Bundle Trust Board Meeting in Public Session 7 March 2023

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 7 February 2023

Chair

Item 5.1 Public Board Minutes February 2023v1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log February 2023.docx

6 Chief Executive Horizon Scan Including ICS

Chief Executive

Item 6 CEO Update, 070323.docx

7 Patient/Staff Story

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

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 (inc ToR)

Item 8.1 QGC Upward report February 2023v1.doc

Item 8.1 Quality Governance Committee Terms of Reference 2022-23.docx

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 (inc ToR)

Item 9.1 POD - Upward Report - February 2023.docx

Item 9.1 People and Organisational Development Committee TOR 2022-23 07.06.2022.docx

9.2 Gender Pay Gap Report

Director of People and OD

Item 9.2 Gender Pay Gap Report FINAL PODC Approved for Trust Board 230223.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 (inc ToR)

FPEC Upward Report February 2023.docx

Finance Performance and Estates Committee TOR 2022-23 v2.docx

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

12 Integrated Performance Report

Item 12 IPR Trust Board Front Sheet.docx

Item 12 IPR Trust Board February 2023.docx

13 Risk and Assurance

13.1 Risk Management Report

Item 13.1 TB - Strategic Risk Report - March 2023.docx

Item 13.1 Appendix A - All risks rated 15-25 - February 2023.pdf

13.2 Board Assurance Framework

Item 13.2 BAF 2022-23 Front Cover March 2023.docx

Item 13.2 BAF 2022-2023 28.02.2023.pdf

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 4th April 2023

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 7 February 2023

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 Paul Matthew, Director of Finance and Digital
Mrs Rebecca Brown, Non-Executive Director
Mr Neil Herbert, Non-Executive Director
Dr Chris Gibson, Non-Executive Director
Mr Paul Dunning, Medical Director
Ms Michelle Harris, Chief Operating Officer

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Lindsay Shankland, Deputy Director of People and Organisational Development
Mrs Sharon Kidd, Patient Experience and Engagement Manager – item 7
Ms Libby Grooby, Divisional Head of Nursing and Midwifery – item 8.2
Mr Simon Hallion, Divisional Managing Director, Family Health – item 8.2
Dr Suganthi Joachim, Divisional Clinical Director, Family Health – item 8.2

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

001/23	**Item 1 Introduction** The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream to the meeting.

002/23	**Item 2 Public Questions** **Q1 from Vi King** **I have raised this on numerous occasions about people from Grantham being told there are no appointments for fractures at Grantham.** **I had been informed by PALS last year that to help this a person had been appointed just to look after Grantham appointments to stop this happening, yet it still keeps happening.** **I understand the first appointment can't always be done at Grantham, but follow up appointments could be.** **Why are fracture clinics only on Monday, Tuesday and Wednesday at Grantham and not five days a week** **This would not only take the pressure off Lincoln but would benefit the people of Grantham.** **I would also like to ask that the state-of-the-art theatres have been built at Grantham which I was invited to see them. Why aren't operations being performed at Grantham using pins and plates.** **Again, this would ease the pressure on the other sites.** The Chief Operating Officer responded:
003/23	When there was a requirement for a patient to access fracture clinic patients were offered a choice of all 3 sites and noted that both Lincoln and Pilgrim offered larger services meaning that appointments could often be sooner. It was noted that there were clinics at Grantham Monday to Thursday with consideration being given to expansion of clinics however there were less slots at the Grantham site due to the smaller environment. The Trust would continue to work through ensuring that the service was responsive to the population and patient need in Grantham. There was, as indicated in the question, a dedicated Clinical Booker at Grantham however this was not solely for the fracture clinic with improvements being sought in all bookings. Operations involving pins and plates were usually associated with trauma which was not routinely dealt with at Grantham which was an elective environment. There was however the benefit of additional theatre capacity which was resulting in the Trust considering planned cases of traumatic injury. Patients would be required to fit the criteria for infection prevention and control should this be progressed.

	The Chief Operating Officer thanked Ms King for the questions raised and indicated that further information could be offered outside of the meeting should this be required.
004/23	**Item 3 Apologies for Absence** Apologies were received from Ms Claire Low, Director of People and Organisational Development and Dr Colin Farquharson, Medical Director.
005/23	**Item 4 Declarations of Interest** There were no new declarations of interest.
006/23	**Item 5.1 Minutes of the meeting held on 6 December 2022 for accuracy** The minutes of the meeting held on 6 December 2022 were agreed as a true and accurate record.
007/23 008/23 009/23 010/23 011/23 012/23	**Item 5.2 Matters arising from the previous meeting/action log** 1265/22 – Integrated Performance Report – The Chair noted that events have moved on significantly since the actions had been raised noting that performance data was offered through the Integrated Performance Report (IPR). The action had been identified to produce a simplified dashboard however given that the IPR for 2023/24 was being built this would be revisited as part of the development process alongside the Integrated Improvement Plan and associated documentation. The Chair confirmed that the action would be discharged and would be progress with the refreshed IPR in 2023/24. 2152/22 – Assurance and Risk Report Quality Governance Committee – The Chair noted the Disclosure and Barring Service (DBS) action had been raised through the Quality Governance Committee noting the actions being taken in response to the concerns raised. The Chair advised that DBS would be remitted back to the People and Organisational Development Committee which had oversight of the issue and was included in the work programme for the Committee. The Chair requested that assurance was offered to the Board through the upward report from the People and Organisational Development Committee.
013/23	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board noting that the NHS continued to be a focus in the media with issues being covered also being felt in Lincolnshire with ongoing winter pressures and the enactment of winter plans alongside coping with industrial action.

014/23	The Chief Executive noted that some improvement in local performance was being seen with improvement in category 2 responses and a reduction in hours that ambulances waited to handover patients to Accident and Emergency departments.
015/23	It was noted that this was a system issue and not just for the Trust but was about the flow through the system.
016/23	The National Urgent and Emergency Care recovery plan was part of the Prime Minister's 5 key promises which would be wrapped up into the work over winter, industrial action, and the operational plan for the next year.
017/23	The Chief Executive noted that the finances for the Lincolnshire system were off plan with a year-to-date deficit of £19m at month 9 compared against a plan of £4m. There was a process in place for systems that were not delivering financial plans to seek agreement from NHS England for an adjustment to the forecast.
018/23	The Lincolnshire system was currently working through making such an application and whilst this was not certain it appeared likely. As a result, this was impacting on the system exiting the Recovery Support Programme (RSP) and again discussions were being held with NHS England and the Secretary of State about the exit date.
019/23	This was a key issue for Lincolnshire to try to bring finances back on track which was a key remaining exit criteria the system was yet to deliver.
020/23	The Chief Executive noted from a Trust perspective that the year-to-date deficit was reported at £12.5m noting that the Trust was part of the system overspend and was off plan. Efforts were in place to bring the Trust back on track however this was not solely a Trust issue.
021/23	The Director of Staff Experience and Engagement, NHS England recently visited Lincolnshire and was complementary of the efforts across the system to engage with the workforce. An e-mail had been received by the Chief Executive regarding the Trust and the great work across the Trust regarding leadership, culture, and behaviour. As a result, in due course it was hoped that improvements should be seen in the set of staff survey results.
022/23	The Chief Executive offered an update on Trust issues including the continued work to deliver the national expectations for 78-week waiters. The Trust had done well to deliver the 104-week wait maximum last year and clear instruction had been received that there would be no 78-week waits at the end of March 2023. Effort was being applied to deliver including seeking alternative support from other providers and mutual aid.
023/23	Professor Tim Briggs, who had a previous relationship with the Trust, continued to be impressed with the Trust for progressing issues on productivity and efficiency and was offering support as a critical friend however was reinforcing the 78-week message as a requirement of the system.
024/23	The Chief Executive was pleased to note the UNICEF Baby Friendly Initiative (BFI) for which the Trust had received a certificate of commitment. Over recent years

	significant improvement had been seen in women's and children's services with the BFI recognising healthcare facilities dedicated to best practice which was excellent news for the local population.
025/23	The Resus Unit at Lincoln had undertaken a media day recently with the official opening and the unit was now in use for the sickest people attending the hospital. Similar developments would be undertaken at Pilgrim with the new build A&E department.
026/23	The Chief Executive advised the Board of the Trust 's Armed Forces Staff Network, noting there were 5 active staff networks, which had held an insight day. This had offered an opportunity to speak and engage with military colleagues, those who had left the military and considering a new career and veterans in order to show the scale of careers available in the NHS.
027/23	The Chief Executive advised the Board that Mr Matthew the Director of Finance and Digital would be leaving the Trust at the end of April to take up the role of Chief Financial Officer at Nottingham University Hospitals NHS Trust.
028/23	Whilst there was sadness that the Director of Finance and Digital would be leaving the Trust's congratulations and well wishes were offered with the Chief Executive advising that plans were in place to seek a replacement.
029/23	The Chair wished the Director of Finance and Digital every success and noted the achievement in the appointment to the role.
030/23	The Chair reflected on the report offered by the Chief Executive noting the continued challenging operational environment however noted some progress was being seen. The Board was committed to deliver the 78-week requirement recognising that there were some specific challenges however plans were well developed to deliver.
031/23	Finance clearly remained very challenging however there was clear focus to mitigate the position to bring this back on plan.
032/23	The Chair noted the celebration points for the Board including the positive feedback regarding staff engagement and the achievement of the BFI certification. The Trust Board: • **Received the report and significant assurance provided**
033/23	**Item 7 Patient Story** The Director of Nursing introduced the Patient Story to the Board noting that this followed on from the Pets as Therapy (PAT) visits that had been undertaken at the Trust in November 2022.
034/23	The Trust Board viewed the video of Trevor telling his story about he and Clyde became volunteers for the PAT Charity and visited Grantham Hospital as their first visit.

035/23	The video presented offered Trevor's experience and that of staff and patients at Grantham Hospital and the positive impact this had had on all of those who came in to contact with the PAT visitors along with future plans for PAT visits.
036/23	The Chair noted how heart-warming the story had been particularly offering both the perspective of Trevor but also the patient.
037/23	The Patient Experience and Engagement Manager, who leads the initiative offered reflections from the visit noting that it had been a privilege to be Clyde's guardian for the day noting the enthusiasm of staff. There were planned visits throughout the course of the year in April, August, and November.
038/23	The Patient Experience and Engagement Manager noted that following feedback from staff who had dogs themselves consideration was being given to signing up staff dogs with the voluntary services department in order to have access to a home-grown source of PAT dogs. This would offer the ability for wards to make a request for staff dogs to undertake a visit alongside the planned events.
039/23	It was noted that an initiative had commenced with Estates and Facilities to have dedicated outside dog areas to facilitate the visits as well as support assistance dogs. There would be designed bespoke areas on each site. This had however stalled with the Patient Experience and Engagement Manager seeking the support of the Board to progress this prior to the planned April visit to enable more dogs on site.
040/23	The Patient Experience and Engagement Manager also advised the Board of the development of the Assistance Dogs Policy which would cover visits by any animal on site with thanks being offered to the Charities team for the support with the initiative.
041/23	The Chair noted the benefit of the initiative and reflected on the ask for support to ensure the sites were dog friendly and requested that this was followed up by the Director of Finance and Digital. **Action: Director of Finance and Digital, 7 March 2023**
042/23	Mrs Buik reflected on the reaction of the patients to the visit and asked how the visit was managed to ensure this was comfortable for everyone including those who were not dog lovers or who suffered with allergies.
043/23	The Patient Experience and Engagement Manager advised that discussions were held with the ward manager to identify areas which could not be visited, and patients were also spoken to in order to understand allergies or nervousness towards dogs.
044/23	There had been one patient who suffered with an allergy and some staff were frightened of dogs along with children in the paediatric area who were also not keen. Time was spent introducing Clyde slowly to them and this resulted in some people overcoming fears to coming close to a dog. It was hoped that there had been some benefit for these people in the longer term.

045/23	Dr Gibson noted that there was a clear positive impact on patients and staff and asked if there were any infection prevention and control (IPC) issues that needed to be considered or other restricted areas.
046/23	The Medical Director noted that this had been addressed through an Executive Leadership Team Live session where staff are able to ask questions of the Executive Directors. It was noted that the Trust had followed the national policy with the IPC team involved from the beginning. There was also a local Trust policy in place and areas where dogs are not able to go. They were restricted to the main wards and no areas of high infection risk could be visited.
047/23	It was also noted that there were restrictions on the type of animals allowed on Trust premises included within the policy noting that this could be viewed by Board members via the intranet if desired.
048/23	The Director of Nursing thanked the Patient Experience and Engagement Manager, volunteers' team, charity, and PAT Charity for supporting the visit and noted that the impact of an animal, like a dog, should not be underestimated. It was pleasing to note that more visits had been scheduled.
049/23	The Chair offered the thanks of the Board to the volunteers, and all involved in the PAT visit but also to Trevor and Clyde for bringing the story to life. The Trust Board: • **Received the patient story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
050/23	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair of the Quality Governance Committee, Mrs Brown provided the assurances received by the Committee at the 20 December 2022 and 24 January 2023 meetings.
051/23	Mrs Brown, as the Maternity and Neonatal Safety Champion Non-Executive Director, echoed the praise offered by the Chief Executive in respect of the BFI achievement.
052/23	Focusing on the January report Mrs Brown noted that clinical harm reviews remained a key focus for the Committee with long waits recognised nationally. The Committee had been pleased to hear that wider categorisation had been included and whilst the Trust had a good process in place this was about ensuring a stronger process.
053/23	The Committee noted the duty of candour was not at the expected level and had begun to reduce over the past few months with the Committee hearing of the additional actions put in place to support improvement. Continued focus would be given going forward.
054/23	The Committee received the safeguarding internal audit noting some outstanding actions that had been in existence since the previous Care Quality Commission

	(CQC) visit. The Committee took this as a serious area of focus and received a robust plan put in place by the safeguarding team and medicine division.
055/23	The Committee felt that due to the serious nature of the actions that it was important to hear from the medicine division and therefore the division would be invited to attend the next meeting.
056/23	Mrs Brown advised that the Committee had been pleased to see that the Trust remained within or below trajectory for C.difficile and MRSA which offered a positive position for the Trust given the footfall through the hospitals.
057/23	The Maternity and Neonatal Oversight Group had reviewed its purpose having been established to move maternity and neonatal services to a better position and focus on areas of concern. Improvements had been made with the group being successful resulting in the Trust being one of the best nationally.
058/23	The review of the group had been robust, and the Committee noted that this would now report on a bimonthly basis due to the strategic nature of the improvements.
059/23	The Committee was pleased to receive the update in respect of the Clinical Negligence Scheme for Trusts (CNST) maternity submission which would be discussed by the Board later on the agenda.
060/23	Mrs Brown noted the update in respect of the Ward Accreditation programme noting the growth in momentum with an increasing number of areas waiting to send evidence reviews into accreditation panels. The Committee was pleased to note the additional support in place for those areas which were challenged.
061/23	Committee members had completed the Committee Self-Assessment and received the first draft of the Annual Report which would be available in readiness for final submission.
062/23	The outstanding Quality Impact Assessment internal audit had been received with the Committee pleased to see actions now taking place which would be signed off shortly.
063/23	There had been agreement to review all outstanding internal audit actions on a monthly basis as requested by the Audit Committee in order to ensure these continued to be updated.
064/23	The Chair noted the good practice of the divisions attending the Committee meeting in order to ensure they were held to account for service delivery and would be interested to see how this worked through and the impact.
065/23	Regarding the improvement in medicines incidents, it was noted that there was some way to go however there was a clear focus in the Committee and the benefit of this was being seen.
066/23	Thanks were also offered to those involved in e-prescribing and implementation with the Board pleased to note that this was being rolled out successfully.

067/23	The Chair also thanked the Director of Nursing for the leadership of the Maternity and Neonatal Oversight Group noting that this demonstrated with the right leadership and focus it was possible to have great outcomes. The Trust Board: • **Received the assurance report**
068/23	**Item 8.2 CNST Declaration** The Chair welcomed the Divisional Head of Nursing and Midwifery, Divisional Managing Director and Divisional Clinical Director to the meeting to present the CNST Declaration.
069/23	The Chair noted that this was a positive item for the Trust Board.
070/23	The Director of Nursing advised that the paper offered a significant level of assurance to the Board following compliance with CNST and was presented to the Board following the submission the week earlier with endorsement sought from the Board.
071/23	This was a fantastic piece of work by the team to achieve full compliance and it was noted that the Trust was one of a few organisations that had achieved full compliance. This was testament to all of the work by the Family Health Triumvirate.
072/23	The Divisional Managing Director noted pride in the division with the work continuing and support from the Maternity and Neonatal Oversight Group and Local Maternity and Neonatal System (LMNS). This was an unusual circumstance for any Trust to achieve full compliance on CNST at this time.
073/23	The Divisional Head of Nursing and Midwifery advised the Board that the CNST had relaunched on 5 May 2022 with new submission date of February 2023. On the new scheme had launched all actions had been held on a bespoke action plan with monthly CNST meeting held to have oversight of the process and safety actions.
074/23	The action plan was updated on a monthly basis and fed through the Maternity Safety Collaborative and on to the Maternity and Neonatal Oversight Group. The assurance report from this group offered assurance onward to the Quality Governance Committee and then the Board.
075/23	It was noted that once the majority of evidence had been collated a review was undertaken with verifications and minor adjustments made. The actions were then reviewed with the LMNS and it was agreed that the standards had been achieved.
076/23	For those safety standards where concerns were present were considered again and on the 19 January by the LMNS and the Maternity Voices Partnership agreed with the achievement of compliance.
077/23	The Divisional Head of Nursing and Midwifery noted that following presentation to the Trust Board in December signatures were offered prior to the submission being sent to NHS Resolution ahead of the 2 February submission date.

078/23	It was evident in the report the amount of evidence collected and reported in order to be assured of the achievement of all 10 safety standards. This had been a huge team effort for achievement which also improved the safety of care being delivered to women who accessed the service.
079/23	The Chair noted that there had been a clear summary of achievement and that the achievement of this was always understated with the Board appreciating how difficult this had been to achieve.
080/23	Mrs Brown noted the very best practice that had been demonstrated with the team seeking external evidence reviews. This was exemplar with significant amounts of evidence being captured and collated. The approach was superb in the team to ensure that issues could be resolved and there was clear leadership from the triumvirate.
081/23	Mrs Wells agreed with the comments made and was impressed as to how the achievement had been articulated and asked if there were plans to share the process used across the organisation.
082/23	The Director of Nursing noted the wider consideration across the organisation as to how this could be applied noting that this was considered for all process of this nature.
083/23	The approach taken was transferable across the organisation and the Deputy Director of Clinical Governance and the Governance Expert employed to support this would be able to take a generalised approach even though this could be topic specific.
084/23	The Director of Nursing echoed the statements made about the amount of evidence the teams had collected to satisfy compliance and the standards and noted that at any time it would be possible to offer the information if requested.
085/23	It was clear that this was about the strength of leadership across the midwifery, obstetrics and management teams under the guidance of the Divisional Managing Director. Work had also been done around having specialist midwives in post to support maternity and neonatal services. The focus of the specialist midwives and the appointments made had been an exceptional support to the Divisional Head of Nursing and Midwifery.
086/23	The Director of Nursing offered thanks to the triumvirate for taking forward the family health services in its totality.
087/23	The Chief Executive echoed the comments made by the Director of Nursing noting that he had not seen this quality of CNST submission before, particularly due to the evidence to support this. The depth and triangulation that had gone into the submission was clear and was a clear sign of the significant progress the organisation had made, particularly this part of the organisation.

088/23	This had clearly been a team effort but the leadership in this should not be minimised due to the truly remarkable transformation achieved.
089/23	Whilst the submission was important for the organisation what was more important was the message to the public about what could be expected when accessing the service, the rigour of assessing the safety and the degree of assurance that should be taken form this when interacting with the service. Services in other parts of the country would not be able to make the statements and submissions the Trust had made.
090/23	The Chief Executive reflected that this offered further confirmation that awarding the Divisional Head of Nursing and Midwifery the Chief Executive's staff award was entirely the right thing to do.
091/23	The Chair thanked the Divisional Head of Nursing and Midwifery, Divisional Managing Director and Divisional Clinical Director for the achievement. The Trust Board: • **Endorsed the CNST submission**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
092/23	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker provided the assurances received by the Committee at the 13 December 2022 and 17 January 2023 meetings.
093/23	Professor Baker noted that at the December meeting the Committee continued to receive details, reassurance and reporting from the sub-groups which had been established during 2022. 2 task and finish groups had also been established for appraisals and statutory and mandatory training with the Committee looking forward to receiving reports from the groups.
094/23	There had been some significant concerns around the progress to establishing the Lincoln Medical School and the alignment with the University of Lincoln strategy and concerns regarding the BMA minimum rates and the impact of this on the Trust. There was ongoing work to resolve the discussions.
095/23	During the December Committee objective 2b of the Board Assurance Framework was considered which had been red rated for a long period. The Committee felt that the improvements in governance and reporting were such that there was a suggestion to increase the rating to amber.
096/23	The recommendation reflects the sustained work but Professor Baker also highlighted the work of the Director of Finance and Digital that had been undertaken and was now being progressed by the Director of People and Organisational Development.

097/23	Professor Baker noted from the January 2023 Committee that the Workforce, Strategy and Organisational Development Group had been stood down due to the critical incident however noted the limited but positive movement of metrics reported within the scorecard.
098/23	The Committee had considered the safer staffing report which included an update on the impact associated with breaking the cycle.
099/23	Time had been spent discussing the staff survey results with further detail to be available once these were fully published however the significant level of improvement was noted.
100/23	Professor Baker advised the Board of the significant ongoing activity in relation to the Freedom to Speak Up Guardian and was pleased to note that most issues being flagged to the Guardian were not being raised anonymously which was positive.
101/23	An update had been considered from Research and Innovation with Professor Baker reminding the Board that assurance had not been received in recent times. The Director of Research and Innovation was now attending the Committee on a monthly basis to discuss plans and proposals.
102/23	The Committee was gratified to receive proposals to improve the function around research and development and was encouraged by the improved engagement with the University Teaching Hospital work which the Committee had been pushing for.
103/23	Professor Baker noted there were some encouraging signs, and it was hoped that this would lead to an improvement in activity and levels of assurance.
104/23	The Committee discussed concerns around the engagement with the University of Lincoln and the funding of clinical academics with further work required that the Committee wished to support.
105/23	Professor Baker alerted the Board to the issues within the People and Organisational Development Directorate noting the necessity for the restructure that was underway with appointments being made and an intention to relaunch the directorate.
106/23	It was anticipated that some patience would be needed as the directorate consolidated the work done noting the progress during 2022 which had been made resulting in improvement to the assurance ratings for objectives 2a and 2b.
107/23	Professor Baker noted that objective 4b remained challenging and hoped that progress would be seen in the coming year.
108/23	The Chair noted that whilst the narrative had offered an update to the Board the ability to move an objective rating on the Board Assurance Framework demonstrated the impact the Committee was having on the business of the organisation and the level of assurance being reported.

109/23	The pressures within the directorate were recognised with the Board appreciative of the need to redesign the directorate and reflective of the need to be patient however there was a need for greater clarity which should be seen through the Integrated Improvement Plan (IIP).
110/23	The Chair requested an update from the Director of Improvement and Integration in respect of the University Teaching Hospital status as the Trust moved in to the 2023/24 year.
111/23	The Director of Improvement and Integration noted that in early December the Secretary of State had reached out to a number of Integrated Care Systems to put integration at the heart of decision making and to better understand challenges and priorities. It was noted that attracting workforce remained a key challenge for Lincolnshire and it was noted that addressing this would also alleviate some of the financial pressures.
112/123	Within the IIP the ambition had been set to achieve University Teaching status and collectively with the Integrate Care Board (ICB) support was being sought for the priority with close working with the University of Lincoln to develop a joint research and innovation strategy and plan to attract clinical academics to meet the University Hospital Association (UHA) guidance.
113/23	More recently a meeting was held with the ICB Clinical Director alongside the Trust's Medical Director, Director of Research and Innovation and the Vice Chancellor of the University of Lincoln, the have a more joined up approach to drive this forward.
114/23	The Chair noted the activity underway and hoped that this offered reassurance to Professor Baker that this was moving forward.
115/23	The Chair requested an understanding of the escalation from the December Committee in respect of the BMA minimum rate.
116/23	The Medical Director stated that, reluctantly, due to patient safety the Trust had agreed to the maximum August BMA rate which had been considered in detail by the Executive Directors however it was noted that significant changes were required due to the significant financial pressures with the rates.
117/23	Therefore, a number of changes had been introduced including a change in the process for the booking of additional rota gaps which was now coordinated through the central medical agency team. It was noted that a gap analysis would be required for a booking to be made and the only doctors on the bank and agency should be used. Any use of BMA rates required authorisation of the divisional triumvirate with no authorisation to exceed the BMA rate.
118/23	The Medical Director advised that some financial measures had been put in place by the Finance Team with no additional funding to the directorates and a cap on spend. This would be monitored through the Performance Review and Financial Performance Review meetings.

119/23	The Chair noted the clear grip and control being exercised with a clear process in place.
120/23	The Chief Executive noted that whilst it was recognised and accepted that the BMA had a right to tell its members to only do work at a set hourly rate it was clear that lots of volume at that level was unaffordable for the Trust and caused additional financial pressures. Stricter controls were in place with a need to focus on minimising the number of occasions people on those rates were used.
121/23	The comments from the Director of Improvement and Integration regarding the University Teaching Hospital status were endorsed by the Chief Executive who was pleased that discussion with the ICB and Secretary of State had considered this topic.
122/23	The Chief Executive noted the development of the directorate noting that there should not be a compromise on the standard of people being appointed to the roles as the Trust needed the best leadership and managers in the function. Support continued to be offered to the Director of People and Organisational Development to ensure that the pace and appointments continued.
123/23	The Chair noted the levels of assurance offered to the Board and the movement of objective 2b on the Board Assurance Framework. The Trust Board: • **Received the assurance report**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
126/23	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini provided the assurances received by the Committee at the 22 December 2022 and 25 January 2023 meetings.
127/23	Ms Cecchini noted a specific item of escalation from the December meeting in respect of estates and the deficiency report received from Lincolnshire Fire and Rescue. This was related to lack of compartmentalisation at 2 of the sites.
128/23	An item of concern from the January meeting had been the recruitment challenges for authorised engineers with focus from the team to progress.
129/23	The Committee had been pleased to receive good interim reports regarding Patient-Led Assessments of the Care Environment (PLACE) results and from a Health and Safety perspective with the team progressing the British Safety Council (BSC) 5-star rating. Assurance would be offered to the Board on Health and Safety arrangements once the outcome had been received by the Committee.

130/23	The Committee considered the possibility of stepping down reporting of low surface temperatures as all work had been undertaken in Trust owned properties. Discussions remained ongoing with NHS Property Services for accommodation utilised but not owned by the Trust. A letter had been sent by the Director of Finance and Digital to NHS Property Services to remind them of their responsibility.
131/23	Ms Cecchini advised that the Trust was recording a £12.6m deficit at the end of December with a likely forecast outturn of £17m deficit. Within the position was £5m provided to the Trust from the ICB in respect of the non-closure of beds.
132/23	The Director of Nursing sought to better understand the rationale for the stepping down oversight of the low surface temperatures given further assurance was required from NHS Property Services.
133/23	The Director of Finance and Digital noted that part of the rationale for stepping this down was the NHS Property Services had been written to and whilst a response offered advised all properties occupied were compliant the final step to complete before closing was to seek evidence of compliance.
134/23	Once evidence of compliance had been received then this could move to a business-as-usual approach as to how the Trust assessed premises being used and to work with landlords outside of NHS Property Services.
135/23	The Director of Finance and Digital wanted to move out of the high level of escalation to business as usual but would only do so once the final evidence was received.
136/23	The Chair noted the need to remember that this had come out of a prosecution case and therefore confirmation was needed that all necessary remedial actions had been completed with evidence to demonstrate this. There was a need to close the loop before this was stepped down with a need to understand how this would be monitored going forward.
137/23	The Chair noted technology issues with Ms Cecchini's camera and therefore the Board would consider the remainder of the report.
138/23	The Chair requested an update, by way of reassurance, that the matter of the fire notices was being progressed.
139/23	The Director of Finance and Digital advised that the notices related to Lincoln and Grantham regarding compartmentation on those sites. Survey work was underway across all sites to validate and confirm the position and into the next year's capital programme the remedial works would be identified for resolution. This would be monitored through the Finance, Performance and Estates Committee going forward.
140/23	The Chair noted from an Information Governance perspective that there appeared to be further work to be completed to achieve higher levels of assurance.
141/23	The Director of Finance and Digital advised that this related to the Data Security and Protection Toolkit (DSPT). As the Trust tried to increase the levels of assurance a restructure had been undertaken with an Interim Head of Information Governance in

	post who had taken a root and branch review of the toolkit. In doing the review this had identified some areas of achievement in a robust way for 30 June deadline.
142/23	This was reported through the Information Governance Group to the Finance, Performance and Estates Committee with the Trust Secretary and Director of Finance and Digital holding monthly meetings with the Information Governance Team, Cyber team and relevant officers from the organisation to move this forward.
143/23	The Director of Finance and Digital advised the Board that compliance with the toolkit at the time of the submission was unlikely however there were clear actions in place to move back to compliance going forward.
144/23	The Chair noted the update provided and was pleased that the Board had been notified of the compliance concerns ahead of the submission and noted the actions being undertaken.
145/23	Dr Gibson noted that the report indicated more than 1000 beds were open at the height of winter pressures and that the NHS England delivery plan for the recovery and urgent and emergency care (UEC) indicated that winter escalations beds would need to be maintained and a future commitment of an additional 5000 beds made across the English NHS.
146/23	Dr Gibson asked how this was being built in to planning for the future and consideration of activity in the community.
147/23	The Chief Operating Officer advised that at the height of winter the Trust had 1070 beds open and whilst there was the offer of additional beds these were not all staffed and therefore added and additional pressure. The Trust would continue to work with the system to ensure that the acute provider did not carry the burden with a need to understand where the beds were that represented the best place for patients to be cared for.
148/23	Additional planning was required along with an understanding where the resource would come from and how this was expected to be used. Care close to home needed to be worked through to ensure that patients did not remain in acute care longer than was needed with a focus on right treatment, right place, right time.
149/23	The Director of Finance and Digital advised that the number of beds open posed a significant financial burden on the Trust and system. There were a number of funding streams covering winter and bed pressures with work underway as to what the plan would look like into the next year. There was a need to understand some of the financial flows in respect of recurrency and work at an Integrated Care System (ICS) level regarding how many beds there should be and in which setting.
150/23	The Director of Finance and Digital advised the Board that it had been an aspirational year but that things had moved on and therefore this had resulted in the burden being carried. Work was underway with the ICS through the planning process as to what this looked like and what would be commissioned. This would drive how the Trust moved forward and would drive discussions around staffing and other elements.

151/23	The Chief Executive advised that the system was committed to work out how many beds the system needed with work having commenced through the System Improvement Director. As stated by the Director of Finance and Digital and Chief Operating Officer this was not just about the acute sector beds but what was needed for the acute part of the pathway alongside the need in social and home care.
152/23	Once this was identified it would be possible to get the right staffing to ensure the beds in the Trust were made sustainable. The strategic direction was around care close to home and would be the pursued model and was what the system wanted to do however it was clear that there was not an answer as to where the beds would be needed or how many.
153/23	The Director of Improvement and Integration advised that internally a process of considering demand and capacity modelling had commenced and was a fundamental pillar. This would be worked through as the Trust moved through the planning process with a need to know the required capacity as a system and to then understand what sat within the acute and community.
154/23	The Chair was aware, from system meetings, that joint working was being undertaken and was something that had been happened previously. It was anticipated that when presented the outcome would be well thought through with data and analytics. This would need to be received in order to understand what this would mean for the Trust.
155/23	Through the MS Teams chat Ms Cecchini noted the risk around 78-week delivery with some detail offered to the Committee about all 78-week waiters requiring an appointment by the end of January.
156/23	The Chief Operating Officer noted that this was one of the 5 promises made where no patient would be waiting over 78-weeks with an appointment booked by the end of January and the first definitive treatment received by the end of March.
157/23	The Board noted that progress was such that currently there were circa 294 patients still being worked with as a result of patient choice but also due to the bespoke nature of the specialty involved.
158/23	Work was being undertaken with the ICB regarding the planned care function and independent sector support to ensure patients were seen and treated in the timescale required. It was noted that the task should not be underestimated with the Trust in a good position. Whilst appointments should have been booked by the end of January the Trust was not unique in not having been able to achieve this with an extended timescale to resolve given until the end of 7 February.
159/23	The Chief Operating Officer noted that regional meetings were taking place to map progress with a level of confidence that patients booked would be treated by the end of March. There were some issues as a result of patient choice and whilst an appointment could be offered patients did not want to attend. Work was taking place with patients to understand how care could be accessed in the right place at the right time to offer the care required.

160/23	The Chair noted the huge volumes of patients however noted that it was clear the number of patients was known with a clear understanding of what was happening for those patients as well as ensuring engagement. It was also clear that there was confidence in people being treated in the timescale.
161/23	The impact of breaking the cycle had been observed with the Chair thanking those in the Trust for managing risk in a different way and stretching to achieve. Thanks were also offered to the Executive Directors for leading on the work. The Trust Board: • **Received the assurance report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
162/23	No items
164/23	**Item 12 Integrated Performance Report** The Chair noted that each of the Committees had considered the relevant aspects of the Integrated Performance Report and noted discussions had taken place where required.
164/23	The Chair offered the opportunity for Board members to provide any further updates or raise questions regarding the report.
165/23	No further points or questions were raised by Board members with the reporting being accepted as presented. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
166/23	**Item 13.1 Audit and Risk Committee Upward Report** The Chair of the Audit and Risk Committee, Mr Herbert presented the report to the Board from the meeting held on 13 January 2023.
167/23	A number of updates were received by the Committee including from external audit which offered the detailed planning that had taken place and the timetable agreed for audit including some resilience which had been built in to allow for the changes to senior finance personnel as described by the Chief Executive.
168/23	Mr Herbert advised the Board that 8 internal audit reports had been received with the Committee pleased to note significant improvements to follow up reviews for estates and recruitment.

169/23	As mentioned by Mrs Brown the safeguarding audit report was received with some concern noted however reassurance was received that a plan and resource was in place to address the issues raised.
170/23	The Committee received assurance that for the remainder of the year resource was in place with internal audit to complete the plan.
171/23	Mr Herbert advised the Board that the Committee had noted the progress to close overdue internal audit actions which would continue to be monitored closely given the number of new actions resulting from the recent reports and changes in the senior management team.
172/23	The Committee noted the progress in respect of risk management which reflected the recent internal audit that had offered significant assurance with some improvement required.
173/23	A policy update had been offered to the Committee offering limited assurance with actions agreed for more detailed progress updates to be provided at the next meeting, including a plan and timeframe for getting back on track in this area.
174/23	Mr Herbert advised the Board that the Committee had considered the Board Assurance Framework (BAF) and advised the Board that the amber rating for objective 2c – well led had been considered in detail in light of the progress made in control and risk management.
175/23	The Committee had acknowledged that the Trust was now out of special measures with all section 31 notices closed and significant assurance, with some improvement from internal audits for risk management and the BAF.
176/23	Whilst there had been progress the Committee had taken the view that more and sustained progress on internal audit actions, policies and settling of leadership change was required before the considering the change to green.
177/23	The Chair noted that the update described a highly effective Committee meeting.
178/23	Mrs Brown reinforced the positive position of risk management noting the assurance received from the internal teams which was down to hard work and leadership in the area and input from the Deputy Director of Clinical Governance and Director of Nursing.
179/23	The Chair noted that there was a clear sense, from the meeting, of strong leadership and the Trust working within governance frameworks which had been demonstrated across all assurance reports offered. The Trust Board: • **Received the assurance report**

180/23	**Item 13.2 Risk Management Report** The Director of Nursing presented the risk report to the Board noting that the risks presented remained the same as the previous month and was primarily due to the cancellation of the risk register confirm and challenge meetings.
181/23	There had been stood down in response to both operational pressures and planning for industrial action.
182/23	The report outlined the movement of some risks due to be discussed and ratified at the end of January with the Director of Nursing confirming that the meeting had taken place and therefore the outcome of this would be seen the following month.
183/23	The Director of Nursing stated that there were no new high and very high risks presented and advised that all risks had been reviewed by each of the Committees with mitigations in place.
184/23	The appendix to the report offered the full suite of strategic risks and a moderate level of assurance was offered with no areas for escalation.
185/23	The Chair offered thanks for the explanation as to why there had been no movement on the report and noted that this demonstrated the dynamic process in place.
186/23	Board members were invited to confirm that the risks presented were accurate and that it was felt appropriate mitigations were in place. The Trust Board: • **Accepted the risks as presented noting the moderate assurance**
187/23	**Item 13.3 Board Assurance Framework** The Trust Secretary presented the Board Assurance Framework (BAF) to the Board noting that this had been considered through all Committees during December and January including the January Audit Committee meeting.
188/23	As noted earlier on the agenda the People and Organisational Development Committee had made the recommendation for Objective 2b to be moved from red to amber.
189/23	The Trust Secretary advised the Board the work had commenced in respect of the development of the BAF for the 2023/24 year which would run alongside the Board Development Sessions over the next 2 months.
190/23	The Chair offered thanks for the reassurance of the development of the 2023/24 BAF and formally invited Board members to endorse the decision of the People and Organisational Development Committee to move objective 2b. The Trust Board: • **Received the report noting the moderate assurance** • **Endorsed the move from red to amber for objective 2b**

191/23	**Item 14 Any Other Notified Items of Urgent Business** The Chair offered apologies for the difficulties experienced with the technology during the meeting.
192/23	The next scheduled meeting will be held on Tuesday 7 March 2023 via MS Teams live stream

Voting Members	**1 Feb 2022**	**1 Mar 2022**	**5 Apr 2022**	**3 May 2022**	**7 June 2022**	**5 July 2022**	**2 Aug 2022**	**6 Sept 2022**	**4 Oct 2022**	**1 Nov 2022**	**6 Dec 2022**	**7 Feb 2023**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	A	X	X	X	X	X	X	X	X	X
Sarah Dunnett	X	X	A	X	A	X	A	A				
Elizabeth Libiszewski												
Paul Matthew	X	A	X	X	X	X	A	X	X	X	X	X
Andrew Morgan	X	X	X	X	A	A	X	X	X	X	X	X
Mark Brassington												
Simon Evans	X	X	X	X	X	X	A	X	X	A	X	
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X
David Woodward												
Philip Baker	X	X	X	X	X	X	X	X	X	X	X	X
Colin Farquharson	X	X	X	X	X	X	X	A	A	A	A	A
Gail Shadlock	X	X	X	X	X	X						
Dani Cecchini	X	X	X	X	X	X	X	X	X	X	X	X
Rebecca Brown								X	X	X	X	X
Neil Herbert								X	X	X	X	X
Paul Dunning								X	X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
5 July 2022	1265/22	Integrated Performance Report	Board to review performance report through IPR ahead of the winter pressures, with focus to be afforded to the scorecard performance and position of a range of metrics.	Trust Secretary	~~06/09/2022~~ ~~04/10/2022~~ ~~01/11/2022~~ 06/12/2022	To be considered in private Board session before being offered to public Board as part of the winter plan in October Deferred to November Action to be held over until discussed through private Board Closed
4 October 2022	1826/22	Integrated Performance Report	Echocardiography deep dive to be reported to Finance, Performance and Estates Committee	Chief Operating Officer	24/11/2022	Complete
4 October 2022	1829/22	Integrated Performance Report	Fractured Neck of Femur update to be reported to Finance, Performance and Estates Committee and consideration to be given to quality impact and possible reporting to Quality Governance Committee	Chief Operating Officer	24/11/2022	Supplementary slide to be included within urgent care component of FPEC operational report in February
6 December 2022	2152/22	Assurance and Risk Report Quality Governance Committee	Update to be provided in respect of prioritisation of DBS Checks for staff	Director of People and Organisational	07/02/2023	DBS Policy and Recruitment Policy have been updated.

				Developme nt		Recruitment Service Manager has been appointed. Interim Head of Business Intelligence is addressing the issues with the data held to identify gaps and to improve the quality of data and to support improvements in reporting functionality going forwards. Joint communications with TLTand staffside are due to start in February 2023. Close
6 December 2022	2229/22	ASR Update	ASR Report being presented to Health Overview Scrutiny Committee to be circulated to Board members prior to being received at HOSC	Director of Improvemen t and Integration	07/02/2023	Complete
7 February 2023	041/23	Patient Story	Follow up of plans for dog friendly outside space ahead of scheduled visits commencing April 2023	Director of Finance and Digital	07/03/2023	

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*7 March 2023*
Item Number	*Item number 6*

Chief Executive's Report

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

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to be under significant operational pressure, bearing in mind that we are now in winter. This is being exacerbated by having to ensure operational resilience during industrial action.
b) Industrial action is continuing, with further strikes in the ambulance service taking place on 6th March and 20th March. Planning is also underway for the Junior Doctor strike which will be for 72 hours between 07:00 on Monday 13th March to 07:00 on Thursday 16th March. There are no agreed derogations (exceptions) for the Junior Doctor strike and as such this poses significantly greater risk around service resilience and continuity. All parts of the system are working through their plans for these strike days.
c) The draft system operational plan has been produced and has been shared with NHS England. This covers all aspects of the plans for 2023/24 including activity, workforce, finance, and target achievement. The final plan has to be produced by the end of March.
d) The system has plans in place to deliver the maximum 78 week waiting time target by the end of March. Significant work has gone in to securing sufficient capacity to meet this target, whilst also complying with patient choice. Risks remain around the delivery of the target but all available mitigations are in place.
e) The Lincolnshire system will not exit the Recovery Support Programme (RSP) at the end of March as originally planned. The system has met two of the four exit criteria. The conditions relating to financial performance have not been met and the system is forecasting to end the year with a deficit of c£21m. An application has been made to NHS England for an extension of the time period the system will remain in the RSP.
f) Work is underway across the system to produce the Joint Forward Plan, known locally as The Lincolnshire NHS 5 Year Strategy, by the 30th June. This work is led by the NHS Lincolnshire Integrated Care Board (ICB). In developing the Joint Forward Plan, the ICB has a duty to have regard to the local Integrated Care Strategy, Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessments. The ICB are expected to develop the plan in partnership with local health and care partners. Workshops are being held in this respect.
g) There are local government elections on 4th May. As such the NHS will enter a pre-election period (also known as purdah) on 13th March. This limits the actions and communication activities of the NHS during the run-up to an election, whilst ensuring that normal and essential operational business is still conducted.

Trust Overview

a) At Month 10, the Trust reported a year to date deficit of £13.1m against a year to date plan of breakeven. As part of the system forecast outturn position (see e) above) the Trust is forecasting a year end deficit of £13.6m.
b) The new Resuscitation Department at Lincoln County Hospital has now opened. This £5.6m facility contains eight treatment cubicles all fitted with patient hoists and the latest equipment needed to provide life-saving support for patients.
c) Linked to the operational plan for 2023/24, the Trust is finalising year 4 of its Integrated Improvement Plan 'Outstanding Care, Personally Delivered.' The plan maintains the focus on the four strategic objectives relating to patients, people, services and partners.
d) The 2022 National Staff Survey results will be published on 9th March. A paper will be presented to a future Board meeting setting out the results and the action for further developing the Trust.

e) Nominations for the Staff Awards 2023 have opened. This year there are two new categories, a Rising Star award and a new Equality, Diversity and Inclusion Champion award. Nominations close on 1st September and the awards ceremony will be in November.
f) A planned full site electrical shutdown took place at Lincoln County Hospital on Sunday 26th February to allow critical essential maintenance work to the high voltage systems. Electrical supply to the site was isolated for 12 hours and during this time the site was running on generator power. This planned shutdown required significant prior planning and on-the-day management. I would like to commend all staff for the work that they did to ensure the site maintained its operational resilience on the day.

I am delighted to advise that Dr Karen Dunderdale, Director of Nursing/Deputy CEO, has been made a Visiting Professor of Nursing at the University of Lincoln. Many congratulations to Professor Dunderdale.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	21 February 2023
Chairperson:	Rebecca Brown, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
	Assurance in respect of SO 1a Issue: Deliver high quality care which is safe, responsive and able to meet the needs of the population **Clinical Harm Oversight Group Upward Report** The Committee received the report noting that the group had spent considerable time considering the harm review process with a report due to be presented to the Executive Leadership Team and Trust Leadership Team meetings prior to prior to the Committee outlining the proposal for change. It was noted that the intention would be to make full use of the Datix system in order to have full risk reporting and auditing which would reduce duplication. The Committee received assurance that whilst the process was developed harm reviews were continuing to ensure these were identified and completed as appropriate. The Committee would receive the recommendation paper to the March meeting. **Patient Safety Group Upward Report inc Mortality Report** The Committee received the report noting that the group had received a paper in respect of a deep dive into patient harm as a result of delays in the emergency departments. It was noted that the report had identified that patients were not coming to disproportionate levels of harm however further work would be undertaken to considered themes. The Committee noted the Never Event Summit had been held and the

	valuable discussions had during the session noting that there had been a focus on culture and attitude and actions identified which would be progressed. The updated plan would be received at the next committee meeting which will include appropriate timescales. **Close Down Report Phase 2 PSIRF** The Committee received the update in respect of the close down of phase 2 of the implementation of the Patient Safety Incident Response Framework (PSIRF). The Implementation Team had signed off and achieved all action for phase 2 and had, as a result, identified further actions to be completed in to phase 3. The Committee noted that phase 2 had been closed early with phase 3 on track for completion with no current risks identified. The Committee noted that the Integrated Care Board received regular updates on the progress of the Trust and it was noted that the Trust was progressing ahead of other within the system. **Serious Incident Summary Report inc Duty of Candour** The Committee received the report noting the position presented. The Committee was pleased to note the improvement in Duty of Candour and the improvement of the governance in respect of incidents. A reduction in the number of actions that remain open, as a result of incident, continued to reduce. **High Profile Cases** The Committee received the report noting the content. **Claim and Inquest Report** The Committee received the report which offered data related to Q3 compared to Q3 of 2021/22 and noted that there remained relatively static levels of claims. The Committee noted the increase between the years of the number of inquests however recognised that there was a backlog due to Covid-19 and inquests being paused by the coroner during this time. A prior request from the Committee for further data comparison and triangulation could not be fulfilled due to the current reporting system in use however, the Committee noted that developments to the system would be made in the next financial year, improving the reporting ability. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report noting that there had been no new cases of MRSA reported in month the action plan in place from a previous case continued to be monitored. There had been 8 cases of C.difficile resulting in the Trust being above trajectory however there had been no periods of increased incidence

	during the month. The group had reviewed the IPC BAF in alignment with the national IPC Strategy with assurance gained in all areas. It was noted the environmental features, due to the Trust's estate, continued to flag due to ventilation requirements however this would be addressed through the procurement of air filtration devices. An update was offered to the Committee in respect of the recent NHS England regional IPC visit which had been very positive. A formal letter of response to the visit would be offered in due course. **Medicines Quality Group Upward Report** The Committee received the report noting the success of the EPMA pilot within specific ward locations and the intention for this to be rolled out during the remaining quarter of the year. An update was offered to the group in respect of the ongoing OPAT rollout with a significant contribution made by the Trust. The Committee was pleased to note the updates being seen in respect of medicines management noting that this was as a result of changes at ward levels and improvements in practice but also due to the improvements in oversight. **Child Protection Information Sharing (CPIS) update** The Committee welcomed members of the medicine division and clinical governance team to the Committee to discuss progress in respect of actions related to CPIS. The Committee was pleased to note the progress being made and the commitment of the division to ensure actions were embedded. It was noted that support would continue from the Safeguarding team until the end of March where ownership would then transfer to the division. The Committee noted that the actions had been outstanding for some time however was reassured on the progress being made the intention that the division would be in a position to evidence the position by the end of the Q1 2023. To gain assurance The Committee requested that an update be offered in April to confirm that the intended actions had been completed as advised.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report noting the input of the group on the co-design work for the Trust Visiting Policy. The group would be relaunching the UHLT Carers Badge which had been

	paused during Covid-19 but would enable carers to be clearly identified as such and support their key role and responsibility to the person they care for outside of NHS care. A carers hub was being developed at the Pilgrim site and would offer similar signposting such as Macmillan, this would be supported through funding bids to the Charitable Funds Committee. **Complaints Quarterly Report** The Committee noted the data that was presented for the quarter, which demonstrated an increase in the number of complaints however it was noted that this may be due to the implementation of the early resolution team as there had been an increase in overall activity. The early resolution team continued to have a positive impact which was allowing a whole team focus on new and overdue complaints with a significant increase in the number of close complaints compared to the previous quarter. The Committee noted that a 6 month review of the new way of working was due to be undertaken in order to confirm the proof of concept prior to this being formally adopted.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report – inc NICE and Clinical Audit Reports** The Committee was pleased to note full compliance with response and outcomes to national audits with included good engagement in respect of the audit for care at end of life. The position in relation to the specialised services quality dashboard was noted with some areas consistently alerting however work was underway to identify and implement relevant actions. The Committee noted concern regarding compliance with clinical audit however recognised the development of an induction programme for clinical governance leads to ensure relevant support was in place and the role outlined accordingly.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report noting that moderate assurance provided at month 10 for the patient objective. There had been progress made in respect of WebV with roll out at 100% compliance. The Committee noted the positive downward trajectory for the Summary Hospital-level Mortality Indicator (SHMI).

	It was noted that work would be undertaken in order to consider the metrics for the next year. **Audit Recommendations** The Committee received the report noting the information presented which offered the position of all audit actions. The Committee noted that the small number of overdue actions and noted that need for further update of the actions to reflect those that had been closed. **Savile Action Plan** The Committee received the report noting that 6 of the 49 recommendations remained partially met. These actions were responsibility of the People and Organisational Development Committee relating to Disclosure and Barring Service Checks and mandatory training. It was noted a further action remained outstanding regarding procurement which would be the remit of the Finance, Performance and Estates Committee. The Committee noted that the report was received on a quarterly basis with this being considered prior to the Committee by the Patient Experience Group. Due to the progress that had been made in respect of the actions and noting that those outstanding sat with other Committees it was agreed that this would no longer be received directly by the Quality Governance Committee. A referral would be made to the People and Organisational Development Committee and Finance, Performance and Estates Committee, to ensure the actions remained sighted and the Patient Experience Group would continue to monitor progress. Escalations would be made to the Committee as required. **CQC Action Plan** The Committee received the action plan noting the progress that had been made with a decrease being seen in red actions. It was noted that progress had been static for a period of time with some actions taking longer to come to fruition. The Committee noted the intention of the Trust to start to prepare for the revised regulatory model from the CQC knowing that this was likely to come on stream in the autumn of 2023 with early self-assessments being undertaken. **Committee Performance Dashboard** The Committee received the dashboard noting that the performance data presented had been considered through the reports offered to the Committee.

