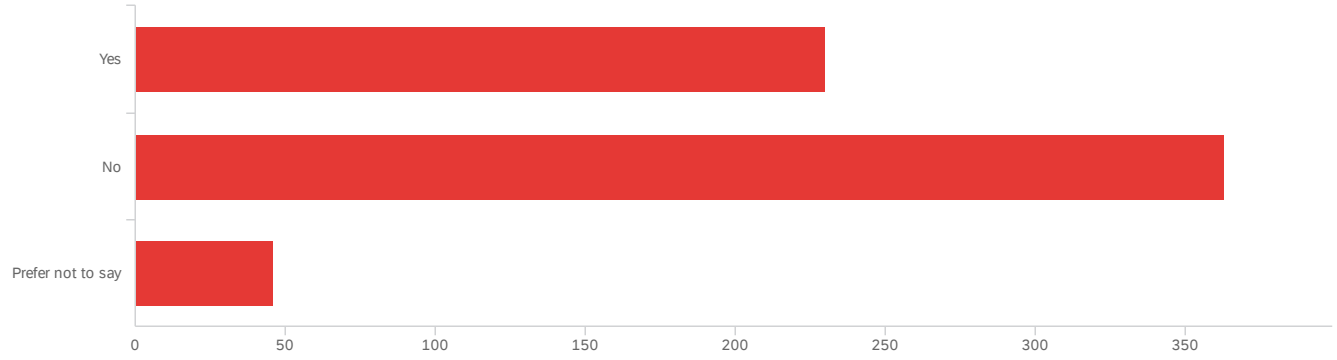
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Age: What age group do you belong to?	1.00	9.00	5.53	1.44	2.09	656

#	Field	Choice Count	
1	16 – 24	0.46%	3
2	25 – 29	2.13%	14
3	30 – 39	6.71%	44
4	40 – 49	13.41%	88
5	50 - 59	21.95%	144
6	60 – 69	29.57%	194
7	70 – 79	20.88%	137
8	80 +	3.05%	20
9	Prefer not to say	1.83%	12

#	Field	Choice Count
		656

Showing rows 1 - 10 of 10

Q11 - Disability: Are your day-to-day activities limited because of a health problem or disability which has lasted, or expected to last, at least 12 months (including any problems related to old age)?

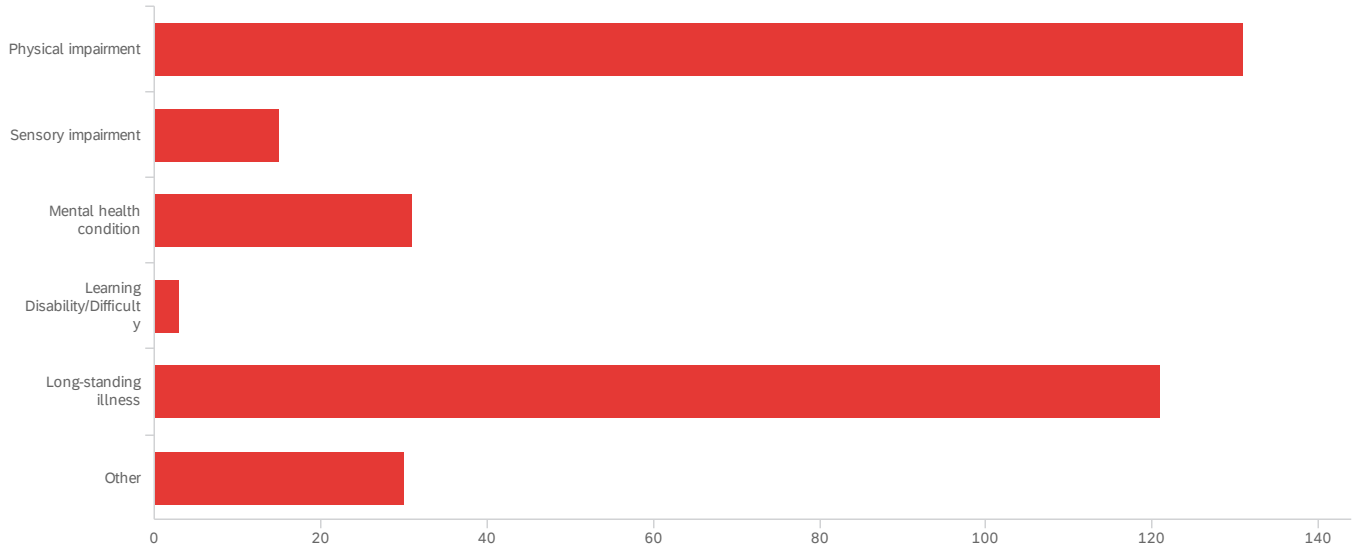


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Disability: Are your day-to-day activities limited because of a health problem or disability which has lasted, or expected to last, at least 12 months (including any problems related to old age)?	1.00	3.00	1.71	0.59	0.35	639

#	Field		Choice Count
1	Yes	35.99%	230
2	No	56.81%	363
3	Prefer not to say	7.20%	46
			639

Showing rows 1 - 4 of 4

Q11a - Please indicate your disability - people may experience more than one type of impairment, in which case you may indicate more than one



#	Field	Choice Count	
1	Physical impairment	39.58%	131
2	Sensory impairment	4.53%	15
3	Mental health condition	9.37%	31
4	Learning Disability/Difficulty	0.91%	3
5	Long-standing illness	36.56%	121
6	Other	9.06%	30
			331

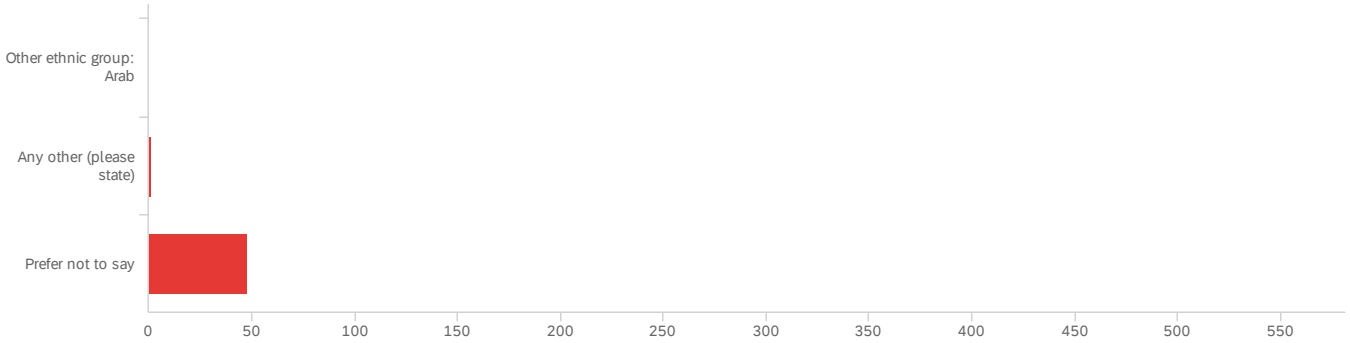
Showing rows 1 - 7 of 7

Q11a_6_TEXT - Other

Other
Cancer treatment related disabilities
Breast Cancer
Brain injury and Spinal cord injury
Memory and lymphoma Cancer

Other
CKD3b
Heart stents
Arthritis
Multiple sclerosis
Polyuria
Autism
Hearing
Arthritis
Cancer
Brain Tumour
Genetic
Osteoporosis
Bowel problems due to Crohn's and prostate cancer.
Cognitive impairment post viral

Q13 - Ethnicity: What is your ethic group? (Please click on the appropriate box to indicate your ethnic group)



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Ethnicity: What is your ethic group? (Please click on the appropriate box to indicate your ethnic group) - Selected Choice	1.00	20.00	13.15	3.13	9.79	631

#	Field	Choice Count	
1	Asian or Asian British: Indian	3.49%	22
2	Asian or Asian British: Pakistani	0.32%	2
3	Asian or Asian British: Chinese	0.00%	0
4	Asian or Asian British: Bangladeshi	0.00%	0
5	Any other Asian background (please state)	0.16%	1
6	Black or Black British: Caribbean	0.16%	1
7	Black or Black British: African	0.00%	0
8	Any other Black background (please state)	0.00%	0
9	Mixed: White and black Caribbean	0.16%	1
10	Mixed: White and Black African	0.00%	0
11	Mixed: White and Asian	0.63%	4
12	Any of mixed background (please state)	0.32%	2
13	White: Welsh / English / Scottish / Northern Irish / British	83.84%	529
14	White: Irish	0.32%	2
15	White: Gypsy or Irish Traveller	0.00%	0
16	White: Eastern European	0.95%	6
17	Any other White background (please state)	1.90%	12
18	Other ethnic group: Arab	0.00%	0

#	Field		Choice Count
19	Any other (please state)	0.16%	1
20	Prefer not to say	7.61%	48
			631

Showing rows 1 - 21 of 21

Q13_5_TEXT - Any other Asian background (please state)

Any other Asian background (please state)
Arab

Q13_8_TEXT - Any other Black background (please state)

Any other Black background (please state)

Q13_12_TEXT - Any of mixed background (please state)

Any of mixed background (please state)
White British: native American
White and Latinamerican

Q13_17_TEXT - Any other White background (please state)

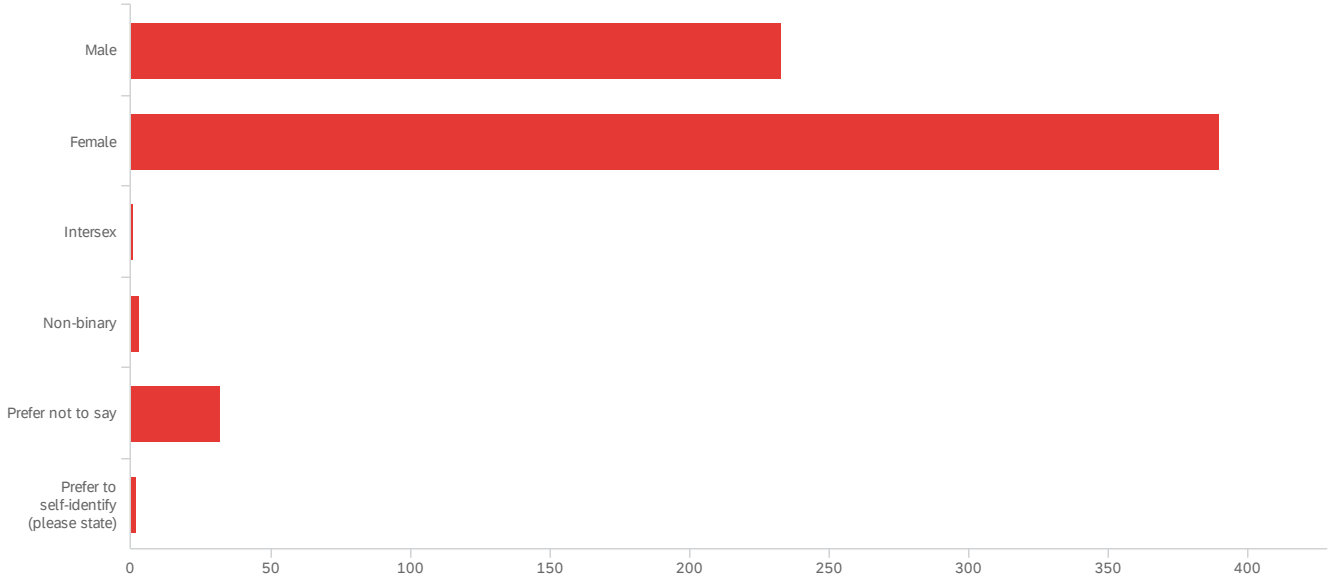
Any other White background (please state)
Western European
Western European
English, British, Kernow/Cornish
White endigenous
South european
Western European

Any other White background (please state)
White British
USA
White

Q13_19_TEXT - Any other (please state)

Any other (please state)

Q14 - What is your gender?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	What is your gender? - Selected Choice	1.00	6.00	1.82	0.91	0.82	661

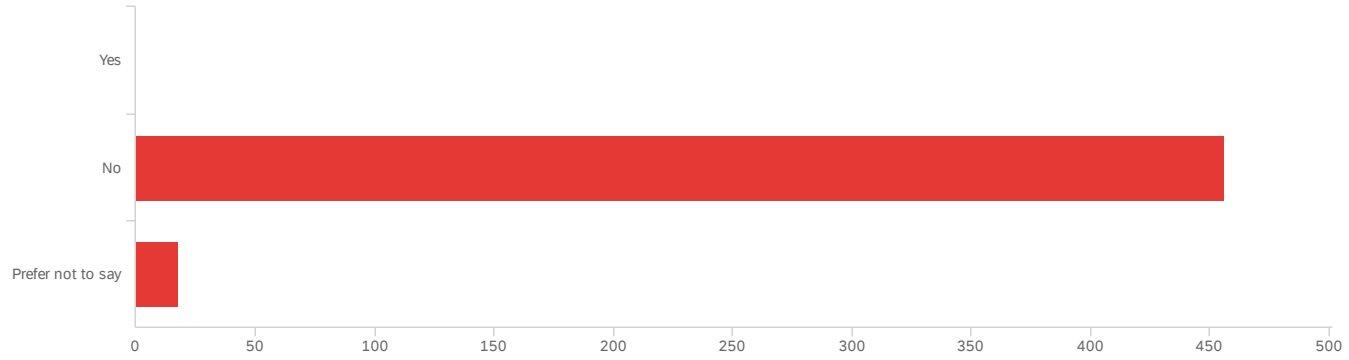
#	Field		Choice Count
1	Male	35.25%	233
2	Female	59.00%	390
3	Intersex	0.15%	1
4	Non-binary	0.45%	3
5	Prefer not to say	4.84%	32
6	Prefer to self-identify (please state)	0.30%	2
			661

Showing rows 1 - 7 of 7

Q14_6_TEXT - Prefer to self-identify (please state)

Prefer to self-identify (please state)
You should be asking for sex. How does being NB affect anything?

Q15 - Gender reassignment: Have you gone through any part of a process, or do you intend (including thoughts or actions) to bring your physical sex appearance, and/or your gender role, more in line with your gender identity? (This could include changing your name, your appearance and the way you dress, taking hormones or having gender confirming surgery)

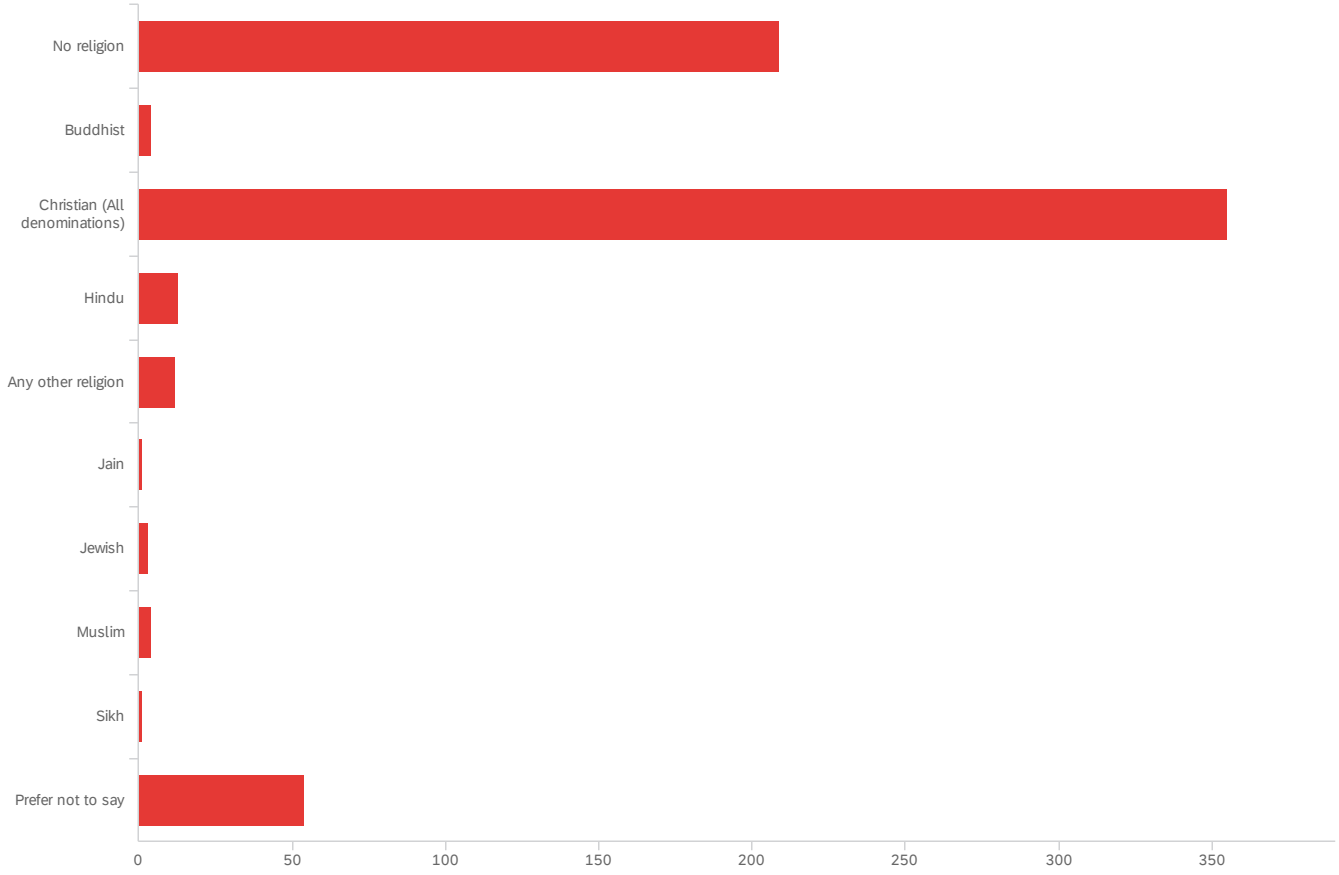


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Gender reassignment: Have you gone through any part of a process, or do you intend (including thoughts or actions) to bring your physical sex appearance, and/or your gender role, more in line with your gender identity? (This could include changing your name, your appearance and the way you dress, taking hormones or having gender confirming surgery)	2.00	3.00	2.04	0.19	0.04	474

#	Field		Choice Count
1	Yes	0.00%	0
2	No	96.20%	456
3	Prefer not to say	3.80%	18
			474

Showing rows 1 - 4 of 4

Q16 - Religion and/or belief: What is your religion/belief?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Religion and/or belief: What is your religion/belief? - Selected Choice	1.00	10.00	3.05	2.39	5.70	656

#	Field	Choice Count	
1	No religion	31.86%	209
2	Buddhist	0.61%	4
3	Christian (All denominations)	54.12%	355
4	Hindu	1.98%	13
5	Any other religion	1.83%	12
6	Jain	0.15%	1
7	Jewish	0.46%	3

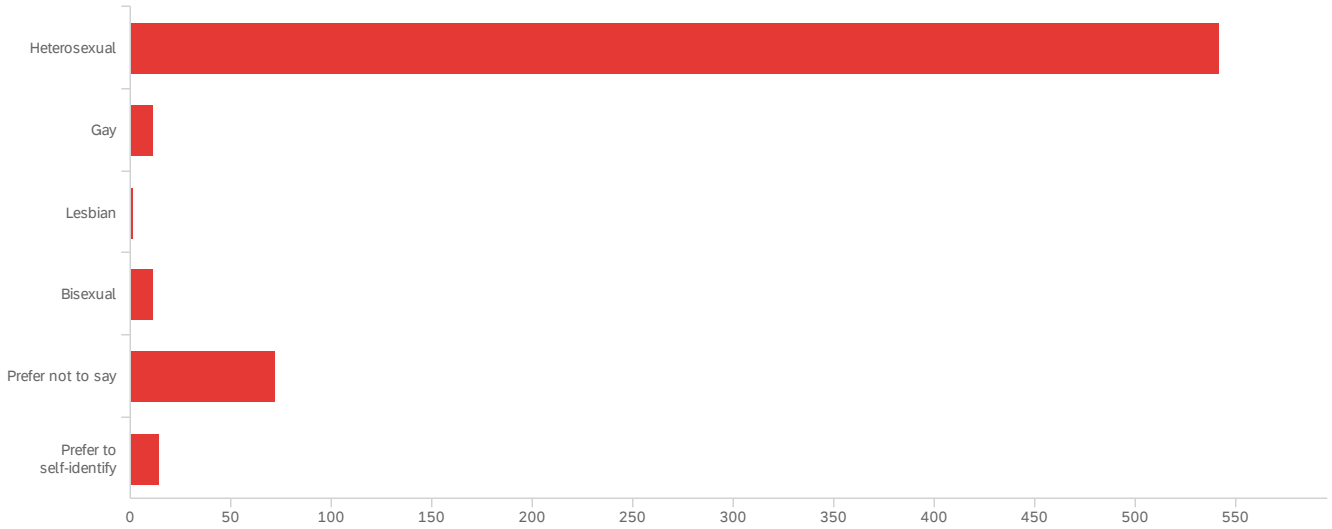
#	Field		Choice Count
8	Muslim	0.61%	4
9	Sikh	0.15%	1
10	Prefer not to say	8.23%	54
			656

Showing rows 1 - 11 of 11

Q16_5_TEXT - Any other religion

Any other religion
Spiritual
Christian and Hindu
Roman Catholic
Agnostic
Humanist
Satanist
Pagan
Unitarian

Q17 - Sexual orientation: Which of the following options best describes you sexual orientation?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Sexual orientation: Which of the following options best describes you sexual orientation? - Selected Choice	1.00	6.00	1.62	1.45	2.10	651

#	Field		Choice Count
1	Heterosexual	83.26%	542
2	Gay	1.69%	11
3	Lesbian	0.15%	1
4	Bisexual	1.69%	11
5	Prefer not to say	11.06%	72
6	Prefer to self-identify	2.15%	14
			651

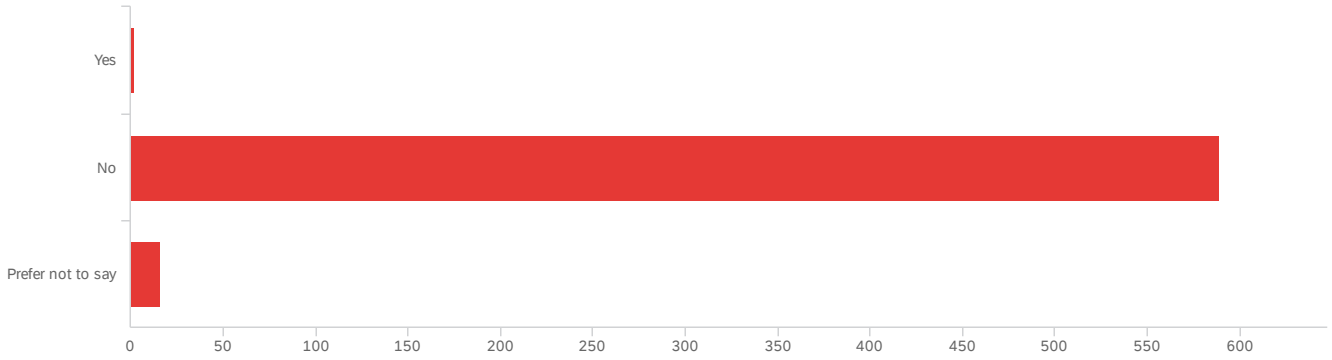
Showing rows 1 - 7 of 7

Q17_6_TEXT - Prefer to self-identify

Prefer to self-identify

Prefer to self-identify
No
not relevant
Dormant with age
Unicorn

Q18 - Pregnancy and maternity: Are you currently pregnant for providing maternity care for a new born baby?

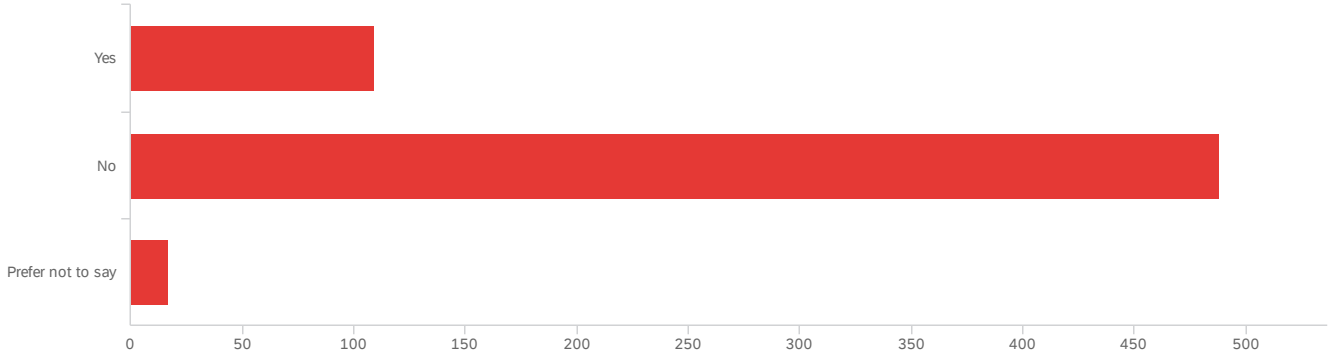


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Pregnancy and maternity: Are you currently pregnant for providing maternity care for a new born baby?	1.00	3.00	2.02	0.17	0.03	607

#	Field		Choice Count
1	Yes	0.33%	2
2	No	97.03%	589
3	Prefer not to say	2.64%	16
			607

Showing rows 1 - 4 of 4

Q19 - Caring responsibilities: Do you have any dependant children aged under 18?

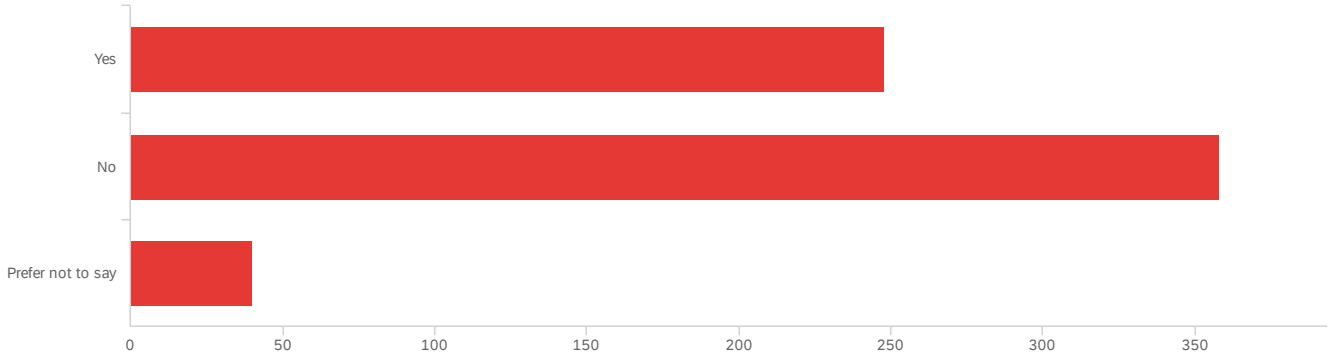


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Caring responsibilities: Do you have any dependant children aged under 18?	1.00	3.00	1.85	0.43	0.18	614

#	Field		Choice Count
1	Yes	17.75%	109
2	No	79.48%	488
3	Prefer not to say	2.77%	17
			614

Showing rows 1 - 4 of 4

Q20 - Caring responsibilities: Do you look after or give any help or support to family members, friends, neighbours or others because of long term physical or mental ill-health/disability or problems relating to old age?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Caring responsibilities: Do you look after or give any help or support to family members, friends, neighbours or others because of long term physical or mental ill-health/disability or problems relating to old age?	1.00	3.00	1.68	0.58	0.34	646

#	Field		Choice Count
1	Yes	38.39%	248
2	No	55.42%	358
3	Prefer not to say	6.19%	40
			646

Showing rows 1 - 4 of 4

End of Report

Quality Impact Assessment

QIA URN: Title	QIA2022-136 : Restructure of Nuclear Medicine Centralising in Lincoln		
Scheme Overview	Centralising the staff and services of Nuclear Medicine on 1 site reducing the equpiment and facilities required and the footprint of the service. It will also reduce the amount of duplication of work on 3 sites.		
Quality Impact Overview	*There will be an improvement in the robustness of the service with regards to staffing and equpiment. The reduction in the duplication of work would mean that the audit process could be more robust. In addition the likelihood of short notice cancellation of patients would be reduced. Batching would be more easily managed, meaning a possibe reduction in waiting times. There would be adverse affects on patient experience, a few staff experience, and public image due to the closing of Pilgrim's and Grantham's department.*		
Quality Indicators			
Project Manager (Lead)	Laura White	**Directorate/Division/Department**	CSS / Diagnostics
Senior Responsible Officer	Yavenushca Lalloo	**QIA Completed By**	Laura White
Financial Value	The NET savings …	**Overall Risk Score**	12

Approved by Director of Nursing		**Date**	
Approved by Medical Director		**Date**	

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score
Patient Safety	Centralising the service will increase the patient safety by ensuring there is enough capacity to perform the required infection control audits and inspections. There would also be more staff to ensure patients who experience adverse events when in the department can be properly monitored while the service contines for other service users. There would be more capacity for training, supervision, and monitoring of staff to ensure continued proficiency. In addition there will be more capacity to not only start new services for the patients but also ensure that the most up to date guidance for all our tests are adopted in a timely fashion. In addition the Lincoln site has a long standing quality system as is accredited to ISO9001:2015. National guidance is that services should aim for some accredited quality system to ensure the quality of their processes and procedures so certalising to Lincoln will mean the whole service in the region will be under this accreditation.	Positive							

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score
Public Image	Centralising in Lincoln would be have an adverse impact on public image as services would be moved from Grantham and Boston, which could be percieved as a reduction in the service provided by ULHT - especially at Grantham who have some recent history of losing services.	Negative	5	4	20	Ensure proper public consultation is undertaken outlining the benefits of centralisation. Communications to detail that centralisation will improve the quality and safety of the service due to consolidation of the available skilled staff, and the addition of up to date equipment.	3	4	12
Clinical Outcomes	Centralising the service should enable us to batch book the patients (due to batching radiopharmacy kits). This should improve efficiency and allow for shorter waiting times for certain less common tests. Up to date equipment will aid diagnosis and turnaround of studies. All staff will be trained in imaging all types of test undertaken in the region meaning robustness of service and little likelihood of cancellation of tests.	Positive							
Clinical Effectiveness	Currently certain workforce groups, such as the Medical Physics Experts, are understaffed compared to what would be expected by the CQC and IRMER. This would be addressed to some degree by reducing the equipment within the service. Centralising in Lincoln, which is already ISO9001:2015 accredited, would be useful and this would also mean that freeing up time to optimise and adopt the latest guidance would be more possible as currently the Medical Physics Experts (MPEs) are stretched managing 3 sites. The equpiment we have will also be better matched with the demand for the service.	Positive							
Clinical Effectiveness	If the service is based at one location, there is a risk to business continuity in the event of a catestrophic event (such as fire, flood, power outage). However the radiophramacy is based only at Lincoln and that is required daily to make the products needed for the tests so the service would be impacted drastically if there was such an event currently.	Negative	2	4	8	There are no stated local mitigations for this as all cameras and radiopharmacy will be in the one location. There is a partnership with Sheffield to provide radiopharmaceuticals but this is a very expensive way of running the service and is not sustainable in the long term.	2	3	6
Patient Experience	Requirement for patients to travel for their scans leading to inconvenience to patients and could lead to some patients going out of county for the tests or not having the test. Where there is the (infrequent) need to scan an inpatient at either Pilgrim or Grantham, that patient will need transferring to Lincoln Hospital, and possibly require admitting to Lincoln	Negative	4	3	12	Centralising in Lincoln means the number of patients affected would be the smallest. In addition patients currently travel now. There are only a handful of tests that are undertaken on in-patients who remain in-patients for their nuclear medicine studies (GI bleeds, white cell scan) and both these need to be performed at Lincoln anyway. Surveys have shown that the patients who do attend all 3 sites are happy with the overall service they get there.	3	2	6

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score
Patient Pathways	One service that would be impacted is breast surgery where the patient received an injection before their surgery (around 63 patients a year affected). They would need to travel to Lincoln for the injection possibly the day before surgery. There may be an increase in DNA's from patients who decide not to travel or have travel plans disrupted on the day.	Negative	4	3	12	The majority of patients have surgery at Lincoln so the number affected would be small. In addition there would be discussions with the surgical team about other possible pathways for the injection and what their plans are for the service as a whole (ie. changing the day of Surgery from a Monday) In addition the changing diagnostic pathway means that some of the tests currently performed by nuclear medicine will be replaced by other techniques. For e.g. magnetic tracers for Sentinel breast surgeries and PET/CT for some cardiac scans.	4	2	8
Accessibility	A number of patients will be required to travel to Lincoln from Boston and Grantham for their procedures (number typically about 1500-1750 patients per year). As the majority of those patients are over 50, and many are older with other long term conditions - this coud mean access to the service may become difficult for those patients.	Negative	3	3	9	Hospital transport can be arranged, but this is often unreliable for timings, and not all patients may be eligible for this service. Apparently there are discussion being had about how transport between the hospitals can be improved. National guidance for eligiblity for non-emergency patient transport services (PTS). These services provide free transport to and from hospital for: *people whose condition means they need additional medical support during their journey *people who find it difficult to walk *parents or guardians of children who are being transported This should mean a number of our patients would be eligible for this transport.	3	2	6
Inequalities of Care	The centralisation of the service may impact on those who are elderly, have a disability or who are geographically isolated, as well as those living in poverty, as having the service on one site may make it difficult for them to get to Lincoln hospital from outlying areas of the county.	Negative	4	3	12	Hospital transport can be arranged, but this is often unreliable for timings, and not all patients may be eligible for this service. Another mitigation is the majority of nuclear medicine tests are stand alone studies so the patient would not be expected to attend numerous times for their study so they might attend once in their lifetime.	4	2	8
Staff Impact	There is a risk that the staff currently based at Grantham or Pilgrim (both clinical and admin) will not want to relocate their base to Lincoln. It could be due to increased travel time, increased expense, or it creating a longer working day. The consequence is that we may have staff retention issues.	Negative	4	4	16	The negative change of base will only affect 3 staff out of 20 so the number are small (2 of these will be able to retire in the next 4 years). It is likely 3 staff will be redeployed to the same. Staff expense payment will need to be discussed and funded, and the working hours of the affected staff members will need addressing via a consultation.	4	3	12

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score
Staff Experience	Training will be easier by centralising as the work can be split between the staff and the onus is less on a few staff. This could reduce stress on those conducting the training, and could lead to increased staff satisfaction and development. Staff will be using more up to date equipment, which may improve staff satisfaction. The opportunities for role extension and learning new skills (such as cardiac stressing, radiophramacy manufacture and therapies) is greater at Lincoln than the other sites. In addition there would be more peer to peer support which is very important with junior staff. Currently the team at Pilgrim is quite small and there is other peers to discuss concerns with. However, the above points may be partly negated by the dissatisfaction from staff due to the change of base (number dissatisfied likely to be 3 (2 who are due to retire in the next 4 years). The other member who may be upset has only been in the UK for 1 year.	Positive				staff consulation will take place and individual interviews with all staff affected. The negative change of base will only affect 3 staff out of 20 so the number are small (2 of these will be able to retire in the next 4 years). It is likely 3 staff will be redeployed to the same site.			
Targets/Performance	Generally test turnaround and optimisation of the service should be improved by centralisation. There should also be more scope for research and development.	Positive							
Equality & Diversity	The centralisation of the service may impact on those who are elderly, have a disability or who are geographically isolated, as well as those living in poverty, as having the service on one site may make it difficult for them to get to Lincoln hospital from outlying areas of the county.	Negative	4	4	16	Hospital transport can be arranged, but this is often unreliable for timings, and would not be a desireable choice for some patients. Another mitigation is the majority of nuclear medicine tests are stand alone studies so the patient would not be expected to attend numerous times for their study so they might attend once in their lifetime.	3	2	6
Free text …	You can also input your own theme with descriptions if something else should be included.								

Equality and Health Inequality Impact Assessment Tool

This tool has been developed by the Equality, Diversity and Inclusion Leads for use in the NHS Provider organisations in Lincolnshire. The tool is designed to ensure due regard is demonstrated to the Equality Act 2010, the Public Sector Equality Duty and potential health inequalities are also identified and addressed (as outlined in the Health and Social Care Act). Please complete all sections below. Instructions are in italics. Email for all correspondence: email to ***alison.marriott@ulh.nhs.uk***

A. Service or Workforce Details	
1. Description of activity	Nuclear Medicine Diagnostic and therapeutic service in ULHT.
2. Type of change	Discontinue at Grantham and Pilgrim Hospital, consolidate service at Lincoln County Hospital (3 sites to 1)
3. Form completed by	Laura White
4. Date decision discussed and agreed	*To be completed please*
5. Who is this likely to affect?	Patients and staff in the Boston and Grantham area.

B. Equality Impact Assessment	
Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty / deprivation, geographically isolated (e.g. rural), carers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g. sex workers), use substances etc. *Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality (e.g. it is recognised that older men from a BAME background, with one or more comorbidities and living in deprivation are more at risk of a poorer outcome if they contract CV-19).*	
1. How does this activity / decision impact on protected or vulnerable groups? (e. g. their ability to access services / employment and understand any changes?) **Please ensure you capture expected positive and negative impacts.**	**Summary** The option of moving the service from 3 sites to 1 will negatively impact on older people, those who have a disability, those who are geographically isolated, as well as those living in poverty, and also households without access to a vehicle. It may impact lower-income households including those with children. Having the service on only one site and ceasing provision at Grantham & District Hospital and Pilgrim Hospital Boston will make it more difficult for a large proportion of the Lincolnshire population to access this service (please see population figures below), including those in the East of the county who are most geographically-isolated from health services. This option would potentially have a significant negative impact for anyone with these protected characteristics, by reducing access to this service and adding barriers to their ability to benefit from these treatments, with potential implications for their health outcomes (including cancer) and for health equality in Lincolnshire. **Lincolnshire Population Total: 766,333** • Boston 70,837 • East Lindsey 142,030 • Lincoln 100,049 • North Kesteven 118,149 • South Holland 95,857 • South Kesteven 143,225 • West Lindsey 96,186 **Sources: ONS 2020 Mid Year Population Estimates/GP Registrations October 2021 (NHS Digital) - Lincolnshire Research Observatory: https://www.research-lincs.org.uk/Population.aspx** In addition, there may be an impact on those attending PHB for breast surgery which requires an SLN injection. The injection is required either on the day of surgery, or the day before surgery. At the moment the surgery is on a Monday and a Thursday. Injection the day before can be accommodated on a Thursday, but not on a Monday (the nuclear medicine service operates from Monday to Friday due to the number of people required within radiopharmacy to make the radiopharmaceuticals). Again the impact is on those who are elderly, disabled, geographically isolated or living in poverty, as two journeys to different hospitals may be difficult. It would also create a negative impact on carers and families with children. Agreement would be required from the Breast Team to change the day of surgery from Monday to ensure the injection could happen the day before. For all patients, reducing the service to one site would mean that the service would be more robust, specifically less-vulnerable to short notice cancellations due to staff being ill or cameras having faults due to them being aged. Reducing the service to one site would also mean that the Trust could purchase more up-to-date, reliable gamma cameras as equipment would only need to be replaced at one site.

