Bundle Trust Board Meeting in Public Session 7 February 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 6 December 2022

Chair

Item 5.1 Public Board Minutes December 2022.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log December 2022.docx

6 Chief Executive Horizon Scan Including ICS

Chief Executive

Item 6 CEO Trust Board report 7223.docx

7 Patient/Staff Story

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

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

8.1 Assurance and Risk Report from the Quality Governance Committee

Chair of QGC

Item 8.1 QGC Upward report December 2022 v1.doc

Item 8.1 QGC Upward report January 2023v1.doc

8.2 CNST Declaration

Director of Nursing/Deputy CEO

Item 8.2 CNST Front Sheet.docx

Item 8.2 MIS_Year4_Board_-Declaration_-Form 26.01.23.pdf

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

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

Chair of PODC

Item 9.1 POD - Upward Report - December 2022.docx

Item 9.1 POD - Upward Report - January 2023v1.docx

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

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

Item 10.1 FPEC Upward Report December 2022 v1.docx

Item 10.1 FPEC Upward Report January 2023 v1.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 page.docx

Item 12 IPR Trust Board January 2023.docx

13 Risk and Assurance

13.1 Audit and Risk Committee Upward Report

Chair of Audit Committee

Item 13.1 Audit Committee Upward Report Jan 23 v1.docx

13.2 Risk Management Report

Director of Nursing/ Deputy Chief Executive

Item 13.2 TB - Strategic Risk Report - February 2023 Updated.docx

13.3 Board Assurance Framework

Trust Secretary

Item 13.3 BAF 2022-23 Front Cover February 2023.docx

Item 13.3 BAF 2022-2023 31.01.2023.pdf

14 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday 7 March 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 6 December 2022

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Dr Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Ms Dani Cecchini, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Mr 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
Mr Simon Evans, 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
Ms Claire Low, Director of People and Organisational Development

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Michelle Harris, Deputy Chief Operating Officer
Dr Maria Prior, Healthwatch Representative
Ms Libby Grooby, Divisional Head of Nursing and Midwifery – item 8.1

Apologies
Dr Colin Farquharson, Medical Director

2067/22	**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.
2068/22	**Item 2 Public Questions** **Q1 from Vi King** **First, I would like to wish all my ex working colleagues on the front line across the Trust a very Happy Christmas and Prosperous New Year.**

2069/22	**Please can I ask if Breaking the Cycle is the same, that was implemented in 2015?** **Is this what the 60-day trial on is based on, that you started on 7th December 2022?** **What are the set number of beds that are required to be empty?** **Please can I ask if you have any other trials to help the patient flow.** The Chief Operating Officer responded: That the question provided a great opportunity to talk about the work being done across the hospital with thanks offered for the kind gesture towards the teams in very challenging times. Breaking the cycle was a different programme to that which had been developed in 2015 but used the same strap line and principle, describing the need to do something differently to response to pressures on the emergency pathway. Breaking the cycle had commenced on 7 November and it was important to make the distinction that whilst this had had a positive impact with this was not something that would solve the issues in emergency care. A system wide response, to alleviate pressures and provide levels of access, was required. The 60-day trial was up and running. Planning guidance and how the Trust would want to run was at 92% bed occupancy. There was research to support and justify different levels however 92% captured a mixture of elective and emergency challenges faced by the Trust and gave the ability to operate in a way which reduced cross infection but with good flow. The Trust would need to have 78 empty beds across all sites at any one time and there was a need to consider beds as the Trust went into the evening in order to deal with demand overnight. For this there was a need to have 15 beds at Lincoln and 12 at Pilgrim and know that there was a plan for all patients who required admission at Grantham. This allowed the Trust to work through the night to ensure that patients did not wait overnight however this had not yet been consistently achieved due to the challenges in the emergency departments and delays to access beds. The Chief Operating Officer advised that other programmes were in place with the next stage of breaking the cycle, working with system partners in the community and Local Authority. This was referred to as Breaking the Cycle 2 and sought to use the same principles of what the Trust was trying to achieve in hospital for continuous flow and to move

	patients to the right place at the right time. This extended to community hospital settings, at home but also in residential and domiciliary placements. Work had commenced and was a Plan, Do, Study, Act (PDSA) cycle with hope that this would reduce the number of patients in hospitals not requiring acute care. The Chair noted the timeliness of the question raised and hoped that the response offered an explanation of the Trust's plans and how these were working. Thanks were offered to all colleagues in the organisation who were working differently around breaking the cycle to achieve the objectives of the work.
2070/22	**Item 3 Apologies for Absence** Apologies were received from Dr Colin Farquharson, Medical Director.
2071/22	**Item 4 Declarations of Interest** There were no new declarations of interest.
2072/22	**Item 5.1 Minutes of the meeting held on 1 November 2022 for accuracy** The minutes of the meeting held on 1 November 2022 were agreed as a true and accurate record.
2073/22	**Item 5.2 Matters arising from the previous meeting/action log** 1914/21 – Endoscopy Establishment Review – The Director of Nursing advised that the review had now been undertaken and ratified by the People and Organisational Development Committee.
2074/22	This now needed to be picked up with the division regarding the existing financial arrangements in order to support this. It would be likely that this would be taken through a business case route to the Capital, Revenue and Investment Group and on to the Finance, Performance and Estates Committee.
2075/22	The Director of Nursing proposed closure of the action for the Board with this moving in to established financial arrangements.
2076/22	The Chair was pleased that the review had been completed and was thorough noting this now needed to progress through the Trust governance arrangements. The action was agreed to be closed.
2077/22	1265/22 – Integrated Performance Report – It was noted that this remained under discussion and would be held over until completed. Whilst this was presented to the Committees there was a need for this to come together and be seen through the Board.
2078/22	1829/22 – Integrated Performance Report – It was noted that the Finance, Performance and Estates Committee had not had sufficient time to consider the

	Fractured Neck of Femur update. The action would remain open until this had been considered by the Committee.
2079/22	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board noting that the health and social care system remained extremely busy noting that the update offered by the Chief Operating Officer with regard to breaking the cycle had been beneficial.
2080/22	It was noted that the system and the Trust were no different to other parts of the country with significant national media coverage. The pressure had not eased during the current week, and this continued to be a challenging and busy week.
2081/22	Some of the media coverage had been in relation to children and Strep A infection which had added to some of the pressures being faced, including within the Accident and Emergency Departments. Despite this the Trust continued to try to achieve continuous flow. Breaking the cycle and breaking the cycle 2 were key elements however there was also a need for continuous flow to happen within the health and social care system.
2082/22	There had been £500m for the adult social care discharge fund with Lincolnshire receiving £5m which would be shared between the County Council and Integrated Care Board (ICB) and used via the Better Care Fund (BCF). This would enable flexibility to have the right interventions in place and enable discharge of patients from hospital once their acute episode of care had finished. The fund was an acknowledgment that medically fit for discharge issues being faced across the system.
2083/22	The Chief Executive noted the Care Quality Commission State of Healthcare and Adult Social Care report for 2021/22 noting the first line of the report which made it clear that the health and care system was gird locked and unable to operate effectively.
2084/22	This reflected the national position and demonstrated why actions were being taken locally with this anticipated to continue through the winter.
2085/22	The Chief Executive advised the Board of the recent ballots for industrial action noting that for the Royal College of Nursing (RCN) and Unison, whilst the majority of those who voted were in favour of strike action, the number of people voting did not hit the required threshold. Therefore, the RCN and Unison would not be striking at the Trust, Lincolnshire Partnership NHS Foundation Trust or Lincolnshire Community Health Services NHS Trust.
2086/22	Action being taken on the 15th and 20th of the month by the RCN would not be applicable to the Lincolnshire system.
2087/22	The Chief Executive would be attending the Integrated Care Partnership following the public Board meeting where the draft Integrated Care Strategy would be reviewed. A review of all Integrated Care Systems had also been announced by the government and would be led by Patricia Hewitt, Chair of NHS Norfolk and Waveney ICB.

2088/22	Recent guidance had been published for NHS Executives regarding support to colleagues through the menopause. There had been some national coverage of this however it was recognised that this was not just about the NHS but applicable to other sectors. Learning from this would be taken and applied locally in Lincolnshire.
2089/22	The Chief Executive noted that the system had been in the Recovery Support Programme (RSP) for some time and advised that a review would take place on 8 December with NHS England. The regular quarterly system review meeting was due the following week with updates to be offered at a future date.
2090/22	The Chief Executive offered an update on the Trust position noting that the financial position would be offered in the Finance, Performance and Estates Committee report. Similarly maternity items were also to be considered on the agenda.
2091/22	Of specific note was the Trust exiting the National Maternity Safety Support Programme which was a significant achievement with major improvements made in maternity services. This should offer confidence to the public in the services offered with the Chief Executive noting delight that the programme had been exited.
2092/22	The Leading Together Forum had received an interesting presentation from Dr Chris Turner on Civility Saves Lives which was consistent with the Culture and Leadership Programme and the work of Professor Michael West in Compassionate and Inclusive Leadership. These messages were being offered to staff in order that there were the correct behaviours in the Trust which benefited patients and staff.
2093/22	50 new wheelchairs had been purchased as this was a known issue in the Trust with these not being available at the front doors once taken for use. The volunteers had raised the issue with the Trust Charity supporting the purchase of the additional wheelchairs which had arrived.
2094/22	The Chief Executive noted the proud history with the military in Lincolnshire and had been delivered that the Trust, on Armistice Day, had marked the occasion on each of the 3 sites.
2095/22	The Chief Executive advised the Board that, whilst not in the report, this would be the Chief Operating Officers last Board meeting. The Chief Operating Officer would be moving to a new role and the Chief Executive noted that he would be missed enormously and offered thanks for all that he had done during his time with the Trust and offered well wishes for the future.
2096/22	The Deputy Chief Operating Officer had agreed to step in to the Chief Operating Officer role as an interim until further notice with the Chief Executive welcoming her to the Executive Leadership team and the Board.
2097/22	In order to support the Deputy Chief Operating Officer in the new role it had been agreed that, until further notice, the Estates and Facilities function would move to the Director of Finance and Digital's portfolio.
2098/22	

	It was recognised that, with the Director of Estates in post, this would enable high level executive oversight and leadership.
2099/22	The Chair recognised the issue of the pressures on the sites and the report had built on the response offered by the Chief Operating Officer to the public question.
2100/22	Dr Prior noted the encouraging positive impacts as part of breaking the cycle noting the small number of concerns regarding patient and staff experience and sought to understand the nature of the concerns.
2101/22	The Chief Operating Officer noted that the process used was one of continuous flow so that patients would be moved out of the emergency departments which were often overcrowded. Patients would be moved to ward even if there was not a conventional bed space available.
2102/22	This was a different approach to the legacy practice of boarding and used designated space on wards which would mean that a patient ready for discharge would sit out on to a chair before all elements of the discharge were completed.
2103/22	A risk tool was utilised to consider the balance of pressures across different departments. There was the potential for patients to have a poorer experience as a result of moving out of a bed space sooner however it was believed that this would, overall, offer a better experience for patients as patients may have waiting in the emergency department without specialist oversight.
2104/22	Whilst concerns had been raised by teams about the potential for poor patient experience there had been an overwhelmingly positive response from emergency department staff. This had fundamentally improved patient experience for those waiting long periods in the emergency departments. The Trust was considering feedback that was being received and wanted staff to come forward to highlight areas of potential concern.
2105/22	The Director of Nursing noted that 4 registered nurses had been met with separately, through direct approach or the Freedom to Speak Up Guardian to raise concerns around the placement of patients.
2106/22	Whilst these were not designated bed spaces there were areas to place patients that were risk assessed and although the nurses had said they did not like this there was an understanding as to the reason for this needing to happen.
2107/22	3 of the 4 nurses who had raised concerns had raised other ideas to make improvement for patients with the Director of Nursing facilitating the ideas to come to fruition.
2108/22	1 formal complaint had been received from a patient which had been responded to through the clinical complaints lead. Furthermore, on a visit to areas being used a patient, a gentleman who had been moved to a designated areas advised of his dislike but noted understanding of what the Trust was trying to achieve.
2109/22	

2110/22	The Director of Nursing noted that the Trust had been able to deal specifically with patient concerns to resolve these alongside staff concerns. There was an underlying understanding of why the action was being taken despite staff indicating that they were uncomfortable.
2111/22	The Chief Executive noted that the actions were being taken to decongest the accident and emergency departments and noted that this ensured the Trust was able to unload ambulances quicker. Equally this allowed ambulances to get back on the road quicker to respond to the patients in the community who were, on occasion, waiting too long and this issue was not always visible in the recording of information across the NHS.
2112/22	Breaking the cycle was not just about the activity in the hospitals with a mindfulness of what was happening before people arrived. Breaking the cycle 2 was in place for when patients finished an episode of acute care and needed to move to a more appropriate setting. This would enable the bed to be available with continuous flow being an important element.
2113/22	The Chair noted the importance of the actions being taken stating this was about the impact for both patients and staff.
2114/22	The Board had had an opportunity to explore breaking the cycle and encouraging signs were noted. There was a need to continue to press on, notwithstanding the challenging operational environment.
2115/22	The other element for consideration was the theatres at Grantham and how these would contribute to some of the elective backlog.
2116/22	The Chair offered congratulations for the exit of the maternity support programme noting the hard work undertaken and the endorsement of the national team on this.
2117/22	This offered assurance to the Board that maternity services in the Trust were operating to the highest standards.
2118/22	The Chair was interested in the focus on civility saves lives presentation and would be interested to see how this was applied in practice within the organisation. It was pleasing to note that the volunteers had received the news well about the new wheelchairs with thanks offered to the charity for supporting the purchase. The Trust Board: • **Received the report and significant assurance provided**
2119/22	**Item 7 Patient Story** The Trust Secretary advised that it had not been possible to present a patient story to the Board due to administrative issues and note that this would be presented to the next Trust Board meeting.

	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
2120/22	**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 22 November 2022 meeting.
2121/22	Mrs Brown noted the report received in respect of the ward accreditation scheme with some improvements being seen in this area. It was noted that one area had achieved a bronze diamond award with 4 others preparing for assessment. A further 16 were on track and over the next 12 months there would be an increase in traction.
2122/22	The Safeguarding report was received with a comprehensive review of a new standard operating procedure for care of autistic children and young people. Whilst this did not have a big impact on the Trust it was good to undertake the review.
2123/22	The Safeguarding team continued to support the emergency departments in child protection and the roll out of training which was an area that the Committee would like to see continued improvement. Clinical holding training continued to be a risk and therefore additional support had been requested from Lincolnshire Partnership Foundation NHS Trust (LPFT).
2124/22	Role out of mandatory training support had been sought due to IT issues which would continue to be monitored by the Committee.
2125/22	Mrs Brown noted that the Committee was saddened by a further case of MRSA and noted that due to the connectivity of this case it was important that these were seen as a whole, and work would be undertaken around invasive device management. This would again be monitored by the Committee and the final report, once completed would be received by the Committee.
2126/22	Mrs Brown was pleased to report the good progress demonstrated within the medicines management upward report where in the previous month this had felt to be a risk. It was pleasing to heard from the Deputy Medical Director of the work being done and the governance in place to strengthen the workstream.
2127/22	The Committee received an update from the Maternity and Neonatal Oversight Group (MNOG) noting the learning taken from the Countess of Cheshire case with good assurance received that demonstrated it was felt the risk to the Trust had been minimised.
2128/22	As had been mentioned by the Chief Executive the Committee was pleased to receive the letter that successfully exited the Trust from the Maternity Safety Support Programme. Mrs Brown noted the particular reference to the leadership of the department which was detailed within the letter.
2129/22	The benchmarking paper for the Kirkup Report had been received with the Trust being forward thinking in this area with good assurance of the position against this. More would be offered to the Board during a development session going forward.

2130/22	The Committee had been pleased to note that staff levels were meeting the Birth Rate Plus standard and there had been an uplift in specialised midwifery roles.
2131/22	Further assurance was received on the successful delivery of the Clinical Negligence Scheme for Trusts (CNST) Maternity, subject to national changes taking place, this looked favourable.
2132/22	Mrs Brown noted the report received from the Patient Experience Group and was pleased to advise the Maternity Voices had re-joined the group and a project was in place to focus on military families.
2133/22	The Committee continued to hear the theme of communication with the same being reported through complaints. This was an area which would have a deep dive undertaken over the next 6-12 months.
2134/22	The new Clinical Complaints Case Manager attended the Committee offering Committee members insight into the work being done. Good assurance was received that the work being done would have an impact and complement the ambitious trajectory to reduce the number of open complaints.
2135/22	Duty of Candour was showing reduced compliance however it was noted that this was a decrease in the time taken to undertake both written and verbale duty of candour. There had been some further reassurances offered of the actions taking place with a continued focus going forward.
2136/22	Mrs Brown noted that the Committee had received the Commissioning for Quality and Innovation (CQUIN) quarterly update with good progress of achievement against most areas. There was a small number of areas not delivering however following agreement with the ICB, reinvestment would be made to the Trust for any income lost.
2137/22	The Committee received an update on Venous Thromboembolism (VTE) with results continuing to deteriorate. The Committee had been advised of a paper being presented to the Trust Leadership Team which was hoped would offer additional support with the establishment of a VTE nurse. This was an area which the Committee would continue to focus.
2138/22	Mrs Brown noted that the Committee had received a paper on Disclosure and Barring Service (DBS) checks for the Trust. The report demonstrated a new and revised approach with a trajectory and timescale to complete the roll out to be able to monitor improvements expected from this. This would also support the Savile action plan.
2139/22	The Chair noted the thorough report which demonstrated the depth and breadth of the agenda and the assurance being received. There had been a number of papers regarding maternity and neonatal care which would be considered.
2140/22	It was pleasing to note the progress of the ward accreditation programme with an award recently presented by the Chair to staff at Grantham.

2141/22	The Chair was grateful that VTE, communications and complaints continued to have focus and similarly for medicines management. There was good partnership with the People and Organisational Development Committee on DBS checks and ensuring assurance functions between the different Committees were tied in.
2142/22	The Chair moved Board members to the Maternity and Neonatal reports offered to the Board and welcomed the Divisional Head of Nursing and Midwifery to the meeting offering congratulations on the progress made.
2143/22	The Director of Nursing noted that as part of MNOG the reports had been shared with the public Board as done each month. Papers would be seen from the Bill Kirkup East Kent Inquiry and there had been clarity that the Trust wanted to ensure direct access at Board level on maternity services.
2144/22	This was in place through the Director of Nursing with the Trust had a Head of Midwifery in post and as part of ensuring access at Board level the Director of Nursing was keen that, at least, twice a year formally the Head of Midwifery and or members of the family health triumvirate attend the Board to offer an update.
2145/22	The Divisional Head of Nursing and Midwifery was in attendance at the Board to offer an update on CNST as there had been changes to guidance around training for this. It was thought that there would be difficulty in meeting the changes to training and the exacting requirements of supernumerary status of labour ward coordinators.
2146/22	The Divisional Head of Nursing and Midwifery advised the Board, as of 5 December, the Trust would be submitting full compliance for CNST. There had been significant work undertaken in order to meet the training trajectories.
2147/22	Notification from NHS Resolution had been received the week prior to advise that the deadline had been extended to 5 January 2023 however the Trust had already achieved compliance with data, clarified supernumerary status and was compliant following the release of new guidance.
2148/22	The Chair offered congratulations on the achievement and reflected on the previous difficult discussions around not meeting the CNST standards and no immediate prospect of achievement. The standards were exacting with the team having worked hard to comply and provide evidence of compliance. This demonstrated the investment in the leadership and what the Trust was trying to achieve for all services but that there was a spotlight on maternity.
2149/22	The Director of Nursing noted the bi-annual staffing report required for CNST and noted that, thanks to the investment from the Board for midwifery services for birth rate plus and enhanced midwifery roles, other organisations were now approaching the Trust to ask how this was being achieved.
2150/22	Whilst it was difficult to achieve the standard it was more difficult to maintain this with continue oversight and assurance on this. Thanks were offered to the triumvirate who lead on Family Health services for the work to support achievement.

2151/22	Dr Gibson congratulated the team on the prompt and detailed responses to the report into East Kent and the criminal case in Chester noting that recommendations from the criminal case were not yet known. It would be plausible however to expect screening of staff in the NHS and whilst activity was underway and reported on DBS to the Committee for existing staff assurance was sought that maternity staff and those in similar roles would be prioritised in the process.
2152/22	The Director of People and Organisational Development offered to provide an update back to the Board on the prioritisation aspect of DBS checks. **Action: Director of People and Organisational Development, 7 February 2023**
2153/22	The Divisional Head of Nursing and Midwifery noted that midwives ought to be considered as a high priority along with paediatric and neonatal nurses and would be happy to support work and discussions around this.
2154/22	The Chief Executive noted that it was helpful to see the Trust's position statement in respect of the East Kent report which did not offer traditional recommendations but identified 4 key theme areas.
2155/22	It would be important to not limit thinking to maternity services as the themes were equally relevant to all of the Trust's services. Comments within the report included culture, civility, compassions, inclusive leadership with a need to take learning from East Kent and apply this to other parts of the Trust.
2156/22	The Chief Executive also offered congratulations to the Divisional Head of Nursing and Midwifery and the team around the CNST rating noting the historical compliance issues faced by the Trust.
2157/22	The Chief Executive also reflected on the Chief Executive Officers Staff Award which had been awarded to the Divisional Head of Nursing and Midwifery for being a true inspirational leader within maternity services. The report offered further evidence as to why the award was so richly deserved.
2158/22	The Director of Nursing shared the comments made by the Chief Executive and reflected on the East Kent report not just applying to maternity services. This was also the case for the Donna Ockenden report with work having commenced through the central governance teams to consider the reports and application across the organisation. Progress on this work would be reported through established governance process.
2159/22	The Chair noted the great work and the continued drive to improve services as indicated by the compliance with CNST. Thanks were offered to Mrs Brown for support in the Maternity and Neonatal Safety Champion role with the report provided with the papers a helpful addition which offered independent oversight to the service. The Trust Board: • **Received the assurance report** • **Received the reports relating to Maternity and Neonatal Services**

	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
2160/22	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker provided the assurances received by the Committee at the 15 November 2022 meeting.
2161/22	Professor Baker advised the Board that the Committee had considered the safer staffing report noting the limited assurance with the increased incidents however patient harm had reduced. This suggested that issues and incidents were being reported sooner.
2162/22	The Committee had reviewed the workforce planning report to NHS England/Improvement and noted that medical recruitment was ahead of plan which had resulted in reduced vacancy rates.
2163/22	It was also noted however that there was a contrasting negative trend across nursing, allied health professionals and clinical support staff but the Committee noted the mitigations in place which was expected to revert to a positive position by March – April 2023.
2164/22	The Committee was attended by the Guardian of Safe Working, Dr Chablani noting that this was Dr Chablani's last attendance due to taking on a new role aligned to the education portfolio of the medical school. The Committee thanked Dr Chablani for his commitment to the position.
2165/22	The Committee noted that there were issues around education supervisions of locally employed doctors who were unable to access similar supervision to other medical staff. The Medical Director had agreed to look in to and address the concerns.
2166/22	There remained ongoing staff issues for Junior Doctors within surgery and again, the Medical Director was familiar with the issues which were ongoing concerns.
2167/22	The Guardian of Safe Working had flagged concerns regarding clinical guidelines which were felt to be out of date and issues regarding patient safety as a consequence of staffing which were felt to be outside of the remit of the Committee. Therefore, referrals had been made to the Audit Committee for the guideline concern and Quality Governance Committee for safety issues.
2168/22	Professor Baker noted the Freedom to Speak Up report which had been received with the Committee commending the significant activity being undertaken. It was pleasing to note that the majority of those speaking up were not doing so in an anonymised way which was a positive trend.
2169/22	The Committee had considered the industrial actions issues which had flagged a potential indirect effect due to other organisations being affected.