	The Committee reflected that this meant the right agenda items were being considered by the Committee on a monthly basis. **PRM Upward Report** The Committee received the report for information noting the BMA rates which would be considered and may require completion of a quality impact assessment. **Strike Action Update** The Committee received the report in respect of Strike Action noting that the Trust undertook cold and hot debriefs following the action being taken. The Committee noted the use of Multi-Agency Discharge Events in order to support flow through the hospitals and ensure zero tolerance was applied to delays. The report offered lessons learned and actions which would be retained for future use and areas to be revised with the Committee noting that this extended to system partners in order to understand the wider impact and what was required for ongoing industrial action. The Chair offered thanks to the Chief Operating Officer and the teams involved in the response to support actions as a result of industrial action.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee wished to refer to the People and Organisational Development Committee and Finance, Performance and Estates Committee the relevant areas of the Savile action plan for these to be monitored and progressed.
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	M	A	M	J	J	A	S	O	N	D	J	F
Chris Gibson Non-Executive Director	X	X	X	X	X	X	X	X	A	X	X	X
Sarah Dunnett Non-Executive Director (Maternity Safety Champion)	X	X	X	X	A	X						
Karen Dunderdale Director of Nursing	X	X	X	X	X	X	X	X	X	X	D	X
Simon Evans Chief Operating Officer	D	X	D	D	A	X	X	X	X			
Colin Farquharson Medical Director	X	X	X	X	X	X	D	D	D	D	D	D
Rebecca Brown, Non-Executive Director (Maternity Safety Champion)						X	X	X	X	X	X	X
Vicki Wells, Associate Non-Executive Director						X	A	X	X	X	X	X
Michelle Harris, Chief Operating Officer										A	X	X

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

United Lincolnshire Hospitals NHS Trust

Quality Governance Committee
Terms of Reference

1. Authority

The Quality Governance Committee is established by the Trust Board in line with the powers set out in the Trust Standing Orders.

The Quality Governance Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Board.

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Committee and any of its established groups.

2. Purpose of the Committee

The Quality Governance Committee exists to scrutinise the robustness of and provide assurance to the Trust Board that there is an effective system of quality governance and internal control across the clinical activities of the organisation that supports United Lincolnshire Hospitals NHS Trust to deliver its strategic objectives and provide high quality care.

The relevant strategic objectives assigned to the Quality Governance Committee for 2022/23 are:

- Deliver high quality care which is safe, responsive and able to meet the needs of the population
- Improve patient experience
- Improve clinical outcomes

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair) (Maternity and Neonatal Safety Champion)
- Non-Executive Director (Deputy Chair)
- Associate Non-Executive Director
- Director of Nursing (DIPC, Lead Director for Safeguarding)
- Medical Director (Accountable Officer for Controlled Drugs)
- Chief Operating Officer

The Committee will routinely be attended by:

- Trust Secretary/ Deputy Trust Secretary
- Deputy Director of Clinical Governance
- Improvement Director, NHS England/Improvement

An invitation to attend will be offered by the Committee Chair to:

- ICB Representative
- Director of Improvement and Integration
- Divisional representatives to attend as required

4. Attendance and Quorum

The Committee will be quorate when four members are present if this includes at least one Non-Executive Director and one Executive Director.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of one Non-Executive and One Executive Director.

5. Frequency

The Committee will meet monthly.

6. Specific Duties

The Quality Governance Committee will:

- Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly
- Consider the control and mitigation of quality related risks and provide assurance to the Board that such risks are being effectively controlled and managed. Whilst the committee's remit covers all of the Trust's services, the committee has a specific oversight role in relation to the quality & safety of the Trust's maternity services (reference: Ockendon)
- Provide assurance to the Board that all legal and regulatory requirements relating to quality are met, including directives, regulations, national standards, policies, reports, reviews and best practice
- Review and provide assurance on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below:

Deliver high quality care which is safe, responsive and able to meet the needs of the population:

- Developing a safety culture
- Ensuring early detection and treatment of deteriorating patients
- Ensuring safe surgical procedures
- Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff

- Maintaining HSMR and improving SHMI
- Delivering on all CQC Must Do actions and regulatory notices
- Ensure continued delivery of the hygiene code and achievement of Infection Prevention and Control (IPC) BAF
- Improve patient safety by learning from incidents, specifically:
    - Maternity services (personalised care)
    - Medication Management
    - Diabetes Management (DKA)
    - Infection Prevention and Control
    - Urgent and Emergency Care

Improve patient experience:

- Greater involvement in the co-design of services working closely with Healthwatch and patient groups
- Greater involvement in decisions about care
- Deliver year three objectives of our Inclusion Strategy
- Enhance patient experience by learning from patient feedback
- Improve delivery of care and patient discharge

Improve clinical outcomes:

- Ensuring our respiratory patients receive timely care from appropriately trained staff in the correct location
- Ensuring recommendations from Get it Right First Time (GIRFT) reviews are implemented
- Ensuring compliance with local and national clinical audit reports
- Reviewing of pharmacy model and service
- Ensuring care delivered to patients is based on evidence based best practice leading to improved clinical outcomes

7. Administrative support

The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair and the Director of Nursing (the Executive Director lead for the committee) prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee of the adequacy of assurances available and contribute to the Annual Governance Statement.

9. Monitoring effectiveness and Compliance with Terms of Reference

The Committee will complete an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its specific duties and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

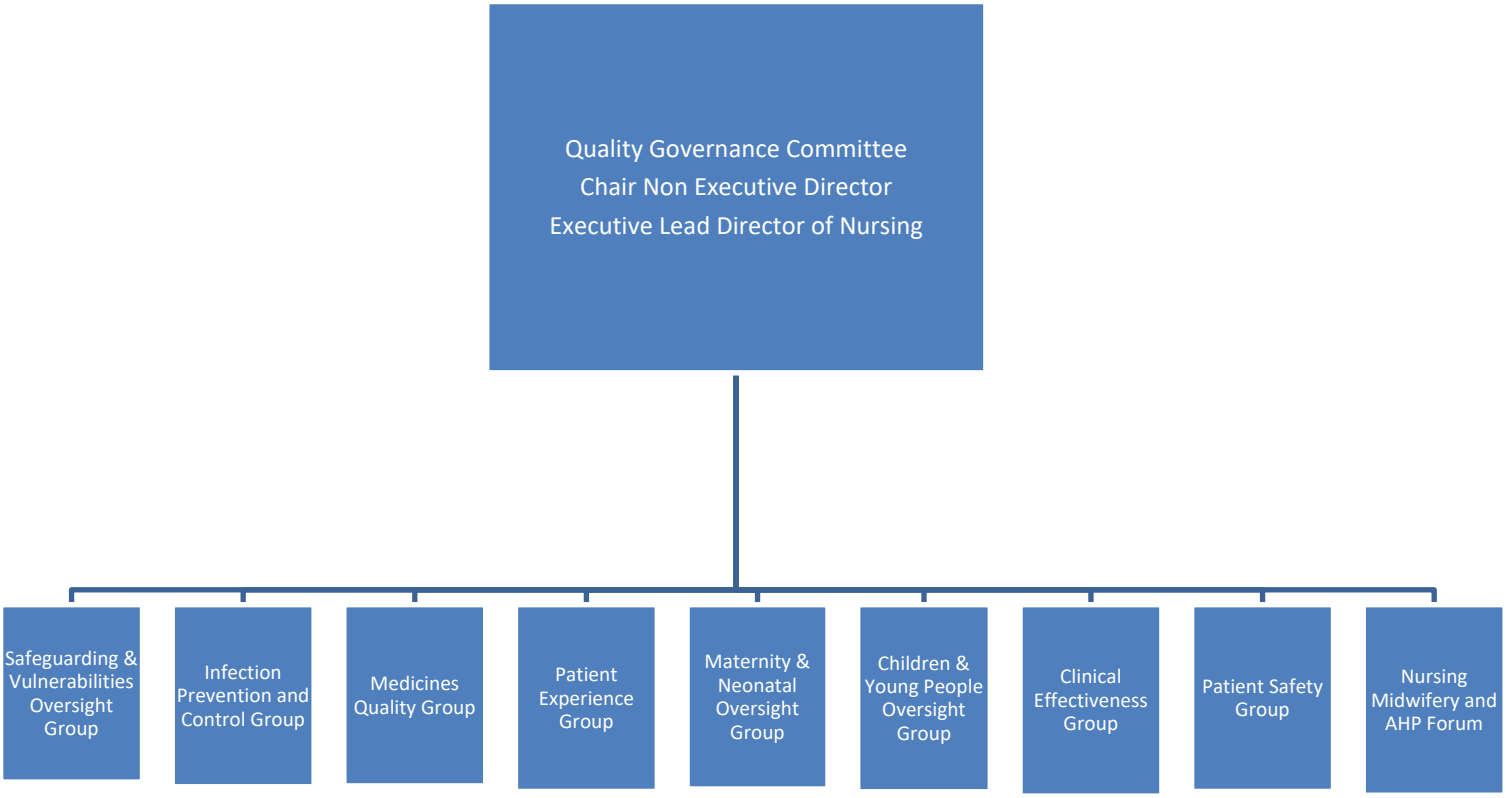
10. Review of Terms of Reference

The Terms of Reference for the Committee will be reviewed annually by the Committee and submitted to the Trust board for approval.

The Committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:
Approved by:
Next Review Date:

Committee reporting group structure:



Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	23 February 2023
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** **Workforce Strategy and Organisational Development Group (WSODG) Upward Report** The Committee received the report noting the intention for the group to be refocused to ensure appropriate business was conducted enabling assurance to be offered to the Committee. The Committee noted the need for there to be senior divisional representation at the meetings in order for these to function appropriately and enable the conduct of core business with a strategic view. **Committee Performance Dashboard** The Committee noted the dashboard as presented recognising further development work was required in order to offer trend analysis of the data presented. With the refocus of the WSODG there would be full scrutiny of the dashboard by the group and a focused trend report offered to the Committee on areas of escalation. **Guardian of Safe Working Report** The Committee welcomed the outgoing and incoming Guardian of Safe Working to the meeting, thanking the outgoing Guardian for the work undertaken whilst in the role. The Committee noted the areas of escalation including out of hours medical cover, induction process, locally employed doctor contracts and vacancies within orthopaedics and surgery.

	The Committee was advised of recent recruitment activity for orthopaedics and surgery which was expected to mitigate concerns once new starters were in post Further discussions would be required in respect of other areas, including the ongoing concern regarding out of hours hot food provision.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Safer Staffing** The Committee received the report which was taken as read noting that there had been an increase in pressure ulcers which were being monitored by the Quality Governance Committee in respect of the quality of care delivered. **Education Funding** The Committee received the report noting that the 2023/24 process was underway with confirmation awaited from both the system and Health Education England on the budgets and priorities for the year. The Committee noted the spend in 2022/23 and the intention to front load Q1 and Q2 in the coming year to ensure utilisation of funding appropriately. The Committee noted the need for a deep dive to be undertaken in respect of funding attached to students to ensure that this was appropriately secured against training. A request was also made for further analysis of the data related to the funding spend to identify distribution by professional group and subjects. **Equality Delivery and Inclusion Group Upward Report inc EDS detailed report** The Committee received the report noting that the group had considered the Gender pay Gap submission prior to presentation to the Committee along with the united against campaign and EDI Objectives and future priorities. The Committee noted the launch of the REACH network, the newly named BAME network. The Committee received the detailed EDS report which offered further detail on the domain descriptors, rationale and identified actions. A forward view was provided which would support the Trust in progressing ahead of the submission the following year. **Gender Pay Gap** The Committee received the gender pay gap submission noting the position that was presented for the Trust and benchmarked against both

	LCHS and LPFT. It was noted that the data was the snapshot for March 2022 and required publication by 30 March 2023. The Committee considered in detail the use of the data presented and how this could be further analysed to support progression in the Trust. The Committee supported the presentation of the submission to the Trust Board to seek approval for the publication.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Research and Innovation Update and University Teaching Hospital Group Upward Report** The Committee received a detailed update in respect of both the University Teaching Hospital and Research and Innovation and noted the progress being made in both areas. Conversations relating to joint academic posts continued to be required in order to ascertain how this would be managed and financed but was hoped that a conclusion would be reached in the near future. The Committee noted that there had been delays in the establishment of the joint Research and Innovation office with the University of Lincoln due to IT issues however work continued to identify a resolution.
	Assurance in respect of other areas: **Agency Spend** The Committee received the report noting the current agency spend and action in place to ensure grip and control was in place with a specific focus on medicine. **PRM Upward Report** The Committee received the report for information noting the intention for reporting to be developed further. **Integrated Improvement Plan** The Committee noted the position presented at month 10 which had moved from moderate to limited noting that this movement centred around appraisals and statutory and mandatory training. The Committee considered both aspects through detailed reports during the meeting. **CQC Action Plan** The Committee received the report noting that the updates offered in respect of appraisal and statutory and mandatory training reflected the actions required within the plan.

	Appraisal Update The Committee received the update noting the position in respect of appraisals and the actions underway to increase completion of appraisal and to identify an electronic solution to record this data. The Committee continued to note that the achievement of the trajectory for appraisals continued to be impacted by culture and leadership factors which were being addressed in the Trust. Whilst the Committee recognised and accepted that there were delays in progress it was noted that significant progress was required, and support was given to ESR being the e-solution for appraisal recording. **Statutory and Mandatory Training Update** The Committee noted the update offered and reflected on the move to core and core plus identified training in line with Skills for Health, not only would this support staff in the completion of training but offers a ticket for staff to move around organisations with a recognised training record. The Committee noted the current achievement of training and the intention to reduce compliance trajectories. Whilst concerns were raised by the Committee due to this proposal it was understood that this was being undertaken in order to improve overall compliance levels.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the current risks presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

Voting Members	M	A	M	J	J	A	S	O	N	D	J	F
Philip Baker (Chair)	X	X	X	No meeting held	X	No meeting held	X	X	X	X	X	X
Gail Shadlock	X	X	A		A							
Karen Dunderdale	X	D	X		X		X	X	D	A	D	A
Paul Matthew	X	X	X		X		X	X				
Claire Low									X	X	X	X
Colin Farquharson	X	A	X		X		D	D	D	D	D	D
Chris Gibson							X	X	X	X	X	X
Vicki Wells							A	A	X	X	X	A

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

United Lincolnshire Hospitals NHS Trust

People and Organisational Development Committee
Terms of Reference

1. Authority

The People and Organisational Development Committee is established by the Trust Board in line with the powers set out in the Trust Standing Orders.

The People and Organisational Development Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Board.

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Committee and any of its established groups.

2. Purpose of the Committee

The People and Organisational Development Committee exists to scrutinise the robustness of and provide assurance to the Trust Board that there is an effective system of governance and internal control across workforce and organisational development that supports United Lincolnshire Hospitals NHS Trust to deliver its strategic objectives and provide high quality care.

The relevant strategic objectives assigned to the People and Organisational Development Committee for 2022/23 are:

- A modern and progressive workforce
- Making ULHT the best place to work
- Becoming a University Hospitals Teaching Trust

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Director of People and Organisational Development
- Director of Nursing
- Medical Director

The following roles will be routine attendees at the Committee:

- Deputy Director of People and Organisational Development
- Trust Secretary/Deputy Trust Secretary
- Associate Director of Organisational Development, Wellbeing and Inclusion
- Finance representative – as required
- Operations representative – as required

An invitation to attend will be offered by the Committee Chair to:

- Director of Improvement and Integration
- Chair of Research and Innovation Governance Group – as required
- Chair of University Teaching Hospital Group – as required
- Chair of Equality, Diversity and Inclusion Group – as required
- Chair of Culture and Leadership Project Team – as required

4. Attendance and Quorum

The Committee will be quorate when four of the membership are present if this includes one Non-Executive Director and one Executive Director.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of one Non-Executive and One Executive Director.

5. Frequency

The Committee will meet monthly.

6. Specific Duties

The People and Organisational Development Committee will:

- Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly
- Consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed
- Provide assurance to the Board that all legal and regulatory requirements relating to the workforce are met, including directives, regulations, national standards, policies, reports, reviews and best practice
- Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below:

A modern and progressive workforce:

- Embedding robust workforce planning and development of new roles
- Delivery of annual appraisals and mandatory training
- Talent Management - Creating a framework for people to achieve their full potential
- Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation

Making ULHT the best place to work

- Address the concerns around equity of treatment and opportunity within ULHT, so that the Trust is seen to be an inclusive and fair organisation
- Improving the consistency and quality of leadership and line management across ULHT
- Resetting the ULHT Culture and Leadership Programme – Trust Values and Staff Charter
- Reviewing the way in which we communicate with staff and involve them in shaping our plans
- Quarterly Pulse Survey to be 'relaunched' as the main moral barometer
- Agreeing and promoting the core offer of ULHT, so our staff feel valued, supported and cared for
- Focus on junior doctor experience key roles: Freedom to Speak Up, Guardian of Safe Working and Wellbeing Guardian
- Embed a programme focused on staff wellbeing
- WRES/WDES agreed objectives and scorecard
- Top 25% of NHS Acute Organisations for indicators for recommend as a place to work

Becoming a University Teaching Hospital

- Developing a business case to support the case for change
- Increasing the number of Clinical Academic posts
- Improve the training environment for students
- Develop a portfolio of evidence to apply for membership to the University Hospitals Association
- Developing a memorandum of understanding with the University of Lincoln

7. Administrative support

The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee of the adequacy of assurances available and contribute to the Annual Governance Statement.

9. Monitoring effectiveness and Compliance with Terms of Reference

The Committee will complete an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its specific duties and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The Terms of Reference for the Committee will be reviewed annually by the Committee and submitted to the Trust board for approval.

The Committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved: 13 September 2022
Approved by: People and Organisational Development Committee
Next Review Date:

United Lincolnshire Hospitals NHS Trust

Committee reporting group structure:

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7th March 2023*
Item Number	*Item 9.2*

Gender Pay Gap Statement

Accountable Director	*Claire Low, Director of People and Organisational Development*
Presented by	*Claire Low, Director of People and Organisational Development*
Author(s)	*Alison Marriott, EDI Project Manager*
Report previously considered at	*People & OD Committee, 23rd February 2023*

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

Risk Assessment	*N/A*
Financial Impact Assessment	*No financial impact*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*This report and associated action plan is to improve pay equity for the female workforce and includes associated benefits for others in the workforce.*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *Approve the publication of this Gender Pay Gap Report, which is due on 30 March 2023*

Executive Summary

This paper provides the Trust Board with the proposed Gender Pay Gap Statement to be published by the Trust as part of our statutory obligations, by the statutory deadline of 30th March 2023.

It is important to note that the Trust, and indeed the NHS nationally, has Job Evaluation and national Pay systems that set the grade for a job regardless of gender. Anyone in that job would receive the grade and pay attached to it regardless of gender.

The Gender Pay Gap work is an opportunity to look at societal and organisational factors or characteristics that may impact pay parity e.g. education, working time, occupational segregation, skills and experience. The initial data is a starting point and the action plan provides for early actions around further data analysis to better understand the specific issues found in this Trust and put in place actions to address them.

United Lincolnshire Hospitals NHS Trust Gender Pay Gap
2022 Report

Executive Summary

Headlines

When reporting Gender Pay Gap data, we are working from the data as at previous 31st March, i.e. **this report is based on data from 31st March 2022**.

In this Trust, women earn 83p for every £1 that men earn when comparing median hourly pay.

When comparing mean (average) hourly pay, women's mean hourly pay is 29.3% lower than men's.

For women who receive a bonus, they receive 50p for every £1 men receive

Women hold 83% of the lowest paid jobs, and 65% of the highest paid jobs. Women also hold around 80% of the lower middle and upper middle-paid jobs.

This compares with a gender pay gap nationally in the NHS where overall, men are paid 7.4% more than women when comparing median pay, increasing to a 47% gender pay gap in favour of men when considering VSM and Directors' pay (Nuffield Trust, 2020).

This means that ULHT's median gender pay gap at 16.8% for snapshot date 31st March 2022 (financial year 2021/22) is more than double the NHS national average compared to the data from Nuffield, 2020.

Beyond the NHS, it is possible to compare like-with-like years, i.e. 2022 data. The national gender pay gap in the whole of the UK was 14.9% (2022) compared to ULHT's 16.8% gap. Therefore ULHT's gender pay gap is higher than national comparators.

For Agenda for Change roles below Band 8A, the gender pay gap is in favour of women. However, beyond 8a it favours men, with the exception of Band 9.

For colleagues on Agenda for Change pay scales (all bands), the gender pay gap is 2% overall. That is, average pay is 2% lower for women overall if working in any Agenda for Change role, whether clinical or non-clinical.

For Medical Consultants, pay is 2.3% higher for men.

Nationally, there remains a large difference in the gender pay gap between employees aged over 40 years and those aged below 40 years – when aged over 40 years, women are more likely to experience a larger gender pay gap.

Compared with lower-paid employees, higher earners experience a much larger difference in hourly pay between the sexes. This is mirrored at ULHT.

National Sources:
Gender pay gap in the UK - Office for National Statistics (ons.gov.uk)

The gender pay gap in the English NHS: Analysis of some of the underlying causes | The Nuffield Trust

This report contains:

- Background to the requirements for Gender Pay Gap Reporting
- Guidance to increase understanding of the indicators and calculations used
- Narrative about the Trust's Gender Pay Gap results, in line with reporting requirements - but most importantly to assist with the Gender Pay Gap Action Plan
- Comparison with previous year's results, which show that the Gender Pay Gap has widened (got worse)
- A proposed Action Plan to address this
- Appendix with all the required data which has been submitted to the Gov.Uk Gender Pay Gap reporting portal, ahead of the 30th March 2023 deadline

This report, which has been completed with input from Equality, Diversity and Inclusion Operational Group (EDIG), the ULHT Women's Network and Staffside representatives, will provide a high level of assurance in terms of compliance with Gender Pay Gap Reporting ready for People and OD Committee (PODC) and Trust Board approval.

It will also provide high levels of assurance that the Trust will take action to reduce (improve) the disparity between pay for men and women, in the form of a detailed action plan.

1. Background

Employers with 250 or more employees have been required to publish information on the pay gap between male and female employees since 31st March 2017, under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which can be found at: The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (legislation.gov.uk).

Organisations in the public sector, such as NHS Trusts, are required to report against a set of six key indicators, based on data from 31st March each previous year. For example, the "snapshot date" for this report is 31st March 2022. They are then required to publish that data and narrative ("Gender Pay Gap Report") so that employees and members of the public can access it, along with an action plan to address disparities, by 31st March each year. For example, this report is to be published on Trust's website by 31st March 2023.

Separately from the report, employers are required to upload their data to the HM Government portal by 31st March at the latest. This data upload has been made already in preparation for publication of this report in March: United Lincolnshire Hospitals Nhs Trust gender pay gap data for 2022-23 reporting year - GOV.UK - GOV.UK (gender-pay-gap.service.gov.uk)
Private sector employers with 250 or more employees are also required to publish Gender Pay Gap information, albeit with a slightly later publication date of 5th April each year.

In preparing this report, the author has consulted and followed the NHS Employers Gender Pay Gap guide: Addressing-your-gender-pay-gap-guide.pdf (nhsemployers.org) which was co-produced with the Health and Care Women Leaders Network.

2. Understanding the Gender Pay Gap Calculations

The six key indicators that the Trust is required to report on are:

1. percentage of men and women in each hourly pay quarter (lower, lower middle, upper middle and upper quartile) by number of employees
2. mean (average) gender pay gap using hourly pay
3. median gender pay gap using hourly pay
4. percentage of men and women receiving bonus pay
5. mean (average) gender pay gap using bonus pay
6. median gender pay gap using bonus pay

The data for the report is drawn from the national Electronic Staff Record (ESR) Business Intelligence standard report.

For the purposes of these calculations, pay includes: basic pay, full paid leave, including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances, shift premium pay, pay for piecework.

Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child-care vouchers), redundancy pay and tax credits.

Bonus pay relates to the Clinical Excellence Awards (CEAs) to Consultants, following the NHS Employers Gender Pay Gap Guide.

We now have five years' worth of data and the opportunity is taken in this report to indicate trends in that data.

What does median mean?

This is the difference between the hourly pay of the median man and the hourly pay of the median woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid.

Medians are useful to indicate what the 'typical' situation is. They are not distorted by very high or low hourly pay (or bonuses). However, this means that not all gender pay gap issues will be picked up. They could also fail to pick up as effectively where the gender pay gap issues are most pronounced in the lowest paid or highest paid employees.

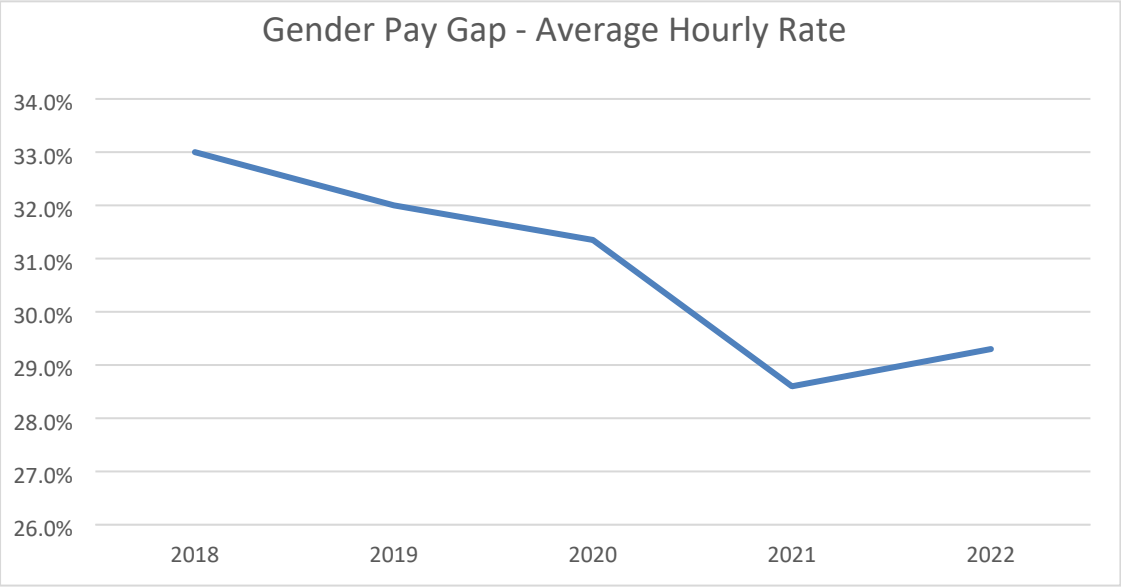
And mean?
The mean gender pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of men, and the mean hourly pay of women. A mean involves adding up all of the numbers and dividing the result by how many numbers were in the list. Very high or very low pay can distort this figure.

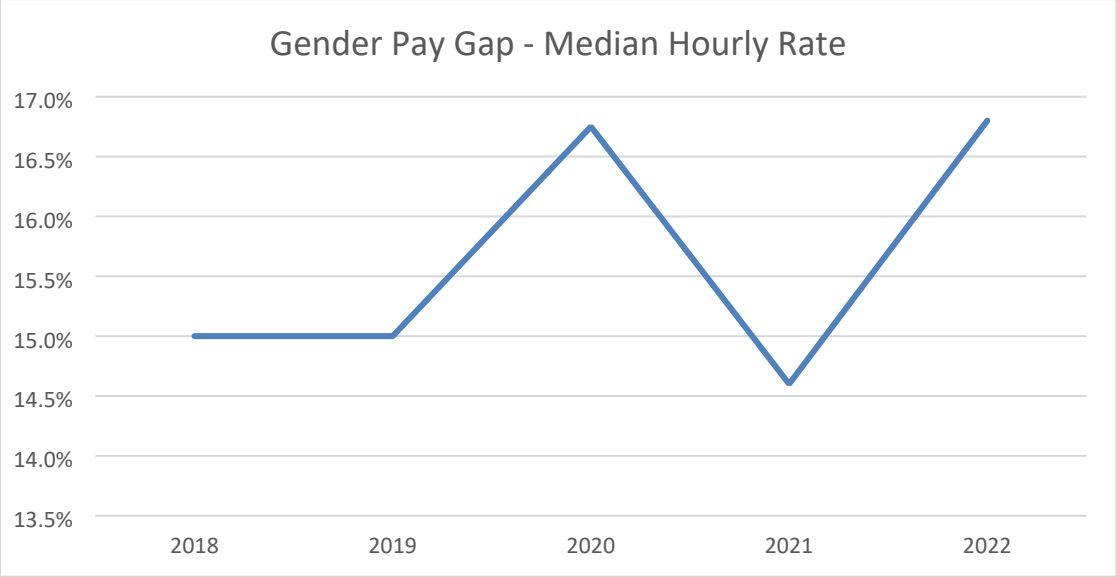
3. About our results

The Trust's Gender Pay Gap had been on a generally decreasing (i.e. improving) trend since reporting began, in line with the national trend both inside and outside of the NHS, until 2022. Based on estimated 2022 data, the national trend of improvement has continued.

It is disappointing to report that the gender pay gap has widened overall in the Trust compared to 2021, by 0.7% for average (mean) hourly rate and 2.2% for median hourly rate. The Trust's gender pay gap for average hourly rate is still better than when reporting began, however the median hourly rate gap is now 1.8% worse.

The trends are illustrated in the charts and tables below.





Trend 2018, 2019, 2020, 2021, 2022

Year	Average Hourly Rate	Median Hourly Rate
2018	33%	15%
2019	32%	15%
2020	31.35%	16.75%
2021	28.6%	14.6%
2022	29.3%	16.8%

As with previous years, the main driver of the Trust's gender pay gap remains the structure of the NHS workforce, with female colleagues comprising the majority of the lower paid roles and men in higher paid roles – for example Consultant medical staff. Also, men are more likely to occupy Very Senior Management (VSM) roles.

Female starters and leavers, April 2021 to March 2022

Grade	Starter	Leaver	Trend
Band 8D	1	1	No improvement
Band 9	1	4	Downward
Director*	1	1	No improvement
Consultant	8	5	Improved

*Does not include Director on secondment to the Trust as data is drawn from the ULHT ESR system.

Gender Disparity - Pay Quartiles

83% of the workforce in the lowest pay quartile is female. This means that women hold 83% of the lowest paid jobs. In comparison, 65% of the workforce in the top pay quartile are women. This means that women hold 65% of the highest paid jobs, disproportionately low for their representation in the lowest pay quartile (83%) and throughout the other pay quartiles (around 80-81%). This position has deteriorated from 2021 data. Please see Appendix 1 for the data table and comparison.

Gender Disparity – Mean Salary
The data in Appendix 1 highlights that below Band 8A Agenda for Change (AfC), women are paid more than men. The exception is where Apprentices are concerned, and men are paid more. The reasons why female colleagues are more highly-paid may relate to length of time in post, career progression and seniority in the nursing and midwifery workforce. Further investigation and actions are included in the Gender Pay Gap Action Plan.

However, from AfC Band 8A to 8D inclusive, men are consistently paid more than women. The reasons for this are not evident from the gender pay gap data, or further analysis of higher increments and gender split in these bands. Therefore, further analysis of the reasons behind this form part of the Gender Pay Gap Action Plan.

Based on Mean Salary	**Gap**
8a	Pay is 1.32% higher for men
8b	Pay is 2.27% higher for men
8c	Pay is 6.7% higher for men
8d	Pay is 8.1% higher for men
9	Pay is +1.02% higher for women
Director	Pay is 12.65% higher for men

At AfC Band 9, women are paid more than men, but at Director-level, men are again paid more than women.

This disparity, combined with the disparity in the pay quartiles where women form the majority of the Trust's workforce, but this is not reflected in the higher pay quartiles and men are paid more in those higher pay quartiles, is contributing to the Trust's gender pay gap.

For the medical workforce, it is positive to note that no gender pay disparity is now reported between starting on same mean salary at FY1 and men earning more by FY2, as was evident in previous data.

However, male Consultants and Speciality Doctors are paid more than their female colleagues, which is likely to relate to the Bonus Pay disparity detailed below, but is also included for closer investigation in the Gender Pay Gap Action Plan as there may be other factors influencing this.

For the group "Hospital Practitioners", women are paid more than men, although the numbers recorded in this part of the workforce are very low and this can influence the results e.g. if one person has much longer service than others and has progressed in their pay band.

Gender Disparity – Bonus Pay
Women's mean bonus pay is 47.2% lower than male staff (48.8% in previous year) and median pay was 50% lower (50.3%). Whilst the mean has improved, the median has not made significant improvement. Women receive 50p in bonus pay for every £1 which men receive in this Trust. In the context of an NHS acute Trust, "bonus pay" relates to the Clinical Excellence Awards Consultants.

0.3% of women received a bonus, compared to 3.8% of men.

This data is particularly stark because the calculations are unweighted and the number of male consultants significantly outweighs the number of female consultants. Further analysis is recommended in the proposed action plan.

The percentage difference in who receives a bonus is also magnified by the fact that calculations have historically been based on percentage of whole workforce. Further investigation of this is included in the action plan, to establish more accurate reporting going forward, should this be approved. For this year, the historical pattern of reporting has continued, but this additional narrative has been added.

The Trust has ensured a gender balance on the awarding panel and taken steps to encourage applications from female consultants for the CEA, and also has distributed awards equally in 2022. However, because there are more male consultants than female, there is still a bonus pay gap.

Also, for the period April 2021 to 2022, the number of female consultants joining the Trust was greater than the number leaving (+3). This is a positive trend but not sufficient to make a difference regarding the bonus pay gap.

As with previous years, ULHT is not out of step with equivalent NHS organisations and national action is still necessary. At a national level, the scheme is generally seen as not delivering on its intent to improve performance and as inequitable. A proposed new scheme was discussed at national level in 2022, but was rejected by BMA on the grounds that it would make inequality worse.

However, some of the fundamental issues relating to the make-up of the NHS workforce can be influenced in a positive direction as a Trust, Integrated Care System (ICS) and Region, with continued and increased focus on fair and equitable recruitment and reward processes. Intentional actions are necessary to improve it.

4. Comparison with other NHS Provider Trusts in Lincolnshire ICB

LPFT (data as at 31st March 2022)

Hourly pay gap
In this organisation, women earn 82p for every £1 that men earn when comparing median hourly pay. Their median hourly pay is 17.7% lower than men's.

When comparing mean (average) hourly pay, women's mean hourly pay is 18% lower than men's.

Percentage of women in each pay quartile
Women occupy 28% of the highest paid jobs and 14% of the lowest paid jobs.

Who received bonus pay?
When comparing mean (average) bonus pay, women's mean bonus pay is 18% lower than men's.

0.2% of women received a bonus, and 2.8% of men

LCHS (data as at 31st March 2021 – 2022 data not yet published)

Hourly pay gap
In this organisation, women earn 84p for every £1 that men earn when comparing median hourly pay. Their median hourly pay is 16.4% lower than men's.

When comparing mean (average) hourly pay, women's mean hourly pay is 26.3% lower than men's.

The percentage of women in each pay quarter
In this organisation, women occupy 78% of the highest paid jobs and 91.6% of the lowest paid jobs.

Who received bonus pay?
No bonus payments were made.

5. How we will make progress to close the gap (Action Plan)

We have identified where we believe the Trust needs to take action. These actions will be taken forward within the context of the overall Integrated Improvement Plan (IIP) and EDI Objectives 2022-2025.

The Gender Pay Gap Action Plan, proposed for further discussion, is included on the next page of this report.

Gap	Lead	Action	Timescale
Data & Analysis Supporting data and analysis, beyond the statutory reporting requirements	**EDI team** Supported by: Workforce Intelligence Team ULHT Women's Network HR	Supply further details alongside the statutory data to allow for more detailed analysis: Role data: • Split of those in each band by gender as already reported • Split of those in each occupational type (as per National Staff Survey – NSS) • Then a cut of both those together – so each band, split by role type, by gender • Include age as a factor • By team profile – e.g. areas where there may traditionally be over-representation/under-representation of men & women. Recruitment data: • Applicants overall – split by gender • Drilled-down – applicants for job types by gender and success rates (job offer) Pay data: • Number of people asking for an uplift to their band/scale point by gender, and the outcome of their request • Colleagues at top/bottom of each band – by gender Bonus (CEA) data: • Number of applications for a Clinical Excellence Award by gender • Number of successful applicants by gender • Anonymised reasons for refusal of CEA application, by theme.	End May 2023, for next reporting cycle Based on gender pay data as at 30.03.23 Data from 2022 round of CEA's will need to be used because of timescales

		• Investigate further ways of reporting the data more accurately in next reporting cycle All of the above will allow more accurate identification of the issues.	
Deeper investigation and analysis on 2023 data	**EDI Team** Supported by: Workforce Intelligence HR ULHT Women's Network Talent Academy Medical Director's Office	• Reasons for higher salaries for men from Band 8a upwards • Reasons for lower salaries for men below Band 8a • Reasons for Apprentice gender salary gap • Any further reasons for the Consultant gender pay gap, beyond the Bonus pay (CEA) disparity • Reasons for the Speciality Doctor gender pay gap	End August 2023
Recruitment & Career Development Ensure that recruitment and other employment processes will increase the likelihood that a woman will a) apply for a top pay quartile role b) succeed in a job offer for the role and c) will be supported to remain and thrive in the role. Ensure talent pipeline is inclusive and supportive of all genders, to access all – e.g. increase male	**Associate Director – Culture and OD** Supported by: Head of Recruitment HR Policy Manager EDI team ULHT Women's Network Talent Academy Medical Workforce team	• Establish confidential Career Clinics, in conjunction with other staff networks • Staff Network representatives, who have completed the Trust's Recruitment and Selection training, to be invited to join Interview Panels/Assessment Centres/AAC Panels for senior roles, including AfC 8a upwards and Divisional Leadership roles, as well as Board appointments. • Identify barriers to applying and succeeding in senior roles – engagement in the Trust and beyond, research papers, NHS Employers. • Talent Academy – continue with excellent schools work to promote the wide range of opportunities in the NHS to people of all genders.	End March 2024

representation in lower and lower middle pay quartiles. Increase female representation in top quartile. Ensure positive trend in recruitment of female Consultants is maintained and intentionally increased.		• Re-establish exit interviews in ULHT fully, with the opportunity to speak to someone who is not your line manager, with opt-back-in if happy to discuss with line manager, to ensure true picture is gained. Analyse by protected characteristic and themes (qualitative) and quantitative (as % of the workforce and absolute numbers leaving). Aim is to establish truer picture of barriers to staying and progressing. • Re-establish "stay interviews" as part of the confidential Career Clinics work • Establish a ULHT Men's Network (already in progress) • Ensure that Consultant recruitment processes encourage applications from women, support them with the process, and help them to succeed at interview/assessment centre, including any potential intersectionality with race, cultural heritage and gender. Also that there is support for them to thrive in their role. • Reset previous "Reverse-Mentoring" programme as "Mutual Mentoring".	
Flexible Working To support all colleagues, including all people with caring responsibilities, whilst recognising that women are still more likely to have these, and men are less likely to be	**Head of OD** Supported by: Flexible Working Lead Head of Recruitment EDI team Wellbeing Team	**Obtain data for:** • Applications for flexible working – number, split by gender, number successful. Reasons by theme and anonymised for rejection. • % of jobs advertised which state flexible working options available • Number of jobs offered with option of part time/job share available	End April 2023 By end 2023

supported or feel confident to request them.	Medical Workforce Team	• Number of staff working to an adjusted contract (part time, condensed hours, annualised hours etc.) – split by gender NB: this data split for flexible working is also part of the WDES Action Plan for 2022-23, in relation to disability. **And also:** • Increase the range of shift patterns available • Increase the number of part-time and/or job-share opportunities at all Bands and types of role • Ensure the Less Than Full Time (LTFT) request process is well-supported and inclusive in the Trust, with medical engagement. • Consider the wellbeing and support offer for colleagues with caring responsibilities in the Trust, be they child or adult dependents. Links with EDI objective: setting up a Carers Network for unpaid carers who work at ULHT as well as their caring responsibilities at home. Links to Lincs ICS carers project.	
Menopause and workplace support To ensure that women impacted by the menopause are supported to remain well, in work, and thrive in their careers, especially as they may be among the most	**Associate Director – Culture and OD** **ULHT Women's Network** Supported by: Head of Occupational Health Director of People & OD	• Pursue menopause-friendly employer accreditation • Implement the ULHT Women's Network proposals, following presentation of business case during 2023.	Approval of business case by end 2023 and implementation begun

experienced colleagues we have. This is the right thing to do, and also may contribute significantly to the Trust's staffing position, retention, and to increasing the number of women in the upper pay quartiles – with associated reduction in gender pay gap.			
Bonus Pay Gap Clinical Excellence Awards (CEAs)	**Director of People and OD and Medical Director** Supported by: Local Negotiating Committee (LNC) CEA Task & Finish Group	• CEA Panel to be as diverse as possible including a minimum of two representatives to be invited from the ULHT Women's Network, • Encourage female Consultants who are eligible to apply for a CEA to apply, including workshops in Summer/early Autumn 2023. Start process early as CEA closing date is two weeks before Christmas. • CEA Task & Finish Group to advise further • Gather feedback on barriers for female Doctors who wish to CESR to become Consultants, and address the barriers.	2023 CEA's

Allyship	**Associate Director – Culture and OD** Supported by: EDI team ULHT Women's Network Executive Leadership Team	• To use the Lincs ICS Allyship toolkit in support of all colleagues, including women. • To have visible male Allies in the Trust, including the Executive Leadership Team and the Divisional Triumverates (leaders)	Throughout 2023

United Lincolnshire Hospitals NHS Trust

Appendix 1 – Gender Pay Gap Data on which this report is based

ULHT Overall Gender Pay Gap 2022 (with 2021 figures in brackets)

The mean and median hourly rates for men and women

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£22.93 (£22.07)	£17.30 (£16.19)
Female	£16.21 (£15.75)	£14.40 (£13.83)
Difference	£6.71 (£6.32)	£2.90 (£2.36)
Pay Gap %	**29.3% (28.6%)**	**16.8% (14.6%)**

The proportion of male and female staff in each quartile

Quartile	Female	Male	Female %	Male %
1	1786 (1743)	362 (365)	83.2% (82.7%)	16.9% (17.3%)
2	1726 (1738)	424 (379)	80.3% (82.1%)	19.7% (17.9%)
3	1760 (1752)	390 (361)	81.9% (82.9%)	18.1% (17.1%)
4	1390 (1418)	761 (694)	64.6% (67.1%)	35.4% (32.9%)

Mean salary for men and women within each pay band or grade 2022

	Gender (Full Time Equivalent)		Mean Salary (£)	
Pay Band/Grade	Female	Male	Female	Male
Band 1 & Apprentices	46.88	11.51	£15,671	£16,057
Band 2	1568.87	364.13	£19,437	£19,419
Band 3	570.02	117.68	£21,126	£21,098
Band 4	359.72	91.13	£23,715	£23,670
Band 5	1180.73	233.95	£28,847	£27,785
Band 6	780.80	191.10	£35,894	£34,857
Band 7	453.39	99.87	£43,003	£42,922
Band 8A	181.59	57.41	£49,062	£49,718
Band 8B	52.67	23.07	£59,333	£60,707
Band 8C	19.60	11.00	£68,581	£73,089
Band 8D	12.00	6.00	£81,241	£88,355

Band 9	4.00	7.00	£100,905	£99,881
Director	1.00	5.00	£146,494	£167,708
Consultant	90.62	247.64	£99,025	£101,354
Associate Specialist	2.60	19.38	£96,698	£96,512
Staff Grade		0.73		£73,570
Specialty Doctor	48.76	140.70	£66,421	£69,938
GPCA/Hospital Practitioner	1.89	0.73	£63,178	£61,843
Specialty Registrar	68.79	87.50	£45,196	£45,739
Foundation Year 2	65.80	60.44	£33,345	£33,345
Foundation Year 1	57.00	36.00	£28,808	£28,808

Mean salary for men and women within each pay band or grade, 2021 figures for comparison

	Gender (Fte)		Mean Salary (£)	
Pay Band/Grade	**Female**	**Male**	**Female**	**Male**
Band 1	94.14	19.40	£17,246	£16,694
Band 2	1622.28	345.45	£18,907	£18,912
Band 3	538.29	121.46	£20,634	£20,520
Band 4	358.15	97.60	£23,112	£23,278
Band 5	1135.62	189.88	£28,229	£27,788
Band 6	775.02	153.69	£34,809	£33,841
Band 7	421.09	97.32	£42,112	£41,679
Band 8A	160.52	49.95	£47,803	£48,286
Band 8B	47.48	19.07	£57,439	£58,758
Band 8C	21.60	10.00	£67,239	£66,725
Band 8D	7.00	7.85	£77,605	£83,452
Band 9	7.00	6.00	£100,949	£93,325
Director	1.00	5.00	£145,356	£147,695
Consultant	89.36	242.29	£95,713	£97,668
Associate Specialist	3.28	20.34	£93,236	£92,766
Staff Grade		0.73		£71,427
Specialty Doctor	45.77	114.90	£64,754	£67,917
GPCA/Hospital Practitioner	1.18	0.73	£69,158	£60,045
Specialty Registrar	83.34	66.74	£44,251	£44,693
Foundation Year 2	46.19	48.56	£32,691	£32,726
Foundation Year 1	27.00	51.00	£28,243	£28,243

Bonus Payments

Mean & median bonus payments for men and women 2022 (with 2021 figures in brackets)

Gender	Avg. Pay £	Median Pay £
Male	11,597.05 (11,579.93)	6,032.04 (6,066.75)
Female	6,127.84 (5,932.45)	3,015.96 (3,015.96)
Difference	5,469.21 (5,647.48)	3,016.08 (3,050.79)

Pay Gap %	**47.2% (48.8%)**	**50.0% (50.3%)**

Number of employees receiving a bonus (with 2021 figures in brackets)

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	25 (25)	7604 (7533)	0.3% (0.3%)
Male	85 (90)	2266 (2079)	3.8% (4.3%)

Number of Female & Male Employees by Band

Grade	Female	Male	Total
Associate Specialist	3	20	23
Band 1	79	14	93
Band 2	2,097	414	2,511
Band 3	676	122	798
Band 4	405	96	501
Band 5	1,377	244	1,621
Band 6	936	203	1,139
Band 7	505	102	607
Band 8A	198	60	258
Band 8B	56	24	80
Band 8C	21	11	32
Band 8D	12	6	18
Band 9	4	7	11
Consultant	96	270	366
Director	1	5	6
Foundation 1	57	36	93
Foundation 2	66	61	127
GPCA/Hospital Practitioner	4	5	9
Specialty Doctor	53	142	195
Specialty Registrar	71	88	159
Staff Grade		1	1
Total	**6,717**	**1,931**	**8,648**

END

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	25 January 2023
Chairperson:	Dani Cecchini, Non-Executive Director
Author:	Jayne Warner, Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational 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 **Health and Safety Committee Upward Report** The Committee were alerted to the enforcement notices still in place in respect of confined spaces. Assurance was given that progress with actions remained a standing item on the agenda at H&S Committee. A request was made that a detailed update on the confined spaces policy come to the committee. The Director of Estates and Facilities escalated that there was a lack of assurance in some areas which were missing from the report. This lack of assurance had resulted from some of the reporting groups failing to provide upward reports. The Radiation Protection Group had not formally met since October. This gave rise to concern from the Committee. The Chief Operating Officer confirmed that she had reiterated the need for the appropriate assurances to be provided and this would be addressed as a matter of urgency. **Fire Safety Report** A Fire safety update report was provided to the Committee. The Committee advised that there was a need for a specific report from the group not just as highlight reporting. The report provided measures in place against the deficiencies identified. Recognising that the Trust still had some way to go.

	The Committee noted that fire training compliance was not at the required level. The Committee agreed that an escalation was needed in to the People and OD Committee to alert that mandatory fire safety training compliance and other mandatory compliance training relating to Information Governance were now impacting when the Trust had visits from regulators. **Emergency Planning Group Upward Report** The Committee were advised that there had been a focussed session on Business Continuity Plans. Assurance was given that these were in place for the Divisions of Family Health and CSS. There was a lack of assurance for the Divisions of Surgery and Medicine. Divisions had been given a deadline of 31 March 2023 to get these fully in place.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts and System Forecast Change Protocol** The Committee received the report noting the month 10 deficit position of £13.1m. The agreed outturn for the year is £13.6m. The Committee noted that the increase in ED nursing costs was recategorised from being a covid cost to a cost built into the acuity of department and the establishment review which has driven staffing costs up. If pressure on the department can be reduced then this should bring the cost down again. The Committee noted that there would need to be a greater focus on cash in the new financial year. Greater focus will be needed on debtor management. The Committee sought assurances for cash management approach in the planning to come back to the next meeting. Significant assurance was offered against delivery of revised plan control total. However, assurance remained limited in relation to delivery of the Trust statutory duties. Limited assurance was offered to the Committee in respect of efficiencies which related to continued failure to deliver the financial CIP plan. The Trust is forecasting £17m delivery compared to a requirement of £29m and plan of £33m. The Trust was able to quantify the productivity schemes and was tracking in year aligned to ISG report. The Trust was demonstrating that it was turning delivery around but noting that there is more to do. Contracting – Committee asked for assurance on whether there will be a gap once contract agreed. Discussions were still in train and so it was not yet clear that there would be a gap. Moderate assurance was given.