2. What data has been/ do you need to consider as part of this assessment? What is this showing/ telling you?	*Lincolnshire Research Observatory, Population, https://www.research-lincs.org.uk/Population.aspx and ONS Population Projections 2018.* *The number of patients requiring the service tells us that the number of patients that may be affected by the surgery would be 63 patients a year (using 2019 data). This would be very dependent on surgical requirement.*

C. Risks and Mitigations	
1. What actions can be taken to reduce / mitigate any negative impacts? (If none, please state.)	Patients and Service Users - For all groups: •Transport is available for those who qualify due to age or medical condition from TASL. There are also 'Call Connect' services which can link those in rural areas to towns which have better connections with Lincoln and Boston. • Review of qualifying circumstances for help with increased costs to patients through the proposed changes, as a wider group of people may now be affected. • Review hospital transport policy for people impacted by the service changes, particularly those unable to arrange their own transport. • Proactive promotion of the Patient Support Service (led by Patient Experience Team) for people impacted by the service change. • Enhanced communication through the NHS Lincolnshire system in relation to the changes, with particular focus on accessible communication for vulnerable groups. • Enhanced focus on designing an inclusive pathway to ensure all groups are welcomed and supported according to their needs. For example, accessible communication for patients throughout the pathway,welcoming LGBTQ+ people & building trust, supporting carers throughout the pathway, meeting the needs of older, frailer patients, and mitigating geographical isolation and transport difficulties by scheduling appointments for these patients at the best possible time for them, whilst recognising that many patients may travel a fair distance to access the services anyway as the catchment area for Lincoln Hospital & Pilgrim Hospital is geographically-dispersed anyway. •In addition there is scope to inject patients on Monday at 9 am in Lincoln and then for them to travel to Pilgrim for their surgery. The injection would not arrive in Pilgrim on Mondays until 10:30 usually anyway. Hospital transport would need to be provided for these patients, which would affect less than 5 patients a month. Often breast surgeries are performed at different sites depending on their complexity, not the patient's geographical location. •In addition we would need to support patients who would be travelling further from their local hospital and their access to transport solutions to travel to Lincoln for their studies. Staff - For all groups:
2. What data / information do you have to monitor the impact of the decision?	Patients and Service Users: • Monitor the number of patients and service users who are going out of county to access these services • Monitor Datix reports • Monitoring of the number of patients who are unable to travel to Lincoln or Boston due to barriers relating to any of the protected characteristics or health inequality groups. Staff: Whilst there is no negative impact envisaged for staff, the following data should also be monitored for any impact • ESR data including leavers • Employee relations data • Staff Survey data (longer term) and recruitment data (improvements in ability to recruit under the new model, or decline)

D. Decision/ Accountable Persons	
1. Agreement to proceed?	Yes / No *Delete as appropriate and add detail or rationale.*
2. Any further actions required?	*eg. risk to be added to the risk register or capturing in local action log etc*
3. Name and job title accountable decision makers	
4. Date of decision	
5. Date for review	*Please note: the equality impact assessment is a 'live' document and must be reviewed regularly / when any significant change occurs.*

Purpose of the Equality and Health Inequality Assessment tool

• The NHS in Lincolnshire has a legal duties under the Equality Act 2010, Public Sector Equality Duty 2011 and the Health and Social Care Act 2012 to demonstrate due regard in all decision making, for example, when making changes to services or workforce practices, to ensure access to services and workforce opportunities are equitable and to avoid harm and eliminate discrimination for each of the protected characteristics and other groups at risk of inequality.
• Within the guidance toolkit there are also some examples of decisions this tool has been used on in other organisations and the impacts they have identified.

Checklist	
Is the purpose of the policy change/decision clearly set out?	
Have those affected by the policy/decision been involved?	
Have potential positive and negative impacts been identified?	
Are there plans to alleviate any negative impact?	
Are there plans to monitor the actual impact of the proposal?	

Scoring Guide for Quality Impact and Risk Assessments

	Severity Score & Descriptor (with examples)				
Risk type	**1** **Very low risk** **(1-3)** (minimal chance)	**2** **Low risk** **(4-6)** (<1% chance)	**3** **Moderate risk** **(8-10)** (1-10% chance)	**4** **High risk** **(12-16)** (10-50% chance)	**5** **Very high risk** **(20-25)** (>50% chance)
Harm (physical or psychological)	Extremely unlikely to result in severe harm to multiple individuals.	Unlikely to result in severe harm to multiple individuals.	Reasonably likely to result in severe harm to multiple individuals.	Quite likely to result in severe harm to multiple individuals.	Extremely likely to result in severe harm to multiple individuals.
Service disruption	Unlikely to result in noticeable disruption to any services.	Likely to result in noticeable disruption to one or more services.	Reasonably likely to result in temporary, unplanned closure of one or more services.	Quite likely to result in extended, unplanned closure of multiple services.	Extremely likely to result in closure of one or more hospitals.
Compliance & reputation	Unlikely to result in complaints or concerns raised.	Unlikely to result in multiple complaints, serious concerns or adverse media attention.	Reasonably likely to result in multiple complaints, serious concerns or adverse media attention.	Quite likely to result in a large number of complaints, serious concerns raised and sustained adverse media attention.	Extremely likely to result in a loss of public, commissioner and / or regulator confidence.
Finances	Unlikely to result in noticeable adverse financial impact.	Unlikely to result in significant adverse financial impact.	Reasonably likely to result in Significant adverse financial impact.	Quite likely to affect the ability of the Trust to achieve its annual financial control total.	Extremely likely to affect the long-term financial sustainability of the Trust.

Likelihood Score & Descriptor (with examples)				
1 **Extremely Unlikely**	**2** **Quite Unlikely**	**3** **Reasonably Likely**	**4** **Quite Likely**	**5** **Extremely Likely**

Unlikely to happen except in very rare circumstances. Less than 1:1,000 (<0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1:1,000 & 1:100 (0.1-1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1:100 and 1:10 (1-10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1:10 & 1:2 (10-50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1:2 (>50% probability). Evidence of substantial threats with significant gaps in control.

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Date discussed at Panel	Panel attendees	Approved/ Rejected
11/05/2022	Colin Farquharson Karen Dunderdale Kathryn Helley Louise Hobson Kevin Johnson Sarah Careless Laura White	Approved

Actions Required	Review required? Y/N
Comprehensive QIA agreed by panel.	No

Date of next review

Quality Impact Assessment

QIA URN: Title	QIA2022-137 : Restructure of Nuclear Medicine to be delivered from Lincoln and Boston		
Scheme Overview	*Rationalising the staff and services of Nuclear Medicine on 2 sites reducing the equipment and facilities required and the footprint of the service. It will also reduce the amount of duplication of work on 3 sites.*		
Quality Impact Overview	*There will be an improvement in the robustness of the service with regards to staffing and equpiment. There would be a requirement for a new department in PHB as the current department is being removed due to the A&E project. The reduction in the duplication of work would mean that the audit process could be more robust. In addition the likelihood of short notice cancellation of patients would be reduced. There would be adverse affects on patient experience, staff experience, and public image due to the closing of Grantham's department.*		
Quality Indicators			
Project Manager (Lead)	Laura White	**Directorate/Division/Department**	CSS / Diagnostics
Senior Responsible Officer	Yavenushca Lalloo	**QIA Completed By**	Laura White
Financial Value	The NET savings …	**Overall Risk Score**	12

Approved by Director of Nursing		**Date**	
Approved by Medical Director		**Date**	

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score
Patient Safety	*Rationalising the service at 2 site will increase the patient safety as there will be more staff to ensure patients who experience adverse events when in our department can be properly monitored while the service contines for other service users.* *There will be more capacity for training and monitoring.* *In addition a lot of work would need to be put and cost to make the Pilgrim site ISO9001:2015 accredited.* *With 2 site model there would be a need to appoint more Medical Physics experts as the current ask from the CQC is based on a single site model. This is a risk as we have historically struggled to recruit these posts.*	Negative	3	3	9	No mitigations put forward for the shortage of Medical Physics experts	3	3	9
Public Image	Rationalising in Lincoln and Boston would be have an adverse impact on public image as services would be moved from Grantham, which could be perceived as a reduction in the service provided by ULHT - especially at Grantham who have some recent history of losing services.	Negative	5	4	20	Ensure proper public consultation is undertaken outlining the benefits of centralisation. Communications to detail that centralisation will improve the quality and safety of the service due to consolidation of the available skilled staff, and the addition of up to date equipment.	3	4	12

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score
Clinical Outcomes	Rationalising in Lincoln and Boston is unlikely to make much impact on the clinical outcomes	Neutral							
Clinical Effectiveness	Currently certain workforce groups, such as the Medical Physics Experts, are understaffed compared to what would be expected by the CQC and IRMER. This would be addressed to some degree by reducing the number of sites served and equipment within the service. In addition the batch booking of studies would be improved by 2 sites instead of 3 sites.	Positive							
Patient Experience	Requirement for patients to travel for their scans leading to inconvenience to patients and could lead to some patients going out of county for the tests or not having the test. Where there is the (infrequent) need to scan an inpatient at Grantham, that patient will need transferring to Lincoln Hospital, and possibly require admitting to Lincoln	Negative	4	3	12	Rationalising in Lincoln and Boston means the number of patients affected would be the smallest. In addition patients currently travel now. Surveys have shown that the patients who do attend all 3 sites are happy with the overall service they get there.	3	3	9
Patient Pathways	One service that would be impacted is breast surgery where the patient received an injection before their surgery. 95% of surgeries are performed at Pilgrim and Lincoln, so the number affected by needing to travel would be very small.	Negative	4	3	12	The majority of patients have surgery at Lincoln so the number affected would be small. In addition there would be discussions with the surgical team about other possible pathways for the injection and what their plans are for the service as a whole (ie. changing the day of Surgery from a Monday) In addition the changing diagnostic pathway means that some of the tests currently performed by nuclear medicine will be replaced by other techniques. For e.g. magnetic tracers for Sentinel breast surgeries and PET/CT for some cardiac scans.	4	2	8
Accessibility	A number of patients will be required to travel to Lincoln from Grantham for their procedures (25% of ULHT procedures are conducted at Grantham so about 800 patients). As the majority of those patients are over 50, and many are older with other long term conditions - this coud mean access to the service may become difficult for those patients.	Negative	3	3	9	Hospital transport can be arranged, but this is often unreliable for timings, and not all patients may be eligible for this service. Apparently there are discussion being had about how transport between the hospitals can be improved. National guidance for eligiblity for non-emergency patient transport services (PTS). These services provide free transport to and from hospital for: *people whose condition means they need additional medical support during their journey *people who find it difficult to walk *parents or guardians of children who are being transported This should mean a number of our patients would be eligible for this transport.	3	2	6

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score
Inequalities of Care	Rationalising in Lincoln and Boston may impact on those who are elderly, have a disability or who are geographically isolated, as well as those living in poverty, as having the service on one site may make it difficult for them to get to Lincoln hospital from outlying areas of the county. 25% of current procedures are done at Grantham.	Negative	4	3	12	Hospital transport can be arranged, but this is often unreliable for timings, and not all patients may be eligible for this service. Another mitigation is the majority of nuclear medicine tests are stand alone studies so the patient would not be expected to attend numerous times for their study so they might attend once in their lifetime.	4	2	8
Staff Impact	There is a risk that the staff currently based at Grantham (currently 2 staff members) will not want to relocate their base to Lincoln or Pilgrim. It could be due to increased travel time, increased expense, or it creating a longer working day. The consequence is that we may have staff retention issues in a staff group that is hard to recruit to.	Negative	4	4	16	Staff expense payment will need to be discussed and funded, and the working hours of the affected staff members will need addressing via a consultation. One staff member is currently working in Lincoln anyway so it would only affect 1 staff member	4	2	8
Staff Experience	Training at Pilgrim will be hard and staff at Lincoln will not have much access to the new equiment. This could lead to some dissatisfaction around equity of training and development, as well as the dissatisfaction from staff due to the change of base.	Negative	3	3	9	No mitigation has been put forward for the possible dissatisfaction from a change of base for staff. One staff member is currently working in Lincoln anyway so it would only affect 1 staff member.	3	3	9
Targets/Performance	Generally test turnaround and optimisation of the service should be improved slightly by rationalising to 2 sites.	Positive							
Equality & Diversity	The centralisation of the service may impact on those who are elderly, have a disability or who are geographically isolated, as well as those living in poverty, as having the service on one site may make it difficult for them to get to Lincoln or Pilgrim hospital from outlying areas of the county.	Negative	4	4	16	Hospital transport can be arranged, but this is often unreliable for timings, and would not be a desireable choice for some patients. Another mitigation is the majority of nuclear medicine tests are stand alone studies so the patient would not be expected to attend numerous times for their study so they might attend once in their lifetime.	3	2	6
Free text …									

Equality and Health Inequality Impact Assessment Tool

This tool has been developed by the Equality, Diversity and Inclusion Leads for use in the NHS Provider organisations in Lincolnshire. The tool is designed to ensure due regard is demonstrated to the Equality Act 2010, the Public Sector Equality Duty and potential health inequalities are also identified and addressed (as outlined in the Health and Social Care Act). Please complete all sections below. Instructions are in italics. Email for all correspondence: email to ***alison.marriott@ulh.nhs.uk***

A. Service or Workforce Details	
1. Description of activity	Nuclear Medicine Diagnostic and therapeutic service in ULHT.
2. Type of change	Rationalisation of the service to Pilgrim and Lincoln.
3. Form completed by	Laura White
4. Date decision discussed and agreed	*To be completed please*
5. Who is this likely to affect?	Patients and staff in the Grantham & District area.

B. Equality Impact Assessment

Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty / deprivation, geographically isolated (e.g. rural), carers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g. sex workers), use substances etc.
Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality (e.g. it is recognised that older men from a BAME background, with one or more comorbidities and living in deprivation are more at risk of a poorer outcome if they contract CV-19).

1. How does this activity / decision impact on protected or vulnerable groups? (e. g. their ability to access services / employment and understand any changes?) **Please ensure you capture expected positive and negative impacts.**	**Summary** The option of moving the service from 3 sites to 2 sites may negatively impact on those who are elderly, have a disability or who are geographically isolated, as well as those living in poverty, and households without access to a vehicle. It may impact lower-income households including those with children. Having the service on only two sites and ceasing provision at Grantham & District Hospital may make it difficult for them to get to Lincoln or Pilgrim hospital from the Grantham and District area. This would potentially have a negative impact for anyone with these protected characteristics, in reducing access to the service, with potential implications for their health outcomes (including cancer) and for health equality in Lincolnshire. **Lincolnshire Population Total: 766,333** • Boston 70,837 • East Lindsey 142,030 • Lincoln 100,049 • North Kesteven 118,149 • South Holland 95,857 • South Kesteven 143,225 • West Lindsey 96,186 **Sources: ONS 2020 Mid Year Population Estimates/GP Registrations October 2021 (NHS Digital) - Lincolnshire Research Observatory: https://www.research-lincs.org.uk/Population.aspx** For staff, providing services across 2 sites rather than 3 is anticipated to have a positive or neutral impact as the requirement to travel to Grantham to support a service there would cease. *Please add in here any feedback from staff consultation* **Patients & Service Users** Age: • Lincolnshire has a higher population of people over 65 years of age compared with the rest of the UK (Census 2011: UK 16%; Lincolnshire 21%). This is expected to grow over the next 25 years (Source: ONS Population Projections 2018) • Older people might have additional challenges in relation to transport, if elective surgery is moved away from their local hospital. Public transport from Grantham to Lincoln and Boston is poor, with railway stations distant from the hospitals, also main bus interchanges are distant from the hospitals. Older people may also find using public transport more challenging from a mobility and frailty perspective. • People of other age groups will face additional challenges and negative impacts in accessing services, for example people who need to arrange childcare to be able to attend a more distant site will be impacted with increased childcare costs, those of working age on zero hours contracts may need to take more time off work to travel further, losing more income. Disability: • People with cancer and potentially other co-existing long-term conditions are likely to be disabled under the Equality Act 2010. • The communication needs of people with sensory impairments (hearing loss, sight loss for example) need to be assured in relation to accessing the service on a site which may be unfamiliar or
2. What data has been/ do you need to consider as part of this assessment? What is this showing/ telling you?	*Lincolnshire Research Observatory, Population, based on ONS population projections 2018 https://www.research-lincs.org.uk/Population.aspx* *The number of patients requiring the service tells us that the number of patients that may be affected by the surgery would be 63 patients a year (using 2019 data). This would be very dependent on surgical requirement. In addition there is scope to inject patients on Monday at 9 am in Lincoln and then for them to travel to Pilgrim for their surgery. The injection would not arrive in Pilgrim on Mondays until 10:30 usually anyway. Hospital transport would need to be provided for these patients, which would affect less than 5 patients a month. Often breast surgeries are performed at different sites depending on their complexity, not the patient's geographical location.* *In addition we would need to look at the characteristics of the patients that would be travelling further from their local hospital and their access to transport solutions to travel to Lincoln for their studies.*

C. Risks and Mitigations

1. What actions can be taken to reduce / mitigate any negative impacts? (If none, please state.)	Patients and Service Users - For all groups: Transport is available for those who qualify due to age or medical condition from TASL. There are also 'Call Connect' services which can link those in rural areas to towns which have better connections with Lincoln and Boston. • Review of qualifying circumstances for help with increased costs to patients through the proposed changes, as a wider group of people may now be affected. • Review hospital transport policy for people impacted by the service changes, particularly those unable to arrange their own transport. • Proactive promotion of the Patient Support Service (led by Patient Experience Team) for people impacted by the service change. • Enhanced communication through the NHS Lincolnshire system in relation to the changes, with particular focus on accessible communication for vulnerable groups. • Enhanced focus on designing an inclusive pathway to ensure all groups are welcomed and supported according to their needs. For example, accessible communication for patients throughout the pathway,welcoming LGBTQ+ people & building trust, supporting carers throughout the pathway, meeting the needs of older, frailer patients, and mitigating geographical isolation and transport difficulties by scheduling appointments for these patients at the best possible time for them, whilst recognising that many patients may travel a fair distance to access the services anyway as the catchment area for Lincoln Hospital & Pilgrim Hospital is geographically-dispersed anyway. Staff - For all groups: • Effective use of Risk Assessment for staff potentially impacted by change, if any negative impact is identified during consultation. • Effective and consistent implementation of the Trust's Management of Change Policy, if this is identified as necessary following consultation. • Effective engagement with Staff-side.
2. What data / information do you have to monitor the impact of the decision?	Patients and Service Users: • Monitor the number of patients and service users who are going out of county to access these services • Monitor Datix reports • Monitoring of the number of patients who are unable to travel to Lincoln or Boston due to barriers relating to any of the protected characteristics or health inequality groups. Staff: Whilst there is no negative impact envisaged for staff, the following data should also be monitored for any impact • ESR data including leavers • Employee relations data • Staff Survey data (longer term) and recruitment data (improvements in ability to recruit under the new model, or decline)

D. Decision/ Accountable Persons	
1. Agreement to proceed?	Yes / No *Delete as appropriate and add detail or rationale.*
2. Any further actions required?	*eg. risk to be added to the risk register or capturing in local action log etc*
3. Name and job title accountable decision makers	
4. Date of decision	
5. Date for review	*Please note: the equality impact assessment is a 'live' document and must be reviewed regularly / when any significant change occurs.*

Purpose of the Equality and Health Inequality Assessment tool

• The NHS in Lincolnshire has a legal duties under the Equality Act 2010, Public Sector Equality Duty 2011 and the Health and Social Care Act 2012 to demonstrate due regard in all decision making, for example, when making changes to services or workforce practices, to ensure access to services and workforce opportunities are equitable and to avoid harm and eliminate discrimination for each of the protected characteristics and other groups at risk of inequality.
• Within the guidance toolkit there are also some examples of decisions this tool has been used on in other organisations and the impacts they have identified.

Checklist	
Is the purpose of the policy change/decision clearly set out?	
Have those affected by the policy/decision been involved?	
Have potential positive and negative impacts been identified?	
Are there plans to alleviate any negative impact?	
Are there plans to monitor the actual impact of the proposal?	

Scoring Guide for Quality Impact and Risk Assessments

	Severity Score & Descriptor (with		
Risk type	**1** **Very low risk** **(1-3)** (minimal chance)	**2** **Low risk** **(4-6)** (<1% chance)	**3** **Moderate risk** **(8-10)** (1-10% chance)
Harm (physical or psychological)	Extremely unlikely to result in severe harm to multiple individuals.	Unlikely to result in severe harm to multiple individuals.	Reasonably likely to result in severe harm to multiple individuals.
Service disruption	Unlikely to result in noticeable disruption to any services.	Likely to result in noticeable disruption to one or more services.	Reasonably likely to result in temporary, unplanned closure of one or more services.
Compliance & reputation	Unlikely to result in complaints or concerns raised.	Unlikely to result in multiple complaints, serious concerns or adverse media attention.	Reasonably likely to result in multiple complaints, serious concerns or adverse media attention.
Finances	Unlikely to result in noticeable adverse financial impact.	Unlikely to result in significant adverse financial impact.	Reasonably likely to result in Significant adverse financial impact.

Likelihood Score & Descriptor (with examples)			
1 **Extremely Unlikely**	**2** **Quite Unlikely**	**3** **Reasonably Likely**	**4** **Quite Likely**
Unlikely to happen except in very rare circumstances. Less than 1:1,000 (<0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1:1,000 & 1:100 (0.1-1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1:100 and 1:10 (1-10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1:10 & 1:2 (10-50% probability). Evidence of substantial threats with some gaps in control.

examples)	
4 **High risk** **(12-16)** (10-50% chance)	**5** **Very high risk** **(20-25)** (>50% chance)
Quite likely to result in severe harm to multiple individuals.	Extremely likely to result in severe harm to multiple individuals.
Quite likely to result in extended, unplanned closure of multiple services.	Extremely likely to result in closure of one or more hospitals.
Quite likely to result in a large number of complaints, serious concerns raised and sustained adverse media attention.	Extremely likely to result in a loss of public, commissioner and / or regulator confidence.
Quite likely to affect the ability of the Trust to achieve its annual financial control total.	Extremely likely to affect the long-term financial sustainability of the Trust.

5 **Extremely Likely**
More likely to happen than not. Greater than 1:2 (>50% probability). Evidence of substantial threats with significant gaps in control.

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Date discussed at Panel	Panel attendees	Approved/ Rejected
11/05/2022	Colin Farquharson Karen Dunderdale Kathryn Helley Louise Hobson Kevin Johnson Sarah Careless Laura White	Approved

Actions Required	Review required? Y/N
Comprehensive QIA agreed by panel.	No

Date of next review

NHS
United Lincolnshire Hospitals
NHS Trust

The future of nuclear medicine in Lincolnshire's hospitals

Public consultation document

OUTSTANDING CARE *personally* DELIVERED

Contents

What is nuclear medicine?

Nuclear medicine is a specialist imaging technique involving the administration of radioactive substances (called radiopharmaceuticals) in the diagnosis and treatment of disease. The technique enables assessment of the function of organs, whereas most conventional imaging modalities (e.g. X-ray) look at anatomy.

The majority of radiopharmaceuticals used for these tests are made daily in an aseptic facility known as a radiopharmacy.

There are over 20 different tests that nuclear medicine can perform and they look at conditions as diverse as Parkinson's disease to delayed gastric emptying. In United Lincolnshire Hospitals NHS Trust (ULHT) hospitals, the most common tests performed are bone scans and heart scans.

After administration of the radiopharmaceutical, patients must wait for a time for the radiopharmaceutical to distribute in their bodies before the images are then taken on a specialist camera called a gamma camera. This camera detects the radiation emitted from the patient to enable the organ of interest to be investigated. A gamma camera is similar in size to a CT scanner.

Due to the fact nuclear medicine involves radiation, the technique is highly regulated and all staff have to undergo extensive specialist training. This is to ensure the risk to the patient from the radiation is outweighed by the benefits of having the procedure.

In addition, a clinician is required to oversee the service and hold an ARSAC (Administration of radioactive substances advisory committee) licence (Practitioner Licence). This licence lists the different diagnostic tests that can be performed under the Practitioner. Only tests that the clinician has proven training and experience in are listed on this licence to ensure the test is diagnostic and the impact on the patient management is optimised. Each site also has an ARSAC licence which requires a Medical Physics Expert (MPE) to oversee the service at that site (site licence), this also lists the tests that can be performed at that site.

Background to the nuclear medicine service at ULHT

Nuclear medicine services are provided at Grantham and District Hospital, Lincoln County Hospital and Pilgrim Hospital, Boston. The imaging is performed at all three sites, using five gamma cameras.

There is also a relatively new £1 million radiopharmacy that produces the radiopharmaceuticals, based at Lincoln County Hospital. This radiopharmacy also provides radiopharmaceuticals for Grantham and Pilgrim hospitals, which are transported there on a daily basis.

The tables below show the current configuration of the nuclear medicine service in ULHT and the number of studies that are performed:

Current configuration of the service			
Sites	**Lincoln**	**Grantham**	**Pilgrim**
Number of gamma cameras	2	1	2
Age of cameras (years)	10,12	16	11,11
Annual Number of patients (2019-2020)*	1771	680	792
Annual number of studies*	2114	886	955
Radiopharmacy on site (needed daily to produce drugs for the scan)	Yes (installed 2019)	No (from LCH)	No (from LCH)

* N.B. Patient numbers are different to number of studies as some tests require two visits

The below tables show staffing and the geographical demand on the service:

Base of current staffing (Whole time equivalents WTE)			
Sites	**Lincoln**	**Grantham**	**Boston**
Technologists	5.65	1.6	2.8
Clinical Scientists Provide support for the 3 sites.	2.8 (1.0 WTE Medical Physics expert)	0	0
Clinical imaging assistants	1.8 (also helps admin)+ 1 apprentice	1 currently vacant	0
Nurses	2.0	0	1.0
Admin	0.8	0	1.06
Total	**14.05**	**2.6**	**4.86**

This table shows the postcodes of patients who use the nuclear medicine service.

Geographical patient demand for nuclear medicine				
Postcode	**LN**	**NG**	**PH**	**Other**
Patients	1540	685	894	124
Percentage	47%	21%	28%	4%

Challenges faced by nuclear medicine nationally

Due to the fact, that nuclear medicine is a very specialist service, there are a number of challenges it faces nationally, in particular with workforce. The following table shows some of these challenges.

Challenge	**Mitigations**
Shortage of trained Clinical Technologists since the end of the national training program (on Governmental Migration Advisor list).	Apprenticeship scheme, but this requires individual departments finding the wage for the trainee. Each apprenticeship course is three years long.
Shortage of ARSAC Practitioners, in addition to a national shortage of radiologists.	None, in fact it is getting harder to get these licences.
Shortage of trained Medical Physics Experts. (takes approximately 10 years to become a consultant Clinical Scientist).*	None.
Aged equipment with a requirement to replace 211 gamma cameras nationally in the next five years.**	None.
Problems with supply of radiopharmaceuticals and isotopes.	Companies supplying the material have altered their process of delivery with additional cost to the company.

(*British Nuclear Medicine Society (BNMS) Scientific Support for Nuclear Medicine guidance 2016)

(** Diagnostics: Recovery and Renewal paper Oct 2020 NHSE)

Challenges faced by the nuclear medicine service in Lincolnshire

When we look at the service in ULHT the challenges mirror those seen nationally:

Shortage of technologists: Lincolnshire has struggled to recruit and retain clinical technologists over the last five years, as can be seen in the table below. This has been impacted further by the national training scheme for nuclear medicine clinical technologists ceasing, meaning there is now a national shortage of trained specialists in the country. Attempts to recruit abroad have been protracted and unsuccessful in a couple of instances.

Sites	LCH	GDH	PHB
Technologists in post (WTE).	5.65*	2.6**	2.8
Number of staff that have left in the last 5 years.	3	4	3
Long standing staff >10 years	3	1.53	1
<5 years of retirement (60 years)	1	1	1

**runs the radiopharmacy (2 tech staff daily) and the imaging of the service.*

*** 1 of these posts converted to an apprentice to try to "grow our own" technologists.*

Shortage of ARSAC Practitioners: We have two part time radiologists in Lincolnshire who hold an ARSAC licence (full list of all tests performed in ULHT) and one full time radiologist with a licence (limited list of tests permitted). Due to the fact that one of the radiologists doesn't have a full licence, to access some tests patients must currently travel to a different site to their local hospital.

Shortage of trained Medical Physics Experts (MPE): Lincolnshire nuclear medicine service has 1.0 WTE Clinical Scientists who can act as MPEs (two staff members who also have other duties). There is a legal requirement to have a specific number of MPEs in every service where radiation is utilised. The ideal number is based on a number of factors including the number of investigations and cameras. Using European and national guidance of how many MPEs the department

should ideally have, we should have 2.44 WTE to be a well-led, progressive department.

Workload of service: Lincolnshire workload demand has been static in the last five years, but the mix of tests performed have altered. The workload demand is only enough for three cameras within the county, however there are currently five.

Aged gamma cameras: The five gamma cameras in Lincolnshire are all over 10 years old, which is the age where consideration of replacement is needed (Diagnostics: Recovery and Renewal paper Oct 2020 NHSE). The oldest camera is 16 years old (currently at Grantham).

Impact of other services: The development of the new Emergency Department at Pilgrim hospital will require the redevelopment of the building that currently houses the nuclear medicine department, and a new area will need to be identified and developed for the nuclear medicine service.

Case for change

Given the challenges faced by the Lincolnshire nuclear medicine service, it is important that we consider changing how we deliver the service to secure it for the patients of Lincolnshire for the future.

At present, the staff and services are spread thinly, meaning that even low levels of staff absence impacts on the amount of work the service can perform.

Delivering the service across three sites means that some staff do not get experience of the variety of studies/techniques performed (as not all the sites have a licence to perform all the tests/treatments). In addition, the junior staff at the smaller sites currently do not have much peer support, which means there is less opportunity for them to be involved in development and to raise suggestions for improvements of the service.

The lack of Medical Physics Experts (MPE) within the county means that optimisation of the service and the ability to introduce new services into the county is limited, as they must repeat work on three sites. This also affects the amount of audit and governance that can be performed.

The fact that all the gamma cameras in Lincolnshire are over 10 years old means they are prone to be unreliable and require repair, causing cancellation of patient studies and a potential waste of radiopharmaceuticals. Due to the fact all these

pieces of equipment are old the replacement parts and expert engineers are getting harder to obtain, and two of the five systems have been served/due to be served end of life notices, meaning if they break repairs may not be possible. This means the services provided become vulnerable with potential long downtimes for some of the cameras.

At present, the utilisation of the equipment is not optimised. The British Nuclear Medicine Society (BNMS) guidance is that it would be appropriate to perform approximately 1500 scans on each gamma camera. This means that, according to our level of demand, Lincolnshire should have three gamma cameras, whereas there are currently five.

Patient experience

The nuclear medicine service carries out a patient experience survey every two years, to help understand patient opinions for the service and where improvements can be made.

Results of these surveys from 2020 and 2018 show that, at present, patients are overwhelmingly complimentary about the service that they receive.

In the most recent survey (2020) the service performed exceptionally well in terms of patients being seen quickly (the majority within a month of referral), staff being polite, helpful and reassuring and cleanliness and the quality of the waiting areas.

Overall, all patients surveyed would recommend the service to their friends or family. It showed that patients are satisfied with the service that they receive in the nuclear medicine department at present in all aspects.

Options appraisal

We believe that the safest way to provide a sustainable, long-term service to the patients of Lincolnshire is to reduce the number of sites that the nuclear medicine service is provided from. This will reduce the redundancy of equipment and create a greater capacity to replace aged equipment.

As mentioned before, the patient demand and the centralised radiopharmacy at Lincoln means there would be no real option to close the service from this site. We recommend that Lincoln remains as either the single site providing nuclear medicine, or operating alongside a second site in the county.

A full options appraisal has been performed to determine the preferred site(s) for the centralisation of the nuclear medicine service in Lincolnshire, taking into account a range of factors including input from the ULHT Patient Panel, as described below.

Below you can see the options that were reviewed. Closing Lincoln was not considered as an option, as the radiopharmacy has recently been built there and this cannot be moved.

	Option
1	Centralise to Lincoln and Pilgrim
2	Centralise to Lincoln and Grantham
3	Centralise to just Lincoln
4	“Hub and spoke” with staff based at Lincoln and running a 2 day a week service at Pilgrim, and close Grantham
5	“Hub and spoke” with staff based at Lincoln and running a 2 day a week service at Grantham, and close Pilgrim
6	“Hub and spoke” with staff based at Lincoln and running a 2 day a week service at Grantham and 3 days a week at Pilgrim

A round table discussion was performed which included staff from nuclear medicine, the diagnostics lead and the Managing Director of the Clinical Support Services division. The weighting score that was used can be seen in the table below.

Factor	Weighting (%)
Patient Experience	25
Quality of Service	25
Robustness of Service	20
Cost/Efficiency	20
Long term Sustainability	10

The hub and spoke options scored highly on patient experience but were low scoring for all other factors. The option that gave the most robust (staff, equipment), efficient, service and ensure responsiveness for urgent patient requests was option three (centralise service at Lincoln).

Patient Panel involvement in developing proposed options for future service model

The ULHT Patient Panel met on Tuesday 19 October 2021 to discuss the challenges facing the nuclear medicine service, and were asked to consider a range of factors to help in determining the proposed options for the future of the service. These were:

- Best use of staff/ ability to develop staff
- Ease of access for patients
- Proximity to facilities and co-dependent services
- Most efficient use of equipment
- Risk of test cancellation
- Cost effectiveness
- Robustness of service

Overall, the panel accepted the need to change the service and consolidate it to fewer sites. There was largely an acceptance that Lincoln should be the main site for centralisation. Some had the view that there should be a second 'hub', with opinion split between whether this should be at Pilgrim or Grantham hospitals.

The overwhelming message from the Patient Panel was a request that the Trust take seriously the concern that patients may struggle to reach their appointments if the service was centralised, and an ask for mitigating actions to be put in place to improve access if the service were to be centralised.

Considering the second site

Below is a comprehensive appraisal of the options for a second site that would provide a service alongside Lincoln hospital, based on a range of factors. **Green** is defined as the optimum, or least disruptive option, with **red** being the least beneficial option.

Patient Experience:

- **Patient travel:** Having **Grantham** as the second site would mean 28% of patients would have to travel further for their tests, based on the postcodes of current referrals. If **Pilgrim** was the second site, 21% would need to travel further. However, both options would mean inconvenience for some patients and concern has been raised about difficulty with access to transport.

- **Test cancellation risk:** The radiopharmaceuticals are made in Lincoln daily. Having the second site at **Pilgrim** would have the highest risk of cancellation due to the poor transport infrastructure in Lincolnshire which can introduce delays. There is a risk that the service at **Grantham** would be affected, but this is smaller than at Pilgrim due to closer proximity to Lincoln.

- **Patient referral to report turnaround:** The radiopharmaceuticals have to be transported to the other sites after being made in Lincoln, meaning studies cannot start at **Pilgrim** or **Grantham** until typically 10.30am-11am. This means fewer tests can be carried out at the other sites per day. In addition, the radiopharmaceuticals decay by approximately 15% during the time it takes to

transport them. They typically expire eight hours post-production and can no longer be used. This impacts on Pilgrim more than Grantham as the travel time to Pilgrim is greater than to Grantham.

- **Patient test availability:** The number of tests available at **Grantham** is more than Pilgrim. The number of tests available at **Pilgrim** is reduced due to their limited licence, and a lot of work would need to be done to get the other tests added to the licence.

- **Therapies:** No therapies are performed at **Grantham,** but **Pilgrim** have a therapy service. If Grantham was the second site then all the therapy patients from Pilgrim would need to travel to Lincoln.

- **Clinical interdependency:** The majority of breast surgeries (59%) are carried out in Lincoln. The number of patients impacted would be lower if the second site was **Pilgrim** (33% of surgeries) compared to **Grantham** (8% of surgeries).

- **Inpatients:** The vast majority of nuclear medicine tests are performed as outpatient procedures. However, if performed as inpatients the most responsive site would be Lincoln as the radiopharmacy orders are more flexible and can be added later in the day, and if possible a second manufacture session can be undertaken to ensure patients have their test as soon as possible which would help with discharge. At the moment, **Grantham** and **Pilgrim** have to order preps the day before, so cannot always do same-day request to scan studies. However, the number of inpatients/urgent patients Pilgrim do see is much higher than Grantham, so there is a preference to having a service at Pilgrim over Grantham.

Staffing:

Staff base: As Grantham has 1.6WTE in post and Pilgrim has 4.86WTE in post, making **Pilgrim** the second site would cause fewer staff members to relocate/be displaced than making **Grantham** the second site.

Support from radiologist/ARSAC: Pilgrim have a full time ARSAC holder on site. Grantham's on site ARSAC holder is part time and is due to retire in 2023.

Medical Physics Experts: There is a legal requirement to have a certain number of these in all nuclear medicine departments to advise on quality control of equipment and images. The recommendations are based on different factors including the number of cameras and equipment the department has. If we reduced the service to three gamma cameras, the number of MPEs would be closer to that recommended by legislation. This would be the same if either Pilgrim or Grantham were picked as the second site.

Efficiency of the service:

Efficiency would be improved by closing either of the sites. There might be some improved efficiency if the second site was Pilgrim compared to Grantham, as there is a larger number of referrals so it would be easier to batch patients. This is because each specific test has a set radiopharmacy kit that needs to be made for it. For a number of reason departments will wait until there is a certain number of a set test ready to book. This always has to be balanced between ensuring the patient does not wait too long for the test. Therefore, if there are less referrals there is less chance to batch patients into a session.

Quality of building and compliance with current legislation:

If Pilgrim is chosen as the second site the department will be a new purpose-built building and will comply with all the relevant legislation, whereas this will be less easy to accommodate at Grantham where the department is already in a crowded area within the hospital with little scope for further expansion.

Robustness of the service:

This would be improved irrespective of the second site and would allow training of new staff more effectively at Grantham or Pilgrim.

Quality and governance:

This would be improved by reducing to two sites, as there would be more time to perform audits, as currently work is duplicated at different sites. The Lincoln site is already IS09000:2015 accredited and is it recommended that all radiation services should have such a governance accreditation. As regards a second site there is no difference between **Pilgrim** or **Grantham** as it is simply about reducing the sites rather than which one.

Summary

Consideration	**Preferred second site (if two site model)**
Patient experience	Pilgrim
Staffing	Pilgrim
Efficiency of service	Pilgrim
Building compliance with legislation	Pilgrim
Robustness of service	No preference
Quality and governance	No preference

The options

Running the nuclear medicine service at three sites is not sustainable, and centralising the service to either one or two sites would ensure a robust service for the people of Lincolnshire.

As a result of the above described options appraisal work, we are consulting with our staff, stakeholders and public on two possible options:

- Option 1: Centralisation of the service at Lincoln
- Option 2: Centralisation of the service at two sites - Lincoln and Pilgrim

The following risks and benefits have been identified for each option.

Option 1 - benefits
Most efficient use of batching kits and studies.
Most efficient use of the cameras and staff.
Robustness for continuity of service if poor weather/traffic problems.
Greater mix of scans and tasks for technologists, so should be more likely to keep staff interested and improve staff retention.
Improve monitoring of Governance (as on one site). LCH is already ISO9000:2015 accredited.
More capacity to introduce new techniques as Clinical Scientists and senior staff will have more time to do this.
Ensure that the service is only using the equipment it needs, negating the need to equip three sites at a cost of £650k per camera (plus approximately £50k per annum servicing) as well as the other equipment and consumables needed.
Ensuring a more responsive service to patients, as the radiopharmacy is on site so can help with discharge. Currently, Grantham and Pilgrim have to order preps the day before, so cannot always do same day request to scan studies.

New camera at Lincoln, meaning a reliable service and access to up to date technology that will aid diagnosis and turnaround of studies. In addition this should increase staff retention.

Risks of this option	**Notes/ mitigations**
Requirement for patients to travel for their scans leading to inconvenience to patients and could lead to some patients going out of county for the tests or not having the test.	Patients already travel for a variety of nuclear medicine tests due to equipment, lack of staffing at Pilgrim and legal requirements for performing the tests. There is also support with transport if required.
Need to transfer inpatients from Pilgrim to Lincoln.	Most nuclear medicine scans do not require the patient to be kept in for their test; those who require a test not performed at Pilgrim already are transferred between sites.
Possible impact on other services that rely on our service before breast surgery.	Will need working through with the teams.

Option 2 - benefits
Somewhat improved efficiency of batching kits and studies.
More efficient use of the cameras.
More capacity to introduce new techniques as Clinical Scientists and senior staff will have more time to do this.
Robustness of service if problem in Lincoln hospital (power outage, flood).
Ensure that the service is only using the equipment it needs, negating the need to equip three sites at a cost of £650k per camera (plus approximately £50k per annum servicing) as well as the other equipment and consumables needed.

Reduced impact on patients - fewer patients will need to travel further for their nuclear medicine tests.	
Reduced impact on staff - fewer members of staff will need to be relocated/displaced.	
Risks of this option	**Notes/ mitigations**
Requirement for some patients to travel for their scans leading to inconvenience to patients and could lead to some patients going out of county for the tests or not having the test.	Patients already travel for a variety of nuclear medicine tests due to equipment. There is also support with transport if required.
Need to transfer inpatients from Grantham to Lincoln or Pilgrim.	Most nuclear medicine scans do not require the patient to be kept in for their test and the number of Grantham inpatients is low.
Retention of some existing issues around effective use of resources and staffing.	Still an improvement on three site model.
Risk that cannot effectively staff 2 sites	Little to mitigate this.
Harder to ensure good governance as management not day to day on site.	Regular visits from Clinical scientists and teams meetings.