2170/22	Professor Baker advised the Board that the Committee had considered issues around research and innovation noting that there was clarity of the current activity not being sufficient.
2171/22	The Committee noted the potential for improved performance aligned to a new leadership group being established and the potential of better links to the University Teaching Hospitals Group. This was an area which would be monitored closely by the Committee.
2172/22	Professor Baker noted that the Committee had received a series of reports from the sub-groups noting that this was an encouraging position which demonstrated the evolved structure.
2173/22	Progress against the CQC action plan red actions had been considered with progress encouraging. The Committee noted the common themes around the action plan which the Committee had considered around ensuring adequate and appropriate mandatory training and appraisal processes. These were 2 ongoing issues which would be monitored by the Committee.
2174/22	The Chair noted the comprehensive report and issues covered by the Committee noting there was a sense of increasing levels of assurance being received on what had been long standing issues. It was noted that there was some way to go on some recruitment campaigns however progress was being seen in respect of medical recruitment.
2175/22	The Director of Nursing referred to the safer staffing discussion noting that, as advised by Professor Baker, although there had been an increase in the number of incidents, harms levels had not increased.
2176/22	There had been investment in recruitment with a 5-year workforce plan, agency and spend had reduced and fill levels were at the highest seen for some time of Trust staff compared to temporary workforce.
2177/22	Limited assurance was offered however due to staffing on the ground not feeling as though this was a better position.
2178/22	The Chair noted that research and innovation was becoming a more prevalent conversation for the Board noting that the Committee was driving forward some of the conversations.
2179/22	Thanks were offered to Dr Chablani, from the Trust Board, for the commitment shown to the Guardian of Safe Working role and the progress that had been made.
	The Trust Board: • **Received the assurance report** • **Noted the referrals as a result of the concerns flagged by the Guardian of Safe Working**

	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
2180/22	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini provided the assurances received by the Committee at the 24 November 2022 meeting.
2181/22	Ms Cecchini noted that there had been a full agenda however there had been good discussion on the items presented.
2182/22	The Committee noted the appointment of a compliance manager within estates and recognised the impact that appeared to be shown with improvement against Planned Preventative Maintenance (PPM).
2183/22	Discussions took place regarding the assurance rating with limited assurance having been received and the Committee wishing to understand what actions would need to be taken in order to move towards an improvement in the assurance level.
2184/22	The Committee received the Authorised Engineers Fire Report which had been issued in February 2022 and whilst this offered limited assurance this provided a good external independent review of the Trust's arrangements and governance which had improved.
2185/22	At future meetings the Committee would receive the fire safety reports appended to the Health and Safety Committee upward reports due to the level of risk being carried in regard to fire.
2186/22	The Committee had received the Health and Safety Committee upward report and also recommended approval of the Health and Safety Annual Report which had been appended for the Trust Board.
2187/22	Low Surface Temperature works continued to be reported with the Committee remaining satisfied that all of the improvements had been made where the Trust had control of buildings. Work continued with landlords where the Trust was a tenant.
2188/22	Ms Cecchini noted the discussions held by the Committee regarding finance with the headline position reported by the Chief Executive. The Committee had given focus to understanding progress made to support efficiency and productivity improvements.
2189/22	The Committee noted the appointment of the Head of Financial Improvement who was support all teams to identify additional cost savings which had seen a significant increase in those identified to date.
2190/22	Limited assurance remained in respect of bigger efficiencies derived from transformation schemes however these could be seen in the Integrated Improvement Plan with work ongoing and traction commencing. The Committee was pleased to note that the Director of Finance and Digital would work with the Director of

	Improvement and Integration in order to determine if it was possible to support further improvements in transformation schemes.
2191/22	Ms Cecchini noted the reduction of £6m in the capital allocation related to the Community Diagnostics Centre which was due to a timing issue and single year allocation.
2192/22	The Committee ratified the terms of reference for the Capital, Revenue and Investment Group.
2193/22	Ms Cecchini advised the Board of the paper received in respect of the financial forecast protocol and noted the revision in the forecast for the financial year which would be submitted to NHS England by the ICB. This would be overseen through the Finance Committee of the ICB.
2194/22	The Committee received a position statement of the forecast outturn with likely deficit however mitigations remained to be found and some changes between partners in the system.
2195/22	Ms Cecchini noted the operational performance report and performance reported within this and in addition noted that this was received alongside the Integrated Improvement Plan as part of the elective recovery self-certification.
2196/22	Performance benchmarking had been received in the report which had support the Committee in understanding the position and identifying areas of focus. Good progress had been noted in respect of colorectal cancer services including patients waiting to see an acute Trust where this was not necessarily required.
2197/22	Significant validation work had been undertaken on waiting list with the Trust seeing a reduction on patients waiting however it was worth noting that this was as a result of the validation exercise with no productivity gains currently.
2198/22	The Committee received the Echocardiogram deep dive report which had been produced by NHS England and noted this demonstrated some interesting factors around the challenges faced in the service. This had been a good independent external view of the service and offered assurance. The Committee noted the outcome of the report and wished to see progress against the action plan at a future meeting.
2199/22	Improvement had been seen in governance of the Integrated Improvement Plan with the Committee recognising the slow start but noting the traction around the pieces of work that was now in place. Most specifically the work on the outpatient recovery and improvements in the reduction of missing outcomes.
2200/22	Meetings were in place with the divisions and Director of Finance and Digital to further understand the position of some of the cost improvements linked to transformation. The Committee had considered the internal planning approach for 2023/24, whilst planning would be system wide, this had presented to the Committee the approach

2201/22	being taken internally to engage the directorates with planning. The appendix offered to the Board demonstrated the timelines.
2202/22	Ms Cecchini noted that the Committee did not have time to consider the internal audit recommendations and CQC action plan. Updates were requested in respect of the red CQC actions to the next meeting.
2203/22	The Chair noted the comprehensive report from the assurance Committee and the phenomenal amount of work taking place. The Chair noted previous discussions about how the Committee ensured enough time was dedicated to the right things although it was helpful to see the depth and breadth of the agenda.
2204/22	The Chief Operating Officer noted that notification had been received from NHS England regarding a number of actions required as an organisation to confirm there was performance oversight at Board level. The return had been submitted back to NHS England and the national team which indicated the scrutiny of the Finance, Performance and Estates Committee and in addition to this, through the performance report to the Board.
2205/22	There was also a routine number of key items, for noting and to ensure continued confirmation of the response to NHS England. Going forward, discussed at Finance, Performance and Estates Committee, was the wish to deep dive and focus on particular elements of this going forward.
2206/22	Between the Chief Operating Officer and Director of Improvement and Integration's portfolios work would be undertaken to ensure there was no duplication but that there was the relevant emphasis on key elements. In particular this would be around productivity that related to the recovery of very long wait patients in planned, cancer and diagnostics going forward.
2207/22	The Chair appreciated the effort that had gong in to completing the template and evidence base noting that the question would be about how the momentum was maintained on this. As noted, there was a need to keep a watchful eye.
2208/22	Ms Cecchini noted that there was joined up working with the Director of Improvement and Integration and noted that there was an understanding of improvements required to support performance. The 2 reports tended to be well aligned with some assurance taken form this.
	Ms Cecchini also noted that the meeting had been the last one for the Chief Operating Officer and reflected on him having been a positive active member of the Committee.
2209/22	The Chair noted the extend of what had been done by the Chief Operating Officer in the context with improvement given to the levels of assurance for estates and facilities being remarkable, particularly in relation to fire.
2210/22	The Chair noted the financial position and the ongoing work to bring this back on plan. There had always been a focus on cost improvement and efficiency, but the Board and Committee were now starting to see the potential impact of this.

2211/22	The Trust Board: • **Received the assurance report noting the appendices offered**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
2212/22	**Item 11.1 ASR Update** The Director of Improvement and Integration presented the update to the Board noting that the Acute Services Review (ASR) had been set up in 2017 by the Lincolnshire Health System to review the need of the local population and configure acute services.
2213/22	A pre-consultation business case was approved on 29 September 2021 by the then Lincolnshire Clinical Commissioning Group (CCG) which then went to public consultation from September to December 2021.
2214/22	Following the consultation an independent company undertook analysis and reported feedback in May 2022 with the CCG approving the key changes to the services within the report.
2215/22	The first round included orthopaedics which had seen a pilot embedded and following approval of the changes needed to make the pilot permanent. This was now complete, and the report highlighted good performance of the orthopaedic teams within Grantham Hospital. The Board was advised that the service now had the shortest wait time for Referral to Treatment (RTT) in England and positive patient feedback was being received.
2216/22	In June 2022 the Trust became one of a few hospital Trusts to carry out super-path keyhole surgeries which were being undertaken at Grantham and meaning that patients needing hip replacements were able to have both done at the same time. There were quicker recovery times and shorter stays and as mentioned in the Chief Executive's report 2 new theatres were in place at Grantham.
2217/22	The Trust continued to invest at Grantham Hospital in order to be a centre of excellence for orthopaedic surgery as outlined in the ASR.
2218/22	The Director of Improvement and Integration noted urgent and emergency care and acute medicines which were being led by the Lincolnshire ICB in 3 phases. Phase 1 was delivering the service specification with Grantham to be an Urgent Treatment Centre (UTC) and integrated acute medical service.
2219/22	A joint working group had been set up and key timelines discussed with the service specification being worked through. It was anticipated that the service specification

	would be completed by February 2023 with sign off of the 2 service specifications followed by a procurement process.
2220/22	The Director of Improvement and Integration noted that the Trust continued to work on a single Lincolnshire Stroke Service and was taking the lead on this aspect of work. A joint working group had been established with Lincolnshire Community Health Services NHS Trust and several workshops held to define the clinical operating model.
2221/22	The workshops had focused on developing a standard operating procedure for the Lincolnshire Stroke service with a key aspect of this being consultation with staff at Pilgrim Hospital who would be impacted. This would be complete by March 2023.
2222/22	The Chair noted the helpful and clear update and noted a sense of impatience however could see the methodology as to what the plan was.
2223/22	Dr Gibson noted the great results for orthopaedics and noted that this offered a reminder of how it was possible to achieve very significant service improvement by bold service reconfiguration.
2224/22	It was noted however that the report did not include formal feedback from a patient experience performance perspective and whilst this had been mentioned informally it would be beneficial for this to be reported.
2225/22	Dr Gibson also noted that the UTC at Grantham had a focus on procurement and formalities noting that this was currently acting as a 24/7 UTC and indicated that it would be useful to receive interim feedback whilst the formal procurement was ongoing.
2226/22	The Director of Improvement and Integration noted that patient experience data had been received with 100 compliments and a report due to be presented to the Health Overview and Scrutiny Committee (HOSC) which outline some of the comments offered. Friends and Family Tests had been considered and there had been responses to some of the services delivered. An update could be provided to include patient experience details and the paper submitted to HOSC.
2227/22	When big bold decisions were made there was a need to follow through with these. The 2 new theatres in place now needed to see a utilisation of the capacity and efficiency with a focus on elective surgery.
2228/22	The comments regarding the UTC will be offered back to the ICB implementation group with feedback on this offered in due course to the Board.
2229/22	The Chair noted that it would be useful for the Board to see the report going to HOSC before this was submitted to ensure Board members were sighted. **Action: Director of Improvement and Integration, 7 February 2023**
2230/22	

	The orthopaedic performance was good to see with the big bold decision working well with good leadership. This offered a good future for the service as well as Grantham Hospital. The Trust Board: • **Received the report noting the progress on the ASR and strong orthopaedic performance**
2231/22	**Item 12 Integrated Performance Report** The Board received the Integrated Performance Report which was offered in the usual format.
2232/22	The Chair noted that all relevant performance data had been discussed in detail through the Committees as presented through the Committee reports and looked to the Executive Directors to offer any further information or for Non-Executive Directors to raise questions.
2233/22	The Chair noted that there were no further items to raise of questions from Board members but noted the People Promise actions and resignations and the work ongoing to avoid resignations through earlier conversations.
2234/22	It was noted that this looked to be a helpful piece of work with the metrics for this welcomed at the next meeting.
2235/22	The Chair noted that limited assurance was offered to the Board however the reason was evident in the content presented. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
2236/22	**Item 13.1 Risk Management Report** The Director of Nursing presented the monthly report to the Board noting 9 quality and safety very high risks which remained the same as the previous month however there had been movement in the risk register.
2237/22	The risk regarding ambulance handover delays was very high and currently being reviewed in light of breaking the cycle. This would be presented to the Risk Register Confirm and Challenge month meeting and therefore was not presented to the Board.
2238/22	There had been 1 new very high risk added regarding the ability to provide a fully funded paediatric epilepsy service, discussions were underway with the Commissioners in relation to the actions to address this.
2239/22	The Director of Nursing noted the high risks regarding planned care recovery, accurate patients medicine information through paper records, potential harm from falls, concern around processing of echocardiograms and the ability to learn lessons.

	It was noted that all of the risks described had been reviewed through the Quality Governance Committee.
2240/22	The Director of Nursing advised of 2 very high workforce risks that impacted on safety with these being recruitment and retention and workforce culture. At the November Board a very high-risk regarding fragility of the stroke service had been presented however this had been reviewed and reduced and as a result, this was not presented in the report. This was due to workforce recruitment and some gaps which were being managed through temporary workforce. The risk had been reviewed by the People and Organisational Development Committee.
2241/22	The Board noted the 3 Finance, Performance and Estates risks which were very high and had been reviewed by the Finance, Performance and Estates Committee. These remained the same as the previous few months with clear mitigations in place.
2242/22	The Director of Nursing advised that the appendices offered all strategic risks which should be recognised by Board members with these having been agreed through the Committees. Moderate assurance was offered in the report.
2243/22	The Chair noted that continuing development of the risk register and the dynamic nature of the report. It was pleasing to note that risks were being reduced and escalated with regular movement in the report. This indicated that the risk register as a tool was active and the process was being used in the organisation.
2244/22	The Chair asked the Board to confirm if the risk register presented real and present risks being faced as an organisation and sought confirmation that mitigations in place were felt to be sufficient.
	The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
2245/22	**Item 13.2 Board Assurance Framework**
	The Trust Secretary presented the report to the Board noting that the Board Assurance Framework (BAF) had been considered by all Committees during November with no changes to the assurance ratings.
2246/22	The Trust Secretary advised that it had been pleasing to receive the final internal audit report for the review of the BAF which had given the Trust significant assurance with improvement actions.
2247/22	The Chair noted that there had been no movement of the assurance ratings but noted that there was an expectation, should reporting continue as expected, that movement could be seen before the end of the financial year.
2248/22	The current position of the BAF reflected the position against the current achievements of strategic objectives.

2249/22	The Chair was pleased to note the outcome of the internal audit and offered thanks to the Trust Secretary for the leadership of the BAF. It was recognised that it had been difficult to have a BAF that represented the complexity of the organisation but that was presented in such a way that this could be used by the Committees, to help structure items and conversations back to the Board. The Trust Board: • **Received the report noting the moderate assurance**
2250/22 2251/22	**Item 13.3 Board Voting Rights** The Trust Secretary presented the paper noting that the standing orders allowed for 5 voting Executive Directors. The current 5th vote sat with the Chief Operating Officer with a proposal that, with the handover of the post as Mr Simon Evans left the Trust, the vote would move to Ms Michelle Harris, in the role of Chief Operating Officer. The Chair took the paper as presented noting that this was received to ensure governance process had been followed and noted that approval was granted. The Trust Board: • **Received the report and approved the voting rights as presented**
2252/22 2253/22 2254/22 2255/22 2256/22 2257/22	**Item 14 Any Other Notified Items of Urgent Business** The Chair noted that this had been the last Board meeting attended by Dr Prior and thanked Dr Prior for representing Health Watch at the Trust Board meetings. Dr Prior had advocated for patients and improvements in services and had done so in a helpful and supportive way to the Trust. The Chair, on behalf of the Board thanked Dr Prior for her attendance at the Trust Board meetings and wished all the best for the future. The Chair also advised that this had been the last meeting for Mr Simon Evans as a Director of the Board of United Lincolnshire Hospitals NHS Trust and offered thanks for the massive contribution made to the Trust. Mr Evans has joined the Trust as Director of Operations and latterly taken on the Board role as Chief Operating Officer. The Chair thanked Mr Evans for taking a leap of faith and joining the Board noting that whilst all executive roles were challenging the Chief Operating Officer role brought it own levels of pressure. This had been a demanding and unrelenting ask and the impact of this was noted at all times however this had been even more significant due to the global pandemic, restoration and recovery phase following the pandemic. The Chair noted the foundations that had been developed by Mr Evans noting that the changes in practice and procedure and the environment in which staff worked would be his legacy to the Trust as Chief Operating Officer and lead for Estates and Facilities.

2258/22	The Chair reflected on the personal resilience, commitment, and contribution to both the Trust and the System noting the huge difference made on how things were now running across health and care in Lincolnshire.
2259/22	The Board often spoke about compassionate leadership, modelling behaviours and living values with the Chair noting that Mr Evans had been the living example of this with infinite capacity to behave in the right way in challenging circumstances.
2260/22	The Chair offered the thanks of the Board and personally to Mr Evans and fully appreciated the decision taken to step away from the role but was comforted by the fact that Mr Evans would continue to work with the Trust in the system.
2261/22	The next scheduled meeting will be held on Tuesday 7 February 2023 via MS Teams live stream

Voting Members	**7 Dec 2021**	**1 Feb 2022**	**1 Mar 2022**	**5 Apr 2022**	**3 May 2022**	**7 June 2022**	**5 July 2022**	**2 Aug 2022**	**6 Sept 2022**	**4 Oct 2022**	**1 Nov 2022**	**6 Dec 2022**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	A	X	X	A	X	X	X	X	X	X	X	X
Sarah Dunnett	X	X	X	A	X	A	X	A	A			
Elizabeth Libiszewski	X											
Paul Matthew	X	X	A	X	X	X	X	A	X	X	X	X
Andrew Morgan	X	X	X	X	X	A	A	X	X	X	X	X
Mark Brassington												
Simon Evans	X	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	X											
Philip Baker	X	X	X	X	X	X	X	X	X	X	X	X
Colin Farquharson	X	X	X	X	X	X	X	X	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
Rebecca Brown									X	X	X	X
Neil Herbert									X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
7 December 2021	1914/21	Action Log	Establishment reviews for endoscopy and ED would be received once considered at Committee in Jan/Feb 2022 Endoscopy review to be received in July	Director of Nursing	~~01/03/2022~~ ~~01/11/2022~~ 06/12/2022	Agenda Item Complete
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
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	Deferred from November meeting of FPEC

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

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 Development	07/02/2023	DBS Policy and Recruitment Policy have been updated. 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.
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 Improvement and Integration	07/02/2023	Complete

United Lincolnshire Hospitals NHS Trust

3Meeting	*Public Trust Board*
Date of Meeting	*7 February 2022*
Item Number	*Item number 6*

Chief Executive's Report

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to be under significant operational pressure. The system winter plans and plans to cope with industrial action have been enacted. A system control centre has been set up to ensure that there is operational oversight of the actions that need to be taken. All of which has seen improved ambulance category 2 response times and reduced the hours lost due to ambulance handover delays. There remains more to do to sustain the position.

b) John Drew the Director of Staff Experience and Engagement NHSE visited Lincolnshire in January, to look at the work we are doing as a national People Promise exemplar Trust. He offered positive feedback to us about our staff engagement work

c) A review of progress in exiting the national Recovery Support Programme (RSP) took place with the Lincolnshire NHS system in December. This has led a review of the timescale for the system to exit RSP.

d) NHSE released their delivery plan for recovering Urgent and Emergency Care services on 30 January 2023 which was a key commitment in the governments Autumn Statement. The plan includes two ambitions for the next two years – a 30-minute mean response time for Category 2 ambulance and 76% performance in A&E wait times. Improvements will be required across the patient pathway, including on 12-hour waits from arrival and on discharge from acute, community and mental health hospital settings. There is an expectation that whilst there is a need to increase capacity in hospitals and in UEC services, delivering this plan will need a cross-system approach, including primary and community services, mental health, intermediate care and social care. The plan sets out actions across five key areas: Increasing capacity; growing the workforce; improving discharge; expanding and better joining up of health and care outside hospital making it easier to access the right care. To support the recovery plan, the government has committed to additional targeted funding including: £1 billion of dedicated funding for 2023/24 to support capacity in urgent and emergency services, as set out in Planning Guidance, and to increase the overall capacity and support for staff. £1.6 billion of additional funding in the Adult Social Care Discharge Fund in 2023/24 and 2024/25, to be pooled into the Better Care Fund.

e) At month 9, the Lincolnshire ICS reported a year to date deficit of £19.3m against a year to date plan of a £4m deficit. In respect of the forecast position; the national protocol for systems to formally request moving their forecast away from their plan was released in Q3 22/23. The Lincolnshire ICS is likely to enact the forecast protocol at month 10, deteriorating their system financial forecast for 2022/23. The four organisations that make up the Lincolnshire ICS are reviewing opportunities to mitigate any adverse movement to the system forecast.

Trust Overview

a) At month 9, the Trust reported a year to date deficit of £12.5m against a year to date plan of break-even. After adjustments, this equates to a deficit of £12.6m in relation to the system financial plan. The focus of the financial recovery continues to be on productivity, agency cost reduction, bed numbers, and CIP delivery.

b) On 12th January the Trusts was awarded the UNICEF Baby Friendly Initiative (BFI) Certificate of Commitment for our Neonatal services. This is the first step towards gaining recognition from the UK Committee for UNICEF (UNICEF UK) BFI. The Certificate will soon be presented to the team for display across our sites.
BFI is a global programme which aims to transform healthcare for babies, their mothers and families as part of a wider global partnership between UNICEF and the World Health Organization (WHO). In the UK, the Baby Friendly Initiative works with public services to better support families with feeding and developing close, loving relationships in order to ensure that all babies get the best possible start in life. The

Certificate of Commitment recognises that a health care facility is dedicated to implementing recognised best practice standards. This is excellent news for our babies who are born prematurely and their families as well as our staff.

c) The Trust continues to implement its plans to achieve the 78 week commitment to have all our 78 week cohort of patients booked an appointment and first definitive treatment completed by the end of March 2023. We are on track to meet this commitment in the majority of our specialities. In those small few where we need support we are in the process of securing mutual aid.

d) The Trust met with Professor Tim Briggs the National Director of Clinical Improvement and Elective Recovery NHSE, regarding productivity. He was complementary of the Trust and our recent track record of delivery on 104 week and elective plans.

e) On the 30th January we officially started to care for patients in our new £5.6 million resuscitation Department at Lincoln County Hospital. This is a very impressive facility and has taken a collective effort from our clinical and support teams to make this ambitious project a reality. A huge well done to everyone involved.

f) Mr Paul Matthews our Director of Finance and Digital, will be leaving the Trust at the end of April to take up a new role as the Chief Financial Officer at Nottingham University Hospital NHS Trust on the 1 May 2023. Plans to find his replacement have commenced.

g) Our Armed Forces Staff Network led the first Step into Health Insight Day in January. This is a programme aimed at all Armed Forces service leavers, reservists, veterans, Cadet Force Adult Volunteers and the families of all of these who may have an interest in a career with the NHS. These are individuals we'd love to have join us, as we work in a county with strong military links, and the event was a great way to reach out to them.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	20 December 2022
Chairperson:	Rebecca Brown, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives. Due to the Trust being in critical incident at the time of the meeting the decision was taken to reduce both the time of the meeting and length of the agenda in order to ensure staff were able to respond to the incident. A number of items were taken for information and some items deferred to the January 2023 meeting.
	Assurance in respect of SO 1a Issue: Deliver high quality care which is safe, responsive and able to meet the needs of the population **Patient Safety Incident Responses (PSIRF)** The Committee received the report for information noting that there had been a detailed update to the Trust Board and that progress remained on course. **Complaints, Legal Claims and Inquests, Incidents and Patient Advise and liaison Service (PALS) Report** The Committee received the report noting that there were no new themes identified and that themes continued around communication, values and behaviours, delays in treatments or procedures and delays to undertaking investigations. It was noted by the Committee that the introduction of PSIRF would result in more detailed reviews of data and the development of a patient safety investigation plan. As a result, the Committee was alerted that the format of the report may change or become obsolete but until the appropriate time the report would continue to be received. The Committee noted the triangulation of the themes within the report to the risks contained within the risk register and reflected that assurance was being received in respect of patient safety.