	The Committee Capital report was positive offering moderate assurance. Contract Award Reports Document storage –Recommendation to Board to support award of contract. Digital Contracts single sign on - Recommendation to Board to support award of contract.
	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Hospital Group Upward Report** The Committee noted the assurances provided **ICS Digital Strategy** Kathy Fulloway Chief Digital Information Officer ICS attended to share the draft digital strategy. The Committee were asked to provide feedback on the direction of travel.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee noted the reporting of the continued improvements in 12 hour waits in ED. Reductions had been seen in 12 hr wait to access inpatient care. There had been continued improvements in ambulance handovers. The Trust had seen increased occupancy in January but had started the de-escalation of extra beds. The Committee had previously sought assurance in relation to fractured neck of femur and compliance against the best practice tariff. The Chief Operating Officer stated that there was still a lack of assurance that the Trust will get consistent achievement month by month due to lack of access to ortho-geriatrician consultants and theatres. The COO was confident that it was in our gift to get there and was in the process of recruiting a new clinical lead. The Committee agreed to receive a further update in 3 months to show consistent achievement. 4 hour transit target set at 76% by March 2024. The Trust has developed a plan to achieve this which is due to be considered at the Trust Leadership Team. Planned bed occupancy rates have increased to 92%. Bed modelling for acute setting indicates a start point of 968 Compared to 1060 currently in use. Modelling to be shared with FPEC post meeting. Planned Care

	By March 2025 the Trust has to achieve zero 52 week waits. Internal ambition is being considered to reduce numbers waiting more than 52 weeks to 700 patients by March 2024 and achieve zero 65 week waits. Diagnostics – cardiology recovery plan was presented. Cancer –Moderate assurance provided. Support from region as Lincolnshire most improved system. Elective Hub visit with Prof Briggs. Positive feedback on visit.
	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 **Planning Update** The Committee received the updated planning guidance. And noted that a detailed discussion had taken place at the Board Development Session earlier in the week. The Committee were updated in the draft planning submission which had been made. ULH submitting balanced plan in own right. Across the ICS this includes £37m assumed income from ICB. Final plan is required by 30 March 2023. **Productive Theatres Deep Dive** Reporting three weeks into sprint. Seeing really good progress. The workstreams within the programme were shared with committee. Progress against each of the plans was provided.
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review No reports
	Assurance in respect of other areas:

	Integrated Improvement Plan Remains limited assurance. More red rag rated projects than amber and green. Need to consider whether some of the targets were too ambitious. Need to close off the year end moving into the next set. Board will consider next steps after this IIP for next year. **Improvement Steering Group Upward Report** Good progress with agency spend and theatre productivity. Medicines Management - key risk to flag struggling to get traction. Need to take stock. Committee agreed that this area needed to escalate to the Board. The programme had been RAG rated Red for last three months. **Audit Recommendations** The Committee sought detailed assurances in relation audit actions for its next meeting. **CQC Action Plan** The Committee sought detailed assurances in relation audit actions for its next meeting.
Issues where assurance remains outstanding for escalation to the Board	The improvement steering group upward report highlighted a key risk as the failure to achieve traction with the medicines management programme. This are had been flagged red rated for the last three months. Committee agreed that whilst Board were aware of concerns relating to Pharmacy it was important that a specific escalation was made.
Items referred to other Committees for Assurance	Escalate to PODC the mandatory fire safety training compliance and other compliance training IG.
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	M	A	M	J	J	A	S	O	N	D	J	F
Dani Cecchini, Non-Exec Director	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson, Non-Exec Director												
Gail Shadlock, Non-Exec Director	A	X	A	A	X							
Director of Finance & Digital	X	X	X	X	X	X	D	X	X	X	X	X
Chief Operating Officer	D	X	D	X	X	X	X	X	X	X	X	X
Director of Improvement & Integration	X	X	X	D	X	D	X	X	X	D	X	X
Sarah Buik, Associate Non-Executive Director						X	X	X	X	X	X	A

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

Finance, Performance and Estates Committee
Terms of Reference

1. Authority

The Finance, Performance and Estates Committee is established by the Trust Board in line with the powers set out in the Trust Standing Orders.

The Finance, Performance and Estates Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Board.

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Committee and any of its established groups.

2. Purpose of the Committee

The Finance, Performance and Estates Committee exists to scrutinise the robustness of and provide assurance to the Trust Board that there is an effective system of governance and internal control areas across finance, operational performance, estates and digital services of the organisation that supports United Lincolnshire Hospitals NHS Trust to deliver its strategic objectives and provide high quality care.

The relevant strategic objectives assigned to the Finance, Performance and Estates Committee for 2022/23 are:

- A modern, clean and fit for purpose environment
- Efficient use of resources
- Enhanced data and digital capacity
- Improving Cancer Services access
- Reduce waits for patients who require planned care and diagnostics to constitutional standards
- Urgent Care
- Establish collaborative models of care with our partners
- Successful delivery of the Acute Services Review

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Director of Finance and Digital
- Chief Operating Officer
- Director of Improvement and Integration

The following roles will be routine attendees at the Committee:

- Trust Secretary/Deputy Trust Secretary
- Deputy Director of Finance
- Director of Estates and Facilities

4. Attendance and Quorum

The Committee will be quorate when four of the membership are present if this includes one Non-Executive Director and one Executive Director.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of one Non-Executive and One Executive Director.

5. Frequency

The Committee will meet monthly.

6. Specific Duties

The Finance, Performance and Estates Committee will:

- Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly
- Consider the control and mitigation of finance, operational performance, estates and digital services related risks and provide assurance to the Board that such risks are being effectively controlled and managed
- Provide assurance to the Board that all legal and regulatory requirements relating to finance, operational performance, estates and digital services are met, including directives, regulations, national standards, policies, reports, reviews and best practice
- Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below:

A modern, clean and fit for purpose environment:

- Developing a business case to demonstrate capital requirement
- Delivering environmental improvements in line with Estates Strategy
- Continual improvement towards meeting PLACE assessment outcomes
- Reviewing and improving the quality and value for money of facilities services including catering and housekeeping
- Continued progress on improving infrastructure to meet statutory Health and Safety compliance

- Implementing year 1 of the estates strategy
- Use of the Premises Assurance Model (PAM)

Efficient use of resources:

- Delivering cost improvement programme
- Delivering financial plan
- Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements
- Implementing the CQC use of resources report recommendations
- Working collaboratively to develop evidence based approach to more efficient services

Enhanced data and digital capability:

- Improving utilisation of the Care Portal with increased availability of information
- Development and approval of Electronic Patient Record OBC
- Rollout of PowerBI as Business Intelligence Platform
- Implementing robotic process automation
- Improving end user utilisation of electronic systems
- Completing roll-out of data quality kite mark

Improving Cancer Services access:

- Improve access for patients by reducing unwarranted variation in service delivery through transformation of cancer care

Reduce waits for patients who require planned care and diagnostics to constitutional standards:

- Improve access for patients by reducing unwarranted variation in service delivery through transformation of planned care

Urgent Care:

- Improve access for patients by reducing unwarranted variation in service delivery through transformation of urgent care

Establish collaborative models of care with our partners:

- Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution
- Play an increasing leadership role within the East Midlands Acute Services Collaborative

Successful delivery of the Acute Services Review:

- Development of a ULHT clinical service strategy with focus on fragile services to provide sustainable and safe services
- Support the implementation for Acute Services Review

7. Administrative support

The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee of the adequacy of assurances available and contribute to the Annual Governance Statement.

9. Monitoring effectiveness and Compliance with Terms of Reference

The Committee will complete an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The Terms of Reference for the Committee will be reviewed annually by the Committee and submitted to the Trust board for approval.

The Committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved: 25 August 2022
Approved by: Finance, Performance and Estates Committee
Next Review Date: April 2023

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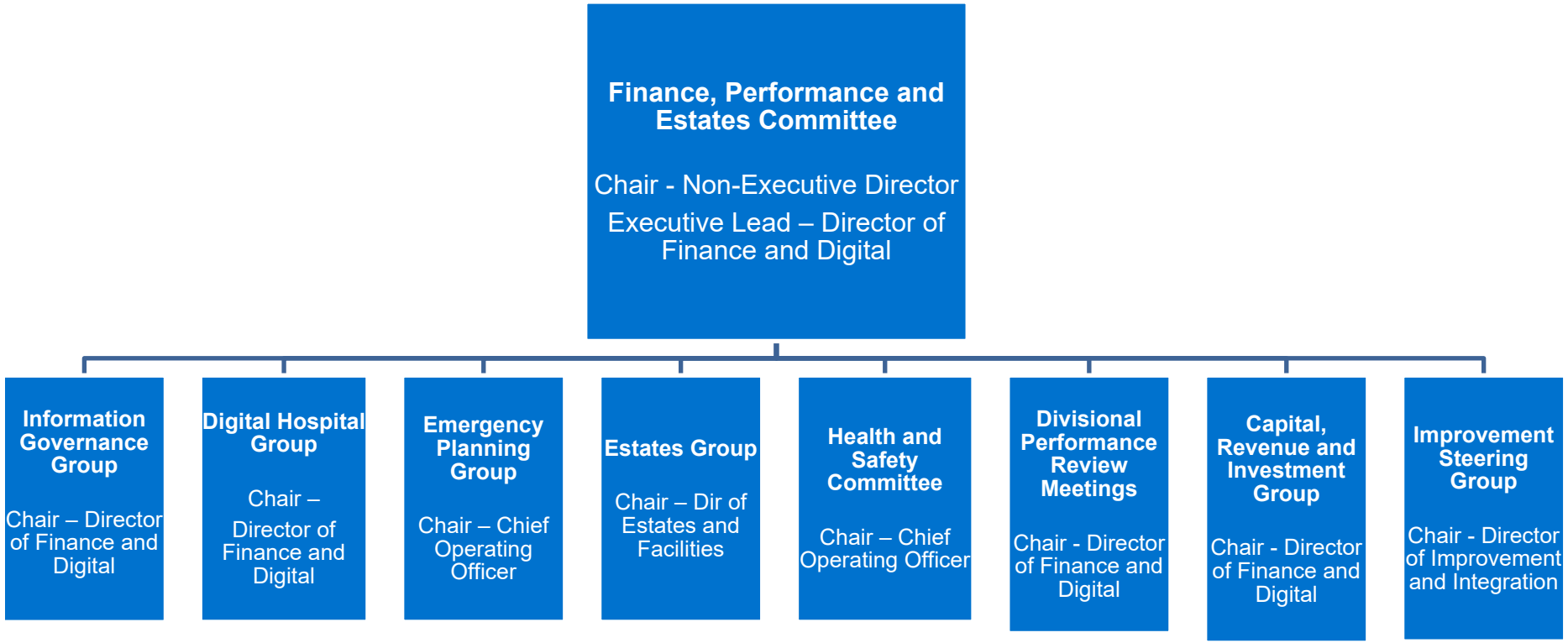
Committee reporting group structure:



United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7th March 2023*
Item Number	*Item 12*

Integrated Performance Report for January 2023

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

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

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

Executive Summary

Quality

Pressure Ulcers

There has been 49 category 2 PU, 3 category 4 PU and11 unstageable PU for January 2023. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. The new Tissue Viability daily documentation risk assessment booklets have been rolled out across adult inpatient areas, this includes a more detailed daily skin assessment which prompts the correct preventative actions to be implemented.

Venous Thromboembolism Risk Assessment

Compliance against this metric remains static for the month of January at 93.7%.

Medications

For the month of January, the number or incidents reported in relation to omitted or delayed medications has reduced slightly from the previous month at 26% with medication incidents causing harm increased at 21%. A number of work programmes through the IIP continue and are currently being monitored through the Medicines Quality Group.

SHMI

The Trust SHMI continues to reduce and is currently at 102.68. SHMI is at the lowest level for the Trust and is '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 91.5% with sending eDDs within 24 hours for January 2023 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 January data

Screening Inpatient child– Screening compliance for inpatient child was at 84.8%.

IVAB ED child - The administration of IVAB for children in ED was at 89% an increase from the last reporting period.

Actions to recover for all sepsis metrics can be reviewed below.

Duty of Candour (DoC) – December Data

Verbal compliance for December was 93% against a 100% target and 81% for written against a target of 100% within the reporting period. The Clinical Governance team continue to notify clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

DKA

This metric includes reported incidents where a patient has developed DKA whilst an inpatient. All DKA incidents are validated through the incident management process and the appropriate level of investigation is instigated which may result in changes with harm levels post investigation. A DKA Task & Finish group is being re-established to address the reconfiguration of services required to manage these patients more effectively.

Operational Performance

At the time of writing this executive summary (14th February 2023), the Trust has 38 positive COVID inpatients. There are 3 patients requiring Intensive Care intervention. The January peak was 49 patients. The current Influenza A inpatients are 12 with the peak in January being recorded at 113 patients. There are currently 6 patients requiring inpatient care for RSV with the peak in January of 45 patients.

The Trust declared 1 Critical Incident in January. The declaration was made on 3rd January and was because of sub optimal flow during the New Year Bank Holiday weekend. Critical pathways were compromised. 'Hot debriefs' took place daily and the formal 'cold debrief took place on 20th January 2023.

This report covers January's performance, and it should be noted the demands of Wave 7 had decreased but as predicted, the number of positive COVID case is once again rising. The teams across the organisation continue to transition to 2022/23 and the recovery of waiting times and continues to return pre-Covid access.

The implementation of the revised Full Capacity Protocol 60-day pilot as part of the 'Breaking the Cycle' initiative completed and is currently going through a formal benefits realisation.

A & E and Ambulance Performance

Whilst the summary below pertains to January's data and performance, the proposed revised Urgent Care Constitutional Standards are now in question and the reporting will be adjusted to reflect any new changes including the new 4-hour performance target of 76%. There is no timeframe currently for any revision of the standards to reach formal agreement. Performance against these will be described in the supplementary combined operational performance FPEC paper including impact from the planned Industrial action from our Ambulance Colleagues.

4-hour performance improved against December performance was initially reported at 42.36% but a data quality issue has been identified. The compliance against the 4-hour target should have been reported at 58.12% in December. This has been addressed. January reported an improvement in performance of 60.67%, which is a 2.55% positive position.

There were 647 12-hr trolley waits, reported via the agreed process in January. This represents a decrease of 387 from December (1034). Sub-optimal discharges to meet emergency demand remains the root cause of these delays.

Performance against the 15 min triage target demonstrated an improvement of 15.31%. 77.99% in January verses 67.63% in December.

There were 497 >59minute handover delays recorded in January, a decrease of 501 from December, representing a 50.21% decrease and a 200.8% improvement. January also experienced a decrease of 53% in >120mins handover delays compared with December and a 55% decrease in >4hrs handover delays.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 5.05 days against an agreed target of 4.5 days The average bed occupancy for January was in excess of 95%, with PHB demonstrating the highest level of occupancy. Increase January saw the highest number of acute beds open – 1069 verses an expected funded core G&A of 882 acute beds.
System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3. Pathway 3 saw a decrease of 6.17days compared to December 2022 and Pathway 1 also reduced by 0.58%.

Elective Length of Stay increased by 22.73% from 2.72 days in December to 3.52 days in January. This will be as a result of multiple elective cancellations in December.

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. Whilst RTT was to be disregarded in the revised constitutional standards, this key metric has now been re-instated.

December demonstrated a deterioration in performance of 0.77%. December outturn was 46.89%. The Trust reported 8,282 patients waiting over 52 weeks, which is an increase of 78 on the reported November position. The position requires close monitoring and scrutiny.

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

At the end of December, the Trust reported zero patients waiting longer than 104 weeks. Discussions are taking place with NHSE weekly in regard to 104- and 78-week waiters with an expectation of zero patients over 78 weeks by end of March 2023 including first definitive treatment.

Waiting Lists

Overall waiting list size has increased since October. December reported 72,530 compared to November's position of 72,281 an increase of 319. 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. As of 5th ASI recovery has demonstrated an improvement (627 in January verses 983 in December) but remains above the agreed trajectory of 550. Additional resource has been directed to resolving missing outcomes which is having an adverse effect on the bookings team being able to move the ASIs to open referrals.

DM01

DM01 for January reported 55.35% versus 51.42% in December compliance against the national target of 99%. A positive variation of 3.93% improvement on the December outturn but still a negative variance of 43.65% against the nationally agreed target. Whilst the main area of concern remains Echocardiography, they are signs of improvement, DEXA backlog has reduced to 1313 in January compared to 1439 in December. We will continue to see a month-on-month reduction of 400 cases a month. Endoscopy backlog due to outpatient recovery, in particular, colorectal. This will be supported by the utilisation of Medinet.

Cancelled Ops

The compliance target for this indicator is 0.8%. January demonstrated a 2.05% compliance. This is a deterioration of 0.31% on December and a negative variance of 1.25% against the agreed target.

The target for not treated within 28 days of cancellation is zero. January experienced 32 breaches against the standard verses 37 in December.

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 50.29% (against 85.4% target.) This demonstrates an improvement of 4.14% in performance since the last reporting period and is 35.11% below the nationally agreed compliance target. However, the position against the Trust recovery trajectory is not just in line but a slight overachievement is noted.

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 and is above the agreed trajectory. There are currently 162 patients waiting >104 days against a target of <10. The current figure is a decrease of 28 patients since the last reporting period. The highest risk speciality is colorectal with 102 greater than 104 weeks, this a reduction of 24 since the last reporting period. 3 times weekly meetings are in place to offer challenge and confirm.

Workforce

Mandatory Training – Mandatory training rates have remained constant at between 89-90%. IT software issues have been resolved in February 2023 which should have a positive impact on course completion rates. A paper is going to February People and OD Committee setting out the organisational issues that are a barrier to compliance and an Improvement Action Plan that has been put in place following the task and finish review to address these barriers and achieve an improvement to completion and therefore compliance rates. The paper sets out work being undertaken in particular around clear definitions of Core and Core Plus training, robust processes for inclusion of training within a Core Training Framework or a Core Plus Training Framework and proposals for updating how compliance is reported against these frameworks is reported. The paper seeks approval for an interim 6-month change to the current compliance target while further work is undertaken as part of an Improvement Action Plan to develop realistic trajectories to reach a compliance target of 95%.

Sickness Absence – There has been a further increase this month by 0.2% to 5.59% which is still above the target of 4.5%. We have experienced an increase in the number of Covid absences which continues to be monitored daily. The HR Team continue to work with managers to reduce issues of non-compliance with completing absence call backs and return to work interviews within the expected time periods. In addition, the Divisional Heads of HR provide reports to senior managers detailing any compliance issues in their areas. Work is also now commencing around the performance management process in regards to managers who are not using AMS to manage their team's absence. Cross reference work between ESR, Healthroster and AMS continues to ensure that all absence is being recorded through AMS as per policy.

Staff Appraisals – Ongoing service pressures and staffing challenges in the Trust continue to impact appraisal completion rates but month on month there is a slight improvement with an increase this month to 64.24%. Further work is in progress in terms of reviewing the 'annual cycle' timings, targets and appropriate systems whilst work continues with Senior HRBP's and completion rates being monitored at the monthly FPAM meetings. Again this piece of work is being addressed as part of the action plan and need for urgent review and recommendations.

Staff Turnover – Turnover continues to see a small month on month reduction with January turnover being 13.67% against a Target of 12%. Operational pressures, staffing and culture challenges mean that a regular proportion of staff are looking for other avenues outside the Trust. The OD team offers face to face / Teams exit interviews to gather deeper insights on the reasons for leaving (in addition to ESR / EF3 form results). People Promise Manager continues to work with the Trust and ICB to explore retention and bring best practice into the organisation to address the challenges. The recent analysis illustrates that 17% of resignations could be avoided through better management, relationships and career opportunities if offered in the Trust. It is anticipated that as well as addressing retention issues through the Culture

and Leadership Programme and People Promise work increased recruitment activity will in time reduce workforce challenges and offer support to challenged clinical areas in reducing turnover.

Vacancies – We saw a 0.7% decrease in vacancy factor in January to 8.3%, this was due to us having a significant number of starters joining the Trust. We need to keep an ongoing focus on HCSWs and Nurses over the coming months, with a particular focus on International Nurses, as this supply route expands. We may see an increase in our vacancy factor in coming months due to sizeable business cases for Community Diagnostics and Housekeeping being signed off which will increase our funded establishment, however despite this due to significant recruitment our net staffing position will continue to grow.

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 £0.6m in January (£0.6m adverse to plan) and the Trust YTD delivered a deficit of £13.1m deficit (£13.1m adverse to plan).

CIP savings of £12.6m have been delivered YTD (£8.8m adverse to planned savings of £21.4m).

Capital funding levels for 2022/23, agreed through Trust Board & FPEC, show a plan of c£38.4m; capital expenditure incurred YTD equated to £19.3m.

The January 2023 cash balance is £38.3m, which is a decrease of £50.0m against the March year-end cash balance of £88.3m.

Paul Matthew
Director of Finance & Digital
February 2023

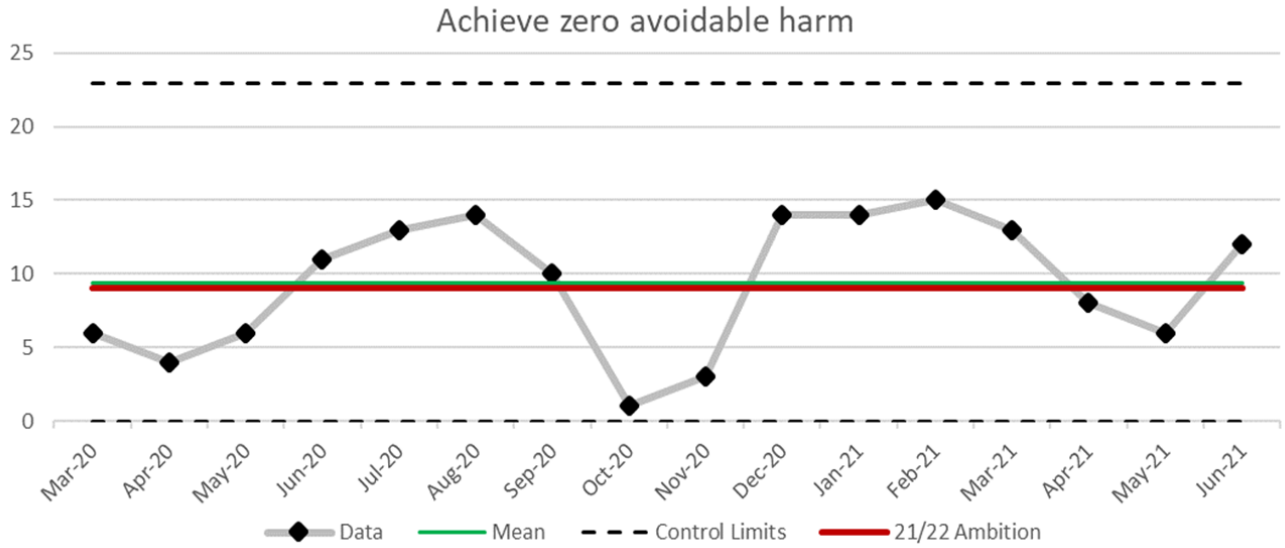
Statistical Process Control Charts

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

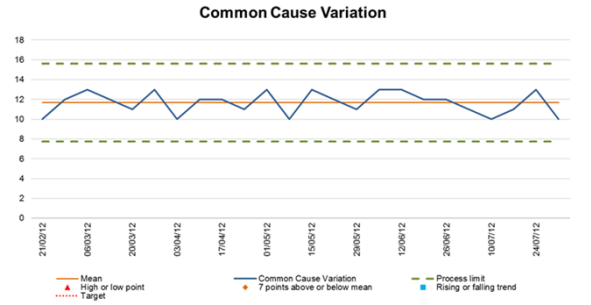
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

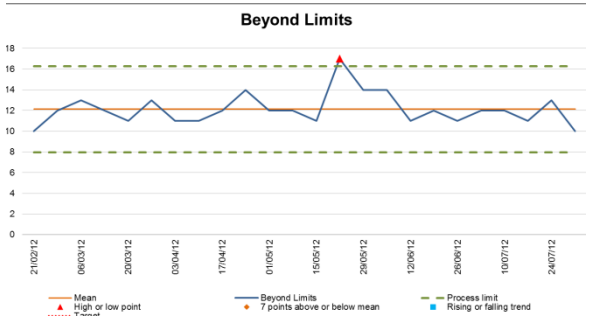
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



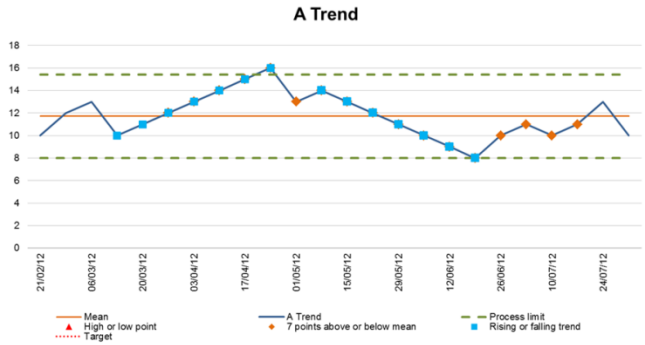
Extreme Values

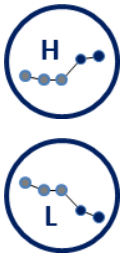
There is no Icon for this scenario.



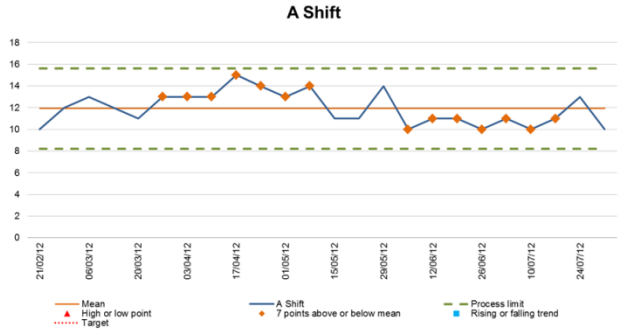
Statistical Process Control Charts

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

Measure ID	Domain	Measure	Measure Definition	SRO	2022/23 Ambition	Tolerance	£'000	Nov-22	Dec-22	Jan-23	Latest month pass/fail to ambition/ tolerance	Trend variation
1	Patients	Implementation of SAFER Bundle – LOS > 7 Days pathway 0	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%		11.94%	12.87%	12.81%	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		Not Available	3rd Quartile (103.16) (75th of 121)	3rd Quartile (102.68) (75th of 121)	P	
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		0.13	0.33	0.39	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		0.13	0.08	0.03	P	
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		0.00	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%		98.90%			P	
8	Services	Financial Plan	Variance aganst plan (£'000)	DoF	£0	£0	£'000	3,209	(3,146)	(610)	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%		14.57%	19.98%	13.88%	F	
10	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	COO	503	100		8,204	8,282		F	H
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%		59.01%	59.56%		F	A
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	DoPOD	9.00%	1.00%		8.77%	8.98%	8.30%	P	
13a	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	DoPOD	90.00%	2.00%		63.26%	63.74%	64.24%	F	A
13b	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	DoPOD	95.00%	2.00%		90.01%	89.78%	89.25%	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%						
16	Partners	Increased recruitment/academic posts (across the ICS)	Number of posts appointed	DII	10	2						
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%		78.29%	78.83%	80.56%	F	A

Quality | Operational Performance | Workforce | Finance

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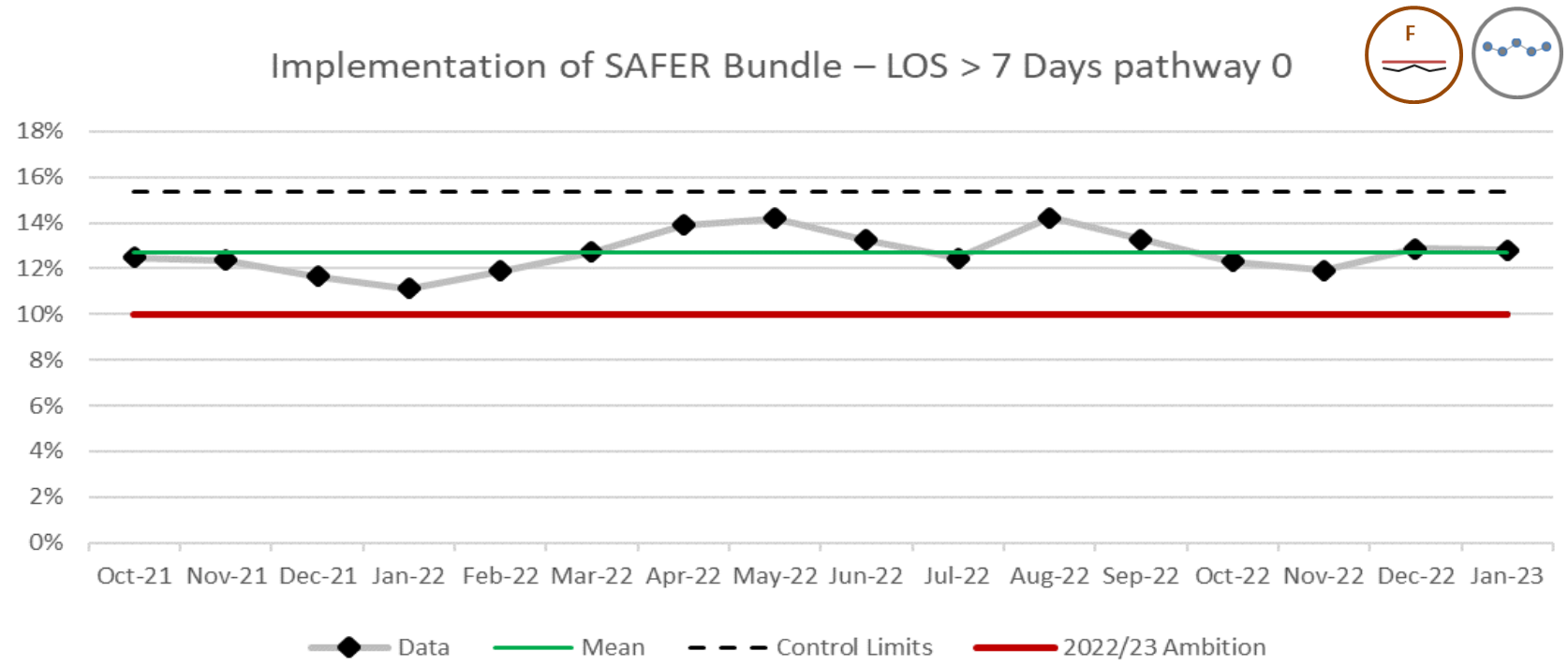

Jan-23
12.81%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
10% with 1% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients.

What the chart tells us:

Whilst not achieving the ambition of 10%, improvements are being realised.
What the chart isn't telling is that the average time from medically Optimised to discharge for Pathway 0 in January was 1.2 days a reduction of 0.3 days experienced in December.

Issues:

Numbers of stranded patients has increased across all 3 Acute Sites, but super stranded patients have decreased in number at LCH and PHB.
Higher acuity of patients requiring a longer period of recovery.
Medical outliers have reduced overall but reduced medical staffing has led to delays in senior reviews.
The number of positive covid cases requiring a longer length of stay has increased slightly. The impact of Influenza A patients requiring inpatient care has also led to extended lengths of stay.
Weekend discharges are still 50% less then weekdays.
Pathway 0 patient discharging remains slow to show improvement but with the continued support of IMPOWER, this is now picking up pace.

Actions:

Line by line review of all pathway 0 patients who do not meeting the reason to reside.
A new infrastructure to apply new focus is in train.
The ULHT Trust Wide Discharge Lead will now have P0 in their portfolio

Daily escalation meetings to confirm and onward escalation to secure increase P0 discharges are being redesigned.

Proactive use of expected date of discharge to allow a forward look at potential discharges over the 7-day period.

Mitigations:

Divisional Bronze Lead continues to support the escalation of exit delays to the relevant Divisions and Clinical Business Units for the time being.
A revised Capacity meeting structure and escalation process will be in place week commenced on 12th December
A daily site update message is 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.

Quality | Operational Performance | Workforce | Finance

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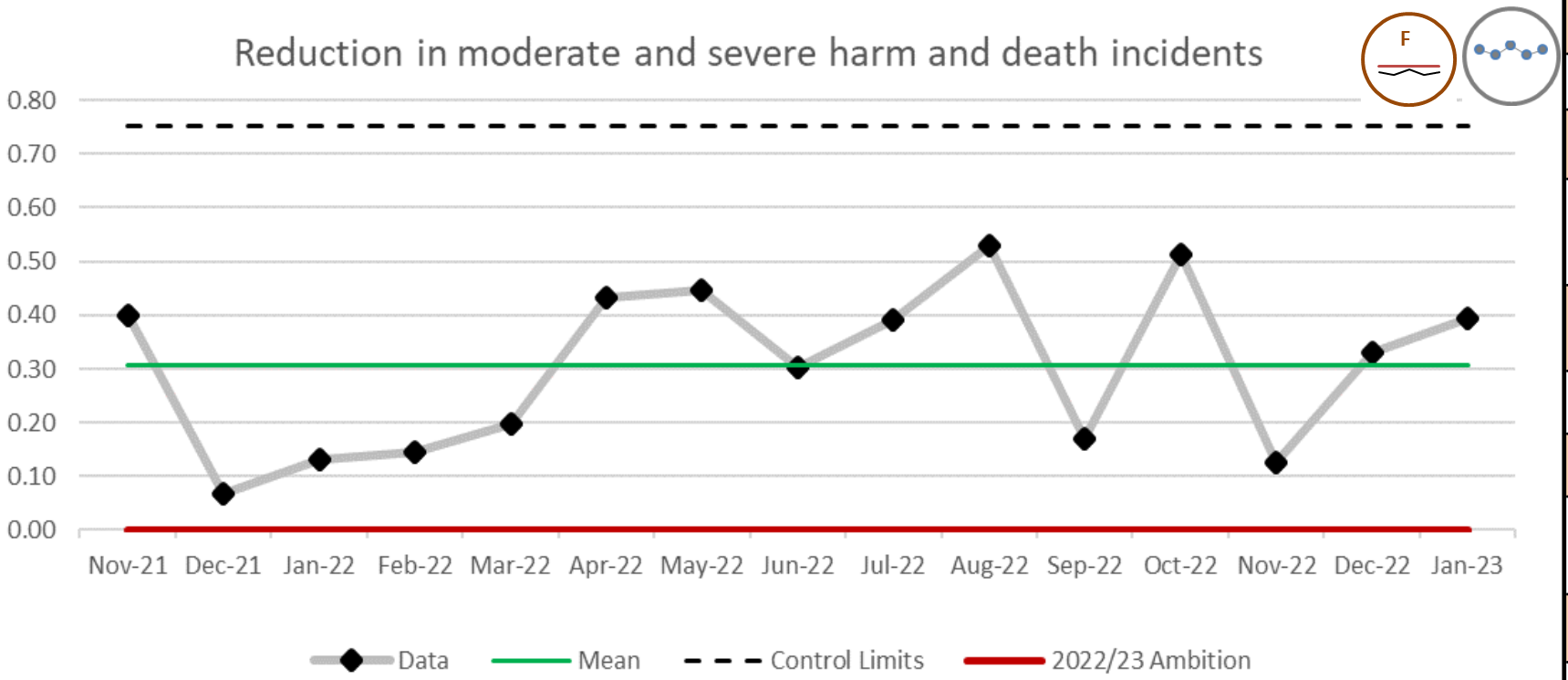

Jan-23
0.39
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
0 with a 0.17 tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:
Serious incidents (including Never Events) of harm - Moderate, severe and death - per 1000 OBD.

What the chart tells us:
The chart shows that there is common cause variation in relation to the number of incidents causing moderate, severe harm or death.

Issues:
The Trust continues to experience high volumes of attendances and is currently working to recover outpatient and elective activity. This has led to potential incidents where harm has been identified.

Actions:
Incidents where there is a recurring theme have been identified and task and finish groups set up to identify actions to be taken to improve patient care.

Mitigations:
The Trust continues to book patients based on clinical need.

Quality | Operational Performance | Workforce | Finance

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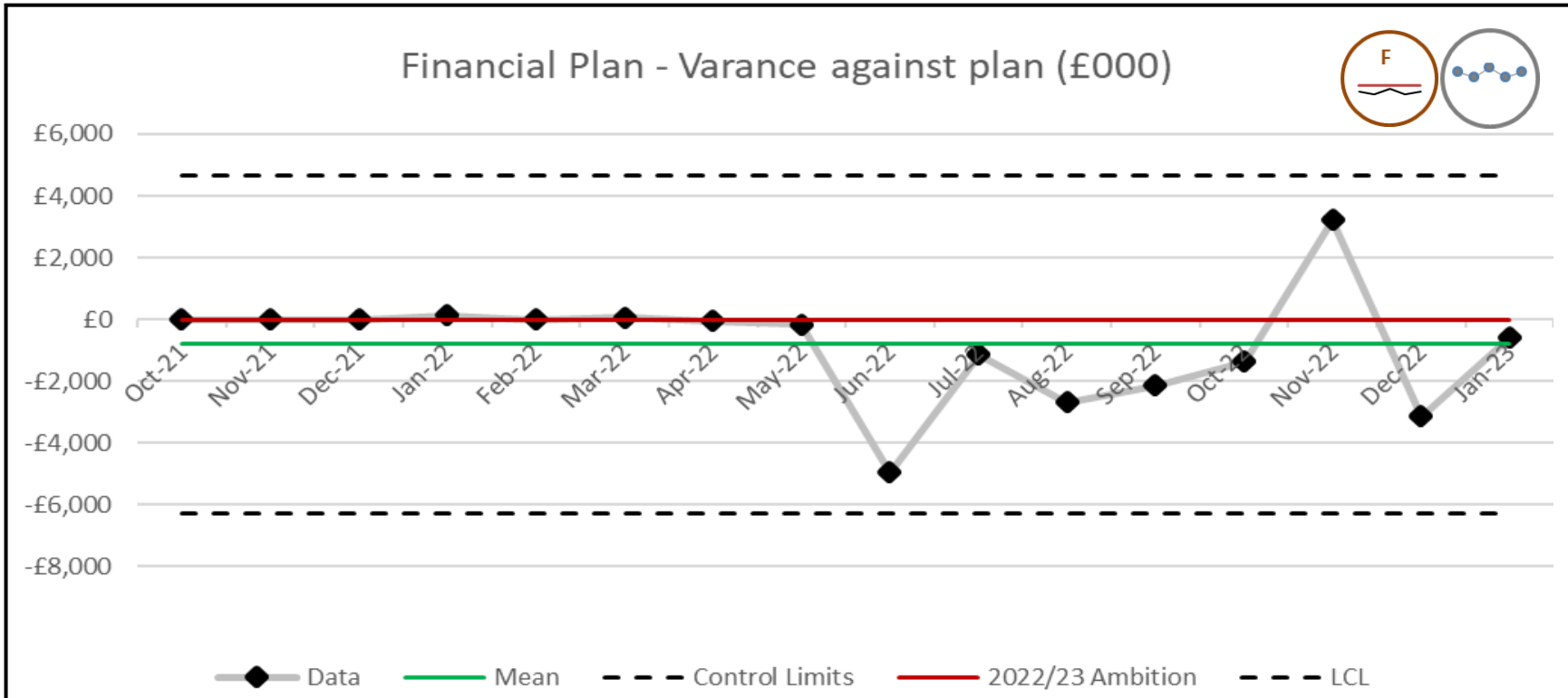

Jan-23
Variance to plan (£610) k
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
£0
Achievement
Metric is failing the target
Executive Lead
Director of Finance

Background:
The Trust has a financial plan in 2022/23 to deliver a break even position.

What the chart tells us:
The chart shows that the Trust has consistently failed in the delivery of this ambition apart from November where our performance reflects receipt of a gain share re CC2H.

Issues:
The main drivers of the deficit are as follows: the under delivery of the cost improvement plan, the cost of the unplanned opening of additional beds, and the continuation of the additional costs of Covid (which were assumed to cease from the end of May 2022).

Actions:
The Trust has strengthened the support to cost improvement and developed a series of actions being monitored via TLT, has agreed contract variations in relation to the Risk and Gain Share for Care Closer to Home, undertaken a QIA review of the additional costs of Covid, and agreed a forecast deficit as part of a revised ICS forecast for 2022/23.

Mitigations:
Continued focus upon the delivery of cost improvement, monitoring of the TLT action plan, agreement to transact the Risk and Gain Share in relation to Care Closer to Home (which has resulted in a contract variation for £5m and a further £3m in relation to the projected slippage), and agreement of a forecast deficit of £14.6m as part of a revised ICS forecast for 2022/23.

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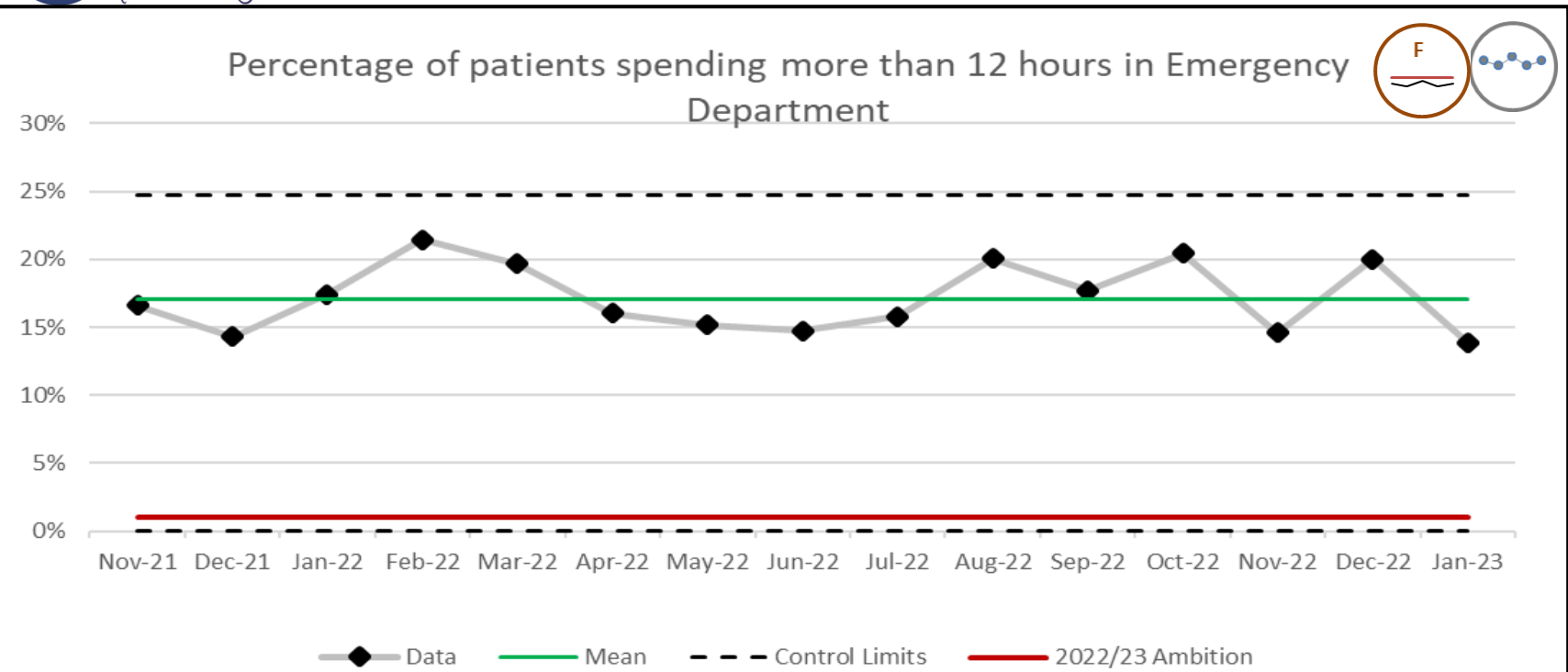

Jan-23
13.88%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
1% with 5% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

January experienced a decrease in the numbers of patients with an aggregated time of arrival greater than 12 hours against total attendance. 1483 compared to 2530 in December. A reduction of 1047.
What this chart doesn't tell us also is that January 23 saw a reduction of 1930 patients into the department compared to only 181 less seen in January 2022.

Issues:

January experienced a 13.4% reduction in Type 1 attendances to ED compared to December. This decrease in Emergency Department attendances resulted in a 5% decrease in non-elective admissions. However the main factor contributing to the delays still seen, is due to inadequate discharges from exit block/ timely recognition of discharges to meet the demand and flow. Increased number of patients experiencing an elongated LOS due to requiring non acute admission but requiring access to an alternative health care setting such as domiciliary care, transitional care, community hospital and Adult Social Care. The establishment of a joint health and social care off for domiciliary care is in place and capacity to access this is increasing.
Delays in time to first assessment contribute to the clear formulation of a treatment plan, especially out of hours.

Actions:

Reduce the burden on the Emergency Department through maximising discharges in the morning to create flow and reduce exit block.
Implementation of the revised Full Capacity Protocol (+1on every adult inpatient area)
Use of alternative pathways such as the UTC, CAS, SDEC, FAU and SAU.
Direct access via EMAS to Community and transitional care facilities established and now in place to SDEC, FAU, SAU, GAU and Virtual Wards
Zero tolerance to escalate any and all SDEC areas
The impact will be monitored through the Capacity Meetings and Executive oversight.

Mitigations:

EMAS have enacted a targeted admission avoidance process which includes non-conveyance of any Category 4.
The Discharge Lounge at LCH and PHB continue to operate a 24/7 service provision to release the burden placed on the Emergency Department at in terms of patients awaiting AIR/CIR, failure to resolve +1 and transport home. Although planned closures of the Discharges Lounges were put in place in October, to support the 'Breaking the Cycle' a 24/7 provision has remained in place.
Increased CAS and 111 support especially out of hours have been further enhanced.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation against a revised protocol.

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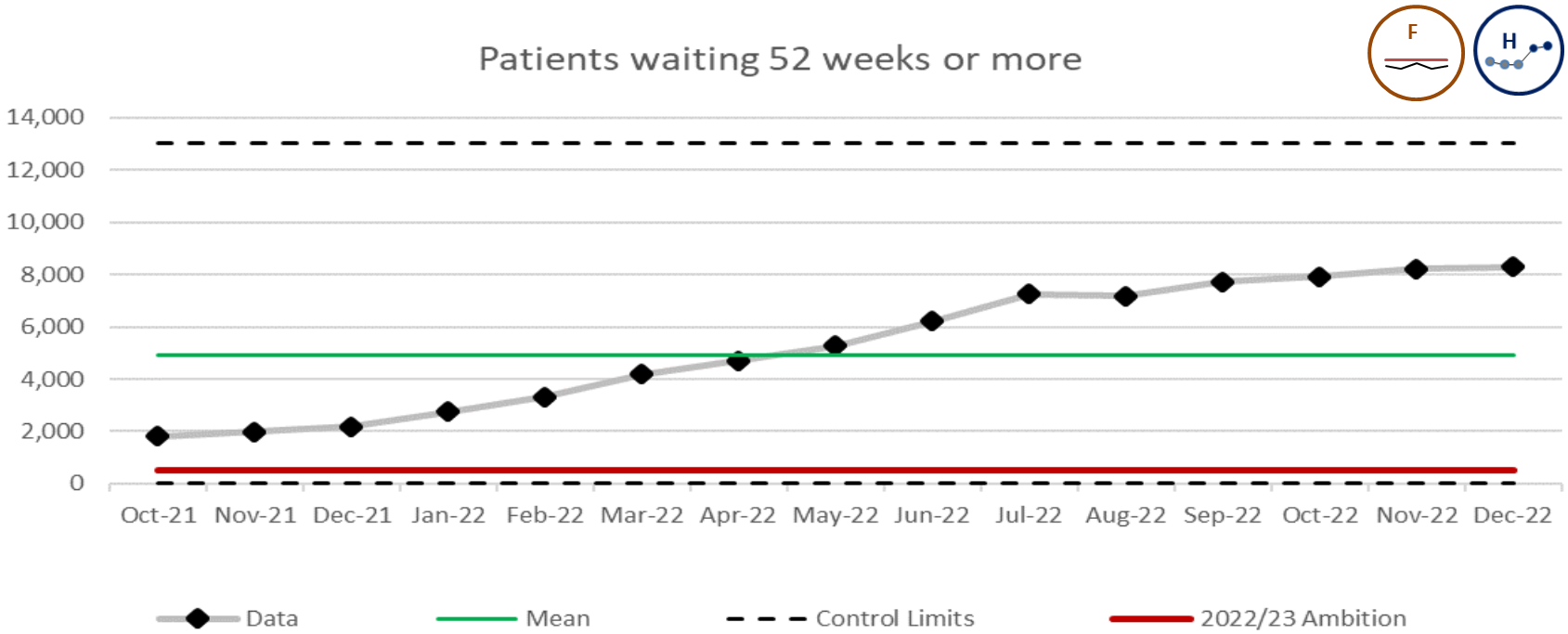

Dec-22
8,282
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
503 with 100 tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 8,282 incomplete 52-week breaches for December, an increase of 78 from November.

Issues:
Whilst ULHT's position is strong with 104 week wait patients, with a zero return, performance is less assured with 52 week waiters. Both admitted and non-admitted patients sit within this backlog, however, the most significant pressure remains in the non-admitted pathways.

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through the PTL meeting with emphasis on longest waiters. The intention is to drive down the wait bands discussed. This is successful with admitted patients, however it is making slow progress with non-admitted patients in some specialties, due to the high volume of patients in this wait bracket.

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

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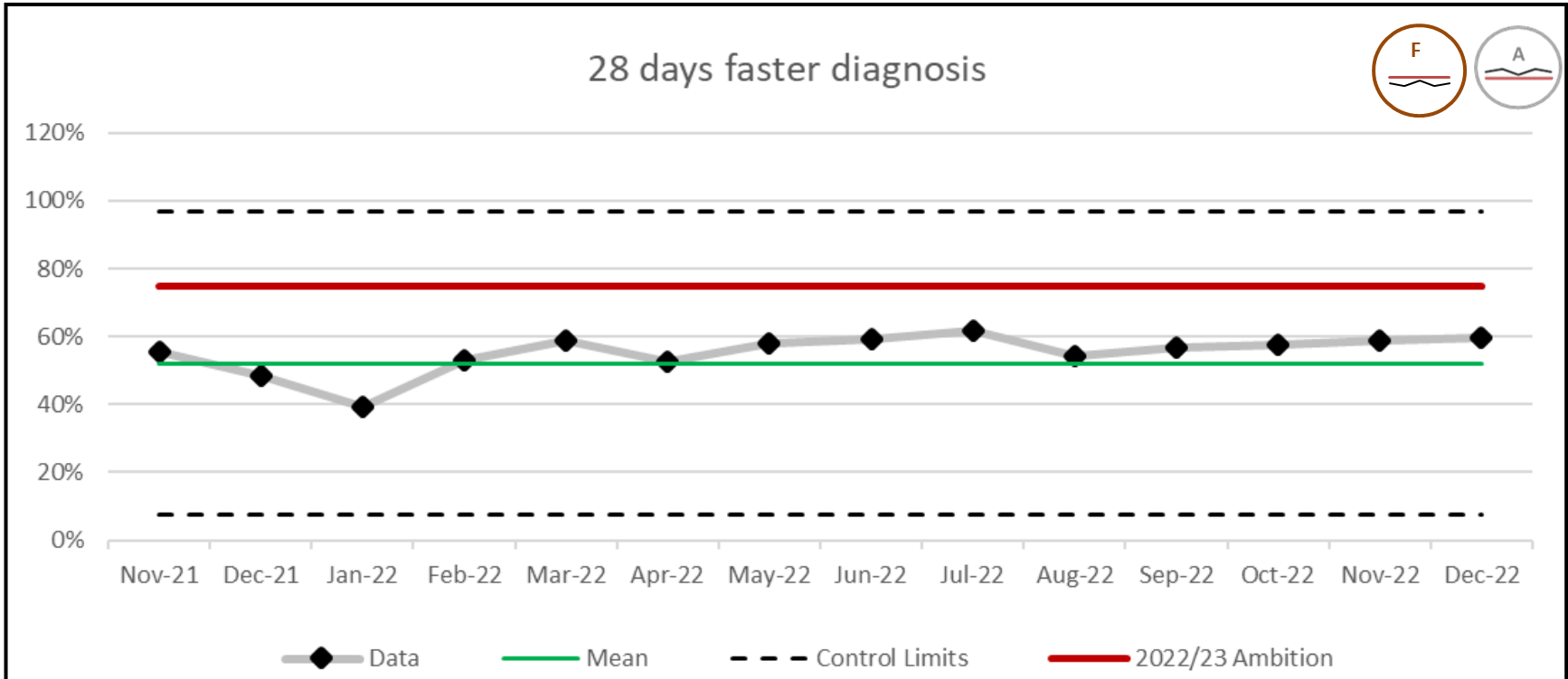

Dec-22
59.56%
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
2022/23 Ambition/Tolerance
75% with 5% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

Number of patients diagnosed within 28 days or less of referral as a percentage of total Cancer pathways.