Have your say

We are carrying out a 12 week public consultation on the future on the nuclear medicine service, focussing in on the two options for the future of the service as outlined in this consultation paper.

We are seeking views from staff, patients and the public of Lincolnshire on the service and how it should be configured for the future.

This consultation will run from Monday 28 February 2022 to Monday 23 May 2022.

These are a number of ways to participate in this consultation, which include:

- Fill in our survey
- Come along to one of our virtual consultation events on Microsoft Teams, details below:
    - Tuesday 8 March- 6.30pm-7.30pm
    - Monday 28 March- 3pm-4pm
    - Wednesday 13 April- 6.30pm-7.30pm
    - Tuesday 3 May- 3pm-4pm
- Invite us to one of your meetings to discuss the service, by emailing communications@ulh.nhs.uk

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NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	4th October 2022
Item Number	*Item 12*
Integrated Performance Report for August 2022	
Accountable Director	Paul Matthew, Director of Finance & Digital
Presented by	Paul Matthew, Director of Finance & Digital
Author(s)	Sharon Parker, Performance Manager
Report previously considered at	N/A

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

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

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

Executive Summary

Quality

Falls

There have been 3 falls resulting in severe harm at the time of reporting. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. A number of themes have been identified across the organisation in particular unwitnessed falls and repeat falling. Actions to recover can be seen below however of note, a full business case for a falls prevention and management team is being completed for submission to the Capital and Revenue Investment Group (CRIG).

Pressure Ulcers

The number of category 2 PU is at 41 and unstageable PU is 6 for the month of August. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. A pilot to develop the role of the Skin Integrity Ambassadors will commence in October 2022. The ambassadors will initially spend one week with the Tissue Viability (TV) team, to develop their knowledge, skills and confidence in all aspects of TV. This will be supported with further follow up sessions. It is aimed that this will provide an additional resource who can cascade their learning back in the clinical area. Updates on the pilot will be presented to Skin Integrity Group (SIG).

Venous Thromboembolism Risk Assessment

Compliance against this metric remains static at 93.57% for the month of August.

Medications

For the month of August, the number or incidents reported in relation to omitted or delayed medications remains static at 26%. For those incidents reported as causing harm, a decrease has been seen this month with the metric at 8.1%. 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.

Patient Safety Alerts

For the one National Patient Safety alert with a due date of August, 7 actions were required and all are complete except 1 which remains in progress resulting in 0% compliance. All CAS alerts are reported through the Patient Safety Group and in the monthly Integrated Divisional Report and appropriate actions taken to escalate if overdue.

SHMI

The Trust SHMI is 106.68, a slight increase from the last reporting period. 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 89.6% with sending eDDs within 24 hours for August 2022 against a target of 95%. A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric at their monthly Performance Review Meeting.

Sepsis compliance – based on July data

Screening / IVAB ED child - Screening compliance for paediatrics in ED was 85.4% with the administration of IVAB for paediatrics in ED at 44.4% for July 2022.

Screening / IVAB Inpatient Child – Screening compliance for inpatient paediatrics was at 85.7% with the administration of IVAB for inpatient paediatrics at 33.3% for July 2022.

Screening Inpatient Adult – Screening compliance for inpatient adults was at 87% for July 2022.

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

Duty of Candour (DoC) – July Data

Verbal compliance for July was 93% against a 100% target and 90% for written against a target of 100%. The Clinical Governance team continue to notify clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion. Duty of Candour compliance is a fluid metric that can and does change daily as it is dependent on a number of factors surrounding incident management, in particular timely incident review and harm grading.

Operational Performance

At the time of writing this executive summary (12th September 2022), the Trust has 37 positive inpatients. There is 1 patient requiring Intensive Care intervention.

This report covers August's performance, and it should be noted the demands of Wave 5/6 have begun to decrease. The Trust moved at pace into the *Recovery* and *Restoration* of services, but increased covid related 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 August's data and performance, the proposed revised 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 July performance of 60.10% being reported at 59.48% in August.

There were 1088 12-hr trolley waits, reported via the agreed process in August. This represents an increase of 336 from July and is the highest number ever recorded by the Trust. Sub-optimal discharges to meet emergency demand remains the root cause. However, due to extended waits in our Emergency Departments for admission, the decision was made to support patients in time order and not Decision To Admit order.

Performance against the 15 min triage target demonstrated an improvement of 1.46%. 80.30% in August verses 78.84% in July.

Overall Ambulance conveyances for August were 3758, an increase of 2 conveyances from July (3756). There were 930 >59minute handover delays recorded in August, an increase of 134 from July, representing a 14.41% increase. Delays experienced at LCH and PHB have seen increased levels of overcrowding in EDs made more difficult whilst continuing to manage pathways with differing levels of infection risk. August demonstrated an increase in >120mins handover delays compared with July, 517 in August compared with 426 in July,

representing a 17.61% deterioration. >4hrs handover delays increased. A total of 123 in August compared to 94 in July. This represents a 21.14% increase. PHB experienced the largest increase in >2hrs and >4hrs.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 5.12 days against an agreed target of 4.5 days The average bed occupancy for August, was 95%. System Partners are challenged with identifying timely support to facilitate discharge from the acute care setting, Pathway 1 capacity (Domiciliary care) continues to be unable to meet the demand and is a large contributor to increased LoS. All delays of greater than 24 hours are escalated within the System.
Elective Length of Stay increase from 3.19 days in July to 3.11 in July. This increase can be attributed to increased complexity of patients being treated.

Referral to Treatment

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

July demonstrated a decrease in performance of 1.01%. July outturn was 49.78 %. The Trust reported 7,246 incomplete 52-week breaches for July end of month which is an increase of 1,030 since June. The position continues to worsen.

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

At the end of August, the Trust reported 3 patients waiting longer than 104 weeks but none of these waits were associated with a lack of capacity to treat but related to patient choice and complexity. All were ULHT patients. Focus has now turned to clearing the remaining 104 week waiters by the end of September and discussions are taking place with NHSE weekly. Current forecast is to have 3 at the end of September, all being down to patient choice.

Waiting Lists

Overall waiting list size has increased since June. July reported 69,947 compared to June's position of 68,140 an increase of 1.807. 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. August demonstrated a reduction (657 verses 815 in July) which is above the agreed trajectory of 550. As of 11th September this has increased to 764. 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 August reported a 50.85% compliance against the national target of 99%. A negative variation of 48.15% against the national target and a 2.27% deterioration on the July outturn. Whilst the main area of concern remains Echocardiography, DM01 continues to have residual impacts from both the fire at LCH and the 'heatwave'. New areas of concern are Audiology (absence driven) and the changes to the Autism pathway (demand increase). Ultrasound has seen improvement.

Cancelled Ops

The compliance target for this indicator is 0.8%. August demonstrated a 2.36% compliance. This is an improvement of 0.51% on July but a negative variance of 1.56% against the agreed target.

The target for not treated within 28 days of cancellation is zero. August experienced 37 breaches against this standard verses 23 in July.

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 51.37 (against 85.4% target.) This demonstrates a deterioration of 1.1% in performance since the last reporting period and is 34.03% below the nationally agreed compliance target.

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

104+ day waiters have increased in line with the trajectory. There are currently 135 patients waiting >104 days against a target of <10. The current figure is an increase of 23 patients since the last reporting period.

Workforce

Mandatory Training – Mandatory training rates have remained constant over the past 3 months yet after a slight decreased of 0.5%pts in in June the rate has started to lift last month and remains stable at 89.86%. Issues in recording learning due to IT software have had an impact on courses completion rates. A solution has been looked at since May by the Digital team with little hope for immediate resolution and remains an issue.

Sickness Absence – The trend has increased by 0.01% to 5.29% which is still above the target of 4.5%. Covid absences are continuing to decrease in numbers.

Extensive work is continuing to get full engagement of using Absence Management System (AMS) Trust wide with all senior management training now having been completed. The AMS Refresher training sessions continue to be run across all Divisions to be completed by the 31st December 2022 for the remaining 320 staff who manage absence. Please note that by gaining full engagement in the use of AMS, we will see an upward trend in the absence rate before we see an improvement in this rate due to the accurate, full reporting.

Work has now been completed to cleanse the Case Manager element of AMS to ensure all open cases can be managed effectively and the ER Team continue to support Managers with this.

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 60.3% to 60.76%.

Staff Turnover – Turnover has remained at over 14.5% for the past 3 months, however this has seen a slight increase for August to 15.09% (Doctor's rotation is excluded). 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). People Promise Manager is now in post and will look deeper into the reasons for leaving to establish any patterns and where interventions can be put in place to support a reduction in turnover. Current analysis shows that 17% of resignations could be avoided through better management, relationships and career opportunities if offered in the Trust.

Vacancies – We saw a 0.3% increase in vacancy factor in August, this was due to us not having as many starters as expected in August, this should be counteracted by a significant number of starters expected to join the Trust in September. Provision has been made to

increase our International Nursing numbers and we expect a significant number to join from our increased levels of activity in September and October. Further funding from NHSEI has also been granted to supplement our AHP recruitment.

Finance

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

The Trust delivered a deficit of £2.7m in August (£2.7m adverse to plan) and the Trust YTD delivered a deficit of £9.0m deficit (£9.0m adverse to plan).

After removing gains from disposals of £0.1m, the Trust YTD delivered a deficit of £9.1m in relation to system achievement.

CIP savings of £5.7m have been delivered YTD (£3.3m adverse to planned savings of £9.0m).

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£5.8m.

The June 2022 cash balance is £70.0m, which is a decrease of £18.3m against the March year-end cash balance of £88.3m.

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

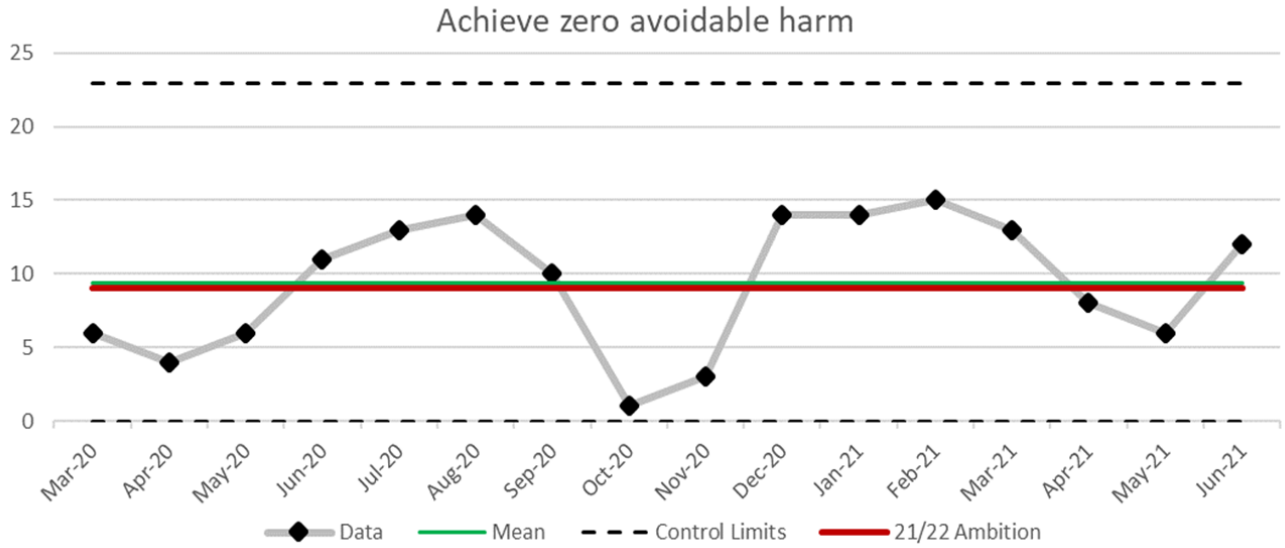
Statistical Process Control Charts

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

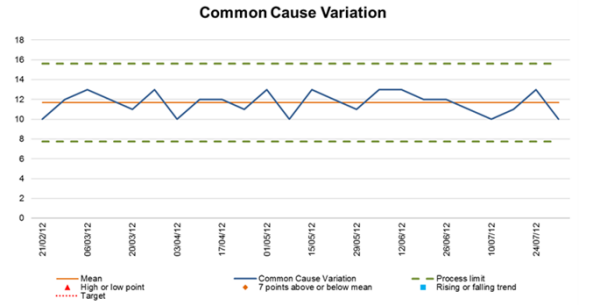
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

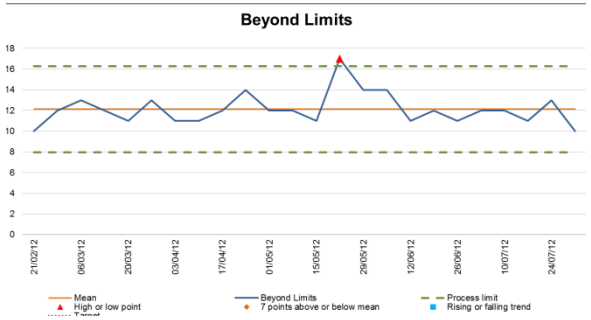
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



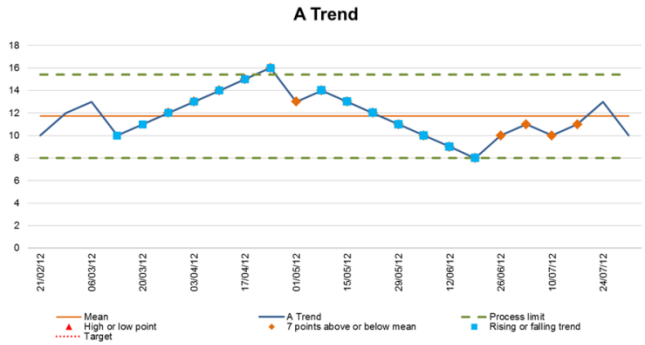
Extreme Values

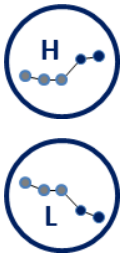
There is no Icon for this scenario.



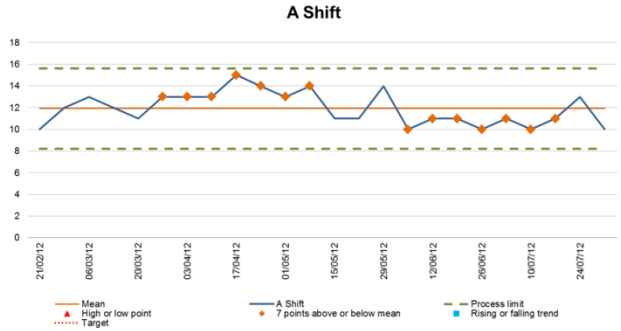
Statistical Process Control Charts

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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EXECUTIVE SCORECARD

NHS United Lincolnshire Hospitals NHS Trust

Measure ID	Domain	Measure	Measure Definition	SRO	2022/23 Ambition	Tolerance	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Latest month pass/fail to ambition	Trend variation
1	Patients	Implementation of the SAFER bundle	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients.	COO	10.00%	1.00%	13.91%	14.19%	13.25%	12.45%	14.23%	F	
2	Patients	SHMI performance	Summary Hospital-level Mortality Indicator. National data published by NHS Digital is for rolling 36 month period ending 5 months prior to current month	MD	100	5 points	4th Quartile (109.48) (107th of 122)	4th Quartile (108.32) (102nd of 122)	4th Quartile (106.63) (91st of 121)	3rd Quartile (106.13) (84th of 121)	3rd Quartile (106.68) (89th of 121)	F	
3	Patients	Reduction in moderate and severe harm and death incidents	Serious incidents (including Never Events) of harm - Moderate, severe and death - per 1000 OBD	DoN	0	0.17	0.43	0.45	0.30	0.46	0.53	F	
5	Patients	Reduction in medication incidents leading to moderate & severe harm or death	Total number of Medication incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	DoN	0	0.07	0.17	0.00	0.03	0.07	0.10	F	
6	Patients	Reduction in DKA incidents resulting in moderate & severe harm or death	Total number of DKA incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	MD	TBD	TBD	0.03	0.00	0.00	0.03	0.03		
7	Patients	Achievement of the IPC BAF	% of green/compliant items from the IPC COVID BAF C1501 v1.8 (quarterly)	DoN	95.00%	1.00%		96.80%			96.80%	P	
8	Services	Financial Plan	Variance aganst plan (£'000)	DoF	£0	£0	(51)	(176)	(4,956)	(1,148)	(2,688)	F	
9	Services	Percentage of patients spending more than 12 hours in department	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	COO	1.00%	5.00%	16.03%	15.16%	14.71%	15.77%	20.04%	F	A
10	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	COO	503	100	4,694	5,282	6,216	7,246		F	
11	Services	28 days faster diagnosis	Number of patients diagnosed within 28 days or less of referral as a percentage of total Cancer pathways.	COO	75.00%	5.00%	52.63%	58.10%	59.40%	61.76%		F	
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	DoPOD	9.00%	1.00%	10.55%	10.31%	12.08%	11.35%	10.73%	F	
13	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	DoPOD	90.00%	2.00%	54.06%	57.62%	59.14%	60.30%	60.76%	F	
13	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	DoPOD	95.00%	2.00%	89.27%	90.26%	89.76%	89.72%	89.86%	F	
14	People	Improved Pulse Survey results (Quarterly staff survey)	Improvement in the % of people rating their likelihood of referring the Trust to Friends and Family (Agree & Strongly Agree)	DoPOD	55.00%	5.00%	44.62%			47.59%		F	
15	Partners	Health inequalities and Core20PLUS indicators	Metric being worked up through review of health inequalities data availability		TBD	TBD							
16	Partners	Increased recruitment/academic posts (across the ICS)	Number of posts appointed	DII	10	2					0	F	
18	Partners	Early Warning Discharge Indicators	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, for pathway 1-3 patients.	COO	50%	10.00%	77.53%	76.32%	79.90%	77.97%	80.45%	F	

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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	Jun-22	Jul-22	Aug-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	5	7	8	30	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	0.07	0.07	0.01	0.06		
	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	0.03	0.01	0.02	0.08		
	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	0.10	0.17	0.17	0.17	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	0	0	3	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	2	0	0	3	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	3	5	6	23	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	94.50%	94.41%	93.57%	94.60%	F	
	Never Events	Safe	Patients	Director of Nursing	0	0	1	0	3	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.14	5.74	6.11	5.58	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	10.5%	13.0%	8.1%	12.48%	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	Jun-22	Jul-22	Aug-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	66%	0%	33.00%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	94.47	94.95	95.30	94.30	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	106.63	106.13	106.68	107.45	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%	90.40%	90.50%	89.60%	89.86%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.8%	87.0%		92.26%	F	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	92.3%	85.7%		86.03%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	95.4%	90.0%		95.26%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	100.0%	33.3%		69.48%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	90.7%	92.8%		90.13%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	81.8%	85.4%		83.93%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.0%	93.9%		93.01%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	70.0%	44.4%		56.43%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	3.03	3.28	3.08	3.21	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%	100.00%	93.00%		92.75%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	100.00%	90.00%		89.00%	F	

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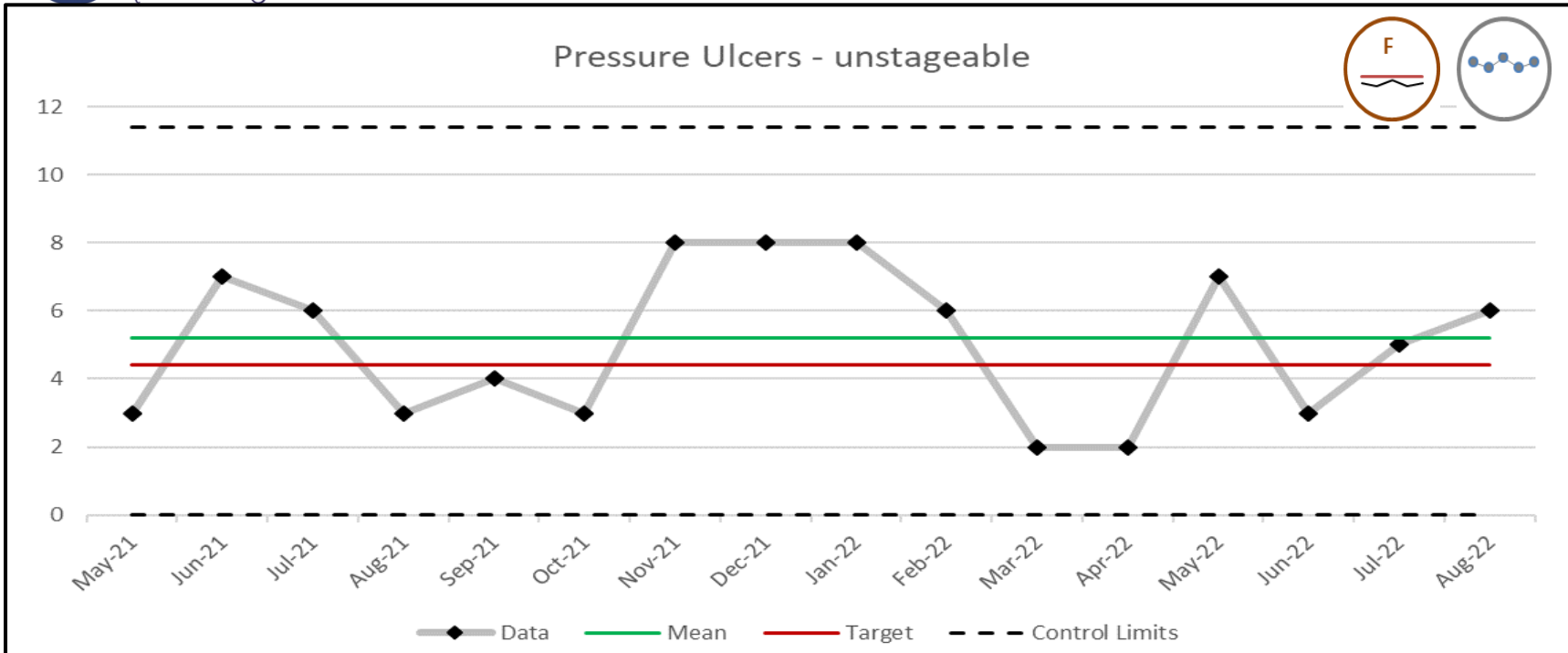
NHS United Lincolnshire Hospitals NHS Trust



Aug-22
6
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.4
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
Unstageable Pressure Ulcers.

What the chart tells us:
We are currently at 6 incidents against a threshold of 4 per month.

Issues:
The number of incidents have increased by 1 in comparison to July 22.
No device related incidents have been reported this month.
It has been identified that 4 of the incidents deteriorated from either a Category 2 pressure ulcer or moisture associated skin damage (MASD).
Through validation it has been noted a contributory factor to a number of the incidents were wound care plans not been followed and gaps in undertaking appropriate repositioning regimes.

Actions:
A pilot to develop the role of the Skin Integrity Ambassadors will commence in October 2022. The ambassadors will initially spend one week with the Tissue Viability (TV) team, to develop their knowledge, skills and confidence in all aspects of TV. This will be supported with further follow up sessions. It is aimed that this will provide an additional resource who can cascade their learning back in the clinical area. Updates on the pilot will be presented to Skin Integrity Group (SIG)

The Pressure Ulcer Support Panel process has been reviewed and a more robust escalation plan developed to ensure investigations are completed in a timely way to support learning to be identified and shared at the earliest opportunity.

The TV team will attend Septembers Sisters/Charge Nurse meeting to share learning and raise awareness of current themes, promoting early pressure ulcer assessment, prevention and management, which can be cascaded back to their clinical teams.

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

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

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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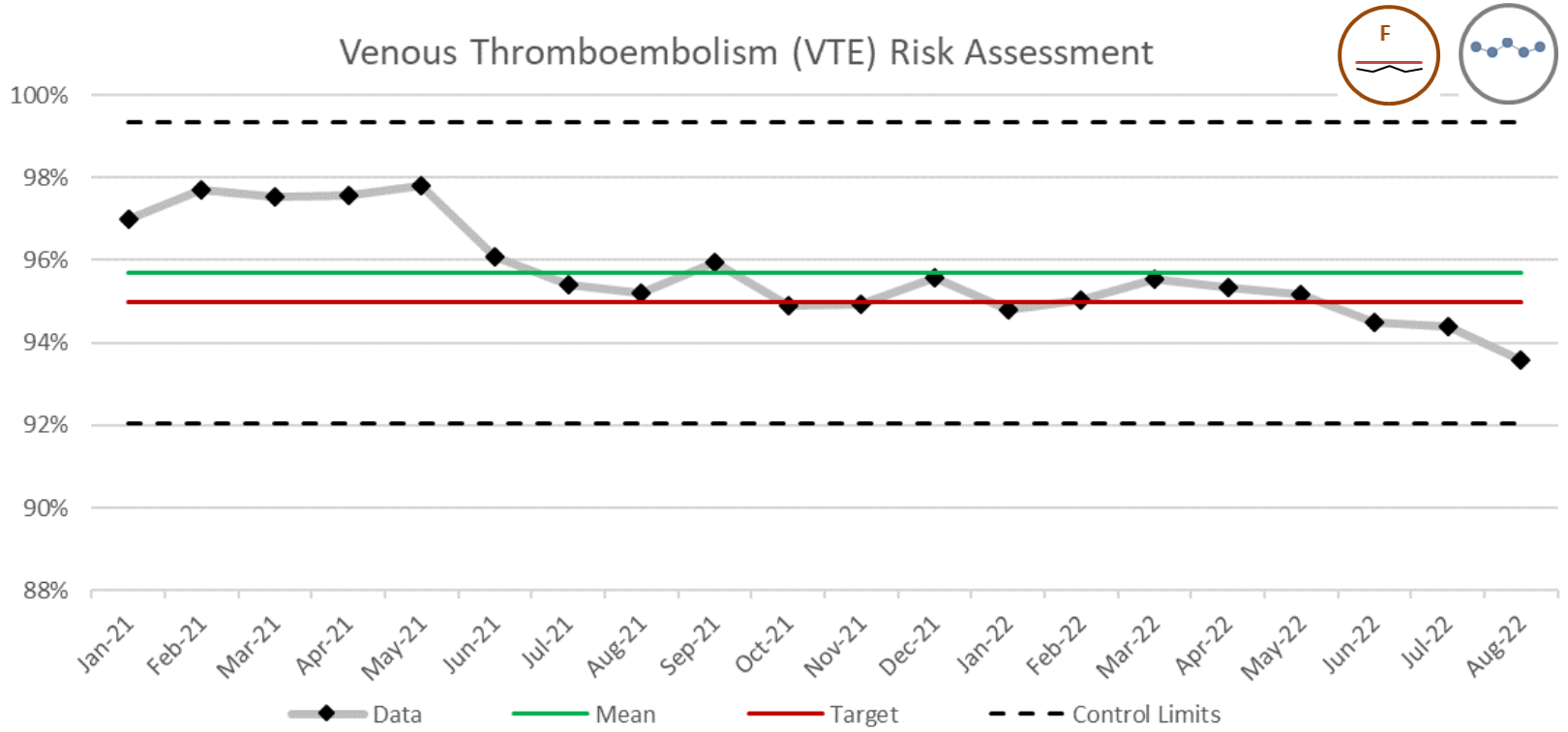

Aug-22
93.57%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is failing the target
Executive Lead
Medical Director

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

What the chart tells us:
VTE risk assessment performance is just below 95% target, currently at 93.57%.

For discussion at the QGC meeting:

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

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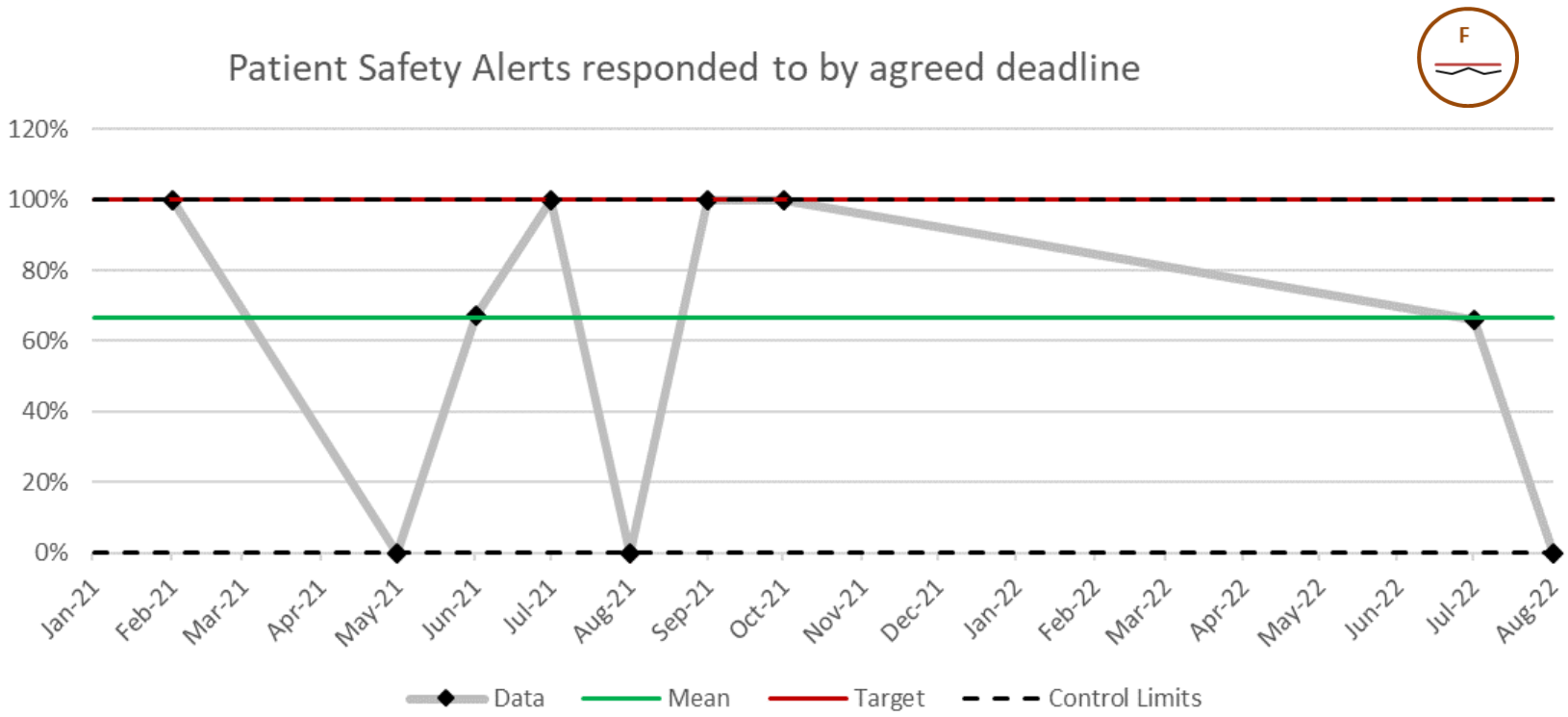

Aug-22
0%
Variance Type
Metric is currently experiencing Special Cause Variation – outside the control limits
Target
100%
Target Achievement
The metric has failed to target
Executive Lead
Medical Director

Background:
Percentage of patient safety alerts responded to by an agreed deadline

What the chart tells us:
There was 1 National Patient Safety Alert with a due date in August 2022. Of the 7 actions required, 1 remains in progress.

Issues:
Patient Safety Alerts are compiled by the national team from analysis of reported incidents and contain safety critical actions.

Compliance is monitored through the NHS Central Alerting System (CAS).

Actions:
The Risk & Incident team within Clinical Governance continue to coordinate the Trust response to all CAS alerts. The Medical Equipment Management System (MEMS) developed within Clinical Engineering is now used as the Trust database and communication tool for all CAS alerts.

Mitigations:
Details of all outstanding CAS alerts are now included in monthly Integrated Clinical Governance Reports that are provided to division, CBU and specialty management teams.

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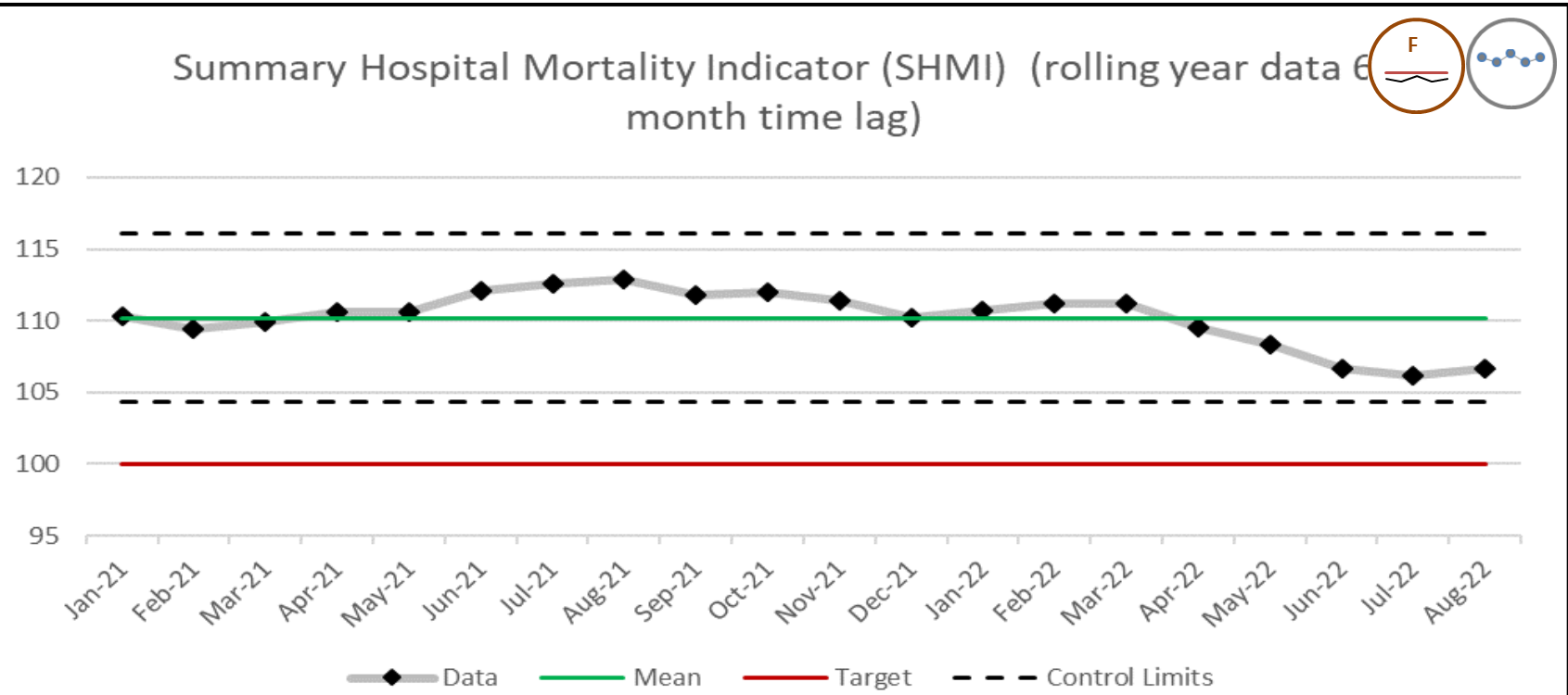


Aug-22
106.68
Variance Type
Metric is currently experiencing Common Cause Variation
Target
To remain in "as expected" range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
ULHT SHMI is 106.68; a slight increase 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 Apr 21 – Mar 22.

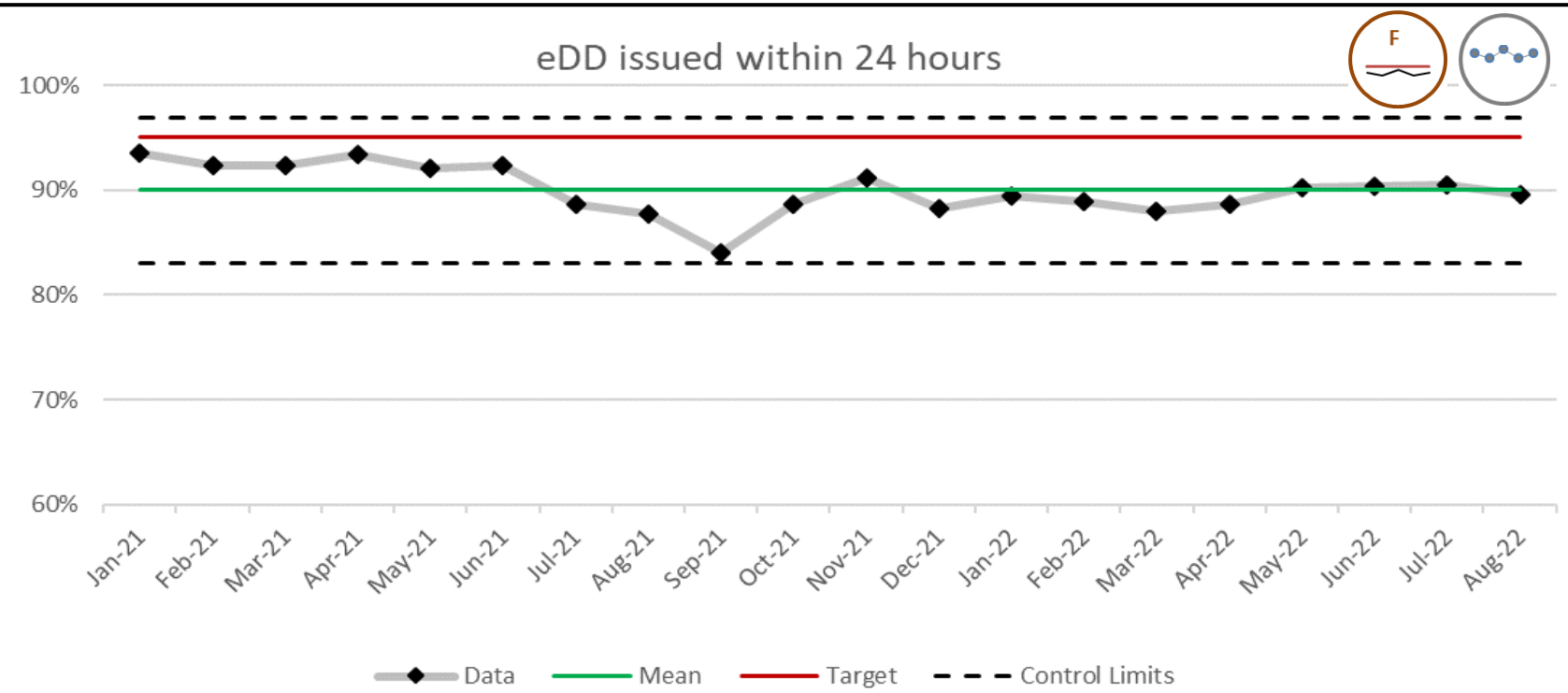
Actions:
Any diagnosis group alerting is subject to a case note review.

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 95.3-lower than expected.



Aug-22
89.60%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 89.60%.