	Serious Incident Summary Report The Committee received the report noting the position presented. **High Profile Cases** The Committee received the report noting the content. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report for information and received the MRSA investigation report which was thorough. The Committee noted the recent concerns raised in the media with regard to antibiotic availability for patients with Strep A. Whilst confirmation was received that the Trust antibiotic supply was sufficient to manage patients the Committee sought assurance from the Integrated Care Board that work was being carried out to ensure ongoing provision of antibiotics or appropriate alternatives. **Medicines Quality Group Upward Report** The Committee received the report noting the continued progress with actions relating to the safe management of medicines with the majority of actions having been completed. The successful pilot of temperature monitoring was noted however this had highlighted issues with ambient areas of drug storage. Following ratification of the results of the pilot a task and finish group would be established to address identified issues. The Committee was pleased to note the development of new ways of working across medicine and reflected that innovation continued despite operational pressures. **Patient Safety Group Upward Report** The Committee received the report noting that there had been a positive upward report from the new chair of the Deteriorating Patient Group which had offered reassurance of the work the group would start to undertake at pace. The group had received the central alert system (CAS) and field safety notices (FSN) report which had demonstrated some improvement with further work required. The group had requested a trajectory for the closure of FSN's from 2021/22 and it was noted that an internal audit would be undertaken for both FSNs and CAS in year. The Committee was pleased to note that the Surgery Divisional Never Event summit had been held which had been well attended with positive feedback received. A number of additional actions had resulted from the summit and would be reported back to the group and upwardly to Committee.

	Clinical Harm Oversight Group Upward Report The Committee received the report noting that the Clinical Prioritisation Cell which had been in place during Covid-19 was now being subsumed into business as usual. The Committee noted the volume of outstanding harm reviews and noted that whilst the level of harm was low there had been large cohorts of patients without contact with clinicians to assess harm. Work was being undertaken with the divisions in relation to time critical patients for follow up and missing outcomes in order to ensure this progressed. Work had also commenced to map harm through datix to harm reviews however it was noted due to only being in place for one month it was premature to report data however levels of harm remained low. Concern was noted regarding harm reviews for cancer patients however the Committee was advised that updates would be provided to the Integrated Care Board Cancer Board in order to monitor progress. The report would also be offered to the Committee. **Postpartum Haemorrhage Report** The Committee received the report noting that this had been an area of focus following reporting to the Maternity and Neonatal Oversight Group (MNOG). The report demonstrated the actions being taken by the Trust which would continue to be monitored by MNOG with upward reporting to the Committee where necessary.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report noting that there had been good attendance with productive discussions held. It was noted that there was a schedule of actions for the group to undertake which were focused on both patient experience but also patient engagement. The Committee was pleased to note the level of involvement and engagement of the Trust with patients and it was noted that this would support the new regulatory approach that was due to be implemented by the Care Quality Commission.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting that the Trust was an outlier for 2 national audits however these were being considered with actions

	due to be reported to the group in January. The Committee raised concern regarding the ophthalmology data base audit and noted that there had been a decrease in measurements being undertaken both pre and post operatively. This would again be considered by the group at the next meeting and an update offered to the Committee.
	Assurance in respect of other areas: **Topical, Legal and Regulatory update** The Committee received the report for information noting that the updates offered through the report were helpful to Committee members. **Outcome of Clinical Governance Reviews – recommendations** The Committee received the report following the additional session held by Committee members to consider the review and recommendations. The Committee noted the recommendations which had been agreed and would be implemented. **Risk Appetite Proposal** The Committee received and noted the risk appetite proposal which had been discussed through the additional session held for Committee members. **Integrated Improvement Plan** The Committee received the report for information. **CQC Section 31 notice** The Committee received the report for information and was pleased to note the removal of the final section 31 notice and recognised the positive position for the Trust. **CQC Action Plan (quarterly report)** The Committee received and noted the report for information **Committee Performance Dashboard** The Committee received the report and noted that due to the discussions held throughout the meeting that all items requiring consideration had been discussed. **Industrial Action** The Committee received substantial verbal assurance on the preparations being taken in respect of the industrial action with a request made by the Chair for information pertaining to the actions to be shared with all Board members.
Issues where assurance remains outstanding for escalation to the Board	None

Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	24 January 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 – Meeting Cancelled** The Committee noted that due to the response to the critical incident the meeting had been stood down however it was noted the pressures being experienced may contribute to harms. The Committee noted the intention to consider a refocus of how harm was assessed to ensure that this continued to be done in the most appropriate way. There was a desire to consider harm in the wider categories with a further paper due to the Committee in February to describe the proposed changes which would demonstrate the Trust was seeking to identify the next level of assurance. **High Profile Cases** The Committee received the report noting the content. **Serious Incident Summary Report inc Duty of Candour** The Committee received the report noting the position presented. The Committee recognised that at the time of writing the Duty of Candour data was low however this was due to the time lag and data would increase over time. Support would continued to be offered to ensure completion of duty of candour due to operational pressures being experienced.

	Safeguarding Group Upward Report inc Internal Audit Report The Committee received the upward report noting the contents and sought to better understand the assurance offered on the internal audit report. The Committee noted that following the internal audit report an action plan had been developed in order to respond to the recommendations made. Further work was required in respect of medical engagement with Child Protection Information Sharing (CP-IS) to ensure that this was completed appropriately to ensure this was embedded with Medics in order that the current support being offered could be stood down. Concern was noted due to the ongoing IT issues which were impacting on the ability for training to be accurately recorded however reassurance was received that this would be resolved in the coming weeks. There was however a preference for face-to-face training which the team continued to facilitate where possible. The Committee had requested attendance by the Medicine Division at the next meeting in order to ensure early action on recommendations identified given that these had previously been raised by the CQC. **Infection Prevention and Control (IPC) Group Upward Report** The Committee noted that due to the response to the critical incident the meeting had been stood down however a report had been offered to the Committee. The Committee was pleased to note that C-Difficilie was on trajectory and MRSA was at or below trajectory which demonstrated an improvement. It was also noted that the Trust was due to receive an IPC visit from NHS England in February. **Patient Safety Group Upward Report – Meeting Cancelled** The Committee noted that due to the response to the critical incident the meeting had been stood down however was advised that there were no escalations. **Maternity Neonatal Oversight Group Meeting Upward Report inc. CNST submission** The Committee received the report and commended the team on the work undertaken to achieve the CNST submission which had been evidence based. The Committee accepted the recommendation that the requirements had been met and was extremely pleased to escalate to the Board the success of achievement. The Committee noted that the future of the Group had been considered

	with a view to retain the group, meeting on a bi-monthly basis, in order to maintain oversight given the ongoing national picture and requirements through reports such as Ockenden. This was supported by the Committee. **Nursing Midwifery and AHP Advisory Forum inc. Ward Accreditation** The Committee noted that due to the response to the critical incident the meeting had been stood down however the Committee received the Ward Accreditation paper. The Committee was pleased to note that a number of areas were due to apply for accreditation having achieved the relevant aspects which now needed to be confirmed through an evidence review and ward accreditation panel. The Committee also noted the success of the accreditation programme with other non-nursing areas wishing to be involved in the accreditation process. Whilst the successes were celebrated the Committee was also pleased to note the level of support offered to areas where improvement was required. **Children and Young People Oversight Group Upward Report inc. Update on Paediatric Model at Pilgrim** The Committee received the report noting the content offered and received a detailed update in respect of the background to the Paediatric Model at Pilgrim. The Committee noted the work that had been undertaken in respect of the paediatric model and supported the development of the planned consultation which would be offered back to the Committee once complete. The Committee was pleased to note that the current model in place continued to function well and that this had been achieved through developments of an initial model which had been put in place.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee noted that due to the response to the critical incident the meeting had been stood down however the papers had been considered by the Chair of the group. The Committee noted the continued development of expert refence groups and experts by experience which was being extended to collaborate with the Improvement Academy to ensure engagement with improvement activities. Discussion took place regarding hard-to-reach groups with limited progress noted however work was taking place with HealthWatch to seek

	support. The Committee noted that communication, staff attitude and behaviour continued to be reported with a communication review group established, from a patient perspective, to consider how this was addressed.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report – Meeting Cancelled** The Committee noted that due to the response to the critical incident the meeting had been stood down however was advised that there were no escalations.
	Assurance in respect of other areas: **Committee Self-Assessment** The Committee received the self-assessment completed by Committee members and the outcome of this recognising there were no actions required. **Draft Annual Report – Committee Effectiveness** The Committee received the draft Annual Report on Committee Effectiveness with Committee members offering some initial feedback on the report. Further feedback would be offered on this by Committee members prior to the final report being received at the Committee for approval to present to the Trust Board. **Integrated Improvement Plan** The Committee received the Integrated Improvement Plan noting that work continued with the system in respect of Breaking the Cycle too. The Committee was asked to consider and reflect on the priorities for the coming year and if those currently set would be continued. The Committee considered the request and noted that there would be benefit in wider discussions in respect of targets/thresholds prior to a full discussion by the Committee. **Quality Impact Assessments (QIA) Report** The Committee received the report which detailed the QIAs which had been reviewed in the previous quarter and either agreed, closed or rejected. The Committee noted the progress being made with staff to recognise the need for a QIA and was advised that a new process would be implemented that would support identification of the need for a QIA, regardless of the scale of change. **QIA Internal Audit Report**

	The Committee received the internal audit report noting that the Trust had requested this be included on the internal audit programme following a full refresh of the process. It was noted that partial assurance had been received which was pleasing given the changes that had been made to improve process. Actions were now in place as a result of the recommendations made which had been afforded short timescales to achieve. Progress of achievement would be monitored. The Committee had agreed to review all actions, associated with all relevant internal audits, on a monthly basis until these were closed. **CQC Action Plan** The Committee received and noted that the position remained largely static however the commencement of the Executive Assurance Meetings would support the progression of actions. **CQC Changes: New assessment framework and phased implementation** The Committee received the report noting the proposed changes to the CQC strategy and approach which had been delayed to the end of the year. Work was underway to develop a proposal for work with corporate functions and divisions in order that the Trust was more proactive in assessment rather than being reactive. **Committee Performance Dashboard** The Committee received the report and noting that VTE assessments continued to be below the control level with continued discussion being held with the surgery division to reinvigorate the VTE Nurse role. Medicines incidents were noted with improvement seen which was recognised as a step change from the previous year. Whilst it was recognised that admitted medicines continued to comprise 32% of incidents there had been successful implementation of e-prescribing.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register.
Matters identified which Committee recommend are	None

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	7th February 2023
Item Number	

CNST update

Accountable Director	Dr Karen Dunderdale, Director of Nursing & Deputy Chief Executive and Chair of the Maternity & Neonatal Oversight Group
Presented by	Libby Grooby – Head of Midwifery Simon Hallion – Divisional Managing Director Suganthi Joachim – Clinical Director
Author(s)	Libby Grooby
Report previously considered at	QGC 24th January 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	*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	
3a A modern, clean and fit for purpose environment	
3b Efficient use of our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish collaborative models of care with our partners	*x*
4b Becoming a university hospitals teaching trust	
4c Successful delivery of the Acute Services Review	

Risk Assessment	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Significant*

	• *Moderate* • *Limited* • *None*

Recommendations/ Decision Required	• *Insert recommendations here* • *Insert recommendations here* • *Insert recommendations here*

Executive Summary

Insert brief summary here which should not exceed 1 side of A4

Main Body
which should not exceed 5 sides of A4
(Section Headings)

Purpose

Key messages

Conclusion/Recommendations

Maternity incentive scheme - Guidance

Trust Name	**United Lincolnshire Hospitals NHS Trust**
Trust Code	**T565**

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please update**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within the condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - action plan summary sheet - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the allocated spaces within this document. Two electronic signatures of the Trust's CEO and AO of the ICS will be required in Tab D as outlined in order to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the declaration form has been submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services and two signatures to declare that there are no external or internal reports covering either 2020/21 financial year or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 2 February 2023.

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on **Thursday 2 February 2023** to nhsr.mis@nhs.net
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Version Name: MIS_SafetyAction_2023_V8

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 6 May 2022 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	Was the surveillance information for eligible deaths where required, completed within one month of the death?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Have at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022, been reviewed using the PMRT, by a multidisciplinary review team?	Yes
5	Were each of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were the reports published within 6 months of death?	Yes
	Q7 and Q8 are linked questions	
7	For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, were parents told that a review of their baby's death will take place?	Yes
8	If parents have not been informed about the review taking place, were the reasons for this documented within the PMRT review?	N/A

Safety action No. 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	By 31 October 2022, did your Trusts have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework?	Yes
2	Was the strategy shared with Local Maternity Systems?	Yes
3	Was the strategy signed off by the Integrated Care Board?	Yes
4	Is a dedicated Digital Leadership in place in the Trust?	Yes
5	Has the Digital Leadership at the Trust engaged with the NHSE Digital Child Health and Maternity Programme?	Yes
6	Was your Trust compliant with at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022?	Yes
Did your Trust's July 2022 data contain:		
7	Height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month?	Yes
8	Complex social factor Indicator (at antenatal booking) data for 95% of women booked in the month?	Yes
9	Antenatal personalised care plan fields completed for 95% of women booked in the month (MSD101/2)?	Yes
10	A valid ethnic category (Mother) for at least 90% of women booked in the month (MSD001) ?	Yes
Has the Trust Board confirmed that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:		
11	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	Q12 is for information only	
12	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	Yes

13	iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion.	Yes

Safety action No. 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care by Thursday 16 June 2022 at the very latest		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to British Association of Perinatal Medicine (BAPM) transitional care framework for practice ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal Systems (LMNS), commissioner and Integrated Care		
3	Has the pathway of care into transitional care been fully implemented?	Yes
4	Has the pathway of care into transitional care been audited quarterly?	Yes
Audit findings must be shared each quarter. If for any reason, reviews were paused, they must have been recommenced using data from quarter 1 of 2022/23 financial year. Has audit findings been shared with:		
5	The neonatal safety champion?	Yes
6	The LMNS?	Yes
7	The commissioner and Integrated Care System (ICS) quality surveillance meeting?	Yes

8	If your Trust have encountered barriers to achieving full implementation of the policy, has an action plan been agreed and progress overseen by both the board and neonatal safety champions?	N/A
c) A data recording process (electronic and/or paper based) for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.		
9	Is standard (c) in place?	Yes
d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.		
	Q10 and Q11 are linked	
10	Is standard (d) in place? This should be achieved by no later than 16 June 2022.	Yes
11	If not already in place is a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered	N/A
e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.		
12	Is standard (e) in place (as per ODN request)?	Yes
f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.		
13	Is an audit trail available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly? If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year.	Yes

14	Is an audit trail available which provides evidence that reviews from Monday 18 July 2022 included **all** term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year?	Yes
15	Do you have evidence that the review includes the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there?	Yes
16	Do you have evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting on a quarterly basis?	Yes
g) An action plan to address local findings from the audit of (standard b) Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, and (standard f) been agreed with the maternity and neonatal safety champions and Board level signed off by the Board no later than 29 July 2022?		
17	Is standard (g) in place?	Yes
h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting each quarter following sign off at the Board.		
18	Has progress with the revised ATAIN action plan been shared with the maternity, neonatal and Board level safety champions each quarter, following sign off at the Board?	Yes
19	Has progress with the revised ATAIN action plan been shared with the LMNS each quarter, following sign off at the Board?	Yes
20	Has progress with the revised ATAIN action plan been shared at the ICS quality surveillance meeting each quarter, following sign off at the Board?	Yes

Safety action No. 4
Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	**Obstetric medical workforce** Have your Trust Board signed off their engagement with the principles outlined in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/?	Yes
	Q2 and Q3 are linked	
2	Was compliance of consultant attendance monitored when a consultant was required to attend in person?	Yes
3	Were episodes where attendance was not possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	N/A
Do you have evidence that your position with the above RCOG document was shared at least once from May 2022:		
4	At Trust Board?	Yes
5	With Board level safety champions?	Yes
6	At LMNS meetings?	Yes
7	**Anaesthetic medical workforce** Do you have evidence of compliance with Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1? The rota should be used to evidence compliance with ACSA standard 1.7.2.1 *(A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)*	Yes
	Q8 and Q9 are linked	
8	**Neonatal medical workforce** Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	Yes
9	If the requirement above has not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS and also include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. Do you have evidence of this?	N/A
	Q10, Q11 and Q12 are all linked	
10	**Neonatal nursing workforce** Does the neonatal unit meet the service specification for neonatal nursing standards?	Yes
11	If the requirement above had not been met in both year 3 and year 4 of MIS, has the Trust Board evidenced progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies?	N/A
12	Has the above action plan been shared with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead?	N/A

Safety action No. 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Requirements number	Safety action requirements
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board m of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ●The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for mana shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cov inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers includes those in management positions and specialist midwives. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labou include plan for mitigation/escalation to cover any shortfalls.
3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseloa their own during their shift) to ensure there is an oversight of all birth activity within the service. The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provi care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action pla mentioned in the section above. Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status?
	Q4 is for information only
4	If you answered **no** to standard c, have you completed an action plan detailing how the maternity services intends to a 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and include timeline for when this will be achieved? Please note, completion of an action plan **will no**t enable the trust to declare compliance with this sub-requirement in four of MIS.
	Q5, Q6 and Q7 are all linked
5	d) Have all women in active labour received one-to-one midwifery care?
6	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service inte achieve 100% compliance with 1:1 care in active labour?
7	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?
8	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 mon during the maternity incentive scheme year four reporting period?

Safety action No. 6
Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?

Requirements number	Safety action requirements	Req met (Yes app
1	Do you have evidence that Trust Board level consideration of your organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019? Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.	Yes
2	Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (ICB). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.	Yes
3	The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. Have you completed and submitted this?	Yes
Element 1 - Reducing smoking in pregnancy Standard a*) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.* *Standard b) Percentage of women where CO measurement at 36 weeks is recorded.*		
4	Has the Trust Board received data for **standard a)** from the organisation's Maternity Information System (MIS) evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe)?	Yes
5	Has the Trust Board received data for **standard b)** from organisation's Maternity Information System or has an audit of 60 consecutive cases been provided to demonstrate >80% of women having a CO measurement recorded at 36 weeks?	Yes
6	Is the audit accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement?	Yes
7	If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. Has this been completed?	Yes
Do you have evidence that the Trust Board has specifically confirmed that within their organisation they:		
8	Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.	Yes
9	Have a referral pathway to smoking cessation services (in house or external)?	Yes
10	Have evidence of an audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service?	Yes
4) Have you generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 period:		
11	Percentage of women with a CO measurement ≥4ppm at booking?	Yes
12	Percentage of women with a CO measurement ≥4ppm at 36 weeks?	Yes
13	Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment?	Yes
Element 2 - *Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)*		
14	Standard 1) Have you provided evidence showing the percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan? The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital If your Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	Yes
15	Has the Trust board received data from the organisation's MIS evidencing 80% compliance or has an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records been undertaken and submitted to Board to assess compliance with this indicator?	Yes
Do you have evidence that the Trust Board has specifically confirmed within their organisation:		

16	Standard 2) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards? If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	Yes
17	Standard 3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation? If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	Yes
18	Standard 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation?	Yes
19	Standard 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT)?	Yes
20	Standard 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (ICBs) following advice from the Clinical Network?	Yes
21	Standard 7) You have undertaken a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.	Yes

Element 3 *Raising awareness of reduced fetal movement.*

A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pre
B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides asse
short term variation).
The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of w
attending with RFM whichever is the smaller to assess compliance with the element three process indicators.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

	Q22 and Q23 are linked	
22	Have you completed an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM (whichever is the smaller) demonstrating 95% compliance with the element three process indicators?	Yes
23	If the process indicator scores are less than 95% , have you submitted an action plan for achieving >95%?	N/A
Element 4 *Effective fetal monitoring during labour*		
	You do not need to submit evidence within element 4, as it is included within safety action 8	
Element 5 *Reducing preterm births*		
	Q24, Q26, Q27 and Q28 are linked	
24	a) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of singleton live births (less than 34+0 weeks) received a full course of antenatal corticosteroids, within seven days of birth?	No
25	b) Has the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids been recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding?	Yes
26	c) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth?	No
27	d) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of women have given birth in an appropriate care setting for their gestation (in accordance with local ODN guidance)?	Yes
28	If your process indicator scores for standards a,c or d are less than 80%, do you have an action plan for achieving >80%?	Yes

29	Do you have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention?	Yes
	Q30 and Q31 are linked	
30	Do women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided?	Yes
31	If this is not the case, has the board described the alternative intervention that has been agreed with their commissioner (ICB) and that their Clinical Network and has agreed this is acceptable clinical practice?	N/A
32	Has an audit of 40 consecutive cases of women booking for antenatal care been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway? The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local ICBs following advice from the Clinical Network.	Yes
33	Does the risk assessment and management in multiple pregnancy comply with NICE guidance or a variant that has been agreed with local commissioners (ICBs) following advice from the provider's clinical network?	Yes

Safety action No. 7

Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you submitted Terms of Reference for your MVP? Do they reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems	Yes
2	Do your minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff?	Yes
3	Have you submitted written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme? Remuneration should take place in line with agreed Trust processes.	Yes
4	Have you provided minutes of the MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it?	Yes
5	Do you have written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way.	Yes
6	Do you have evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality	Yes
7	Do you have evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP	Yes

Safety action No. 8

Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?
In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you evidence that:		
1	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. should include the following 6 core modules: • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support	Yes
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group has attended an 'in house' one day multi-professional training day, that includes maternity emergencies?		
2	90% of Obstetric consultants?	Yes
3	90% All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota, including GP trainees?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	yes
5	90% of Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)?	yes

6	90% of Obstetric anaesthetic consultants?	yes
7	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota?	yes
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring?		
8	90% of Obstetric consultants?	yes
9	90% of all other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	yes
10	90% of GP trainees who have any obstetric commitment to intrapartum care?	yes
11	90% of midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres (if applicable)?	yes
12	Are fetal monitoring sessions consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness?	yes
13	Has the Trust board specifically confirmed that within their organisation 90% of eligible staff have attended local multi-professional fetal monitoring training annually as above?	yes
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course?		
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% Neonatal junior doctors (who attend any births)	Yes
16	90% of Neonatal nurses (Band 5 and above)	Yes
17	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
18	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.	yes

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety an quality issues?