What the chart tells us:

We are currently at 59.56% against a 75% 2022/23 ambition with a 5% tolerance.

Issues:

The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is.
2ww OPA capacity in high volume tumour sites such as skin and breast (see 2ww Suspect).
Diagnostic capacity challenges and clinical review capacity.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program.
Recruitment to vacant CNP post focus on clinical reviews below 28 days is currently on hold until potential re-banding and substantive funding is in place.
The 90 minute standard to be introduced to Gynaecology specialty once approved through the governance process – due February 2023.
Recruitment is underway in Respiratory, ENT and Haematology specialties to improve Consultant availability and clinical review capacity.
Theatre capacity for urology diagnostics challenges 28 day performance – work to increase this capacity and reduce bottlenecks is ongoing.

Mitigations:

A new electronic and streamlined admin process is in place in respiratory and being embedded at LCH – this is now also being reviewed for PHB too.
A process is now in place 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/support. However, the Pre-Diagnosis Team workload continues to be impacted by an increasing backlog.
All tumour site CBUs recently attended and engaged with the introduction of the Cancer Centre FDS Dashboard to understand their performance and explore areas to focus on improvement. The Dashboard went live on 06/02/2023.

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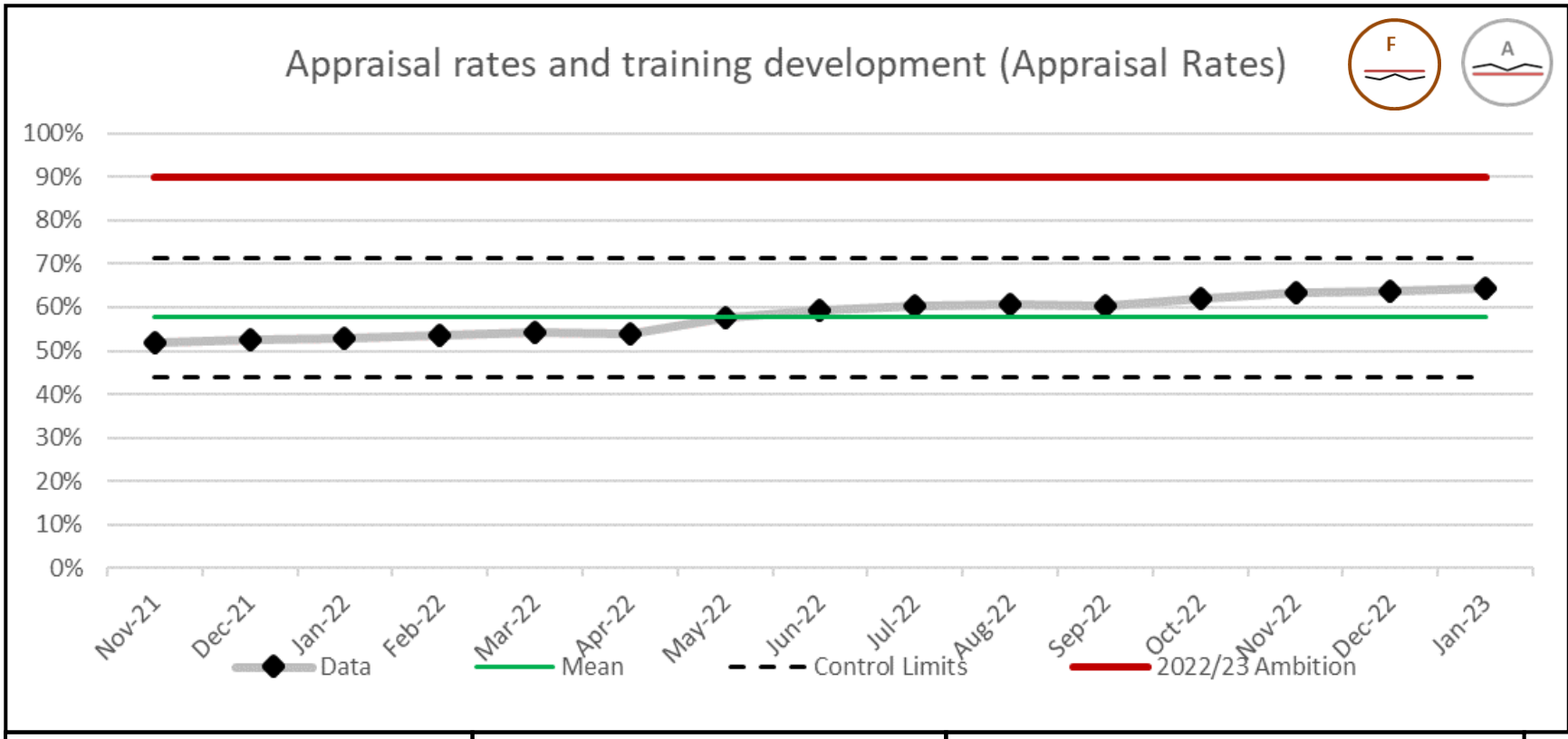

Jan-23
64.24%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
90% with 2% tolerance
Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 64.24%

What the chart tells us:
Operational pressures and staffing challenges continue to impact appraisal completion rates although there is a small monthly improvement

Issues:
- Operational pressures continue to have an impact on completion
- In addition, initial scoping as part of a task and finish review has identified two key issues that need reviewed to support completion of Staff Appraisals and therefore compliance rates. These are the 'appraisal cycle' and an e-Appraisal solution
- Progress has been slower than desired due to current resourcing issues within People and OD

Actions:
- Resources are being allocated to review these two key issues and report back to the Director of People and OD by 31/3/23
- Further areas of work are also scheduled to commence in March 2023 which will support the development of an Improvement Action Plan and realistic trajectories to eventually reach a compliance target of 90%
- Appraisal completion to be focussed on through FPAM
- Appraisal Training remains available

Mitigations:
See actions

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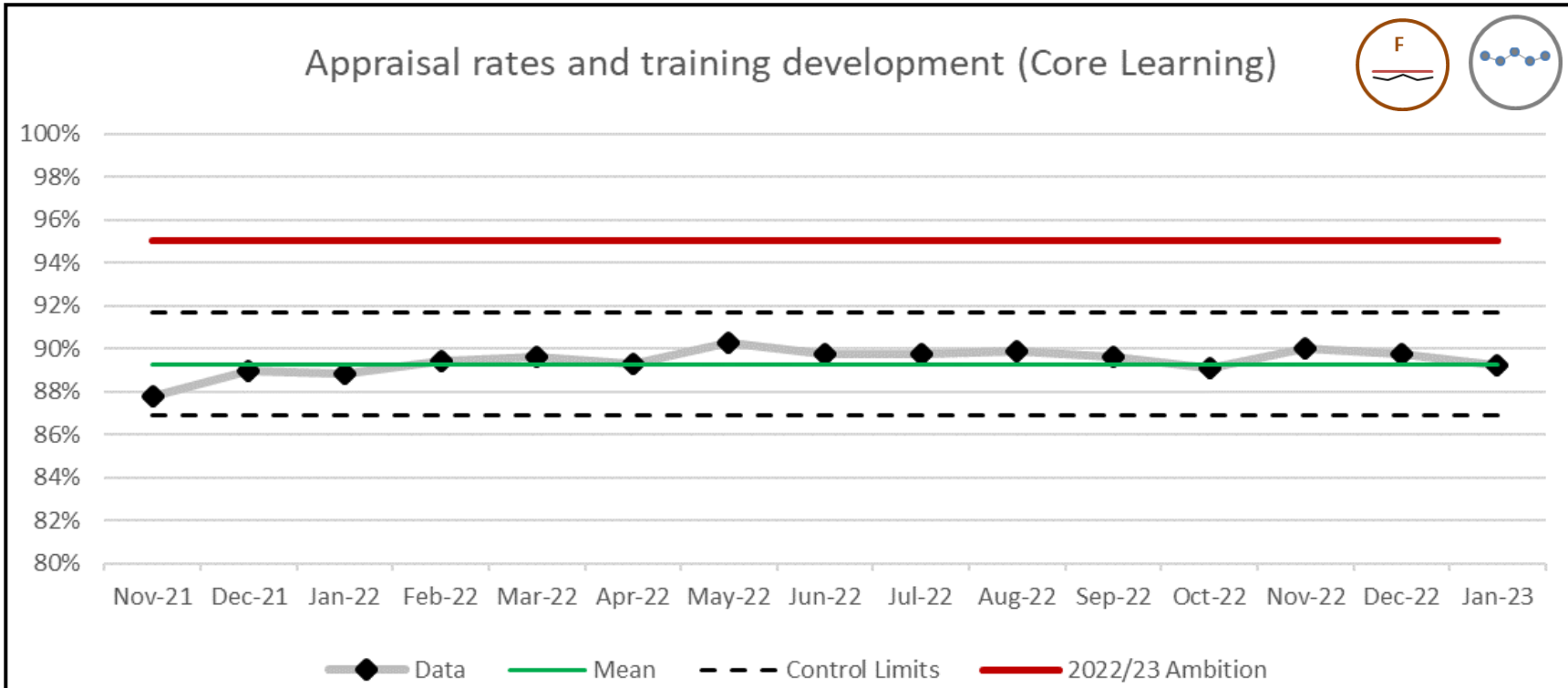

Jan-23
89.25%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
95% with 2% tolerance
Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Mandatory training compliance remains stable over the past months falling between 89-90%

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:
- Improvement Action Plan has been put in place following the task and finish review to address barriers and achieve an improvement to completion and therefore compliance rates
- Particular work being undertaken around clear definitions of Core and Core Plus training and robust processes for inclusion of training within a Core or Core Plus Training Framework

Mitigations:
Improvement Action Plan

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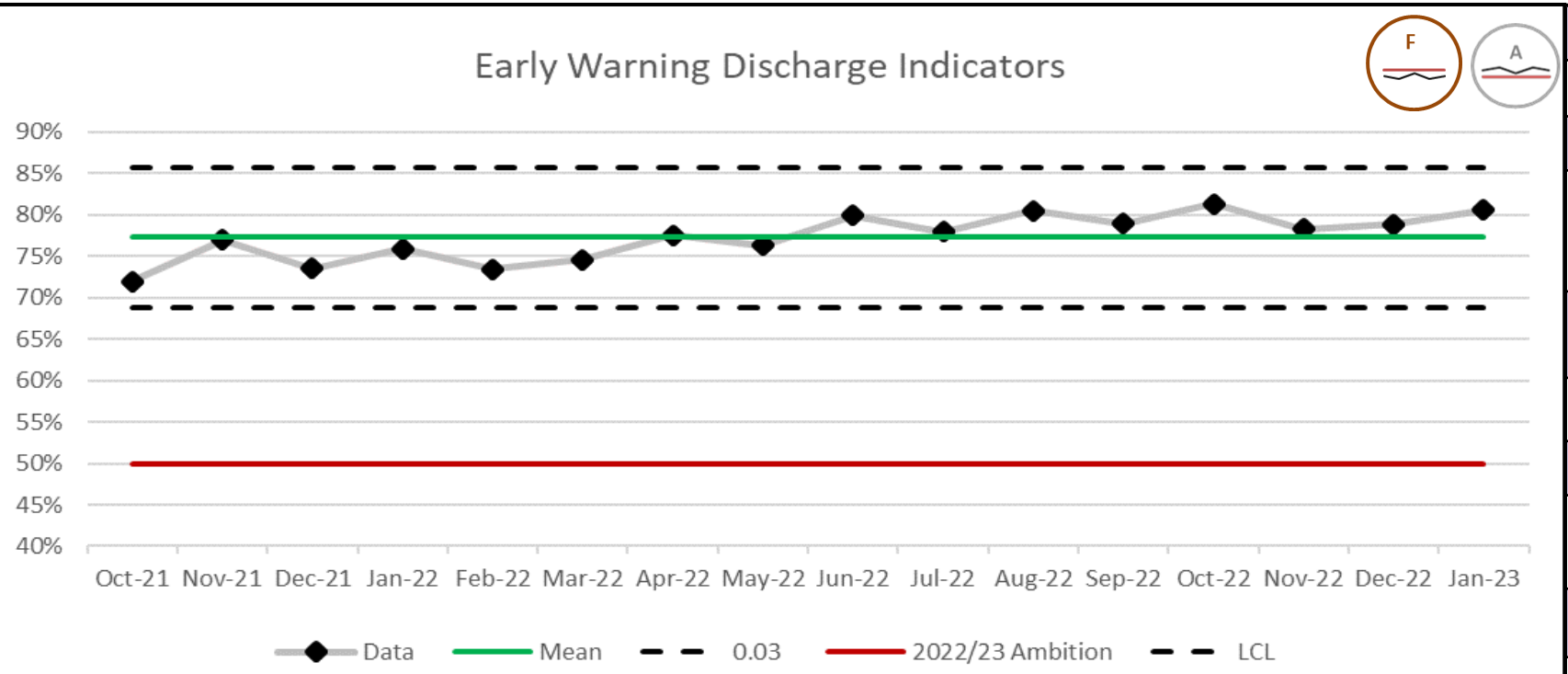

Jan-23
80.56%
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
2022/23 Ambition/Tolerance
50% with 10% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, for pathway 1-3 patients.

What the chart tells us:

The Trust is currently at 80.56% against a 50% 2022/23 ambition with a 10% tolerance. This is an improvement of 1.73% compared to December 22.

Issues:

Numbers of stranded has increased but super stranded patients have decreased 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 slowly but there remains insufficient capacity to meet the increasing demand.
The Transfer of Care Hub continue to gain more traction on moving discharges forward at an improved pace.

Actions:

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
The move to Lateral Flow Testing as opposed to PCR testing for access to onward non acute care is proving beneficial once Community and social care is secured.
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.
Transfer of Care Hub escalation of barriers to discharge are monitored though the Capacity Meetings and Hub meetings.

Mitigations:

A new rolling programme of MADE has been agreed and the frequency has been agreed as an 8-week rolling programme.

Increased Transfer of Care Hub workforce approved through Winter Monies to apply a continued focus across the 7 day period.

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Nov-22	Dec-22	Jan-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	4	1	8	60	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.00	0.03		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.01	0.05		
	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	0.16	0.00	0.08	0.13	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	0	1	5	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	3	7	F	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	5	7	11	59	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	94.98%	93.68%	93.70%	94.41%	F	B
	Never Events	Safe	Patients	Director of Nursing	0	0	1	0	5	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	6.19	6.02	5.02	5.88	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	14.1%	13.7%	21.0%	13.49%	F	

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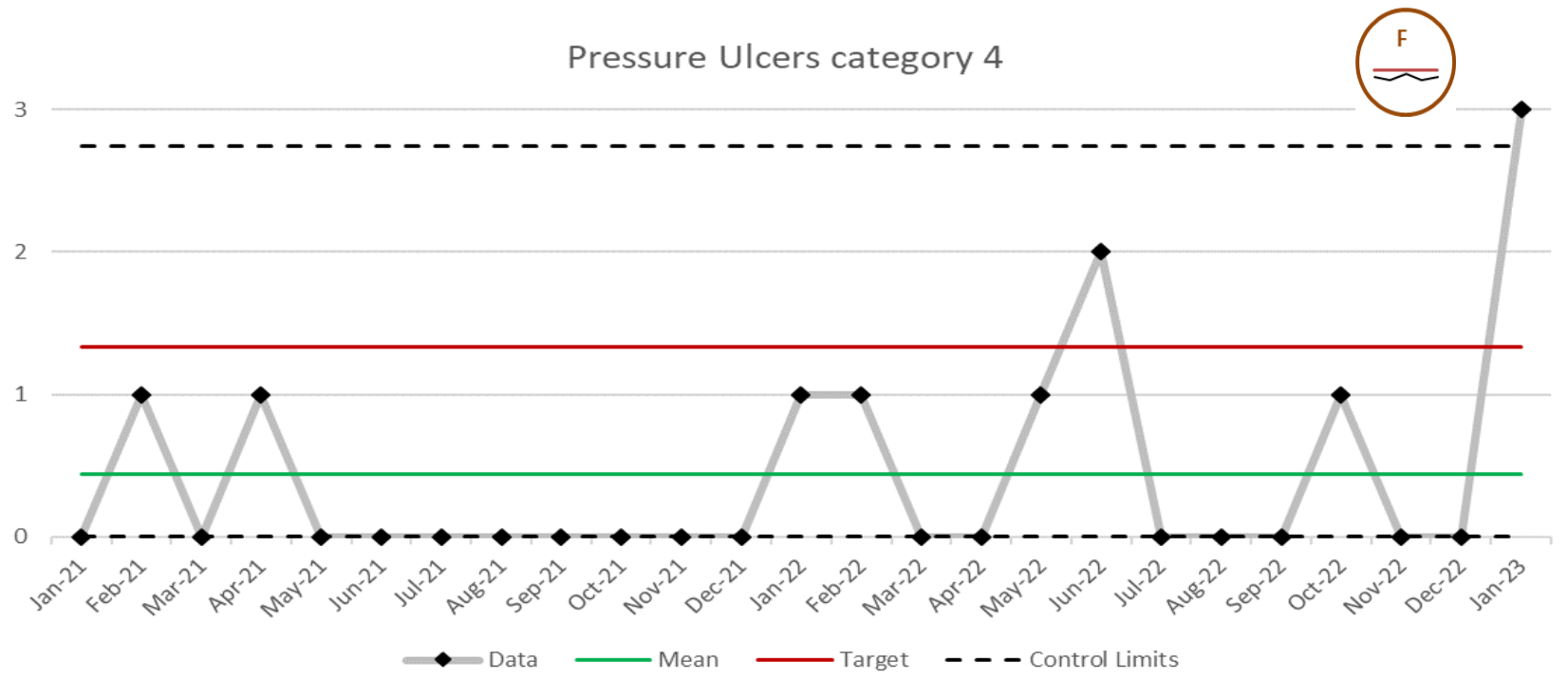
PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-22	Dec-22	Jan-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	100%	None due	100%	63.20%	P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	Not available	94.89	93.98	94.52	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	Not available	103.16	102.68	105.87	F	L
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	100.00%	99.60%	P	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	90.40%	89.20%	91.50%	90.15%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.3%	87.0%	90.0%	90.78%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	84.8%	81.7%	84.8%	86.18%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	91.8%	92.0%	94.0%	93.77%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	71.4%	100.0%	100.0%	79.87%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.1%	89.0%	92.0%	90.53%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	86.1%	84.0%	90.0%	85.80%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	93.9%	92.0%	96.0%	93.88%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	66.7%	57.0%	89.0%	63.29%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.20	2.21	2.44	2.80	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%	74.00%	93.00%		85.67%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	53.00%	81.00%		78.67%	F	A



Jan-23
3
Variance Type
Metric is currently experiencing Special Cause Variation – outside the control limits
Target
1.3
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Pressure Ulcers Category 4

What the chart tells us:
We are currently at 3 against a threshold of 1.3 per month.

Issues:
There have been three Category 4 pressure ulcers reported in January. These will be investigated in accordance with the serious incident framework. This is an increase from 0 in December.
Following validation, it was evidenced that 1 incident was a deterioration from a Deep Tissue Injury that occurred in December.
One incident was device related from a plaster cast.

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

Immediate actions have been instigated in conjunction with the Trauma Coordinator team to review the Plaster Cast/Splint care pathway. There will also be a review of the training for cast management in collaboration with the Tissue Viability team.

Mitigations:
As above

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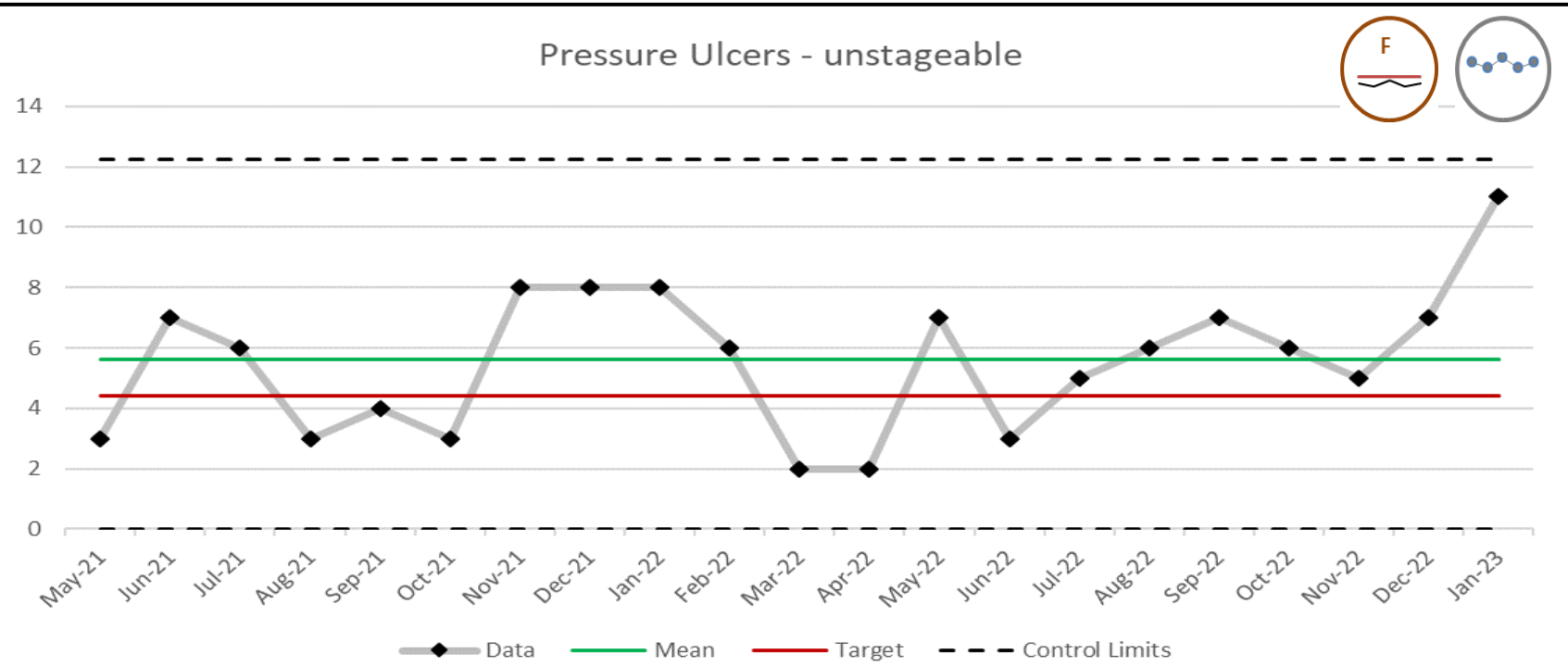


Jan-23
11
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.4
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:

Unstageable Pressure Ulcers.

What the chart tells us:

We are currently at 11 incidents against a threshold of 4 per month.

Issues:

The number of incidents have increased by 4 from December 2022.

Following validation, it was evidenced that 6 incidents were attributable to a deterioration of existing deep tissue or category 2 pressure damage.

2 incidents were miscategorised when initially reported.

Device related unstageable pressure ulcers have increased by 3 from 0 last month. This will be an area of focus to improve.

Actions:

Unstageable incidents will continue to be investigated and reviewed through the pressure ulcer incident process. Themes identified will provide further areas of focus to improve. A lessons learned communication will be shared to support the cascade of learning identified at Pressure Ulcer Panel.

Learning from Incidents is a regular agenda item at SIG (Skin Integrity Group) to support the wider organisational learning of the themes and trends.

The Tissue Viability (TV) team continue to attend the Sister/Charge Nurse meeting to share themes and trends, educate staff regarding how to accurately categorise ulcers, and promote the importance of appropriate escalation to the TV team.

The new daily skin assessment documentation which has been introduced includes a prompt for staff to record any devices that are in place and when skin checks have been performed.

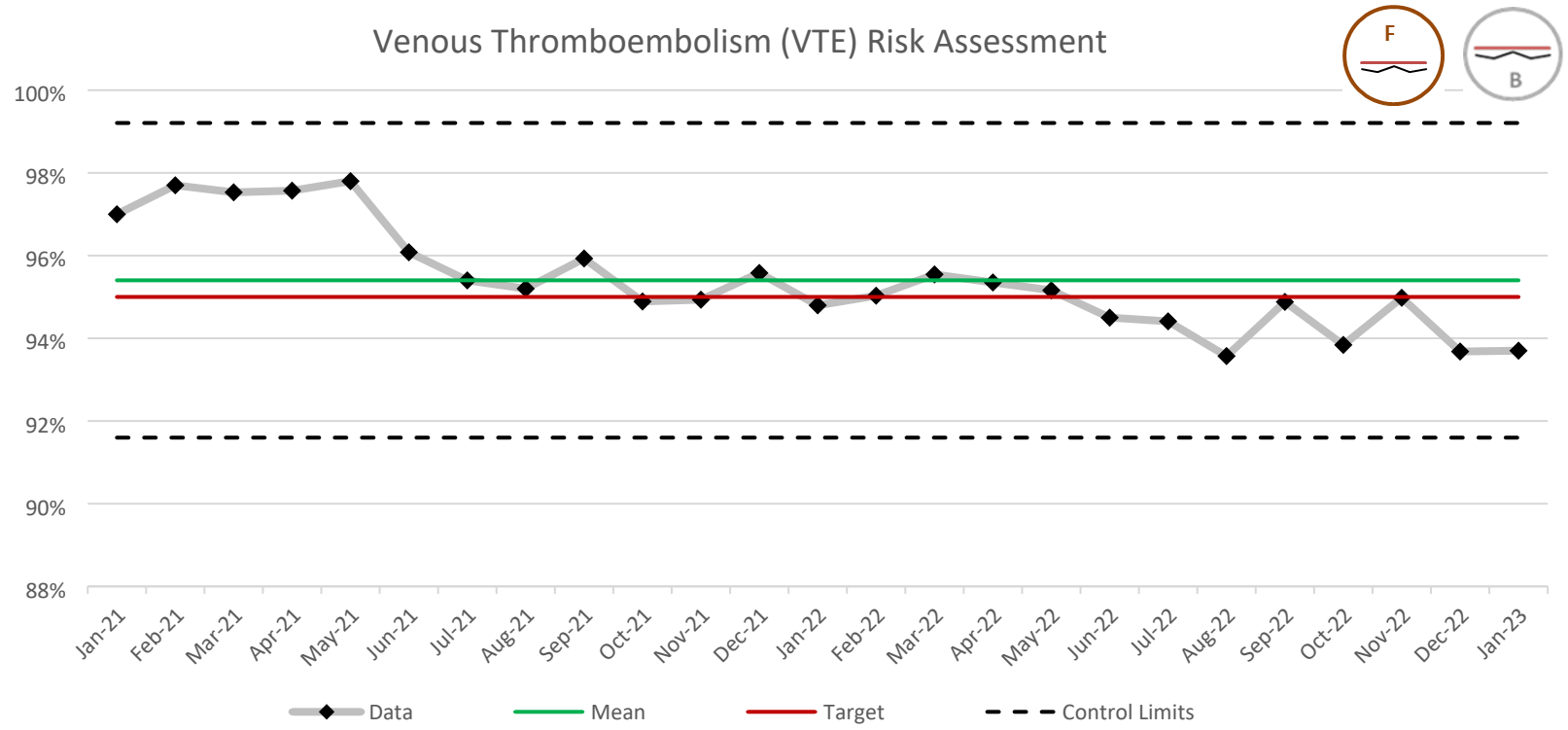
Mitigations:

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

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

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

Quality | Operational Performance | Workforce | Finance



Jan-23
93.70%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
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 continues under perform.

Actions:
A paper was taken to Trust Leadership Team in November 2022 proposing the reinstatement of the VTE Specialist Nurse. This was agreed and work will now take place to identify a funding stream.

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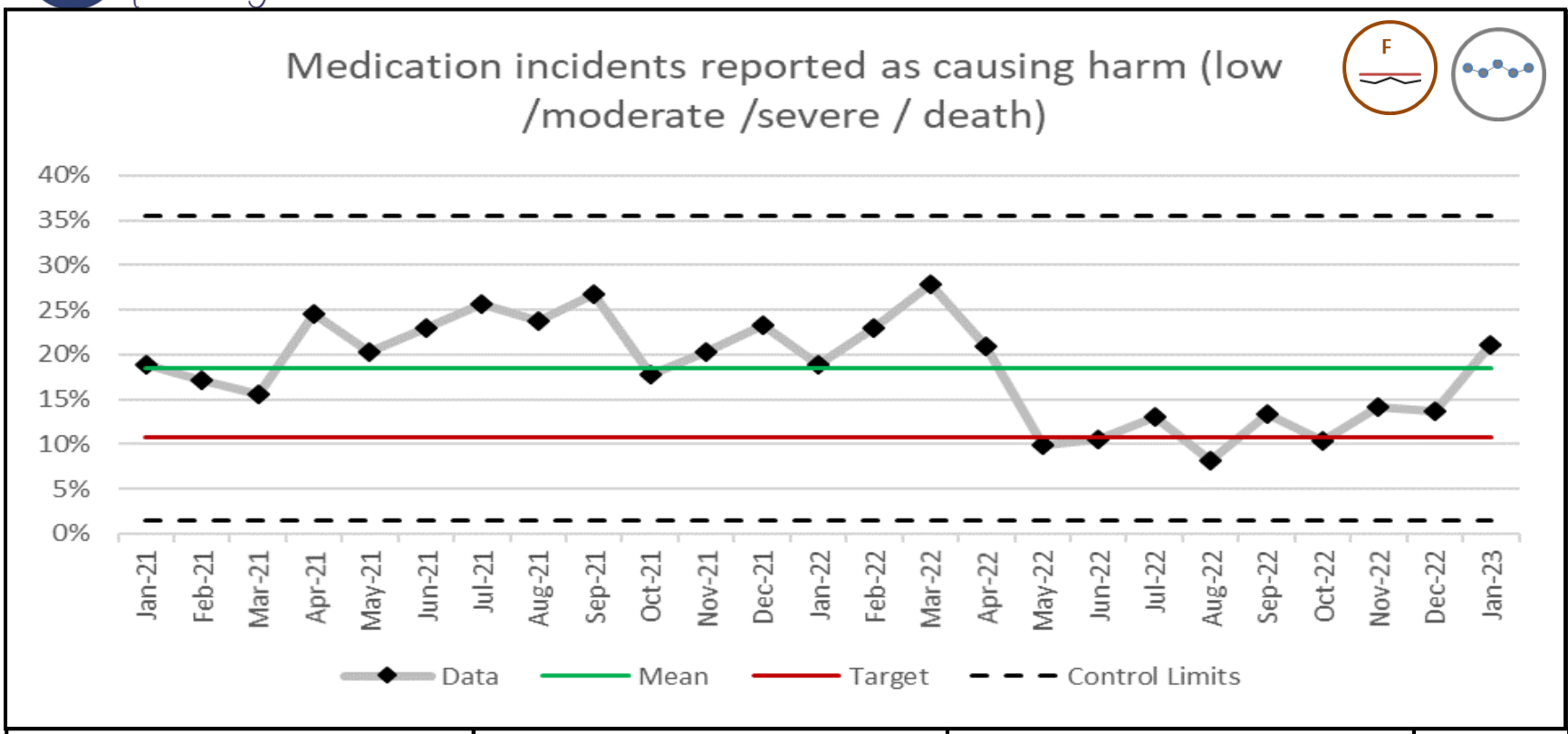

Jan-23
21.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10.7%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of January the number of incidents reported was 185. This equates to 5.20 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 21% which is above the national average of 11%.

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

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

Mitigations:

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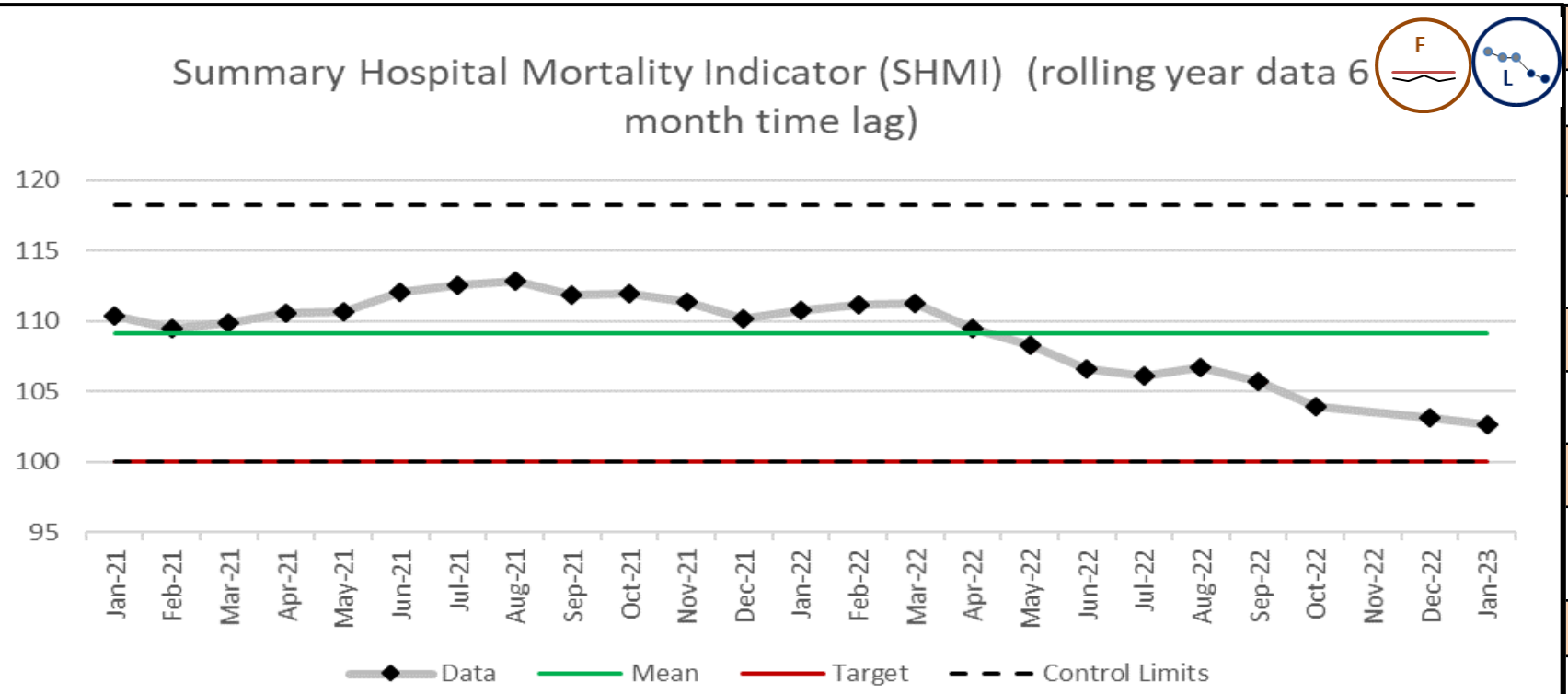

Jan-23
102.68
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
To remain in "as expected" range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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:
SHMI is at the lowest level for the Trust and is 'as expected'.

Issues:
The data includes deaths within 30 days. When all GPs are participating in the ME service, greater intelligence will be available to understand if there is any learning required.

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

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

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

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

HSMR is 93.98 (rolling 12 months)

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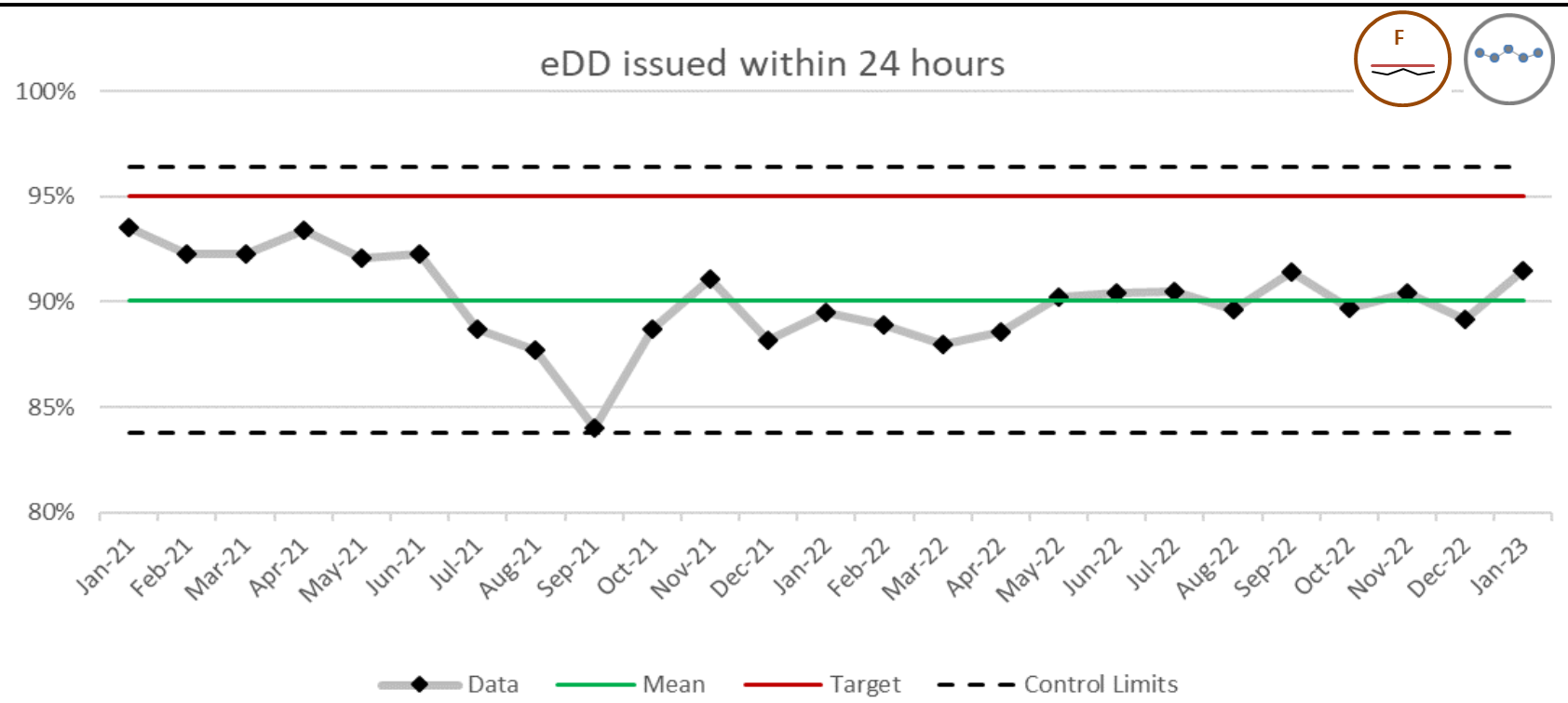

Jan-23
91.50%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 91.50%.

Issues:
Ownership of completion of the EDD remains an issue, including the timely completion.

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

Mitigations:
eDD should be considered by Divisions to include in PRM discussions.

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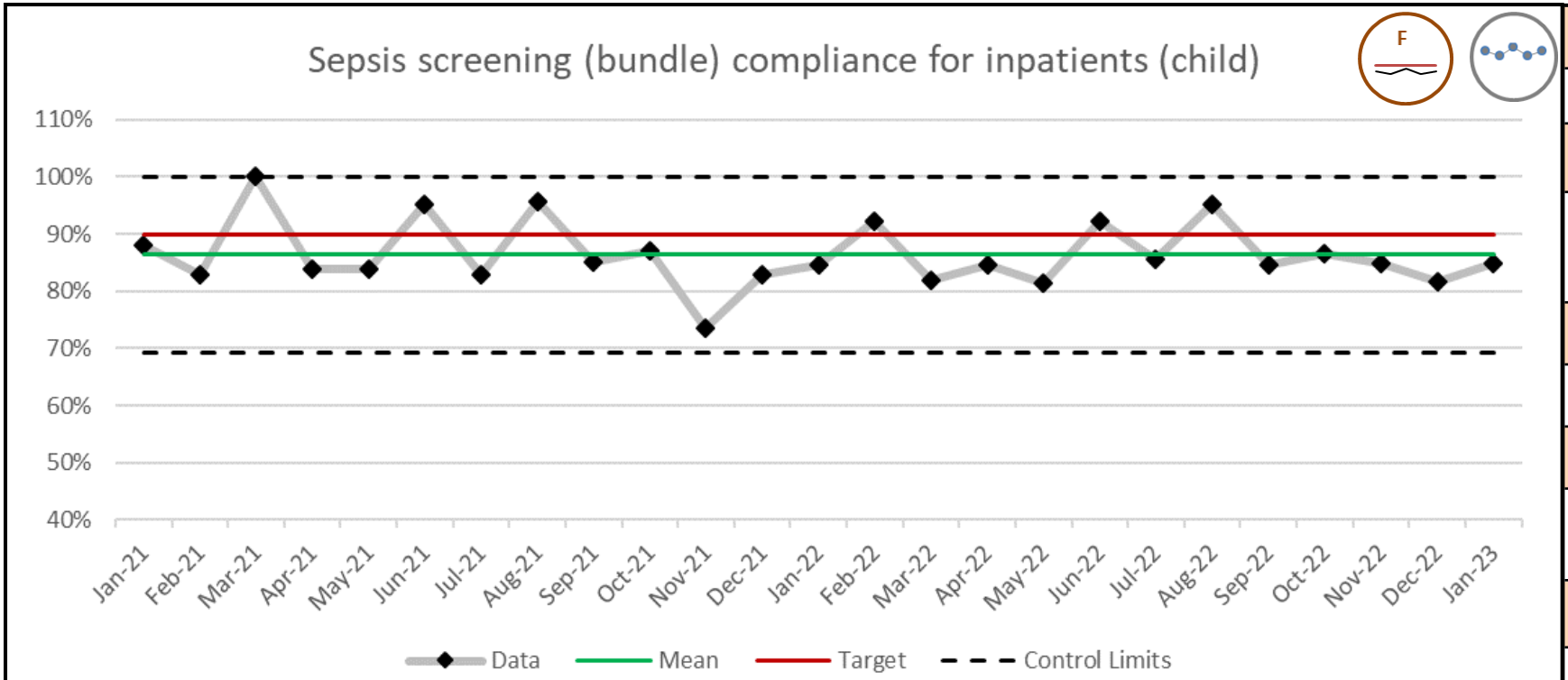

Jan-23
84.8%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The metric for inpatient child screening has failed to achieve the metric at 84.8%
This represents 50 of 59 patients or 9 patients who were not screened within 60 minutes of raised PEWS.

Issues:
All 9 of the missed / delayed screens were children found to have a viral cause for illness.
All 9 of these patients were on one site and one nurse had 3 missed / delayed screens.
No children were delayed in getting any treatment if treatment was required.

Actions:
The paediatric sepsis practitioner has met with the ward Educator and Ward manager to discuss the delays. The Educator is going to do some further training with the one nurse who had 3 missed screens as well as any further staff that would like it. Sepsis Practitioner will support this if required.
Paediatric Sepsis Sim training for ward staff has taken place and there is more planned after the next Drs handover.

Mitigations:
The ward educators are continuing to undertake harm reviews that are relevant to their area. Some of the issues are associated with medical staff and teaching continues for this staff group.
Issues currently discussed at Paediatric Governance as well as in deteriorating patient meetings.

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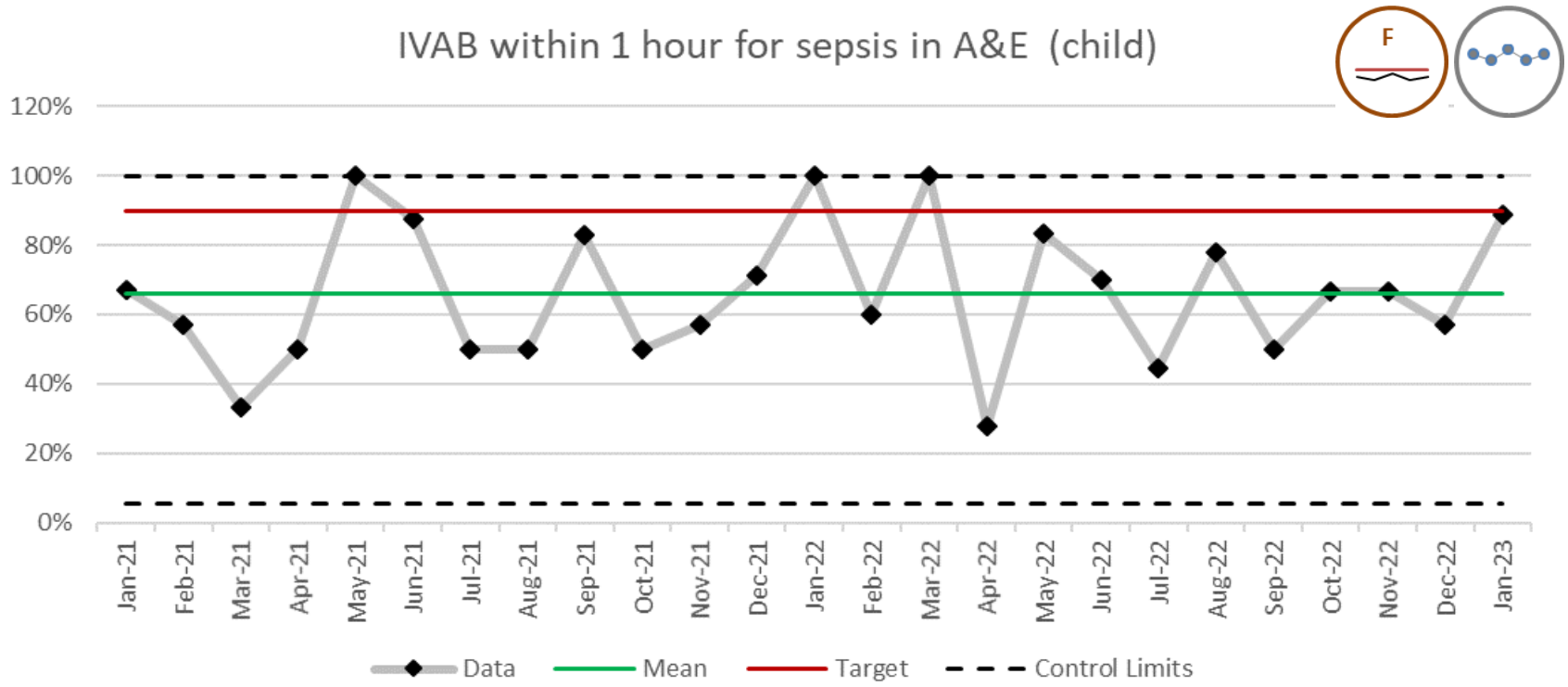

Jan-23
89.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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 88.9%, which is 8 of 9 patients, and is below the 90% target. 1 patients was delayed in receiving antibiotics.

Issues:
There was 1 patients in ED this month that was delayed in receiving antibiotics. This child presented with a cough which was initially thought to be viral. The child was not improving with treatment and further testing showed a chest cause for infection. IV antibiotics were commenced and the child suffered no harm.

Actions:
Sepsis training has been delivered for new Doctors starting in August.
Simulation training has been reintroduced in ED areas with the first one happening in Jan 23.
There will be more training with ED staff about how to fill in/ use the unsure option appropriately.
A new policy has been brought in for Paediatrics to see all children under 3 months of age.

Mitigations:
There are ongoing meetings between the Sepsis team and ED which happen once a month. There appears to be more engagement from ED staff, especially those with a Paediatric interest, which is a positive.
Each area has an identified lead to discuss harm reviews so that they can feedback lessons learnt directly to the staff involved.

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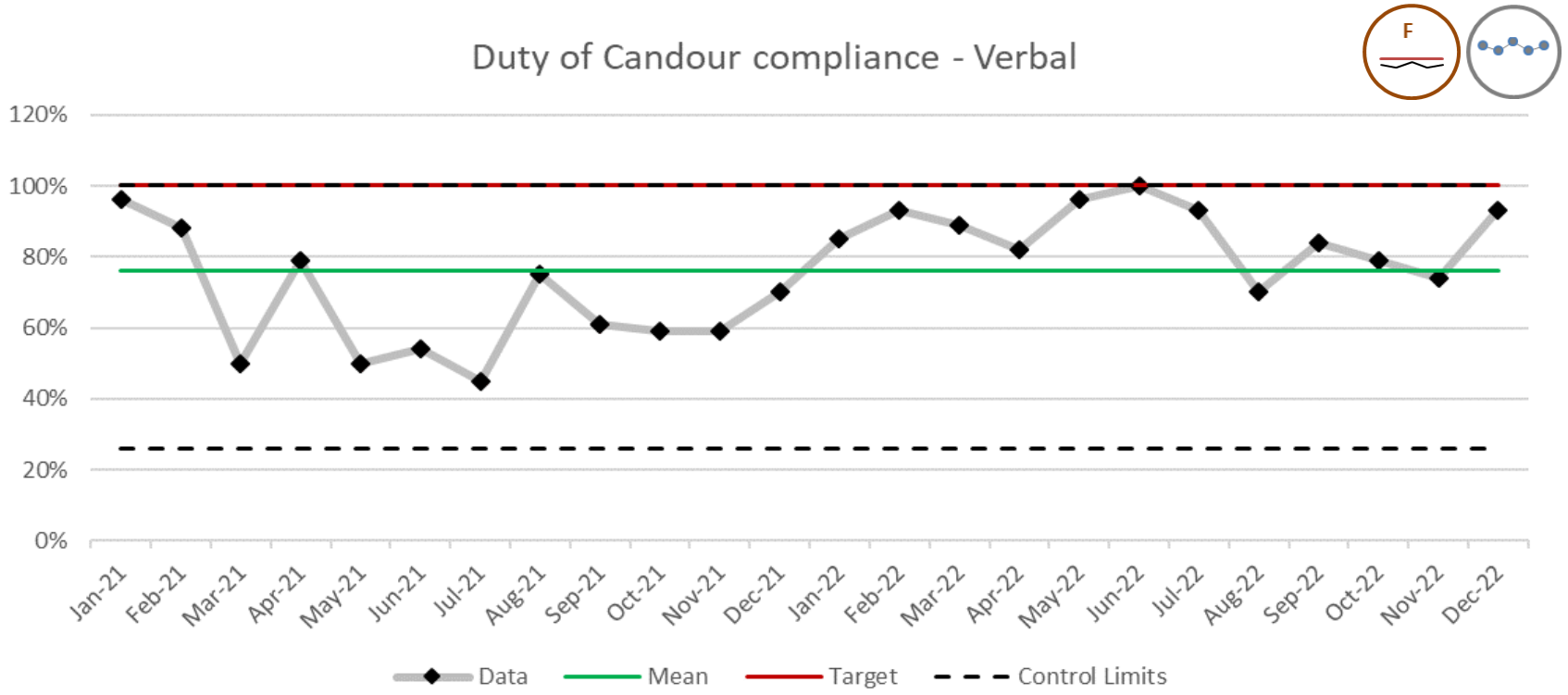

Dec-22
93.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The Trust has not been consistently achieving 100% compliance with Duty of Candour requirements within 1 month of notification.