Issues:

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

Mitigations:

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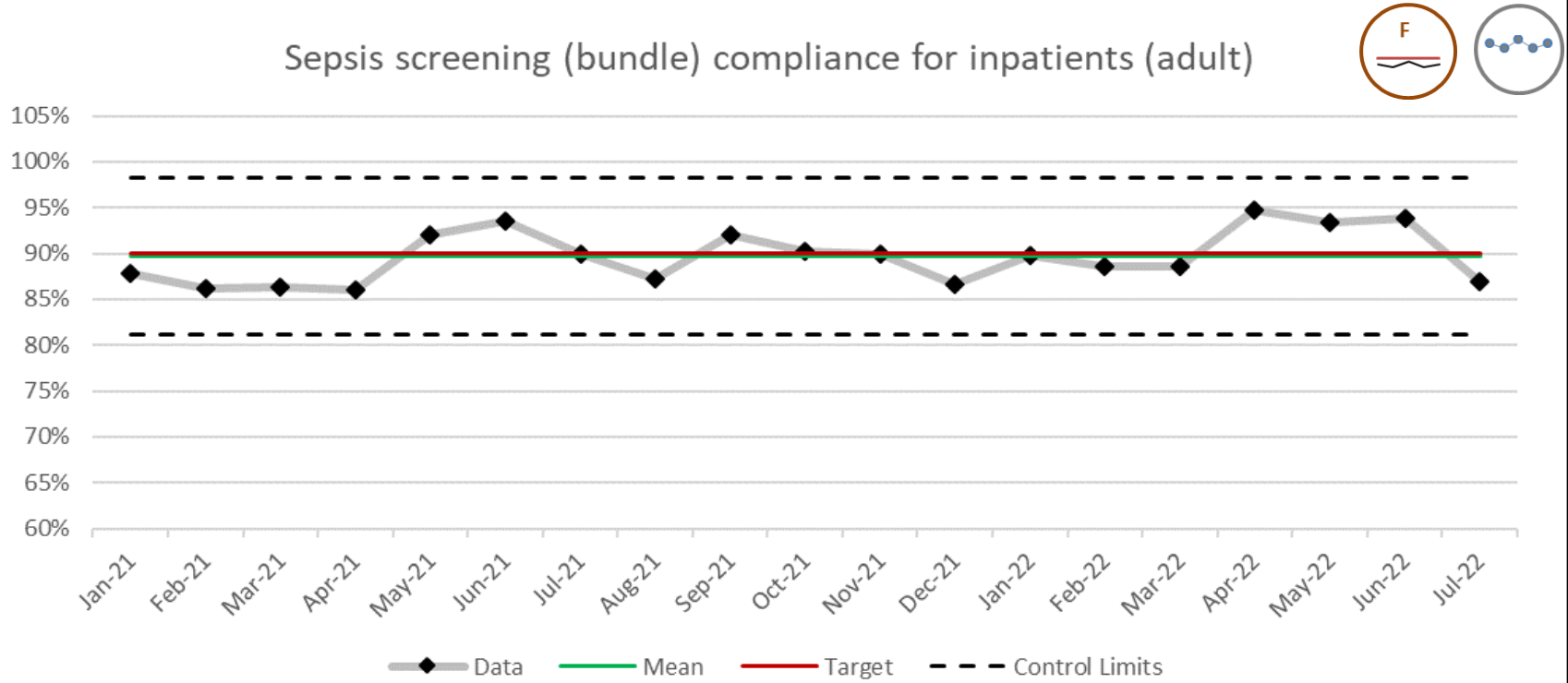

Jul-22
87.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance for adult inpatients is 87% against a standard of 90%. This represents 283 of 325 patients or 42 patients who had a missed or delayed screen.

Issues:
This is the first drop in compliance for 3 months and stems primarily from a worsening of compliance in medical wards. Treatment for those patients requiring the sepsis bundle remains above 90% and no serious harms have been seen because of a fall in compliance.

Actions:
A number of wards have reported issues with newly appointed staff having little understanding of sepsis or how to complete a screen on web v.
Targeted teaching is taking place on those wards that have identified specific training needs and wards are being signposted to a voice over video that demonstrates how to complete a screen on web v.
Additional on line resources are being developed that can be accessed via the intranet.

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

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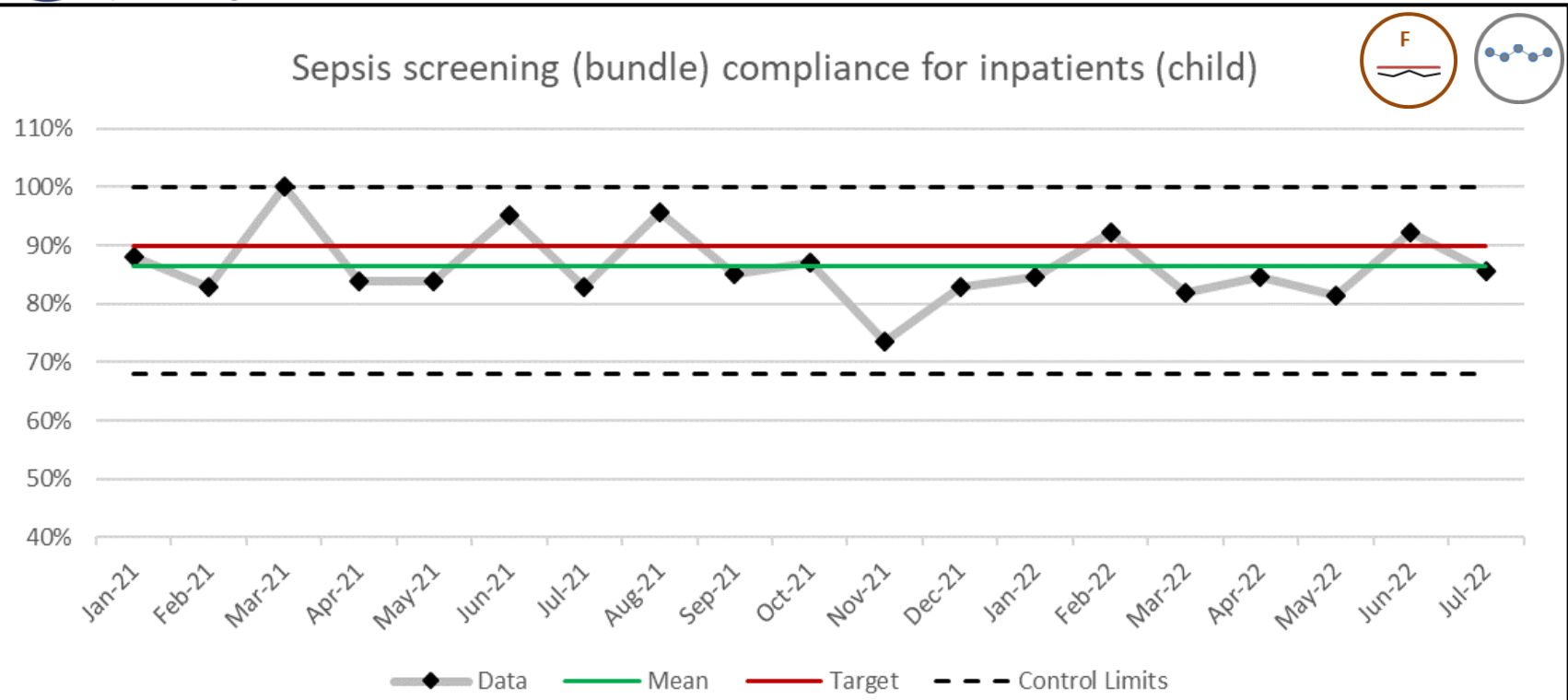

Jul-22
85.70%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The inpatient compliance this month for screening has fallen to 85.70%. 66 of 77 patients were successfully screened.

Issues:
There were several patients that scored and a screen was added but not completed. This was a mix of substantive and temporary staff.

Actions:
Harm reviews were completed for all patients with a delayed or missed screen and no harm was found. The main reason found for the delayed screen was for patients waiting for a medical review and decision.

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

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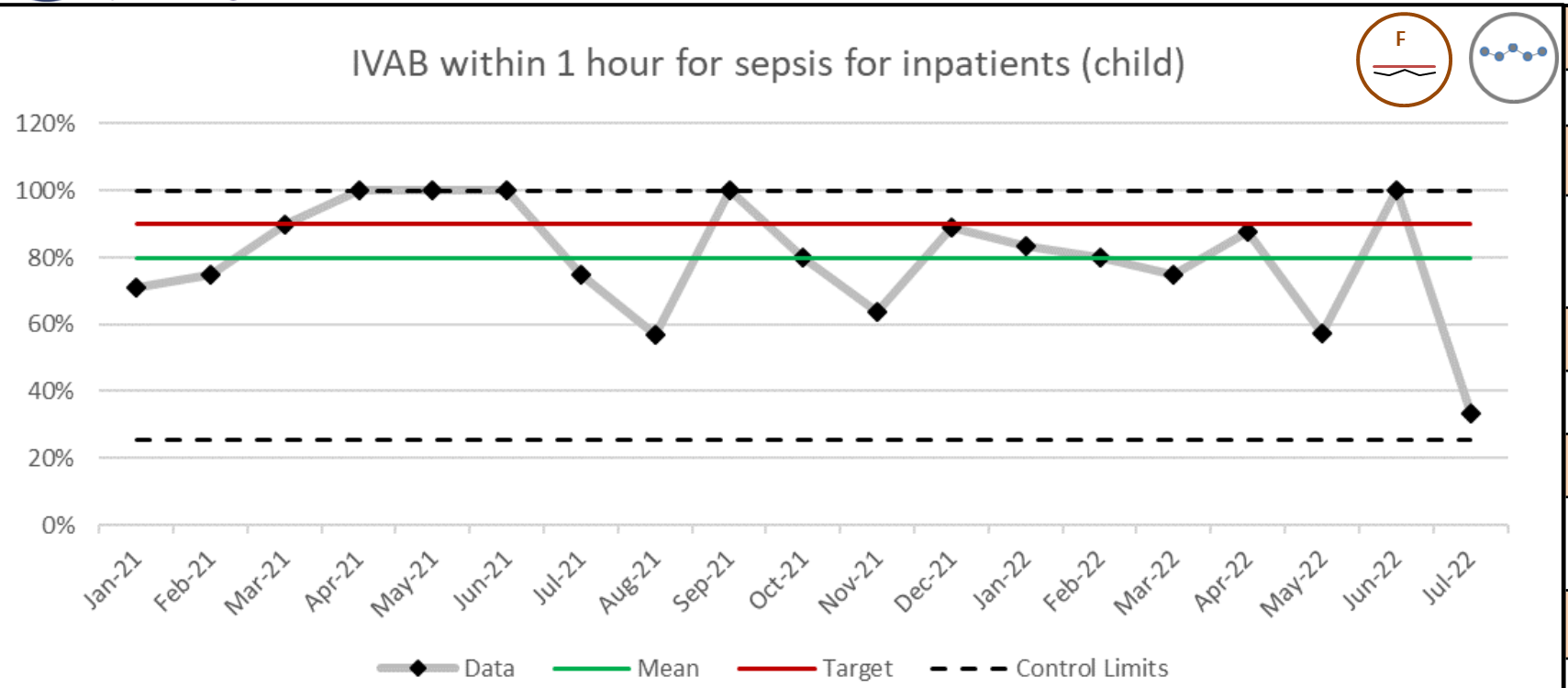

Jul-22
33.33%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The treatment figures for inpatient Sepsis were very disappointing this month at 33.3%. Only 2 out of 6 patients received IV antibiotics within the hour.

Issues:
There were 4 patients with delayed treatment within the inpatient areas. 2 of these patients had a delayed medical review due to other sick patients being in the department. 2 other patients had delayed treatment due to delays getting IV access.

Actions:
Harm reviews were completed for all 4 of these patients and no harm was found from delay.

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

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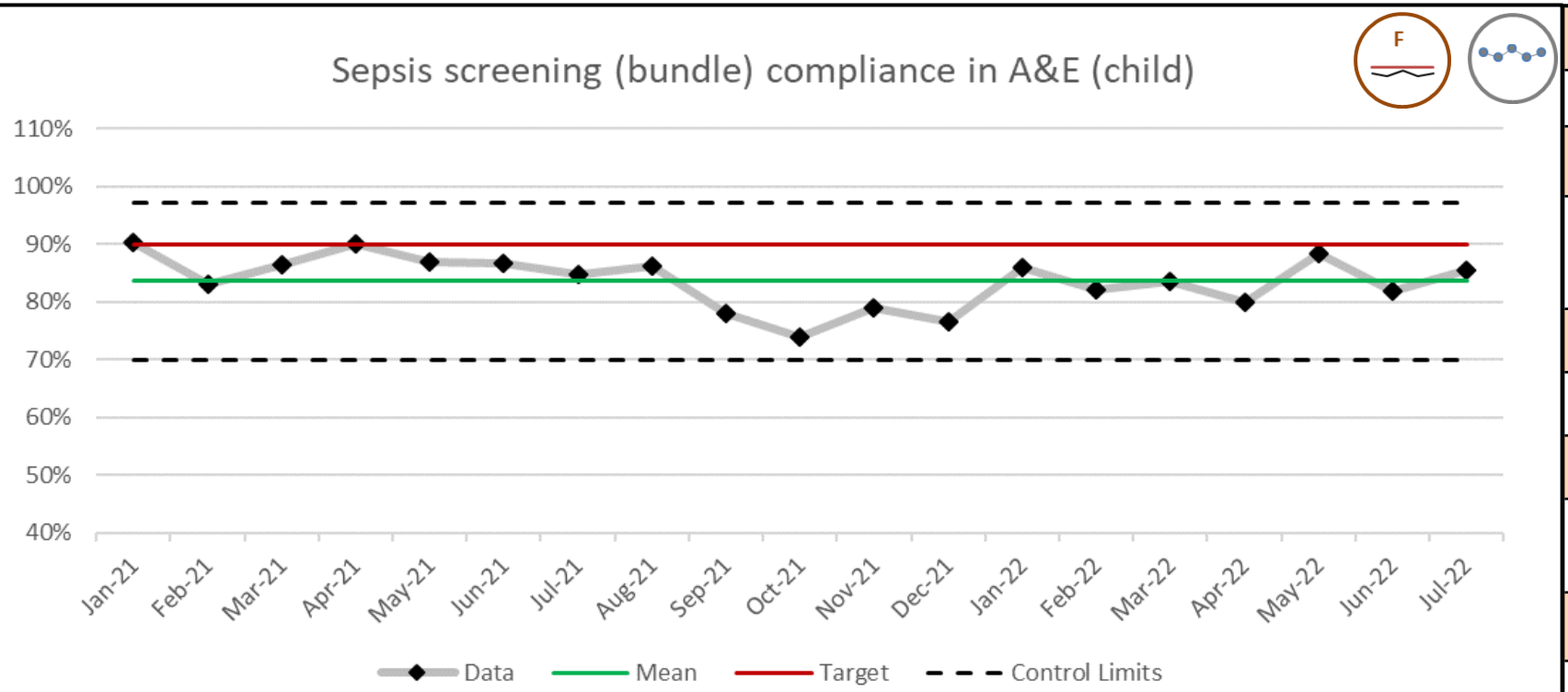
NHS United Lincolnshire Hospitals NHS Trust



Jul-22
85.40%
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 85.40% which is below the 90% target. 240 of 281 patients received screening for sepsis within the hour. This is an improvement on last month.

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 a further 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.

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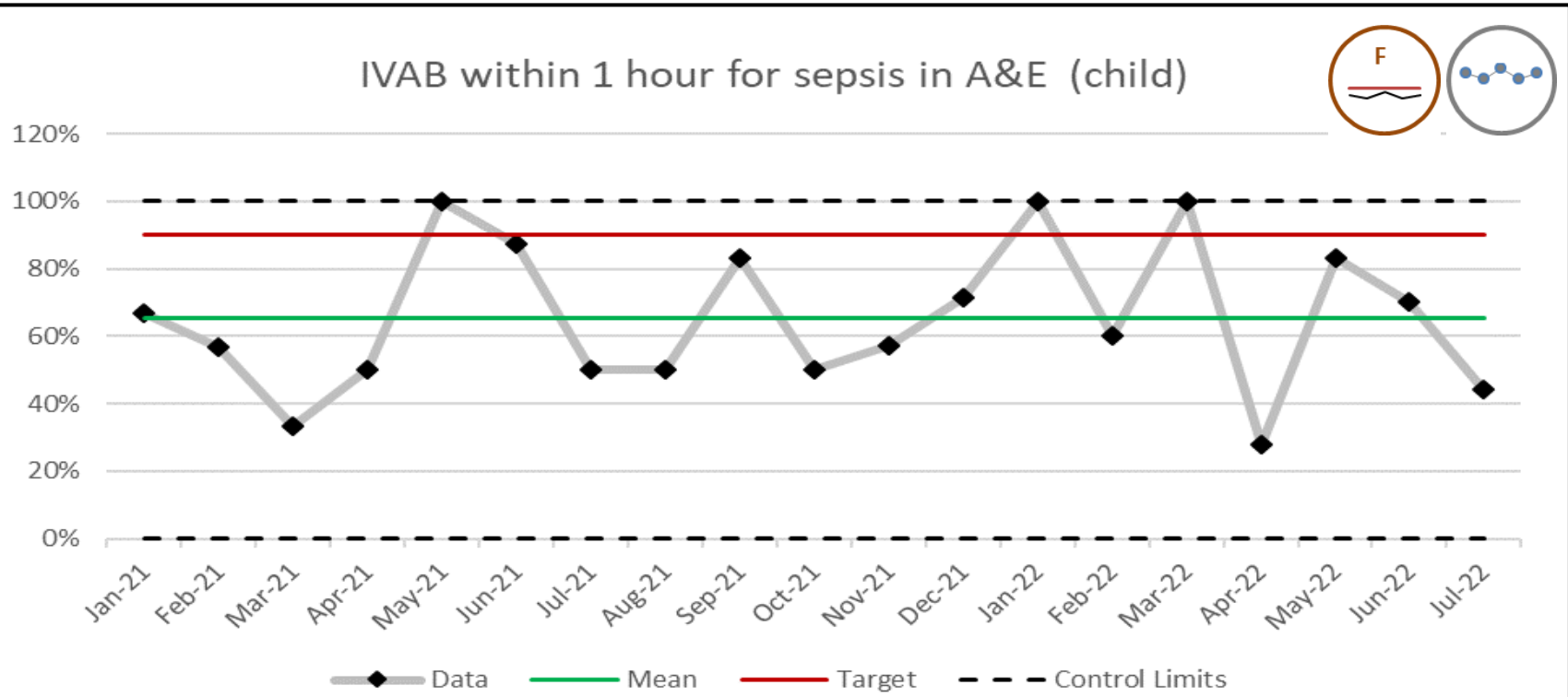

Jul-22
44.40%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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 44.4%, which is 4 of 9 patients, and is below the 90% target. There is a decrease against last month.

Issues:
There was 5 patients in ED this month that was delayed in receiving antibiotics. Two of these children were seen at Grantham but not treated until they were transferred to Lincoln. One child was screened incorrectly initially as viral, but attended with meningitis symptoms and was treated on ward for meningitis. One patient was delayed due to difficult IV access. One child had a delay of 4 hours as paediatric team wanted to perform Lumbar Puncture prior to treating.

Actions:
A harm review was completed for all 5 patients and no harm was found.
Sepsis training has been undertaken for new Doctors starting in August.
Simulation training is to be reintroduced in ED areas as soon as possible.
There will be more training with ED staff about how to fill in/ use the unsure option appropriately.

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

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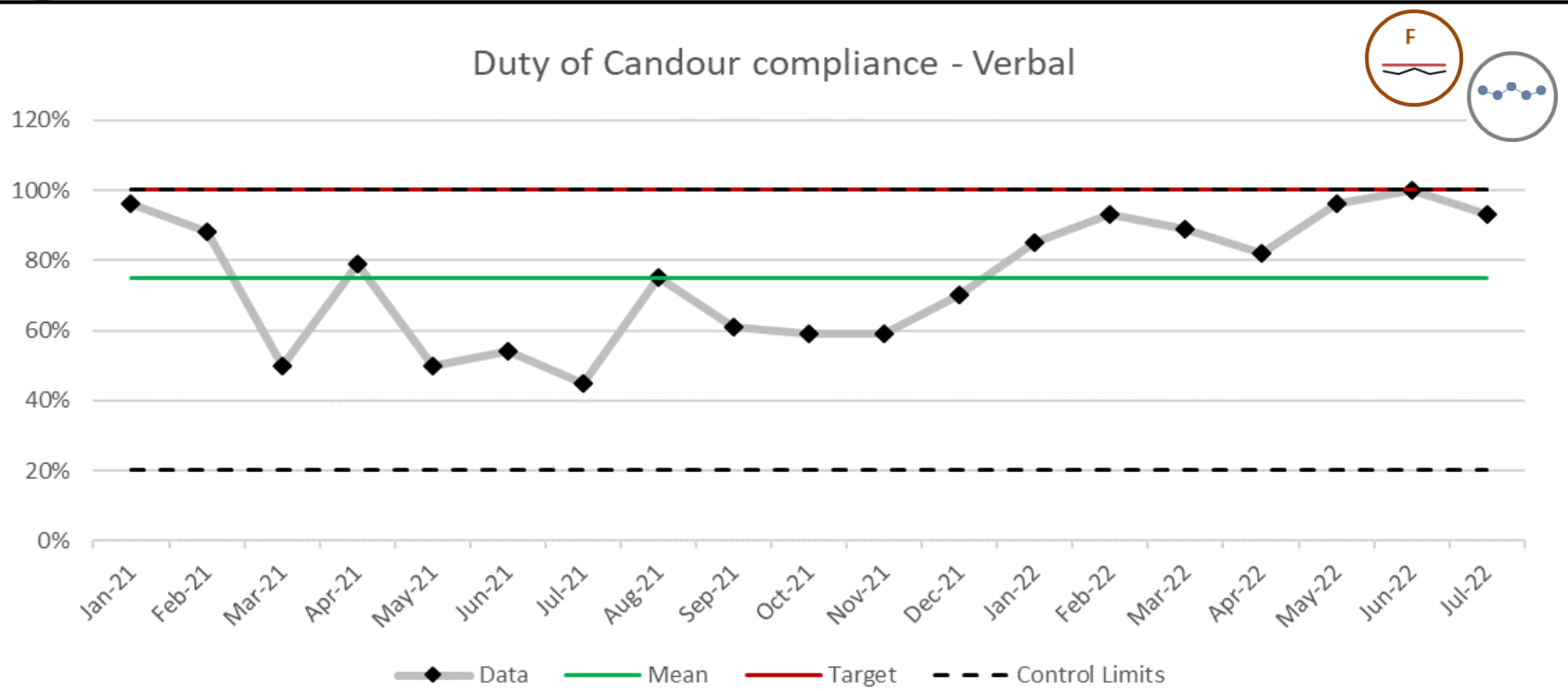


Jul-22
93%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

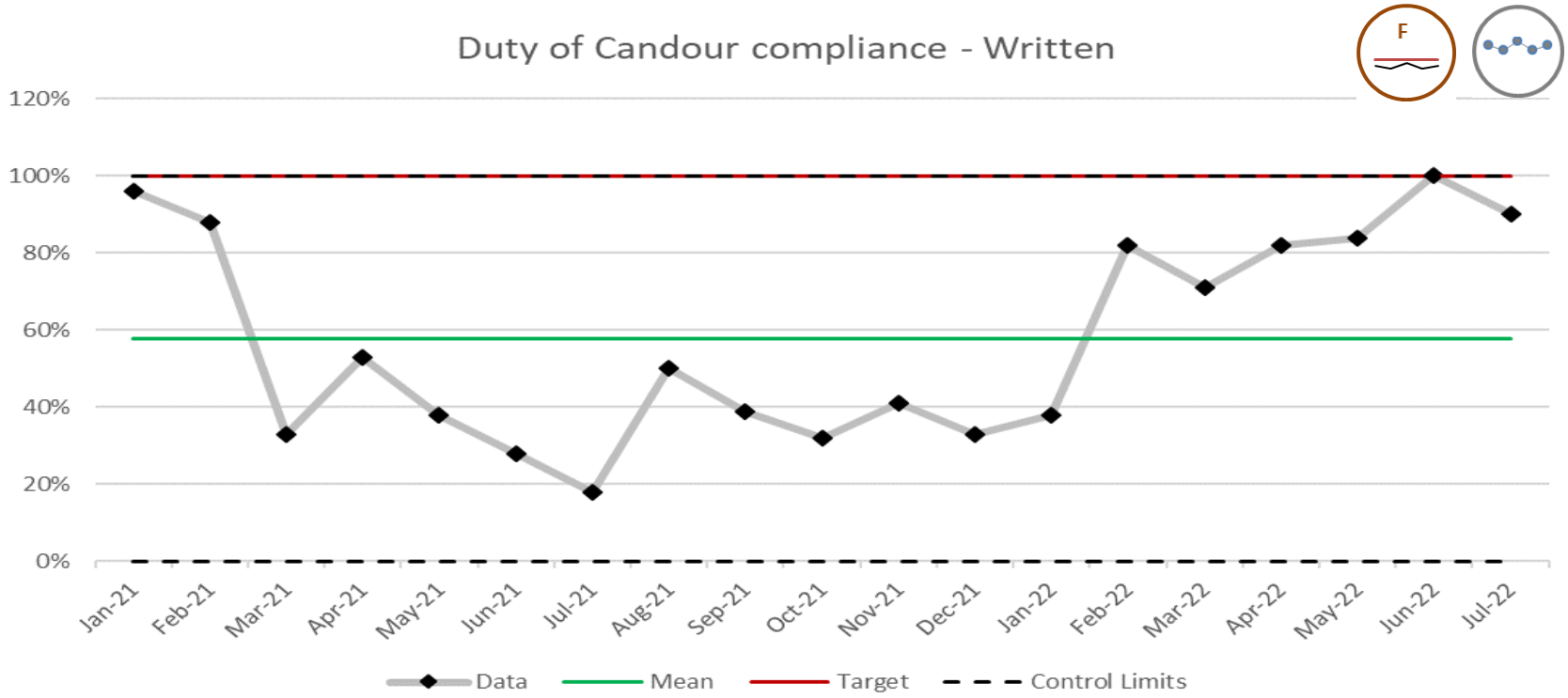
What the chart tells us:
The Trust does not consistently achieve 100% compliance within a given month.

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

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

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

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



Jul-22
90%
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:
The Trust does not consistently achieve 100% compliance within a given month.

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

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

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

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

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-22	Jul-22	Aug-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.17%	0.25%	0.43%	0.20%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	62.10%	60.10%	59.48%	61.68%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	692	752	1088	3957	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	82.62%	78.84%	80.30%	81.85%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	6216	7246		23,448	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	50.79%	49.78%		50.71%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	68,140	69,947		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	52.47%	51.37%		49.41%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	48.96%	56.08%		61.25%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	29.23%	32.14%		24.28%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	89.76%	93.67%		90.97%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	98.99%	99.21%		98.14%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	63.64%	80.00%		69.73%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	98.08%	97.89%		96.87%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	72.41%	53.33%		65.64%	90.00%			

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PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-22	Jul-22	Aug-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%	63.95%	79.72%		69.97%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	52.43%	53.12%	50.85%	54.02%	99.00%	F	L	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	2.17%	2.87%	2.36%	2.21%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	21	23	37	134	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	78.95%	63.75%	68.60%	71.99%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	68.42%	50.00%	46.51%	52.70%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,778	3,756	3,758	3,834	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	722	796	930	803	0	F	A	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	123	113	135	647	50	F	A	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.79	3.11	3.19	3.12	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	5.25	4.85	5.12	5.06	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	23,087	23,034	22,951	23,098	4,524	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	40.07%	33.36%	33.18%	39.14%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	36.84%	38.46%	41.56%	37.85%	45.00%	F		

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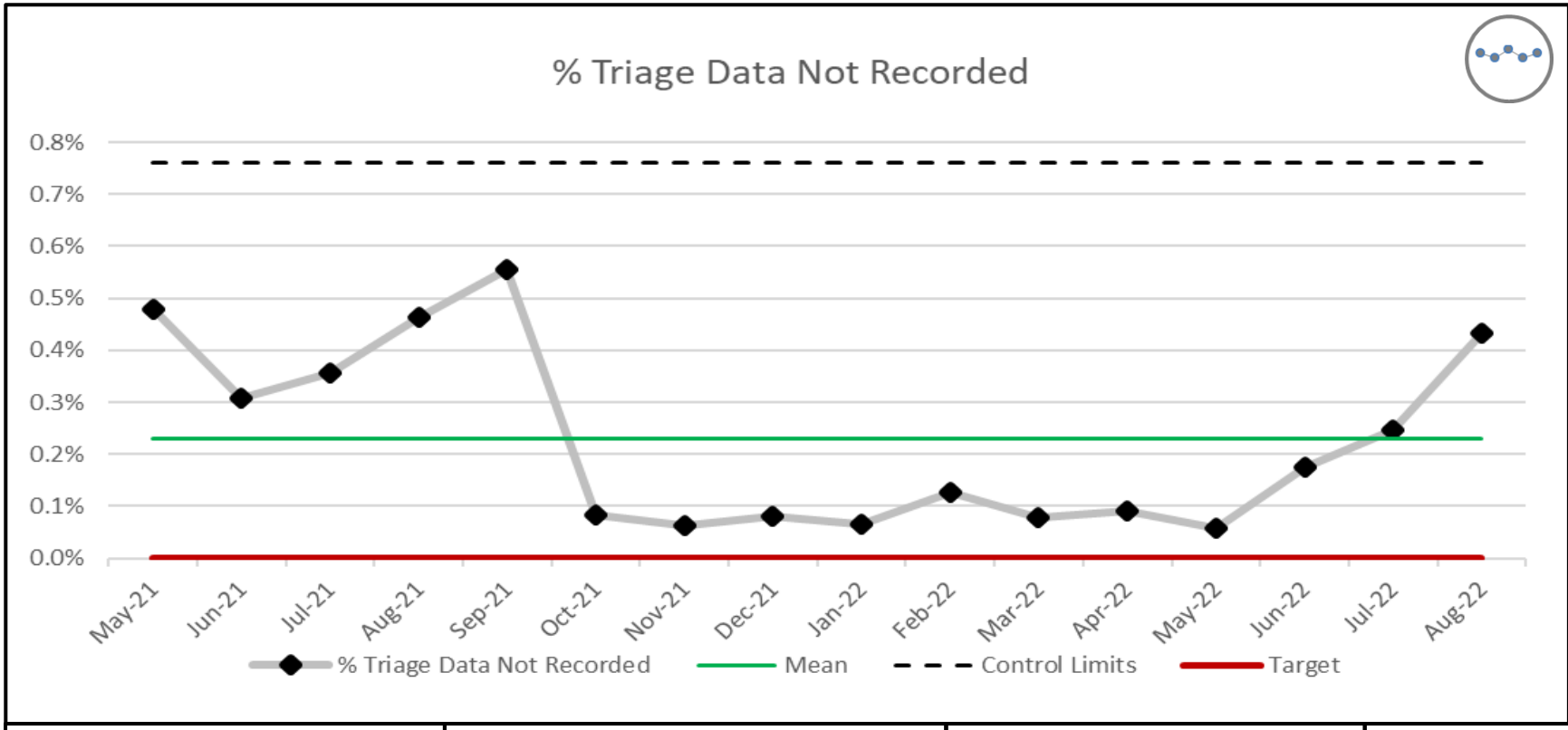

Aug-22
0.43%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%.
August reported 0.43% data not recorded verses 0.25% in July.
August demonstrated a 0.18% negative variation compared with July. This is the 3rd month of worsening performance.
This metric is below target.

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

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

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

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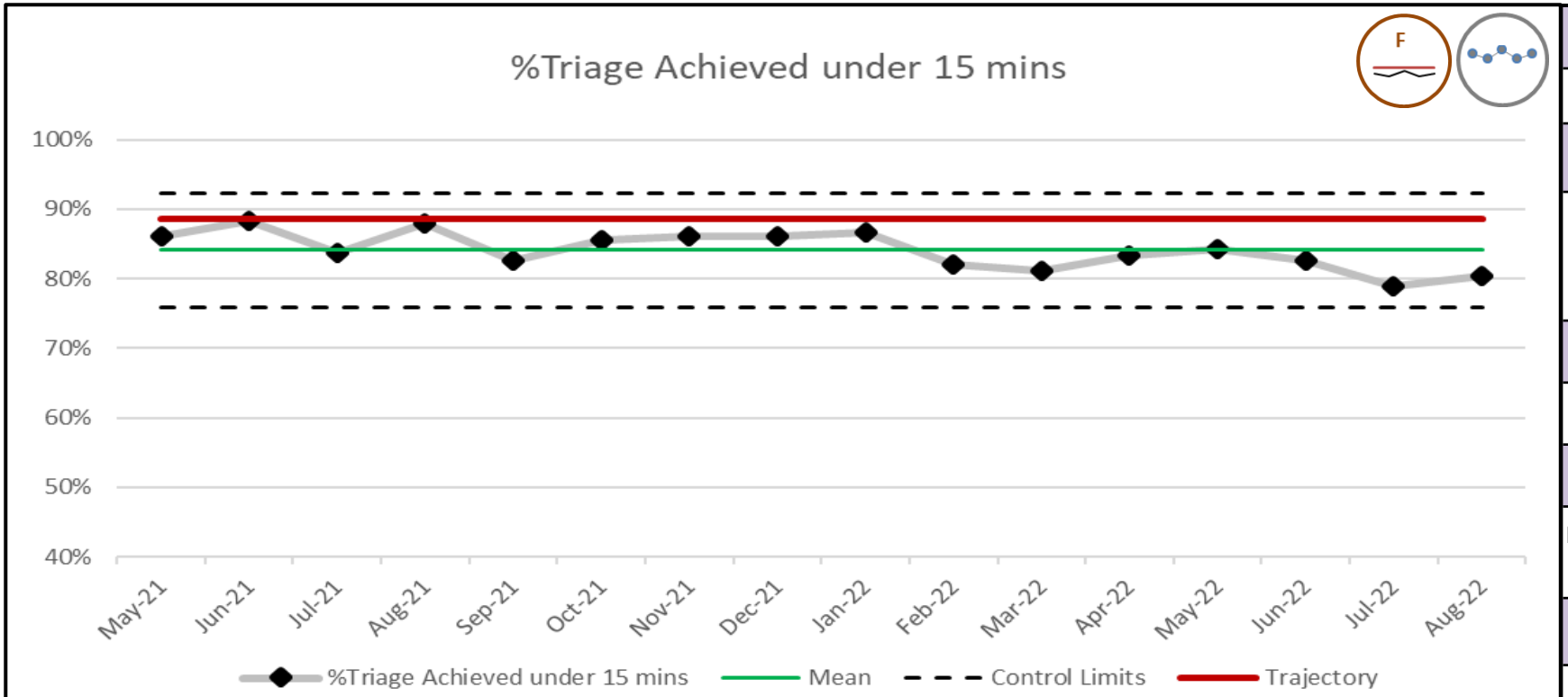

Aug-22
80.30%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of triage achieved under 15 minutes.

What the chart tells us:

The compliance against this target is 88.50%.
August outturn was 80.30% compared to 78.84% in July.
This demonstrated an improvement in performance of 1.46% compared with July and an 8.20% negative variance against the agreed target.

This target has not been met.

Issues:

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

Actions:

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

Mitigations:

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

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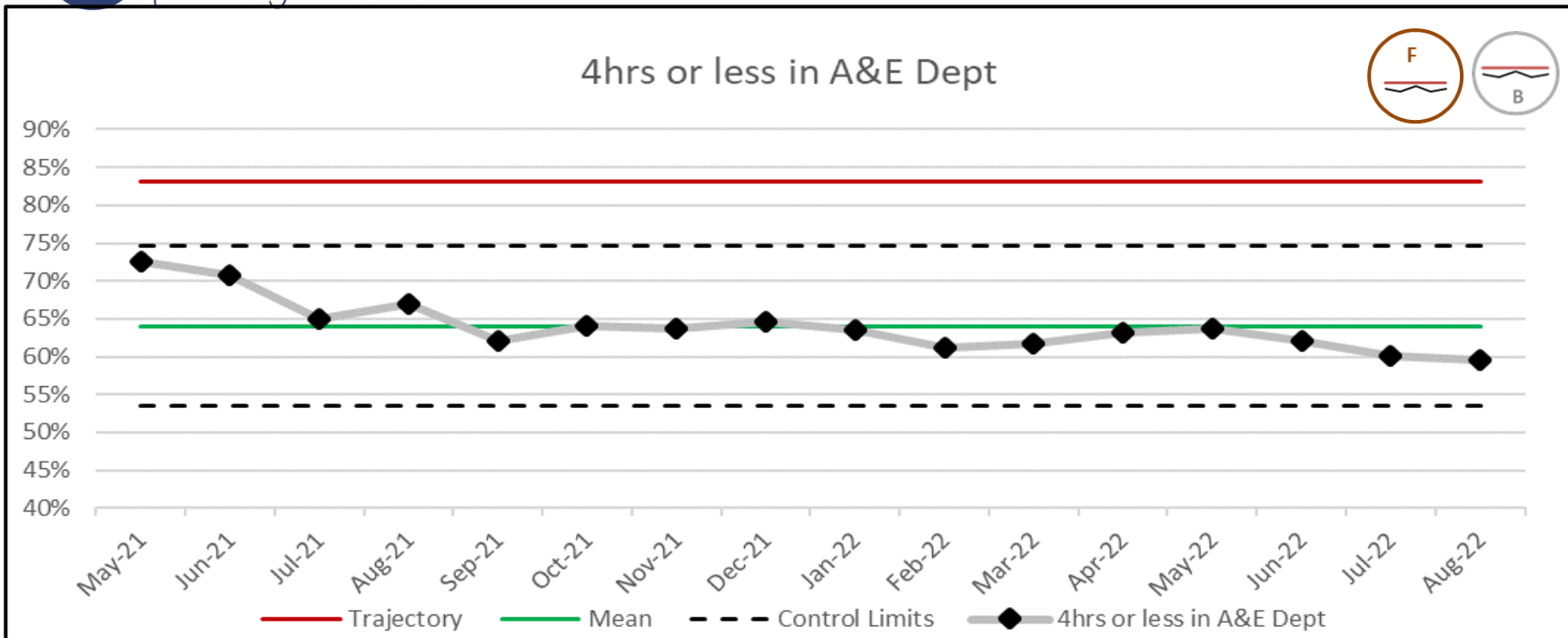

Aug-22
59.48%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 4-hour transit target performance for August was 59.48% compared to 60.10% in July which is a deterioration of 0.62%.
The target compliance is 83.12% and is an historic target that has been unchanged in 2 years.

Issues:

The Emergency Departments saw an 8.89% decrease in attendances in August (2,064 patients) compared to July. 16,548 combined attendances (ED and UTC) in August compared to 18,162 combined attendances in July.
Of the 16,548 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 11,078 and type 3 accounted for 5,470. This is a decrease on type 1 and type 3 across all 3 sites.
Inadequate daily discharges to meet the admission demand remains the main issue leading to extended ED LOS.
Ongoing medical and nursing gaps that were not Emergency Department specific.
Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps.
Escalation of some SDEC areas into Inpatient areas.

Actions:

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

Mitigations:

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

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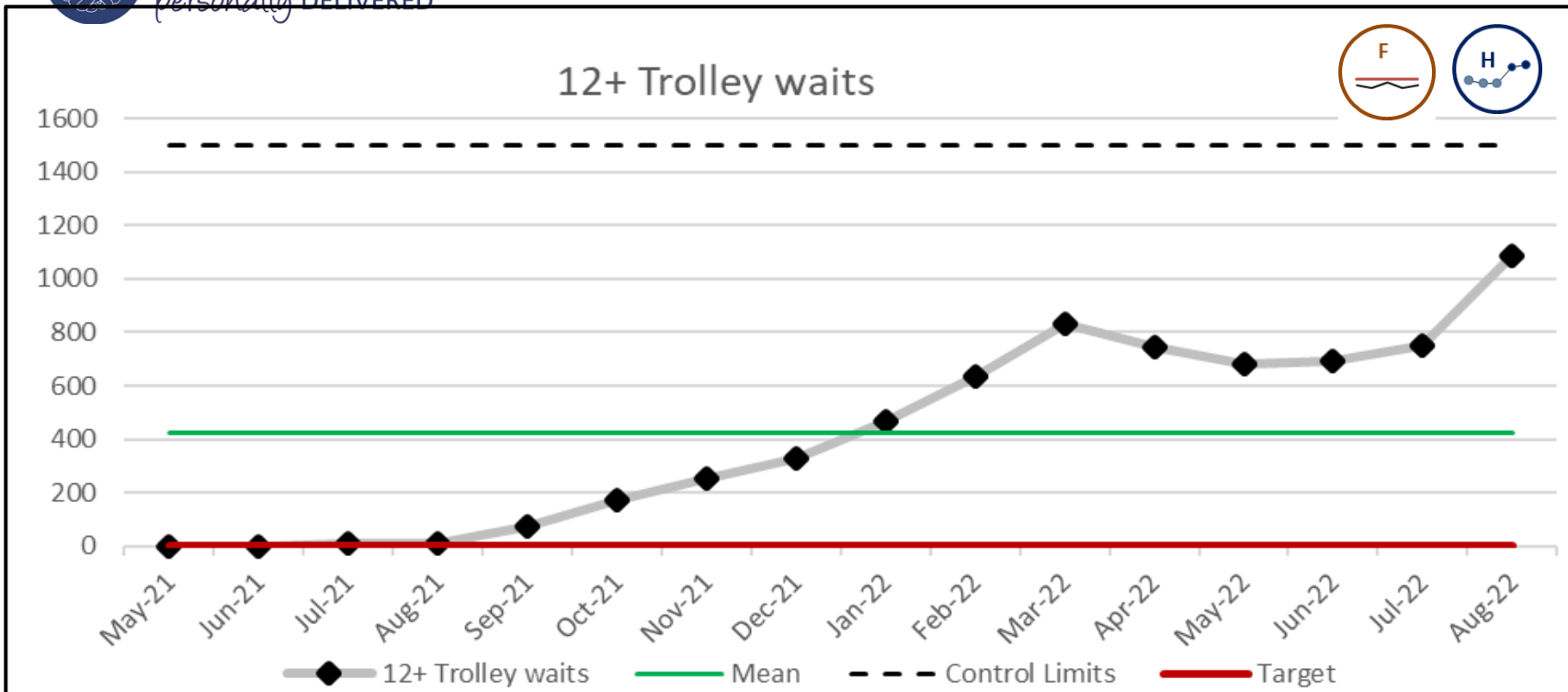

Aug-22
1088
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

August experienced 1088 12-hr trolley wait breaches. This is the unvalidated position. This is an increase of 336 12-hr trolley wait breaches compared to July. This represents an increase of 7.98%. This equates to 9.82% of all type 1 attendances for August.