Requirements number	Safety action requirements	Requiremer met? (Yes/ No /N applicable)
Have you submitted evidence of a revised pathway which describes how frontline midwifery, obstetric and Board safety champions share safety intelligence between:		
1	a) each other?	yes
2	b) the Board?	yes
3	c) new LMNS/ICS quality group?	yes
4	d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model?	yes
Have you submitted evidence of a revised pathway which describes how frontline neonatal Board safety champions share safety intelligence between:		
5	a) each other?	yes
6	b) the Board?	yes
7	c) new LMNS/ICS quality group?	yes
8	d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model?	yes
Have you submitted evidence that a clear description of the pathway and names of safety champions are visible to:		
9	Maternity staff?	yes
10	Neonatal staff?	yes
11	Have you submitted evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues?	yes
12	Have you submitted evidence that discussions regarding safety intelligence, including staff feedback from frontline champions and engagement sessions?	yes
13	Have you submitted evidence that discussions regarding safety intelligence, including minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022? NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.	Yes
14	Have you submitted evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board?	yes
15	Have you submitted evidence of progress with actioning named concerns from staff workarounds are visible to maternity staff and reflects action and progress made on identified concerns raised by staff and service users?	yes
16	Have you submitted evidence of progress with actioning named concerns from staff workarounds are visible to neonatal staff and reflects action and progress made on identified concerns raised by staff and service users?	yes
17	Have you submitted evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting?	yes
18	Has a decision been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended? This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent discussion should be included in the trust Board submission.	yes
Is there Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to:		
19	Active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities	yes
20	Engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member	yes
21	clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network?	yes
22	Utilise insights from culture surveys undertaken to inform local quality improvement plans?	yes
23	oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement	yes
24	Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by 5th December 2022.	yes
25	Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5th December 2022.	yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported all qualifying cases to HSIB from 1 April 2021 to 5 December 2022?	yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022?	yes
For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that:		
3	The family have received information on the role of HSIB and NHS Resolution's EN scheme	yes
4	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	yes
Can you confirm		
5	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution.	yes
6	Sight of evidence that the families have received information on the role of HSIB and EN scheme	yes
7	Sight of evidence of compliance with the statutory duty of candour.	yes
8	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	yes

Section A : Maternity safety actions - United Lincolnshire Hospitals NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?	Yes
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Yes
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an ‘in house’, one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	Yes

Section B : Action plan details for United Lincolnshire Hospitals NHS Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

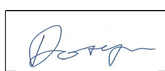
Maternity incentive scheme - Board declaration Form

Trust name United Lincolnshire Hospitals NHS Trust
Trust code T565

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	-		
Total sum requested			-	

Sign-off process:

Electronic signature 

For and on behalf of the board of United Lincolnshire Hospitals NHS Trust

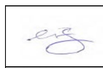
Electronic signature 

For and on behalf of the board of United Lincolnshire Hospitals NHS Trust

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

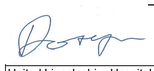
Electronic signature 

For and on behalf of the board of United Lincolnshire Hospitals NHS Trust

Electronic signature 

For and on behalf of the board of United Lincolnshire Hospitals NHS Trust

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature 

For and on behalf of the board of United Lincolnshire Hospitals NHS Trust

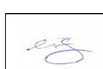
Electronic signature 

For and on behalf of the board of United Lincolnshire Hospitals NHS Trust

Confirming that:
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature 

For and on behalf of the board of United Lincolnshire Hospitals NHS Trust

Electronic signature 

For and on behalf of the board of United Lincolnshire Hospitals NHS Trust

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the

Name: Andrew Morgan
Position: Chief Executive
Date: 24-Jan-23

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

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2022/23 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Lack of Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Workforce Strategy and Organisational Development (WSOD) Group Upward Report** The Committee received the report from the group noting that there had been some improvement in a number of key performance indicators however the Committee remained cautious of the improvements reported. The Committee was pleased to note the progress with job plans noting that 200 were at the third stage sign off or had been signed off. A series of panels were due to be undertaken before the Christmas period to ensure sign off where possible. **Committee Performance Dashboard** The Committee received the dashboard noting that this had been considered by the WSOD Group and was pleased to note that the absence management system metrics had been added to the scorecard. The Committee requested further development of the scorecard in order to track progress over the year. **Lincolnshire People Plan update** The Committee received the Lincolnshire People Plan and noted the involvement of all system partners. Consideration had been given to possible incentives across the Christmas period to support staffing requirements which would be approved at a future meeting. The Committee challenged the new ways of working noting the need to be bolder in terms of new ways of working including skill mix, models of

	service and provision of virtual wards. It was noted that further discussions would be undertaken to move forward. **Mandatory Training Update** The Committee received the update noting that work was underway to ensure compliance and alignment with the CQC must do actions. A task and finish group had been established to focus on mandatory training and undertaken a review of what required inclusion. It was noted that the divisions would be included in the work being undertaken to reset completion trajectories which would be evidence based. The Committee noted that once completed this would increase the proportion of staff completing mandatory training. An update report would be offered to the Committee in January. The Committee was advised of the establishment of an Appraisal Task and Finish Group, again working with the division and HR business partners, in order to set realistic appraisal trajectories. The Trust would move to a cycled appraisal system which would be in line with priority and objective setting of the organisation between April – June each year. Once the initial scoping exercise was complete the Committee would be better sighted on timescales for progression.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Industrial Action and Emergency Planning Risk Assessment** The Committee received a verbal update on the current position of industrial action and noted the risk assessment which had been offered. The Committee noted that the industrial action, whilst not directly impacting on the Trust, would have implications. **Culture and Leadership Group Upward Report** The Committee received the report noting that there had been numerous activities undertaken which predominantly focused on living the Trust values and large-scale organisational development programmes. The Cultural Ambassador programme had been rolled out and there had been a positive response to the recent Leading Together Forum which had received a guest speaker focusing on civility.

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

Medical School Update
The Committee received the report noting the successful delivery of the foundation programme and the commencement of the advanced practice first module in February 2023.

The Committee noted the risk related to advanced clinical modules however also recognised the positive feedback from the recent GMC visit with a further review due to be undertaken in January 2023 by the University of Leicester.

Whilst progress was being seen the Committee raised concern about the alignment of the medical school with the University strategy and the need to continue to engage and progress.

Research and Innovation Strategy Update
The Committee received the update noting that a further update including timelines would be offered to the Committee in January to ensure activity developed in a more robust manner.

It was recognised that there was a need to develop research and innovation (R&I) across the Trust to reduce the isolation of the department and engage all staff groups with R&I.

The launch of the R&I forum would take place in the new year with the University of Lincoln invited to be part of this to support partnership working.

The direction of travel for R&I was supported by the Committee however concern was noted regarding external support to the Trust alongside the capacity to deliver however the Committee was reassured of the progress that was anticipated over the coming months.

University Teaching Hospital Group Upward Report
The Committee received the report and associated letter received from the University Hospitals Association noting that there was a need for the Trust to appoint 21 clinical academics.

It was noted that the framework for the rural healthcare strategy required development with stakeholder engagement to be undertaken. It was recognised however that a joint strategy would be required to successfully progress developments.

	Assurance in respect of other areas: **Topical, Legal and Regulatory Update** The Committee received the report noting the updates offered to the Committee with discussion being held regarding the BMA rates and the impact upon the Trust. The Committee noted that there would be a financial impact of the increase in rates, and it was noted that a proposed offer had been declined. Work continued to address the issue and try to resolve the position. **Integrated Improvement Plan** The Committee received the report noting the content and the overall moderate assurance offered at the end of month 8. The Committee was pleased to note that the vacancy rates had been below the in-month target of 12% with planning commencing for 2023/24. **Internal Audit Recommendations** The Committee received the report noting the recommendations presented and reflected that a review of these would be undertaken and updates offered where possible. **CQC Action Plan** The Committee received the report noting that this reiterated the position of aspects such and mandatory training and appraisal as discussed by the Committee. The Committee noted the progress and the enhanced position reported.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to escalate to the Board the concerns regarding the BMA minimum recommended rate.
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. The Committee agreed that Objective 2b Making ULHT the best place to work should be uprated to Amber given the improvements seen in reporting and governance processes to support the Committee.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

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

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	17 January 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 Scorecard/themes** The Committee noted that the Workforce Strategy and Organisational Development Group (WSODG) had been stood down in December due to the organisation being in critical incident. The Committee received the scorecard noting the decrease in vacancy rates and agency spend with significant effort in place to reduce this. The Committee requested consideration of the presentation of the information noting that month on month, whilst changes were in the right direction, these were minimal. **Safer Staffing inc Breaking the Cycle** The Committee received the safer staffing reporting which offered the November position and demonstrated an improvement in fill rates in month, across both days and nights. The Committee noted that less agency shifts had been utilised in November resulting in a decrease in spend for the first time since May 2022. Reduced levels of harm were also noted across all areas however there had been an increase in the number of falls. It was noted that correlation between patient levels, skill mix and harm provided useful triangulation however there was complexity to this with some harms being multifactorial. The Committee noted the focus in month on Breaking the Cycle which had commenced in November as a 60-day trial. This had now moved to business as usual to try and relieve pressures in respect of patient flow.

	Whilst this had been well received by staff who understood why this was needed there had in the early stages been some concerns which varied across the sites and departments due to the potential acuity of patients. The Committee was pleased to note that the Patient Experience Team had been involved in gathering information which would continue in order to support the embedding of the process.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **NHS Staff Survey** The Committee received the embargoed NHS Staff Survey results noting a level of improvement which would be considered in further detail once the results were published. **Freedom to Speak Up Guardian Report** The Committee received the report from the Freedom to Speak Up Guardian noting the ongoing activity and actions being undertaken in the Trust. The Committee continued to be pleased to note that staff were not speaking up anonymously which demonstrated the level of confidence in the Guardian. **GMC Junior Doctor Survey Update** The Committee received the report noting that the data presented was from March 2022 and the main areas of concern noted in the report had previously been alerted to the Committee. The findings had been considered with enhanced support and actions in place as a result. The Committee was mindful of the cultural deep dive being undertaken into areas of concern noting that the outcome would be reported once concluded. **Equality Delivery System** The Committee received the report noting that there was a statutory requirement for the report to be published by 28 February. The Committee noted the 3 domains within the report and the assessment undertaken by the Trust against these. The Committee noted that the report had been received and considered in detail by the Equality, Diversity and Inclusion Group and requested that a specific highlight report be offered to the Committee regarding the discussions.

	Cultural Deep Dive The Committee received the report for information noting that further consideration would be afforded to this upon the completion of the current cultural deep dives which were underway.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Quarterly Research, Development and Innovation Update and Research and Innovation Governance Group Upward Report** The Committee welcome the Director of Research and Innovation to the Committee who offered an update on the progress being made within Research and Innovation. The Committee noted that additional appointments had been made to the department which would strengthen not only the resource but the approach to R&I. The Committee received the updated terms of reference for the Research and Innovation Governance Group noting that this would report into the Medical Director function operationally with the Research and Innovation Oversight Group reporting to the Committee. **University Teaching Hospital Group Upward Report** The Committee received the upward report noting that there had been little change since the previous report to the Committee. It was noted that a letter had been written to the Secretary of State to request further support from the ICB. The Committee noted the improved engagement between the Group and Research and Innovation as these went hand in hand. Concern continued to be noted in respect of the engagement with the University of Lincoln and the continued lack of clarity on the funding of clinical academic posts.
	Assurance in respect of other areas: **Committee Self-Assessment** The Committee received the self-assessment completed by Committee members and the outcome of this recognising there were no actions required. **Committee Effectiveness Draft Annual Report** The Committee received the draft Annual Report on Committee Effectiveness and would offer feedback on this prior to the final report being received at the Committee for approval to present to the Trust Board.

The report would support the completion of the Trust's Annual Report and Annual Governance Statement.

People Directorate Update

The Committee received the report in respect of the ongoing work to restructure the People and Organisational Development Directorate noting the current pressures being faced by the Directorate.

A number of appointments had been made with an approach to foundations and fundamentals being taken as part of the process. Part of the development would be to focus on cultural change and behaviours.

Work would be undertaken to ensure that there was a relaunch of the service to the organisation with a clear definition of expectations as to the level of service being offered.

Whilst the Committee noted the progress there was an understanding that timelines for activity may slip due to recruitment processes. It was anticipated that full capacity would be in place in May 2023.

Integrated Improvement Plan

The Committee received the month 9 position noting the overall moderate assurance that was offered with steady progress being made in respect of vacancy rates, appraisals and staff survey results.

It was recognised by the Committee that there remained significant work to be undertaken in these areas.

Absence Management Internal Audit

The Committee received the internal audit report for absence management noting the introduction of the Absence Management System.

The Committee noted that this had been launched as Covid-19 had arisen and noted that there had been some relaunch of the system to support full utilisation. It was noted that further work was required with manager to address the recommendations within the report.

Recruitment follow up Internal Audit

The Committee received the follow up recruitment internal audit noting the progress that had been made since the initial report although it was noted that further work was required.

The actions relating to preemployment checks and completion of DBS check also linked to the actions resulting from the Savile report and the introduction of new DBS regulations.

	CQC Action Plan The Committee received the report noting the update offered and the work due to take place to ensure actions were updated ahead of the February Committee.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to alert to the Board the concerns noted in respect of the People and Organisational Development Directorate and the current pressure being faced. The Committee wished to bring to the attention of the Board the continued lack of progress in respect of University Teaching Hospital status.
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	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**
Philip Baker (Chair)	X	X	X	X	X	No meeting held	X	No meeting held	X	X	X	X	X
Sarah Dunnett	X												
Gail Shadlock		X	X	X	A		A						
Karen Dunderdale	X	X	X	D	X		X		X	X	D	A	D
Paul Matthew	X	X	X	X	X		X		X	X			
Colin Farquharson	X	X	X	A	X		X		D	D	D	D	D
Chris Gibson									X	X	X	X	X
Vicki Wells									A	A	X	X	X

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives. Due to the Trust being in critical incident at the time of the meeting the decision was taken to reduce both the time of the meeting and length of the agenda in order to ensure staff were able to respond to the incident. A number of items were taken for information and the Committee was not quorate for periods of the meeting as staff responded to the incident.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Group Upward Report** The Committee received the report noting the positive improvement in Planned Preventative Maintenance (PPM) however noted the impact that had been seen as a result on reactive maintenance. The Committee was advised of the outcome of the recent fire safety inspection which had taken place at Lincoln Hospital noting the outcome of this had been a notice of deficiency being issued to the Trust in respect of compartmentalisation. Further detailed would be shared with the Trust Board. The Committee was pleased to note the interim PLACE results and noted the approach being taken regarding the British Safety Council 5 star rating which would provide assurance on the Trust's Health and Safety arrangements. **Low Surface Temperature Report** The Committee received the report and noted the recommendation for reporting to the Committee to cease and for this to be managed a business as usual. The Committee supported the proposal however requested that prior to agreement of this that a letter be sent to the Director of Finance for

	NHS Property Services and managers of buildings to reiterate their responsibilities. The letter would be shared with the Committee.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts, PLICS and CRIG Upward Report** The Committee received the suite of reports taking a number of items for information. The Committee noted the capital position recognising the ongoing work to deliver the capital programme. The system forecast outturn position continued to be reported at circa £30m deficit with the Committee noting the regional and national position which aimed for a maximum deficit position of £15-18m. The Committee noted the continued work to bring the position in line with the expected position by year end and noted that a re-forecast position would be submitted formally at month 9. The Trust position was reported as £3.2m surplus in month however it was noted that this was due to the £5m returned to the Trust as part of the risk and gain share for care closer to home. The Committee noted that the position continued to be driven by cost improvement, open number of beds and Covid-19 costs however actions continued. Agency pricing was considered, and it was noted that further assurances would be required for the Committee to have clear sight of the agency price reduction. The Committee would undertake an extraordinary meeting in January to support further discussions regarding the electronic patient record business case ahead of Board approval. The Committee noted the efficiency report and the increasing plans which were being developed with some improvement being seen. Whilst improvements were being seen these were in productivity and not necessarily generating cost out. **Procurement Update** The Committee received the report and taken for information.
	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Hospital Group Upward Report** The report was received by the Committee and taken for information with no escalations noted.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards**

	The Committee received the report noting the updates offered against cancer, planned and urgent care performance. The Committee noted the initial improvements seen as a result of the introduction of breaking the cycle and recognised the need to continue to accelerate the programme and see consistent results. The Committee noted the update in respect of planned care noting that a national letter had been received stating that Trusts should have no patients waiting longer that 104 or 78-weeks by the end of March 2023. The Trust was starting to see a positive impact in terms of alignment to plan and trajectory with work being undertaken to ensure validation of waiting lists were included. The Committee noted that the Trust had not achieved any of the 10 cancer standards during November however some improvement had been seen in backlog clearance with an improving trajectory. Consistent improvement was noted across the cancer pathways which offered greater confidence in performance and consideration was given to the Board Assurance Framework assurance rating. The Committee considered that whilst improvement was being seen further assurance would be required before agreement of the assurance rating improving from red to amber.
	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 **Objective 4a Update Report** The Committee received the report noting the position and update offered. The report offered assurance on the systems and processes in place to manage specialty reviews. The Committee noted the packs being developed for the specialties including the use of data which offered a clear position from which to commence service review. There had been positive clinical input during the cardiology review which had been undertaken with further reviews scheduled to take place.
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review

	Objective 4c Update Report The Committee received the report noting the position presented and the progress being made in relation to the delivery of the acute services review. It was noted that an update on orthopaedic services had been offered to the Health Overview and Scrutiny Committee which had been received positively with progress being made. The Committee noted that the Trust was now first against peers and 9th out of all Trusts across the country for orthopaedic services. It was noted that there may be a procurement exercise may be required in respect of beds at Grantham Hospital with further work required alongside system partners. The 100-day improvement programme had been deferred due to a recent critical incident however had been rescheduled for January and it was hoped that the recent reductio in length of stay from 16 to 12 days would be further reduced as a result.
	Assurance in respect of other areas: **Topical, Legal and Regulatory Update** The Committee took the report for information noting the updates offered. **Integrated Improvement Plan and Improvement Steering Group Upward Report** **Committee Performance Dashboard** The Committee received the report for information noting those items that had been considered through **CQC Action Plan** The Committee took the report for information noting that a number of items remained red and asked that there was a focus to continue to move forward with actions.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to escalate formally to the Board the issue of the Lincolnshire Fire and Rescue notice of deficiency which had been received by the Trust.
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified

Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

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

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Report inc. H&S, Fire Safety and LST** The Committee received the report noting areas of escalation including fire safety and authorised engineers. The Committee noted the continuing themes in the notices of deficiency issued by Lincolnshire Fire and Rescue with a meeting scheduled to take place with Lincolnshire Fire and Rescue to discuss this further. Continued monitoring was in place through Authorised Engineers with progress on this demonstrated however there remained concern with recruitment. The Committee noted the letter sent to NHS Property Services to seek assurance in respect of Low Surface Temperature works at properties not owned but utilised by the Trust. Some correspondence had been received however further assurance was required. Planned Preventative Maintenance was discussed with the Committee noting that works were prioritised based on risk and statutory requirements.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts and CRIG Upward Report** The Committee received the report noting the month 9 deficit position of £3.1m which continued to be driven by medical bank rates, number of open beds above the bed base and Covid-19 costs.

	The Committee noted the CIP position which was underpinned by a number of technical elements and reflected the need for transformational CIP to be developed and implemented. The Committee noted that whilst actions were in place to deliver CIP the grip and control on this needed to increase in order to ensure accountability on delivery. Capital spend was reported at £15.7m year to date, £5.3m behind the revised plan. There was an overall allocation of £37.5m capital resource in year with £5.3m drawn down for frontline digitisation. The Committee noted that £22m remained to be spent in the remainder of the year with the continued overcommitment in place however reduced to £0.5m. The Committee received the Capital, Revenue and Investment Group Upward report noting the items that had been received and considered. Discussion was held by the Committee in respect of requests for investment and how these would be considered for approval in the current financial position of the Trust recognising the need to be clear on the funding of investment opportunities prior to approval. **Financial Plan 2023/2024** The Committee received the report noting that this had been considered during a recent Board Development session and reflected on the process for 2023/24. There was a requirement for the Trust to submit a financial plan on 23 February which would align to the system financial plan ahead of a final submission date of 30 March. The plan would include consideration of activity, workforce and finance along with CIP which was currently assumed at 2%. The Committee noted that a report would be offered to the Board with further updates following the recent publication of further guidance.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the upward report noting the escalations including the ICO Audit follow up review due in March, concerns regarding the Data Security and Protection Toolkit (DSPT) submission and the increase of related risks due to be considered at the risk confirm and challenge session. The Committee noted the proactive work being undertaken to engage with the ICO in order to be able to offer a detailed position for the Trust in respect of subject access requests.

	The movement in respect of compliance with the DSPT had been deliberate as more rigour was applied to the governance of this with increased check and challenge. As a result of the concerns raised the Committee requested further assurance and detail of the action plan in place as the Committee was advised that there was concern regarding achievement of compliance.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting the immediate impact that had been seen following the launch of breaking the cycle with a reduction in patients waiting more than 12 hours in A&E along with an impact on ambulance handovers. A 20% increase in attendances to A&E in November and December had been seen with a 14% increase in patients requiring onward care due to flu, Covid-19 and Strep A. The Committee noted the continued focus on flow and discharge across the hospital sites and the continued focus of clinical directors to drive this forward. The Committee noted the national directive in planned care to eradicate patients waiting over 78 weeks by the end of March and all patients to have a booked appointment by the end of January. Where necessary the Trust was seeking mutual aid in order to meet national expectations. The Committee was advised that the Trust continued to experience reduced capacity within cancer services and whilst this was not the level desired improvement was being seen. There had been significant traction on colorectal services with ongoing work with GPs to ensure relevant diagnostics were completed prior to patients being admitted on to pathways to ensure these were correct. The Committee noted the 4 scenarios that had been included within the winter plan for the Trust and recognised that at the highest point in December there had been in excess of 1000 beds open with all escalation areas opened. Consideration was being given to the development of a seasonal plan rather than a focus on winter to reflect the summer period where the Trust also experienced an increase in demand.
	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 **Community Diagnostics Centre Update** The Committee received the report for information noting the update provided.
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review No reports
	Assurance in respect of other areas: **Committee Self-Assessment** The Committee received the self-assessment completed by Committee members and the outcome of this recognising there were no actions required however considered the need for actions to be identified to ensure development of the Committee. The Committee reflected on its effectiveness, ability to deep dive into agenda items given the breadth of scope of the Committee And reflected the need for more focused papers to be offered. **Draft Annual Report – Committee Effectiveness** The Committee received the draft Annual Report on Committee Effectiveness with Committee members offering feedback prior to the final report being received at the Committee for approval to present to the Trust Board. **Integrated Improvement Plan** The Committee received the report noting that assurance ranged from limited to moderate across the programmes of work. The Committee was asked to consider and reflect on the priorities for the coming year and if those currently set would be continued. An initial discussion was held in this regard with the Committee reflecting that a wider discussion with the Board on risk appetite to support prioritisation would be beneficial. **Improvement Steering Group Upward Report** The Committee received the report noting the 9 programmes were either limited and moderate in assurance, however the programmes were making steady progress every month. The Committee noted the there was an understanding of the programmes of work and where there were issues in these being able to progress. Recruitment and competency issues continue to be challenging within the improvement team.