Issues:
Duty of Candour compliance is measured by extracting patient safety incident data from the Datix system, which may not always be updated promptly.
In addition, the chart above shows compliance within 1 month of an incident being reported. It does not show where Duty of Candour is completed after more than 1 month.

Actions:
Risk & Governance Coordinators are sighted on each day's notifiable incidents and are working closely with the Divisional teams to eliminate the backlog and improve the timeliness of completing Duty of Candour. There is now only 1 case outstanding for verbal Duty of Candour from Jan – Oct 2022.

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

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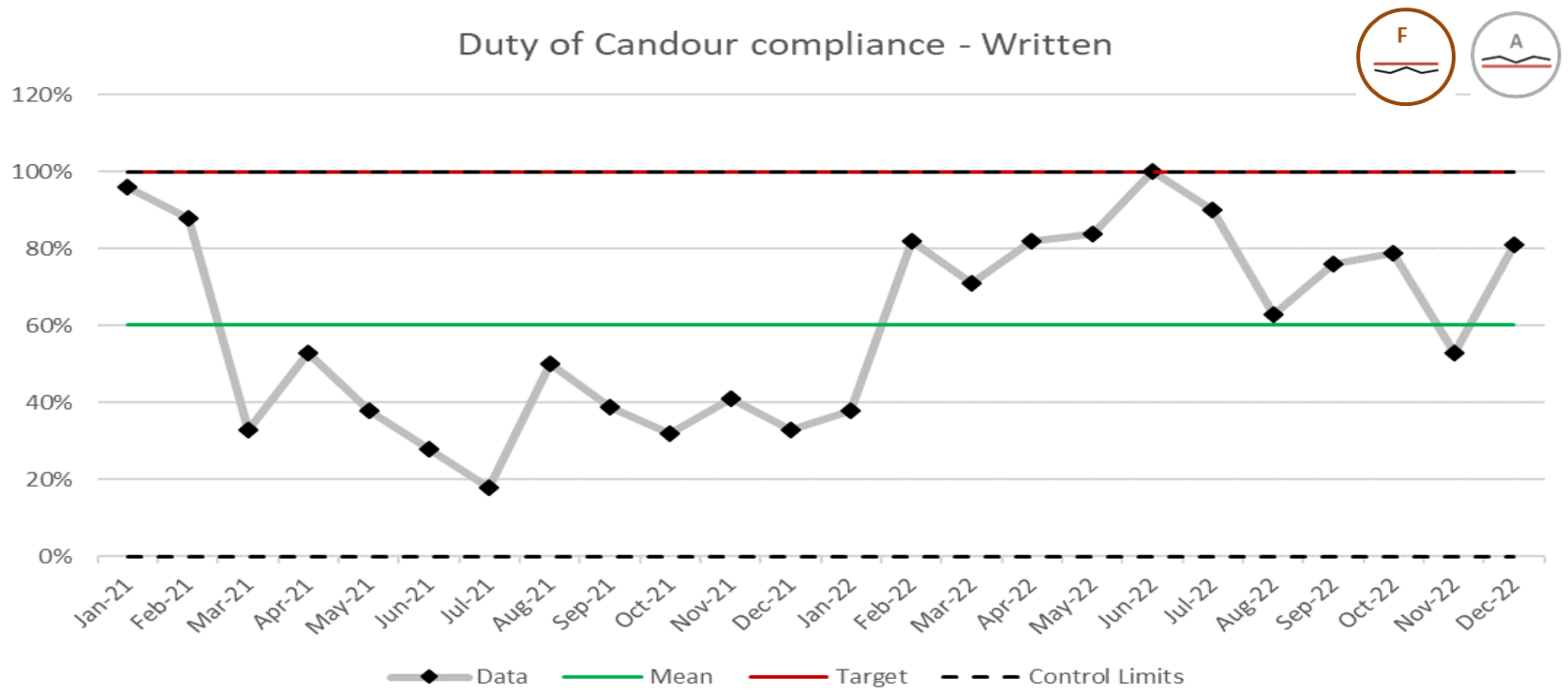

Dec-22
81.00%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The Trust has not been consistently achieving 100% compliance with Duty of Candour requirements within 1 month of notification.

Issues:
Duty of Candour compliance is measured by extracting patient safety incident data from the Datix system, which may not always be updated promptly.
In addition, the chart above shows compliance within 1 month of an incident being reported. It does not show where Duty of Candour is completed after more than 1 month.

Actions:
Risk & Governance Coordinators are sighted on each day's notifiable incidents and are working closely with the Divisional teams to eliminate the backlog and improve the timeliness of completing Duty of Candour.
There are now only 2 cases outstanding for written Duty of Candour from Jan – Oct 2022.

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

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PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Nov-22	Dec-22	Jan-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.39%	0.54%	0.26%	0.31%		F	A	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	60.99%	58.12%	60.67%	60.79%	83.12%	F		
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	560	1034	647	8181	0	F		
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	78.00%	67.63%	77.99%	79.19%	88.50%	F		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	8204	8282		62,758	0	F	H	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	47.67%	46.89%		49.16%	84.10%	F	B	
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	72,281	72,530		n/a	n/a	F	H	
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	46.15%	50.29%		49.58%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	65.29%	61.43%		59.49%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	36.15%	21.51%		25.75%	93.00%	F		
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	92.48%	93.47%		91.01%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	97.40%	95.10%		97.39%	98.00%	F		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	78.79%	86.49%		73.78%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	98.00%	96.81%		96.08%	94.00%	P		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	75.00%	69.23%		67.62%	90.00%	F		

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PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Nov-22	Dec-22	Jan-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	69.67%	74.75%		70.11%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	52.19%	51.42%	55.35%	53.07%	99.00%	F	B	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.64%	1.74%	2.05%	2.17%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	35	37	32	312	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	85.71%	86.52%	88.46%	76.40%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	68.83%	66.29%	67.95%	56.86%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,906	3,614	3,638	3,805	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	494	998	497	791	0	F		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	156	190	162	1,481	100	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.97	2.72	3.52	3.01	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.86	5.14	5.05	5.04	4.5	F		
	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	21,212	22,042	22,664	22,707	4,524	F		
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	33.41%	32.63%	32.60%	35.65%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	44.33%	43.60%	43.47%	37.97%	45.00%	F		

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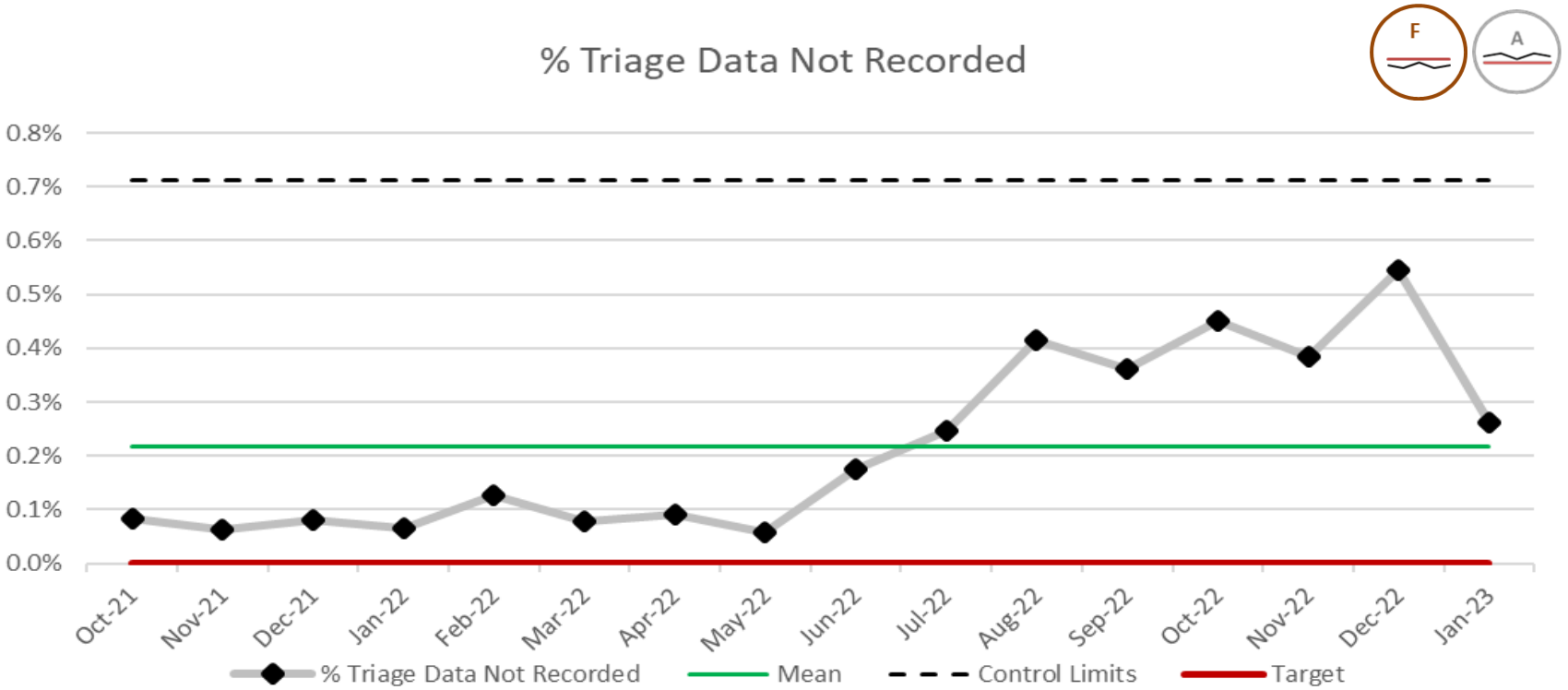

Jan-23
0.26%
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%.
January reported a non-validated position of 0.26% of data not recorded verses December reported validated position of 0.54% data not recorded
This will improve further once validation is complete
This metric is below target.

Issues:

- Recognition of patients that "Did Not Wait". 72.54% of those "triage data not recorded" were due to patients leaving the department prior to triage being conducted.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been less problematic at all three sites.
- Staffing gaps, sickness and skill mix issues

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 but remains problematic.

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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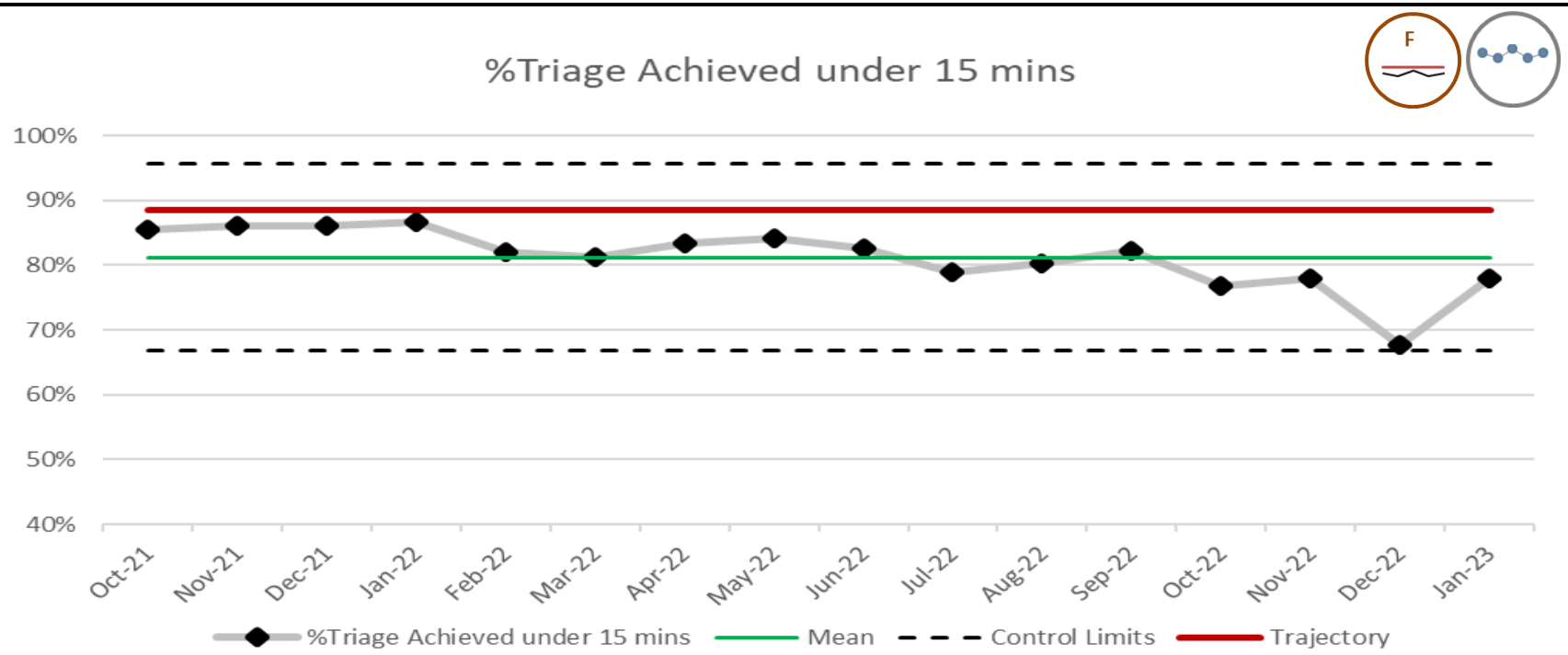

Jan-23
77.99%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of triage achieved under 15 minutes.

What the chart tells us:

The compliance against this target is 88.50%.
December outturn was 77.99% compared to 67.63% in December (validated).
This demonstrates an improvement in performance of 15.31% and a 10.51% 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.
- Increased demand in the Emergency Depts and overcrowding.

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.
The 60-day trail of the revised Full Capacity Protocol will either see improvement of or expose of departmental planning issues.

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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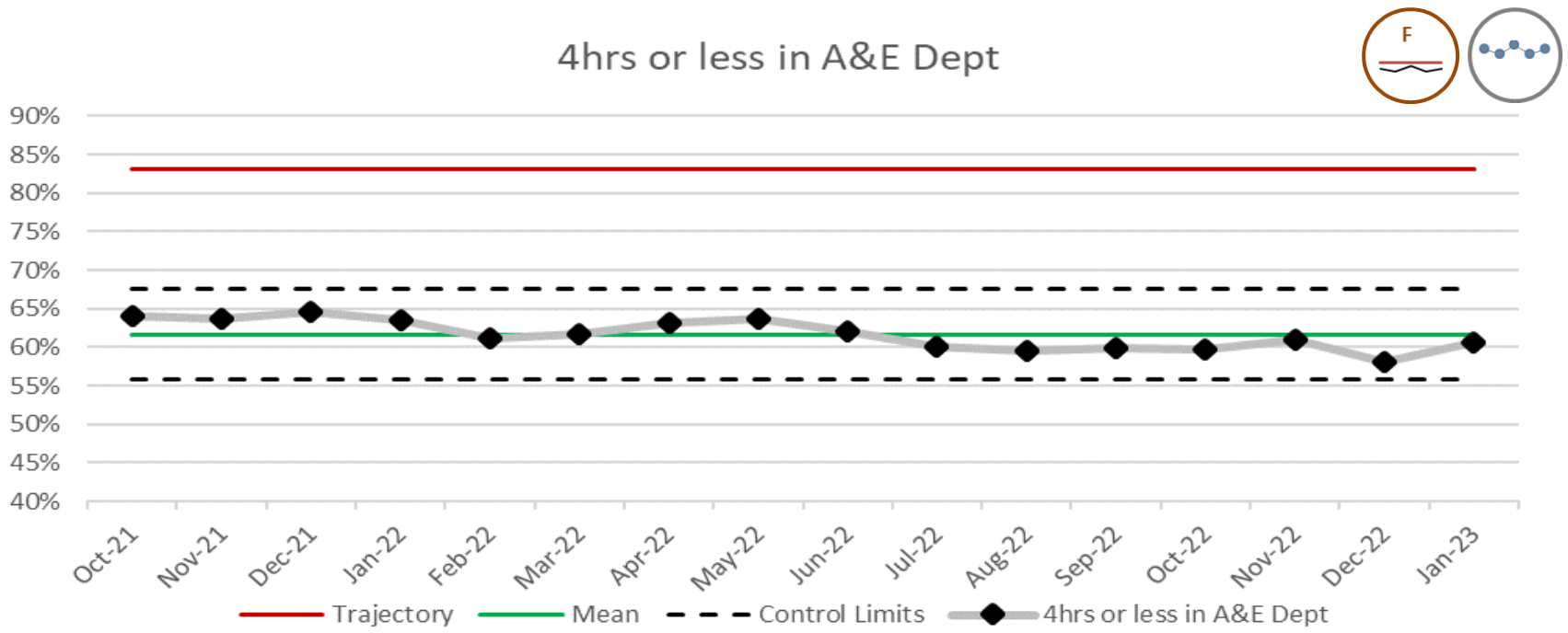

Jan-23
60.67%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

The 4-hour transit target performance for January was 60.67% compared to 58.12% in December, which is an improvement of 2.55%.
The target compliance is 83.12% and is an historic target that has been unchanged in 2 years.

Issues:

Main factor in improvement due to reduction of attendances within the Emergency Departments experienced in January of 1,930 patients compared to December. 17,613 combined attendances (in ED and UTC) compared to 20,521 combined attendances (ED and UTC) in December

Inadequate daily discharges/ early recognition of discharges to meet the admission demand remains the main issue leading to extended ED LOS.
Increased acuity in presentation in the Emergency Departments was observed.
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 was frequent.

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 improvements to increase access pathway 1 (D2A) capacity and the 'Care Closer to Home' programme.
Breaking the Cycle initiative experienced a reduced benefit during December so has been re-launched and daily discharge target have been set for the organisation and marked through the course of the day.

Mitigations:

EMAS continue to enact a targeted admission avoidance process, including no Cat 4 conveyances should arrive at the Emergency Department.
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.

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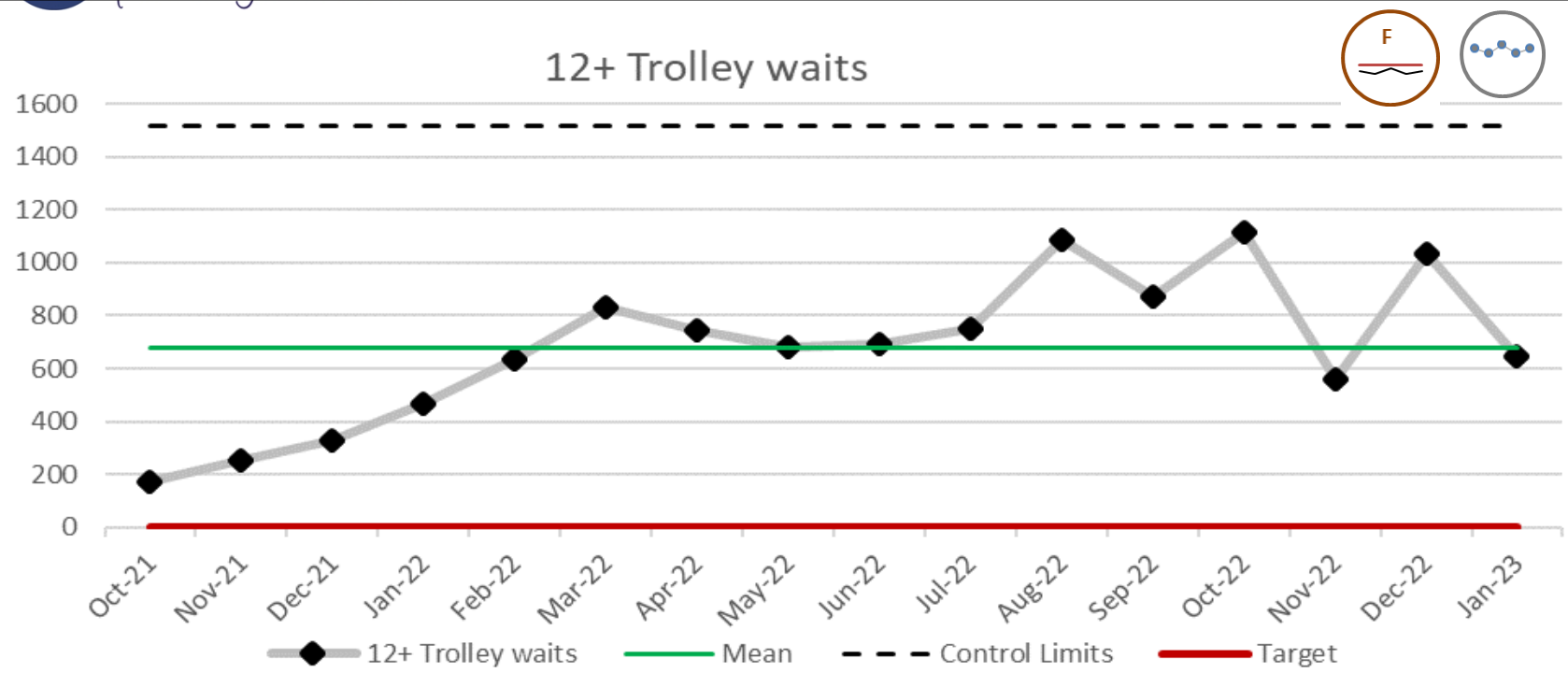


Jan-23
647
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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:

January experienced 647 12-hr trolley wait breaches. This is a decrease of 387 12-hr trolley wait breaches compared to December. This represents an improvement of 37.42%. This equates to 5.2% of all type 1 attendances for January.

What the chart does not explain is the internal decision to move from 12hr DTA to total time in ED to minimise exposure risk.

January saw a reduction.

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.

January has continued to experience increased attendances for respiratory viruses such as RSV, Influenza A and Covid. Which in turn has impacted inpatient areas/availability for beds to be offered timely to ED.

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.

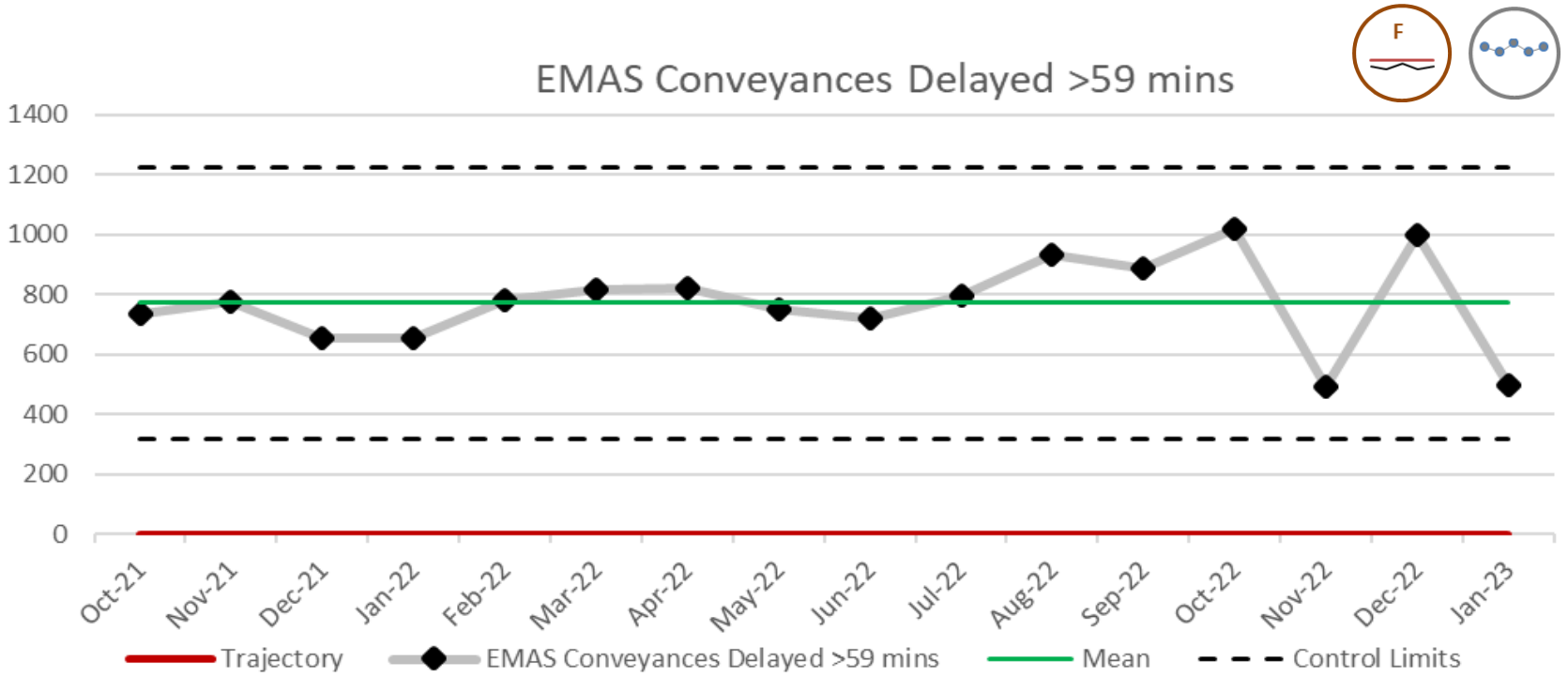
Internal actions on admission avoidance are focussed on Same Day emergency Care and recent developments have shown a 100% increase in some areas when not escalated into.

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.



Jan-23
497
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

January demonstrated a decrease in greater than 59 minutes' handover delays. 497 compared to 998 in December. This represents a 200.8% improvement.
What the chart does not tell us is that the conveyances actually increased in January compared to December – but were able to meet the demand and continue improvement.
January saw 0.66% more conveyances than December.
Also 55% less waiting >4hrs, 53% less waiting >2hrs

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 completely de-escalate due to a number of patients waiting for admission, although this number reduced.
December continued to experience >24hr DTA breaches.

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.
December experienced the enactment of the Rapid Handover Protocol less frequently throughout the day, evening and overnight as direct result of handover delays.

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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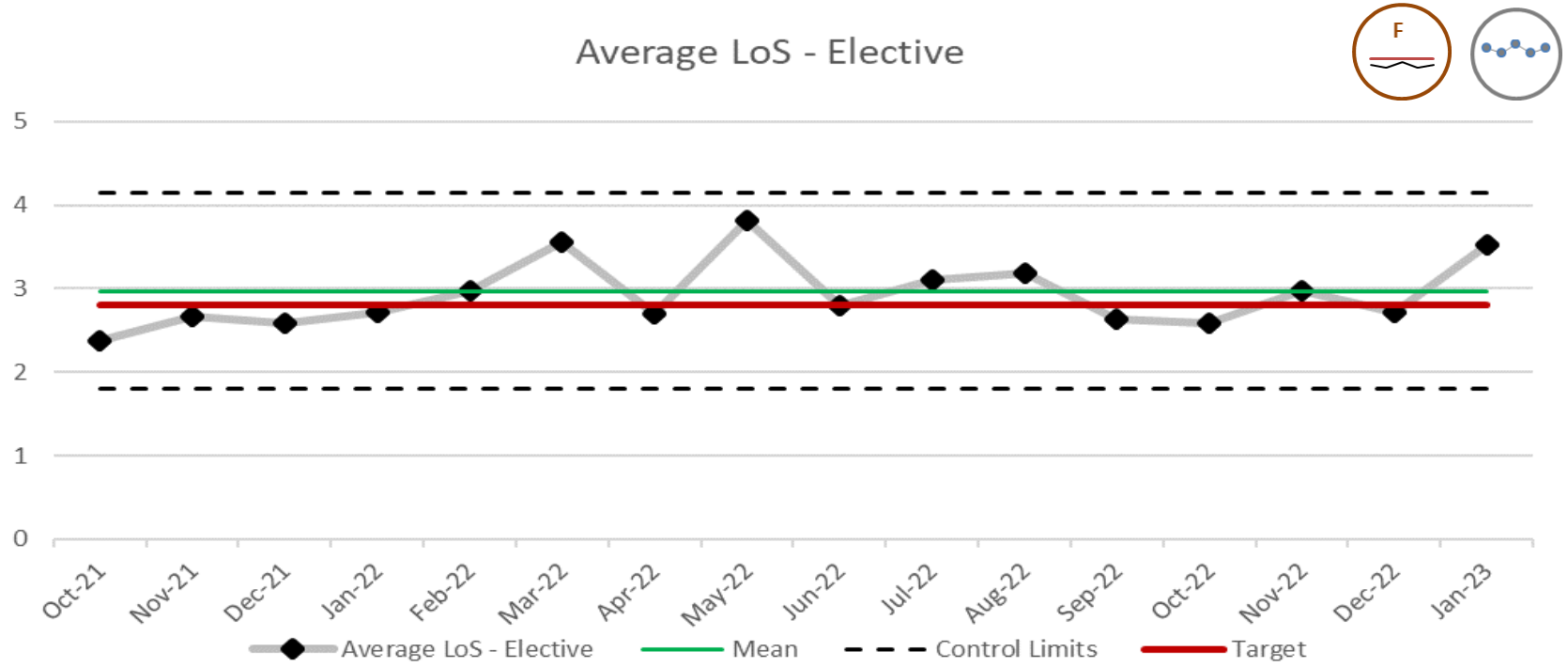

Jan-23
3.52
Variance Type
Metric is currently experiencing Common Cause Variation
Target
2.80
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for Elective inpatients.

What the chart tells us:
The average LOS for Elective stay has increased from 2.72 days in December to 3.52 days in January. This is an increase of 0.8 days and represents a negative variance of 0.72 days against the agreed target.
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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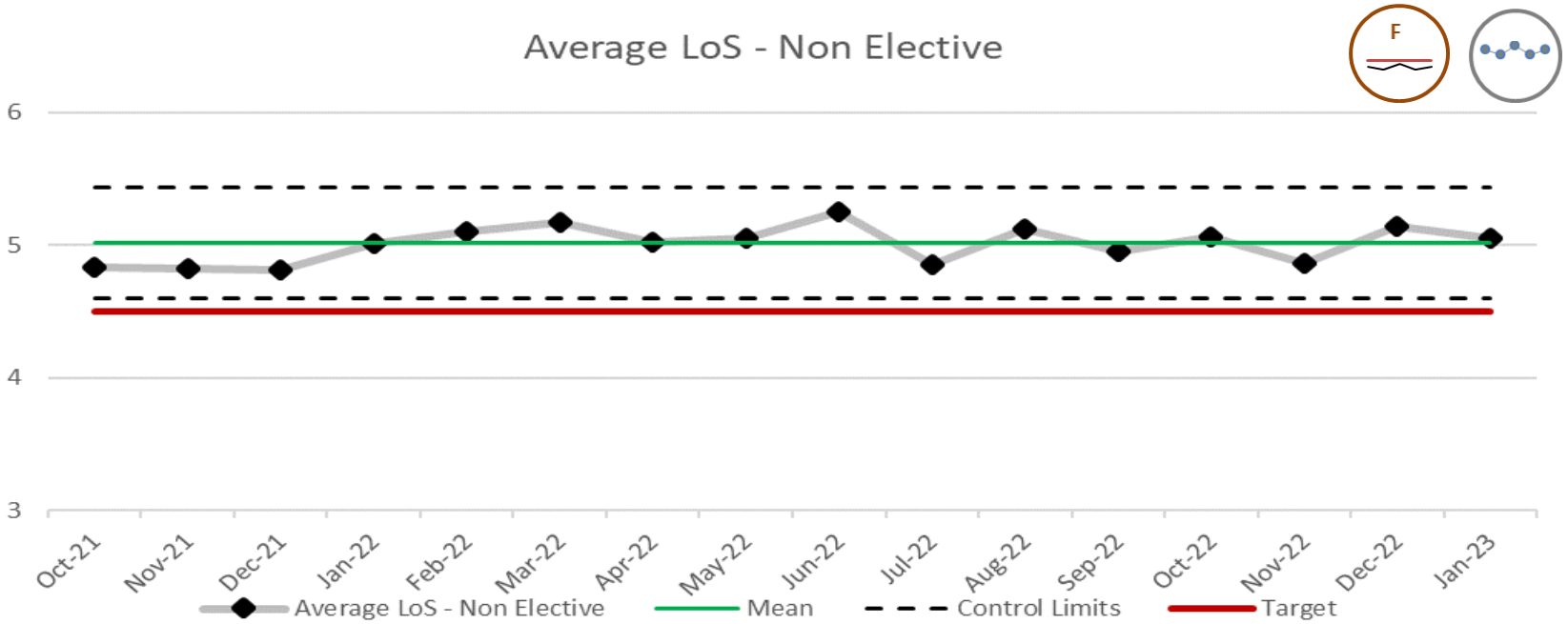


Jan-23
5.05
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for non-Elective inpatients.

What the chart tells us:

The agreed target is 4.5 days verses the actual of 5.05 days in January vs 5.14 days in December.
This is a decrease of 0.09 days and a 0.55-days negative variance against the agreed target.
What the chart doesn't tell us is that the improvement has shown most within Pathway 3 by 6.17days less compared to December 22. Pathway 1 also has reduced by 0.58%

Issues:

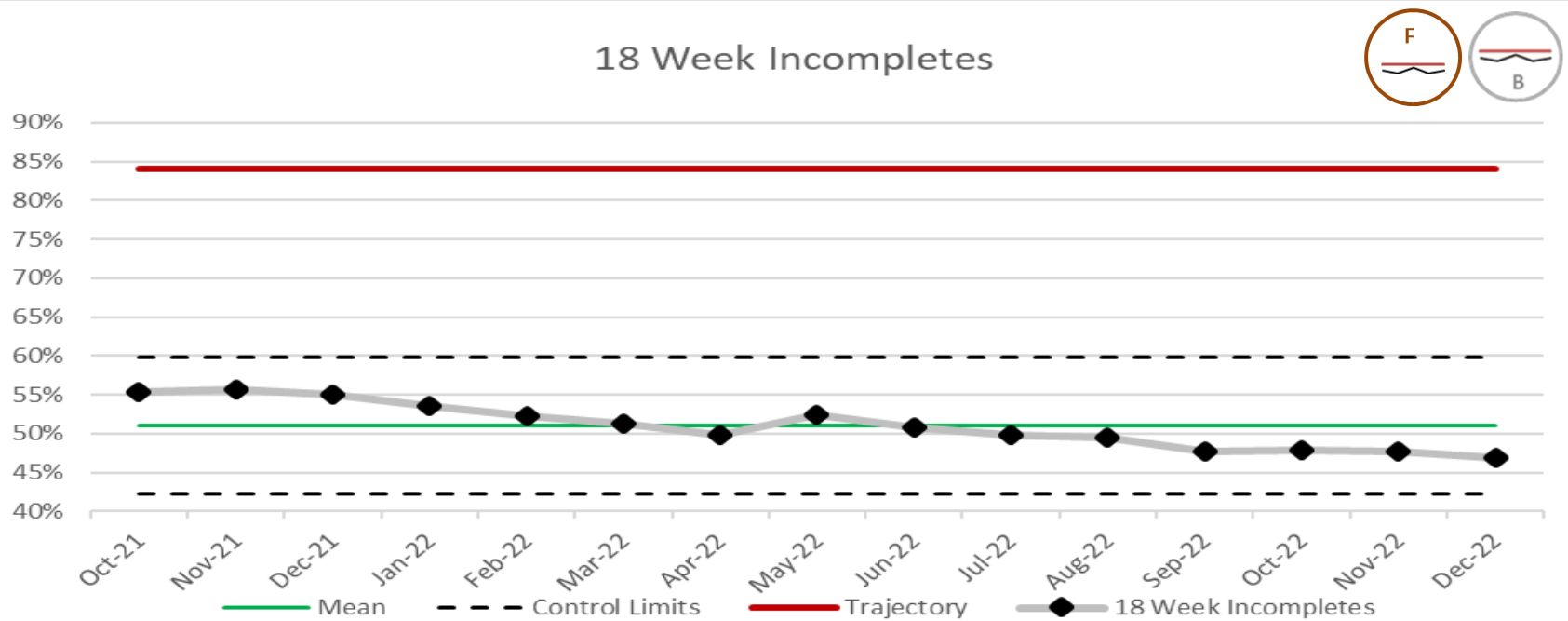
Super –stranded patients has seen a reduction from Decembers 146 to January 137. However Stranded patients continues to remain high since November 22.
Increasing length of stay of all pathways 1-3. The most significant increase in volume of bed days is Pathway 1
Domiciliary care but since the advent of the joint D2A process and additional funding benefits are being realised slowly but there remains insufficient capacity to meet the increasing demand.
The Transfer of Care Hub continue to gain 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 alongside RSV and Influenza cases requiring a longer length of stay and increased 'contact' patients leading to delayed discharge has also impacted on an increased length of stay.

Actions:

These actions are repetitive but still appropriate
Focused discharge profile through daily escalations.
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
The move to Lateral Flow Testing as opposed to PCR testing for access to onward non acute care is proving beneficial once Community and social care is 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 fully 0 patients who do not meeting the reason to reside.
A new approach to SAFER and P0 discharges is being considered via URIG
Breaking the Cycle implementation and refocus.

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.



Dec-22
46.89%
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. December saw RTT performance of 46.89% against a 92% target, which is 0.77% down from November.

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 – 5887 (increased by 93)
- Gastroenterology – 3901 (increased by 16)
- Dermatology – 3256 (decreased by 41)
- Respiratory Medicine – 2759 (decreased by 22)
- General Surgery – 2674 (increased by 46).

Actions:

Priority remains focussed on clinically urgent and Cancer patients. National focus has now turned to patients that are over 78 weeks with the target to be at zero by March 2023. Resource is now targeted at patients >65weeks as these have the potential to be >78 weeks in March 2023. Recent schemes to address backlog include;

- Validation programme
- Outpatient utilisation
- Tertiary capacity
- Outsourcing/Insourcing
- Use of ISPs
- Missing Outcomes

Mitigations:

Improvement programmes established to support delivery of actions and maintain focus on recovery.
HVLC/Theatre Productivity – To ensure best use of theatres and compliance with HVLC procedures and starting 16th January, the Theatres Super Sprint project to increase day case activity and reduce late starts.
ORIG – To ensure Outpatients are fully utilised and efficiency schemes are implemented and well used. Focus on capturing all activity
Clinical prioritisation – Focusing on clinical priority of patients using theatres.

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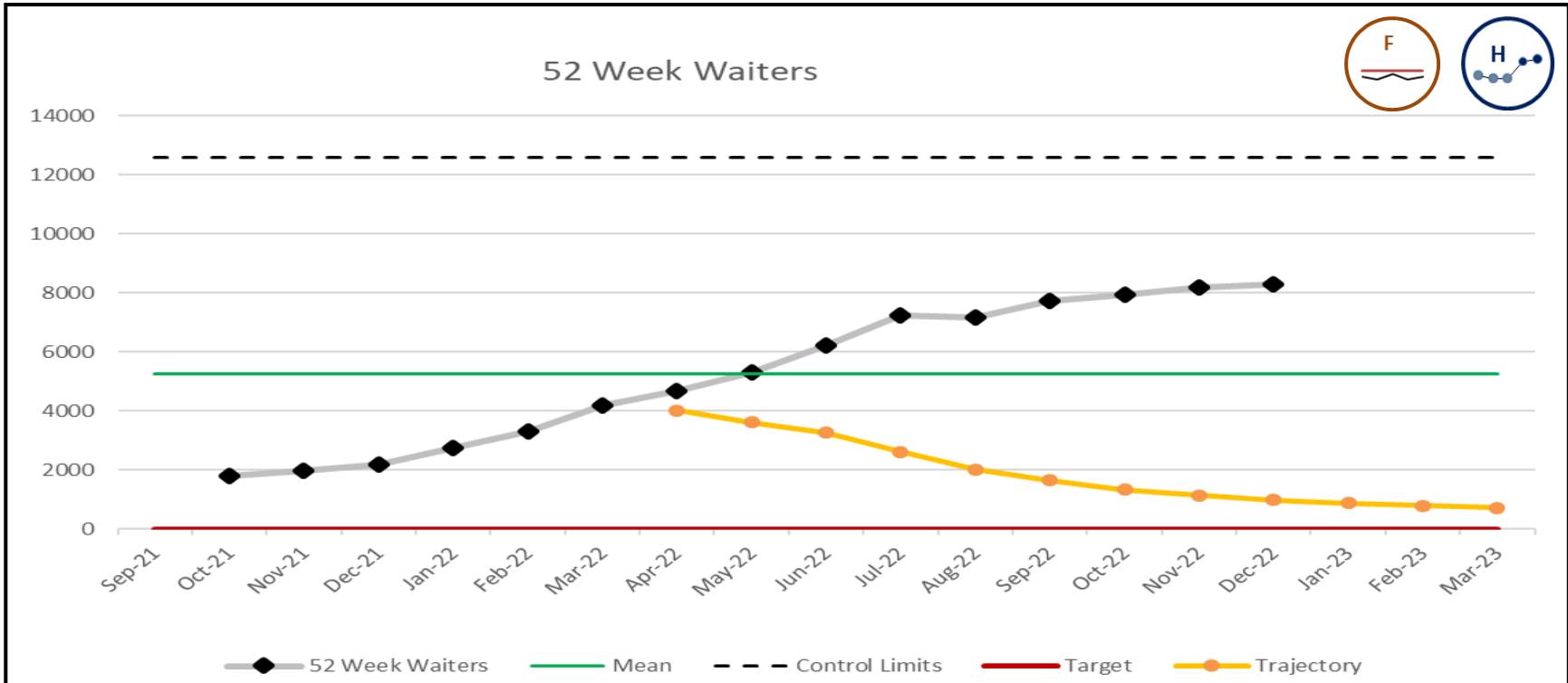

Dec-22
8282
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 8,282 incomplete 52-week breaches for December, an increase of 78 from November.

Issues:
Whilst ULHT's position is strong with 104 week wait patients, with a zero return, performance is less assured with 52 week waiters. Both admitted and non-admitted patients sit within this backlog, however, the most significant pressure remains in the non-admitted pathways.

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through the PTL meeting with emphasis on longest waiters. The intention is to drive down the wait bands discussed. This is successful with admitted patients, however it is making slow progress with non-admitted patients in some specialties, due to the high volume of patients in this wait bracket.

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

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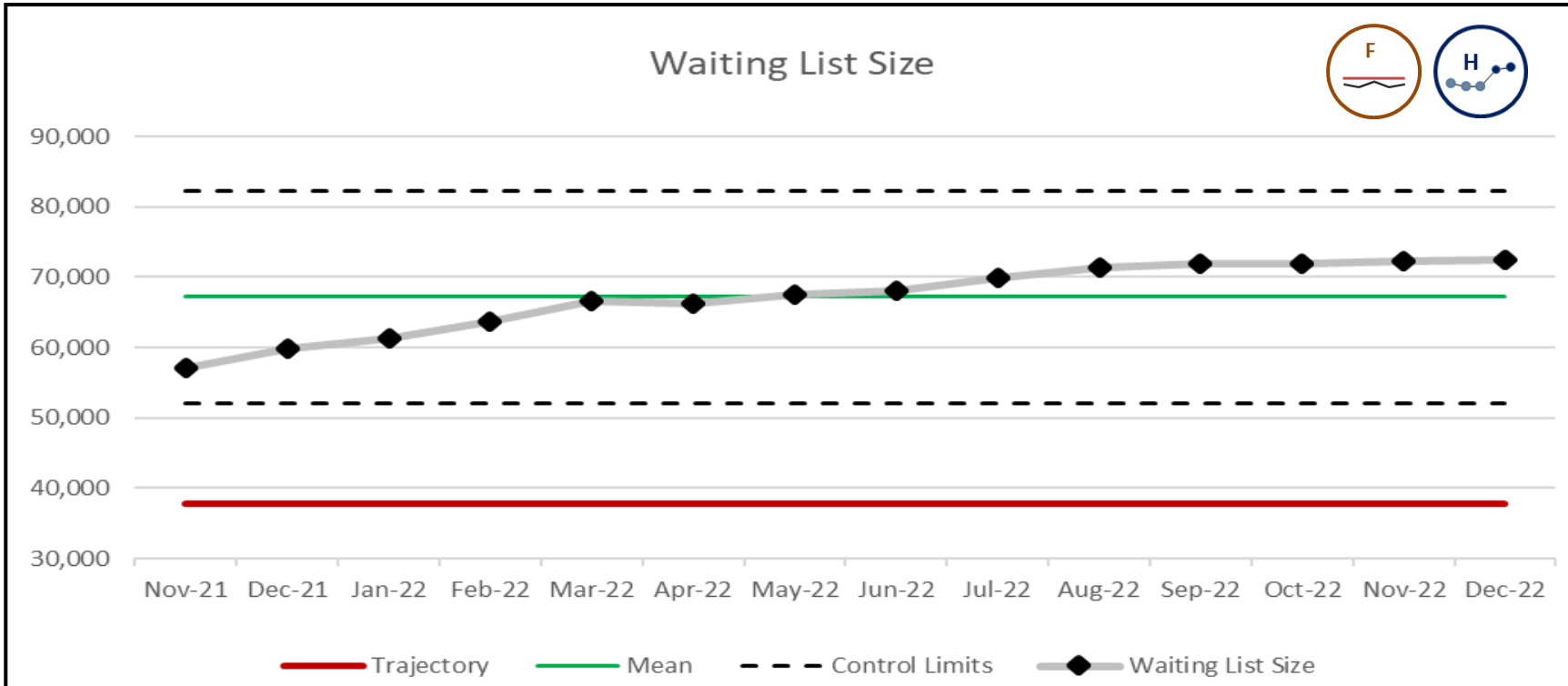

Dec-22
72,530
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has increased from November, with December showing an increase of 249 to 72,530
This is more than double the pre-pandemic level reported in January 2020.

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

- ENT – 8816
- Ophthalmology – 6144
- Gastroenterology – 6032
- Dermatology – 5193
- Gynaecology - 5157

Actions
Improvement programmes as described above for RTT performance. In addition, all patients >52 weeks are monitored weekly by the Trusts RTT team. Validation programme due to start, with phase 1 being technical validation of pathways; followed by phase 2 being an administrative review, involving contacting patients to review the need for treatment.

Mitigations:
Patients 78w+ are monitored and discussed at a weekly PTL meeting.
Transferring of appropriate admitted patients to ISP's continues. Non admitted patients in the most pressured specialities continue to be transferred out to ISP's or insourced, with an established process for this now in place for several specialties.

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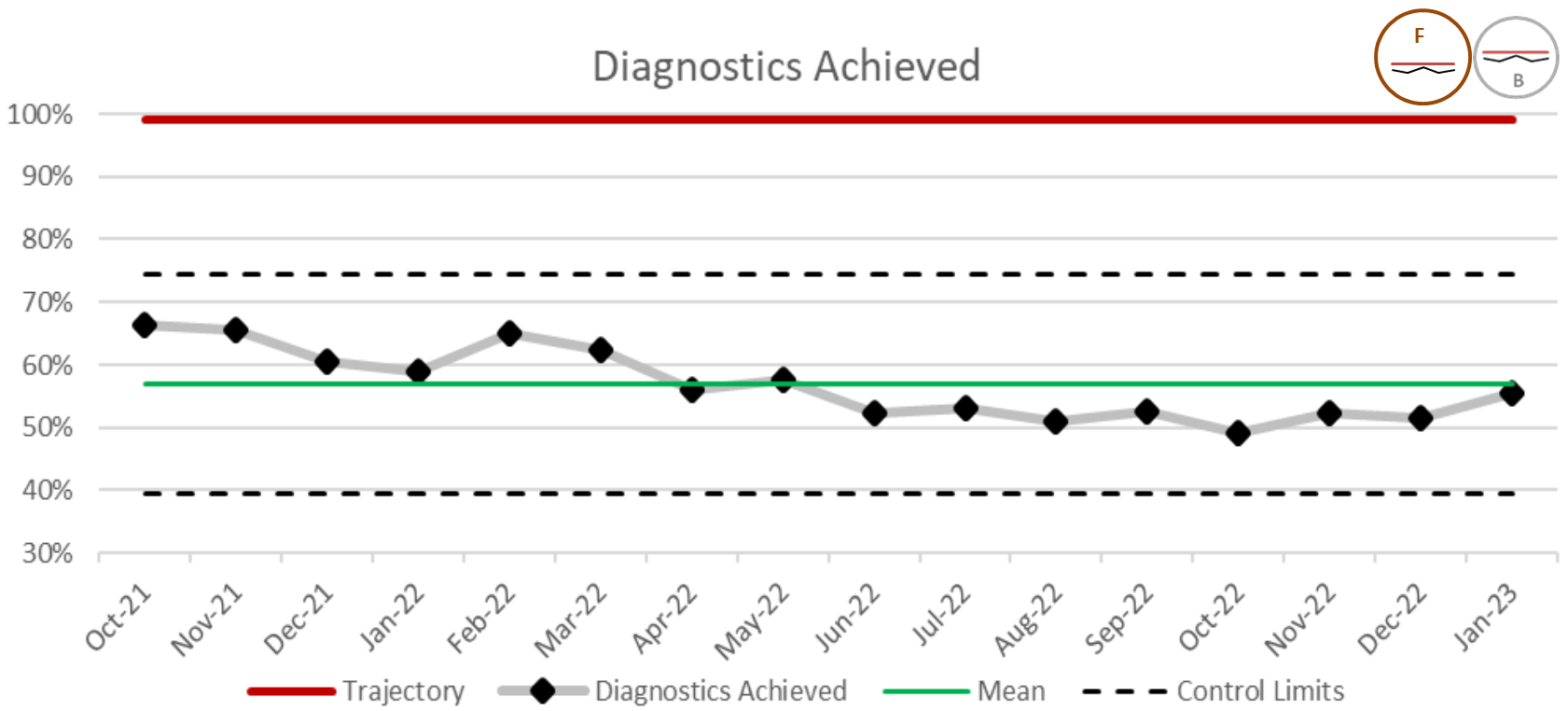


Jan-23
55.35%
Variance Type
Metric is currently experiencing Special Cause Variation – below the trend
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

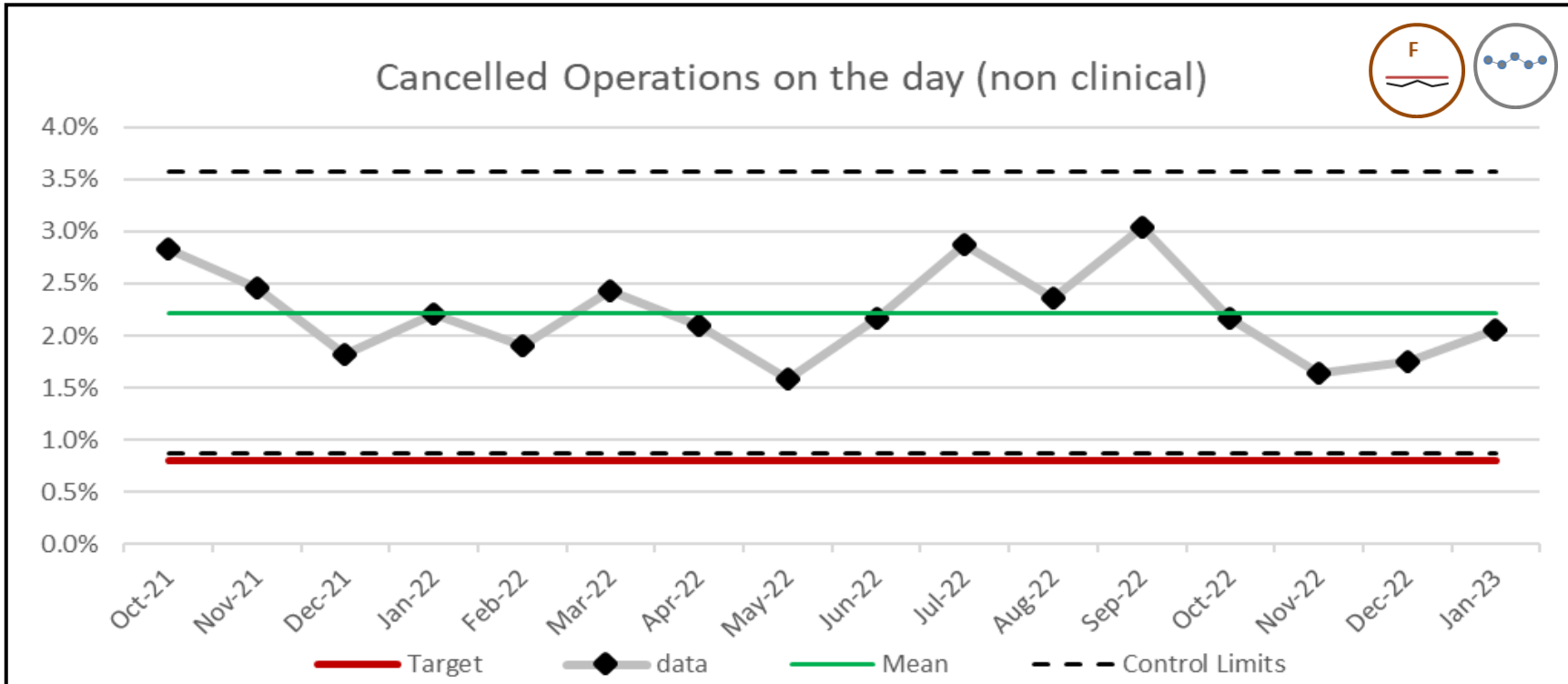
Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 55.35% against the 99.00% target.