What the chart does not explain is the internal decision to move from 12hr DTA to total time in ED to minimise exposure risk.

Issues:

Sub-optimal discharges to meet the known emergency demand.

All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings. The actual number of 12hr trolleys wait breaches, whilst anticipated against flow predictions, exceeded actual expectations.

August has experienced an increase in incidental positive covid cases and nosocomial transmission, which as restricted the use of several inpatients' beds, impacting further on flow.

To prevent nosocomial transmission, the use of boarding areas as per the Full Capacity Protocol areas has been problematic.

The Trust has made the safety and risk based assessment to move to total time in ED as opposed to the 12hr DTA standard.

Actions:

The Trust continues to work closely with national regulators in reviewing and reporting these breaches.

Due to the number of 12hrs trolley waits breaches currently, harm reviews are completed by the UEC team, DATIX are completed and escalations to the CCG and NHSE/I are in place.

A daily review of all potential 12hr trolley waits is in place and escalated to all key strategic tactical and operational leads and divisional triumvirates.

System Partners and Regulators remain actively engaged and offer practical support in situational escalations.

A substantial programme of work out of hospital is in place with system partners to reduce delayed discharges which are upwards of 15% of all beds at times.

Internal actions on admission avoidance are focussed on Same Day emergency Care and recent developments have shown a 100% increase in some areas.

Mitigations:

All potential DTA risks are escalated at 8hrs to the Daytime Tactical Lead, out of hours Tactical Lead On Call Manager and CCG Tactical Lead – in and out of hours. Rectification plans are agreed with all CBU teams in hours.

A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support. This demonstrates a positive impact but due to staffing gaps, there is an increased request to close this facility. Permission to close these areas now sits solely with the Chief Operating Officer and Director of Nursing or delegated officer

A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.

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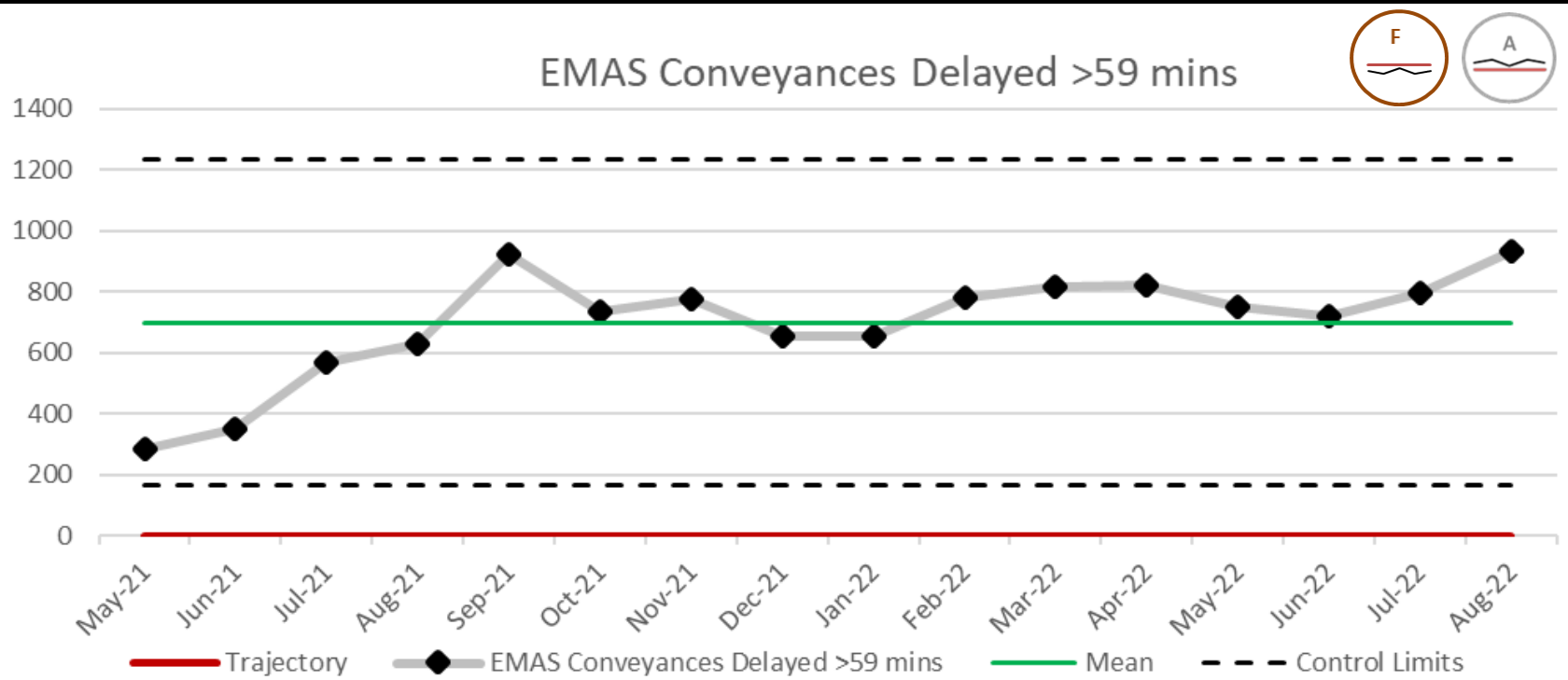

Aug-22
930
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

August demonstrated an increase in greater than 59 minutes' handover delays 930 in August compared to 796 in July. This represents a 14.41% increase.
What the chart does not tell us is the increase of >2hrs in August 2022 (517 in August vs 426 in July) and an increase in >4hr delays (123 in August vs 94 in July).PHB saw the largest increase in both >2hrs and >4hrs.
Overall conveyances were comparable in August to that

Issues:

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

Actions:

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

Mitigations:

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

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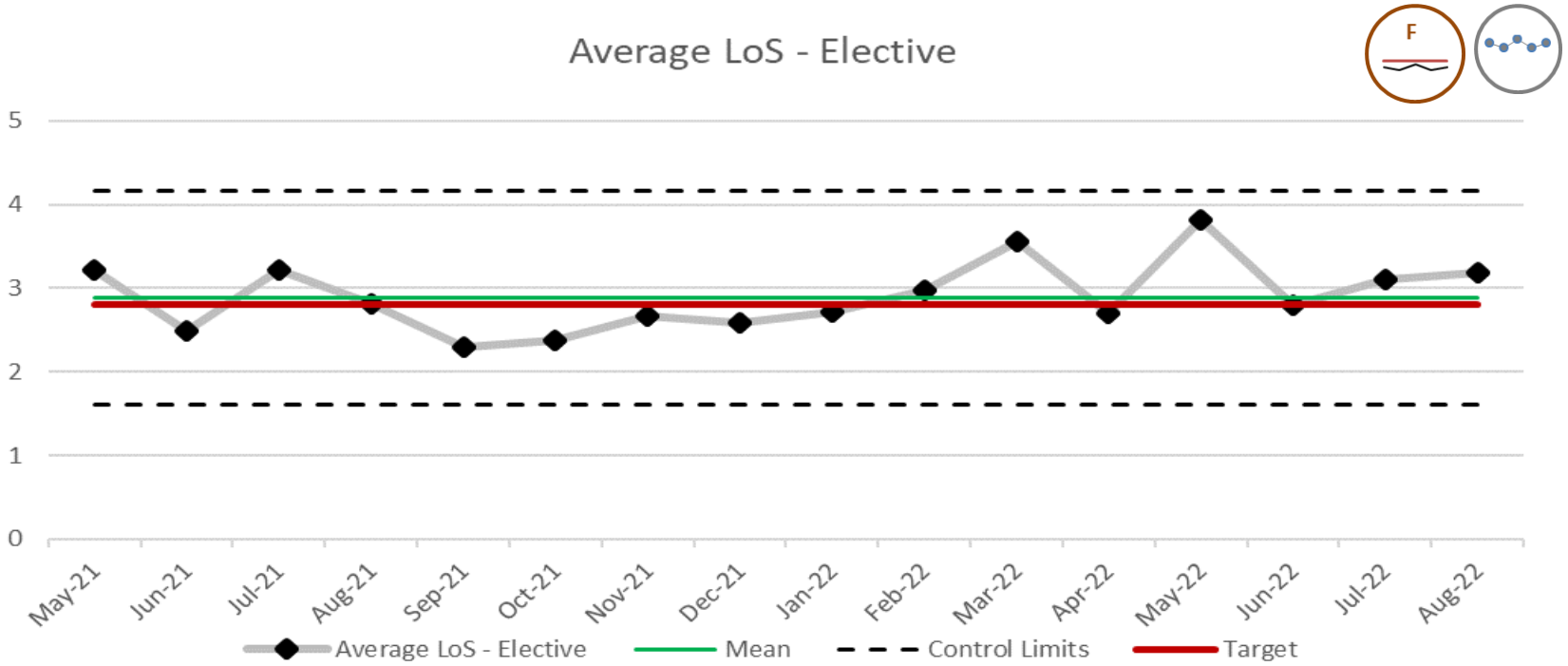

Aug-22
3.19
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
2.80
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for Elective inpatients

What the chart tells us:
The average LOS for Elective stay has increased from 3.11 days in July to 3.19 days in August. This is a marginal increase of 0.08 days and represents a negative variance of 0.39% against the agreed target. The trajectory for Elective LOS is 2.8 days.

Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

Actions:
The reduction in waiting times is being monitored weekly.
Focus on speciality waiting lists where patients have been identified as having increased morbidity which will impact of increased LOS.
Timely ITU 'step down' of level 2 care to level 1 'wardable' care.
The complete review and allocation of 'P' codes. This is currently at c6weeks.
Work is in train to include an ALOS predictor against procedure normal LOS vs patient specific indicators when scheduling patients for theatre.

Mitigations:
6-4-2 weekly theatre scheduling meeting will identify those patients that will need an extended LOS and consideration for increased optimisation to reduce predicted LOS.
All elective areas are to now escalate pre-operatively any post-operative requirements that may lead to an extended LOS outside of the expected LOS.
The utilisation of GDH for both low and medium risk patients.

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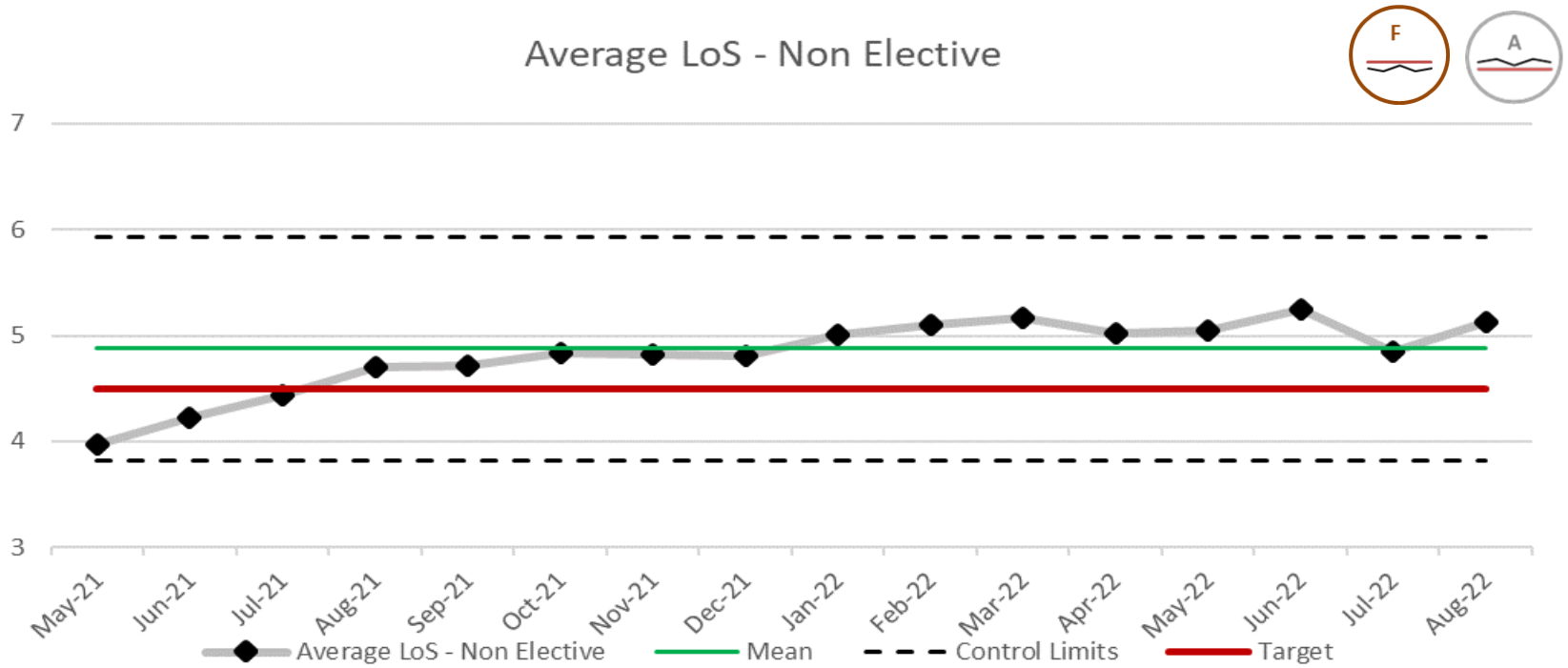


Aug-22
5.12
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 5.12 days in August vs 4.85 in July.
This is an increase of 0.27 days
compared with July
This is a 0.62-day variance against the agreed target.

Issues:

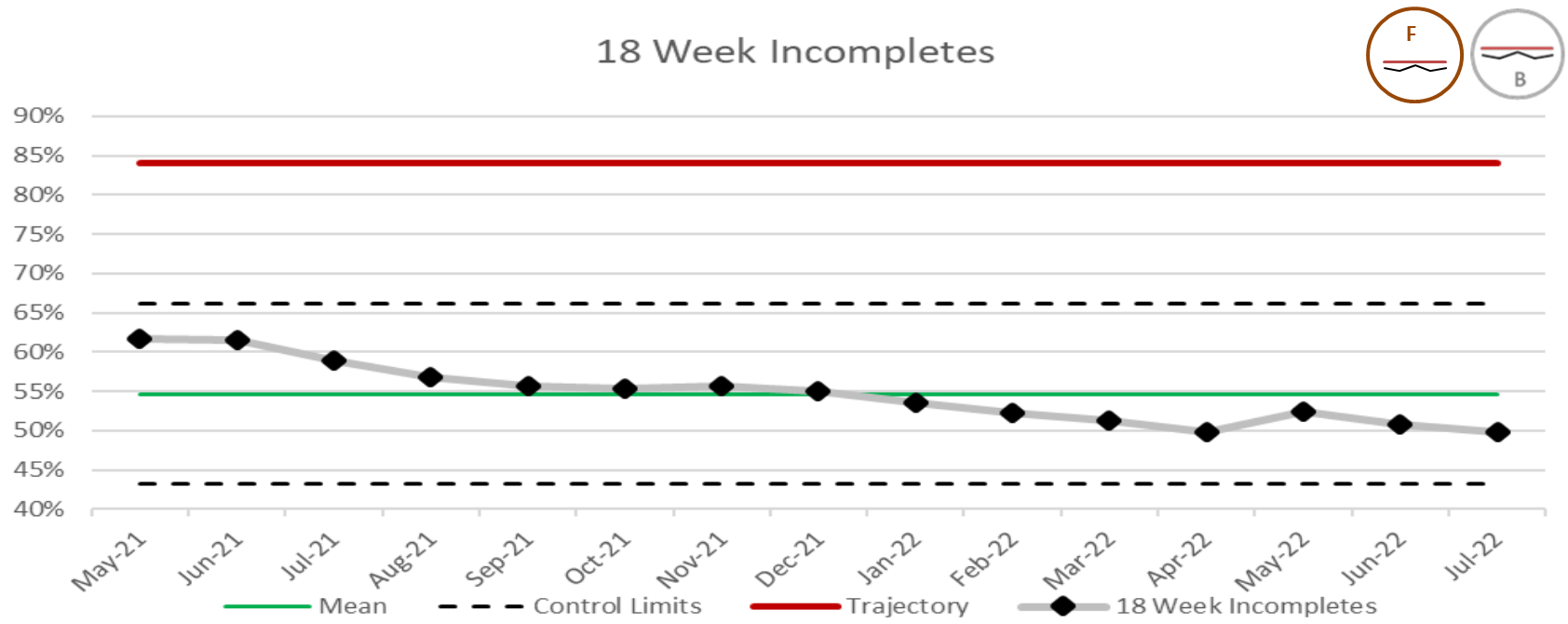
Numbers of stranded and super stranded patients are static in number.
Increasing length of stay of all pathways 1-3. The most significant increase in volume of bed days is Pathway 1 Domiciliary care but since the advent of the joint D2A process and additional funding benefits are being realised but there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

Actions:

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

Mitigations:

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



Jul-22
49.78%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There is significant backlog of patients on incomplete pathways. July saw RTT performance of 49.78% against a 92% target, which is 1.01% down on June.

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 – 5953 (increased by 302)
- Gastroenterology – 3907 (increased by 274)
- Dermatology – 3228 (increased by 132)
- Gynaecology – 2507 (decreased by 78)
- General Surgery – 2392 (increased by 108).

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. With IPC support, Outpatient areas have dropped the 2m rule and all areas are returning 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 continue to be assessed for their suitability to be transferred to Independent Sector Providers and offered this choice for treatment.

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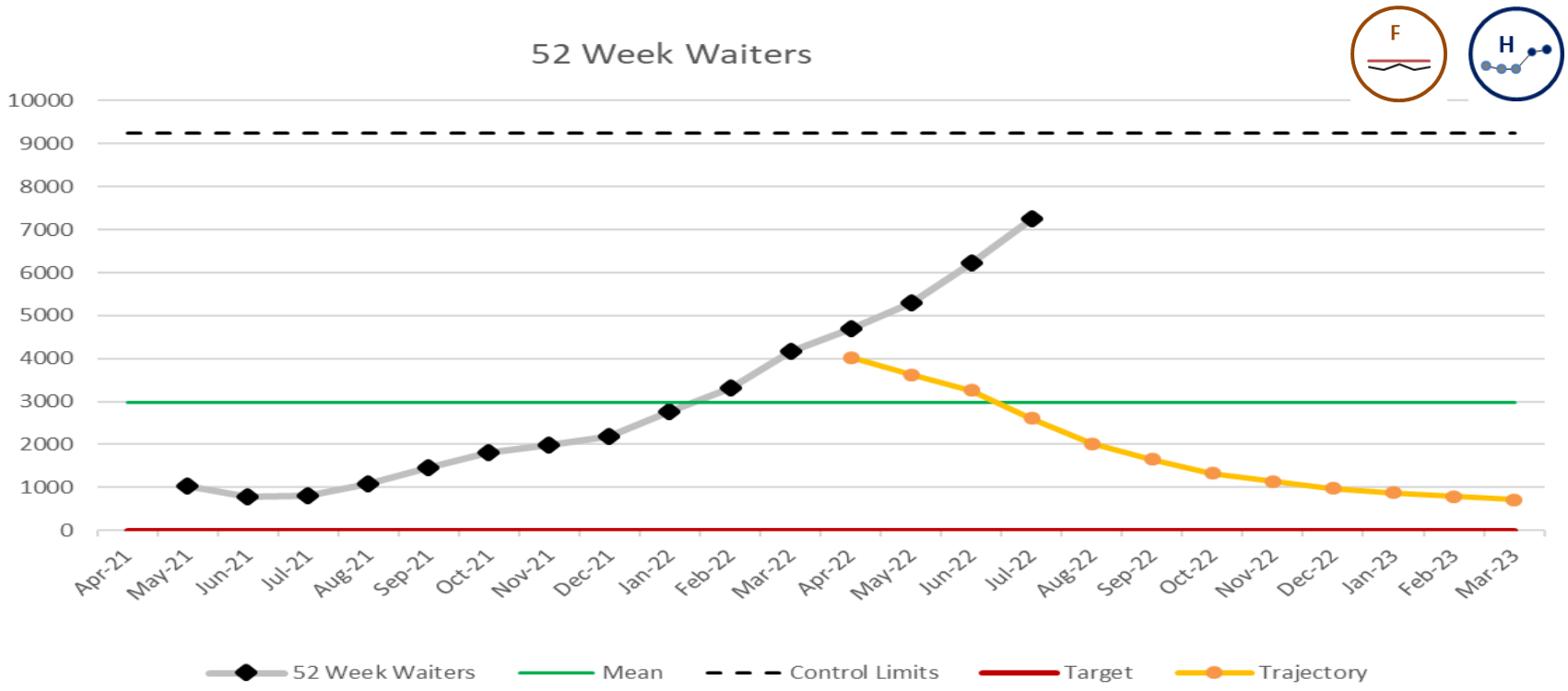

Jul-22
7246
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 7246 incomplete 52-week breaches for July. An increase of 1030 from June.
The number of 52-week breaches has increased considerably since August 2021.

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

Actions:
Admitted patients are individually graded and allocated a priority code utilising C2AI.This 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 volumes and severity closely monitored. The in-house monitoring and recording software that was being developed has been identified as unsuitable.

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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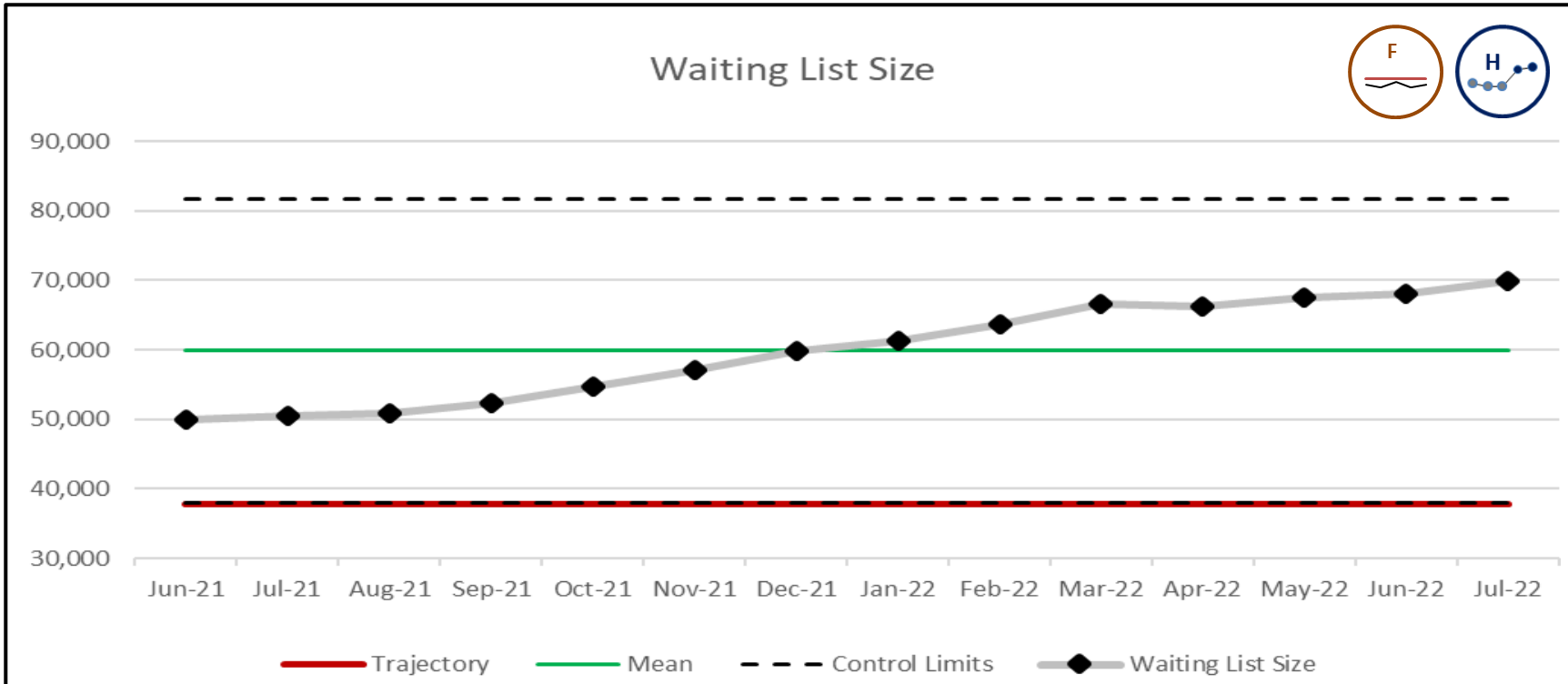

Jul-22
69,947
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has increased from June, with July showing an increase of 1807 to 69,947.
The incomplete position for July 2022 has increased by approximately 31,921 more than the reported pre pandemic size in January 2020.

Issues:
Recent extreme weather temperatures have caused service delivery issues, necessitating the cancellation 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 June are:

- Dermatology + 377
- Community Paediatrics + 210
- Trauma and Orthopaedics + 199
- Gastroenterology + 196
- Maxillo-Facial Surgery + Ortho+ 186

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

- Paediatrics – 102
- Ophthalmology - 86
- Gynaecology - 63
- Infectious Diseases - 33
- Clinical Oncology - 32

The Trust reported 14,003 over 40 week waits, an increase of 1399 on June. Patient numbers waiting over 26 weeks increased by 824.

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 ICB meeting. Transferring of appropriate admitted patients to ISP's continues. Non admitted patients in the most pressured specialities continue to be transferred out. The tender process to procure an external company to undertake validation of pathways is now at evaluation stage with an anticipated September start.

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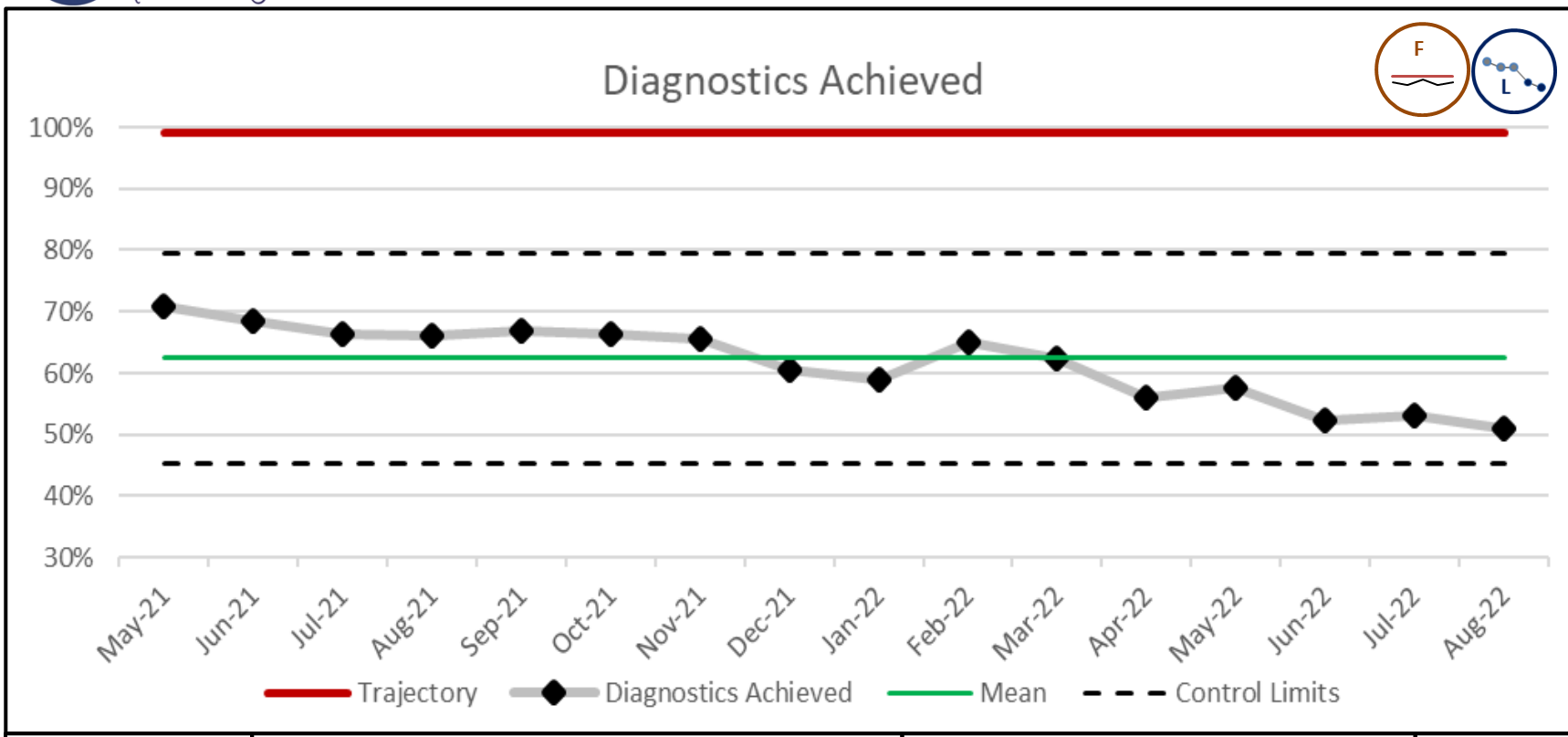

Aug-22
50.85%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 50.85% against the 99.00% target.

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 Audiology have had capacity issues due to sickness and maternity. And the change in the Autism pathway has caused an increase in demand. Back log now being seen for Dexa due to loss of scanner due to fire.

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. All areas have completed a recovery trajectory to NHSE.

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

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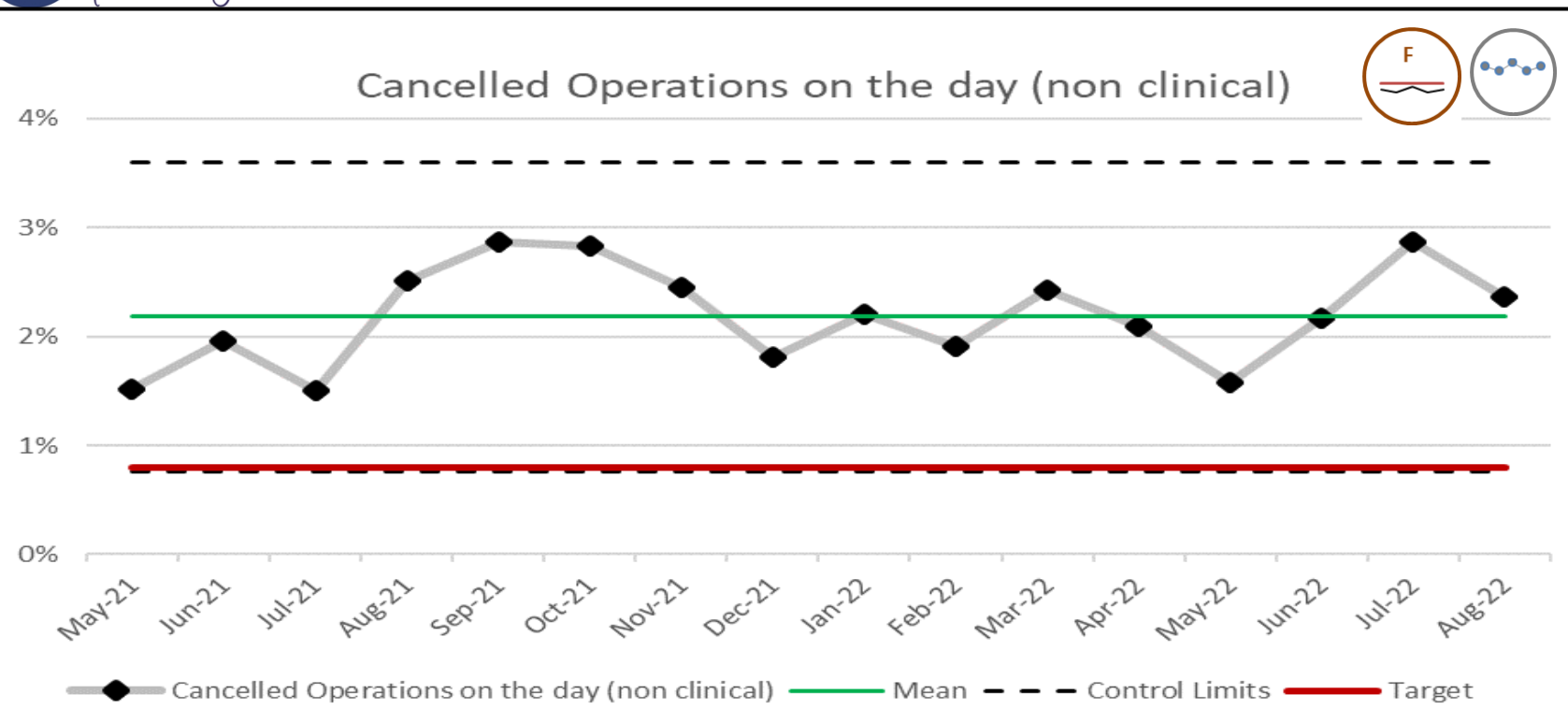


Aug-22
2.36%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us
July shows a decrease to 2.36% for patients who have had their operation cancelled on the day of surgery however remains above the agreed trajectory of 0.8%.

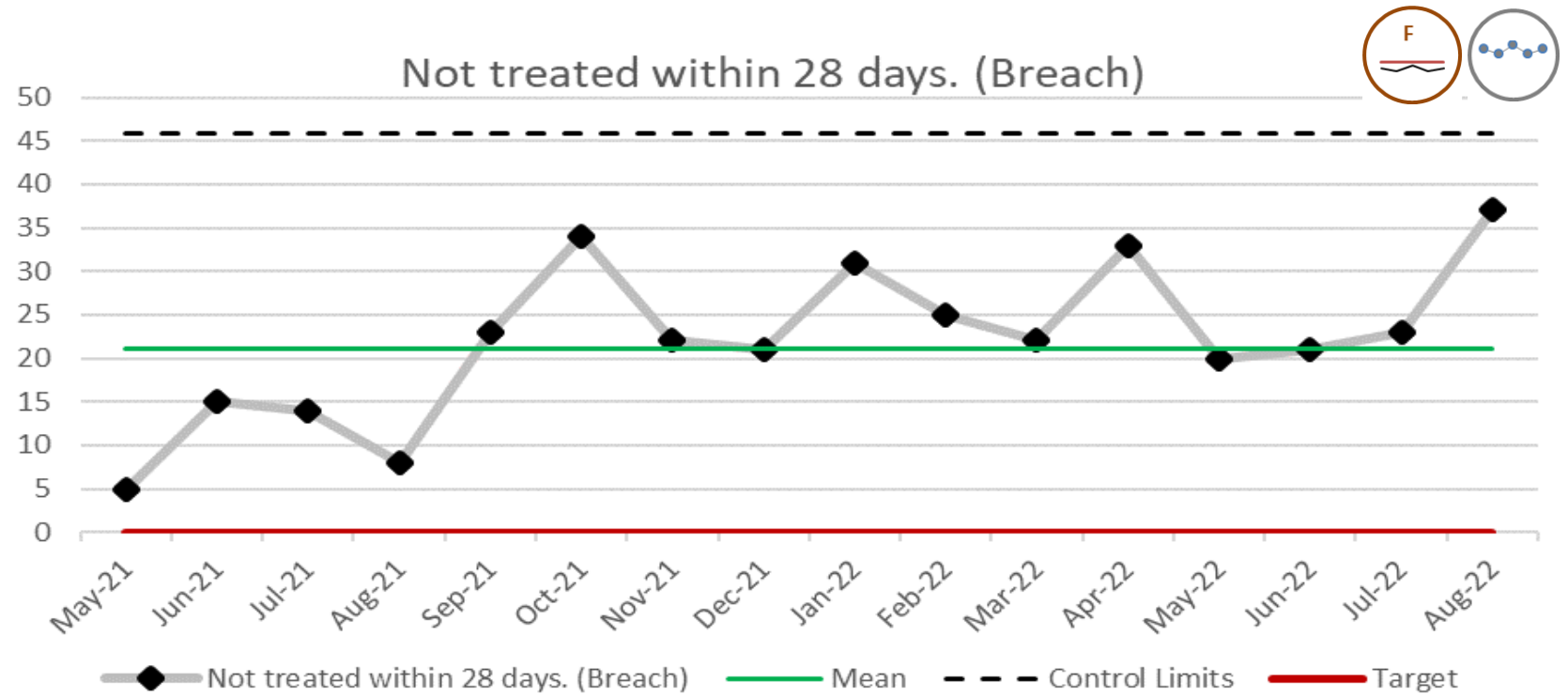
Issues:
The top 3 reasons for same day non-clinical theatre cancellations for August are identified as:

1. No surgeon;
2. Lack of time; and
3. No general beds.

Actions:
Further information is being gathered with regard the high number of patients cancelled due to lack of time. This will be sought to confirm list start times, avoidable delays and any unforeseen circumstances that would lead to this high number.
SAL at Lincoln is changing patients admission time to 7am to reduce late starts due to admission delays.

Mitigations:
An increase in COVID related absence within our surgical colleagues meant a higher than usual number of on the day cancellations.

Additionally, incorrect recording of a small number of those recorded as lack of time should be corrected as lack of surgeon.



Aug-22
37
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
This chart shows the number of breaches during August 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 August is 37, which is a significant increase from 23 in July.
The agreed target of zero has not been achieved.

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

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

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

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

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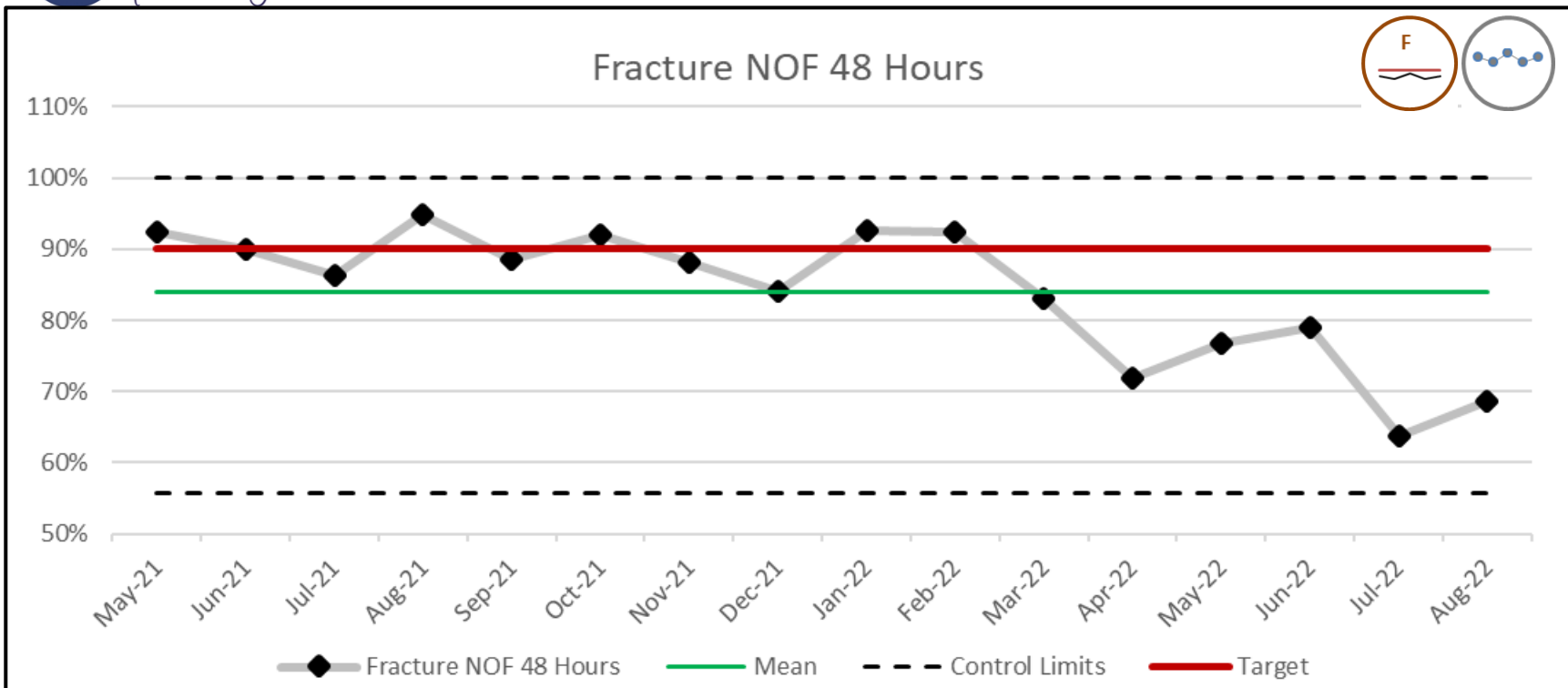

Aug-22
68.60%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

August performance out turned at 68.60 % against the agreed target of 90%.