	Committee Performance Dashboard The Committee received the dashboard for information noting that detailed discussions had taken place through the relevant agenda items. **Estates Management follow up – Internal Audit** The Committee received the follow up report noting the outcome and the recommendations with one action remaining to be completed. **CIP Internal Audit** The Committee received the internal audit and noted that the risks identified, and associated actions were, in the most part, due to be complete by year end. **CQC Action Plan** The Committee took the report for information noting that a number of items remained red and asked that there was a focus to continue to move forward with actions with a specific concern related to the completion of the 6-facet survey.
Issues where assurance remains outstanding for escalation to the Board	
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

United Lincolnshire Hospitals NHS Trust

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

Integrated Performance Report for December 2022

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

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	*X*
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	*X*
3f Urgent Care	*X*
4a Establish 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 38 category 2 PU and 7 unstageable PU. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. A number of actions have been taken with the Emergency departments to address prolonged time spent in the departments as a result of the ongoing operational pressures. One of these is the introduction of grab packs to enable to staff to manage wound care appropriately on arrival.

Venous Thromboembolism Risk Assessment

Compliance against this metric has decreased for the month of December to 93.68%.

Never Events

There has been a further Never Event declared in December pertaining to an error in procedure booking resulting in a patient undergoing a flexible sigmoidoscopy that was not clinically indicated for them. This is the fifth Never Event for this financial year. The Division have undertook a preliminary review of the incident and all immediate actions have been taken.

Medications

For the month of December, the number or incidents reported in relation to omitted or delayed medications has remained the same as the previous month at 32% with medications causing harm at 13.7%. A number of work programmes through the IIP continue and are currently being monitored through the Medicines Quality Group.

SHMI

The Trust SHMI has reduced again for December and is currently at 103.16. 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 89.2% with sending eDDs within 24 hours for December 2022 against a target of 95%. A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric at their monthly Performance Review Meeting.

Sepsis compliance – based on November data

Screening Inpatient/ED child– Screening compliance for inpatient child was at 84.8% and ED 86.1%.

IVAB Inpatient/ED child - The administration of IVAB for inpatient paediatrics was at 71.4% and ED 66.7%.

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

Duty of Candour (DoC) – November Data

Verbal compliance for November was 74% against a 100% target and 53% for written against a target of 100% within the reporting period. This percentage has continued to increase and is currently at 81% for verbal and 69% for written. The Clinical Governance team continue to notify clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

Operational Performance

At the time of writing this executive summary (17th December 2022), the Trust has 27 positive COVID inpatients. There are zero patients requiring Intensive Care intervention. The December peak was 48. We had a total of 355 confirmed cases of a combination of Influenza A, RSV and COVID. The highest recorded Influenza A patients requiring inpatient care was 68. However, we know this was higher, but we experienced a reporting lag.

The Trust declared 3 Critical Incidents in December. 2 were in direct relation to loss of critical pathways and 1 was due loss of critical pathways and the Ambulance Strike. The 1st Critical incident was declared on 6th December 2022 and was stood down on 7th December 2022. The 2nd Critical Incident was declared on 20th December 2022 and was stood down on 22nd December 2022 – this Critical incident was in conjunction with a System declaration of Standby Major incident. The 3rd Critical Incident was declared on 28th December 2022 and was stood down29th December 2022. 'Hot debriefs' took place daily and the formal 'cold debrief is planned for 20th January 2023.

This report covers December's performance, and it should be noted the demands of Wave 6/7 have decreased. The teams across the organisation continue to transition to 2022/23 and the recovery of waiting times and return towards pre-Covid access.

The implementation of the revised Full Capacity Protocol 60-day pilot as part of the 'Breaking the Cycle' initiative demonstrated an improvement in most of the Urgent Care metrics in November but due to increased pressures the continued benefit was not realised.

A & E and Ambulance Performance

Whilst the summary below pertains to December'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. 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.

4-hour performance deteriorated against November performance of 59.76% being reported at 42.36% in December.

There were 1034 12-hr trolley waits, reported via the agreed process in December. This represents an increase of 744 from November. Sub-optimal discharges to meet emergency demand remains the root cause.

Performance against the 15 min triage target demonstrated a deterioration of 10.39%. 67.63% in December verses 78.02% in November.

There were 998 >59minute handover delays recorded in December, an increase of 504 from November, representing a 50.51% increase. Delays experienced at LCH and PHB have seen increased levels of overcrowding in EDs. December also experienced an increase in >120mins handover delays compared with November, 634 in December compared with 219 in November, representing a 65.46% deterioration. >4hrs handover delays also increased. A total of 267 in December compared to 55 in November. This represents a 79.41% increase.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 5.14 days against an agreed target of 4.5 days The average bed occupancy for December was in excess of 95%. System Partners are challenged with identifying timely support to facilitate discharge from the acute care setting, Pathway 1 capacity (Domiciliary care) continues to be unable to meet the demand and is a large contributor to increased LoS. All delays of greater than 24 hours are escalated within the System. December saw the highest number of acute beds open – 1062 verses an expected funded core G&A of 882 acute beds.

Referral to Treatment

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

November demonstrated a slight deterioration in performance of 0.18%. November outturn was 47.67%. The Trust reported 8,204 patients waiting over 52 weeks, which is an increase of 277 on the reported October 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 November, the Trust reported 1 patient 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.

Waiting Lists

Overall waiting list size has increased since October. November reported 72,281 compared to October's position of 71,962 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. December demonstrated an increase (983 verses 766 in November) which is above the agreed trajectory of 550. Additional resource has been directed to resolving missing outcomes which is having an adverse effect on the bookings team being able to move the ASIs to open referrals.

DM01

DM01 for December reported 51.42% versus 51.19% in November compliance against the national target of 99%. A positive variation of 0.23% improvement on the November outturn but still a negative variance of 47.58% against the nationally agreed target. Whilst the main area of concern remains Echocardiography, they are signs of improvement, DEXA has developed a backlog of 1439 but as the new scanner is now in place, we will see a month-on-month reduction of 250 cases a month. Endoscopy backlog due to outpatient recovery, in particular, colorectal.

Cancelled Ops

The compliance target for this indicator is 0.8%. December demonstrated a 1.74% compliance. This is a deterioration of 0.10% on November and a negative variance of 0.94% against the agreed target.

The target for not treated within 28 days of cancellation is zero. December experienced 37 breaches against these standard verses 35 in November.

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 46.15% (against 85.4% target.) This demonstrates a deterioration of 0.12% in performance since the last reporting period and is 39.25% below the nationally agreed compliance target. However, the position against the Trust recovery trajectory is in line.

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 190156 patients waiting >104 days against a target of <10. The current figure is an increase of 34 patients since the last reporting period. The highest risk speciality is colorectal with 126 greater than 104 weeks.3 rimes weekly meetings re in place to offer challenge and confirm.

Workforce

Mandatory Training – Mandatory training rates have consistently been between 89-90% since July 2022 against a target of 95%. Issues in recording learning due to IT software have had an impact on courses completion rates but the identified solution should be in place by 28 February. Further work is on-going in terms of reviewing the 'core' and 'role specific' modules required to be undertaken by our staff moving forward. The target has been reviewed to make it realistic and attainable with a paper going to February People and Organisational Development Committee. An Education and Learning Manager has been appointed as part of the People and Organisational Development restructure and is due to take up role on 1 April 2023 and the role of Statutory and Mandatory Training Coordinator is at interview stage. These appointments will help address the current capacity issues and move actions forward with pace.

Sickness Absence – The trend continues to increase by 0.13% to 5.52% which is still above the target of 4.5%. We have experienced an increase in the number of Covid and flu related absences across this period which continues to be monitored daily. The ER and AMS Teams have supported the redeployment work by completing call backs on behalf of managers to support the return of absent employees across the Critical Incident timeframes. The daily reporting continues to support absence management across the Trust.

Staff Appraisals – Ongoing service pressures and staffing challenges in the Trust continue to impact appraisal completion rates. There continues to be growth from 60.30% in July 2022 to 63.74% in December 2022. Further work is in progress in terms of reviewing the 'annual cycle' timings, targets and appropriate systems whilst work continues with Divisional Heads of HR and completion rates being monitored at the monthly FPAM meetings. The target has been reviewed to make it realistic and attainable with a paper going to February People and Organisational Development Committee. A 'task and finish' group is being established to identify and address the main barriers to compliance. Again pace and deliverables will be aligned to the creation of an Education Department and appointment of staff.

Staff Turnover – Whilst turnover rate has fluctuated there has been a decrease from 15.6% in July 2022 to 13.79% in December 2022 (Trust Target 12%). Operational pressures, staffing and culture challenges mean that an increasing proportion of staff are looking for other avenues outside the Trust. The OD team offers face to face / Teams exit interviews to gather deeper insights on the reasons for leaving (in addition to ESR / EF3 form results). People Promise Manager continues to work with the Trust and ICB to explore retention and bring best practice into the organisation to address the challenges. The recent analysis illustrates that 17% of resignations could be avoided through better management, relationships and career opportunities if offered in the Trust. It is anticipated that increased recruitment activity will in time reduce workforce challenges and offer support to challenged clinical areas in reducing turnover.

Vacancies – The Trust Wide Vacancy Rate has decreased from 11.35% in July 2022 to 8.98% in December 2022. We saw a 0.2% increase in vacancy factor in December due to an increase in funded headcount and minimal International Educated Nurse recruitment in the month. Our vacancy rate is at its lowest in a significant time. We expect to see significant recruitment across January, February and March which should further reduce our vacancy rate.

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 £3.1m in December (£3.1m adverse to plan) and the Trust YTD delivered a deficit of £12.5m deficit (£12.5m adverse to plan).

After removing gains from disposals of £0.1m, the Trust YTD delivered a deficit of £12.6m in relation to system achievement.

CIP savings of £9.8m have been delivered YTD (£8.1m adverse to planned savings of £17.9m).

Capital funding levels for 2022/23, agreed through Trust Board & FPEC, show a plan of c£37.5m; capital expenditure incurred YTD equated to £15.7m.

The December 2022 cash balance is £41.3m, which is a decrease of £47.0m against the March year-end cash balance of £88.3m.

Paul Matthew
Director of Finance & Digital
January 2023

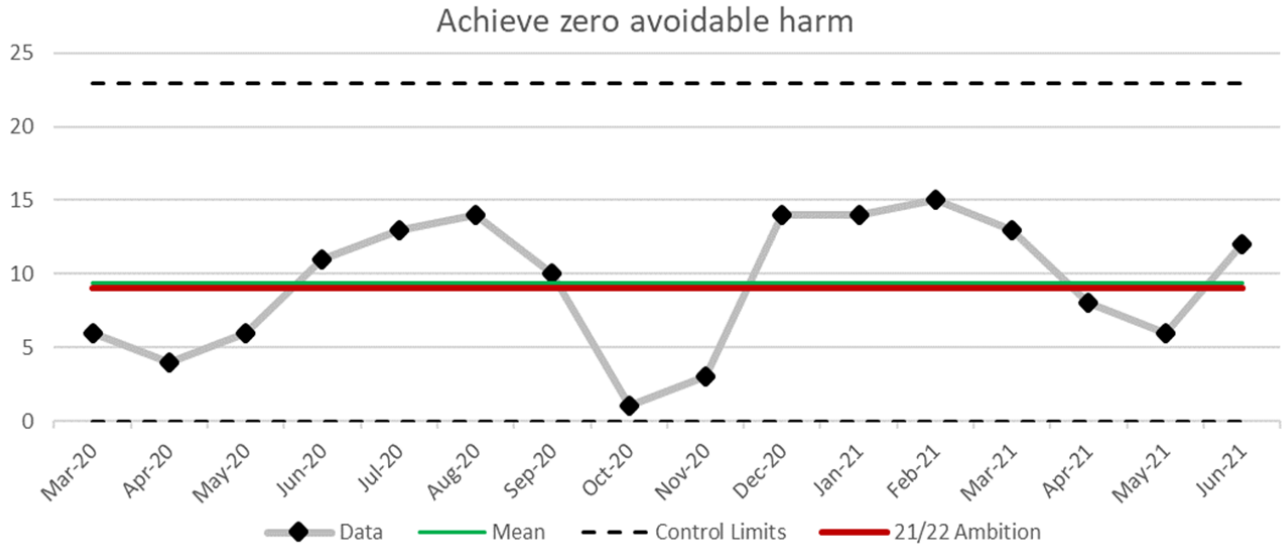
Statistical Process Control Charts

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

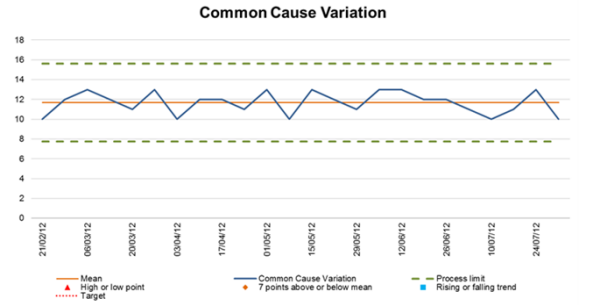
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

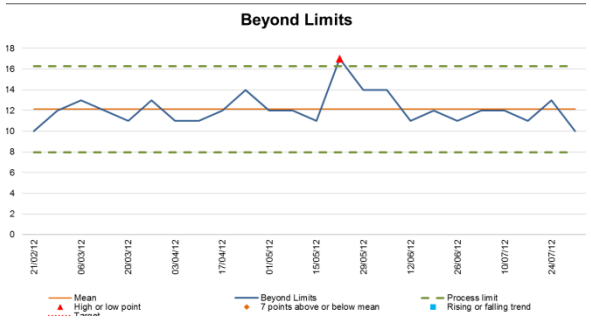
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



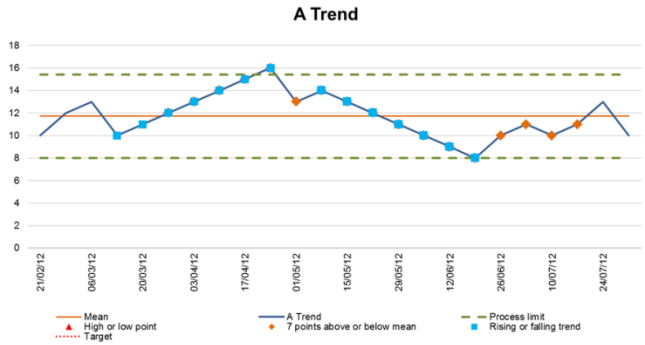
Extreme Values

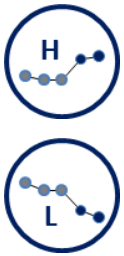
There is no Icon for this scenario.



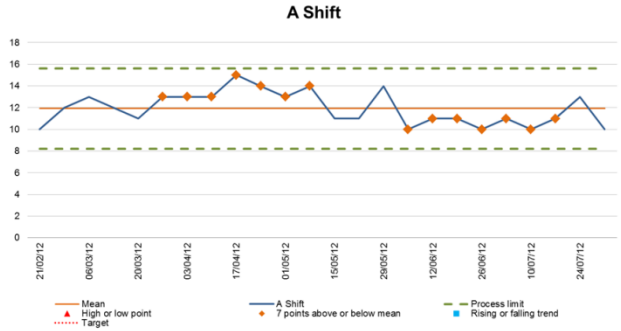
Statistical Process Control Charts

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

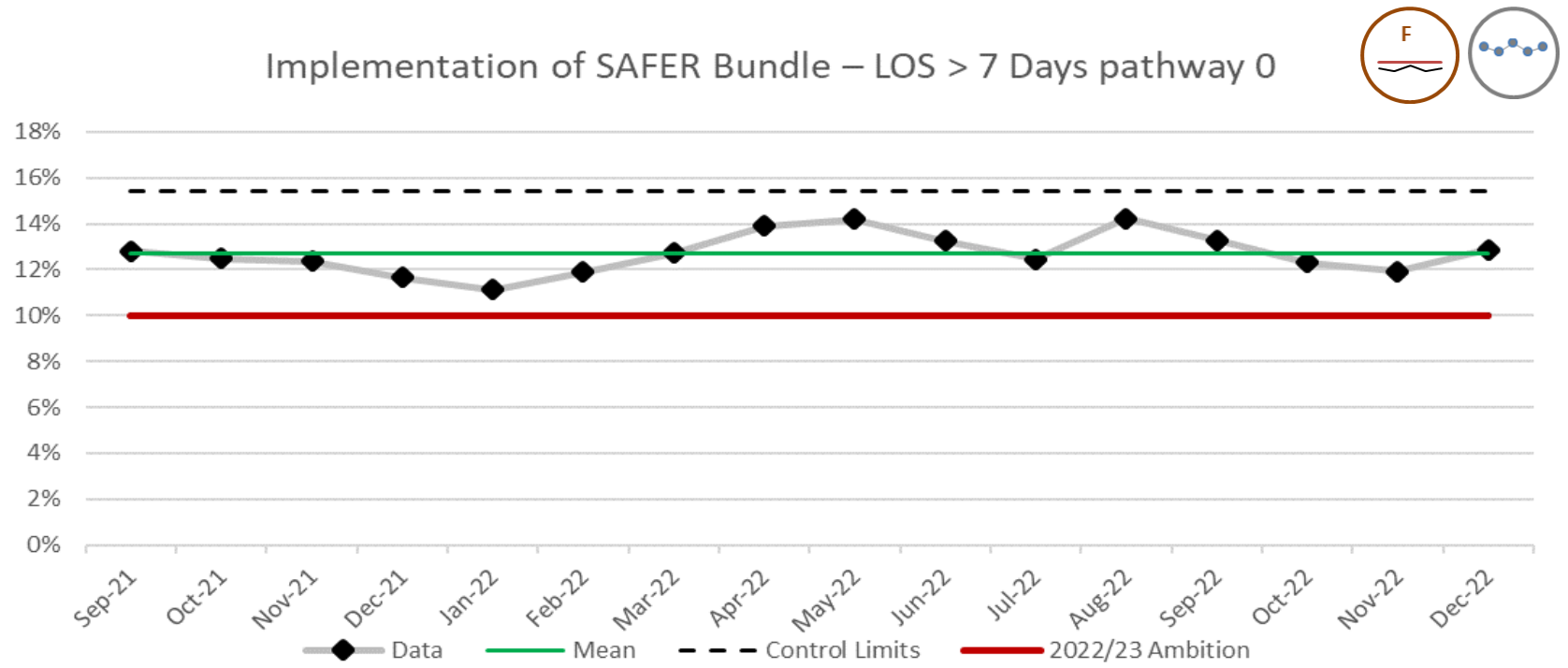
EXECUTIVE SCORECARD

Measure ID	Domain	Measure	Measure Definition	SRO	2022/23 Ambition	Tolerance	£'000	Oct-22	Nov-22	Dec-22	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%		12.31%	11.94%	12.87%	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		3rd Quartile (103.97) (76th of 121)	Not Available	3rd Quartile (103.16) (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		0.51	0.13	0.33	P	
5	Patients	Reduction in medication incidents leading to moderate & severe harm or death	Total number of Medication incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	DoN	0	0.07		0.06	0.13	0.08	F	
6	Patients	Reduction in DKA incidents resulting in moderate & severe harm or death	Total number of DKA incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	MD	TBD	TBD		0.00	0.00	0.00		
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	(1,371)	3,209	(3,146)	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%		20.44%	14.57%	19.98%	F	A
10	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	COO	503	100		7,927	8,204		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%		57.40%	59.01%		F	A
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	DoPOD	9.00%	1.00%		9.31%	8.77%	8.98%	P	
13a	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	DoPOD	90.00%	2.00%		62.05%	63.26%	63.74%	F	
13b	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	DoPOD	95.00%	2.00%		89.09%	90.01%	89.78%	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%					F	
16	Partners	Increased recruitment/academic posts (across the ICS)	Number of posts appointed	DII	10	2					F	
18	Partners	Early Warning Discharge Indicators	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, for pathway 1-3 patients.	COO	50%	10.00%		81.27%	78.29%	78.83%	F	A

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-22
12.87%
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.

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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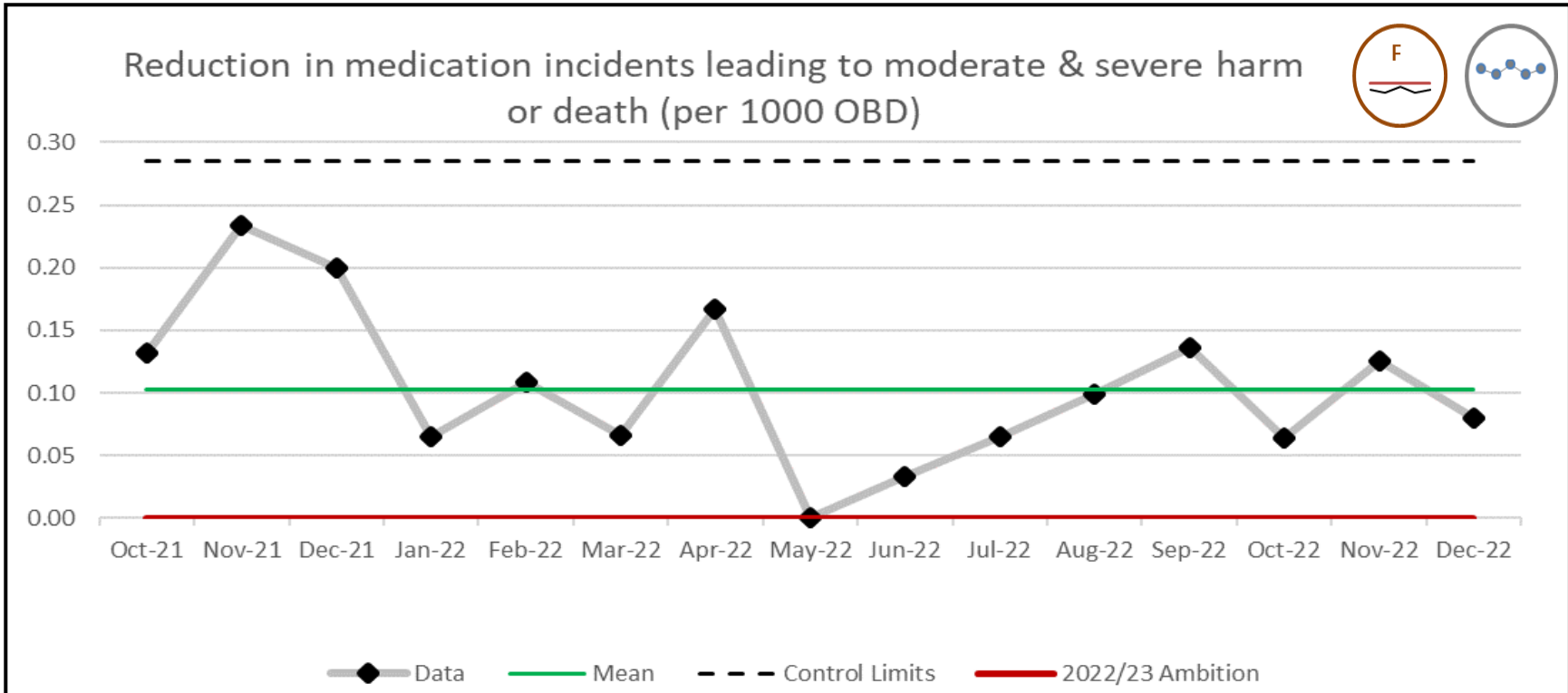
NHS United Lincolnshire Hospitals NHS Trust



Dec-21
0.08
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
0 with a 0.07 tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:
Total number of Medication incidents reported as causing harm (moderate /severe / death) - per 1000 OBD.

What the chart tells us:
We are currently at 0.08 per 1000 bed days against a target of 0 with a 0.07 tolerance.