Issues:
The majority of diagnostic breaches sit in Cardiac Echo with 6025 breaches recorded in January 2023.
MRI has 1519 breaches. Additional outsourcing to help reduce the backlog from January 2023 hopefully reducing breaches to within limits by April
There are 1313 Dexa Breaches as the scanner is not up and running we should see a reduction of around 400 breaches each month
We are now seeing Breaches in Endoscopy due to the increase in demand from the Colorectal pathway.

Actions:
Where demand out strips capacity additional resource is being sort. All areas have completed a recovery trajectory to NHSE. Additional list are being undertaken for Cardiac echo and a reduction should be seen in the backlog going forward. MRI has additional outsourcing from January. Dexa should see 250 reduction each month as now up and running. Expecting a big reduction in March DMO1 as additional sessions placed.

Mitigations:
All waiting lists are being monitored. 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.



Jan-23
2.05%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us
There was an increase of patients cancelled on the day from to 1.74% in December to 2.05% in January and this remains above the agreed trajectory of 0.8%

Issues:
The top 3 reasons for same day non-clinical theatre cancellations for January have been identified as:

- No surgeon
- Patient DNA'd
- Lack of time

Actions:
The Super Sprint started on 16th January and one focus is the NiNE approach (Needle In at Nine Everytime) which has shown a reduction in the number of patients being cancelled due to lack of time from 17 in December to 9 in January.
A text reminder service is currently in design with IT colleagues in order to reduce the number of DNAs.

Mitigations:
Short notice surgeon sickness played a significant part in on the day cancellations across all theatres has had a significant impact on cancellations on the day.

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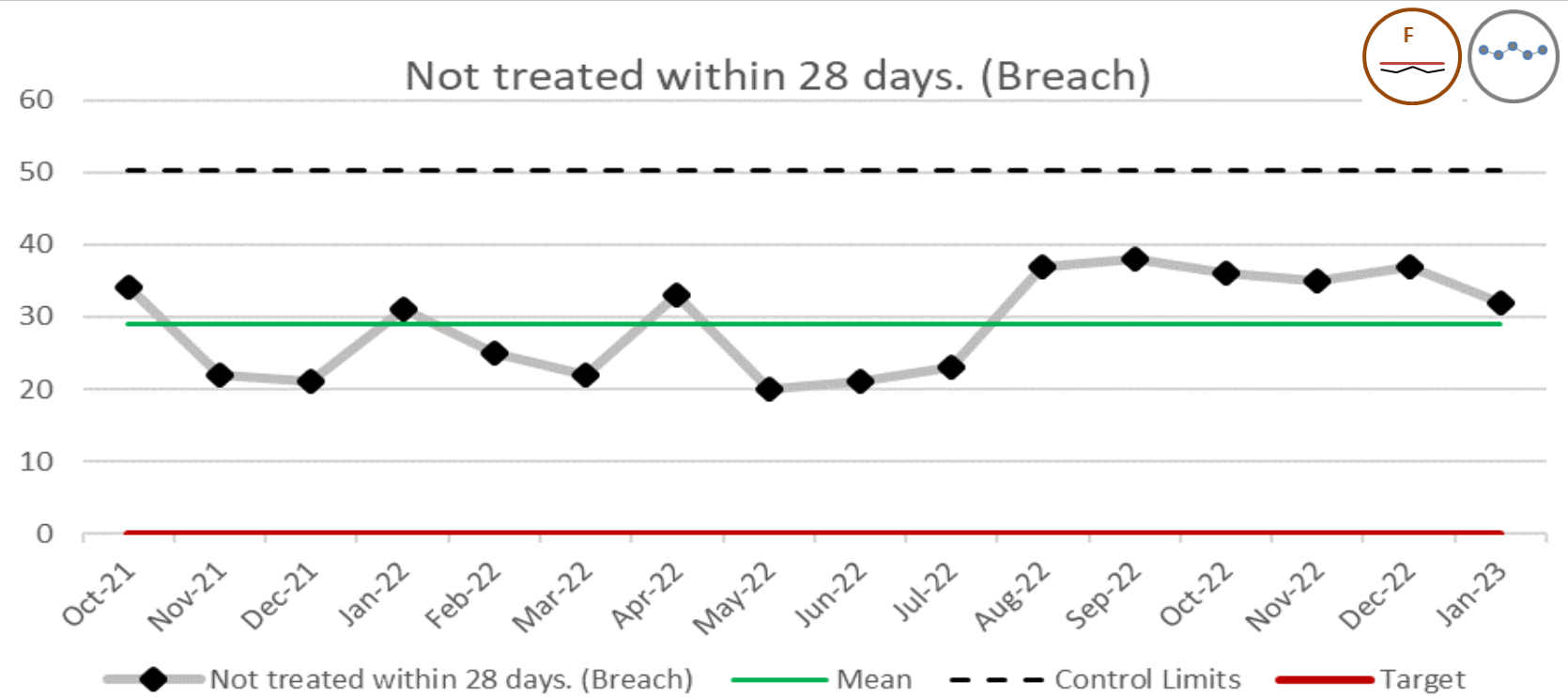

Jan-23
32
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
This chart shows the number of breaches during January 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 January is 32, which is a decrease of 5 from December, though the agreed target of zero has not been achieved.

Issues:
Some general surgery lists have been closed during January to concentrate on non-admitted activity. This has reduced availability of lists for cancelled on the day patients.

Actions:
Waiting List teams continue to ensure planned list activity is at a minimum of 90%.

CBUs are reminded, during job planning, to identify lists that can be relocated to Grantham and Louth to ensure full utilisation of the new theatres. These sites record no cancellations due to site pressures.

Mitigations:
The ongoing bed pressures at the larger sites means reduced capacity for inpatient activity.

The Super Sprint work has meant more focus on list utilisation and therefore this has supported ensuring lists are fuller, providing ability to reduce breaches.

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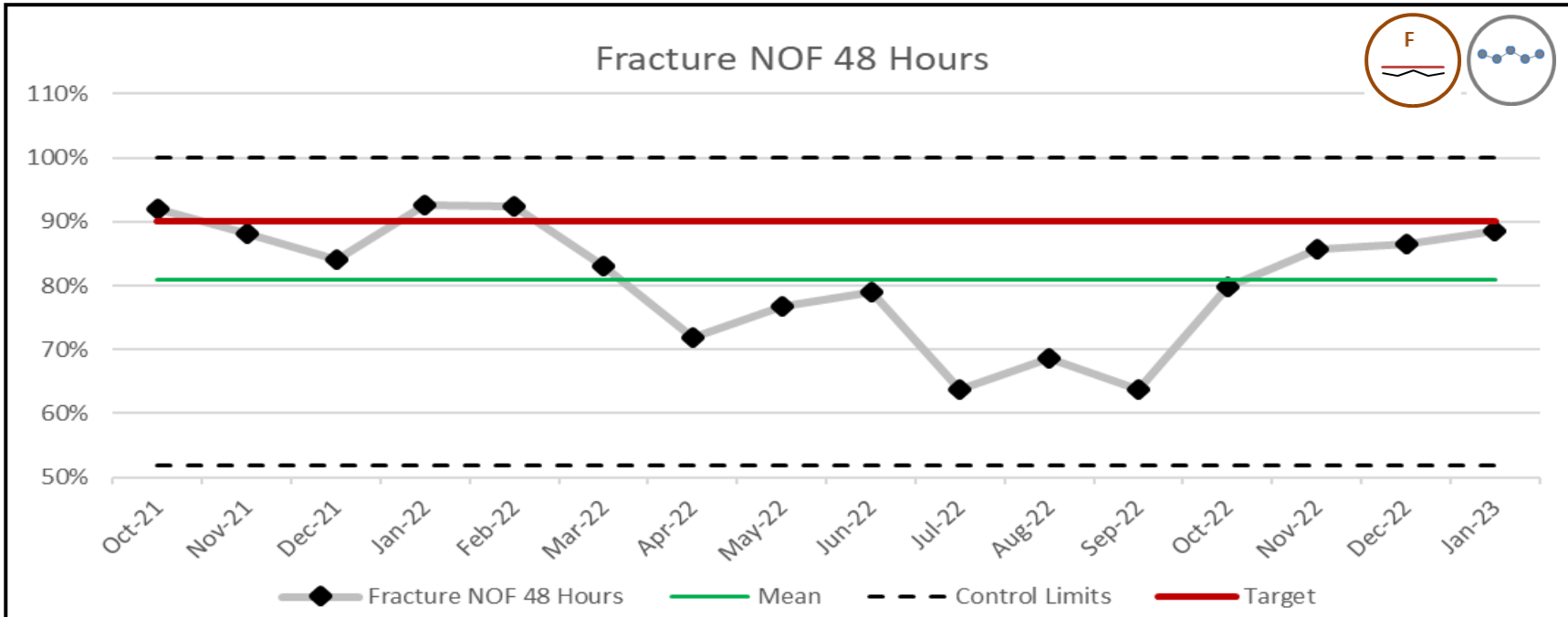

Jan-23
88.46%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

January performance out turned at 88.46% against the agreed target of 90%. This is an improvement on December's position

LCH Site underperformed at 87.18% and PHB at 89.74%.

Issues:

Increase in trauma demand over recent months.
High vacancy rate in theatres and anaesthetic sickness has severe impact on 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 for large cases.
Reduction in specialty trauma lists on Boston and Lincoln sites.

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 peaks in activity seen (adding trauma to elective lists)
'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 cases.
Additional trauma and reduction of electives over winter months to ensure optimal trauma flow.
Current involvement with LCHS in T&F Group for improving outcomes, particularly neck of femur length of stay.
Review of additional trauma lists through job planning process

Mitigations:

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

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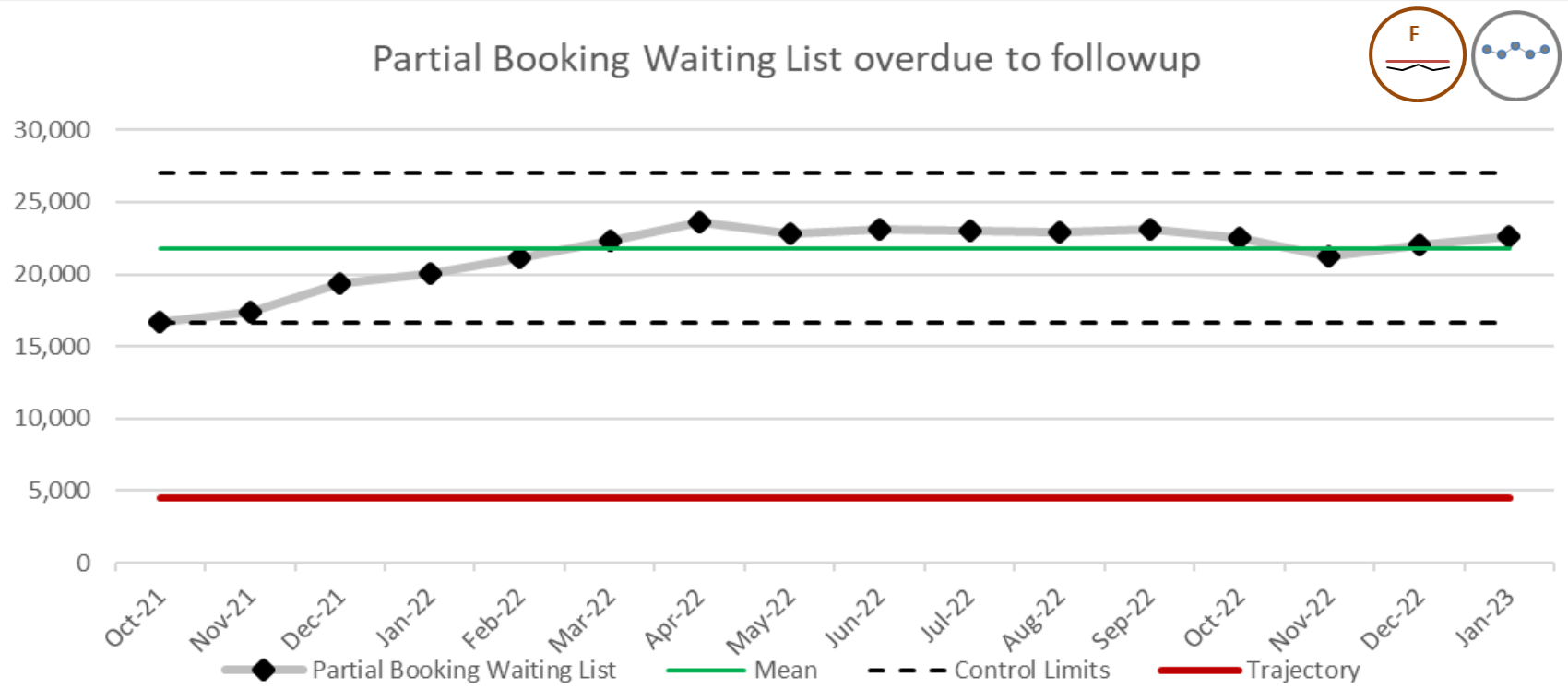

Jan-23
22,664
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 22,664 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased and has continuously increased until April 2022. Since then the PBWL has remained reasonably stable with small decreases / increases per month.

Issues:
The organisation is continually pressured in a number of areas especially in urgent / emergency care, requiring patient flow to be prioritised. Activity is reduced against pre-covid activity levels with resources being the main driver to the reduced activity.

Actions:
PBWL meeting will be relaunched in February with a new agenda and template to improve attendance and focus with PBWL.
PIFU implementation has been refreshed and will be rolled out to the relevant specialties.
Personalised Outpatient Plan is still being worked on to maximise validation, clinical triage, and technological solutions.
Discussions ongoing with external validators to start reviewing outpatient's waiting lists and the booking prioritisation of patients.

Mitigations:
Outpatients support organisational priorities in ED and urgent care cancelling outpatient clinics when required. The priority has been to ensure patients waiting in the over 78 week cohort get an appointment and are seen ASAP.

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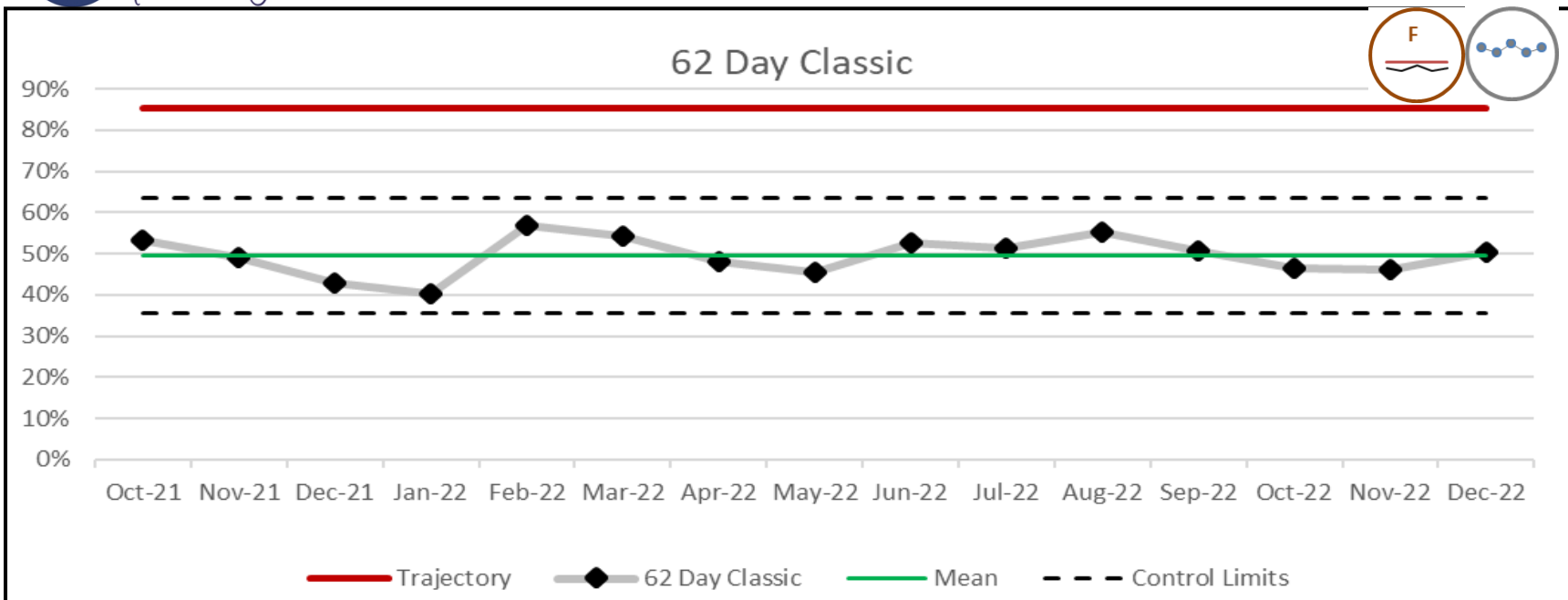


Dec-22
50.29%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

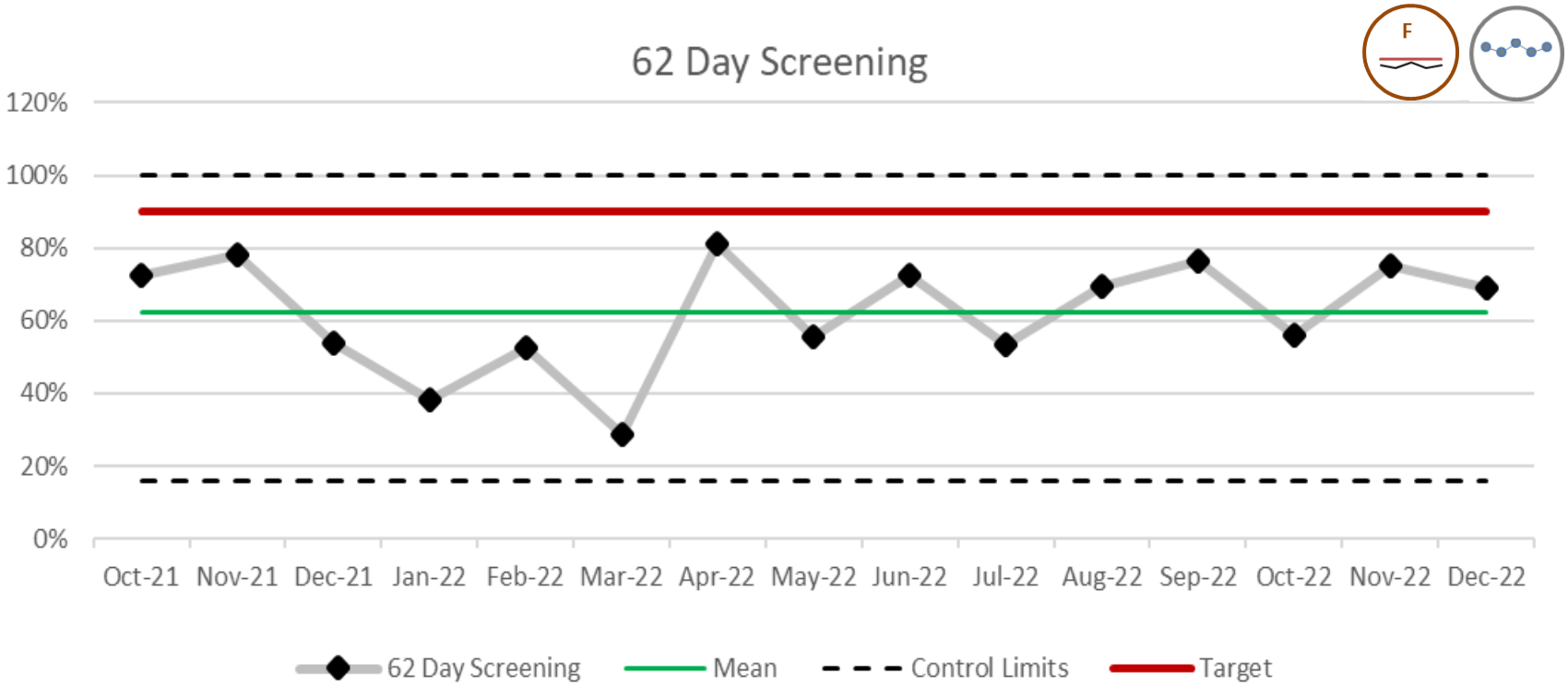
What the chart tells us:
We are currently at 50.29% against an 85.4% target.

Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Gynaecology and Lung.
Limited theatre capacity continues to impact cancer pathways across the Trust. Anaesthetic assessment capacity is also limited and impacts the ability to be able to populate lists at short notice.

Actions:
Recruitment is ongoing to secure locum, NHS locum or substantive post. 3 Medical Oncologist posts are out to advert as locums. A 6 month Oncology SpDr post went out to advert from which we have 2 appointable candidates. Confirmation as to whether both can be appointed is awaited.
Theatre capacity is improving and will be further alleviated now that the new theatres have opened at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.
Please also see Actions on accompanying pages

Mitigations:
A process is now in place 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.

Please also see Mitigations on accompanying pages



Dec-22
69.23%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

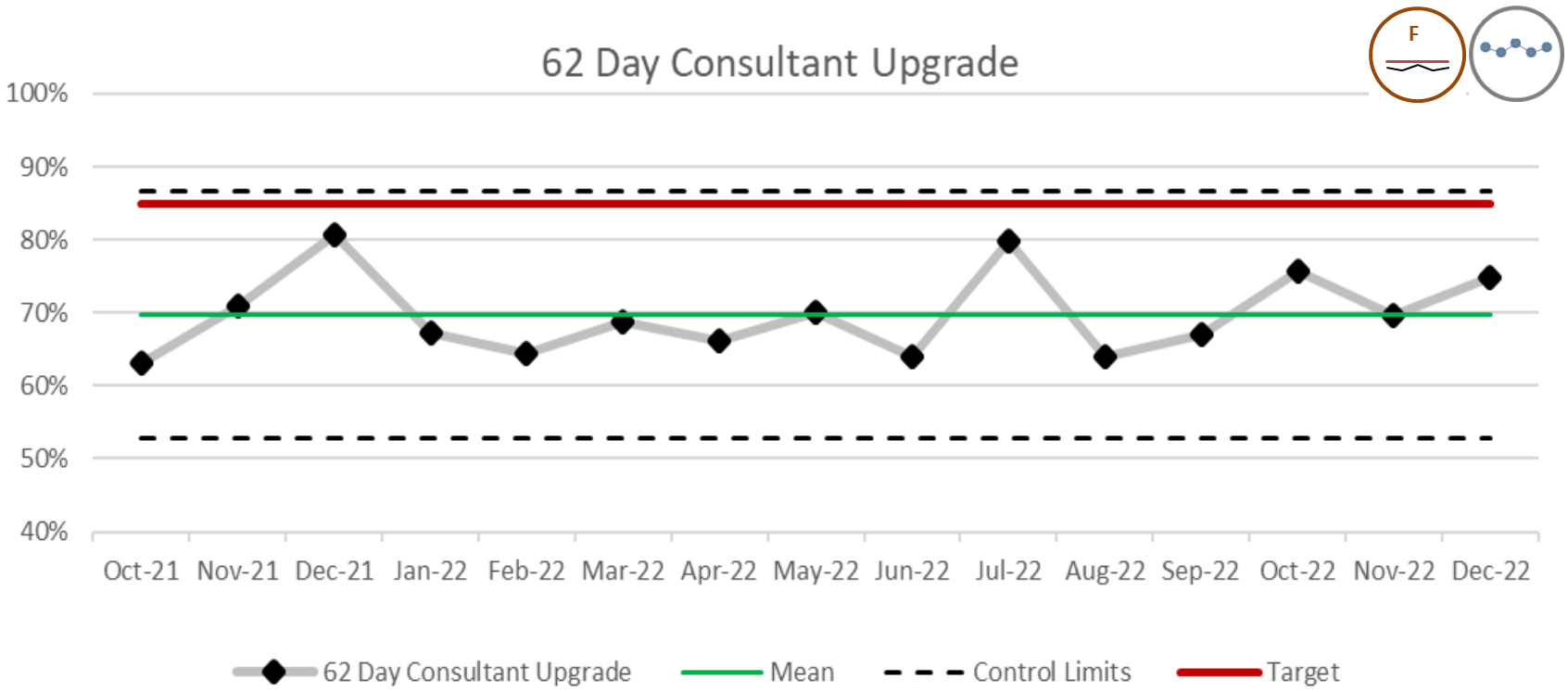
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 69.23% 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.



Dec-22
74.75%
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 74.75% 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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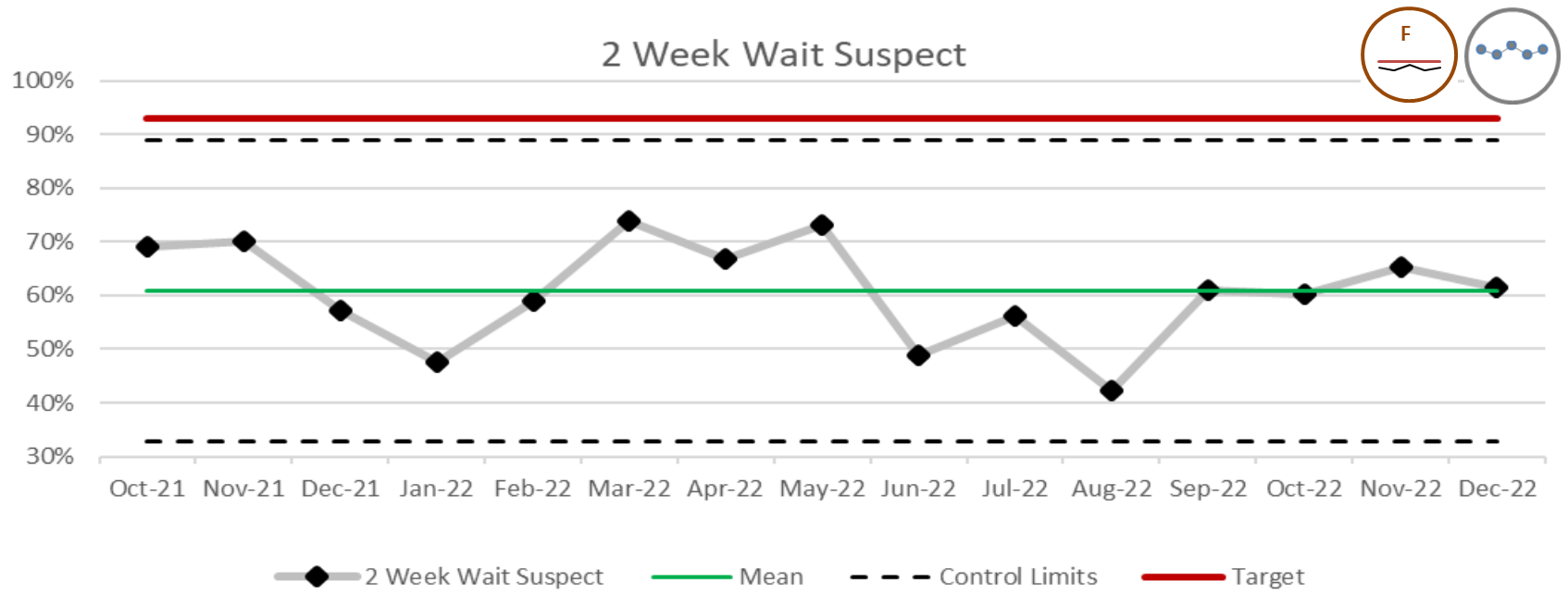
NHS United Lincolnshire Hospitals NHS Trust



Dec-22
61.43%
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 61.43% against a 93% target.

Issues:

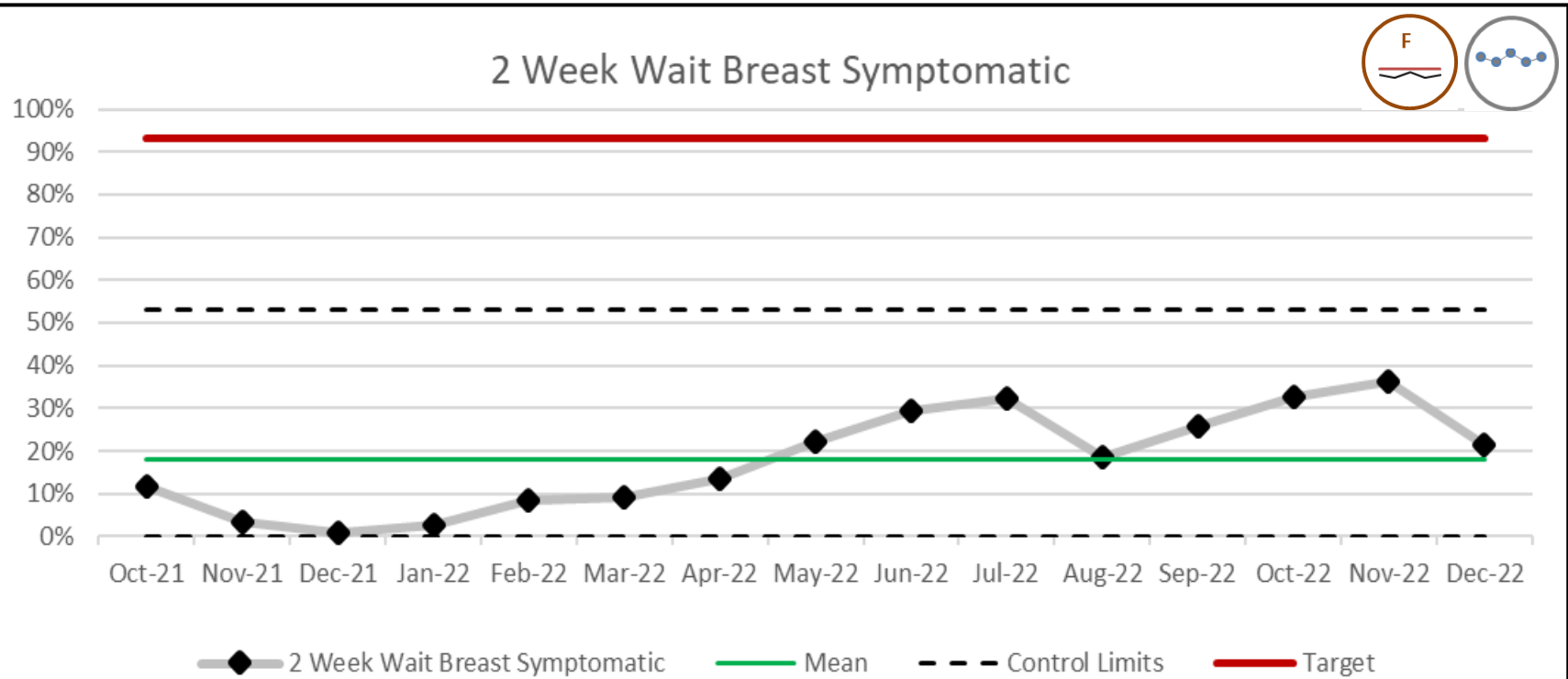
Patients not willing to travel to where our service and/or capacity is available.
Nurse Triage / CNP capacity issues in colorectal specialty.
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with 33% of the Trust's December 14 Day breaches within that tumour site.
Also of concern in December was skin performance which also accounted for 33% of the Trust's 14 day breaches.
Capacity has been limited due to increased referral over summer and Autumn and clinical, nursing and administrative staff sickness.

Actions:

The Gynae tumour site accounted for 12% of December breaches. A number of work streams are expected to be identified following the follow-up oncology strategy meeting which took place on 03/02/2023. Referral triage by the CNS team and referral redesign work is still underway to address 1st OPA capacity challenges.
The Radiology Recruitment Strategy is in place to address the Breast Service One-Stop appointment alignment issues. 2 x Registrars are undergoing assessments that will allow them to hold their own clinics thereby improving capacity, and another Specialty doctor is due to commence in Feb '23.
In December, Lung accounted for 11% of the Trust's breaches and over 50% of 2ww referrals did not have their first OPA until after day 28 of the pathway. Consultant capacity is a continuing issue alongside an increased number of referrals. ICB Analysis of the FReD Referrals is in progress and an ongoing BC for an increase in consultant workforce to 10-15 consultants is underway.
UGI Referral and Triage processes are being reviewed and a Gap Analysis supported by the ICB has been completed. A bid is being developed for UGI CNS to triage at the start of UGI pathway.
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:

In Urology, a Deep Dive, supported by the ICB, commenced on 23/01/2023 to identify and address pathway improvements including the quality of primary care referrals as well as capacity and flagging issues.
Haematology is in fragile services due to vacancy/capacity. EMAP work has started but the next EMAP meeting has been pushed back from Jan to March. ICB colleagues were not initially invited to the meetings but CSM has provided ICB with information to make contact with the EMAP project lead re future meetings. Ongoing issues with inappropriate referrals and GP engagement continue to be escalated, as are the delays in the booking and utilisation of appointment slots which are still being addressed with C&A.



Dec-22
21.51%
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 21.51% against a 93% target.

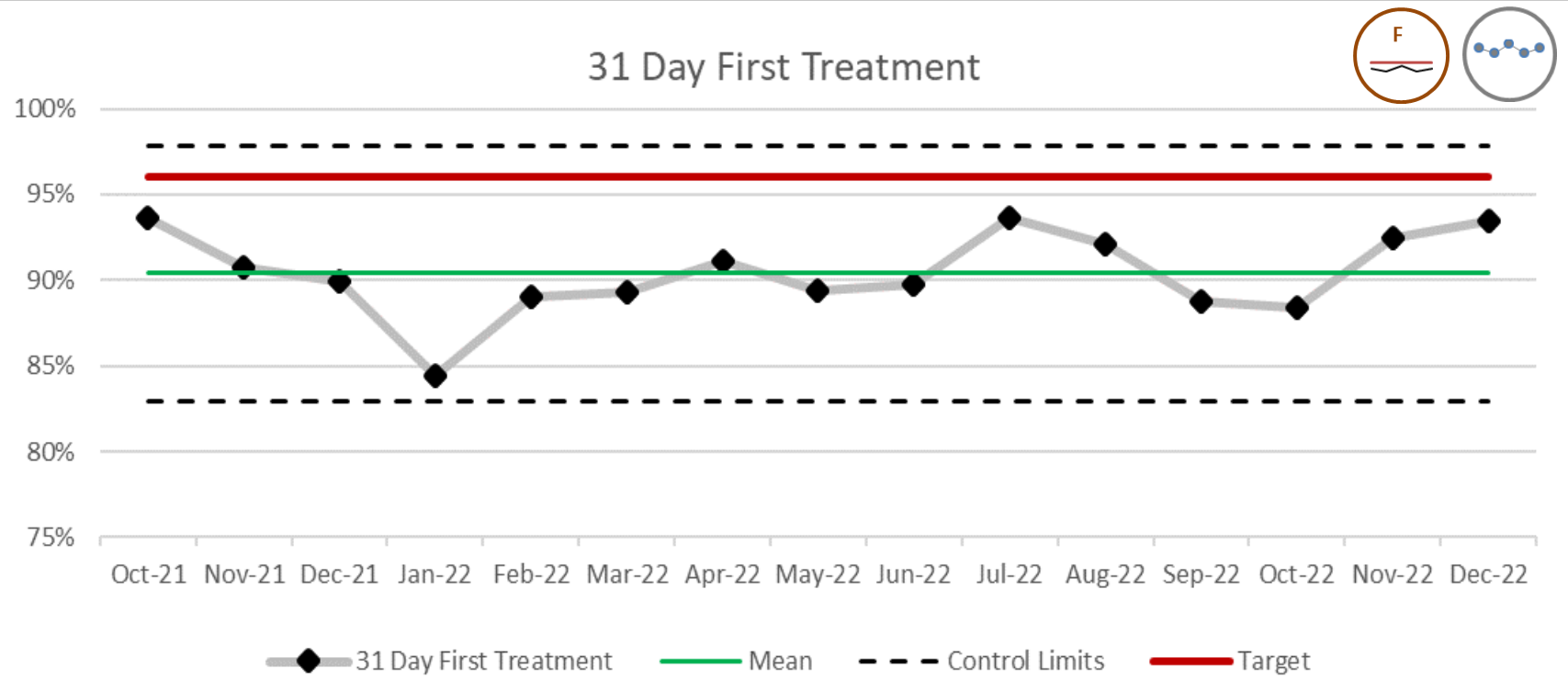
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

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

Mitigations:
A mastalgia pathway is now up and running with primary care and system partners which has the potential to reduce inbound referrals by circa 15-20%.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-22
93.47%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

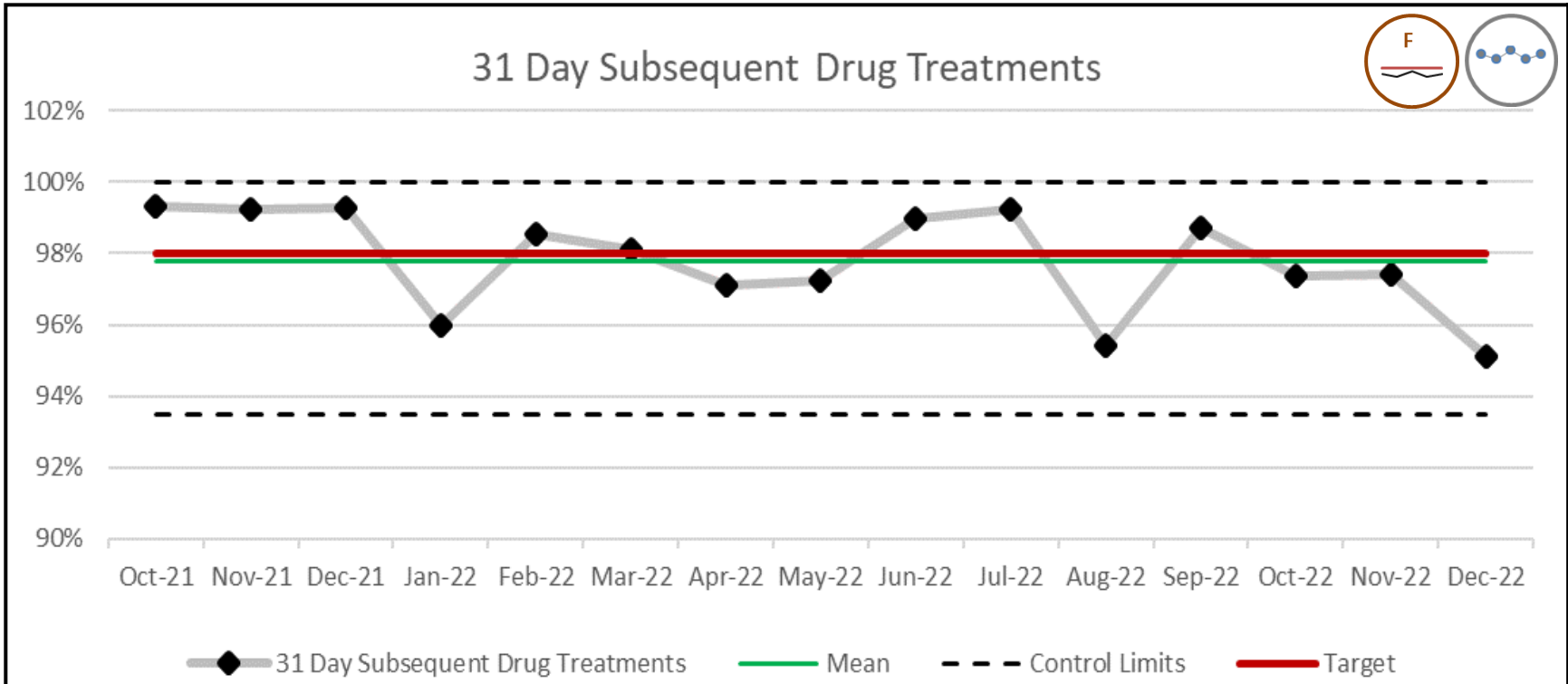
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 93.47% against a 96% target.

Issues:
The failure of the 31 Day standards was primarily attributed to lack of AA and theatre capacity.
Patient compliance including willingness to travel to where our service and / or capacity is.

Actions:
Recruitment in Oncology is ongoing to secure locums, NHS locum or substantive posts. 3 Medical Oncologist posts are out to advert as locums. A 6 month Oncology SpDr post went out to advert from which we have 2 appointable candidates. Confirmation as to whether both can be appointed is awaited.
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity.

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



Dec-22
95.10%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

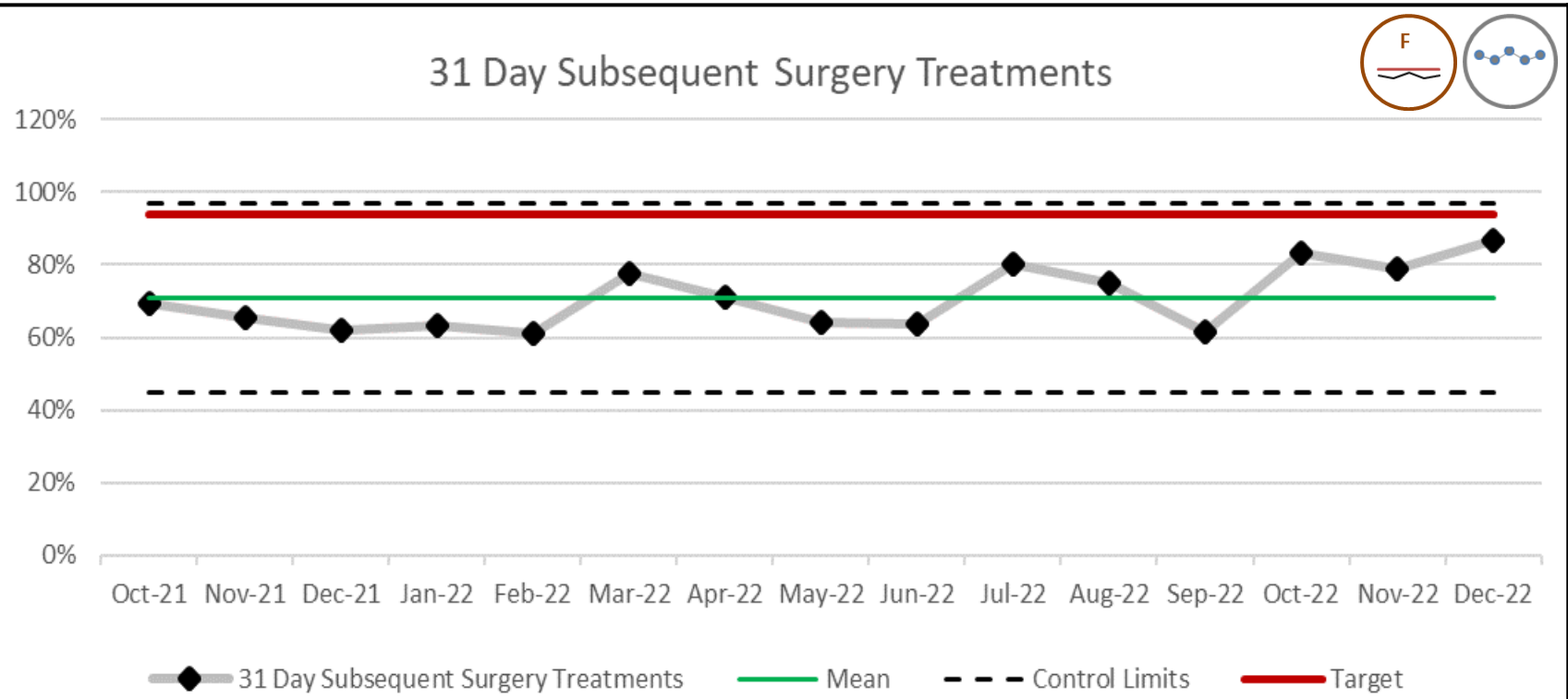
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was drugs.

What the chart tells us:
We are currently at 95.10% against a 96% target.

Issues:
The failure of the 31 Day standards was primarily attributed to lack of AA and theatre capacity.
In November, for the subsequent standards the Trust achieved the RT standard, narrowly missing the standard for Drug.

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

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



Dec-22
86.49%
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 86.49% against a 94% target.

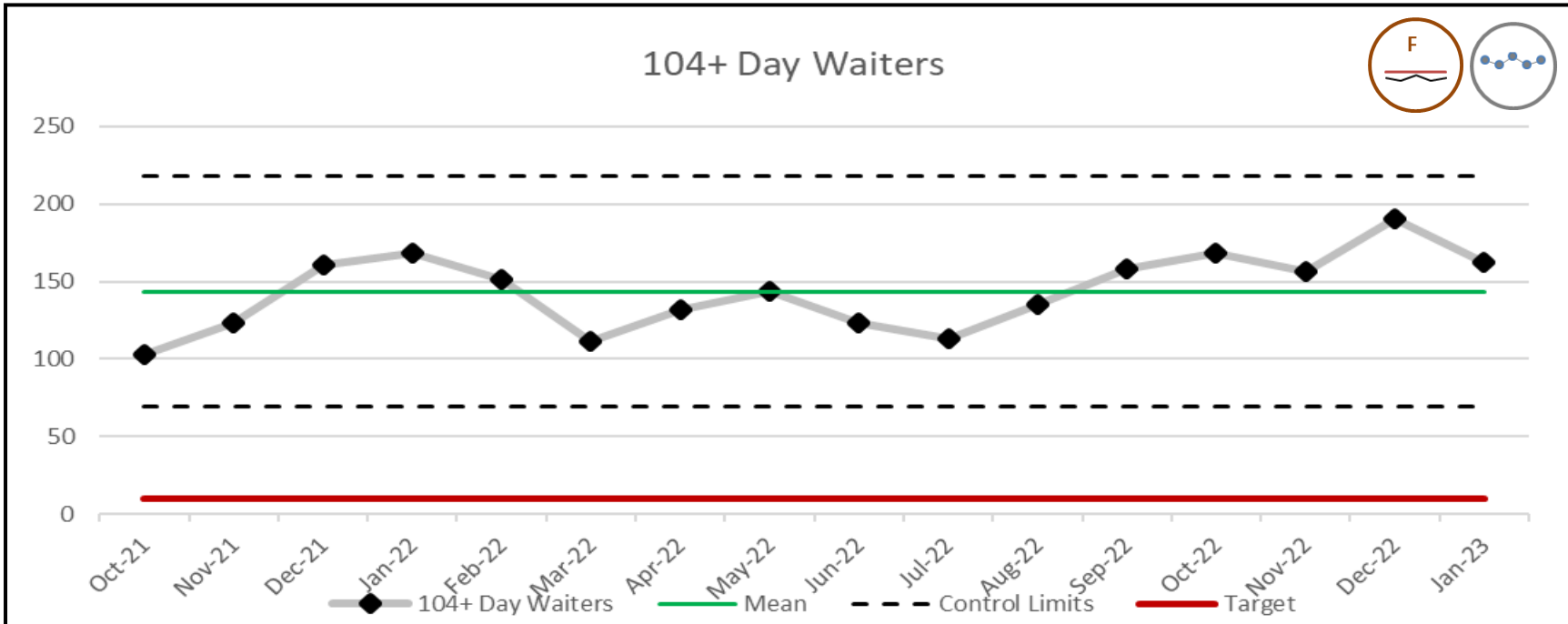
Issues:
The failure of the 31 Day standards was primarily attributed to lack of AA and theatre capacity.
In November, for the subsequent standards the Trust achieved the RT standard, narrowly missing the standard for Drug.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-23
162
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 February the 104 Day backlog was at 162 patients. The agreed target is <10.