Both sites underperformed with PHB at 56.76% and LCH 77.55%, which has led to deterioration in performance.

Issues:

Increase in trauma demand over recent months, particularly during BH weekend in August.
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.
7a escalation beds open to support trauma.
Reduction in elective lists on Lincoln/Boston sites to accommodate trauma.

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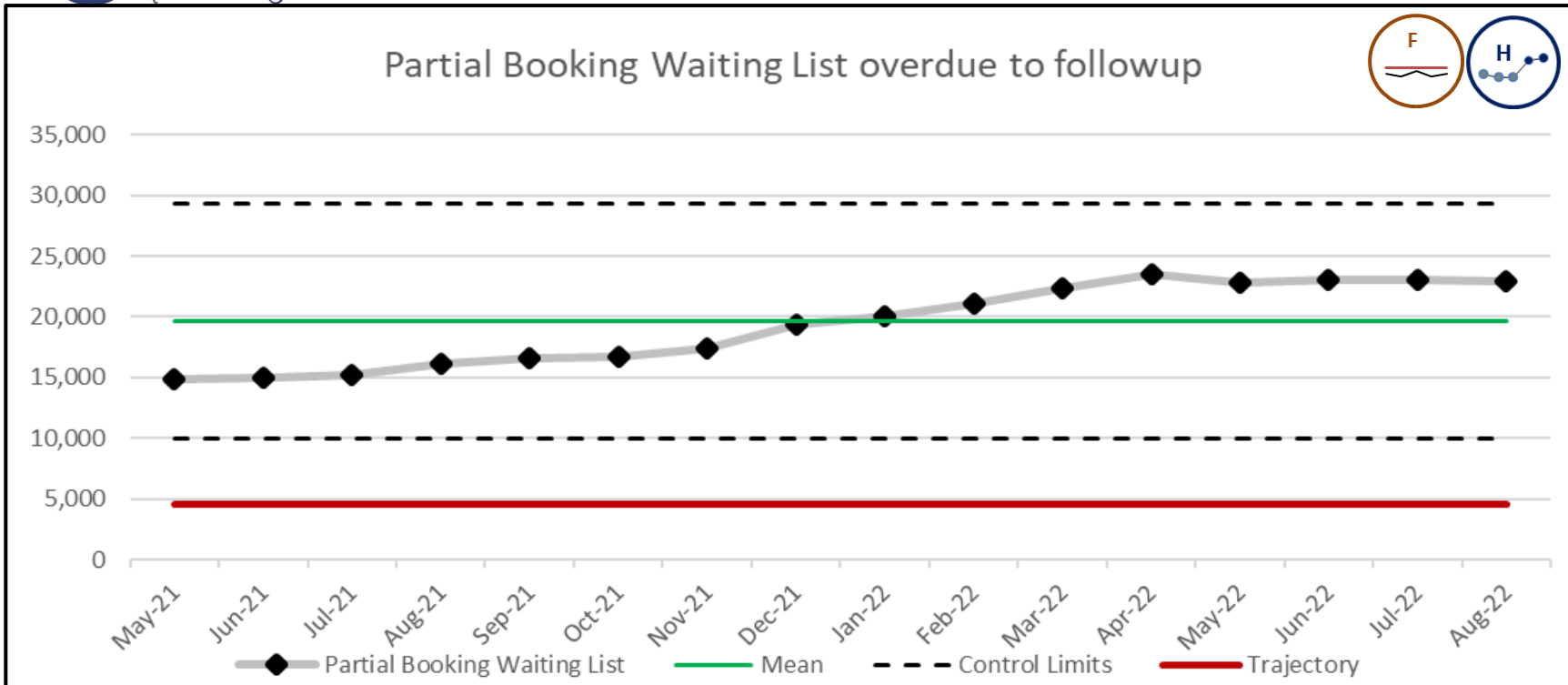

Aug-22
22,951
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 22,951 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased and has continuously increased since until April 2022. Since then the PBWL has remained reasonably stable with minimal increases and decreases per month.

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

Actions:
Specialities have agreed plans to increase activity for 2022/23 which will improve their PBWL position and reduce patient waits. Clinic templates have increased back to pre-covid templates in almost all specialties. Resource identified to progress Personalised Outpatient Plan including maximising validation, clinical triage, technological solutions and PIFU. Currently, reviewing tender bids for a validation team to review the PBWL patients and prioritisation of patients.

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

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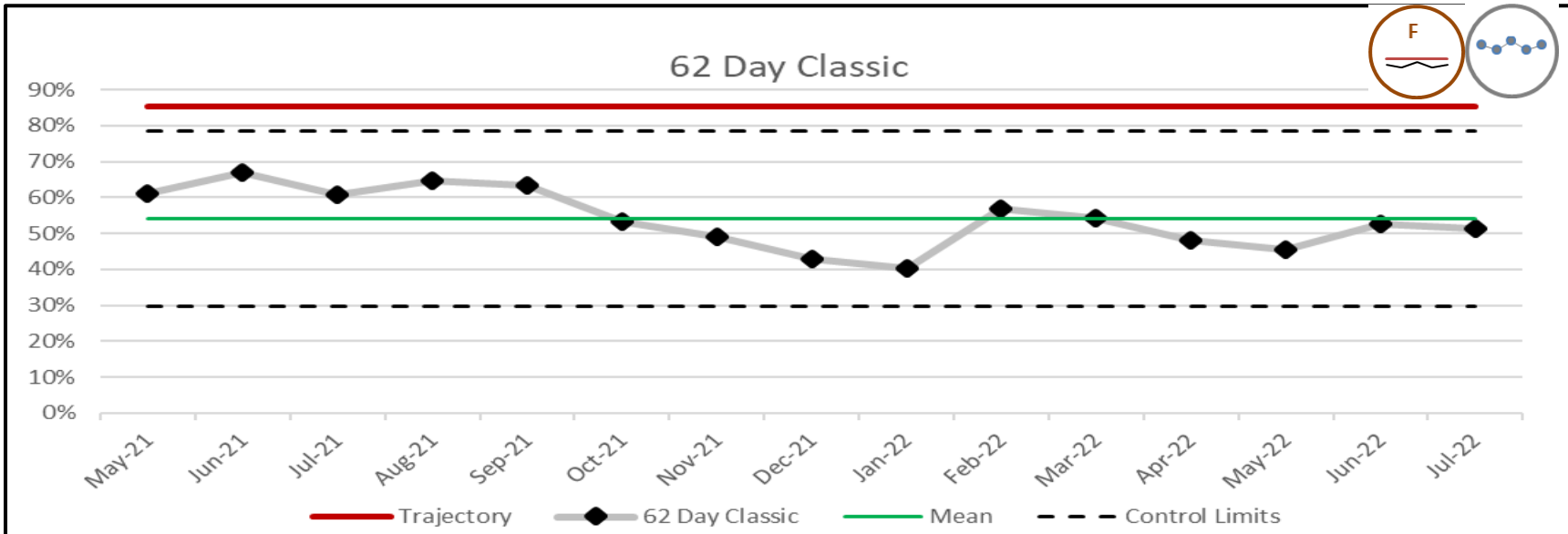


Jul-22
51.37%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 51.37% against an 85.4% target.

Issues:

The impact of ongoing pathway, staffing and capacity challenges.

Continued 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, Head & Neck and Lung.

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

Actions:

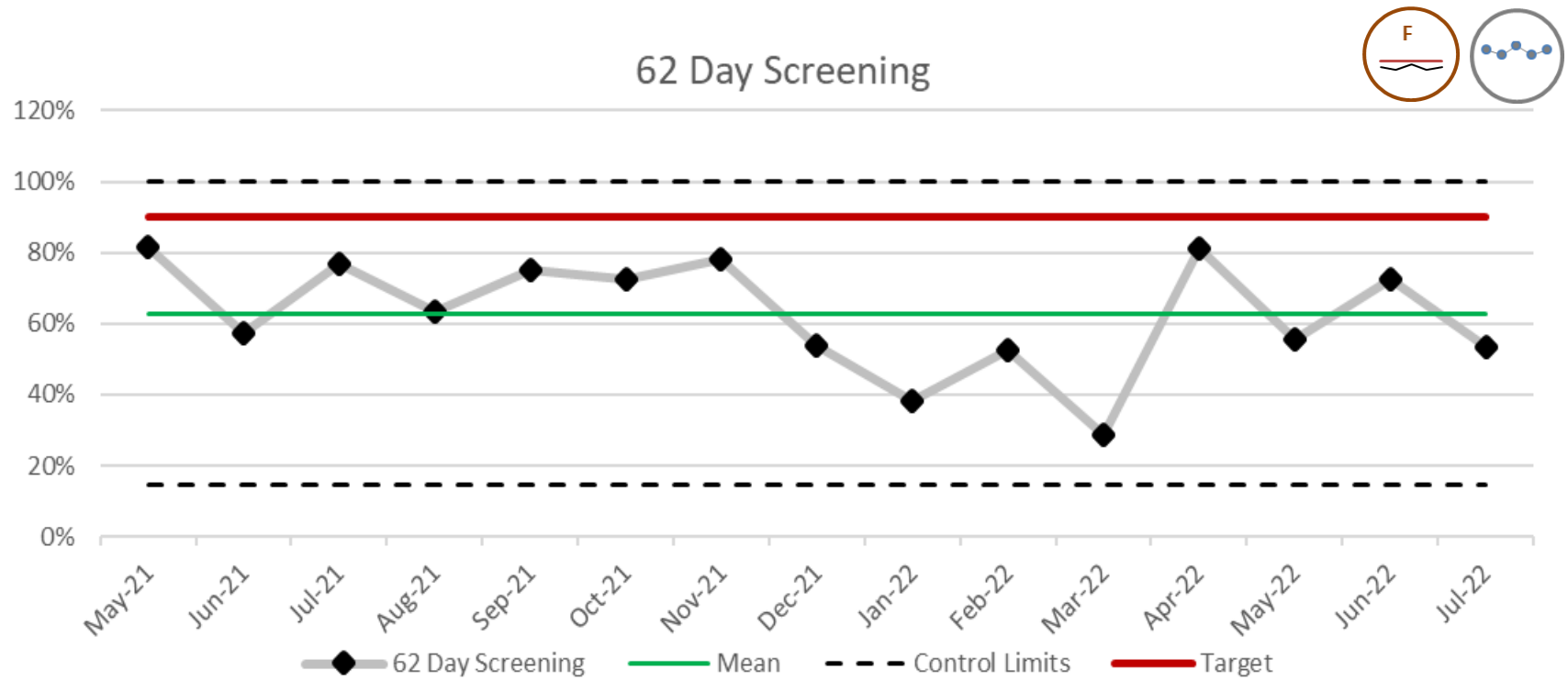
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program. Recruitment in Oncology is ongoing, working with HR, Holt and Advanta to secure locums, NHS locum or substantive posts. 2 posts have recently been offered and start dates are TBC. There is a significant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

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

Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics.

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.



Jul-22
53.33%
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 53.33% against a 90% target.

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

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

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

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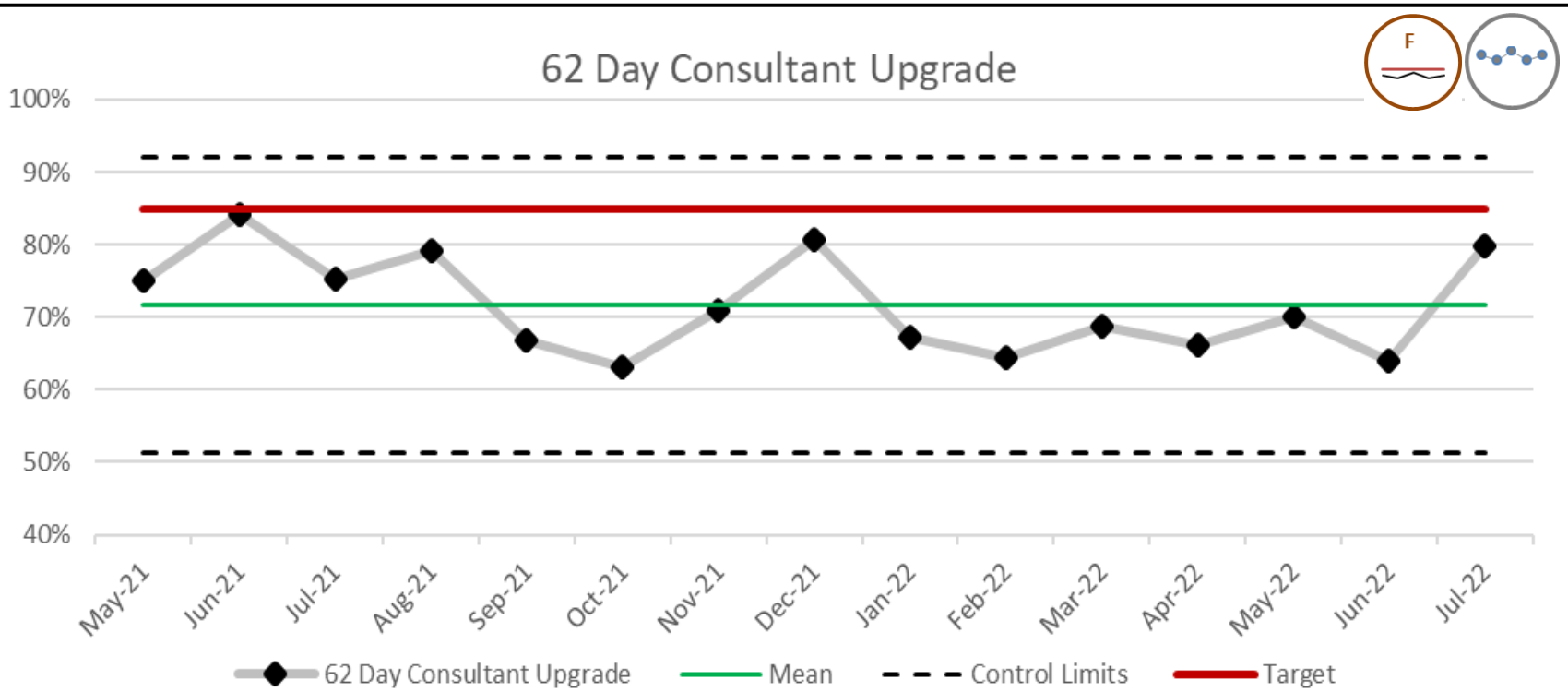

Jul-22
79.72%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 79.72% 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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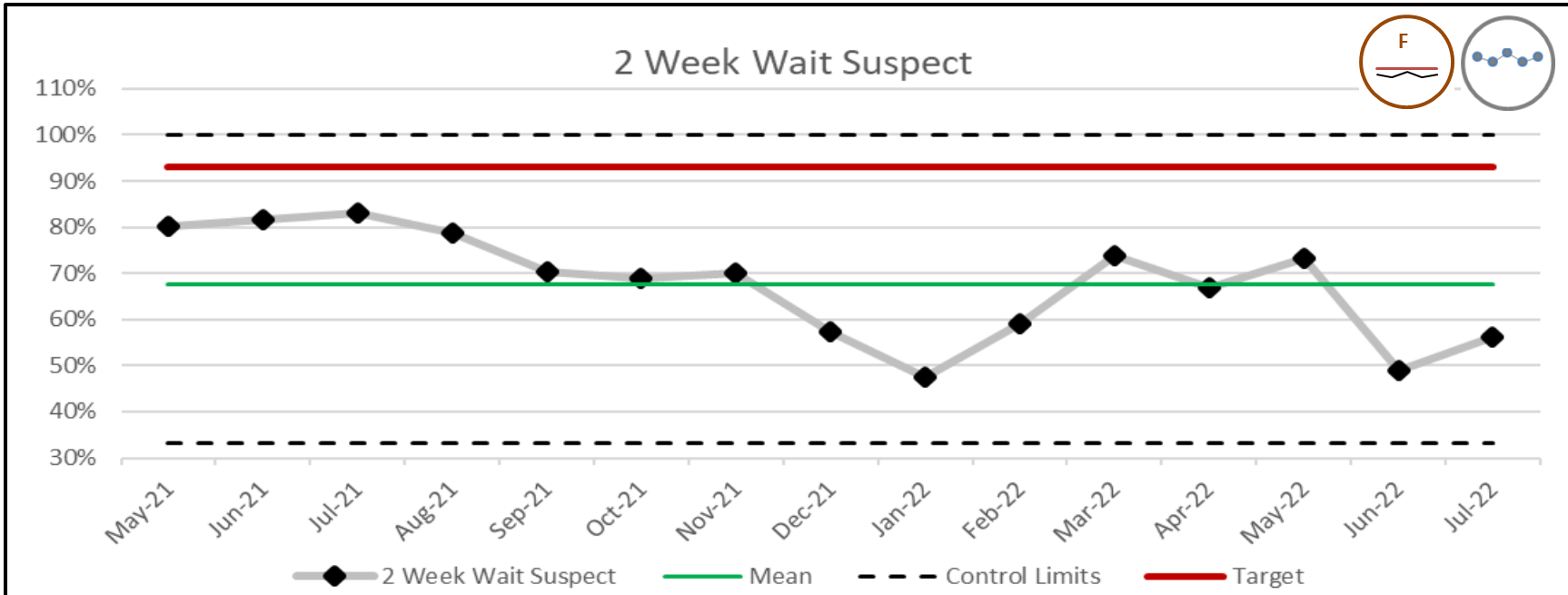

Jul-22
56.08%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 56.08% 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 44.6% - 17% of the Trust's 14 Day breaches were within that tumour site. Of greater concern in July was colorectal performance at 20.3% - colorectal accounted for almost 37% of the Trust's 14 day breaches. The other tumour sites that considerably under-performed include Lung (13.3%), Skin (59.8%) and Gynaecology (61.9%).
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.
Substantive and NHS Locum posts in Respiratory are back out to advert following withdrawals and unappointable candidates.
Ongoing BC for increase in consultant workforce to 10-15 consultants.
A Gynae review of specialist nurse workforce and oncology strategy follow up meeting is to be scheduled following the successful initial meeting on 15th July.
Challenges due to medical sickness and lack of STT capacity in Urology – plans are in place to improve STT capacity from end Sept.
These and other key action progress are tracked through the Urgent Care Cancer group chaired by the Medical Director and run with full system partner involvement.

Mitigations:

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

Additional weekend Urology clinics continue to be set up to resolve capacity issues. Work is being undertaken with Endoscopy to increase capacity across sites and ensure efficient utilisation of current clinic capacity. Recruitment for CBU booking clerks is underway.

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

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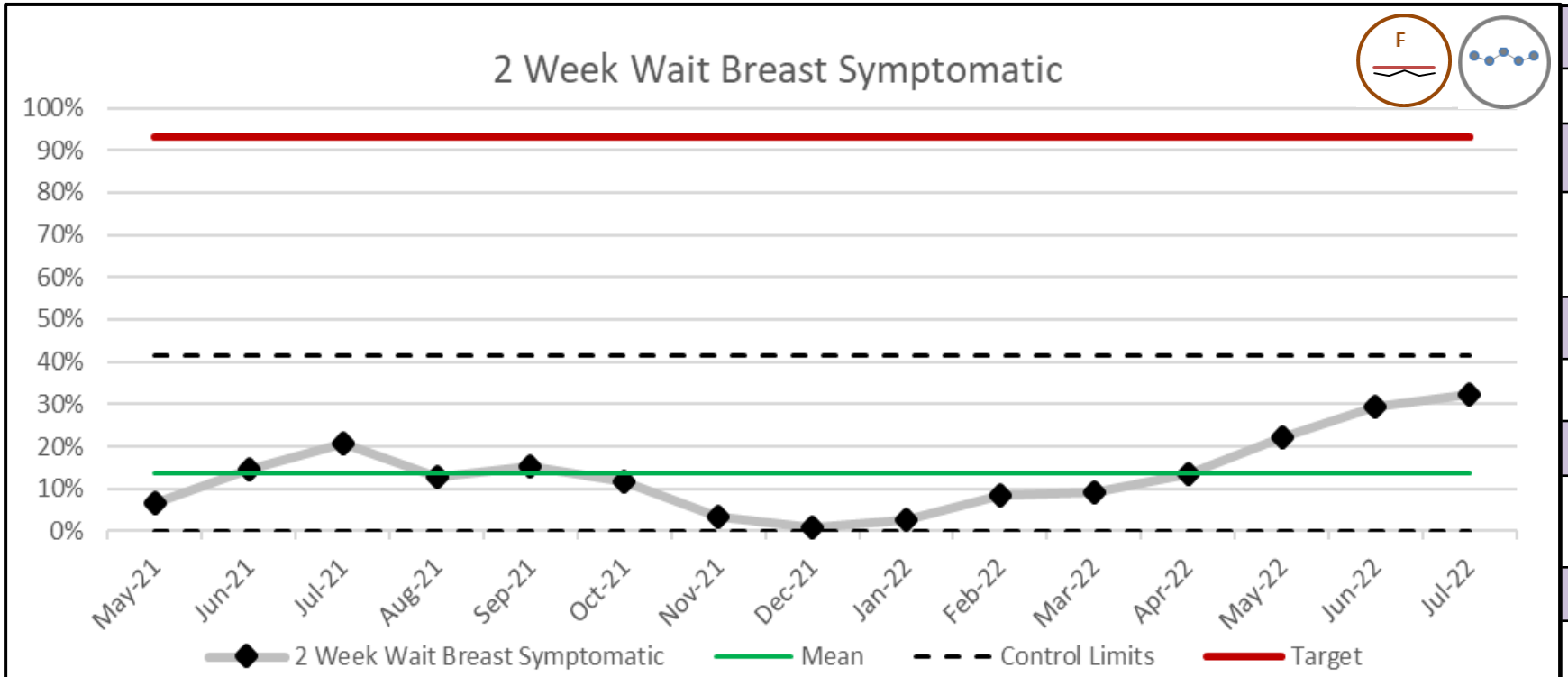

Jul-22
32.14%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 32.14% against a 93% target.

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

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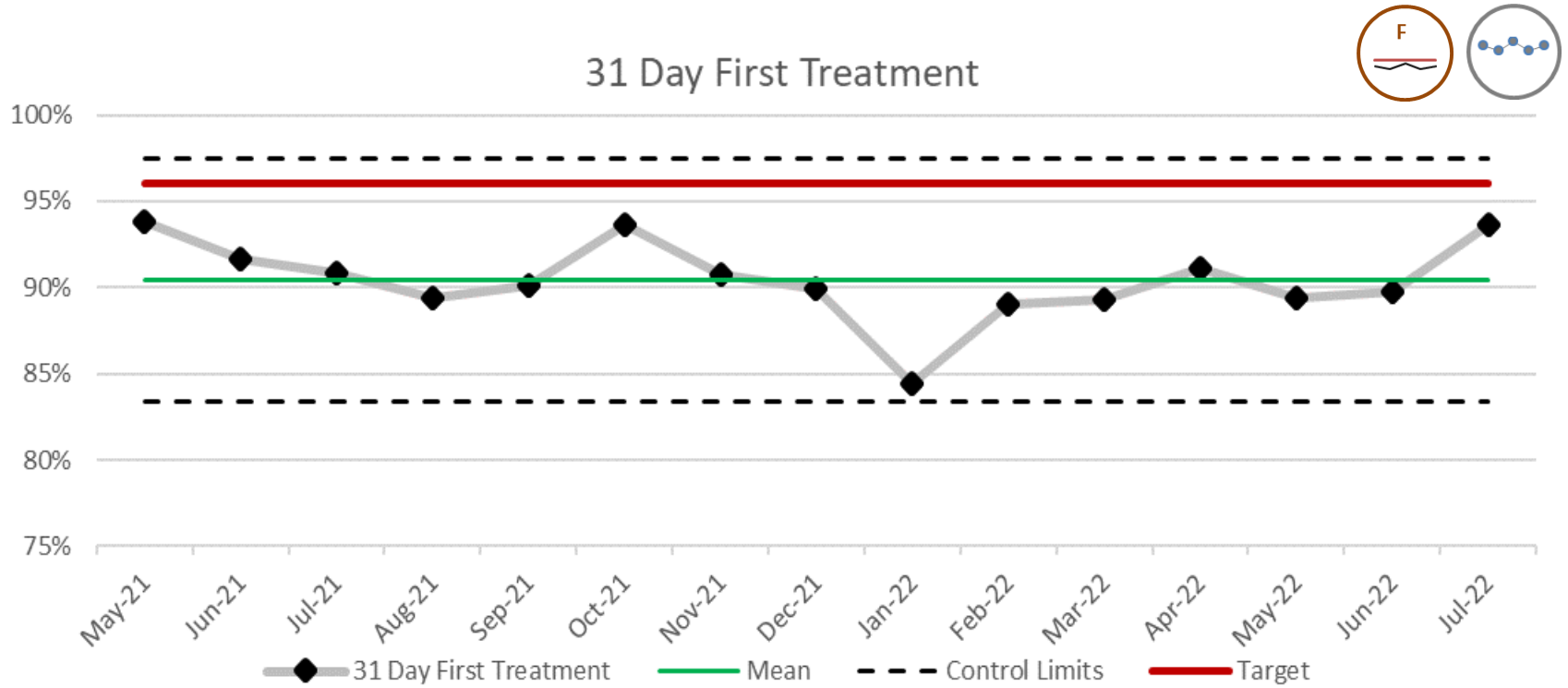

Jul-22
93.67%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 93.67% 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. The subsequent work streams emerging from this are ongoing.

Mitigations:
Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity.

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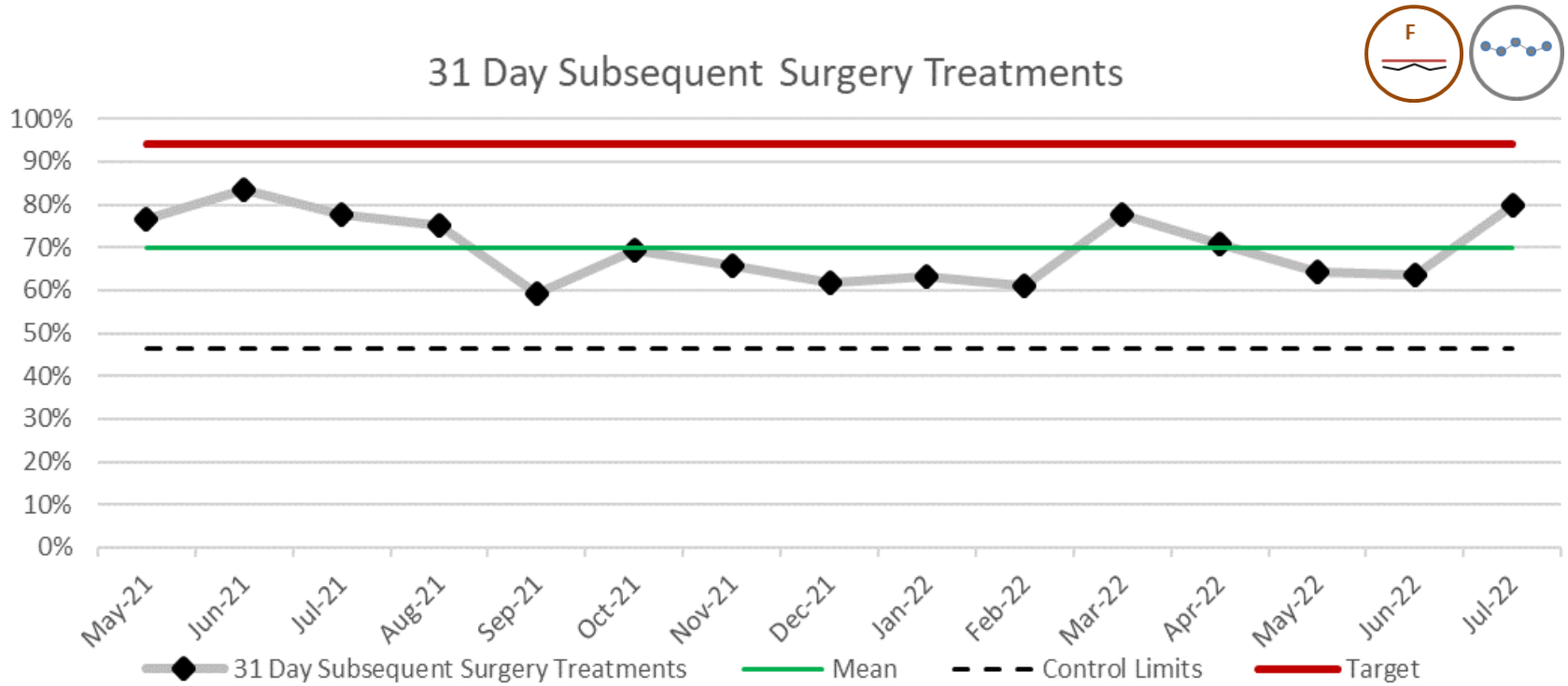

Jul-22
80.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 80% 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 and Drug standards, failing only in the Surgery standard.

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

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

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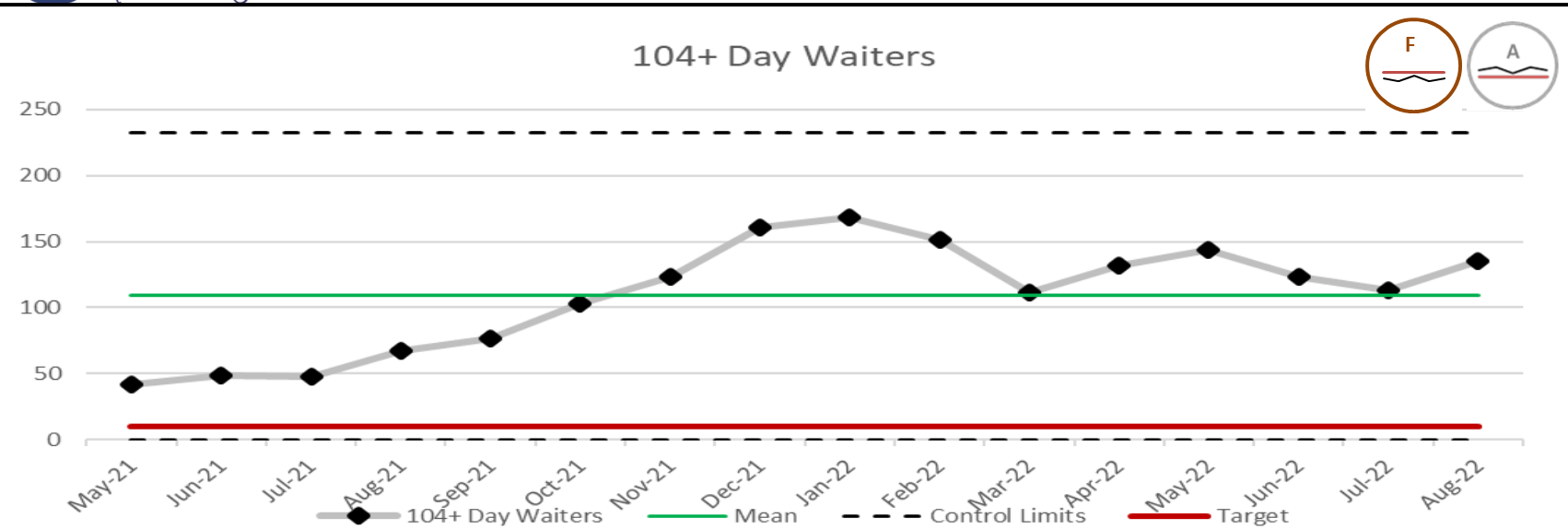

Aug-22
135
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Number of cancer patients waiting over 104 days.

What the chart tells us:

As of 9th September the 104 Day backlog was at 135 patients. The agreed target is <10.

There are two tumour sites of concern
Colorectal 92 (majority awaiting diagnostics, outpatients and clinical review)
Upper GI 19

Issues:

The impact of ongoing pathway, staffing and capacity challenges.
Continued 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, Gynaecology, Head And Neck and Lung.
Approximately 21% 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 ICB and EMCA colleagues. The Deep Dive's subsequent work streams are ongoing.

Mitigations:

Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity.
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	Jun-22	Jul-22	Aug-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%	89.76%	89.72%	89.86%	89.77%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	12.08%	11.35%	10.73%	11.00%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.28%	5.28%	5.29%	5.27%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	14.82%	15.06%	15.09%	14.85%		F	H	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	59.14%	60.30%	60.76%	58.38%		F		

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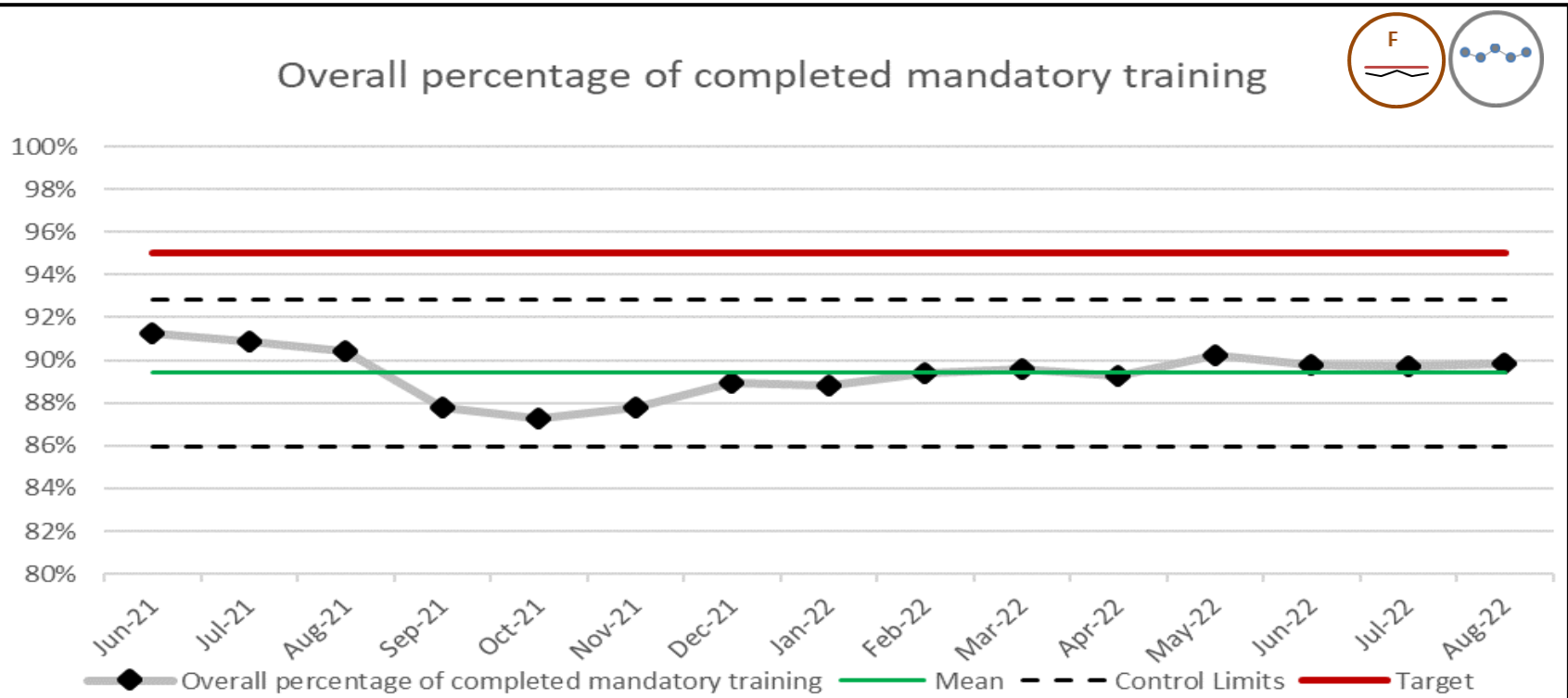

Aug-22
89.86%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Mandatory training shows a slight 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 recording of learning by ESR cited as having an impact on rates
- Core learning suite too large and under review.

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

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

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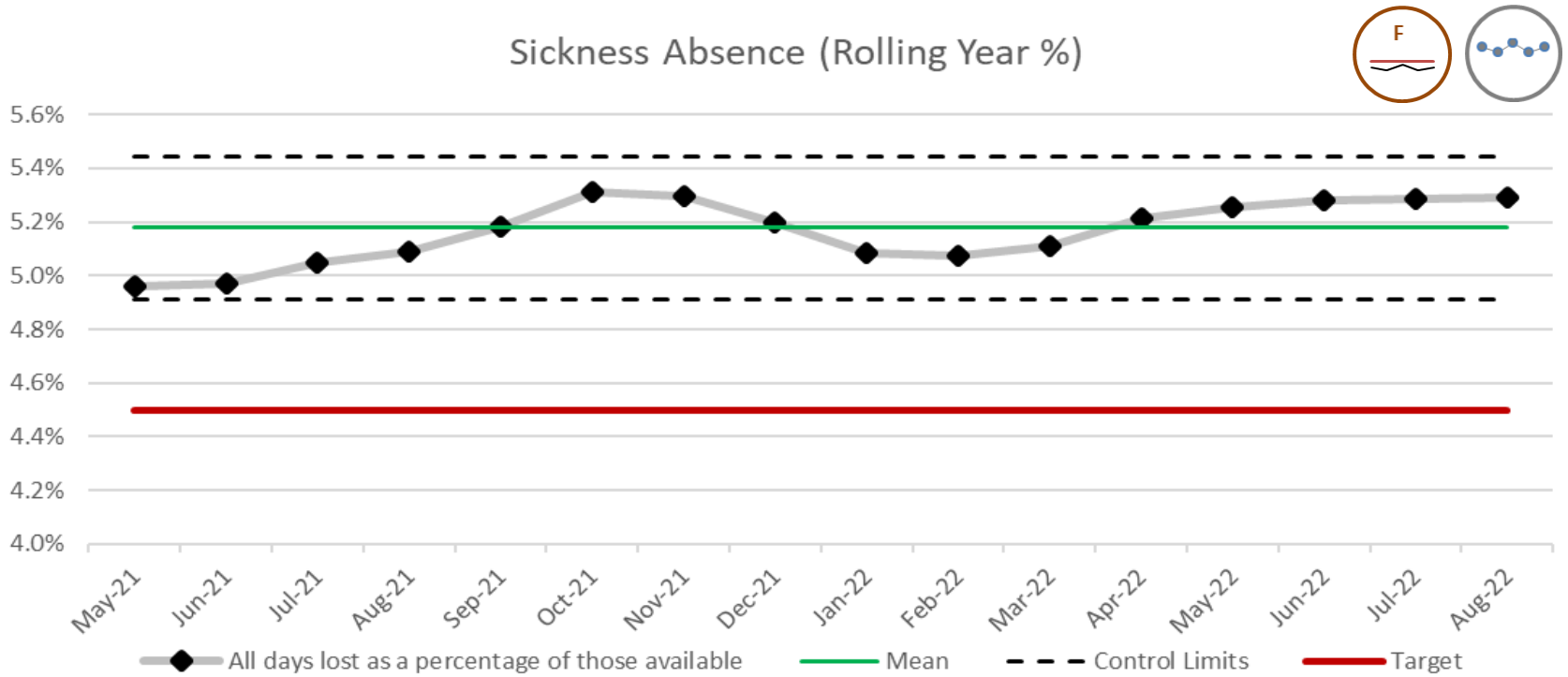


Aug-22
5.29%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The trend has increased by 0.01% to 5.29% which is still above the target of 4.5%.