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

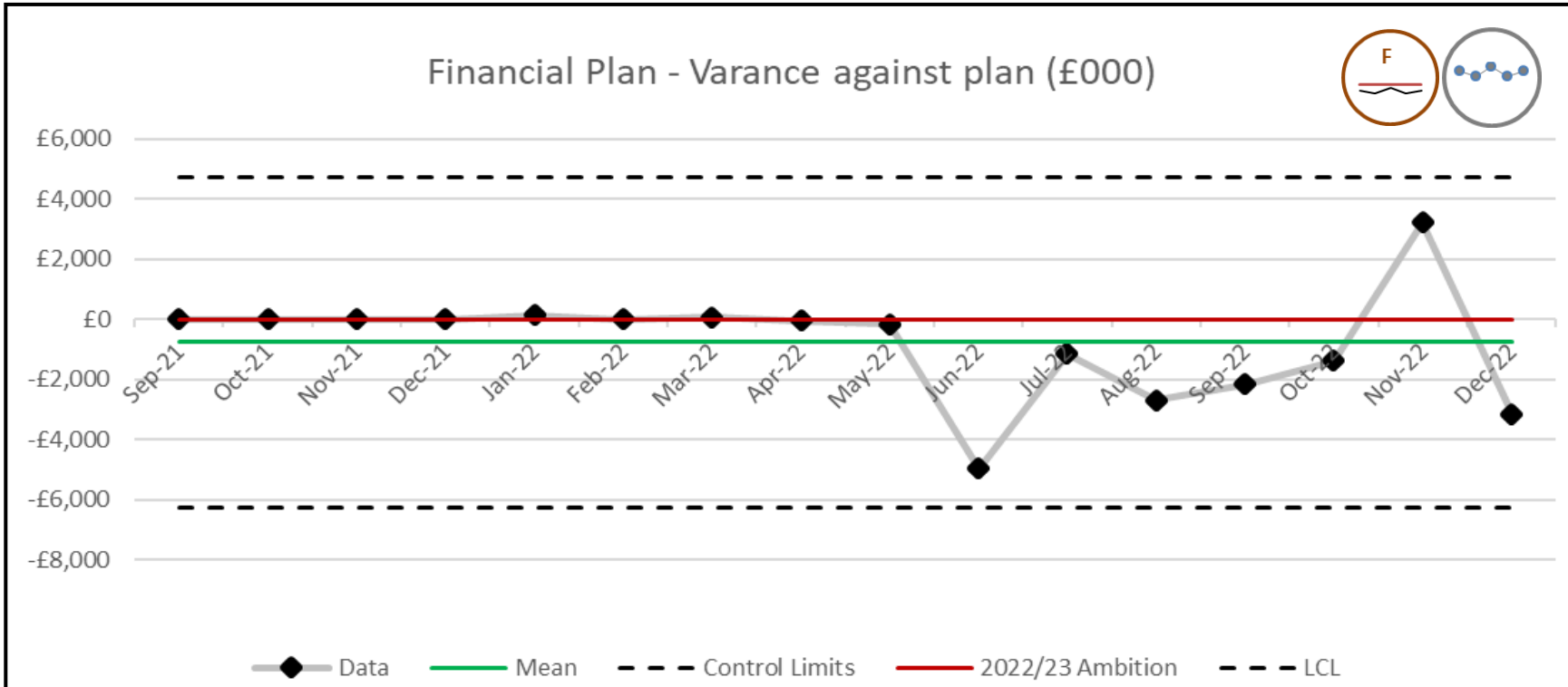
Actions:
A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management and reduce the number and potential severity of medicines incidents.

Mitigations:

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-22
Variance to plan (£3,146.00)k
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
£0
Achievement
Metric has passed in month but is consistently failing to ambition
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.

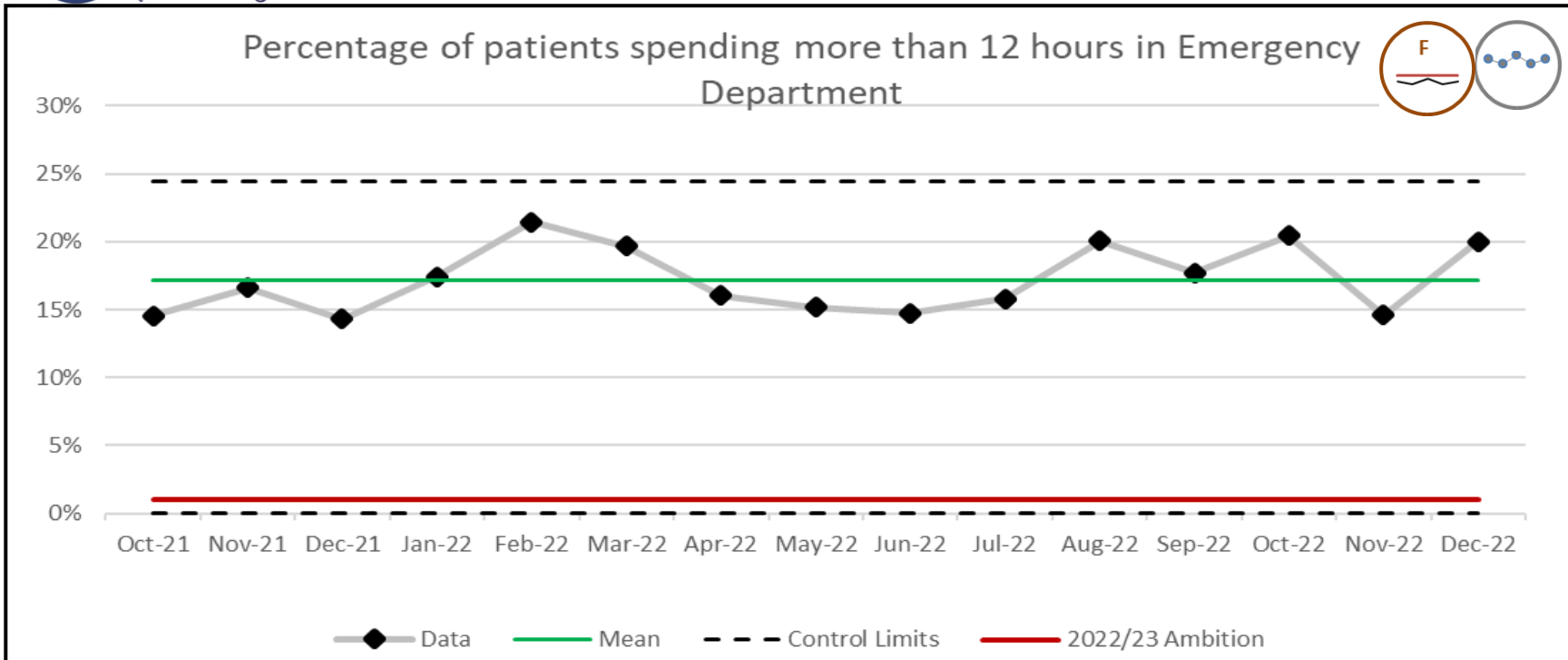
Issues:
The main drivers of the deficit are as follows: the under delivery of the cost improvement plan, the cost of the unplanned opening of additional beds, and the continuation of the additional costs of Covid (which were assumed to cease from the end of May 2022).

Actions:
The Trust has strengthened the support to cost improvement and developed a series of actions being monitored via TLT, is in discussion with the System re the Risk and Gain Share in relation to Care Closer to Home, and has undertaken a QIA review of the additional costs of Covid.

Mitigations:
Continued focus upon the delivery of cost improvement, monitoring of the TLT action plan, and discussion with system partners re the Risk and Gain Share in relation to Care Closer to Home (which has resulted in a contract variation for £5m in relation to the YTD slippage).

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-22
19.98%
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:

December experienced an increase in the numbers of patients with an aggregated time of arrival greater than 12 hours against total attendance. 2529 in December compared to 1772 in November. An increase of 757.
The target for this metric has not been met but is improving.

Issues:

The main factor in the first part of the month was contributed to exit block due to inadequate discharges to meet the demand. An increase in Emergency Department attendances of greater than 20%was experienced which resulted in a 14% increase in non-elective admissions.
Escalation of SDEC areas (although less frequent) continued to impact on 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.

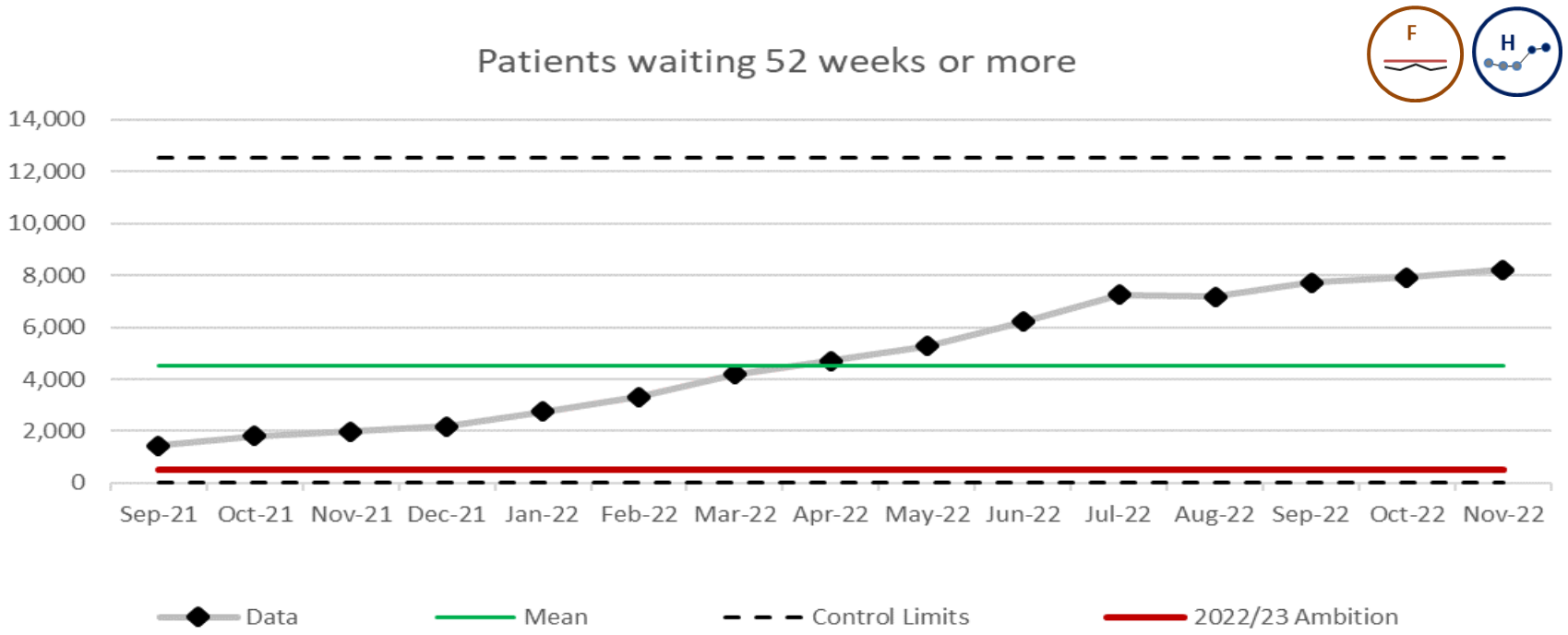
Mitigations:

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.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Nov-22
8,204
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 8204 incomplete 52-week breaches for November, an increase of 277 from October.

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

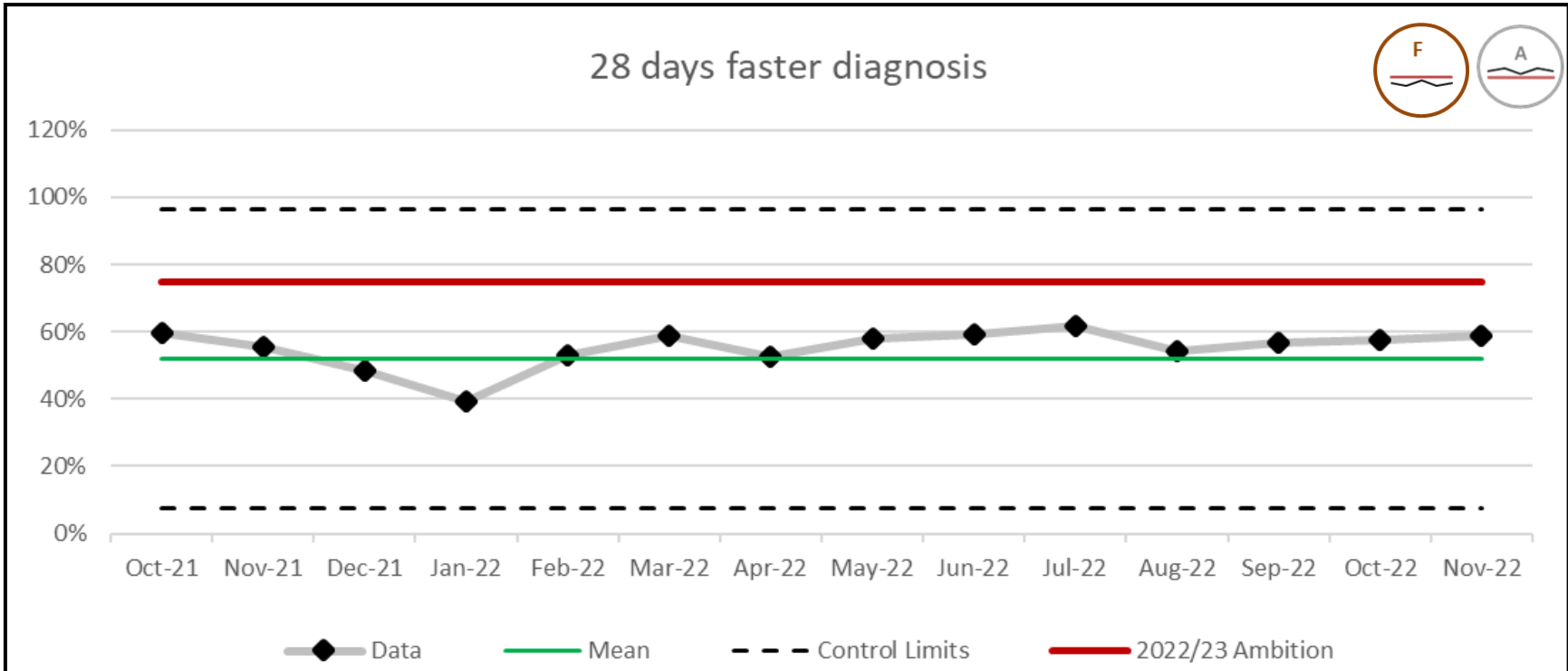
Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through the PTL meeting with emphasis on longest waiters. The intention is to drive down the wait bands discussed. This is working in some specialties that have lower numbers of patients; however, it is making slow progress in many, 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.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Nov-22

59.01%

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 59.01% 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 (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.
In colorectal, recruitment to vacant CNP post is underway to increase CNP focus on clinical reviews below 28 days. 90 minute standard to be further supported by secretarial teams.
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. A review of the Lung MDT process is underway with the Cancer Lead.
All 2ww Head and Neck clinics are now F2F, not VC which reduces the number of patients being brought back to clinic further down the pathway unnecessarily. The CNS communication clinic is also being further utilised to support this.
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 remains overwhelmed by an increasing backlog.

Quality | Operational Performance | Workforce | Finance

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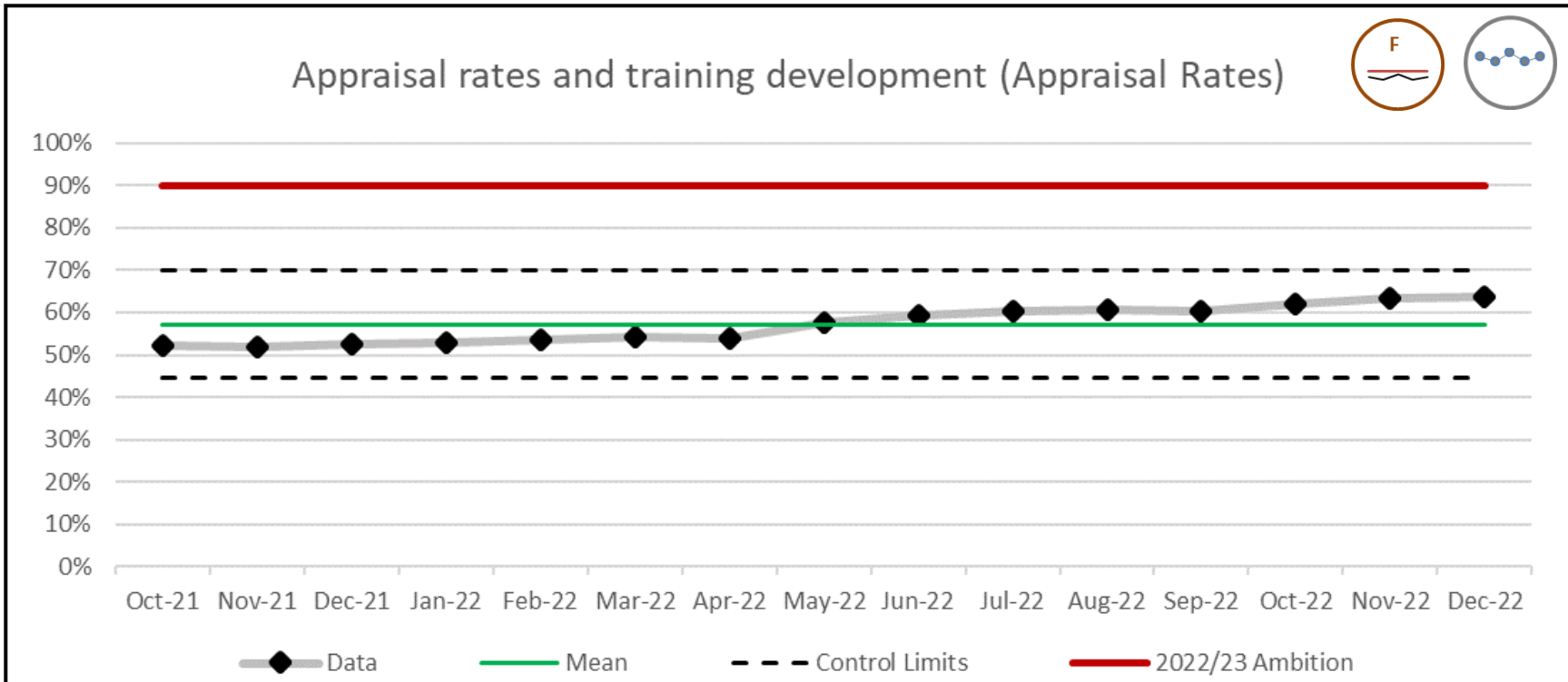


Dec-22
63.74%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
90% with 2% tolerance
Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 63.74.

What the chart tells us:
Operational pressures and staffing challenges continue to impact appraisal completion rates. The completion rate has slightly increased from 60.30% in July 2022 to 63.74% in December 22.

Issues:
- Operational pressures are causing an impact on completion.
- Appraisal discussions stood down in previous months still felt in December 22 due to back log compounded by three critical incidents being declared.
- Staffing issues and increased turnover impact availability of staff to attend appraisals with manager working clinically.
- Capacity within the OD team is having a negative impact on delivery.

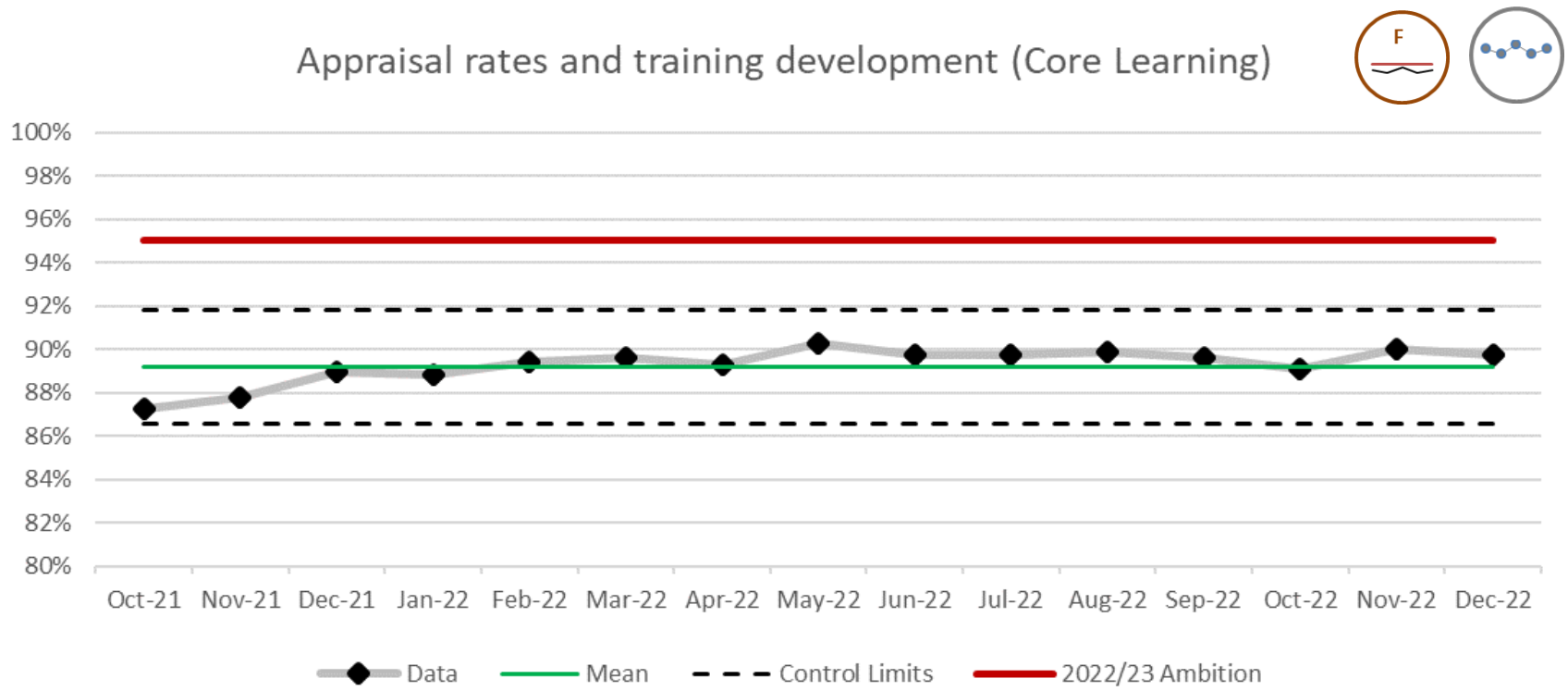
Actions:
- Appraisal completion to be focussed through the divisions regardless of operational pressures. OD and Divisional Heads of HR to continue to prioritise message to divisions
- Appraisal clinics continue to be run by OD to all who require support
- Appraisal Training remains available
- Task and Finish Group established to identify and remove barriers to non-completion

Mitigations:
See actions

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-22
89.78%
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 remains stable over the past month with very slight decrease. Since July 2022 the rate has consistently been 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:
- The new Education team is being established with the appointment of the Education and Learning Manager and the selection process in progress for a Stat & Man Training Co-ordinator.
- Discussion around protected time for training has not progressed.
- Divisional Heads of HR continue to work with their Areas and support compliance.
- Work continues with regards to single contract Bank staff and mandatory training/payment for training.
- Priority review taking place for capacity of

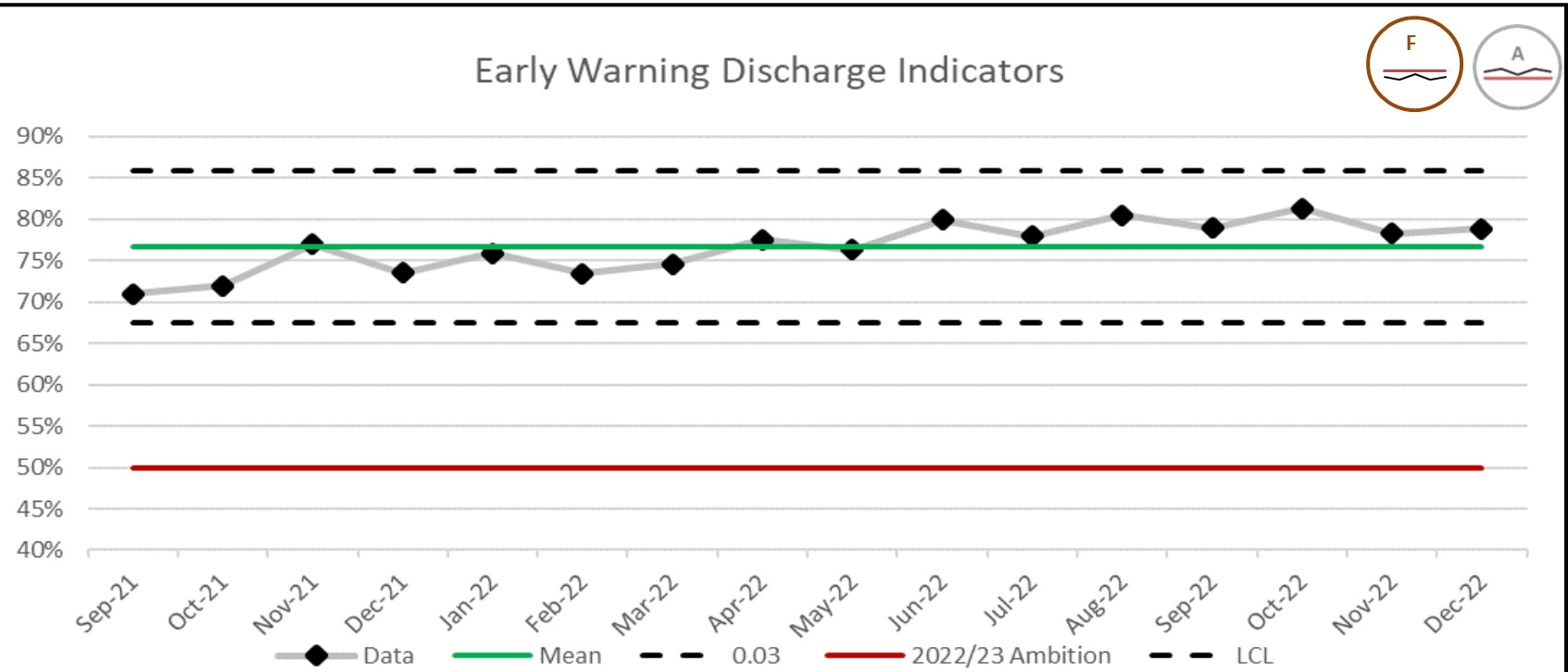
Actions continued:
- Further work is on-going in terms of reviewing the 'core' and 'role specific' modules required to be undertaken by our staff moving forward.