There are four tumour sites of concern
Colorectal 102 (majority awaiting diagnostics, outpatients and clinical review)
Urology 19
Lung 13
Upper GI 11

Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced OP, diagnostic and 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, and Lung.
Approximately 23% 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:
See Actions on previous pages

Mitigations:
See Mitigations on previous pages

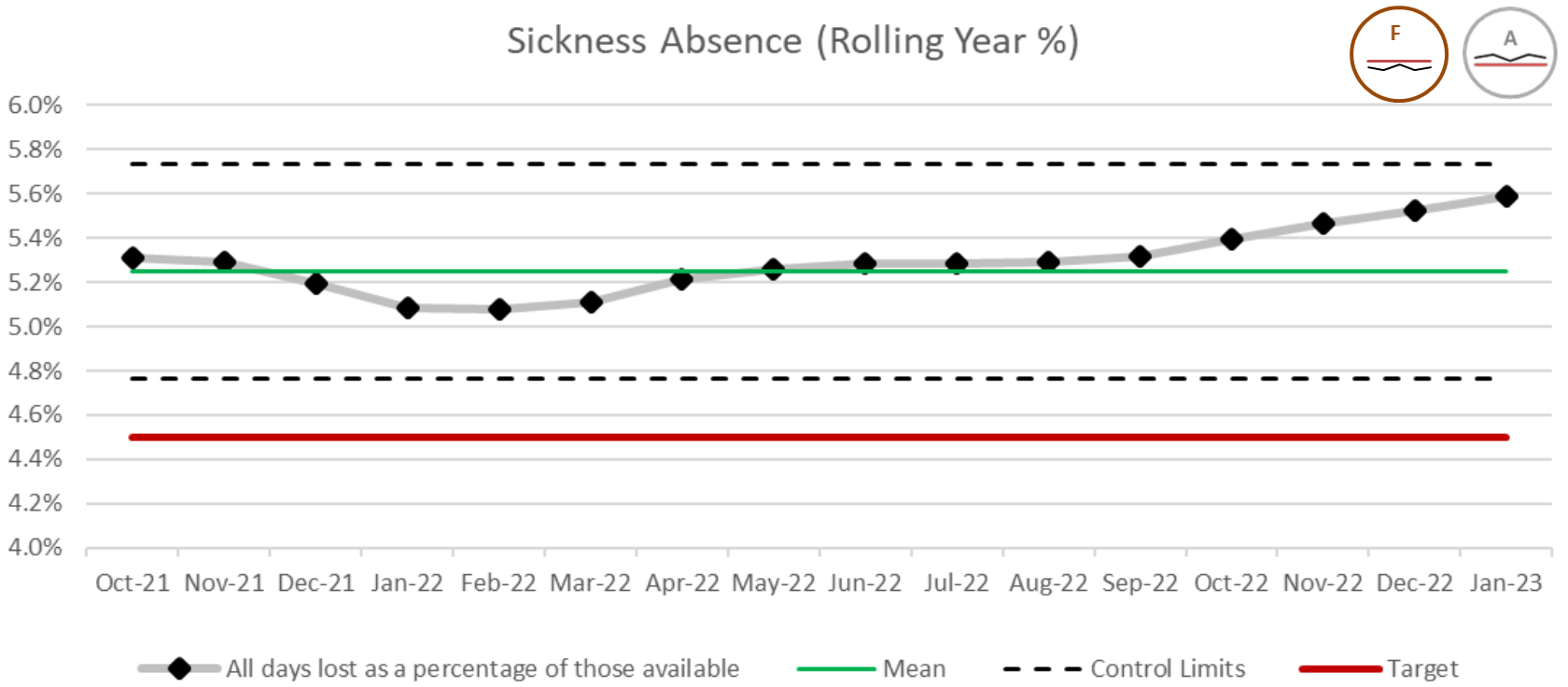
PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Nov-22	Dec-22	Jan-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	90.01%	89.78%	89.25%	89.66%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	8.77%	8.98%	8.30%	10.04%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.46%	5.52%	5.59%	5.36%		F	A	
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	14.18%	13.79%	13.67%	14.52%		F		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	63.26%	63.74%	64.24%	60.56%		F	A	

See Executive Scorecard section for relevant failing metrics above.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-23
5.59%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The rate has increased by a further 0.2% to 5.59% which is above the target of 4.5%.

Issues:

- We have experienced an increase in the number of Covid absences. This continues to be monitored daily.
- Stress & Anxiety remains the top reason for absence, followed by other MSK problems and Covid 19.

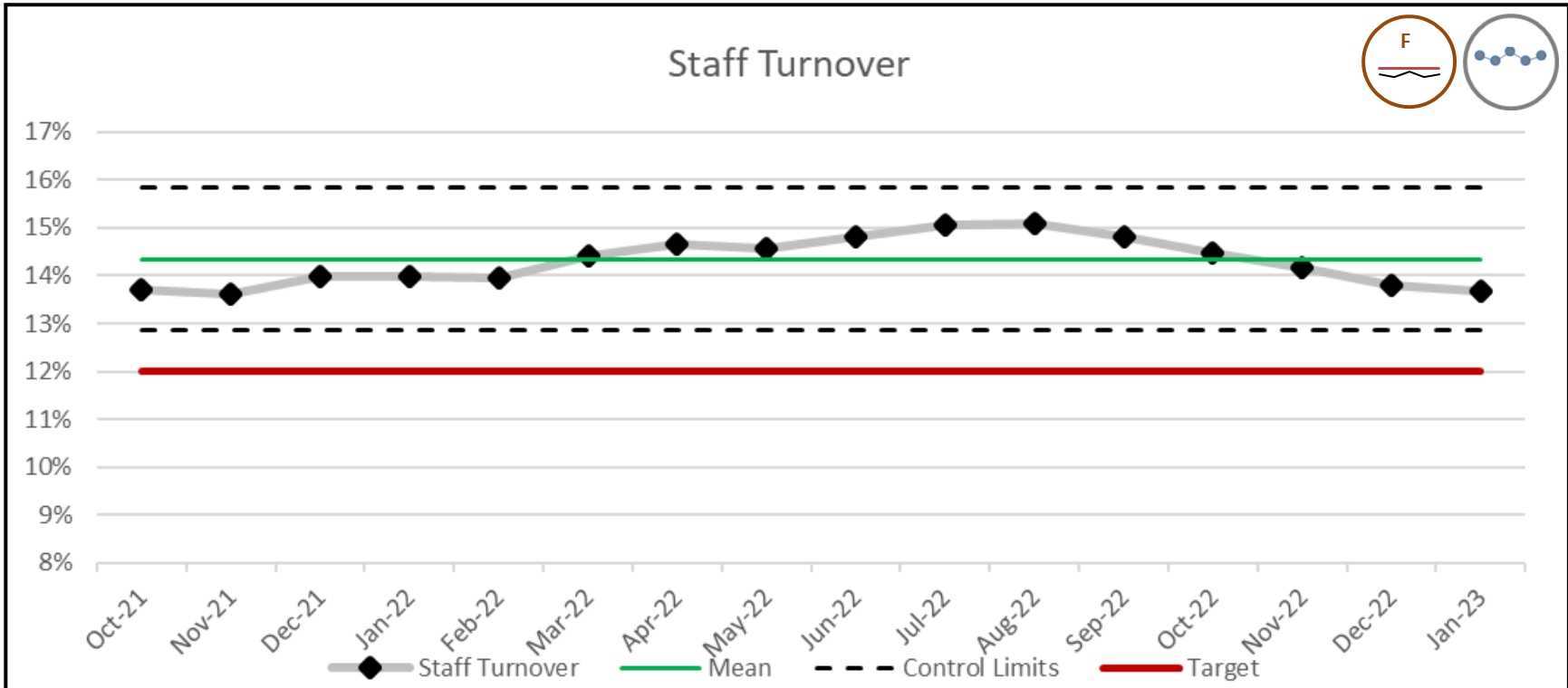
Actions:

- The HR Team continue to work with managers to reduce issues of non-compliance with completing absence call backs and return to work interviews within the expected time periods. In addition, the Divisional Heads of HR provide reports to senior managers detailing any compliance issues in their areas.
- Work is also now commencing around the performance management process in regards to managers who are not using AMS to manage their team's absence.
- Cross reference work between ESR, Healthroster and AMS continues to ensure that all absence is being recorded through AMS as per policy.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jan-23
13.67%
Variance Type
Metric is currently experiencing Common Cause Variation
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 and decreased slightly month on month but are still higher than 12% target

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 People Promise Manager dedicated to ULHT who is focussing on retention issues including career conversations and flexible working
- Culture and Leadership ambassadors have been recruited and are commencing their induction/training
- Leadership and management training programmes continue to be delivered

Mitigations:
See actions

Financial Position Month 10 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

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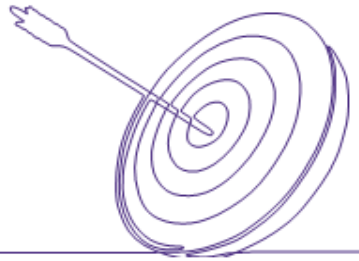
OUTSTANDING CARE
personally DELIVERED

Quality | Operational Performance | Workforce | **Finance**

Finance Spotlight Report (Headlines)



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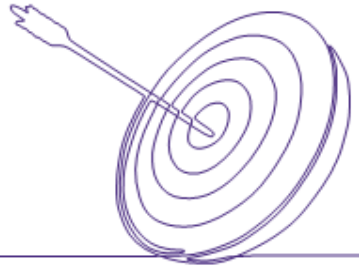
Adjusted financial performance	Current Month			Year to Date		
	£'000	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	52,453	56,835	4,382	524,655	548,318	23,663
Other operating income	3,405	3,925	520	30,614	35,709	5,095
Employee expenses	(37,608)	(39,827)	(2,219)	(364,916)	(395,187)	(30,271)
Operating expenses excluding employee expenses	(17,663)	(21,152)	(3,489)	(184,599)	(198,103)	(13,504)
OPERATING SURPLUS / (DEFICIT)	**587**	**(219)**	**(806)**	**5,754**	**(9,263)**	**(15,017)**
NET FINANCE COSTS	(642)	(423)	219	(6,374)	(4,453)	1,921
Other gains/(losses) including disposal of assets	0	0	0	0	128	128
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(55)**	**(642)**	**(587)**	**(620)**	**(13,588)**	**(12,968)**
Remove capital donations/grants/peppercorn lease I&E impact	55	32	(23)	620	497	(123)
Adjusted financial performance surplus/(deficit)	**0**	**(610)**	**(610)**	**0**	**(13,091)**	**(13,091)**

- The table above shows that the Trust delivered an adjusted deficit of £0.6m in M10 (£0.6m adverse to plan) and YTD delivered an adjusted deficit of £13.1m (£13.1m adverse to plan).
- At M9, the Trust had a Most Likely Case forecast deficit of £17.4m for 2022/23; since M9, the Lincolnshire ICS has reviewed its forecast outturn position, and the Trust has agreed a £13.6m deficit forecast to support ICS delivery of a revised £21m deficit forecast.
- The Trust's M10 position is aligned to the financial trajectory required to deliver its revised forecast deficit of £13.6m.
- CIP savings of £12.6m have been delivered YTD, or £8.8m (41.1%) adverse to planned savings of £21.4m.

Finance Spotlight Report
(Key areas of focus - Income)



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The Income position is £28.8m favourable YTD to plan; this includes:

- **NHS Patient Care income contract - favourable variance of £22.9m**; this includes £8.1m pay award funding (net of NI reduction), over performance of £3.9m re Variable Drugs (Lincs and NHSE) for which there will be an offset in Non Pay, £1.1m of NHS England prior year income for the true-up, £0.5m mutual aid income for working being undertaken for Leicestershire ICB in T&O and £119k of other variable charges to providers and devolved administrations). In addition, the YTD position now includes £6.0m of funding to compensate the Trust for beds that have not yet closed as a result of the CC2H scheme, £908k of winter funding, £985k of digital and cyber funding, and another £200k of other allocations across a number of schemes. £725k has also been assumed from Lincolnshire ICB in relation to variable diagnostics.

- **NHS Patient Care - additional potential investment**: Bids were submitted to NHSE Specialised for c£2m additional non-recurrent funding schemes to be spent by 31st March. Two bid were successful in relation to renal £136.2k and specialised chairs for Ashby Ward £3.9k

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

- **Education & Training - favourable variance of £1.5m** including £0.5m notional income re the apprenticeship levy.

- **Income in respect of employee benefits accounted for on a gross basis – favourable variance of £0.9m.**

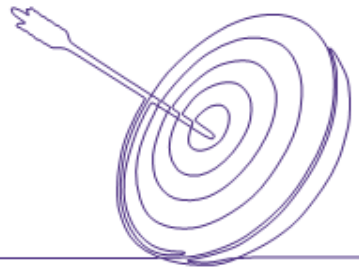
- **Non-Patient Care services - favourable variance of £0.6m.**

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

- **Research & Development – favourable variance of £0.2m**

- **Other miscellaneous movements – favourable variance of £1.0m**.

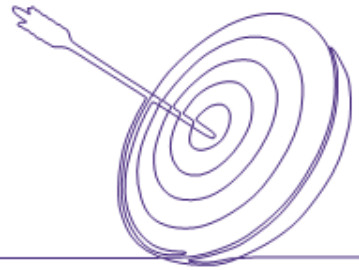
Finance Spotlight Report
(Key areas of focus - Pay)



United Lincolnshire Hospitals NHS Trust

- **The YTD pay position is £30.3m adverse to plan including under delivery on Pay CIP of £8.2m.**
- Actual pay expenditure in January of £39.8m was £0.5m higher than £39.3m in December inclusive of an accrual of £0.2m for Bank Holiday enhancements.
- The £0.5m increase in Pay expenditure was driven by the increase in Bank Pay, which in the main reflects the impact of the rate card increase.
    - **Substantive pay is £4.0m adverse to plan (inclusive of £1.2m of technical CIP delivery)**
        - Expenditure of £30.9m in January is £0.2m lower than expenditure of £31.1m in December.
    - **Agency pay is £20.2m adverse to plan**
        - Expenditure of £3.9m in January is £0.1m lower than expenditure of £4.0m in December.
        - YTD efficiency savings of £2.8m in Agency Pay are £11.6m adverse to plan; the YTD position also reflects higher than planned bed numbers, sickness levels & vacancies.
    - **Bank Pay is £6.0m adverse to plan**
        - Expenditure of £5.1m in January is £0.8m higher than expenditure of £4.2m in December; Medical bank was £0.7m higher driven by the rate card increase implemented from 12 December and the retrospective inclusion of shifts worked in December.
        - The rate card increase has increased Medical Extra Duty costs by £1.0m since it was implemented on 12 December.

Finance Spotlight Report
(Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

Non Pay

- The YTD Non-Pay position is £13.5m adverse to plan including under delivery on CIP of £2.0m; £2.6m of the technical CIP savings released YTD have been in Pay & Income rather than Non Pay as planned.
- The YTD position reflects generally lower than planned activity levels (though elective volumes continue to recover), higher than planned pass-through expenditure (which is only offset in part by additional income) and unplanned expenditure offset by additional income e.g. £1.5m re the radiology fire, £1.0m re System Digital & Cyber, £0.5m re mutual aid, and £0.2m re a one off adjustment re Bad Debt.
- Non Pay expenditure in January of £21.2m was £0.2m higher than £20.9m in December; while Non Pay overall was largely unchanged, there was considerable variation by category.

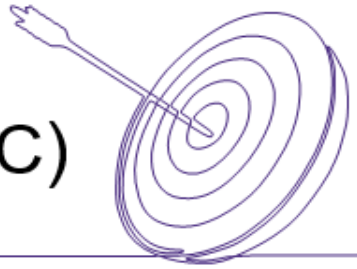
CIP

- 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 £21.4m by the end of M10; actual savings of £12.6m (58.9%) have been delivered, such that YTD delivery is £8.8m (41.1%) 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£19.3m.

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



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Cash

- The January 2023 cash balance is £38.3m; this is a decrease of £50.0m against the March year-end cash balance of £88.3m.

- The Trust will be drawing capital PDC of £19.7m in March, the majority of which is unlikely to be utilised until April / May. The year end cash position is therefore expected to increase to circa £60m.

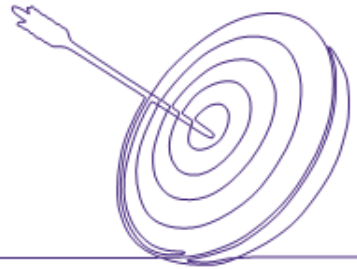
- Whilst current cash levels remain comfortable; the position will narrow as we move into 2023/24 and will require careful management of cash and working capital.

BPPC

- The BPPC performance for the year to January was 78% / 70% by value / volume of invoices paid (appendix 5d); this compares to the full year performance in 2021/22 of 89% / 83%.

- Performance during January itself was 84% / 70%. This is comparable to the period prior to the August Cyber attack, but remains below levels before the finance system migration in December 2021.

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

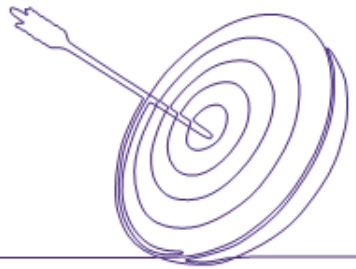
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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	JAN 2023
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.02
Capital service cover rating	4	4	4	1	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(9.47)
Liquidity rating	4	4	1	1	3
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(2.24%)
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%	(2.24%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	4

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

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-22	31-Jan-23		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Intangible assets	7,675	6,274	6,333	6,080
Property, plant and equipment	267,753	282,335	272,216	287,961
Right of use assets	12,468	12,009	12,231	11,825
Receivables	1,848	1,848	1,894	1,848
Total non-current assets	**289,744**	**302,466**	**292,674**	**307,714**
Inventories	6,006	6,006	7,317	7,000
Receivables	15,520	23,709	31,612	28,500
Cash and cash equivalents	88,297	43,768	38,295	65,213
Total current assets	**109,823**	**73,483**	**77,223**	**100,713**
Trade and other payables	(89,017)	(62,414)	(70,873)	(95,765)
Borrowings	(2,552)	(3,290)	(3,137)	(2,847)
Provisions	(8,774)	(5,295)	(8,017)	(6,903)
Other liabilities	(1,130)	(1,130)	(5,737)	(1,130)
Total current liabilities	**(101,473)**	**(72,129)**	**(87,764)**	**(106,645)**
Total assets less current liabilities	**298,094**	**303,820**	**282,133**	**301,782**
Borrowings	(13,751)	(12,276)	(12,574)	(12,553)
Provisions	(3,182)	(3,071)	(2,402)	(3,087)
Other liabilities	(11,572)	(11,152)	(11,153)	(11,069)
Total non-current liabilities	**(28,505)**	**(26,499)**	**(26,129)**	**(26,709)**
Total assets employed	**269,589**	**277,321**	**256,004**	**275,073**
Financed by				
Public dividend capital	704,178	712,591	704,180	723,888
Revaluation reserve	29,294	28,714	28,701	28,587
Other reserves	190	190	190	190
Income and expenditure reserve	(464,072)	(464,174)	(477,067)	(477,591)
Total taxpayers' equity	**269,589**	**277,321**	**256,004**	**275,073**

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 (£12.28m) and the I&E reserve (£0.19m).
Both the plan and actual for 2022/23 are stated on an IFRS 16 basis.

Note 2: Cash at £38.3m has reduced £3m from December but is expected to increase before the year end with the drawdown of £19.7m capital PDC in March.

Note 3: Receivables continue to be supressed below pre-pandemic levels and will remain so throughout the remainder of 2022/23 with the continuation of block contract payments. See Appendix 5a-b

Note 4: The overall level of Trade and other payables at £70.9m remains above historic levels by circa £5-10m. This includes Annual leave (£6m) and other pay accruals.
BPPC and aged creditor performance is reported at Appendix 5c-d.

Note 6: The capital programme for 2022/23 will result in asset additions of £37.8m. This is to be funded through internal cash resources but with an injection of £19.7m PDC capital. A significant proportion of the additions will be during the final quarter meaning the level of year end capital creditors is anticipated to exceed £20m.

Note 7: The year end valuation is underway, this is likely to result in movements in the value of non-current assets and the revaluation and I&E reserves.

Cashflow reconciliation – April 2022– March 2023

United Lincolnshire Hospitals NHS Trust

	31-Mar-22	31-Jan-23		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Operating surplus / (deficit)	549	5,754	(9,262)	(9,065)
Depreciation and amortisation	15,736	16,066	16,296	19,734
Impairments and reversals	7,340	-	-	-
Income recognised in respect of capital donations	(27)	-	(30)	(50)
Amortisation of PFI deferred credit	(503)	(420)	(419)	(503)
(Increase) / decrease in receivables and other assets	11,261	(8,189)	(16,059)	(12,930)
(Increase) / decrease in inventories	504	-	(1,311)	(994)
Increase/(decrease) in trade and other payables	9,745	(11,494)	(751)	10,416
Increase/(decrease) in other liabilities	(457)	-	4,607	-
Increase / (decrease) in provisions	5,860	(3,560)	(1,498)	(1,927)
Net cash flows from / (used in) operating activities	**50,008**	**(1,843)**	**(8,427)**	**4,681**
Interest received	34	200	882	1,185
Purchase of intangible assets	(994)	-	(38)	(38)
Purchase of property, plant and equipment	(35,132)	(44,892)	(36,802)	(40,133)
Proceeds from sales of property, plant and equipment	148	-	151	151
Net cash flows from / (used in) investing activities	(35,944)	(44,692)	(35,807)	(38,835)
Public dividend capital received	26,610	8,411	-	19,708
Other loans repaid	-	(403)	(403)	(403)
Capital element of finance lease rental payments	-	(1,999)	(1,940)	(2,250)
Interest paid	(1)	-	-	-
Interest element of finance lease	-	(98)	(102)	(108)
PDC dividend (paid)/refunded	(6,418)	(3,901)	(3,323)	(5,872)
Cash flows from (used in) other financing activities	-	(4)	-	(5)
Net cash flows from / (used in) financing activities	20,191	2,006	(5,768)	11,070
Increase / (decrease) in cash and cash equivalents	**34,255**	**(44,529)**	**(50,002)**	**(23,084)**
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**	**43,768**	**38,295**	**65,213**

Note 1: Cash held at 31 January was £38.3m against a plan of £43.8m. This represents a decrease of £50.0m against the March year-end cash balance of £88.3m.

Note 2: Although the cash position is broadly in line with plan; this masks the fact that a shortfall in planned payments against the capital programme of £8.1m, coupled with more 'favourable' movements in working capital than planned have largely compensated for the current I&E deficit and delayed drawdown of PDC.

Note 3: Underlying cash balances remain above 2019/20 levels primarily due to:

- The continued block payment regime
- 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 in the region of £60m, due in large part to the level of capital creditors forecast.

Looking into 2023/24, depending upon mitigation of risks and changes in the financial regime, cash balances will further reduce and will require careful management.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7th March 2023*
Item Number	*Item 13.1*

Strategic Risk Report

Accountable Director	*Karen Dunderdale, Director of Nursing & Deputy Chief Executive Dr*
Presented by	*Karen Dunderdale, Director of Nursing & Deputy Chief Executive*
Author(s)	*Rachael Turner, Risk & Incident Facilitator*
Report previously considered at	*Lead assurance committees for each strategic objective*

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

Risk Assessment	*Multiple – Please see report*
Financial Impact Assessment	*None*
Quality Impact Assessment	*None*
Equality Impact Assessment	*None*
Assurance Level Assessment	*Significant*

Recommendations/ Decision Required	• *The Trust Board is invited to review the content of the report, no further escalations at this time.*

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks to the Trust's strategic objectives (those with a current rating of High or Very high risk, 15-25); only risks that have been validated by the Risk Register Confirm & Challenge Group and reported to the appropriate lead committee are included in this report.

- The highest rated quality and safety risks recorded on the Trust risk register at present relate to:
    - Ambulance handover delays;
    - Unexpected surge in emergency demand;
    - Patient flow through Emergency Departments;
    - Recovery of planned care admitted pathways;
    - Recovery of planned care non-admitted (outpatients) pathways;
    - Recovery of planned care cancer pathways;
    - Reliance on paper medical records;
    - Reliance on manual prescribing processes;
    - Potential for serious patient harm due to a fall;
    - Processing of echocardiograms;
    - Epilepsy service provision in Paediatrics
    - Learning lessons from previous patient safety incidents.
    - Gaps in tertiary advice and support for children and young people with complex epilepsy – NEW Risk validated at the Risk Register Confirm & Challenge meeting in January 2023

- The highest rated workforce risks recorded at present relate to:
    - Recruitment and retention of staff (Trust-wide)
    - Workforce culture (Trust-wide)
    - Disruption to services due to potential industrial action (Trust-wide)

- The highest rated finance, performance, information and estates risks recorded at present relate to:
    - Potential for a major fire;
    - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
    - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
    - Reliance on agency / locum medical staff in Urgent & Emergency Care
    - Reliance on agency / locum nursing staff in Urgent & Emergency Care
    - SAR's Compliance and access to Health records in accordance with statuary requirements – increased rating validated by Risk Register Confirm & Challenge Group in January 2023

Purpose
The purpose of this report is to enable the Trust Board (TB) to review the management of significant risks to strategic objectives and consider the overall extent of risk exposure within the Trust at this time.

1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. This report is focussed on significant risks to each objective, those with a current rating of Very high risk (a score of 20-25).

1.2 Full details of all active Very High and High risks (those with a current risk score of 15-25) are included in **Appendix A**, and a summary of Very High risks is provided in Section 2 below. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level.

1.3 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.

2. Trust Risk Profile

2.1 There were 329 active and approved risks reported to lead committees this month. This is 8 more than were reported last month.

2.2 There were 22 risks with a current rating of Very high risk (20-25) and 25 rated High risk (15-16) reported to lead committees this month. **Table 1** below shows the number of active risks by current risk 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%)	**61** (18%)	**218** (68%)	**25** (7%)	**22** (6%)

Strategic objective 1a: Deliver high quality care which is safe, responsive and able to meet the needs of the population

2.3 There were 10 Very high risks and 6 High risks reported in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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 and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (25)	- 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	21/02/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5016	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding. This may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Very high risk (25)	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED.	27/01/2023
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, a poor patient experience 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.	27/01/2023
5073	Safety risk from inability to source tertiary advice and support for children and young people with complex epilepsy	Very high risk (20)	1. Liaison with tertiary centres via ICB and specialist commissioning representatives to aid establishment of referral pathway. 2. Liaison with tertiary centres via ICB and specialist commissioning representatives to aid establishment of contracts.	12/01/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	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.	13/01/2023
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.	09/01/2023

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 (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	26/01/2023
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)	- 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)	23/01/2023
5057	If there are substantial delays to patient handovers from ambulances then it could lead to patients being treated in an area that is not optimal for patient care for example the in the back of an ambulance resulting in potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Very high risk (20)	Estates increase at Lincoln County ED will support the reduction in handover delays System work to reduce the number of ambulance conveyances to ED's Work within ULHT to support alternate destinations to ED for ambulance conveyances e.g. SEAU / Paeds / SDEC PHP SOP revision to strengthen and ensure appropriate persons treating the patient.	27/01/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4804	If there is an unexpected surge in emergency demand that exceeds staffing capacity or available space within one of the Trust's Emergency Departments then it could lead to delayed diagnosis and treatment resulting a reduced likelihood of a positive clinical outcome for multiple patients	Very high risk (20)	Clinical governance arrangements in U&EC / Medicine Division Performance Review Meeting (PRM) process	27/01/2023

Strategic objective 1b: Improve patient experience

2.4 There were no Very high risks and 3 High risks reported in relation to this objective.

Strategic objective 1c: Improve clinical outcomes

2.5 There were 3 Very high risks and 3 High risk reported in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4972	Safety risk from an inability to provide a fully funded epilepsy service that complies with relevant NICE guidance.	Very high risk (20)	1. Development of business case to enable establishment of fully funded epilepsy service.	13/02/2023
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 from mid Oct.	02/02/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	02/02/2023

2.6 The following risks are awaiting validation from the Risk Register Confirm & Challenge Group (RRC&CG):

- Ambulance handover delays (25, Very high to 12, Moderate)
- Surge in emergency care demand (25, Very high to close and be incorporated within ED Capacity and Demand, reducing from 25 to 20, Very high risk)

Strategic objective 2a. A modern and progressive workforce

2.7 There was 1 Very high risk and 3 High risks reported in relation to this objective. A summary of the Very high risk 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.	31/01/2023

Strategic objective 2b. Making ULHT the best place to work

2.8 There were 3 Very high risks and 2 High risks reported in relation to this objective. A summary of the Very high risks 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	31/01/2023
4439	If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Very high risk (20)	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	31/01/2023

Strategic objective 4b. To become a University Hospitals Teaching Trust

2.9 There were no Very high or High risks reported in relation to this objective.

Strategic objective 3a: A modern, clean and fit for purpose environment

2.10 There were 2 Very high risks (20-25) and 1 High risk (15-16) reported in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4648	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk. - Fire safety protocols development and publication. - Fire drills and evacuation training. - 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. - Planned preventative maintenance programme by Estates	06/12/2022
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 - 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	06/12/2022

Strategic objective 3b: Efficient use of our resources

2.3 There were 3 Very high risks (20-25) and 3 High risks (15-16) reported in relation to this objective. A summary of the Very high risks 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	02/02/2023
5019	If there is a continued reliance on bank and agency staff for nursing workforce in Urgent & Emergency Care there is a risk that there not sufficient fill rate in each department which will impact on patient safety and have a negative impact on the CBU budget.	Very high risk (20)	Robust recruitment plan. International recruitment.	27/01/2023
5020	If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget.	Very high risk (20)	Robust recruitment plan. International recruitment. Medical Workforce Management Project.	27/01/2023

Strategic objective 3c: Enhanced data and digital capability

2.4 There was 1 Very high risk (20-25) and 3 High risks (15-16) reported in relation to this objective. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."	Very high risk (20)	"Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints."	02/02/2023

Strategic objective 3d: Improving cancer services access

2.5 There were no Very high risks (20-25) or High risks (15-16) reported in relation to this objective.

Strategic objective 3e: Reduce waits for patients who require planned care and diagnostics to constitutional standards

2.6 There were no Very high risks (20-25) or High risks (15-16) reported in relation to this objective.

Strategic objective 3f: Urgent Care

2.7 There were no Very high risks (20-25) or High risks (15-16) reported in relation to this objective.

Strategic objective 4a: Establish new evidence based models of care

2.8 There were no Very high risks (20-25) or High risks (15-16) reported in relation to this objective.

Strategic objective 4c: Successful delivery of the Acute Services Review

2.9 There were no Very high risks (20-25) or High risks (15-16) reported in relation to this objective.

3. Conclusions & recommendations

3.1 There were 13 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month:

- Ambulance handover delays;
- Unexpected surge in emergency demand;
- Patient flow through Emergency Departments;
- Recovery of planned care admitted pathways;
- Recovery of planned care non-admitted (outpatients) pathways;
- Recovery of planned care cancer pathways;
- Reliance on paper medical records;
- Reliance on manual prescribing processes;
- Potential for serious patient harm due to a fall;
- Processing of echocardiograms;
- Epilepsy service provision in Paediatrics
- Learning lessons from previous patient safety incidents.
- Gaps in tertiary advice and support for children and young people with complex epilepsy – NEW Risk validated at the Risk Register Confirm & Challenge meeting January 2023

3.2 There were 3 Very high risks (20-25) reported to the People & Organisational Development Committee this month:

- Recruitment and retention of staff (Trust-wide)
- Workforce culture (Trust-wide)
- Disruption to services due to potential industrial action (Trust-wide)

3.3 There were 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month:

- Potential for a major fire;
- Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
- Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- Reliance on agency / locum medical staff in Urgent & Emergency Care
- Reliance on agency / locum nursing staff in Urgent & Emergency Care
- SAR's Compliance and access to Health records in accordance with statuary requirements – increased rating validated by Risk register Confirm & Challenge Group in January 2023

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

Appendix A - All risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	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**																			
4789	Physical or psychological harm	Evans, Simon	Ratcliff, Carl	Children & Young Persons Oversight Group	Clinical Effectiveness Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	27/01/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	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	[27/01/2023 10:16:42 Charles Smith] 27/01/23 - Charles Smith DGM - CDC work had to go via tender, expected to start ~01/02/23. Delivery of 3000 from backlog. Midlands visit action plan/meridian recommendations largely implemented. R&R has preliminary sign-off from trust. Trajectories have total WL eradication in 2024 if no changes, 6w and 13ww cohorts within 12/12. FUrther workforce challenges with Mat leave and new resignations. Position remains difficult in terms of capacity and fragility of workfoce. [01/12/2022 10:58:41 Carl Ratcliff] New working group in place lead by COO Plans being worked up to open CDC when contract agreed Extra room now found at LCH - start to sue next week R/R paper submitted to COO for approval Need to obtain recovery graph to show impacts of each / all action [04/11/2022 12:28:16 Carl Ratcliff] Approval now in place to use CDC at Grantham to cover 300 pts in back log. Process being agreed with procurement / operations to start. Plan for other half of waiting list being worked up for agreement. Booking team now transferred to Cardiology team to manage. Deep dive review completed by NHSE/I with actions in place - monitored with weekly meeting in Division to complete actions. 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	4	31/03/2022	31/03/2023	20/04/2023
5073	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	12/01/2023	20		Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Safety risk from inability to source tertiary advice and support for children and young people with complex epilepsy	1. None - ULHT is currently treating patients with complex epilepsy that should be referred into tertiary services for specialist input. Tertiary services cite lack of contract and/or lack of capacity as reason for declining to offer advice and assistance. This increases the risk of children and young people developing complications that have short, medium and long-term consequences.	1. Number of declined referrals	13/02/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	1. Liaison with tertiary centres via ICB and specialist commissioning representatives to aid establishment of referral pathway. 2. Liaison with tertiary centres via ICB and specialist commissioning representatives to aid establishment of contracts.	[13/02/2023 14:07:10 Jasmine Kent] For review at governance for possible merge with other epilepsy risk.	4	12/01/2024		13/03/2023
4879	Physical or psychological harm	Evans, Simon	Rimmer, Lucy	Patient Safety Group	Children & Young Persons Oversight Group	28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU			If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	13/01/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	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	[13/01/2023 15:07:01 Paul White] Closed in error - re-opened. [17/11/2022 12:24:41 Rose Roberts] 4736 can be closed as Estates have investigated everything they can and Paula is launching an education and poster campaign. Trust comms have already gone out. [16/11/2022 15:54:57 Rose Roberts] Ongoing 4/8/22 Confirmed it is an ongoing corporate risk being managed at divisional level. Ongoing	8	31/03/2023	31/03/2023	28/02/2023
5016	Physical or psychological harm	Wall, Mrs Tracey	Thomson, Cheryl	Patient Safety Group	Patient Safety Group	02/09/2022	25		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	27/01/2023	Quite likely (4)	71-90% chance	Extreme (5)	Very high risk (20-25)	20	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	[27/01/2023 11:17:57 Helen Hartley] Risk reviewed and updated. [23/11/2022 11:28:16 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed. [10/11/2022 13:40:59 Helen Hartley] No change at governance [07/11/2022 07:03:00 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:20:43 Helen Hartley] No changes made at governance	10	02/09/2023	31/03/2024	27/02/2023

Appendix A - All risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	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
5051	Physical or psychological harm	Rivett, Kate	Flatman, Deborah			31/10/2022	20		Family Health	Children and Young Persons CBU	Children's Community Services	Community	Quality and safety risk from inadequate capacity within the children's community diabetes nursing team	1. Team leader currently supporting provision of clinical duties across all 3 sites. 2. Prioritisation of workload to help match against available nursing capacity; 3. Support from OD team to help optimise team working and dynamics; 4. Business case in development to support expansion of diabetes services.	1. Complaints; 2. Compliance with National guidance; 3. Feedback from Peer Review audits; 4. Ability to provide Best Practice Tariff services; 5. Health and wellbeing of nursing workforce.	07/02/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	1. Prioritisation of which services can be provided with focus on those that are essential to maintaining safety; 2. Liaison with ICB CYP Programme Manager (one priority of this role is to support delivery of national priorities, which includes CYP diabetes). 3. To create satellite clinic for diabetes patients in Boston team due to geographical location. Could increase amount of patients able to be seen.	[21/02/2023 10:42:37 Rachael Turner] Risk validated at Confirm and Challenge 25/01/2023. [07/02/2023 14:21:16 Kate Rivett] 07/02/2023 - KR 1. Risk to remain as is.... full time Band 6 post remains vacant despite recruitment effort. Impending retirement will also create Team Leader vacancy. [20/01/2023 11:24:42 Alison Barnes] Mitigation in place. SBAR case reviews. [20/12/2022 13:21:55 Jasmine Kent] No change, Matron to add some more information re: risk reduction. [08/12/2022 12:32:07 Paul White] Rating increased on review.	3	31/10/2023		07/03/2023
4624	Physical or psychological harm	Davies, Angela	Addlesee, Sarah	Patient Falls Steering Group	Nursing, Midwifery and AHP Forum	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.	09/01/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	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	[14/10/2022 10:29:24 Rachael Turner] Risk reviewed-no change. • Weekly Falls Investigation Panel embedded / Falls Prevention Steering Group meets monthly / Falls improvement work ongoing across the Trust and focused pieces of work identified through the steering group / training package approved at NMAAF in Jan 22. • A Falls QI Project Development and Implementation Group has been established which has multidisciplinary representation from divisional and corporate teams. Dedicated support is being provided by the Improvement Academy. Oversight and monitoring will be provided by FPSG who will receive monthly updates on actions being taken and progress made by the QI group. • A schedule of face to face falls prevention and Flojac training commenced in April 2022 delivered within clinical areas by the Quality Matron and Health & Safety teams. Wards identified as having higher falls occurrences are being prioritised. • The Chief Nursing Information Officer (CNIO) has been working with the Quality Matron team to identify how the identification and handover of patients vulnerable to falling can be improved through the support of digital applications. • Update 17/08/22 Case of Need for a Falls Prevention Service was presented at CRIG meeting on 22nd July 2022.CRIG supported the ask of the Case of Need and to proceed to the next stage. A Standard Business Justification Case will be completed with an aim to be submitted to CRIG in	4	31/12/2021	31/03/2023	09/02/2023
4878	Physical or psychological harm	Evans, Simon	Carter, Mr Damian	Patient Safety Group	Outpatient Improvement Group	28/03/2022	20	Risk assessments	Corporate	Operations		Trust-wide	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care non-admitted pathway & booking systems / processes (outpatients) - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Outpatient Recovery Group; Reports through Divisional PRMs (for performance), and FPEC and System Planned Care Group - Clinical Harm Oversight Group	2ww first O/Ps back within national target Urgent 1sts 90% <13 weeks by 31.03.23 Time critical follow ups (452/2657 overdue) – target to eliminate (mainly neurology, cardiology, rheumatology) by 31.03.23 RTT non-admitted: Clear >104wws by 31.03.22 Clear >78wws by 31.03.22 (with few remaining by 30.06.22) Clear >65wws by 30.09.22 Clear >52wws by 31.12.22	13/12/2022	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	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	[13/12/2022 13:31:41 Rachel Thackray] As per previous update, no change to risk grading [21/10/2022 09:42:00 Rachel Thackray] Work continues on the Outpatient Improvement Programme (ORIG) to improve clinic utilisation, reduce demand and increase activity back to 19/20 levels and above. Key progress since last update includes; 1. Contract awarded for Validation contract – Start date November 2022 2. Commencement of personalised Outpatient plan – Start date December 2022 3. Super September completed and yielded 40% reduction in non-admitted pathways that were validated 4. Plan to reinstate tertiary clinics to increase capacity 5. Dedicated support to reduce missing outcomes 210622 No change due to major pressure on the system due to covid backlog. 230922 An externally procured validation team have been identified and they are due to start end of October. Risk transferred to Operations from Outpatients following discussion re ownership.	8	31/03/2023	31/03/2023	12/01/2023
4877	Physical or psychological harm	Evans, Simon	Carter, Mr Damian	Patient Safety Group		28/03/2022	20	Risk assessments	Corporate				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	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	26/01/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[26/01/2023 15:06:57 Corporate Dashboards] Risk moved from Surgery to Corporate as this is an operational risk, not divisional. [21/10/2022 09:40:36 Rachel Thackray] Work continues on three main improvement programmes to address capacity for Surgery 1. HVLC/GIRFT – Looking at best use of theatres by ensuring HVLC procedures are completed as daycases rather than Electives. This maximises productivity of lists and reduces length of stay to ensure bed availability for surgery. Compliance with HVLC has started to increase over recent weeks 2. Theatre efficiency/productivity – The trust deployed a company called Foureyes insight to work with the surgical division and implement a 16 week improvement programme around best use of theatres to drive efficiency and productivity. This piece of work has now concluded and yielded improvement in utilisation and internal processes. This now needs to be embedded as business as usual 3. Clinical prioritisation – Looking at the prioritisation of patients for surgery based on their clinical need to ensure limited theatre resource is used for the patients that most need it. The output of this work has seen good list usage for our most urgent patients and an appropriate mix of lower priority patient in order to maximise list utilisation Risk lead updated to Head of Operations.	8	31/03/2023	31/03/2023	26/02/2023

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ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	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
4779	Physical or psychological harm	Evans, Simon	Ratcliff, Carl		Clinical Effectiveness Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	27/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[27/01/2023 10:23:30 Charles Smith] 27/01/23 - CS DGM - Ongoing area of concern due to workforce and ACP gaps (being recruited to but time required to train). TIA still a concern but stable numbers. [16/12/2022 14:35:47 Carl Ratcliff] Additional work in palce to find external support / validate PWL and push patients through system [22/11/2022 17:25:10 Carl Ratcliff] Aim to have outliers back in right place and work continues to improve OPD work. Limited consultant numbers still mean there is a risk to OPD planned care work 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	31/03/2023	28/01/2023
4935	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha		Patient Safety Group, WORK	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.	09/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		09/02/2023
4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	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.	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	05/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	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.	[21/02/2023 08:53:55 Paul White] Note from Risk Register Confirm & Challenge Group - risk to be reviewed from Family Health perspective, including current rating and where responsibility for the risk should belong. [05/01/2023 14:08:19 Lisa-Marie Moore] To be raised again at MQG and action to be taken agreed 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.	4	30/09/2022	31/03/2023	09/02/2023
4974	Physical or psychological harm	Hallion, Simon	Naydeva-Grigorova, Tanya	Safety Group	Safety Group	14/07/2022	9	Professional Guidance	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Safety risk from an inability to provide a diabetes service that complies with relevant NICE guidance and ensures ability to secure best practice tariff.	1. Two Consultant Paediatricians (TN-G and AB) are currently managing all children with diabetes;	1. Audit of compliance with NICE guideline NG18 - Diabetes (Type 1 and Type 2) in Children and Young People: Diagnosis and Management and Adults and NICE quality standard QS125 - Diabetes in Children and Young People.	12/12/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Business case being developed to address resources shortfall (e.g. dietitian, psychologist, admin support, additional nurses) - agreed in principle at CRIG meeting. 2. Increase in clinic capacity to meet demand as per consultants database	[13/12/2022 14:42:45 Alison Barnes] No change. [18/11/2022 11:43:21 Alison Barnes] We are already scoring this highly. The mitigation has been reliant on funding to support an uplift of nursing, doctor time, psychology, dieticians etc. This funding whilst provisionally approved has not been forthcoming, with no clear plan in sight. We need to adjust mitigation to a position of reducing general service and prioritising those children most in need, and in doing so accept that we will not meet BPT or audit requirements. The score therefore needs to be reviewed. Recommend to change to 20. cabinet to escalate, agree at governance. 09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion.	3	31/07/2023		12/03/2023
4646	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	NIV Working Group	Clinical Effectiveness Group	14/12/2021	20	Policy/Protocol Issues, Risk assesesments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	13/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	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.	[13/01/2023 13:14:40 Donna Gibbins] Case of need agreed and SFBC being written following approval at establishment review for staffing establishment. Recruitment complete for LCH Respiratory wards with minimal vacancies once all staff in place. Task and finish group arranged for phase 2 of the respiratory project to review NIV standards at PHB and additional areas of focus including domiciliary NIV. To commence end of January 23. Monthly NIV audit continues-Timeliness of the commencement of NIV is improving, issues relating to availability of NIV bed and appropriate referrals a current issue to bed pressures. Escalated and reported through escalation structure. Agreed risk remains high but reduced, requires to remain at 16 until for confirmation of Trust wide achievement of BTS standards. New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB are on hold with provisions in place to allow NIV to be delivered in the bay where there are x 4 monitored beds (IPC agreed) Risk discussed at Risk Register Confirm & Challenge Group in May 2022. Still inconsistencies with timeliness against BTS standards, particularly at Lincoln, and inability to ring-fence beds but an improving position. Agreed that risk remains high but has reduced. Recommendation for rating to change from 20 to 16.Overall compliance monitored with a monthly NIV report. Case of need for funding of ward nurses in new environment agreed to ensure BTS standards are delivered, SFBC now required- commenced and in process, ew costings awaiting due to agreed pay rise on agenda for change	4	30/09/2022	31/12/2022	07/04/2023
Strategic Objective		**1b. Improve patient experience**																								

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ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	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
4985	Reputation	Sanz Torres, Aurora A	Cawley, Martin		Clinical Effectiveness Group	28/07/2022	16	Professional Guidance	Clinical Support Services	Cancer Services CBU	Radiotherapy		Not meeting NHSE/Service specification. Not being able to offer complete SABR technique.	Shared MDT with Nottingham Patient transferred to Nottingham if unable to treat	Number of patients of patient referred to Nottingham.	20/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Take case of need 2021_37V2 to CRIG for: Upgrade of Linear accelerators to version 2.7 Version 2.7 enables upgrade of the AlignRT system for improved functionality in motion management of SABR.	[21/02/2023 08:52:00 Paul White] Note from Risk Register Confirm & Challenge Group - risk description to be expanded to include cause / event / effect and rating to be agreed at division level prior to presentation at RRC&CG for validation. [20/02/2023 10:04:15 Martin Cawley] Still awaiting AlignRT upgrade. [16/01/2023 08:58:16 Martin Cawley] No change [21/12/2022 12:18:40 Rose Roberts] Teams message from Martin Cawley: "case of need written, not suitable for CRIGs current acceptance criteria therefore will be presented in April". I think this should be on 5062 which is the staffing for SABR. 4985 is the equipment which is already going ahead." [15/12/2022 13:44:30 Alex Measures] case of need written, not suitable for CRIGs current acceptance criteria therefore will be presented in April [21/11/2022 11:06:17 Martin Cawley] This is linked to 4984 please refer to that risk for updates. MGC PO for TB 2.7 has been raised. The upgrade to AlignRT will be scheduled once the TB2.7 is settled. Expect this can happen in December or early January depending on availability of engineers from VisionRT. This is now work in progress ____ Awaiting case of need to be presented to CRIG.	8	17/07/2023	27/01/2023	31/03/2023
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.	23/01/2023	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	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.	[23/01/2023 17:04:59 Jasmine Kent] Included within capital allocation bids for next financial year. Agreement from trust board that works will take place in next financial year. Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15 26/09/2022 - Unchanged	6	31/03/2025	31/03/2025	24/04/2023
4724	Physical or psychological harm	Rimmer, Lucy	Bradley, Mrs Lesley		Patient Experience Group	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.	15/12/2022	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	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. Prioritisation tool helps to identify patients with greatest acuity or importance which will directly impact patient flow and current bed situation.	[13/01/2023 12:51:48 Lesley Bradley] 13/1/23 NHSE reviewed Ashby ward this month-await recommendations for staffing levels [15/12/2022 09:53:21 Alex Measures] No update [30/11/2022 10:04:52 Rose Roberts] Neuropsychology bid is still awaiting CRIG approval as CRIG has been stood down. Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	30/11/2021	31/03/2023	31/03/2022
Strategic Objective							**1c. Improve clinical outcomes**																			
4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group, Medicines Governance Group, Patient Safety 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.	02/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	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	[02/02/2023 14:18:48 Lisa Hansford] Expected end date of implementation 31/03/23 [05/01/2023 14:07:02 Lisa-Marie Moore] Pilot phase in Cardio LCH complete. Roll out to begin on Stroke w/c 9th January [08/12/2022 12:43:26 Lisa-Marie Moore] Pilot still underway in cardiology at LCH. No update received to date on when roll out will occur. Issues external to pharmacy may hinder roll out e.g staff to add patients on careflow on admission/transfer [14/10/2022 16:05:51 Rachel Thackray] Pilot being undertaken in cardiology w/c 10 October 2022 which will take place over the next month. This will then be reviewed following completion. Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. 17/5/22 No change 150622 Discussed that a further risk is to be added concerning accurate medicines reconciliation as	4	31/12/2023	29/12/2023	09/02/2023
4972	Physical or psychological harm	Hallion, Simon	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/07/2022	9	Clinical Audit Reports	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Safety risk from an inability to provide a fully funded epilepsy service that complies with relevant NICE guidance.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition.	Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People.	13/02/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	1. Development of business case to enable establishment of fully funded epilepsy service.	[13/02/2023 14:05:26 Jasmine Kent] For discussion at governance for possible merge with other epilepsy risk and to duplicate onto community paeds risk reg. B7 unable to start but B6 is still due to start. [13/12/2022 14:48:22 Alison Barnes] Appointed 2 x epilepsy nurses. Steps in right direction. [18/11/2022 11:44:07 Alison Barnes] Agreement for spending, close advert for b7 and b6 due to be appointed epilepsy workshop with ICB. Gaps identified, work in progress. [11/10/2022 13:22:37 Alison Barnes] Adverts out for b6 and b7 epilepsy nurses, with interest, cost pressure whilst sorting funding. 09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR	3	11/07/2023	11/07/2023	13/03/2023

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ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	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
4731	Physical or psychological harm	Harris, Michelle	Parkin, Mr Lee	Medical Records Group	Information Governance Group, Patient Experience Group,	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Draft policy produced further discussion with changes required with Divisional Clinical Lead - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	02/02/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	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.	[02/02/2023 15:31:12 Rose Roberts] KB going to ask crg meeting if the new policy has been signed off. [15/12/2022 14:24:51 Madeline (Maddy) Ward] Ongoing, issue raised with clinical records meeting with control of health records for resolution, further meeting to be held mid-December [29/11/2022 11:04:59 Rose Roberts] Policy still awaiting final ratification so please extend by 1 month. [27/10/2022 12:08:42 Rose Roberts] Ongoing OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Digital Hospital Group. 120522 - Review of policy is underway – sent to h/recs managers for amendments before being sent for sign off to Lee and via the CRG 210622 Now further update until Nov. In Nov expect to get preferred bidder for it. Updates will come from Electronic records system project. 23/09/2022 - No further updates	4	30/06/2018	31/03/2023	31/03/2023
4932	Service disruption	Rimmer, Lucy	Chester-Buckley, Sarah		Clinical Effectiveness Group	24/05/2022	16	Workforce Metrics	Clinical Support Services	Cancer Services CBU		Trust-wide	Services will be stopped and/or disrupted due to non-recurrent funding (Macmillan/RDC/SDF funding streams). These include CNS, CCC, Waiting List Clerk, Trainee ACP's/ACP's, Advanced Practitioner Radiographer, PTL administrator, PTL Tracker, Deputy nurses-leadership roles.	List of job roles provided to Finance. CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology.	Via jo roles list	15/12/2022	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology.	[30/01/2023 16:12:51 Rose Roberts] Contracts end March 2023, if not in receipt of further funding non specific symptom (NS pathway will have to stop. Pre diagnosis service will have to stop. Currently we have a tick box on all 2 ww referrals which allows complex and vulnerable patients to be identified for support from this team, circa up to 40 pt per week. The other contracts that end end of March for transitional care specifically for colorectal and urology, would stop. [15/12/2022 13:32:54 Alex Measures] case of need completed for all four divisions within the trust, paper submitted to CRIG awaiting date for presentation Reduced to moderate as finance are now fully aware of the situation. Ongoing	8	31/10/2022		31/03/2023