Issues:

- The Covid absences are continuing the downward trend.
- Stress & Anxiety remains the top reason for absence, followed by other MSK problems and injury/fractures.

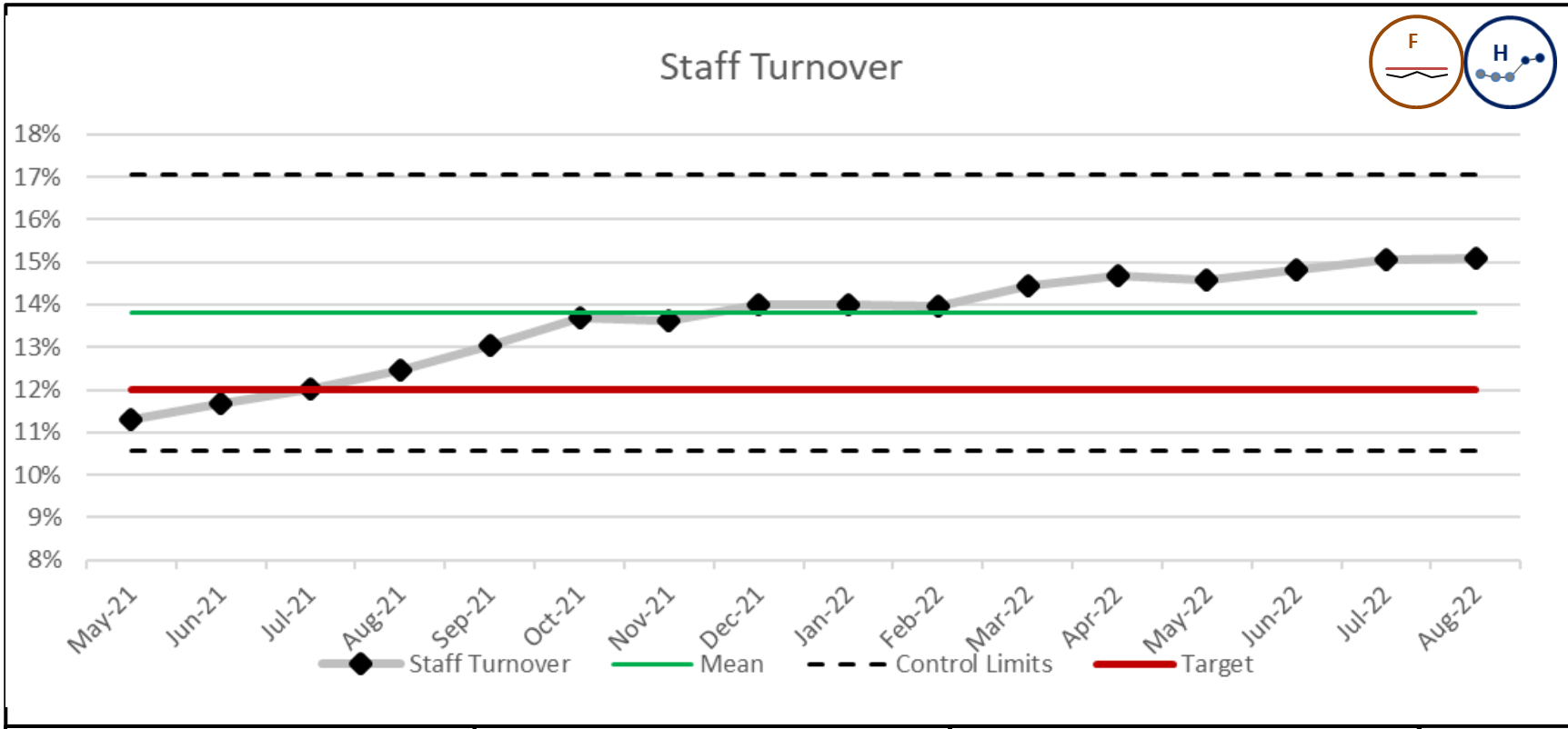
Actions:

- Extensive work is continuing to get full engagement of using AMS Trust wide with all senior management training now having been completed. The AMS Refresher training sessions continue to be run across all Divisions to be completed by the 31st December 2022 for the remaining 320 staff who manage absence. Please note that by gaining full engagement in the use of AMS, we will see an increase in the absence rate before we see an improvement due to accurate, full reporting.
- Work has now been completed to cleanse the Case Manager element of AMS to ensure all cases are managed effectively and the ER team continue to support managers with this.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-22
15.09%
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:
Recent Analysis of exit survey data shows reasons as follows

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

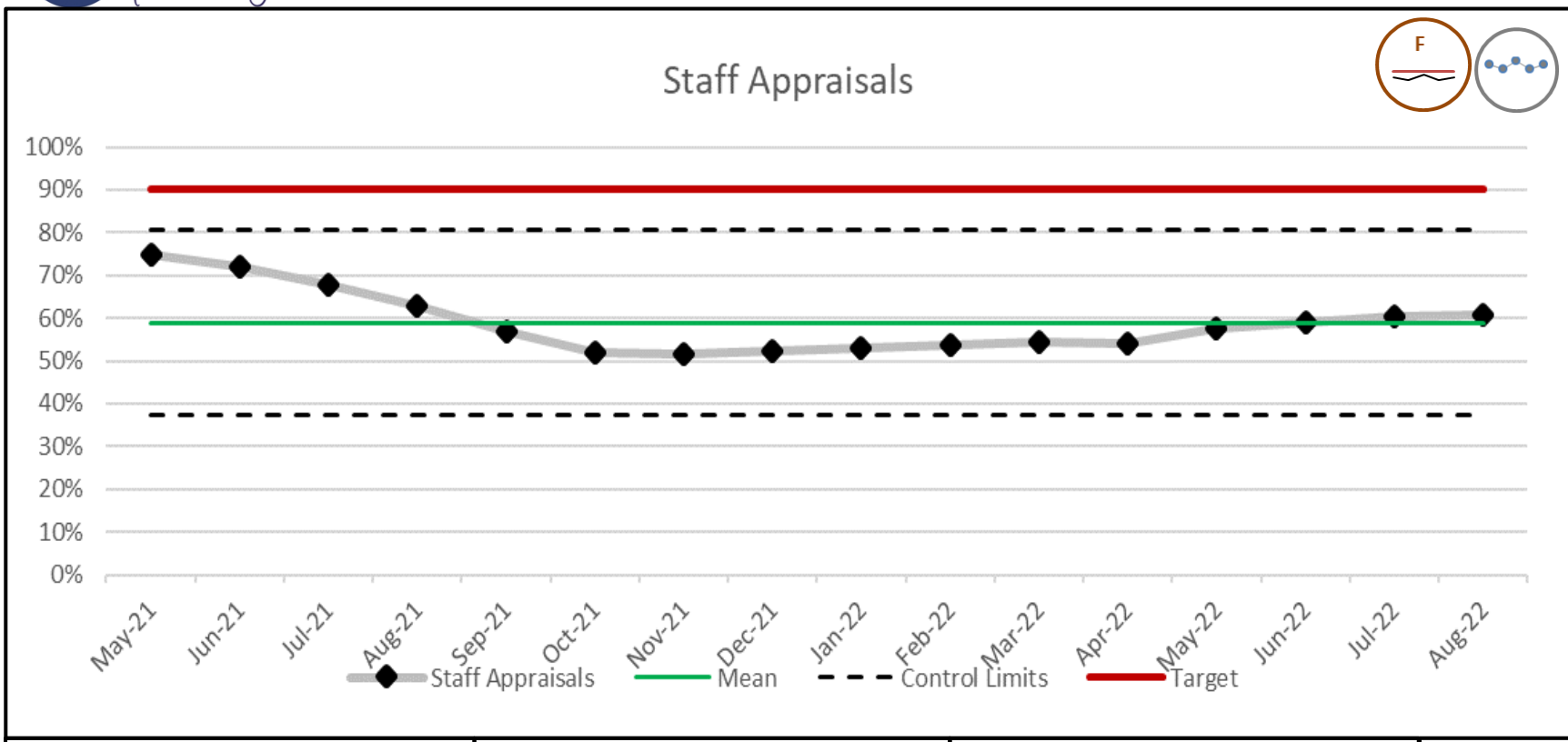
Actions:

- A Culture and leadership 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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-22
60.76%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 60.76%.

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

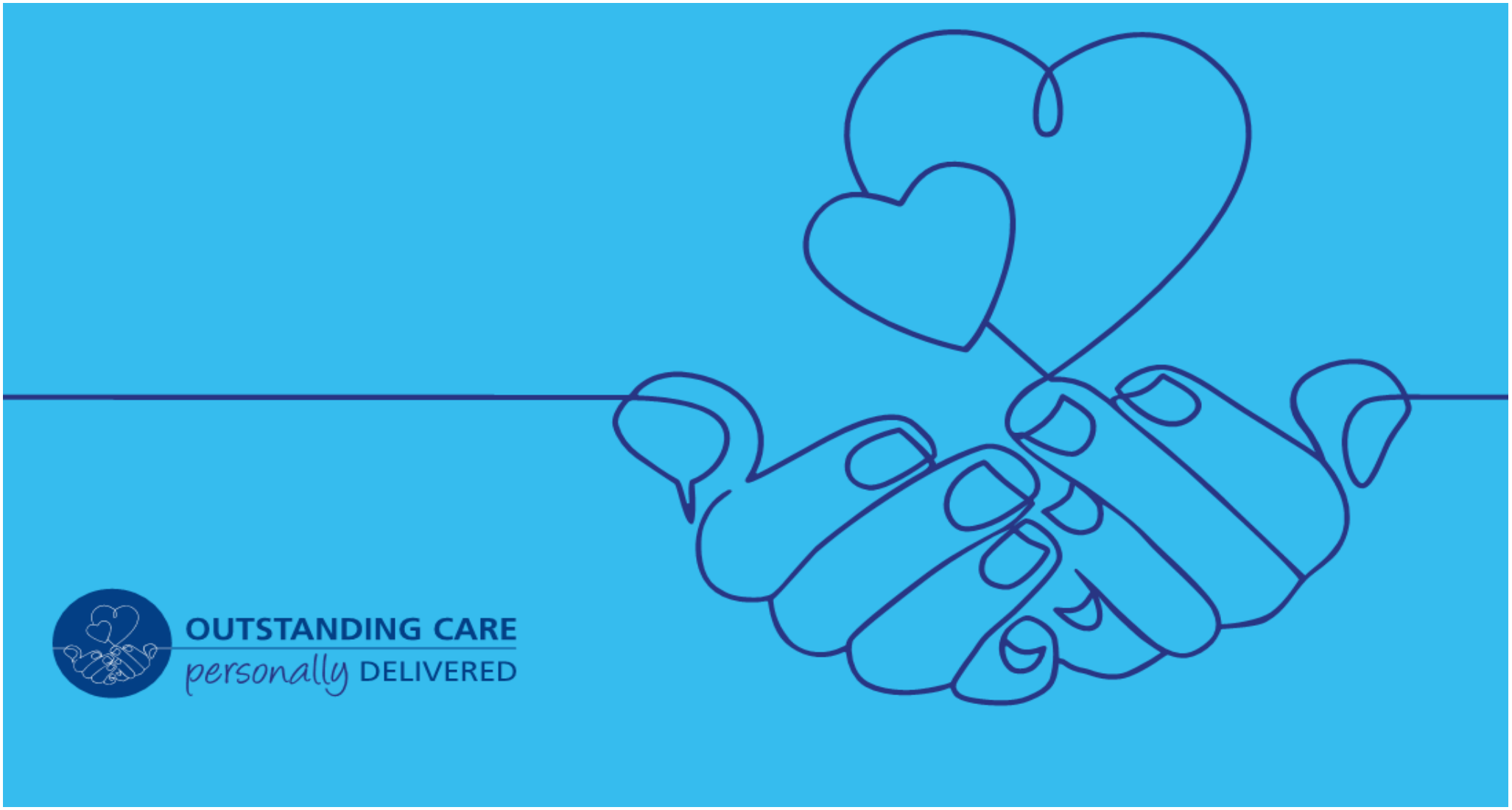
Issues:
- Operational pressures are causing an impact on completion.
- Appraisal discussions stood down in previous months still felt in August 22 due to back log
- Staffing issues and increased turnover impact availability of staff to attend appraisals with manager working clinically.

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 since May 2022.
- Dedicated appraisal page with resources to support Managers in place end of July 22.
- Appraisal Training to resume

Mitigations:
See actions

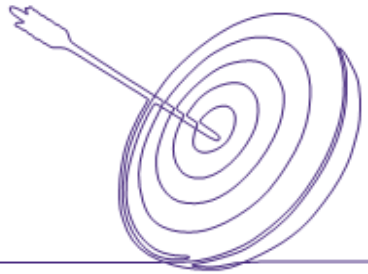
Financial Position Month 05 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust



Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)



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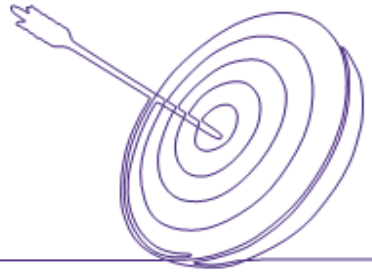
	Current Month			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	52,456	54,090	1,634	262,379	264,726	2,347
Other operating income	3,060	3,296	236	14,993	17,312	2,319
Employee expenses	(36,245)	(39,722)	(3,477)	(181,106)	(193,379)	(12,273)
Operating expenses excluding employee expenses	(18,688)	(19,811)	(1,123)	(93,437)	(95,005)	(1,568)
Operating Surplus / (Deficit)	**583**	**(2,147)**	**(2,730)**	**2,829**	**(6,346)**	**(9,175)**
Net Finance Costs	(640)	(593)	47	(3,170)	(3,054)	116
Other gains/(losses) including disposal of assets	0	1	1	0	116	116
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(57)**	**(2,739)**	**(2,682)**	**(341)**	**(9,284)**	**(8,943)**
Remove capital donations/grants/peppercorn lease I&E impact	57	51	(6)	341	265	(76)
Adjusted financial performance surplus/(deficit)	**0**	**(2,688)**	**(2,688)**	**0**	**(9,019)**	**(9,019)**
Less gains on disposal of assets	0	(1)	(1)	0	(129)	(129)
Adjusted financial performance surplus/(deficit) for system achievement	**0**	**(2,689)**	**(2,689)**	**0**	**(9,148)**	**(9,148)**

- The above table shows that the Trust delivered an adjusted deficit of £2.7m in August (£2.7m adverse to plan) and YTD has delivered an adjusted deficit of £9.0m deficit (£9.0m adverse to plan).
- After removing gains from disposals of £0.1m, the Trust YTD has delivered a deficit of £9.1m in relation to system achievement.
- Actual CIP savings of £5.7m have been delivered YTD, such that YTD delivery is £3.3m (36.8%) adverse to planned savings of £9.0m.

Finance Spotlight Report (Key areas of focus - Income)



United Lincolnshire Hospitals NHS Trust

The Income position is £4.7m favourable YTD to plan; this includes:

- **NHS Patient Care income contract - favourable variance of £2.2m**; this includes over performance of £1.1m re Variable Drugs (Lincs and NHSE) for which there will be an offset in Non Pay, £0.7m of NHS England prior year income for the true-up, and £0.6m mutual aid income for working being undertaken for Leicestershire ICB in T&O.

  The mutual aid funding relates to YTD activity, but agreement has only just been reached on how this will be funded, and as a result £0.4m of this relates to previous months. In addition, further information on drugs has also resulted in a reduction of £0.2m for previous months; this is shown in the respective month for the income and activity analysis, but has impacted on the current month income position as it cannot be back-posted in the finance ledger.

- **Radiology fire - favourable variance of £1.4m**; the financial plan did not include the I&E impact of the Radiology fire; this variance offsets an adverse variance of £1.4m in expenditure (mainly in Non Pay in relation to hire of clinical equipment).

- **Injury cost recovery – favourable variance of £0.2m.**

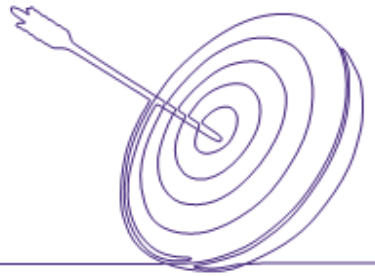
- **Bad debt provisions - favourable variance of £0.2m**; this reflects a one off change in month 2 which offsets an adverse variance of £0.2m in Non Pay.

- **Education & Training - favourable variance of £0.2m** (including notional income re the apprenticeship levy); this variance offsets an adverse variance of £0.2m in Non Pay.

- **Non-Patient Care services - £0.2m favourable to plan.**

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

Finance Spotlight Report (Key areas of focus - Pay)



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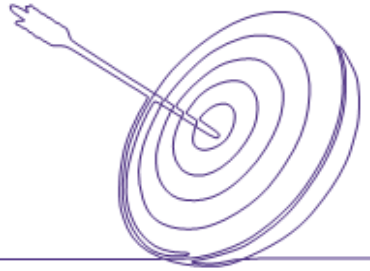
- **The YTD Pay position is £12.3m adverse to plan including under delivery on Pay CIP of £2.5m.**
- Actual Pay expenditure in August of £39.7m was £1.0m higher than £38.7m in July.
- The August Pay position includes no non-recurrent technical CIP savings compared to £0.5m in July and £0.2m of Bank Holiday enhancements whereas there were no bank holidays in July; the underlying Pay position has thus moved adversely by £0.3m in comparison to July (driven by substantive staffing costs).
    - **Substantive pay is £0.8m favourable to plan (driven by £1.1m of technical CIP savings release)**
        - Expenditure of £30.9m in August is £1.0m higher than expenditure of £29.9m in July; while no technical CIP savings were released in August (compared to £0.5m in July), August also included £0.2m of Bank Holiday enhancements; the balance of the movement (or £0.3m) covers a number of issues e.g. new starters, locums moving from agency to substantive, nurses getting their PINs, payment of arrears owing not previously accrued for etc.
    - **Agency pay is £9.2m adverse to plan**
        - Expenditure of £4.5m in August is £0.4m lower than expenditure of £4.9m in July.
        - YTD efficiency savings of £0.4m in Agency Pay are £4.9m adverse to plan; the YTD position also reflects higher than planned bed numbers, sickness levels & vacancies.
    - **Bank Pay is £3.8m adverse to plan**
        - Expenditure of £4.3m in August is £0.4m higher than expenditure of £3.9m in July; this 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

- The YTD Non-Pay position is £1.6m adverse to plan including under delivery on CIP of £1.4m; £1.9m of the technical CIP savings released YTD have been in Pay & Income rather than Non Pay as planned.
- Non Pay expenditure in August of £19.8m was £1.0m higher than £18.8m in July; this increase includes £0.5m increase in the pharmacy ascribe drugs feed, estates costs of £0.4m in relation to CBRE backlog maintenance and Louth radiators, and other miscellaneous movements of £0.1m net.
- The YTD position reflects lower than planned activity levels, but this under spend has been more than offset by c£2.1m of unplanned expenditure for which there is an offset within income e.g. £1.3m in relation to the radiology fire, £0.6m in relation to mutual aid, and £0.2m in relation to a one off adjustment re Bad Debt.

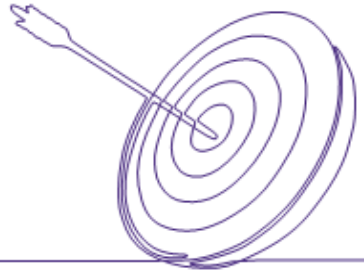
CIP

- The original financial plan assumes that the Trust will deliver CIP savings of £25m (3.6%) in 2022/23; the plan resubmission increased the total CIP savings requirement by £4.0m.
- The financial plan assumed CIP savings delivery of £9.0m by the end of month 5; actual savings of £5.7m (63.2%) have been delivered, such that YTD delivery is £3.3m (36.8%) adverse to plan.

Capital

- Capital funding levels for 2022/23 agreed through Trust Board & FPEC show a plan of c£38.4m; Capital spend incurred YTD equates to c£5.8m.

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



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Cash

- The August 2022 cash balance is £70.0m; this is a decrease of £18.3m against the March year-end cash balance of £88.3m. The increase of £6.4m in August is driven by the cyber-attack upon the Trust's finance system provider 'Advanced'. This prevented all but the most urgent payments being made and those were made using 'manual' processes.

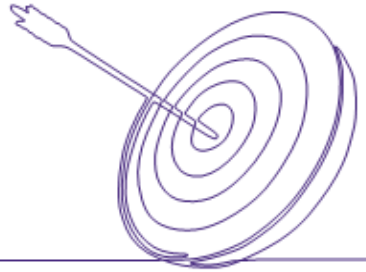
  The overall reduction in cash since March is driven by multiple factors, the most significant being the reduction in year end capital creditors from £22.6m to £6.1m and an increase in receivables from £15.5m to £28.5m.

BPPC

- The BPPC performance for the four months to July was 78% / 74% by value / volume of invoices paid (appendix 5d); this compares to the full year performance in 2021/22 of 89% / 83%.

  The cyber-attack in August means that relatively few invoices were cleared in month and performance data is currently unavailable. A retrospective update will be provided next month. Performance, however, is anticipated to be poor during August and for the next few months; this expectation reflects the fact that the system was unavailable for 28 days, pushing virtually all invoices beyond the 30 day target and generating a significant backlog of invoices yet to be registered onto the system.

Finance Dashboard



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NHS Trust

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

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

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

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last three full financial years and the current 2022/23 position are as follows

Finance and use of resources rating	Full Year ending:				Actual
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	AUG 2022
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	0.47
Capital service cover rating	4	4	4	1	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(3.30)
Liquidity rating	4	4	1	1	2
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(3.20%)
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%	(3.20%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	4

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

Balance Sheet

United Lincolnshire Hospitals NHS Trust

	31-Mar-22	31-Aug-22		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Intangible assets	7,675	6,889	6,931	6,032
Property, plant and equipment	267,753	273,484	267,150	290,020
Right of use assets	12,751	13,077	11,852	11,374
Receivables	1,848	1,848	1,827	1,848
Total non-current assets	**290,027**	**295,298**	**287,759**	**309,274**
Inventories	6,006	6,006	6,423	6,006
Receivables	15,520	23,428	28,500	24,137
Cash and cash equivalents	88,297	53,212	70,046	49,672
Total current assets	**109,823**	**82,646**	**104,969**	**79,815**
Trade and other payables	(89,017)	(67,261)	(87,030)	(67,436)
Borrowings	(2,381)	(3,290)	(2,583)	(2,855)
Provisions	(8,774)	(8,895)	(8,435)	(2,073)
Other liabilities	(1,130)	(1,130)	(6,581)	(1,130)
Total current liabilities	**(101,302)**	**(80,576)**	**(104,629)**	**(73,494)**
Total assets less current liabilities	**298,548**	**297,368**	**288,099**	**315,595**
Borrowings	(14,264)	(13,714)	(13,390)	(12,087)
Provisions	(3,182)	(3,103)	(3,099)	(3,099)
Other liabilities	(11,572)	(11,362)	(11,362)	(11,069)
Total non-current liabilities	**(29,018)**	**(28,179)**	**(27,851)**	**(26,255)**
Total assets employed	**269,530**	**269,189**	**260,248**	**289,340**
Financed by				
Public dividend capital	704,178	704,180	704,180	724,498
Revaluation reserve	29,294	29,004	28,997	28,593
Other reserves	190	190	190	190
Income and expenditure reserve	(464,131)	(464,185)	(473,120)	(463,940)
Total taxpayers' equity	**269,530**	**269,189**	**260,248**	**289,340**

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

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

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

Note 2: Cash has increased by £6.4m in August. The cyber-attack upon the Trust's finance system provider, 'Advanced' led to business continuity plans being implemented. The loss of the system, however, prevented all but the most urgent payments being made with those made using 'manual' processes.

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

Note 4: The August cash increase is mirrored by an increase of £10.3m in Trade and other payables, attributable in the main to the cyber attack, but also reflecting progress within the capital programme.

The overall level of Trade and other payables at £87m remains above historic levels by circa £20-25m. This is driven by the heightened level of trade creditors, but also Annual leave (£8m) and other pay accruals.

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

Cashflow reconciliation – April 2022– March 2023

United Lincolnshire Hospitals NHS Trust

	31-Mar-22	31-Aug-22		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Operating surplus / (deficit)	549	2,829	(6,346)	6,544
Depreciation and amortisation	15,736	8,152	8,026	19,192
Impairments and reversals	7,340	-	-	-
Income recognised in respect of capital donations	(27)	-	-	(50)
Amortisation of PFI deferred credit	(503)	(210)	(210)	(503)
(Increase) / decrease in receivables and other assets	11,261	(7,908)	(13,076)	(8,567)
(Increase) / decrease in inventories	504	-	(417)	0
Increase/(decrease) in trade and other payables	9,745	(6,419)	11,305	(8,346)
Increase/(decrease) in other liabilities	(457)	-	5,451	-
Increase / (decrease) in provisions	5,860	72	(382)	(6,754)
Net cash flows from / (used in) operating activities	**50,008**	**(3,484)**	**4,351**	**1,516**
Interest received	34	100	296	680
Purchase of intangible assets	(994)	-	-	-
Purchase of property, plant and equipment	(35,132)	(30,688)	(22,281)	(51,109)
Proceeds from sales of property, plant and equipment	148	-	138	137
Net cash flows from / (used in) investing activities	(35,944)	(30,588)	(21,847)	(50,292)
Public dividend capital received	26,610	-	-	20,318
Capital element of finance lease rental payments	-	(964)	(710)	(2,413)
Interest paid	(1)	-	-	-
Interest element of finance lease	-	(48)	(47)	(119)
PDC dividend (paid)/refunded	(6,418)	-	-	(7,224)
Net cash flows from / (used in) financing activities	20,191	(1,013)	(757)	10,151
Increase / (decrease) in cash and cash equivalents	**34,255**	**(35,085)**	**(18,253)**	**(38,625)**
Cash and cash equivalents at 1 April - brought forward	54,042	88,297	88,297	88,297
Cash and cash equivalents at period end	**88,297**	**53,212**	**70,044**	**49,672**

Note 1: Cash held at 31 August was £70.0m against a plan of £53.2m.

Note 2: Principle reasons for the cash variance to plan of £8.2m are:

- A temporary increase in NHS deferred income which will reverse before the year end.
- The backlog of trade payables associated with cyber-attack and system outage through August.
- An increase in the level of prepayments in the first 5 months, this being consistent with prior years.

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

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

Note 4: Despite pressures / risks associated with the in-year financial position, no immediate cash pressures are anticipated. The forecast year end cash position is anticipated to be circa £45-50m. Looking into 2023/24, depending upon mitigation of risks and changes in the financial regime, cash balances are likely to reduce.

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective												**1a. Deliver Harm Free Care**													
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
4879	Physical or psychological harm	Evans, Simon	Rimmer, Lucy		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU			If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and 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	04/08/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	4/8/22 Confirmed it is an ongoing corporate risk being managed at divisional level.	8	31/03/2023	31/03/2023	30/09/2022
5103	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)	02/09/2022	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 - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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	17/08/2022	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.	• Weekly Falls Investigation Panel embedded / Falls Prevention Steering Group meets monthly / Falls improvement work ongoing across the Trust and focused pieces of work identified through the steering group / training package approved at NMAAF in Jan 22. • A Falls QI Project Development and Implementation Group has been established which has multidisciplinary representation from divisional and corporate teams. Dedicated support is being provided by the Improvement Academy. Oversight and monitoring will be provided by FPSG who will receive monthly updates on actions being taken and progress made by the QI group. • A schedule of face to face falls prevention and Flojac training commenced in April 2022 delivered within clinical areas by the Quality Matron and Health & Safety teams. Wards identified as having higher falls occurrences are being prioritised. • The Chief Nursing Information Officer (CNIO) has been working with the Quality Matron team to identify how the identification and handover of patients vulnerable to falling can be improved through the support of digital applications. • Update 17/08/22 Case of Need for a Falls Prevention Service was presented at CRIG meeting on 22nd July 2022.CRIG supported the ask of the Case of Need and to proceed to the next stage. A	4	31/12/2021	31/03/2023	30/09/2022
4789	Physical or psychological harm	Evans, Simon	Ratcliff, Carl		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	23/08/2022	Extremely likely	High	Very high risk	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	Echo backlog remains high. Meridian re-engaged to support service. Number of measures being undertaken to increase capacity. Progress being reported into planned care board. Discussed at Risk Register Confirm & Challenge Group on 25 May 2022. Agreed that this is a broader quality of care and experience risk potentially impacting on a large number of patients, rather than a specific risk of serious harm. 23.08.22 Proposals been completed for internal improvement and also use of CDC - both will start in October. Funding and approvals being sought- will update once completed 10.08.2022- Meridian deep dive completed. Recommendations being reviewed by General Manager. Further options for recovery include R&R package, weekend working, extra rooms being explored by General Manager. ECG Monitoring proposal approved and potentially will have impact on echo waiting list. 23 AUG 22 CR Update: CCG / CDC plan approved in principal. ULHT (parallel) plan approved in principal - plan(s) to reduce backlog c. 12ms from commencement. Commencement target 01 Oct	4	31/03/2022	31/03/2023	03/10/2022
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 things go wrong with patient care, so that changes can be made to improve policies and procedures, there is an increased likelihood of similar occurrences in the future which could have a significant adverse effect on a large number of patients.	National Policy: - NHS National Patient Safety Strategy - NHS National Reporting and Learning System (NRLS) ULHT Policy: - Analysing and Learning from Patient Safety Incidents, Complaints, Claims and Coroners Inquests Policy (approved April 2019, due for review April 2022) ULHT governance: - Trust Board assurance through Quality Governance Committee (QGC) and sub-groups"	- Recurring themes in patient safety incidents, complaints, PALS & claims (e.g. patient falls SIs; pressure ulcer incidents; DKA incidents) - Recurring themes in audits / reviews of risk / incident / complaints / claims management"	06/09/2022	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 - Business case for Datix CloudIQ approved and final sign off undertaken September; plan will be to roll out over the next 6 months Directorate review (May 2022) - agreed that this would remain Very high (20) subject to learning lessons work being completed and evidence that repeated incidents are reducing -Reviewed at SMT 13/06/22-no change. -Reviewed at SMT 22/08/22 - Business case for DatixIQ approved and implementation to commence shortly over the next six months. Patient Safety Incident Response Framework (PSIRF) now released; Clinical Governance team to develop an implementation plan over the next 12 months including all key stakeholders.	4	31/01/2019	31/03/2023	06/10/2022

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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	23/08/2022	Quite likely	High	High risk	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB are on hold with provisions in place to allow NIV to be delivered in the bay where there are x 4 monitored beds (IPC agreed) Risk discussed at Risk Register Confirm & Challenge Group in May 2022. Still inconsistencies with timeliness against BTS standards, particularly at Lincoln, and inability to ring-fence beds but an improving position. Agreed that risk remains high but has reduced. Recommendation for rating to change from 20 to 16.Overall compliance monitored with a monthly NIV report . Case of need for funding of ward nurses in new environment agreed to ensure BTS standards are delivered, SFBC now required- commenced	4	30/09/2022	01/12/2022	03/10/2022
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.	27/07/2022	Quite likely	High	High risk	16	1. Use of tamper proof boxes/trays being purchased. 2. The only control to prevent the risk is to prepare the injections prior to administration (within 30 minutes) as per guidance (National and Trust). 3. If the practice is to continue, the prepared products should be labelled to include the recommended information. A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day.	Following a Datix (ref no: 255637), it has been identified that intravenous medication required for a Lower Segment Caesarean Section (LSCS) is being prepared in advance of the procedure in case of an emergency. The Lead Obstetric Anaesthetist has discussed the practice with the team and the consensus is that for safety the drugs need to be prepared in advance for potential emergencies. The team has sourced tamper proof drug trays to store the drugs once prepared. This risk assessment has been done for Pilgrim Hospital, Boston. However, the practice seems to replicate at Lincoln County Hospital. Full risk assessment is attached to Datix. 17/5/22 No change 150622 Ongoing awaiting confirmation on drugs that can be bought in. Risk is in the medical quality	4	30/09/2022	30/09/2022	15/08/2022
4779	Physical or psychological harm	Evans, Simon	Ratcliff, Carl		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	23/08/2022	Quite likely	High	High risk	16	defined plans to address backlog for at risk areas	Plans in place to address backlogs across all areas. Significant area of risk for TIA. 23.08.22 Remains an issues although noting covid cases have dropped. Will be resolved once the improvement work on wards in completed to remove outliers and pts are in the correct place with appropriate bed numbers	4	31/03/2022	30/06/2022	01/12/2022
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
4958	Physical or psychological harm	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group	30/06/2022	12	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	The Trust may not be able to fully and effectively implement the requirements of the National Patient Safety Strategy, resulting in potential missed opportunities to significantly improve patient safety and possible non-compliance with national standards	National policy: - NHS Pateint Safety Strategy: Safer culture, safer systems, safer patients ULHT policy: - Patient Safety Improvement Team (Clinical Governance) - Patient Safety Specialists ULHT governance: - Patient Safety Group (lead) / Quality Governance Committee (assurance)	Frequency and severity of patient safety incidents reported. Monitoring implementation of the National Patient Safety Strategy.	08/09/2022	Quite likely	High	High risk	16	Patient Safety Strategy implementation plans, including: - Preparations for introduction of the new national Patient Safety Incident Response Framework (PSIRF) - Upgrade to Datix CloudIQ to enable information upload to the new national Learning from Patient Safety Events (LFPSE) system - Recruitment and induction of Patient Safety Partners (PSPs)	As a result of delays to the procurement of Datix Cloud IQ, along with an estimated implementation timeline of 6 months to upgrade the system, there is now an increased likelihood of not being ready to integrate with the LFPSE system by the April 2023 due date. Rating increased from 12 to 16. Update 08/09/2022 - communication received this week from RL Datix to say that DatixWeb (the Trust's current version) has now been approved for connection to the LFPSE system). This	4	31/03/2023	31/03/2023	31/12/2022
Strategic Objective								**1b. Improve patient experience**																	

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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
4629	Reputation	Davies, Angela	Negus, Jennie	Patient Experience Group	09/04/2018	12	Risk assessments	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If we do not listen to the voices of our patients, carers and families through not seeking out, hearing and appreciating their experiences and then acting on them, we will fail in our ambition to deliver patient centred care.	• Patient & Carer Experience Plan and associated workplan. • Patient experience metrics and reporting (FFT, Care Opinion, PALS & Complaints, Healthwatch data, compliments all of which are triangulated through SUPERB); • National survey reports (inpatient, UEC, Maternity, NCPES, CYP). • Patient Experience Group - rolling programme of divisional assurance reporting. • Patient Experience upward reports to Quality Governance Committee through agreed reporting schedule. • Monthly Patient Panela dn expert reference groups reporting upwards to Patient Experience Group. • Patient Stories at Trust Board. • PLACE annual inspections and internal PLACE Lite visits. • Ward and department assurance visits as part of Quality Accreditation programme. • Carers Policy • Care of the Dying Patient and Care after Death procedures and guidelines. • Visiting Procedures. • Policy for the Development of Written Patient Information. • Complaints & PALs Policy	Patient feedback; volume and theme: • PALs & complaints • FFT • Care Opinion • National and local surveys • Healthwatch data • Patient Panels and expert reference groups • Patient feedback through ward assurance and Quality Accreditation programme • Patient stories • Triangulated data through SUPERB	16/06/2022	Quite likely	High	High risk	16	• Continue delivery of Patient Experience Training programme. • Support teams to use SUPERB and Envoy (FFT) dashboards to access their data and intelligence. • Continue to promote & spread Academy of FAB NHS Stuff to share and celebrate achievements, motivate, and energise teams • Develop Patient and Carer Experience Plan workplan. • Deliver IIP project improving communication and engagement with patients. • Explore development of further Expert Reference Groups. • Continue to develop Patient Panel. • Continue current work to embed patient voice and experience within QSIR programmes. • Strengthen divisional assurance reporting to spotlight actions taken as a result of feedback received including o Patient stories o You said, we did o Learning & improvement o Adoption of 'What Matters to You' • Develop new database to record patient experience activity and initiatives. • Analyse trends and themes in patient experience data to inform the need for targeted support and interventions by Patient Experience Team. • Consolidate and support the FAB Experience Champions network to support local actions and improvements.	• Training programme running weekly March – June and then monthly thereafter. >110 staff attended to dat. • Academy of FAB NHS team scheduled to visit in July to highlight ULHT as part of 2022 Fab Change Day. • Patient and Carer Experience Plan due to June PEG, workplan to be developed on approval. • Continue to deliver IIP project improving communication and engagement with patients. • Settle and embed Expert Reference Groups: o Sensory Loss o Breast Mastalgia o Cancer – first meeting end May 22 o Dementia Carers – out to advert • Patient Panel continues to develop & their story shared with Trust Board in May. • Divisional assurance reporting template refreshed and circulated. • Additional Patient Experience Manager commenced in March 2022. • FAB Experience Champions network meetings scheduled. Rating increased from 12 to 16.	4	30/09/2019	31/03/2023	30/09/2022
4980	Reputation	Davies, Angela	Negus, Jennie	Patient Experience Group	25/07/2022	16	Patient Surveys	Corporate	Nursing Directorate	Patient Experience	Trust-wide	Patient engagement can inform service design and evaluation as well as enhance its delivery and governance. It is the process of building the involvement of patients, families and carers, supporting their active involvement in order to enhance their care, care experience, safety, quality and patient-centredness. If we do not build the expectation to engage with our patients then we will not achieve patient centred care and if we do not reach out to 'hard to reach' groups our intelligence will fail to be diverse and inclusive.	• IIP project driving delivery of engagement and communication with patients and public. Reaching Out objective within this focuses on hard to reach groups. • Patient Panel meets monthly. • Expert reference groups in development: o Sensory loss group established o Breast Mastalgia group established o Cancer group established (first meeting May 2022) o Dementia Carers group in development • Patient Experience Training • Stakeholder involvement at Patient Experience Group: o Healthwatch o Carers First o Young Carers o Maternity Voices • Monthly reports from Healthwatch with feedback and queries. • Continued implementation of 'What Matters to you' initiative	• IIP milestone reports including Reaching Out objective. • Patient Panel evaluations. • Upward reports to Patient Experience Group • Expert reference groups evaluations will be undertaken. • Patient Experience Training requires a staff pledge on completion; these are being analysed and themes collated. • Stakeholder feedback and engagement at Patient Experience Group • Evaluations and outputs from implantation of 'What Matters to You' initiative through QSIRv	16/06/2022	Quite likely	High	High risk	16	• Deliver against IIP milestones. • Reaching out project objectives targeting hard to reach communities: o Mental Health o Learning Disabilities & Autism o Traveller community o Children and Young People o BAME & Easter European groups o LGBQT+ Older People: • Scoping development of further Expert Reference Groups. • Seeking to secure Neonatal Voices representative and involvement. • Launch of Cohort 2 QSIRv What Matters to You.	• IIP milestone plan to be updated following communication of Year 3 priorities. • Reaching out project: o Mental Health – links established with MH colleagues, options being explored to reach in to seek feedback and engagement. o Learning Disabilities & ASD – new ULHT LD nurse in post; exploring means for working with existing experts by experience. o Traveller community – link established with development team and community nursing. o Children and Young People – Youth Panel and Expert Family groups being explored. o BAME & Easter European groups – links being explored within communities. o LGBQT+ - links established with ED&I lead to scope. o Older People: o Launch of Dementia Carers Expert Reference Group planned for July 2022 o Proposal for Virtual Ward Expert Reference group being considered by CCG colleagues. • Seeking applicants for Cohort 2 What Matters to You	4	31/03/2023	31/03/2023	31/10/2022
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, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	27/07/2022	Extremely likely	Medium	High risk	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.	Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	30/11/2021	31/03/2023	15/08/2022