Mitigations:
See actions.
Issues of access and recording of learning being addressed by digital team.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-22
78.83%
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 78.83% against a 50% 2022/23 ambition with a 10% tolerance. This a deterioration of 0.88%

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.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Oct-22	Nov-22	Dec-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	6	4	1	52	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	0.01	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	0.02	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	0.00	0.16	0.00	0.14	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	0	0	4	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	0	0	4	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	6	5	7	48	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	93.84%	94.98%	93.68%	94.49%	F	B
	Never Events	Safe	Patients	Director of Nursing	0	1	0	1	5	F	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	6.74	6.19	6.02	5.97	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	10.4%	14.1%	13.7%	12.66%	F	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Oct-22	Nov-22	Dec-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	50%	100%	None due	54.00%	P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	94.93	Not available	94.89	94.58	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	103.97	Not available	103.16	106.27	F	L
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	98.00%	100.00%	100.00%	99.56%	P	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	89.70%	90.40%	89.20%	90.00%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	90.3%	93.3%		91.34%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	86.5%	84.8%		86.92%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	94.9%	91.8%		93.96%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	100.0%	71.4%		74.83%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	88.7%	94.1%		90.53%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	86.1%	86.1%		85.50%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.9%	93.9%		93.85%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	66.7%	66.7%		60.86%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.67	2.20	2.21	2.84	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%	79.00%	74.00%		84.75%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	79.00%	53.00%		78.38%	F	A

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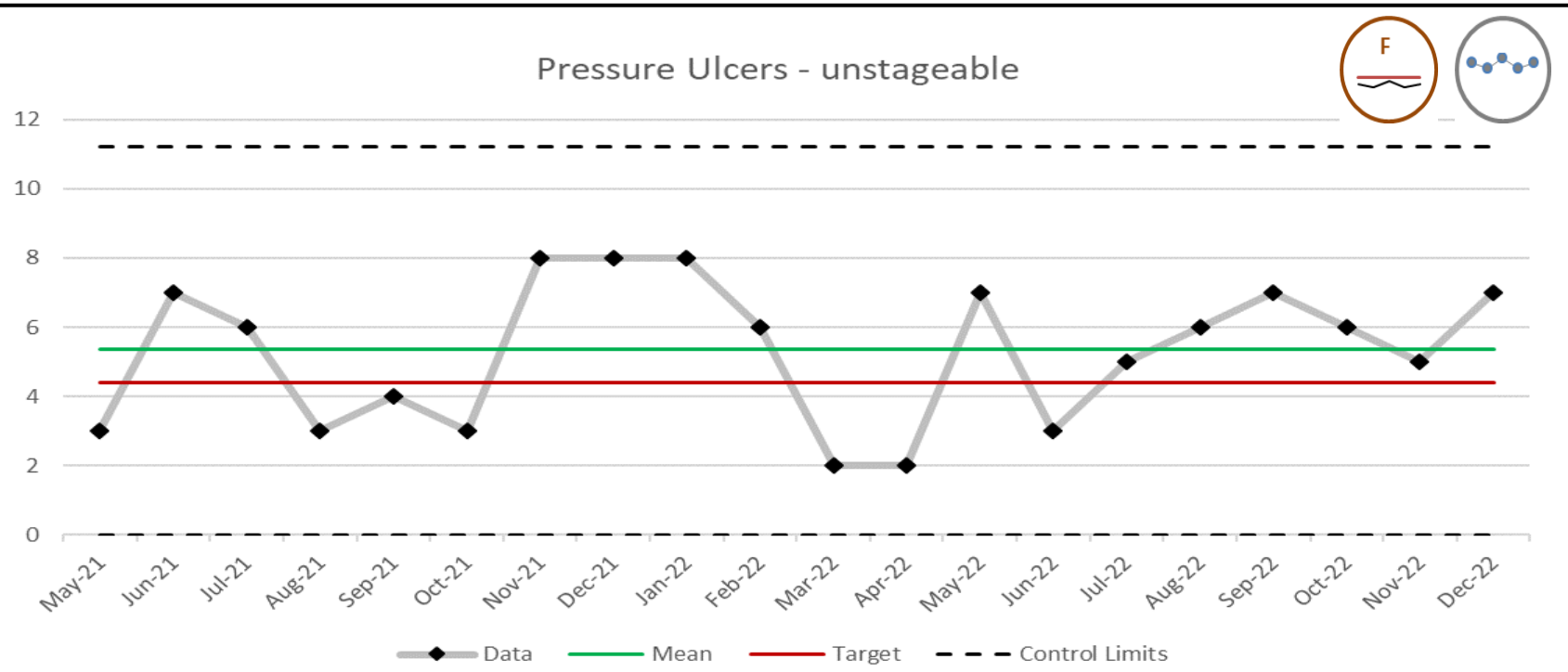
NHS United Lincolnshire Hospitals NHS Trust



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

Background:

Unstageable Pressure Ulcers.

What the chart tells us:

We are currently at 7 incidents against a threshold of 4 per month.

Issues:

The number of incidents have increased by 2 from November 2022.

There have been no device related unstageable pressure ulcers.

Following validation, it was evidenced that 6 incidents were attributable to a deterioration of existing pressure damage.

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. Lessons learned communication will continue to be shared monthly through the Skin Integrity Group (SIG).
Quality Matron and Tissue Viability team will continue to attend the Sister/Charge Nurse meeting to share themes and actions being taken.
Patient stories are shared at SIG to ensure wider learning.
The new Tissue Viability daily documentation risk assessment booklets have been rolled out across in patient areas. Rollout and training is being supported by Quality Matron and Clinical Education teams. Recorded teaching sessions also available. The new paperwork includes a more detailed assessment of patient's pressure areas and guides to best practice for those patients at increased risk of developing pressure damage.

Mitigations:

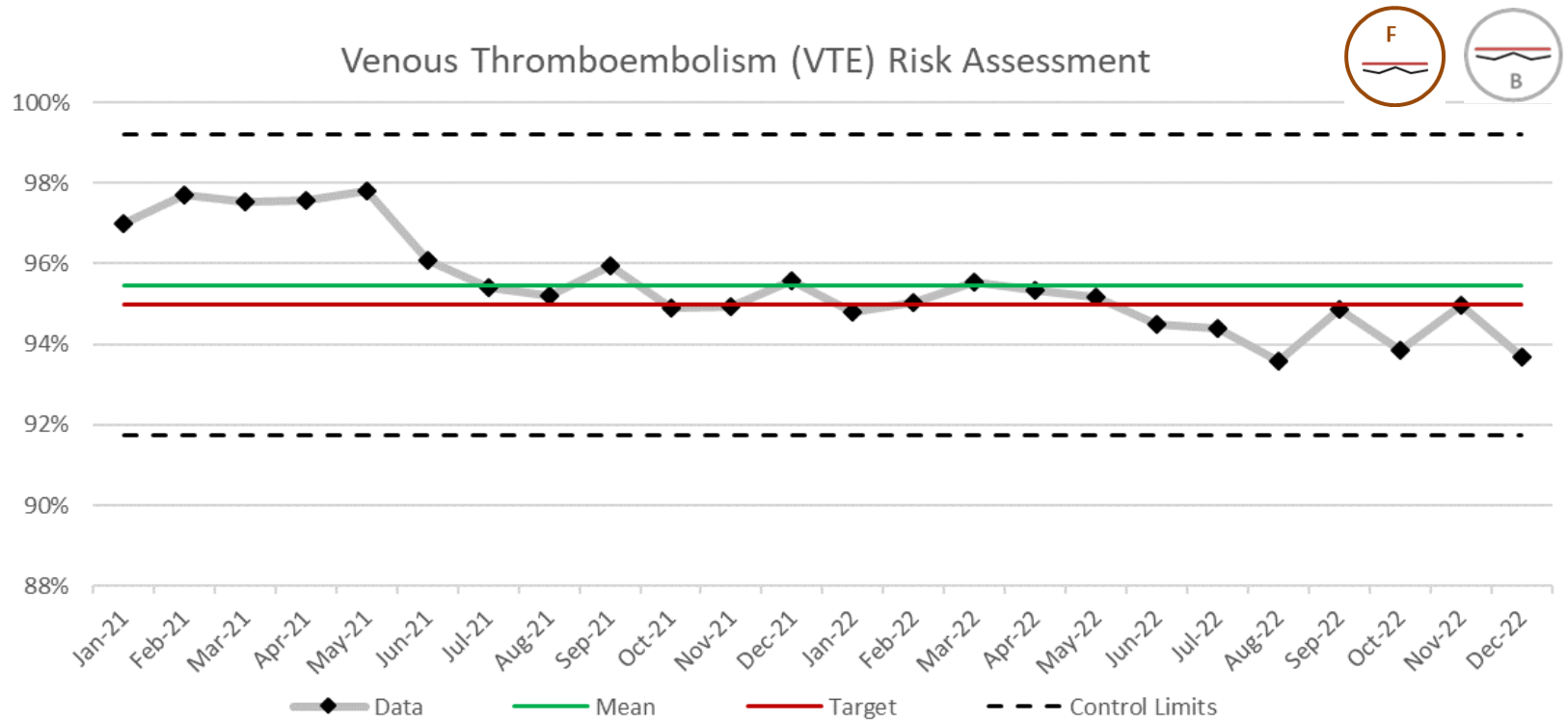
Skin Integrity care is reviewed in the weekly ward/dept. leader's assurance and monthly Matrons audits.

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-22
93.68%
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.

Quality | Operational Performance | Workforce | Finance

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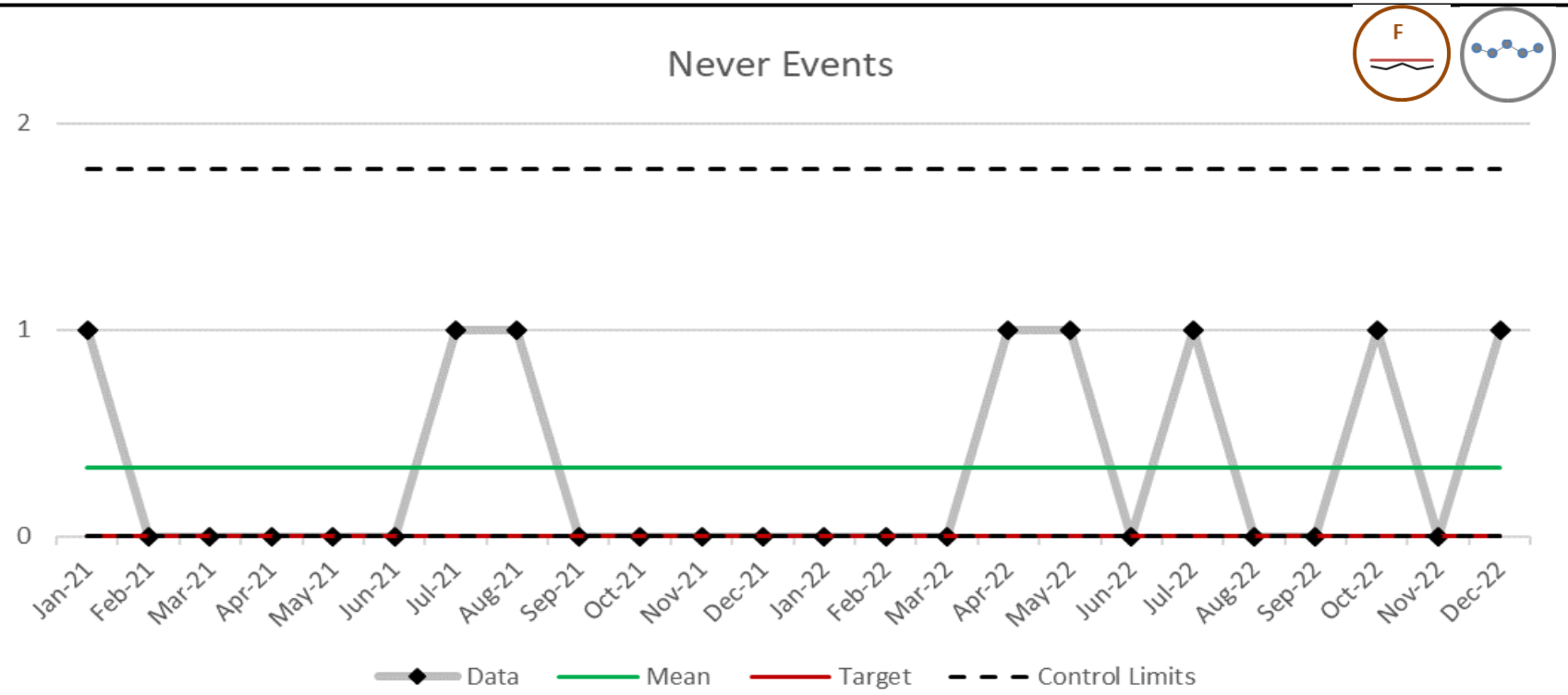
NHS United Lincolnshire Hospitals NHS Trust



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

Background:
Never Events are deemed to be Serious Incidents that have been defined by the NHS as 'wholly preventable where nationally available systemic barriers have been locally implemented.

What the chart tells us:
There was 1 Never Event declared in April 2022, 1 in May, 1 in July, 1 in October and 1 in December.

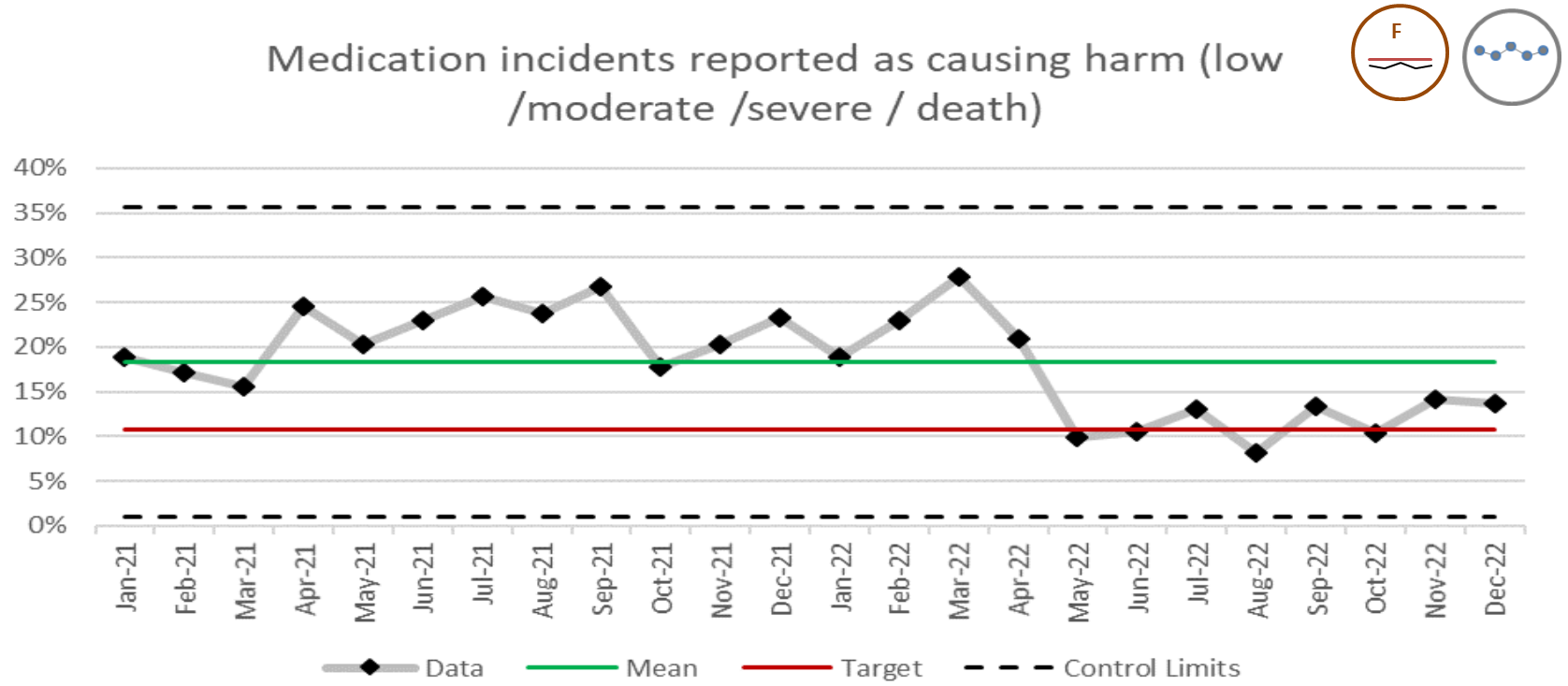
Issues:
There have now been 5 Never Events declared by the Trust in 2022/23.
The Never Event declared in December 2023 involved a flexible sigmoidoscopy performed on the incorrect patient as a result of an error in the appointment booking process

Actions:
The Surgery Division held a Never Events Summit in December 2022 to review learning and planned actions from completed investigations.

Mitigations:
All confirmed Never Events are declared as Serious Incidents and have comprehensive investigations, supported by the Risk & Governance team and overseen by the Serious Incident Panel.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-22
13.7%
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:
Medication incidents reported as causing harm (low /moderate /severe / death)

What the chart tells us:
In the month of December the number of incidents reported was 218. This equates to 6.02 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 13.7% 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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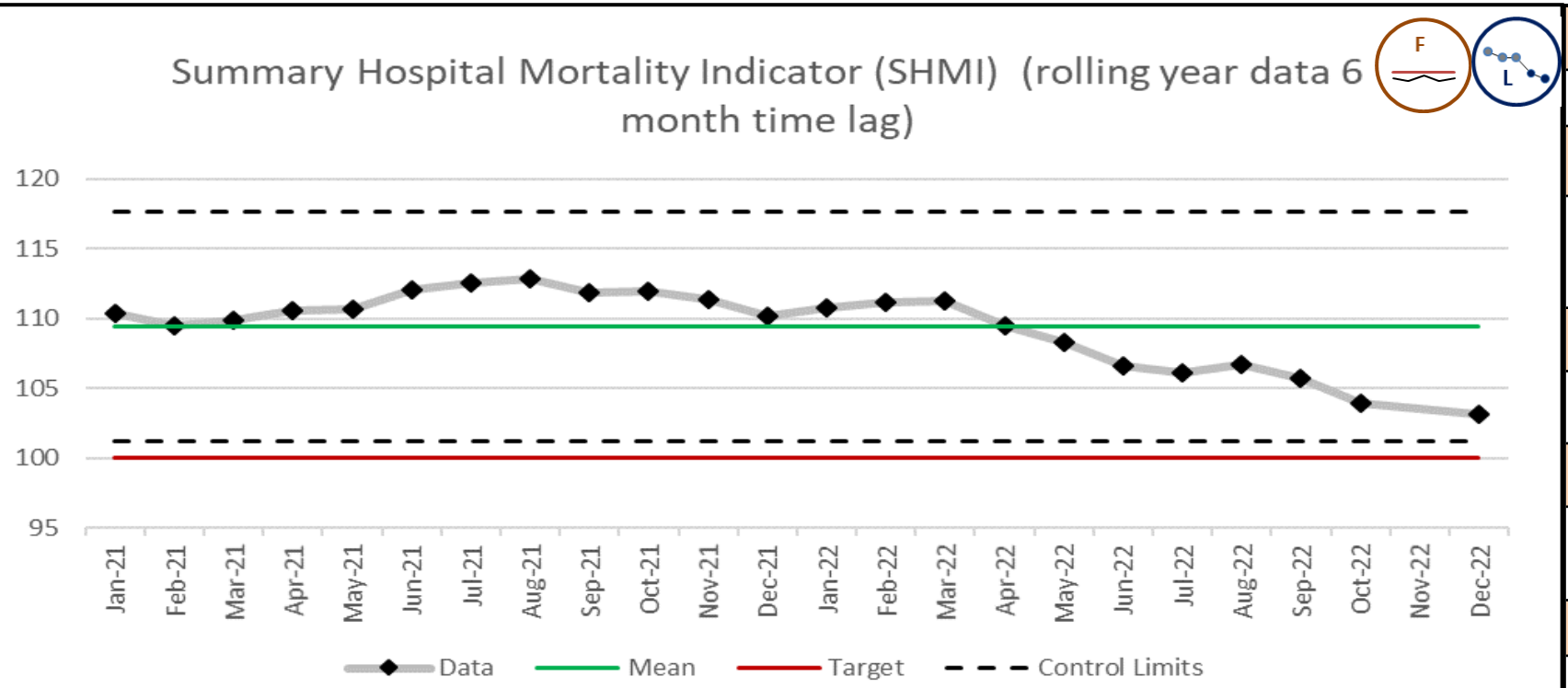


Dec-22
103.16
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
To remain in "as expected" range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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.