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4928	Service disruption	Evans, Simon	Ratcliff, Carl		Clinical Effectiveness Group	28/04/2022	16	Professional Guidance	Medicine	Cardiovascular CBU	Cardiology		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across Cardiology arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	27/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[27/01/2023 10:20:57 Charles Smith] 27/01/2023 - CS - DGM - Further 2x Cons departures (Ads out). C&A not able to support PIFU implementation yet. Further loss of agency Cons at PHB to remove reliance on agency (cost). NHS national ask is to reduce FU work, this will have negative impact so currently negotiating via D&C process. [16/12/2022 14:40:47 Carl Ratcliff] Work underway to fill all clinics but no major concerns with perf [22/11/2022 17:29:18 Carl Ratcliff] RTT for cardiology starting to improve, however backlogs still place and risk not yet reduced. Specialty review work will lead t plan to bring RTT performance back into line but could take 6/12 Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Additional details to be added to risk reduction plan. 10.08.2022- New consultant starting September 2022- 2 x clinics per week for new patients only Existing new patients currently being validated by support manager. TOE list capacity being utilised for PBWL patients. Plans in plan for PIFU for cardiology (next meeting end of August 2022).	8	30/06/2022	31/07/2023	27/04/2023
4905	Physical or psychological harm	Cooper, Mrs Anita	Bradley, Mrs Lesley		Clinical Effectiveness Group, Workforce Strategy Group	22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on acute wards, delayed discharges, delayed referral to response times. Patient reviews delayed for botox treatment. Paediatric services- delayed response to new diabetes referrals and unable to see current diabetes patients in clinic- could lead to patient harm.	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 help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff-(normally B6 N&D staff)	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service.	15/12/2022	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	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.	[13/01/2023 12:54:24 Lesley Bradley] 13/01/2023 Continue to review staffing levels, vacancies and reasons for sickness on a monthly basis [15/12/2022 09:55:40 Alex Measures] still looking at models of how to measure safe staffing levels, just asking each team to provide there funded establishment, what they would expect on a usual day and what is the minimum level of staffing, then we can start measuring whether we are falling below safe staffing levels, we have no method of recording that at the moment [30/11/2022 10:07:42 Rose Roberts] Continuing to look at staffing. Currently have a lot of sickness. Looking at levels of staffing so able to report whether staffing levels fall below a safe level. 130622 Looking at staffing vacancies and looking at line by line post analysis. OT IR 8 posts KPI's for Integration include reduce vacancies Promotional Commms for AHP week and Trac being produced to attract staff Improved recruitment strategies.	9	30/06/2023	31/03/2023	31/03/2022
Strategic Objective							**2a. A modern and progressive workforce**																			
4991	Service disruption	Low, Claire	Shankland, Lindsay	Workforce Strategy Group		08/08/2022	20		Corporate	People and Organisational Development	Operational HR	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience.	ULHT policy: - Workforce planning processes - Recruitment & Selection Policy & Procedure - Rota management systems & processes - Locum temporary staffing arrangements - Workforce management information - Core learning / Core+ programmes? ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Vacancies & turnover rate. Staff survey results relating to job satisfaction / retention. Core learning compliance rates?	31/01/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	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.	[31/01/2023 15:11:35 Rachel Thackray] Developing workforce planning report to be submitted to HEE by 31 March 2023, this has a monthly breakdown of anticipated recruitment plans across staff groups with an aim to take us to a vacancy factor of approx 2%. This will be monitored at an organisational and system level monthly. Staff survey results from November 2022 show increased positive scores across all factors which should influence retention issues. Risk reduction plan - Presentation to ELT on 10/11/22 to update international recruitment plan, revised projection on increasing nurse recruitment to get to zero vacancy position by March 2023 Currently 250 nurse vacancies - task and finish group created by Head of Recruitment to work in conjunction with divisional leads to pull together a recruitment activity plan for the remainder of 2022/23 and 2023/24. Plan for recruitment of 285 nurses by the end of the financial year. 1. New to care recruitment being extensively used for HCSW role with 14 appointed & a further 40 offered. 2. Nursing associate recruitment embedded 3. Medical Support Worker role now looking to be embedded as business as usual. 4. Agency providers increased to a minimum of three for key roles, rather than 1 previously. 5. Restructure process started within wider HR team will result in significant greater capacity for recruitment activities and overall oversight and proactivity. 6. Restructure process started, to introduce internal agency aspect to ULHT recruitment. 7. Medical recruitment expertise aspect being reintroduced via restructure, support already in place via agency staff. 8. Relationship with LRDP now embedded, GMC registered Drs and MSWs recruited. 9. Agreement reached with third party supplier to support Philippines recruitment for difficult to recruit AHP roles. 3 recruits in progress	4	31/03/2023	31/03/2023	28/02/2023
4741	Service disruption	Cooper, Mrs Anita	Chester-Buckley, Sarah	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	16/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	[16/01/2023 12:13:46 Sarah Chester-Buckley] Interviews being set up for leadership role. [15/12/2022 13:42:46 Alex Measures] leadership posts out to advert [16/11/2022 15:56:34 Rose Roberts] Posts being mitigated by employing high cost locums, risk with this mitigation is that locums need only give one weeks notice. Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements. 220622 Agency Clinical oncologists recruited. So improved cover for Head and neck and melanoma. Ongoing	4	31/03/2023	31/03/2023	30/06/2023

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4862		Ratcliff, Carl	Rumble, Callum		WORK	22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU	Respiratory Medicine		Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting.	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The Business Unit have this week (06/09) put a bid in to the EMCA to gain funding of 250K to support a General Medicine to work in Respiratory so that our Substantive teams can be released to support Respiratory Cancer Capacity - This bid is currently being reviewed. We have worked in the background to book x 2 Agency Locum General Medicine Consultants 1 at Boston and 1 at Lincoln which will take us over budget, but supports the respiratory patients of lincolnshire and the welfare of consultant staff.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	01/12/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Close working with Agency to try and recruit agency locums to temporarily fill gaps. Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff. Additional funding from Cancer alliance for Gastro and Resp to allow for additional Gen Med Locum to reduce burden on current workforce. Remote working in place to support outpatients where possible. Agency spend supporting out of hours workload - for example, covering the substantive consultants on calls to allow them to focus on Cancer work instead of on call - supporting patient care.	[01/12/2022 11:15:13 Carl Ratcliff] plan for 3 consultants now being on boarded New plan to develop ACP nodule role Most recent update: Dear Carl, Following the catch up earlier, Claudia, Ashley and I have compiled our thoughts on what could go down to support the services..... Option Take down: Benefits Risks: 1 Do Nothing None Cancer patients continue to wait prolonged periods for care. • Inpatient services at LCH and PHB continue to become extremely depleted • Welfare of current consultant workforce continues to suffer, potentially leaving to sickness / prolonged absence • Boston have only x2 Consultants, currently utilising support from already depleted LCH Team. (If annual leave / sickness, we have only 1 consultant on the Pilgrim site) 2 Grantham inpatient respiratory services (Preferred) Releases x1 Agency Locum Consultant who can ?potentially? go over to Lincoln (as per previous agreement) • Releases a consultant to cover the rota to a 'safe' level Non-compliance with ASR due to taking out inpatient respiratory services at GDH • ?1 consultant from the Acute on Call rota at Grantham. • Dr E could decide to leave ULHT due to not agreeing with request 3 Respiratory to come off the outlier rota for General Medicine Capacity to support the ward referrals / CT triage Impact on other specialties / or risk for outliers not to be seen daily (sick and new only) 4 Cancellation of non DCC roles for substantive workforce (Governance / Audit Lead / Community Lead) Increased DCC availability to focus on Cancer / safely cover inpatients Impact on wellbeing of consultant workforce • Risk to not comply with governance metrics	4	30/12/2022	01/04/2023	01/03/2023
4762	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy		Nursing, Midwifery and AHP Forum, WORK	14/01/2022	15	Risk assessments	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	09/01/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[09/01/2023 14:29:40 Caroline Donaldson] Staffing position remains the same - still an issue. Advert out for posts. Second Clinical Educator post has been recruited to. Level 3 beds still capped at 8 (both sites). [29/11/2022 15:15:09 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. No change to previous progress note. [20/10/2022 14:04:40 Caroline Donaldson] 20/10/2022 Discussed with Lead Nurse. Still ongoing workforce issues. Interviews are in progress for additional clinical educator post and approach has been made to the Clinical Education team to support with that. Individualised action plans are being drawn up and put in place for new members of nursing staff in order to support them. 16/09/2022 Skill continues to be an issue. Additional clinical educator to be appointed to support training needs of team. Level 3 beds still capped at 8. Risk continues and includes skill mix as well as numbers of staff. Mitigation - ongoing recruitment, block booking of Agency staff, daily review of staffing undertaken, liaison with University of Lincoln to support new starters.	6	30/06/2021	30/09/2022	09/02/2023
Strategic Objective		**2b. Making ULHT the best place to work**																								
4990	Reputation	Low, Claire	Shankland, Lindsay	Workforce Strategy Group		08/08/2022	20		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally.	1. National and local lessons learnt for engaging staff effectively with surveys 2. Dedicated 'staff experience/engagement' role proposed to lead programme of work (including corporate and local action planning)	1. Pulse Staff Survey response rate (quarterly) 2. NHS Staff Survey response rate (annual)	31/01/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	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	[31/01/2023 15:15:19 Rachel Thackray] Staff survey responses from November 2022 indicate a perceptible positive shift across most questions. Improvement evident in position within our group on Picker moving from last place to 57/65. [09/11/2022 14:55:58 Rachel Thackray] Staff survey currently live with a good uptake and comms on a daily basis. HRBPs working with divisional leads to promote areas with low uptake. Promise Manager now in post from September 2022 working on staff retention. 1. Pulse Staff Survey - Q2 (July'22) 2. Reset approach (communication, engagement of and management) for sign off - ELT (June'22) 3. Local action planning process - now live 4. 7 Big Ticket Priorities proposed following NHS Staff Survey	4	31/03/2023	31/03/2023	28/02/2023
4439	Service disruption	Low, Claire	Shankland, Lindsay	Emergency Planning Group	WORK	16/11/2018	20		Corporate	People and Organisational Development	Operational HR		If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Workforce plans & rota management procedures. Temporary staffing arrangements. Business Continuity Policy with associated procedures & guidelines. Local service-specific business continuity plans & recovery procedures. Executive oversight (Chief Operating Officer) through Emergency Planning Group.	Frequency of industrial action events. Publicised staff polls / surveys by professional bodies on possible industrial action.	31/01/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	[31/01/2023 15:18:02 Rachel Thackray] Current risk assessment in place and working group set up to prepare for potential ongoing industrial action, links in with operational planning to ensure a joined up approach. [07/11/2022 11:13:23 Rachel Thackray] There is a likelihood that there will be some form of industrial action before the Christmas period in 2022. Therefore, it is necessary to increase the likelihood of this risk from low to extremely likely. As such he Associate Director of Workforce is working with the Emergency Planning team to revise the current action plan in place involving staff side reps and the Senior Management Team. The communications team will also be involved. There is a meeting taking place on the 8 November 2022 to implement a Task and Finish group. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review).	4		31/03/2023	28/02/2023
4993	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	WDES (Workforce Disability Equality Standard): limited awareness and implementation of reasonable adjustments and other forms of support which results in limited equality and equity of opportunity for staff classified as having a 'disability'; impedes Trust's ambitions to create an inclusive culture and foster belonging; difficulties in attracting as well as retaining talent	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	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	[31/01/2023 15:22:04 Rachel Thackray] WDES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. WDES action plan prioritised for engagement, development and delivery 2. July 2022: ULHT review datasets, declaration rates (from 1/7/22 ULHT required to submit metrics and narrative data via the DCF online platform by Aug'22). 3. End October 2022: deadline for ULHT to publish WDES 2022 annual report (include metrics report and WDES action plan)	4	31/03/2023	31/03/2023	28/04/2023

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ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	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
4992	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	WRES (Workforce Race Equality Standard): low compliance/ limited improvement and action to address indicators i.e. increase senior representation and better lived experience of BAME staff working in ULHT. Risk is this results in low number of applications for vacancies which then remain unfilled (difficulty attracting talent); poor turnover rates (difficulty in retaining talent) and a poor employer brand locally, regionally, nationally and overseas. This will impact on the culture of the organisation and the ability to recruit with increased turnover. Wider risk with regards to broader protected characteristics linked to the delivery of the EDI objectives.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	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)	[31/01/2023 15:23:43 Rachel Thackray] WRES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. EDI Group and regular reporting established (for assurance) 2. Anti racism strategy and delivery plan socialised with stakeholders and live 3. NHS Staff Survey results - deep dive and analysis of lived experience of staff with protected characteristics 4. Draft EDI objectives 2022-25 - socialised and ready for sign off (end June) 5. ULHT workstream lead - addressing BAME disciplinary gap (Lincs Belonging Strategy) 6. People Promise Manager successfully appointed from end May'22	4	31/03/2023	31/03/2023	28/04/2023
Strategic Objective							**3a. A modern, clean and fit for purpose environment**																			
4647	Reputation	Evans, Simon	Davey, Keiron	Fire Safety Group	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)	06/12/2022	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	[06/12/2022 14:55:09 Rachel Thackray] Fire safety team currently working with estates colleagues to identify any areas of lower assurance are included within PPM schedule [02/11/2022 12:40:28 Rachel Thackray] No change, risk grading remains the same LFR previously served ULH with an Enforcement notice and action plan (since removed) in which the storage of items within corridors was highlighted: "Article 14(2) Emergency Routes and Exits There are combustible materials and items that pose an ignition risk are located on escape routes within the hospital. It required that Corridors and stairways that form part of an escape route should be kept clear of obstruction and hazard free at all times. Items that maybe a source of fuel or pose an ignition risk should not normally be located on any corridor or stairway that will be used as an escape route." In light of identified storage issues and subsequent non-compliance with these requirements, there is now a high potential for immediate enforcement notice with a view to prosecution in accordance with the regulator's compliance code. Task & finish group set up to address storage issues at local and at senior levels. Fire Safety Advisors working with local managers; IR1s reported when storage issues are identified, with escalation to divisional leads where necessary. Lack of PPM assurance identified - escalated to Estates management team for action, including improvements to the Micad system.	4	30/06/2022	31/03/2024	06/01/2023
4648	Physical or psychological harm	Evans, Simon	Davey, Keiron	Fire Safety Group	Emergency Planning Group, Health and 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.	06/12/2022	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[06/12/2022 14:53:59 Rachel Thackray] New security provider undertaking internal patrol routes with escalation to porters when storage discovered. [02/11/2022 12:39:13 Rachel Thackray] Regular audits conducted by fire safety team by Fire Safety team within corridors, and IR1s being submitted to line managers for action. Escalation to matrons has now begun via IR1s. 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	06/01/2023

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ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	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
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	Emergency Planning Group, Estates Infrastructure and Environment 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.	21/10/2022	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	[21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	21/01/2023
Strategic Objective							**3b. Make 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)	02/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	[02/02/2023 14:17:26 Rachel Thackray] The Trust is forecasting a 52.8m agency usage in 22/23 this is driven by increased volume requirements due to the number of beds open and significant breach of the agency price caps due to market conditions. The Trust has significant oversight and plans to control and manage in a phased and safe way agency reductions in Q4 22/23 and into 23/24. [02/11/2022 11:06:31 Rachel Thackray] The Trust agency spend continues on a similar trajectory driven by significant and increased demand for patient services – primarily in the NEL pathway and pressures in ED. This has resulted in additional beds being required above those planned and subsequently a need to staff the beds with temporary and high cost nursing and medical staff to remain safe. The Trust has introduced a financial improvement plan that is heavily focused on increased agency oversight across all staff groups with a number of Exec lead schemes. 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	02/03/2023
5020	Finances	Wall, Mrs Tracey	Thomson, Cheryl		WORK	02/09/2022	20		Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	09/02/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[27/01/2023 11:36:10 Helen Hartley] Reviewed today, will be discussed further on 6 Feb to potentially lower. [23/11/2022 11:25:30 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed but may be reduced on next review taking account of mitigating controls. [10/11/2022 13:40:37 Helen Hartley] No change at governance [07/11/2022 07:03:07 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:24:16 Helen Hartley] No changes made at governance	10	02/09/2023		09/03/2023
5019	Finances	Wall, Mrs Tracey	Spendlove, Mrs Clare			02/09/2022	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is a continued reliance on bank and agency staff for nursing workforce in Urgent & Emergency Care there is a risk that there not sufficient fill rate in each department which will impact on patient safety and have a negative impact on the CBU budget	Robust nursing plan for every post meetings Daily operational matrons identified for Lincoln and Pilgrim Daily safer staffing lead identified for escalation Establishment review DON Monthly roster clinics / workforce dashboard Daily staffing meetings 3x day Monthly director of nursing quality dashboards. Temporary staffing solutions group - purpose is to reduce agency spend attendance. Improvement in fill rates when shifts are put out Reduce consequence level because of existing mitigations in place affecting staffing and there is a proposed end .	Plan for every post meetings Budget reports	09/02/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment	[09/02/2023 16:12:57 Helen Hartley] Met with Tracey Wall, Cheryl Thomson and Rachel Thackray - to be reduced to 16 and added mitigations [27/01/2023 11:39:06 Helen Hartley] Reviewed today but another meeting in diary early February to discuss in more detail potential to lower. [23/11/2022 11:25:56 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed but may be reduced on next review taking account of mitigating controls. [10/11/2022 13:40:02 Helen Hartley] No change at governance [07/11/2022 07:03:20 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:24:02 Helen Hartley] No change at governance	8	02/09/2023		10/03/2023
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.	02/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	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.	[02/02/2023 14:25:19 Rachel Thackray] The Trust is forecasting £5.8m COVID related costs for 22/23. This is a much improved position from the 21/22 spend however this is still a pressure, although much reduced, in the financial position. All schemes that have been reduced or ceased have been through a QIA assessment. Risk to be reassessed in April 2023. 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	03/04/2023

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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	02/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	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.	[02/02/2023 14:13:16 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme for 22/23 a shortfall of £11m against its revised plan, which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. [02/02/2023 14:12:00 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. 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	02/05/2023
4965	Finances	Hallion, Simon	Edwards, Nick		WORK	11/07/2022	9	Workforce Metrics	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Financial risk due to reliance upon temporary staff (nursing and medical) to cover vacancies in Paediatrics.	1. Scrutiny of rosters to ensure optimal use of existing staffing resources; 2. Review of all shifts that are placed with either Nursing or Medical Bank to ensure these are required; 3. Use of bank staff in preference to agency staff in view of potential cost savings; 4. Utilisation of tier 1 and 2 agencies in view of potential cost savings; 5. Use of long line agency in view of potential cost savings and increased assurance that shifts are safely staffed.	1. Reviewed via temporary staffing expenditure and safe staffing metrics; 2. Agency spend reviewed via at FPAM	12/12/2022	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1. Robust recruitment and retention plan for nursing and medical staff across Children and Young People Clinical Business Unit.	[13/12/2022 14:40:14 Alison Barnes] No change [18/11/2022 11:42:37 Alison Barnes] Positive feedback around nursing recruitment. Start dates for medical staff currently delayed beyond predictions impacting on higher than anticipated use of agency staff. Agency spend closely monitored at trust level. 09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR Discussed at Risk Register Confirm and Challenge meeting. Confirmed that risk is solely financial as there is mitigation in place to ensure quality and safety are maintained (eg long line booking of regular agency staff). Some discussion about whether this risk should sit on the divisional risk register or whether it is captured in the corporate risk that focuses on the impacts of vacancies. To discuss at forthcoming risk meeting.	3	31/07/2023		12/03/2023
Strategic Objective							**3c. Have enhanced data and digital capability**																			
4657	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team.	Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	02/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[02/02/2023 09:01:03 Fiona Hobday] Risk taken to Confirm and Challenge meeting in Jan 23- agreed score should increase to 20. [30/01/2023 14:01:47 Rachael Turner] Risk requested to be increased to a score of 20 at Confirm and Challenge group as we are not meeting statuary requirements and continue to have a large backlog. This risk also impacts on Complaints and PALS. Agreed at C&C group for risk score to be increased. [06/12/2022 15:51:15 Maria Dixon] Ongoing communications with ICO. Changes to clinical review part of process. Some additional temporary resource brought in. This is a significant ongoing piece of work that is going to take at least 12 months to overcome. Office 365 implementation Trust-wide in progress, to enable search of emails / systems. Still has limitations & requires staffing capacity to manage demand for SARs. Discussed at Risk Register Confirm & Challenge Group, 23 March 2022. Agreed recommendation that current rating should potentially be increased from 12.	6	30/06/2023	30/06/2023	02/03/2023
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the required data protection / privacy impact assessment process and subsequent contractual requirements is not followed consistently at the start of a system/ process 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 or third-party incompliance that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	National policy: - Data Protection Act 2018 & General Data Protection Regulation - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy and 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	Monitoring of IG project tracker into IG Group. Internal audit review of data protection / PIA processes	06/12/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	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. Work to review and implement a formal process with procurement/ contracting. Work to develop and implement the IAO strategy.	[06/12/2022 15:00:16 Maria Dixon] Developed new template to go live this month. Strategy is drafted going to IGG for escalation in Jan 2023. Interim Head of IG currently in post. 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	31/03/2024	30/06/2023	28/02/2022
4658	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework it runs the risk of not meeting national best practice. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management.	02/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments.	[02/02/2023 14:17:13 Fiona Hobday] Revise score approved at Confirm and Challenge meeting in Jan 23. [06/12/2022 15:09:53 Maria Dixon] DPO & Interim Head of IG raised with SIRO as part of O365 discussion. Development of health records retention & disposal policy in progress. Discussed at Risk Register Confirm & Challenge Group, 23 March 2022. Currently the Trust is storing paper records for longer than it should and there remains a lot of unknowns as to where records are stored. Likelihood should be increased, severity may possibly be lower.	4	28/06/2024	28/06/2024	02/05/2023

Appendix A - All risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4641	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	Emergency Planning 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 (4) 71-90% chance	Severe (4)	High risk (15-16)	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

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*7 March 2023*
Item Number	*Item number 13.2*

Board Assurance Framework (BAF) 2022/23

Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

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

Executive Summary

The relevant objectives of the 2022/23 BAF were presented to all Committees during February 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.

Significant updates for objectives 3e - Reduce waits for patients who require planned care and diagnostics to constitutional standards and 3f - Urgent Care were offered to the Finance, Performance and Estates Committee and whilst the updates were accepted by the Committee work will be undertaken during the update process during March to ensure appropriate alignment of the narrative within the document.

The following assurance ratings have been identified:

Objective		Rating at start of 2022/23	Previous month (January)	Assurance Rating (February)
1a	Deliver harm free care	Green	Green	Green
1b	Improve patient experience	Amber	Amber	Amber
1c	Improve clinical outcomes	Amber	Green	Green
2a	A modern and progressive workforce	Red	Amber	Amber
2b	Making ULHT the best place to work	Red	Amber	Amber
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 collaborative models of care with our partners	**Amber**	**Amber**	**Amber**
4b	Becoming a University Hospitals Teaching Trust	**Red**	**Red**	**Red**
4c	Successful delivery of the Acute Services Review	**N/A**	**Amber**	**Amber**

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2022/23 - February 2023

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

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Programme of work in place to implement the requirements of the National Patient Safety Strategy (culture and systems) Human Factors faculty in place and face to face training restarted. Commencing next steps of cultural work with external agency. Pascale survey work continues to be undertaken. Safe to Say Campaign launched. (PSG)	Further work required in conjunction with People and OD to develop the Just Culture framework. Issues linking National Patient Safety Training to ESR are impacting on our ability to meet National training requirement.	To be considered as part of the Trust Culture and Leadership Programme	Safety Culture Surveys Action plans from focus groups and Pascal survey findings. Regular update reports to the Patient Safety Group and upwardly reported to QGC and through TLT. Theatre Safety Group reporting progress against a Quality Improvement plan to PSG. Regular upward reports received from Divisions.	None identified	Not applicable		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	None identified.	Not applicable	Upward reports from QGC sub-groups 6 month review of sub-group function Annual review of QGC takes place.	None identified	Not applicable		
						Effective sub-group structure and reporting to QGC in place (CG)	None identified.	Not applicable	Sub-Group upward reports to QGC	None identified.	Not applicable		

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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	5016 4804 5057 4624 4877 4878 4879 4789 4935	CQC Safe	Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG. Training has been delivered to approximately 40 members of staff to undertake SJR's. Bespoke training and support offered from the Mortality team to the Divisions. (PSG)	Gaps in the number of structured judgement reviews undertaken - this is not across all Divisions, good practice exists and is demonstrated through the mortality group. Impact of Covid-19 on coding triangles	Following the success in UTOO for ACP's contributing to the SJR reviews, further training is going to be rolled out to the MDT.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Dr Foster data on depth of coding. Dr Foster data is now available.	Gap identified in the ability to draw learning from SJR's due to ongoing delays with completion Inconsistent approach to Mortality and Morbidity meetings across specialties.	Local data sources are used where possible. Gaps in learning mitigated by ME process and escalation of concerns via incident management processes. New Deputy MD reviewing MORaLs and M&M meetings with a view to making recommendations.	Quality Governance Committee	**Green**
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG)	Clinical harm review processes not all documented & aligned with incident reporting Recognition of a skills gap for investigations at different levels of the organisation	Implementation of a Clinical Harm Delivery Group reporting into the Clinical Harm Oversight Group which is a sub-group of QGC. Appointment of a Clinical Harm and Mortality Manager Investigation training will be addressed as part of the implementation of the PSIRF and National Patient Safety Strategy. Plan to refocus PRM with a specific focus on quality and safety.	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports Strong divisional reporting to MORALs	None identified.	Not applicable		
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Improvement seen across all divisions in terms of development of NatSIPs/LocSIPs, however audit is required in order to provide assurance of implementation.	Individual Divisional meetings now in place; quarterly reporting to PSG Additional support provided to medicine from the Patient Safety Improvement Team	Audit of compliance	Pilot audit tool developed and currently being trialled prior to full rollout.	Review occurring through the Divisional meetings with quarterly reporting to PSG.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
			Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	4750 4779 4868 4974 4646		Medicines Quality Group in place with a focus on improving medication safety / appropriate prescribing / appropriate management of drugs and controlled drugs Robust medicines management policies and procedures in place 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. The Medicines Management Action group in place to oversee the programme of works from the IIP programme. MQG will retain oversight of the relevant IIP programme of work (MQG)	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 Lack of adherence to Medicines management policy and procedures Lack of 7 day clinical pharmacy service	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Deputy Medical Director led Action / Delivery Group in place and meeting fortnightly to progress actions and reporting to the MQG.	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 Omitted doses audit Prescribing Quality reports Robust Divisional reporting and attendance into MQG monthly IIP upward report into MQG monthly Internal Audit report	Medicines Quality Group have not been receiving reports regarding progress with the medicines management IIP however this is planned to commence from November; Lack of upward reporting from the DTC and the Medical Gas Audit Pharmacy audits only occurring in areas they are providing a clinical service to.	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	DPG meeting not meeting as frequently due to loss of Chair. New Chair identified and commenced in post October 2022.			
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	Paper presented to CRIG and funding agreed - currently sat in reserves and awaiting drawdown by Estates and Facilities who will manage the trainers	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting to Mental Health, Neuro Diversity and Autism group	DMI training to commence delivery in November 2022. 05.01.2023 - Training commenced delivery in November but not fully rolled out as only 1 trainer in post. New Training jobs are out to advert this month with a view to being in post for March / April 2023 when full rollout will begin	Datix being monitored by safeguarding team to ensure review of any restraint incidents Funding agreed by CRIG. new roles to be managed within Estates and Facilities. 05.01.2023 - New Training jobs are out to advert this month with a view to being in post for March / April 2023 when full rollout will begin 07.02.23 - all posts now advertised and shortlisted - interviews early March - likely appointment dates May 2023		
						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)							

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
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads(CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				
						Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group - the group continues to develop its maturity Meeting may be stood down due to operational pressures at time of operational extremis.	The Group meets monthly and has a work plan and schedule. If the meeting is stood down, then the papers are reviewed and Chairs report provided.	Upward reports to QGC monthly and responds to feedback Review of ToR in May 2022 and annually as part of the work schedule. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report Divisional Reports have developed in reporting maturity and include a patient story / risks and issues / actions. This is a well embedded part of the PEG meeting.	Themes from the Divisional assurance reports and the Complaints reports and others sources of information are being triangulated, so oversight across the themes is clear, this is work in progress.	Overall report being developed and monitored through PEG.		
						Patient and Carer Experience (PACE) plan 2022 - 2025 (PEG)	The PACE Delivery Plan to be actioned and embedded over the life of the delivery plan.		Patient Experience & Carer Plan progress report to Patient Experience Group as per schedule.	Ongoing assurances provided to PEG re: actions. Assurance is variable due to the number of actions being delivered. But overall oversight of the plan = moderate assurance	The delivery plan will be monitored through PEG		

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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	4701 4724	CQC Caring	Quality Accreditation and assurance programme which includes weekly and monthly audits which include feedback on patient experience from patients in the clinical areas.(PEG)	Further development of alignment of findings in audit data to patient experience surveys overarching plan and other sources of patient experience information. Annual Ward / Dept quality review visits may be paused due to operational pressures in times of extremis.	Head of pt experience can access the audit date. Deep dives into areas of concern as identified in quality metrics dashboard meetings Update reports to PEG and QGC as required. Weekly and monthly audits continue to take place including during times of extremis.	Reports to PEG and upwardly to QGC	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year, which include the patient experience team as part of the visit team. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support.	Quality Governance Committee	**Amber**
						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. Recruitment for new panel members will happen through Nov / Dec 22. Sensory Loss group upwardly reports to Patient Panel. You Care - We Care to Call (YCWCC) Campaign pilot being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. Communication working group set up to look at a range of communication issues affecting patient experience.	Upward reports and minutes to the Patient Experience Group	Diversity of patient engagement and involvement is limited.	Partnership working established with Healthwatch to reach out to Eastern European community; staff BAME network approached for community links and contacts. Expert reference groups progressing well: Breast mastalgia group has completed its co-design but will meet again in the future as part of service evaluation, Cancer group meeting quarterly, Dementia Carers group has had first meeting and will meet alternate months. Cardiology and QI groups being developed		
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting. Audit planned for Jan 23 and to report to PEG in Feb/March 23	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work. Audit planned for Jan 23 combined with EOL visiting audit.	Report to PEG through complaints & PALs reports; upward reports were received from Visiting Review working group which has now disbanded; the planned audit will report back to PEG and propose any further recommendations. With visiting restrictions now removed the previous issues cited within complaints and PALs have not been seen. This will continue to be monitored through the winter months. from Visiting Review working group.	Patient information currently subject to review and work is ongoing.	Audit of visiting experience planned for Jan 23 will provide an understanding across all aspects of visiting now that all COVID precautions have been stepped down. This will also tie in with national work on Care Partners and visiting guidance under the Health & Care Advisory Board which the Head of Patient Experience is a member of.		

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						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports will need to develop in maturity regarding patient experience	Head of Pt Experience to discuss with EDI lead to ensure data is relevant and triangulated.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic; national programme recommenced September 22	PLACE Lite continues & reports to PEG plus the annual report will be received at PEG, due Jan 23		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements.	Discharge experience reports to PEG quarterly.	Lead Nurse for discharge to attend PEG in October. Deferred to Nov. Deferred to Dec.	Patient Experience Team to meet with Lead Nurse for Discharge to support and ensure experience data is collected, analysed and acted upon.		
						Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust.	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics.	Review of Terms of Reference to be undertaken. Invites to speakers to come direct from Mr Simpson as Chair of the Group in future.	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	Isolated pockets where upward reports are not always submitted.			
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4731 4828 4972 4905	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 although this is due to recommence.	National reports to be presented at Governance Meetings once produced		
						Specialised services quality dashboards (SSQD)	SSQD data collection now commenced again post Covid. Areas with outliers identified with some plans for improvement, however not all required areas currently have plans.	Continued support from the Clinical Effectiveness Team and requirement to attend CEG and provide update on progress.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	Actions plans not yet received for all necessary areas.	Continued requirement to attend CEG to provide updates.		
						Process in place for implementing requirements of the CQUIN scheme.	Plans now in place for delivery of 2022/23 CQUINs, although assurances not yet received that these are fully implemented.	CQUIN delivery group commenced again.	Quarterly reports to CEG and upwardly reported to QGC	Some gaps identified in reporting processes.	Being dealt with via the CQUIN delivery group		
						Process in place for ensuring high quality of record keeping including Medical Records Group.	Medical Records Group not meeting regularly.	Refocus of the Medical Records Group planned by the new Chair.	Programme of record keeping audits taking place.	Audits do not demonstrate compliance with record keeping standards.	Divisional governance leads to pick up within each area.		

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						Process in place for monitoring of and implementation of NCEPOD requirements.	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.				
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
					CQC Safe CQC Responsive CQC Effective	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)			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	None identified			
						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.	Work continues with the regional roll out of the KPMG workforce tool and from a ULHT perspective a group has been created to support the submission of the Q4 workforce planning submission. First draft of the workforce submission has been submitted with a final submission required at the end of March 2023.		

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2a	A modern and progressive workforce	Director of People and Organisational Development	Possible disruption caused by system wide strike action and capacity of Pillar leads	4362 & new high risk on POD register		Recruitment to agreed roles - plan for every post	Availability of workforce	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.	None identified		People and Organisational Development Committee	**Amber**
						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 Task and Finish Group Statutory and Mandatory Training Task and Finish Group Appraisal	Talent management - on hold	Restructure and resource in to People and OD Directorate	Executive CQC Assurance Panel Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training	Appraisal compliance levels not at expected level Mandatory Training compliance not at agreed level	A task and finish group continue to review the Statutory and Mandatory training requirements, final papers to be presented at February PODC to provide update on this and the on-going appraisal review.		
						Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural change when the ability of the ULHT teams to engage when we are operationally challenged Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects)	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations Working with each improvement programme and Divisions to develop identify and align improvement plans	Internal training reports produced by Improvement academy Improvement programmes identifying personalised training needs for ULHT staff Divisions training plan (aligned to the IIP) presented at FPAM	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams.	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement)		
						Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Support and training from HRBPs External consultancy briefings with divisional leads	Sickness/absence data	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.	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. Stats are reported through FPAM.		

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						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service (pending P&OD restructure)	Training and Development department	Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education Recruitment to Head of Education and Training infrastructure. Interim resource in place	System LEAD (Learning, Education and Development) Board to provide system oversight (agreed) Apprenticeship uptake and utilisation of levy through WSODG	None identified			
						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	Vacancy of accountable officer	Appointed post holder due to commence March 2023. Interim cover in place. Task and Finish Group established	Improved vacancy rates reported through WSODG	None identified			
						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	Training and Development and review of existing OD infrastructure	Recruitment to Head of Education and Training infrastructure. Interim resource in place. Realignment of OD priorities, due to go live April 2023	Workforce and OD Group IPR - Appraisal compliance Culture and Leadership Group Priority updates to PODC	None identified			
						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	Low completion rates and compliance with job planning	System support being considered for job planning	WSODG TSSG Medical Staffing Group	None identified			
						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			People Board	None identified			

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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	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 NSS results (Feb 2023)	Delivery of agreed output	Pending first formal issue of the outputs on the National Staff Survey early link in with Comms will be required to share the outputs with all Trust Staff before general release on the 9th March.	People and Organisational Development Committee	**Amber**
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.			Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) Leadership SkillsLab - launched June'22	Training and Development department	Leadership SkillsLab - launched June'22	National Quarterly Pulse surveys (mandated from July'22) Number of staff attending leadership courses	Limited oversight of outputs of Pulse Surveys	Work on-going in terms of launch of next pulse survey and promotion.		
						Lincs Belonging Strategy EDI Delivery Plan 2022-25			Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified			
						Staff networks			Council of Staff Networks	None identified			
						Employee Assistance Programme implemented May 2022			System Health & Wellbeing Board Linc People Board (NB. Wellbeing Pillar) Employee Wellbeing Group (pending)	Wellbeing activity (for reporting to Workforce, Strategy and OD Group)	Core data is now included in the POD scorecard which is tabled at the Operational working group.		

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						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian			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	None identified			
						Embed compassionate and inclusive leadership (aligned to People Promise)	Training and Development department		Culture and Leadership Group	None identified			
2c	Well led services	Chief Executive	Risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes 4 sessions during Oct / Nov 21 Risk Register Confirm and Challenge Group ToRs Upgrade to datix system Full Risk Register review	Policy and Strategy document updated	Complete	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**
						Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6			

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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 Divisional breakdown of policies requiring review being shared with PRMs	Review of document management processes - Complete New document management system - SharePoint - In place Reports generated form existing system - Complete All policies aligned to division and directorates - Complete Single process for all polices clinical and corporate - Complete	Fortnightly ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
						Ensure system alignment with improvement activity							
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. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.		
						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.		

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3a	A modern, clean and fit for purpose environment	Director of Finance and Digital	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)	4648 - Fire Safety 4647 - Fire Safety 4858 - Water	CQC Safe	Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID	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.	Finance, Performance and Estates Committee	**Amber**
						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	Estates Group Upward Report				
						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 FPAM PRM	Ability of clinical and operational colleagues to engage due to service pressures. Evidence of system and Trust schemes to reduce the operational pressures and beds numbers in the Trust. Traction in year to produce cost out from cross cutting targeted and transformational schemes	Divisional - Progress is being reviewed monthly with Divisions through FPAMs. Trust wide improvement schemes - Progress is being reviewed monthly with Exec, Divisional and Corporate teams through the Improvement Steering Group. System wide - Progress is being reviewed monthly with system partners including Exec, Operational and Corporate teams through various forums.		

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3b	Efficient use of our resources	Director of Finance and Digital	Not identifying and then delivering the required £29m CIP of schemes The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 22/23 financial settlements The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. Failure to deliver the nationally activity targets of 104% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire. Substantial unplanned reduction in the Trust's income, or missed opportunities to generate income	4384 - ERF Clawback 4957 - COVID costs 4664 -Agency cap 4665 - CIP 5019 - Reliance on agency - Nursing 5020 - Reliance on agency - Medical 4965 - Reliance on temp staff paeds	CQC Well Led CQC Use of Resources	Inflation - The Trust is working to actively manage its contracts and to flag excess inflation due to market conditions as part of the national collection process in relation to this spend area	Impact of unstable market conditions led to the Trust forecasting excess inflation of £5.8m in its 2022/23 financial plan, primarily in relation to Utility costs but also impacts in other non-pay contracts. As prices continue to rise may be unable to mitigate these cost increases.	Financial plan set out the Trust expectation in respect of inflation aligned to the national allocations Annual budget setting process cascades and apportions the Trust inflation allocation to Divisions and Directorates. Monthly financial management & monitoring arrangements are in place to identify variation of excess inflation against financial plans at all levels of expenditure from department up to Trust. The Trust actively manages its external contracts to ensure value for money.	The Trust is monitored externally against the inflation impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific inflation forecasts Divisional focus against specific contracts (e.g. Utilities) is reviewed at the relevant FPAM	Forward view of market conditions.	Internally through FPAMs and upwards into FPEC. Externally through greater dialogue with suppliers and proactive contract management	Finance, Performance and Estates Committee	**Red**
						Agency - Financial Recovery Plan schemes: Recruitment improvement; Medical job planning; Agency price reduction; Workforce alignment	Reliance on temporary staff to maintain services, at increased cost Management within staff departments and groups to funded levels. Maximisation of below cap framework rates Rapid ability to on-board temporary staff to substantive contracts	Proposed centralised agency & bank team. Workforce Groups to provide grip Improvement Steering Group to provide oversight Non-Clinical Agency sign off process	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans. Rota and job plan sign off in a timely manner Large scale recruitment plans to mitigate vacancies.	The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups		
						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 104%. National steer is to not clawback under delivery in H1	Maximisation of the Trust Resources - Theatre and Outpatient productivity. Impact of the COVID patients and flow on availability of beds to provide capacity. Ability to recruit and retain staff to deliver the capacity.	Divisional ownership and reporting Improved counting and coding, including data capture and missing outcome reductions. Shared risk and gain share agreements for the Lincolnshire ICS.	Delivery of the 104% target	The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 104% activity target.	The Trust is monitored externally against the Trust activity target through the monthly activity returns The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns		

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						COVID costs - The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID.	The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	Financial plan set out the Trust Budget allocations in respect of COVID spend Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. QIA of risk of removal of all COVID schemes, outcomes reviewed at TLT for decision Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base.	Cease or approved COVID costs continuation as part of the Trust investment prioritisation process.	Correlation between the response to COVID and the new cost base. Ability to remove COVID costs at pace. Prevalence of COVID patients in the Trust.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FPAM.		
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Ranked in 4th place nationally of ICS usage of Care Portals.				
						Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	EPR OBC to be approved by Frontline Digitalisation NHSE/I OBC requirements (including financial) being worked through with Frontline Digitalisation NHSE/I OBC approved at Aug FPEC and Sept Board Updated 'affordable' OBC to go to Jan / Feb 2023 FPEC / Board FPEC supported new version of OBC on 1st Feb. Now going to Trust Board for approval on 7th Feb.		

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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	4641 - Digital infrastructure 4661 - DPIA	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	Skilling up internal resource. Exploring opportunities with Northampton General Hospital who provide RPA Services LCHS and ULHT contracts being migrated to one at next renewal.					
						Improve end user utilisation of electronic systems	Business case for additional staff under development	Digital team providing advice and guidance hoc to address pressure points					
						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. Additional metrics have been added and reviewed, and a work plan and deadlines associated with completion is being drawn up. These will be shared with the Director of Finance & Digital for sign off.		
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 (3 x weekly) of key concern specialties increase the scrutiny of reporting and pathway performance led by COO Colorectal now seeing a well managed recovery and the Surgical Division is now reviewing the Prostate Cancer Pathway. Breast continues to see improvement. The 62 day backlog continues to be aligned to the agreed recovery trajectory.	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 Recovery plans at specialty level. To date have delivered required reductions in 104 week waits 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	Inconsistent approach to waiting list validation CBUs do not have traction or insight into the non admitted or admitted waiting lists Maximum Outpatient and theatre capacity not apparent as yet. Demonstration of change at pace is lacking.	National edict to see and treat all patient waiting greater then 78 weeks by 31 March 2023 in place. Twice daily monitoring and reporting is now in place. The largest DM01 risk is Echo Cardiology. A plan is now in place to offer and recruitment and retention premium. The recommendations and action plans suggested following the Regional Diagnostic Team external review is realising some benefits. Local, System, Regional and national assurance meetings in place to monitor progress and delivery. Use of independent sector, mutual aid and insourcing/outsourcing providers to ensure delivery. ICB and COO holding the Trust to account for delivery against national deadline. Internal design, development and agreement of a 'production plan'. Review of all consultant Job Plans is in train.	Finance, Performance and Estates Committee	**Amber**
						Outpatient Recovery & Improvement Programme (ORIG)	Focused on 3 activities to support outpatient specialties to be able to reduce backlogs and provide enough capacity to meet demand 1. Clinic slot utilisation key metric being tracked to drive up access to outpatient services and reduce the backlogs 2. e-RS -All directory of services (DOS) reviewed and services to be uploaded to ensure polling for primary care 3. Missing outcomes backlog addressed and reduced with sustainable plans OP Sprint above completed - next phase of OP work in Q4 to continue to address slot utilisation, improve Patient Initiated Follow Up , no patients waiting over 78 week & root cause issues of missing outcomes & DNA in Trauma & Orthopaedics	ORIG working with division to get back to pre-covid clinic templates and develop recovery plans Specialty based capacity and demand modelling to ensuring outpatient resource focused in correct areas-focus on division specific areas of improvement required	OP Data Activity tacker from Performance Team reviewed weekly monthly in divisional FPAM	Escalations & issues through ISG when required	Reporting through Improvement Steering Group & FPEC		

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						HVLC/GIRFT Programme - Theatre productivity and efficiency	Ability of the ULHT teams to engage in the programme Emergency pressures resulting in elective cancellations Culture mindset change takes time.	Full robust Theatre programme with focus on KPIs now meeting weekly to oversee and drive changes	Theatre dashboard has been created and reviewed by operational teams for booking & scheduling - aim for 90% 6-4-2/scheduling now in place Weekly Capacity meetings held to ensure theatre utilisation	Increased in NEL demand may impact staffing levels, elective bed capacity, and therefore could impact on elective activity. KPIs potentially impacted: OTD cancellations and actual utilisation against planned levels	Reporting through Improvement Steering Group/FPEC/HVLC		
						Clinical prioritisation Group	Ability to list appropriate mix of P2/3/4 due to effective preop Unnecessary on the day cancellations Increased non-admitted waiting list waiting to convert to admitted	Preop workstream via FEI Review and management through prioritisation group and Surgical PRM Management through ORIG/HVLC/Surgical PRM			Reporting through FPEC/HVLC		
			Insufficient clinical capacity or		Emergency Care Clinical	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. Development of clinical vision for Urgent and Emergency Care	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 Breaking the cycle updates (as delivery of the clinical vision) A revised 4hr transit target of 76% agreed nationally and improvement trajectories being confirmed.	Gaps in Early Warning Dashboard Pathway 1 capacity admission avoidance impact, waits and capacity for primary care. Clear Treatment plans for P0 patients to support exit. Assurance in regard to Bed closure plan.	LHCC Programme Board reviewing Early Warning Dashboard - additional reports on progress. The System have now adopted SHREWD as the method of actual position and early warning LHCC Programme Board reviewing progress Weekly CEO Forum review where evidence is and any gaps supplemented with twice weekly CEO and COO calls.		

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3f	Urgent Care	Chief Operating Officer	expertise, inefficiently configured services, failure of system partners to provide capacity or reduce demand to pathway and excessive demand above capacity available		Indicators (12hr, 4 hour CRTP, 60 minute decision and 15 minute triage)	Urgent Care Recovery Improvement Steering Group which oversees a programme of work linked to increase capacity, flow and discharge through the Trust Wide Emergency Departments, Urgent Treatment Centres and Same Day Emergency Care Breaking the cycle pilot has now ended and lesson learnt document shared and agreed recommendations for embedded changes agreed at UCRIG	Large complex programme which required system working to reduce pathway 0 waits and deliver right care right time principals	Large programme of work so additional resource has been provided through a consultancy Impower & ECIST to assist in identification of areas to improve and on the ground support	Metrics dashboard developed for discharge and flow linked to bed reductions trajectory	Data metrics to demonstrate impact on of the interventions is being developed. There is a risk to the delivery of non-elective length of stay target and increase in daily discharges due to the reliance of other specialties and external agencies outside of the control of the hospital There is a risk that winter pressures and will outstrip length of stay and occupancy gains preventing delivery of discharge/ bed closures.	Reporting through Urgent Care Improvement& Recovery Steering Group and Improvement Steering Group monthly	Finance, Performance and Estates Committee	**Red**
						Recovery Support Plans	Risk of further waves, increased emergency demand and covid related sickness	Urgent and Emergency Care Board.			Daily review via Capacity and performance meetings Weekly reporting to ELT Fortnightly reporting to TLT		
SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and other planning priorities puts an added constraint on time, capacity and headspace to engage with the ICS agenda. Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority specialities for service reviews by July 2022. Heat Map finalised and used to identify the Specialties that were to be prioritised first for Specialty Review. Initial 17 data packs completed in readiness for Specialty Reviews during Feb/Mar 2023. Pilot within Cardiology undertaken in Nov 2022.	Finance, Performance and Estates Committee	**Amber**
						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 - completed. Year 4 IIP under development and due to be completed within Mar 2023 following a robust Business Planning Session in Q4 of 2022/23 (including Divisional IIP completions).		

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			collective roles as Anchor institutions			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 Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) The process of building the Trust Clinical Strategy has commenced taking information from Specialty Reviews to inform accordingly, and building on outputs from the Business Planning process.		
						Developing a business case to support achievement of University Hospital Teaching Trust Status	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee	Further understanding of the costs involved to increase size of R&I department and also to develop an R&I facility	R&I team reworking business case with a phased approach		
						Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increase clinical academics by 20 and RCF funding worth £200k within the last 2yrs Further clarification and implications of the changed guidance on univ hospital status required. Funding for Clinical Academic posts and split with UOL to be agreed	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Contract agreed with UOL for Clinical academic posts. UoL have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - linked to roadmap and Research Event to identify specialties. RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position - now amalgamated into the monthly Steering Group with ad hoc meetings between SRO's where needed to discuss funding for Clinical Academics. ULHT have a recruitment roadmap in place which will include some pump prime from vacancies. Additionally a joint Research Event is being planned for Q3 of 2022/23 with the University to identify future areas of collaboration with research and Clinical Academic recruitment. Event planned for Q3 of 2022/23 cancelled by the University as they wanted to review outputs from a previous event they hosted in August 2022 to understand if there was any potential alignments that could be made for onward joint collaborations.		

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4b	Becoming a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Improve the training environment for students	Understanding of our offer of the facilities required for a functioning clinical academic department	Revision of the library and training facilities to ensure that facilities are fit for purpose for all staff who will require access to training facilities, library, ICT equipment to be able to perform their role. This will be aligned to the UHA Guidance, and will include those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unknown timescales of completion	A new R&I group has been set up being led by Director of R&I/Deputy Medical Director, this will provide more oversight and rigor in developing an R&I agenda with representation from key stakeholders and clear milestones for delivery	People and Organisational Development Committee	**Red**
						Developing a joint research strategy with the University of Lincoln	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU, with a local version between ULHT and UoL created as we move forward and understand the finer details of the partnership. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy.	RD&I Strategy and implementation plan agreed by Trust Board	Drafts in place which broadly cover joint research and teaching approach across the organisations, unable to outline in strategy financial commitment. UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group	
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	Evidence bound by UHA requirements	Portfolio of evidence is being captured and is available on the shared drive Identified leads to liaise with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Roadmap developed to identify required evidence for portfolio	Clear understanding of rigidity of UHA requirements Letter to CEO of UHA agreed at TLT on 15/09/2022 and being sent by IID Director to ask for meeting to discuss approach.	Discussions being held to clearly identify opportunity for movement within guidance and steps being taken for a name change application		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	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. Two potential candidates have been identified for the Clinical Academic recruitment.		

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4c	Successful delivery of the Acute Services Review		Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data) Engage with services to develop plans as to how best to approach a clinical review, First Implementation Oversight Group meeting scheduled for September	Heat maps now drafted, with service reviews linked with improvement and clinical strategy development Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	Process being developed to identify services for review. This includes the development of a HEAT Tool to identify areas where services are not meeting targets, such as RTT, Cancer, Finance data. Initial discussions with divisions have been had with a view to ensure that the services most needing priority review are identified. Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning at TLT on 13/10/22 for review and sign off. Publish ULHT clinical service strategy end of 2022/23 Working with Divisions to identify ASR implementation requirements with draft outline plans in place for Orthopaedics and Stroke. Stroke Capital/Estates Group meetings now diarised and being led by the Business Case Team. Orthopaedics ASR taken to HOSC in Dec 2022 and confirmed as complete through ULT upward reporting. Stroke ASR are working on a 'Perfect Week' to further progress and have commenced relevant staff consultation processes required.	Finance, Performance and Estates Committee	**Amber**

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

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

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

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

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