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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
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.	27/07/2022	Extremely likely	High	Very high risk	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Digital Hospital Group. 120522 - Review of policy is underway – sent to h/recs managers for amendments before being sent for sign off to Lee and via the CRG 210622 Now further update until Nov. In Nov expect to get preferred bidder for it. Updates will	4	30/06/2018	31/03/2023	15/08/2022
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	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	27/07/2022	Extremely likely	High	Very high risk	20	Planned introduction of an auditable electronic prescribing system across the Trust. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct	Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. 17/5/22 No change 150622 Discussed that a further risk is to be added concerning accurate medicines reconciliation as defined in NICE medicine and optimisation guidance NG5. And connection to staffing. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct.	4	31/03/2022	30/09/2022	15/08/2022
4905	Physical or psychological harm	Cooper, Mrs Anita	Bradley, Mrs Lesley		22/04/2022	12	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.	27/07/2022	Extremely likely	Medium	High risk	15	Getting locums and bank staff in place. Good use of relocation allowance. Actively managing the waiting lists and dealing with urgent cases to avoid harm eg telephone contact with patients. Case of need for GDH orthopaedic staffing. Case of need for rehabilitation consultant post. Case of need for upper GI dietician. Case of need for Neuro Psychology staff on Ashby. Case of need for OT staff at PHB and LCH in ITU. Over recruitment of band 5s in dietetics. Competency frameworks and preceptorship.	130622 Looking at staffing vacancies and looking at line by line post analysis.	9	30/06/2023		15/08/2022
4819	Regulatory compliance	Cooper, Mrs Anita	Clark, Paul		16/01/2022	20	Risk assessments	Clinical Support Services	Diagnostics CBU	Radiology		Lack of radiology support for the symptomatic and breast screening services. unable to cover the required clinics needed to deal with the symptomatic demand and screening demand. Backlog of 220 2ww and 5000 breast screening. just able to support current 2WW demand difficult to reduce the backlog.	Diagnostics clinical governance arrangements / CSS Division Exploring overseas recruitment Secured additional breast screening support for 12 months-mobile van and agency staffing. Providing overtime shifts 7 days to help provide additional capacity.	Monitoring radiology 2ww performance/ screening round length	27/07/2022	Extremely likely	Medium	High risk	15	continued recruitment of radiologists, mammographers, consultant mammographer and the use of locums when available, working closely with family health to maximise capacity via weekly capacity meeting. Working with outsourcing companies and additional Locums to provide extra screening capacity to try and shorten the current screening round length.	NHSE have raised concerns around the screening round length and have asked for a plan to reduce back to 36 months, Looking for locums, NHS England raised concerns about backlog. 290622 Have additional international and UK mamographers. Now 21 days backlog. due to staff leaving due to retirement and moving jobs this has caused the risk score to be increased to 15 as there has been a drop in capacity.	6	30/09/2022	30/09/2022	15/08/2022
Strategic Objective												**2a. A modern and progressive workforce**													

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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
4991	Service disruption	Matthew, Mr Paul	Low, Claire	People and OD Committee	19/05/2022	20	Workforce Metrics	Corporate	People and Organisational Development	Recruitment	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	ULHT policy: - Workforce planning processes - Recruitment & Selection Policy & Procedure - Rota management systems & processes - Locum temporary staffing arrangements - Workforce management information - Core learning / Core+ programmes? ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Vacancies & turnover rate. Staff survey results relating to job satisfaction / retention. Core learning compliance rates?	12/07/2022	Extremely likely (5)	4 (High)	Very high risk	20	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	1.New to care recruitment being extensively used for HCSW role with 14 appointed & a further 40 offered. 2.Nursing associate recruitment embedded 3. Medical Support Worker role now looking to be embedded as business as usual. 4. Agency providers increased to a minimum of three for key roles, rather than 1 previously. 5.Restructure process started within wider HR team will result in significant greater capacity for recruitment activities and overall oversight and proactivity. 6.Restructure process started, to introduce internal agency aspect to ULHT recruitment. 7.Medical recruitment expertise aspect being reintroduced via restructure, support already in place via agency staff. 8.Relationship with LRDP now embedded, GMC registered Drs and MSWs recruited. 9. Agreement reached with third party supplier to support Philippines recruitment for difficult to recruit AHP roles. 3 recruits in progress	Low risk	31/03/2023	31/03/2023	31/08/2022
4780	Service disruption	Ratcliff, Carl	Ratcliff, Carl	Workforce Strategy Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke	Trust-wide	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	23/08/2022	Quite likely	Extreme	Very high risk	20	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. Review update on 28.04.2022- Risk level increased to 20; only 1 substantive stroke consultant in place. Further risk summit undertaken in April 2022. Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Agreed with current rating.	Moderate risk	31/03/2022	31/03/2023	30/06/2022
4741	Service disruption	Farquharson, Colin	Sanz Torres, Aurora A	Workforce Strategy Group	13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung Clinical oncology - head and neck, skin, upper GI (RT only). Lack of cover for leadership roles (Chemotherapy lead)	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements	Monitoring tumour site performance data	27/07/2022	Quite likely	High	High risk	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements. 220622 Agency Clinical oncologists recruited. So improved cover for Head and neck and melanoma.	Low risk	31/03/2022	31/03/2023	15/08/2022
Strategic Objective								**2b. Making ULHT the best place to work**																	
4990	Service disruption	Matthew, Mr Paul	Low, Claire	People and OD Committee	19/05/2022	20	Risk assessment	Corporate	People and Organisational Development	Culture and OD	Trust-wide	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally	1. National and local lessons learnt for engaging staff effectively with surveys 2. Dedicated 'staff experience/engagement' role proposed to lead programme of work (including corporate and local action planning)	1. Pulse Staff Survey response rate (quarterly) 2. NHS Staff Survey response rate (annual)	12/07/2022	Extremely likely (5)	4 (High)	Very high risk	20	1. National mandate for NHS organisations to run Pulse Survey every quarter (1,2&4) 2. Comprehensive and robust positioning to complement NHS Staff Survey and part of a wider staff listening and engagement plan 3. You said campaign to drip feed/communicate how staff intelligence is improving working environment and services - now live	1. Pulse Staff Survey - Q2 (July'22) 2. Reset approach (communication, engagement of and management) for sign off - ELT (June'22) 3. Local action planning process - now live 4. 7 Big Ticket Priorities proposed following NHS Staff Survey	Low risk	31/03/2023	31/03/2023	31/08/2022

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4992	Reputational risk	Matthew, Mr Paul	Low, Claire	People and OD Committee	19/05/2022	16	Risk assessment	Corporate	People and Organisational Development	Equality, Diversity and Inclusion	Trust-wide	WRES (Workforce Race Equality Standard): low compliance/ limited improvement and action to address indicators i.e. increase senior representation and better lived experience of BAME staff working in ULHT. Risk is this results in low number of applications for vacancies which then remain unfilled (difficulty attracting talent); poor turnover rates (difficulty in retaining talent) and a poor employer brand locally, regionally, nationally and overseas. This will impact on the culture of the organisation and the ability to recruit with increased turnover. Wider risk with regards to broader protected characteristics linked to the delivery of the EDI objectives.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	12/07/2022	Quite likely (4)	4 (High)	High risk	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	1. EDI Group and regular reporting established (for assurance) 2. Anti racism strategy and delivery plan socialised with stakeholders and live 3. NHS Staff Survey results - deep dive and analysis of lived experience of staff with protected characteristics 4. Draft EDI objectives 2022-25 - socialised and ready for sign off (end June) 5. ULHT workstream lead - addressing BAME disciplinary gap (Lincs Belonging Strategy) 6. People Promise Manager successfully appointed from end May'22	Low risk	31/03/2023	31/03/2023	31/10/2022
4993	Reputational risk	Matthew, Mr Paul	Low, Claire	People and OD Committee	19/05/2022	16	Risk assessment	Corporate	People and Organisational Development	Equality, Diversity and Inclusion	Trust-wide	WDES: (Workforce Disability Equality Standard): limited awareness and implementation of reasonable adjustments and other forms of support which results in limited equality and equity of opportunity for staff classifed as having a 'disability'; impedes Trust's ambitions to create an inclusive culture and foster belonging; difficulties in attracting as well as retaining talent	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	12/07/2022	Quite likely (4)	4 (High)	High risk	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	1. WDES action plan prioritised for engagement, development and delivery 2. July 2022: ULHT review datasets, declaration rates (from 1/7/22 ULHT required to submit metrics and narrative data via the DCF online platform by Aug'22). 3. End October 2022: deadline for ULHT to publish WDES 2022 annual report (include metrics report and WDES action plan)	Low risk	31/03/2023	31/03/2023	31/10/2022
Strategic Objective												**3a. A modern, clean and fit for purpose environment**													
4647	Reputation	Evans, Simon	Davey, Keiron	Fire Safety Group	14/12/2021	20	External Inspections	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees	- Compliance audits against fire safety standards - Progress with fire safety improvement plans - PPM compliance assurance (current lack of required detail for internal and regulator assurance)	13/09/2022	Extremely likely	High	Very high risk	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	LFR previously served ULH with an Enforcement notice and action plan (since removed) in which the storage of items within corridors was highlighted: "Article 14(2) Emergency Routes and Exits There are combustible materials and items that pose an ignition risk are located on escape routes within the hospital. It required that Corridors and stairways that form part of an escape route should be kept clear of obstruction and hazard free at all times. Items that maybe a source of fuel or pose an ignition risk should not normally be located on any corridor or stairway that will be used as an escape route." In light of identified storage issues and subsequent non-compliance with these requirements, there is now a high potential for immediate enforcement notice with a view to prosecution in accordance with the regulator's compliance code. Task & finish group set up to address storage issues at local and at senior levels. Fire Safety Advisors working with local managers; IR1s reported when storage issues are identified, with escalation to divisional leads where necessary.	4	30/06/2022	31/03/2024	31/10/2022

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4648	Physical or psychological harm	Evans, Simon	Davey, Keiron	Fire Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	13/09/2022	Quite likely	Extreme	Very high risk	20	- 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 - costed budget plan for FEG submission Sept 2022 - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	Rating increased on review to 20 - combustible storage in common areas frequently found (including life lobbys); emerging lessons learned from recent arson incident at LCH (including spread of smoke beyond the room of origin). Actions undertaken recently - IR1s issued to local managers and owners of storage risk, including escalation to senior managers. Setting up task & finish group to look at storage issues. Reviewed all fire risk assessments in Diagnostics across all 3 sites; other FRAs for public areas have also been reviewed. Reviewed all external security patrols and implemented alterations to routes to ensure possible higher risk areas are also patrolled. New tagging points added to patrol routes. Implementation of further required actions continues to progress.	10	31/03/2022	31/03/2025	31/10/2022
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	10/02/2022	Reasonably likely	Extreme	High risk	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	Scheme of work and design currently being produced.		30/10/2020	31/03/2023	30/06/2022
Strategic Objective												**3b. Efficient use of our resources**													
4664	Finances	Matthew, Mr Paul	Young, Jonathan		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	National policy: - Agency spending cap set by Government ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Annual budget setting process cascades and apportions the Trust temporary staffing spend limits to the Divisions and Directorates. - Monthly financial management & monitoring arrangements are in place to identify variation temporary staffing financial plans at all levels of expenditure from department up to Trust. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Financial Review Meeting (FRM)	22/06/2022	Extremely likely	High	Very high risk	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	The Trust has exited the 21/22 financial year with an agency spend of c£44m. This has in part been driven by COVID pressures and a large number of escalation beds open increasing the requirement for temporary staff. The Trust has agreed an ambitious CIP programme that is heavily focused on agency reductions through the recruitment of staff and reducing the number of NEL beds required. This will take time to embed. Reviewed at RRC&CG - score increased from 16 to 20.	8	31/03/2023	31/03/2023	31/07/2022

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4665	Finances	Matthew, Mr Paul	Young, Jonathan	Financial Turnaround Group	11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £25m CIP target for 22/23. If the Trust fails to deliver The CIP Plan it will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to achieve their financial plans.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial plan inclusive of CIP. (Transformational) - Establishment of the service framework to prioritise Speciality improvement reviews. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process from 1st April. (Transactional) ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process - Programme Management Office (PMO) & dedicated Programme Manager. - Introduction of the Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes - Refresh of the FRMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I The Trust monitors internally against its CIP targets inclusive of specific Divisional and Scheme targets Divisional focus against Transactional schemes is reviewed at the relevant FRM Trust focus against Targeted and Transformational schemes is reviewed at the Improvement Steering Group	22/06/2022	Quite likely	High	High risk	16	- Refresh of the CIP framework and training to all stakeholders. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust IIP and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	The Trust has delivered its CIP plan for the past 3 years, albeit a reduced requirement during the 2 financial years that cover COVID. The Trust is embedding a new Improvement framework with CIP included within it and is also working with system partners to make financial improvements due to pathway changes. This will take time to embed and alongside the operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the CIP target. Reviewed at RRC&CG - agreed score of 16.	4	31/03/2023	31/03/2023	30/09/2022
4957	Finances	Young, Jonathan	Young, Jonathan		28/06/2022	16	Professional Guidance	Corporate	Finance and Digital	Finance	Trust-wide	The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. The national planning assumption is that all COVID costs incurred in Acute settings in relation to COVID will cease from 1st June 2022 aligned to the anticipated reduction in COVID patients to extremely low levels.	National policy: - Government financial planning assumptions due to COVID ULHT policy: - Financial plan set out the Trust Budget allocations in respect of COVID spend - Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). ULHT governance: - Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. - Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base. - The Planning and Recovery Steering group will provide oversight of the COVID costs.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FRM.	22/06/2022	Quite likely	High	High risk	16	Alignment of the Directorate and Divisional budgets to the national strategy for the removal of COVID costs from 1st June 20222. By exception reporting of all COVID costs not removed from financial positions.	The Trust incurred c£13m of direct costs in relation to COVID with a further indirect cost e.g. staff sickness. The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	8	31/03/2023	31/03/2023	30/09/2022
4384	Finances	Matthew, Mr Paul	Young, Jonathan		24/09/2018	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	If there is a substantial unplanned reduction in the Trust's income, or missed opportunities to generate income, it could have a significant adverse impact on the Trust ability to achieve the annual financial plan. Failure to deliver the nationally activity targets of 104% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire.	National policy: - NHS financial planning and monitoring processes ULHT policy: - Trust and System Financial Plans built from the bottom up Trust Divisional Demand and Capacity Plans. - The Trust national activity submission was aligned to the delivery of 104% activity targets for planned care PODs ULHT governance: - Internal weekly internal Planning and Restoration meetings to review progress - Improved counting and coding, including data capture and missing outcome reductions. - Shared risk and gain share agreements for the Lincolnshire ICS.	The Trust is monitored externally against the Trust activity target through the monthly activity returns. The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets. The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns.	22/06/2022	Quite likely	High	High risk	16	Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 104%.	The Trust and the Lincolnshire ICS ability to achieve the 104% activity target is a concern. The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 104% activity target. Reviewed at RRC&CG - agreed current score as 16.	8	31/03/2023	31/03/2023	31/12/2021
Strategic Objective								**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.	4	31/03/2023	31/03/2023	18/08/2022

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the required data protection / privacy impact assessment process is not followed consistently at the start of a system change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	National policy: - Data Protection Act 2018 - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy (approved May 2018, due for review May 2021) & supporting appendices ULHT governance: - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group - Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles	Internal audit review of data protection / PIA processes	24/03/2022	Quite likely	High	High risk	16	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process.	Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues. Reference to DPIAs in Data Security and Awareness mandatory training. Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required. Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data.	4	31/03/2022	31/01/2023	30/06/2022

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4 October 2022*
Item Number	*Item 13.1*
Strategic Risk Report	
Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Paul White, Head of Risk & Governance*
Report previously considered at	*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 Leadership Team is invited to review the content of the report prior to its submission to the Trust Board.*

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) a reduction of 1 the last reporting period, which relate to:

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

Within the Trust's workforce risk profile there are 3 Very high risks (20):

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

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

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

There are also 21 active risks with a current rating of High (15-16).

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

Purpose

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

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

1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). Details of all active Very high and High risks (15-25) are provided in **Appendix A**, organised by strategic objective and current risk rating however a summary of Very high risks is provided below in sections 2.3-2.10. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level.

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

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

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

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

2. Trust Risk Profile

2.1 There are 250 active risks, approved and recorded on the Trust risk register. There are 15 risks with a current rating of Very high (20-25), a reduction of one since the last reporting period and 21 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%)	**41** (16%)	**170** (70%)	**21** (7%)	**15 (-1)** (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	22/06/2022
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	22/06/2022
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	04/08/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5018 (was 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. **This risk has been included in a full review of Emergency Care risks and a revised assessment will be presented to the RRC&CG for consideration at the next available opportunity**	02/09/2022
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.	17/08/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4622	If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients.	Very high risk (20)	- Safety Culture Project, part of Integrated Improvement Plan (IIP) - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previously called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ	06/09/2022
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm and a poor clinical outcome	Very high risk (20)	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	23/08/2022

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

2.4 There are currently no Very high risks and 4 High risks to this objective as per the previous reporting period.

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

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

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4828	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust. Update 4th July 22- 26th July, ePMA functionality version 10.21 will be upgraded. ePMA pilot from 13/09/22, full Trust wide roll out- mid Oct.	27/07/2022
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.	27/07/2022

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 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
4991	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	Very high risk (20)	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	12/07/2022
4780	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	Very high risk (20)	Monthly review of provision in place. Ongoing recruitment campaigns for vacancies. Expansion of ACP workforce (business case being developed) to increase medical capacity to support consultant workforce. **Risk reduced on review by the division from Very high (20) to Moderate (12). Awaiting validation by Risk Register Confirm & Challenge Group.**	23/08/2022

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

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

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

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

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

2.9 There are currently 2 Very high risks and 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
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - PPM reporting for FEG and FSG By Estates Teams - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk	13/09/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4648	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	Very high risk (20)	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022 - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	13/09/2022

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

2.10 There are currently 1 Very high risk and 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 highest priority quality and safety risks at present relate to:

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

3.2 The most significant workforce risks at present relate to:

- the recruitment and retention of clinical staff; and
- the impact of workforce morale on quality of care and services

3.3 Within finance, performance and estates the most significant risks at present relate to:

- fire safety; and
- the cost of reliance upon temporary clinical staff

3.4 The Trust Board is invited to review the content of the report and note the most recent updates to significant risks, no further escalations at this time.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4 October 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 AMBER rating of objective 2a – A modern and progressive workforce*

Executive Summary

The relevant objectives of the 2022/23 BAF were presented to all Committees during September and the Board are asked to note the updates provided within the BAF.

Updates provided to the Committees and offered to the Board are identified by green text.

Following review through the Committees the People and Organisational Development Committee are proposing the objective 2a – A modern and progressive workforce be rated amber from red.

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 (August)	Assurance Rating (September)
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**	**Amber**
2b	Making ULHT the best place to work	**Red**	**Red**	**Red**
2c	Well led services	**Amber**	**Amber**	**Amber**
3a	A modern, clean and fit for purpose environment	**Amber**	**Amber**	**Amber**
3b	Efficient use of resources	**Amber**	**Red**	**Red**
3c	Enhanced data and digital capability	**Amber**	**Amber**	**Amber**

3d	Improving cancer services access	**N/A**	**Red**	**Red**
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	**N/A**	**Amber**	**Amber**
3f	Urgent Care	**N/A**	**Red**	**Red**
4a	Establish new evidence-based models of care	**Amber**	**Amber**	**Amber**
4b	Becoming a University Hospitals Teaching Trust	**Red**	**Red**	**Red**
4c	Successful delivery of the Acute Services Review	**N/A**	**Green**	**Green**

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2022/23 - September 2022

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

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Programme of work in place to implement the requirements of the National Patient Safety Strategy (culture and systems) Human Factors faculty in place and face to face training restarted. Commencing next steps of cultural work with external agency. Pascale survey work continues to be undertaken. Safe to Say Campaign launched. (PSG)	Further work required in conjunction with People and OD to develop the Just Culture framework. Issues linking National Patient Safety Training to ESR are impacting on our ability to meet National training requirement.	To be considered as part of the Trust Culture and Leadership Programme	Safety Culture Surveys Action plans from focus groups and Pascal survey findings. Regular update reports to the Patient Safety Group and upwardly reported to QGC and through TLT. Theatre Safety Group reporting progress against a Quality Improvement plan to PSG.	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	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)	Improvement seen across all divisions in terms of development of NatSIPs/LocSIPs, however audit is required in order to provide assurance of implementation.	Individual Divisional meetings now in place; quarterly reporting to PSG Additional support provided to medicine from the Patient Safety Improvement Team	Audit of compliance	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.		

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			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			Medicines Quality Group in place with a focus on reducing medication errors Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit MQG and MMT&FG will retain oversight of the relevant IIP programme of work, including DKA. (MQG & MMT&FG)	Lack of e-prescribing leading to increase in patient safety incidents due to medication errors Gaps identified within the recent internal audit undertaken by Grant Thornton	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Medical Director led Medicines Management Task & Finish Group convened to ensure the required pace and progress of delivery of the Improving the Safety of Medicines Management IIP. Divisional representation at the Task & Finish Group confirmed as Divisional Clinical Director or Divisional Nurse. Action / Delivery Group also in place and meeting fortnightly to progress actions and reporting to the Task & Finish Group.	Upward Report from the Medicines Quality Group to QGC Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group	Medicines Quality Group have not been receiving reports regarding progress with the medicines management IIP; there has been a lack of Divisional attendance at the Medicines Quality Group	Divisional representation at Medicines Quality Group reinforced by Medical Director and Director of Nursing and template for divisional reporting of BAU medication safety activities in to Medicines Quality Group developed and in place		
						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training occurs through MNOG.		

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						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA (Ensuring early detection and treatment of deteriorating patients) (PSG)	Work required to develop the maturity of the group. New Chair identified and full review of membership and remit required. Maturity of some of the sub-groups of DPG not yet realised. This will be considered as part of the review of DPG.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE; DKA	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas Number of incidents occurring regarding lack of recognition of the deteriorating patient	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		
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG) One central monitoring process now in place.	Review of compliance metrics required.	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads(CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity Meeting stood down due to operational pressures. The group meets monthly, has developed a work reporting plan Papers reviewed and Chair's report provided. Any risks to quality and safety are discussed at the relevant cell meeting, e.g., quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.		Upward reports to QGC monthly and responds to feedback Review of ToR in July 2021. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Divisional assurance reports to PEG providing limited assurance; further work needed to improve this. Will be monitored through PEG.	Head of Pt Experience revising divisional assurance report template and have discussions with divisional clinical leads re: requirements for the reports. Template approved through PEG Nov 21	Quality Governance Committee	**Amber**
						Patient Experience & Carer plan 2019-2023 (PEG)	Number of objectives in the plan paused due to Covid Pandemic; this means the plan need a full review.	Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level. Patient & Carers Experience Plan to be reviewed by end Sept 21 and present to Oct PEG	Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports.	Limited assurance until the plan is reviewed.	Plan is being reviewed with a draft final date of end of January 22.		
						Quality Accreditation and assurance programme which includes section on patient experience. (PEG)	Lack of alignment of findings in accreditation data to patient experience plans. Ward / Dept review visits paused due to operational pressures	Head of pt experience to have access to accreditation data. Deep dives into areas of concern as identified in quality meetings and accreditation reports. Update reports to PEG and QGC as required. Matrons audits continue to take place. Any risks to quality and safety identified are discussed at the quality cell and issues escalated to gold as appropriate.	Reports to PEG and upwardly to QGC	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support.		
						Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging Sensory Loss group upwardly reports to Patient Panel.	Upward reports and minutes to the Patient Experience Group IIP reporting to Support & Challenge group.	Diversity of patient engagement and involvement.	CCG exploring dev of a Health Inequalities cell to combine efforts in reaching out. Date not yet secured. ULHT Experts by Experience project progressing with Mastalgia Expert ref group (ERG)established, Cancer Board recruiting 2022 discussions continue with Gastro & CYP (Expert Families).		

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						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Inconsistency in applying end of life visiting exceptions.	Exceptions guidance re-issued. Monitor through complaints & PALs.	Report to PEG through complaints & PALs reports; upward reports from Visiting Review working group. Visiting experience section within complaints & PALs reports.		Complaints/PALs reports to include visiting concerns; div ass reports to include visiting related issues. Visiting review indicates inconsistency in EoL visiting; criteria and process being strengthened. Request to ME's to ask relatives about visiting experience at EoL.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports not being received by PEG	Head of Pt Experience to discuss with EDI lead to agree a way forward. Head of Pt Experience & EDI lead meeting to agree a way forward. Links to Reaching Out IIP project.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic;	PLACE Lite continues & reports to PEG.		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients including the embedding of the SAFER bundle.							
						Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust.	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics.	Review of Terms of Reference to be undertaken. Invites to speakers to come direct from Mr Simpson as Chair of the Group in future.	Effective upward reporting to QGC from reporting groups.	Divisional reports still in their infancy.	Verbal updates provided by divisional representatives at the group.		
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	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.		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	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.	Quality Governance Committee	**Green**
						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		
						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		
						Specialised services quality dashboards (SSQD)	SSQD data collection now commenced again post Covid. Areas with outliers identified with some plans for improvement, however not all required areas currently have plans.	Continued support from the Clinical Effectiveness Team and requirement to attend CEG and provide update on progress.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	Actions plans not yet received for all necessary areas.	Continued requirement to attend CEG to provide updates.		
						Process in place for implementing requirements of the CQUIN scheme.	Plans now in place for delivery of 2022/23 CQUINs, although assurances not yet received that these are fully implemented.	CQUIN delivery group commenced again.	Quarterly reports to CEG and upwardly reported to QGC	Some gaps identified in reporting processes.	Being dealt with via the CQUIN delivery group		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.				

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SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)	People System Plan has been reviewed and objectives agreed	System People Team/People Board	System PP - Each 'pillar assigned system lead Progress/assurance reported to People Board (quarterly) Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan Priorities agreed for 2022/23		Monthly updates on progress are tabled at local People Team Meeting and People Team Board, with each of the pillar leads agreeing key performance indicators. The final people hub role (Attraction Lead) was appointed week and commencing in post in October 2022. Regular monthly pillar lead meetings also are now embedded in the diary to escalate any issues/offers of support.		
						Workforce planning and workforce plans	Overall vacancy rate declining	A new pillar for workforce planning and transformation is being created as part of the People Directorate restructure. The Trust have an Associate Director of Transformation and Workforce planning in post who is leading workforce planning in conjunction with HRBP's, finance and improvement team. This is established and regular reviews are now in place.	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend.	Some areas remain hard to fill however full and comprehensive workforce plans are in place 'plan for every post' and workforce scorecards are in place and are reported through to the Operational Workforce and Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board.	The workforce plan was submitted and work continues to measure the deliverables set against the plan with HR/Finance and Planning. Working closely with the SHRBP's pipeline and vacancy information is tabled at the FPAM meetings and a full scorecard is now tabled with escalation in place for People & OD Committee highlight report.		
						Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up and completion of actions. Recruitment key performance metrics feature as part of the People & OD scorecard which is tabled at the Workforce Strategy and Operational meeting and then is reported upwards by expectation to People & OD Committee via the highlight report.		Recruitment has been busy with doctors rotation and a new AAC process which is being currently being rolled out. Additional resource has been sourced and bi weekly recruitment deep dive is now held by Deputy Director of People & OD. Recruitment are working very closely with the divisions/HR and as a system a potential overseas trip is being planned for India (nurses/AHP's). Recruitment training is due to go live with Managers in October and the recruitment team has now been aligned to three distinctive areas - AFC/Medical/Overseas.		

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						Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established (8B - 12 month) Temp/12 month fixed term People Promise Manager appointed (Liz Smith - ULHT) from end May 2022	IIP projects on hold	IIP Projects New Appraisal launched (Jul22) - aligned with PP and supported with new resources and information to improve quality and frequency of Appraisals Appraisal Improvement Plan - agreed Sept'22 Mandatory Training Improvement agreed - Sept'22 Mandatory Training Group established to provide oversight Talent management - on hold	Regional Midlands Talent Board Model Employer ambition Executive CQC Assurance Panel Appraisal compliance Mandatory training compliance	Appraisal compliance levels not at expected level Mandatory Training compliance not at agreed level	Work continues with interim solution for appraisals with further work required to move to a yearly cycle rather than an anniversary of joining. Review of mandatory and statutory training core subjects is undergoing in addition to the training platforms used.		
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff - To be discussed following review of development offer (on hold)					

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2a	A modern and progressive workforce	Director of People and Organisational Development	Vacancy rates rises Turnover increases Sickness absence rises Under-investment in education & learning Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce	4362	CQC Safe CQC Responsive CQC Effective	Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	The AMS project has been relaunched and additional capacity identified. Training has started to be rolled out with divisions and a position paper is currently being prepared. Reporting will start to feature as part of the Workforce Cell meetings and monthly one to ones with key HR staff. Work continues to highlight absence stats through the PRM meetings via the SHRBP's and AMS have presented an overview of the reporting functionality to HR and Trust executives which will move forward in terms of deep dives into the data available. Sickness data is now included as part of the Finance People and Activity Meetings (FPAM) in which the SRHBP's present key metrics and plans to address escalation issues.	People and Organisational Development Committee	**Amber**
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service (pending P&OD restructure)	IIP projects in early stage of delivery	IIP projects - education and learning Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year System LEAD (Learning, Education and Development) Board to provide system oversight (agreed)		Linked to restructure and a more internal focus on the talent academy ensuring maximisation of the apprenticeship levy and the creation of an Education Department.		
						Creation of robust Workforce Plan •Values based recruitment and retention •Maximising talent management opportunities •Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn' Promote benefits and opportunities of Apprenticeships			Improved vacancy rates		Direct link to workforce planning. Review of assessment centres and time to hire are key pieces of work currently under way. Final stages of reviewing the ACC process for consultant recruitment.		

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						Improve the consistency and quality of leadership through:- Reset leadership development offer and support (Leadership SkillsLab and PME) •Improved mandatory training compliance •Improved appraisals rates using the WorkPal system •Developing clear communication mechanisms within teams and departments			Appraisal rates and training development Workforce and OD Group IPR - Appraisal compliance Culture and Leadership Group		Measured through the people metric scorecard and escalated to the People & OD Committee if needed.		
						Providing a stable and sustainable workforce by:- •Ensuring we have the right roles in the right place through strong workforce planning •Reducing vacancy rates and ensuring that posts are filled through a positive and values recruitment approach •Reducing our agency staffing levels/spend •Strengthening the Medical Workforce Job Planning processes							
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						NHS People Plan & System People Plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future	Awaiting sign off of system people plan Delivery of IIP projects in early stage of delivery	People Plan - in draft System EDI Strategy underway 5 pillar -leads confirmed (ULHT Lead for leadership and lifelong learning)	People Board		Linked to delivery of the system People Plan agenda as above.		

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						Alignment with People Promise Reset and alignment of Trust values & staff charter (with safe culture) Reset ULH Culture & Leadership	Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Group Culture and Leadership Programme Group upward report	Delivery of agreed output	Improved function of group and reporting to be in place for November report		
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work				
						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 (mandated from July'22) Number of staff attending leadership courses		Proposal to be shared with ELT (Dec'21): gradual introduction of L&M activities NB. L&M apprenticeship on going		

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	Lincs Belonging Strategy EDI Delivery Plan 2022-25	EDI Group (report to PODC) live from Dec 2021 Reset of ULHT EDI objectives 22-25 (PSED) from Jun'22	EDI Group membership reset - to ensure representation and coverage	Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NNSS	New WRES_22/23 Action Plan New WDES_22/23 Action Plan	Ongoing monitoring of WRES and WDES action plans and EDI Objectives delivery plan (Y1) through Committee. WRES/WDES and Internal Audit actions being monitored through Committee. The Trust has committed to implement and embed the Leading Inclusively with Cultural Intelligence (CQ) programme across the Trust and develop a social movement of intentionally inclusive leaders. A launch event has been held for CQ and masterclass sessions now created for members of the Trust leadership team to enrol. Work continues for the creation of a dedicated intranet website and members page.	People and Organisational Development Committee	**Red**
						Staff networks	Universal Terms of Reference Strategic goals and objectives	Continued work to embed the networks and provide them with effective support Following recruitment of new SN Chairs - agree Universal Terms of Reference Support groups in developing strategic objectives for the next 12 months	EDI Group Council of Staff Networks		Governance for EDI Recruitment process for SN Chair/VC - Feb'22		
						Demonstrate that we care and are concerned about staff health and wellbeing		EAP implementation from May'22	System Health & Wellbeing Board Linc People Board (NB. Wellbeing Pillar) Employee Wellbeing Group (pending)	OH KPIS to be agreed (for reporting to PODC) System Hub activity Wellbeing activity (for reporting to Workforce and OD Group)	Commence reporting from 2022		

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						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian		Junior doctor forum	Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee		Junior Dr Survey results (alignment with NNSS21 findings)		
						Embed compassionate and inclusive leadership (aligned to People Promise)			Culture and Leadership Group Culture and Leadership Programme Group upward report				
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**												
						Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.		

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments PLACE Full assessments starting in September 22	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response. With PLACE Full assessments starting in September gaps will be closed further.	Finance, Performance and Estates Committee	**Amber**
						Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID	Improvement teams have started in 2022/23 working through value for money and financial efficiency schemes included development of Housekeeping, Security and Portering Business Cases for future models	MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Groups will report through to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not with Annual Reporting providing assurance and gap analysis on all AE domains.		
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report Letter from British Safety Council on External Review				
						Implement Year 1 of our Estates Strategy	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes					

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3b	Efficient use of our resources	Director of Finance and Digital	Not identifying and then delivering the required £29m CIP of schemes The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 22/23 financial settlements The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. Failure to deliver the nationally activity targets of 104% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire. Substantial unplanned reduction in the Trust's income, or missed opportunities to generate income	4382 (CIP) - Risk rating 16 4383 (Reliance on agency) - Risk rating 20 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	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.	Finance, Performance and Estates Committee	Red
						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		
						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. Rota and job plan sign off in a timely manner Large scale recruitment plans to mitigate vacancies.	The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups		
						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 104%.	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		

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						COVID costs - The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID.	The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	Financial plan set out the Trust Budget allocations in respect of COVID spend Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. 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.		
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal		EMAS, GPs, mental health, community, social care and care homes data now also available within the Care Portal.		
						Development and approval of Electronic Patient Record OBC		Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of OBC		EPR OBC to be approved by Frontline Digitalisation NHSE/I OBC requirements (including financial) being worked through with Frontline Digitalisation NHSE/I OBC going to Aug FPEC and Sept Board		

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3c	Enhanced data and digital capability	Director of Finance and Digital	Approval of OBC for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure		CQC Responsive	Rollout of PowerBI as Business Intelligence Platform during 2022/23			Delivering improved information and reports Implement a refreshed IPR Rollout increasing, having replaced QlikView dashboards. New dashboards in place to support Vaccination reporting and HR EF3 processes. Work underway to automate IPR production for Trust Board and Committees, as well as Divisional PRMs.	IPR refresh for 22/23. Completed for Jan 2022	Steady implementation of PowerBI through specific bespoke dashboards and requests.	Finance, Performance and Estates Committee	**Amber**
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues						
						Improve end user utilisation of electronic systems	Business case for additional staff under development						
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion.		
3d	Improving cancer services access	Chief Operating Officer	Insufficient clinical capacity, insufficiently optimised pathways, Dependency on services (primary care, pathology) that are unable to deliver required access or level of service		Cancer Standards 62 day, 14 day and 28 Day FDS	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Cancer Care Integrated Improvement Programme and Assoc Governance System Cancer Improvement Board	Recovery post COVID and risk of further waves Specialty Capacity strategies not in place Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) East Midlands Cancer Alliance Increased Oversight	Cancer board assurance and performance reports Deep Dive information and reports on gap analysis Routine Performance and pathway data provided by Sommerset system	Process information below the cancer stages are not always captured Some digital systems are not linked and not all wait information is recorded e.g. MIME system	Targeted Improvement (Daily reviews) of key concern specialties increase the scrutiny of reporting and pathway performance led by COO	Finance, Performance and Estates Committee	**Red**

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3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer	Insufficient clinical or physical capacity, insufficiently optimised pathways		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Planned Care Integrated Improvement Programme and Assoc Governance System Planned Care and Diagnostic Group	Recovery post COVID and risk of further waves Specialty strategies not in place Elective Theatre Programme Transformation team not yet established.	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Outpatient Improvement Group Foureyes Theatre Improvement Programme GiRFT and High Volume Low Complexity Programme Group	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and NHSE Review data			Finance, Performance and Estates Committee	**Amber**
3f	Urgent Care	Chief Operating Officer	Insufficient clinical capacity or expertise, inefficiently configured services, failure of system partners to provide capacity or reduce demand to pathway and excessive demand above capacity available		Emergency Care Clinical Indicators (12hr, 4 hour CRTP, 60 minute decision and 15 minute triage)	Daily System control meetings in collaboration with 3x daily internal capacity meetings. Integrated Improvement plan for urgent care and Urgent Care improvement Group. System Urgent Care Partnership Board. LHCC Improvement Programme Board and LHCC Board	Recovery post COVID and risk of further waves Internal professional standards not embedded External dependencies lack of visibility of capacity and system control to move risk/capacity between services. E.g. community care hours, care home ,assessment capacity etc.	External reviews used to identify gaps in services and assess capacity shortfalls. Emergency Care Intensive Support Team, IMPOWER specialist consultants and Dr Ian Sturgess specialist consultant reviews identify control and process and capacity gaps.	Improvement against strategic metrics Suite of performance metrics and benchmarking % of patients in Emergency Department >12 hrs (Total Time) Reports produced by ECIST IMPOWER and Improvement Consultants	Gaps in Early Warning Dashboard Pathway 1 capacity admission avoidance impact, waits and capacity for primary care.	LHCC Programme Board reviewing Early Warning Dashboard - additional reports on progress LHCC Programme Board reviewing progress Weekly CEO Forum review where evidence is and any gaps	Finance, Performance and Estates Committee	**Red**
SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
						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.		

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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	Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements in 22/23- (1) continued improvements in patient safety and experience (2) reduce long waiting times for treatment (3)make our people feel valued and supported by improving our culture and leadership	Embedding and sustaining cultural change when we remain operationally challenged with staffing issues etc. Ability to demonstrate quick impact on the cultural change due to various interventions as part of our Outstanding Care Together programme will be limited (as these are multi year/multi factorial projects)	ELT/TLT oversight Board / system reporting	Updated IIP reported at relevant Board Committees	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh	Finance, Performance and Estates Committee	**Amber**
						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain ULHT anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS		
						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		

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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	Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increase clinical academics by 20 and RCF funding worth £200k within the last 2yrs Further clarification and implications of the changed guidance on univ hospital status required. Funding for Clinical Academic posts and split with UOL to be agreed	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Contract agreed with UOL for Clinical academic posts 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 - now amalgamated into the monthly Steering Group with ad hoc meetings between SRO's where needed to discuss funding for Clinical Academics. ULHT have a recruitment roadmap in place which will include some pump prime from vacancies	People and Organisational Development Committee	Red
						Improve the training environment for students	Understanding of our offer of the facilities required for a functioning clinical academic department	Revision of the library and training facilities to ensure that facilities are fit for purpose for all staff who will require access to training facilities, library, ICT equipment to be able to perform their role. This will be aligned to the UHA Guidance, and will include those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unknown timescales of completion	University Teaching Hospital Status working group has been renewed with more drive, ensuring representation from key stakeholders and clear milestones for delivery		
						Developing a joint research strategy with the University of Lincoln	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU, with a local version between ULHT and UoL created as we move forward and understand the finer details of the partnership. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy.	RD&I Strategy and implementation plan agreed by Trust Board	Drafts in place which broadly cover joint research and teaching approach across the organisations, unable to outline in strategy financial commitment	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group		

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						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	Evidence bound by UHA requirements	Portfolio of evidence is being captured and is available on the shared drive Identified leads to liaise with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Roadmap developed to identify required evidence for portfolio	Clear understanding of rigidity of UHA requirements	Discussions being held to clearly identify opportunity for movement within guidance and steps being taken for a name change application		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	HRBP at ULHT is part of the Steering Group to assist with working through the contractual issues The project team now also includes a HRBP from UoL and has a dedicated project resource aligned.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Having a project lead at UoL has further supported the partnership approach and ability to co-create solutions and gather evidence for the UHA - specifically with regard to Clinical Academic recruitment.		
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, Engaging with the Integrated Care Board to take ASR implementation work forward. First Implementation Oversight Group meeting scheduled for September	Heat maps now drafted, with service reviews linked with improvement and clinical strategy development Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	Process being developed to identify services for review. This includes the development of a HEAT Tool to identify areas where services are not meeting targets, such as RTT, Cancer, Finance data. Initial discussions with divisions have been had with a view to ensure that the services most needing priority review are identified. Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning Publish ULHT clinical service strategy end of 2022/23 Working with Divisions to identify ASR implementation requirements	Finance, Performance and Estates Committee	**Green**

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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.

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