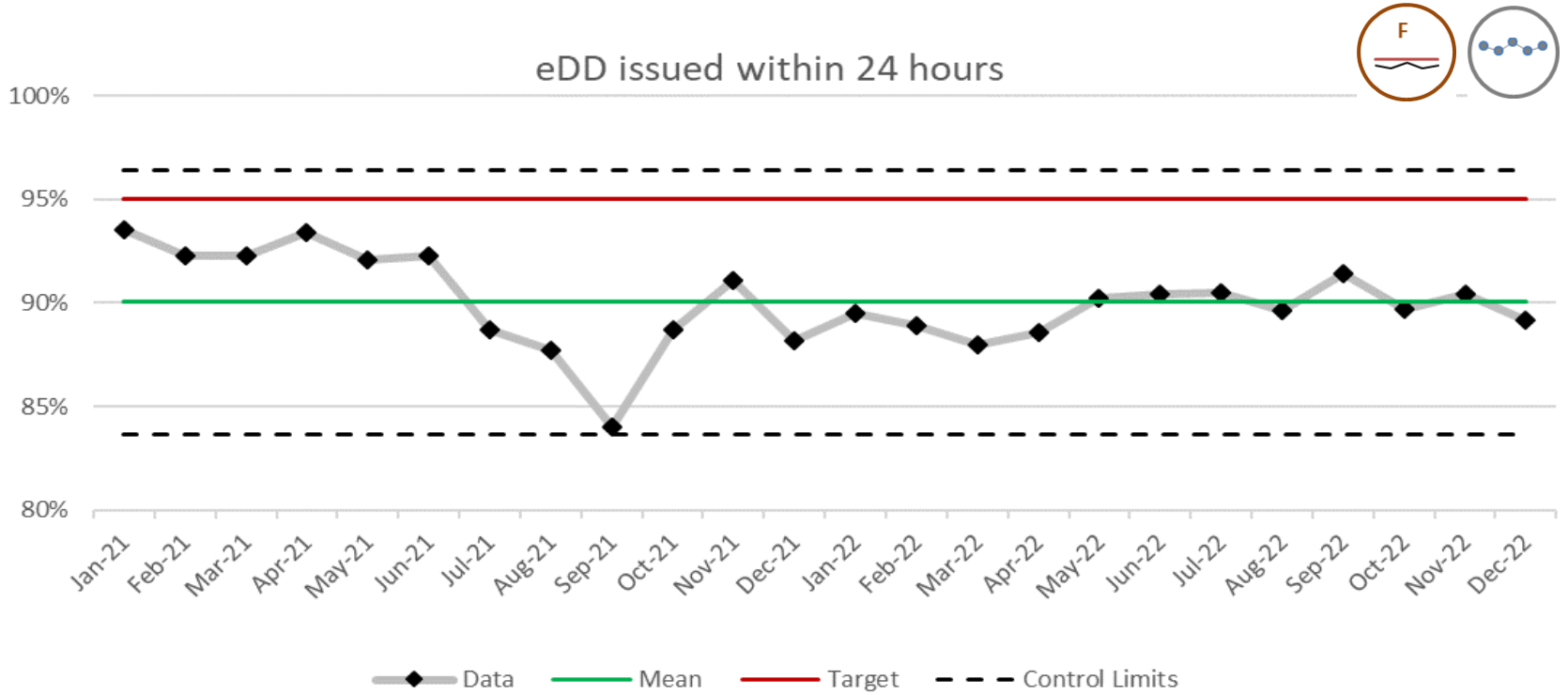
Actions:
Any diagnosis group alerting is subject to a case note review.

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 94.89 (rolling 12 months)



Dec-22
89.20%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 89.20%.

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 at their monthly Performance Review Meeting.

Mitigations:
Discussion will continue to take place at PRM in order to identify further actions to improve.

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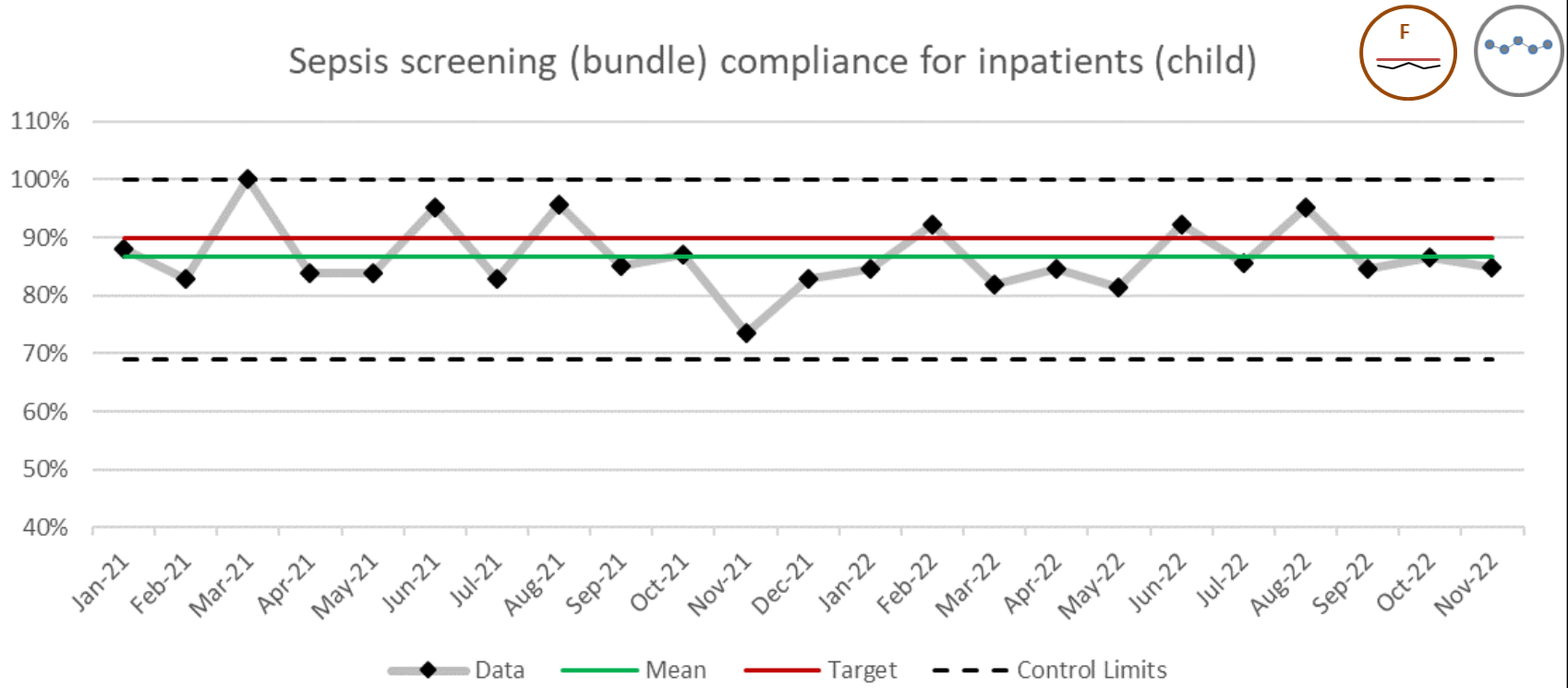

Nov-22
84.8%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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 67 of 79 patients or 12 patients who were not screened within 60 minutes of raised PEWS.

Issues:
As is common with previous months the majority of the patients with delayed or missed screens have a viral cause for the raised PEWS.
A majority of missed or delayed screens were found to be done by agency nursing staff.

Actions:
The paediatric sepsis practitioner has met with the ward Educators to discuss training for Agency Nurses. They will make sure all agency nurses do the Sepsis workbook as well as targeted training on the ward for the staff members identified.
Sepsis scenarios feature in PILS training and the availability of this course has increased.
Paediatric Sepsis Sim training for ward staff has taken place and there is more planned after the next Drs hand over.

Mitigations:
The ward educators are continuing to undertake harm reviews that are relevant to their area so that they can give direct support as cases arise. 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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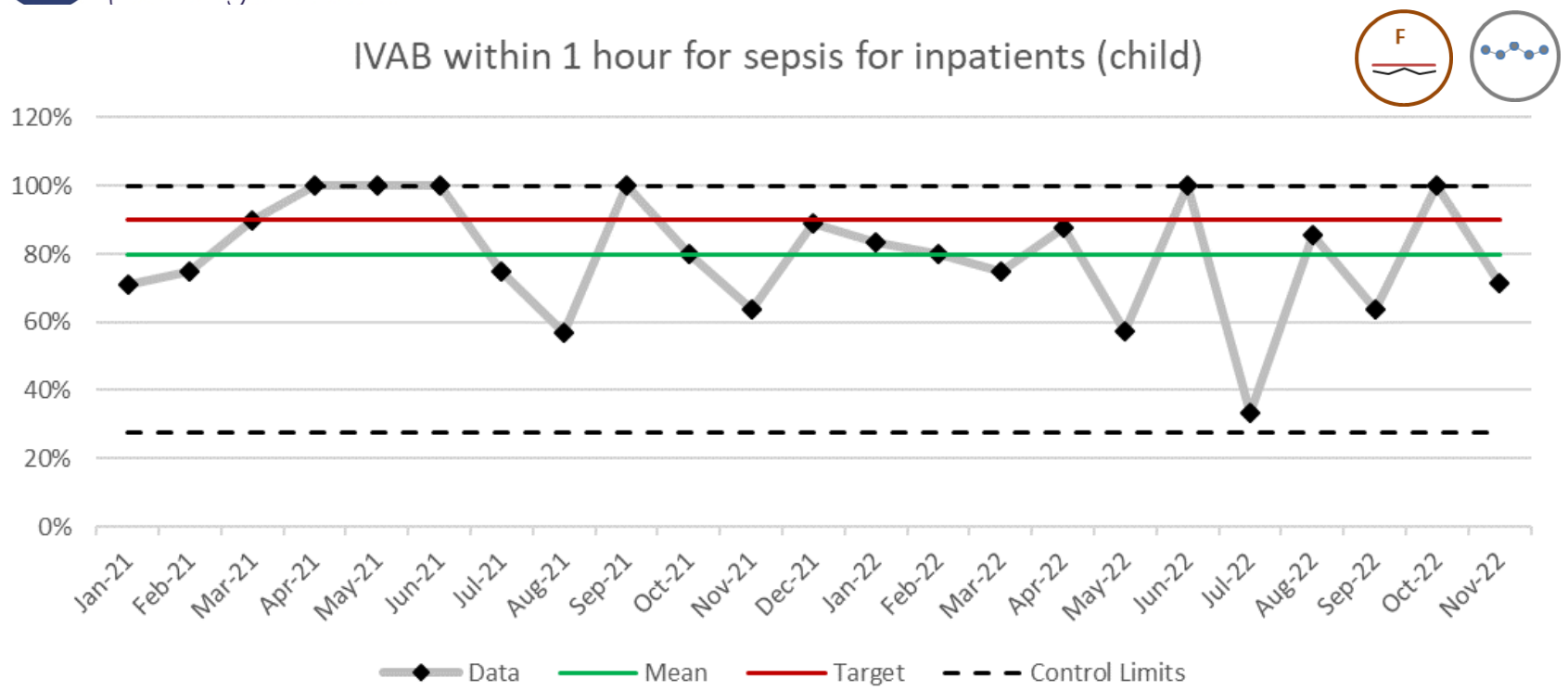

Nov-22
71.4%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:

There were 5 patients out of 7 that received antibiotics within the hour.

Issues:
2 patients had delayed antibiotic treatment in this month.
One patient had to be moved from ED to the ward for their portacath to be accessed in order to complete bundle.
The second patient had all investigations within the hour but antibiotics just after the hour as they were waiting for a medical decision.

Actions:
Harm reviews were completed by the ward for both of these patients and no harm was found.
Both cases will be discussed at Speciality Governance.
Harm Reviews to be shared with Medical staff going forward so that lessons may be learnt.

Mitigations:
Ward staff to attend ED if able to access lines such as Portacath and Hickman
Sepsis practitioner is meeting regularly with nursing staff and medical staff to discuss cases.

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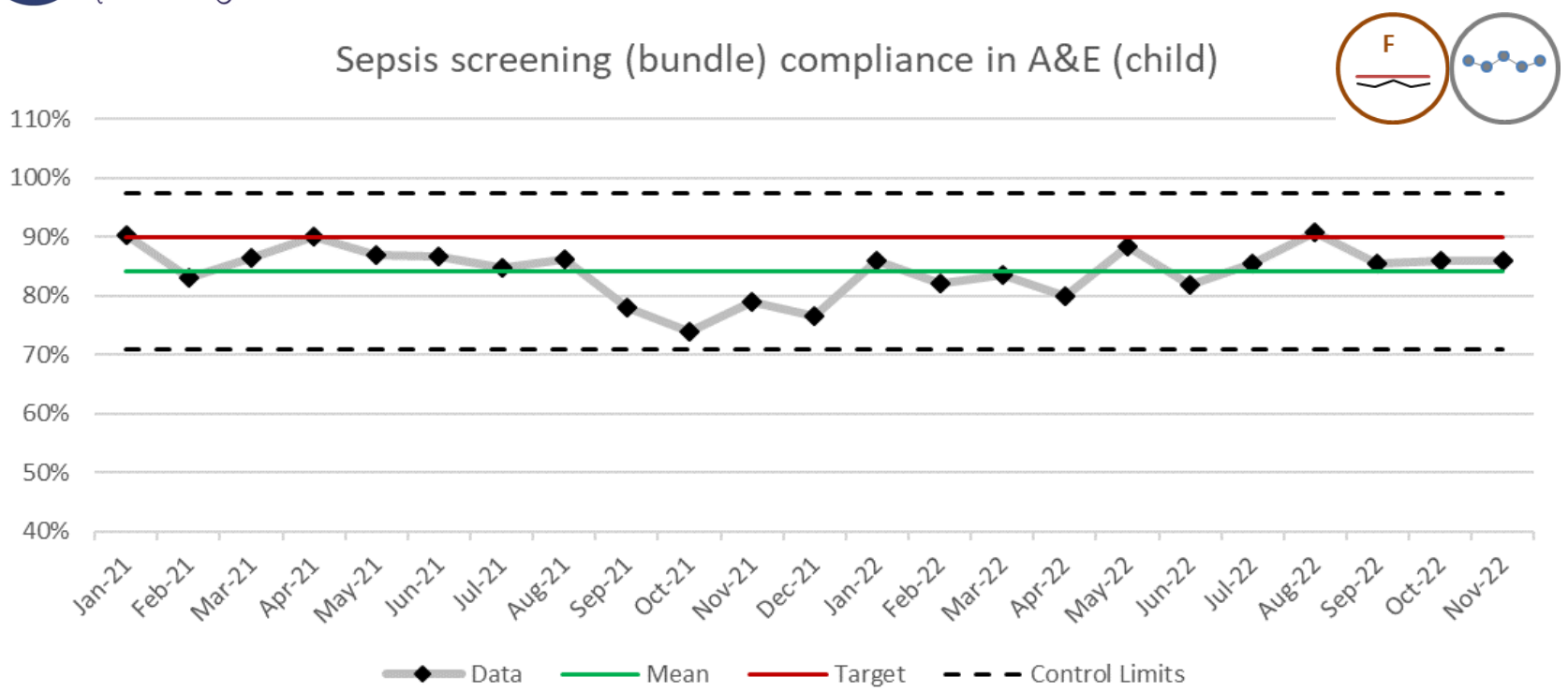

Nov-22
86.1%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for the current month has dropped to 86.1% which represents 316 of 367 patients.

Issues:
A worsening picture in Lincoln ED has mainly driven the drop in compliance. There was an interruption in the monthly focus group meetings whilst new leadership of this group was established.
There is a large increase in numbers of paediatric patients attending our A & E departments

Actions:
A relaunch of the sepsis focus group has now taken place and this will improve scrutiny and allow for improved thematic analysis.
Simulation training will provide the best route for improving understanding and knowledge and these have now commenced.
There has been meetings between ED staff (Medical and Nursing) as to how we can feed back harm reviews and therefore learn from them.

Mitigations:
A Consultant colleague has been identified at Lincoln to drive the various improvement initiatives and this will improve engagement.
Cross site working has begun between consultant staff and this will allow for best practice to be shared between sites. The main issues appear to be on one site so more support has been offered to that area from Sepsis Practitioners.

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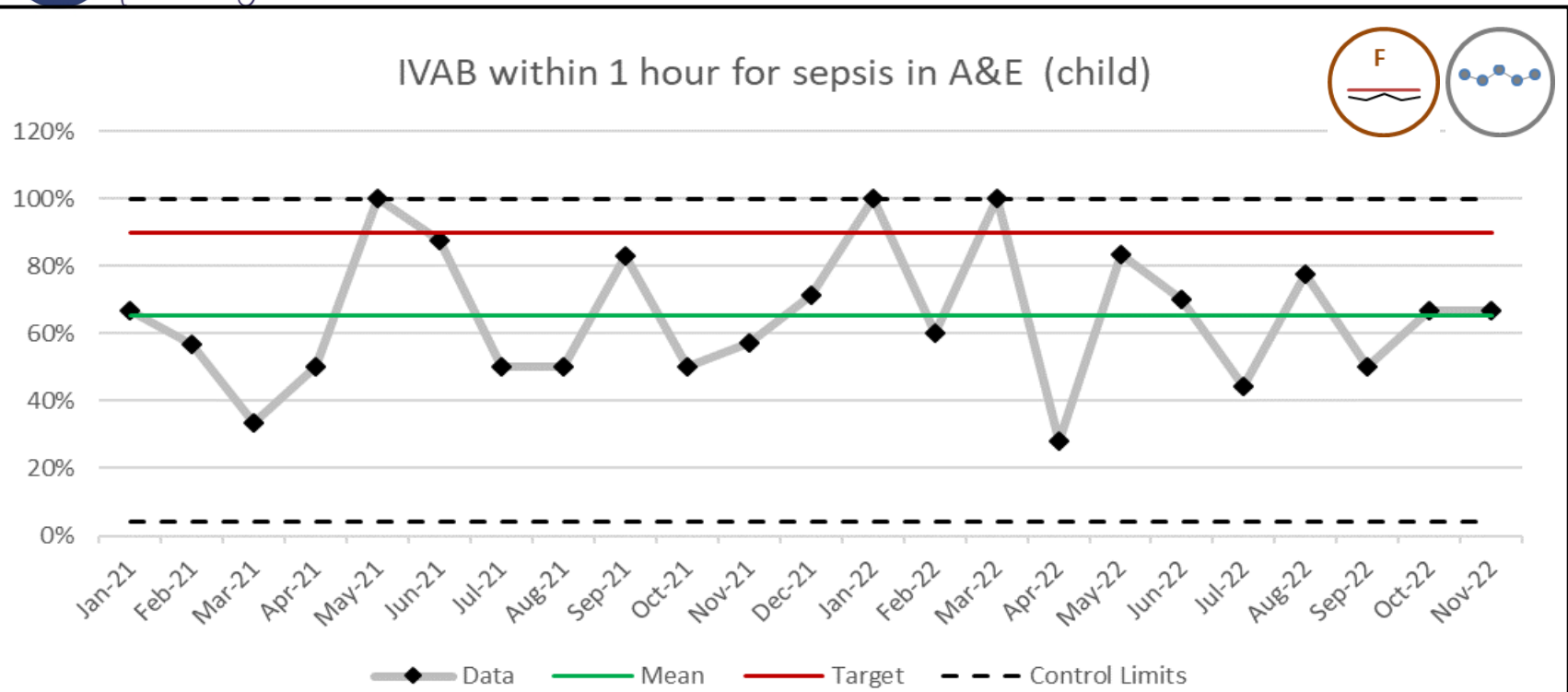


Nov-22
66.7%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

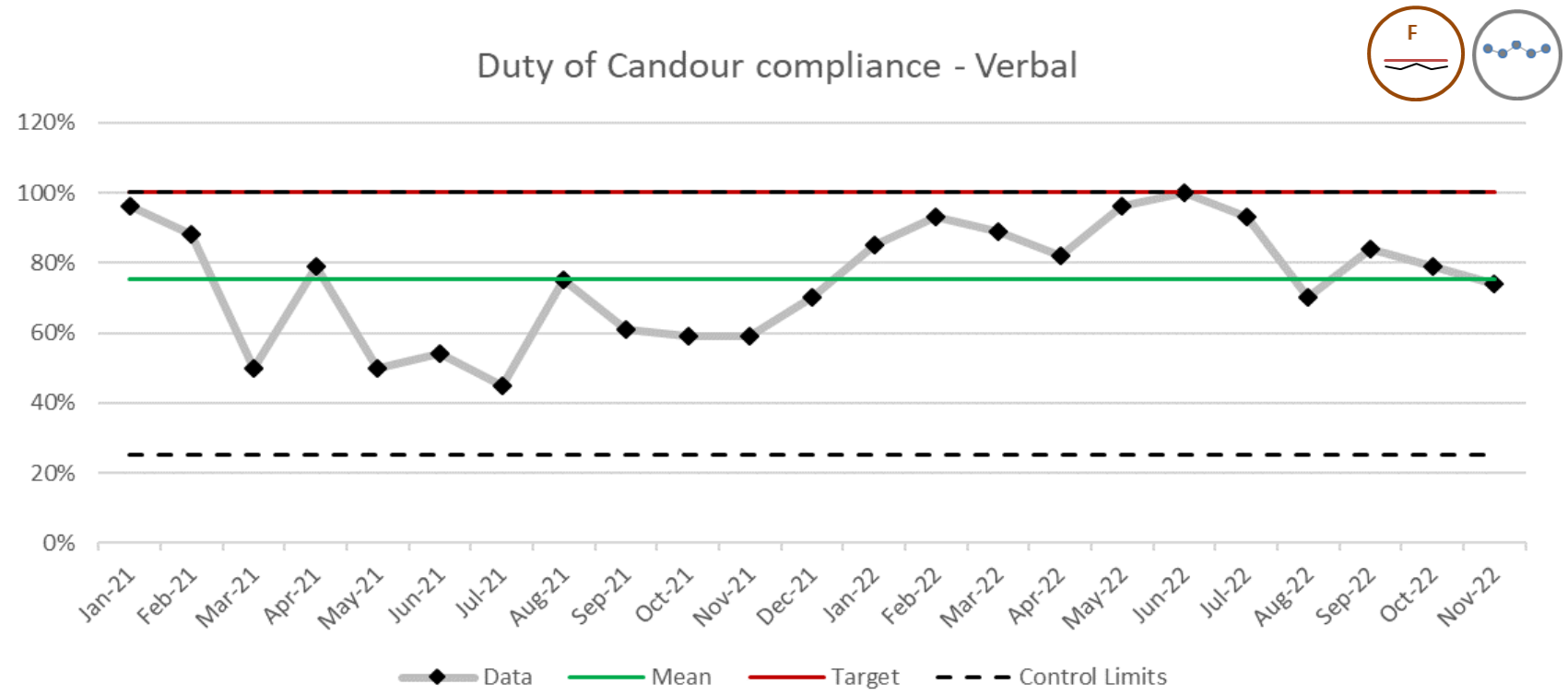
What the chart tells us:
The data this month shows that the IVAB compliance was 66.7%, which is 6 of 9 patients, and is below the 90% target. 3 patients were delayed in receiving antibiotics.

Issues:
There were 3 patients in ED this month that were delayed in receiving antibiotics. One antibiotic was given at 86 minutes. This was due to the child being an emergency call and requiring stabilisation first. Two children were initially thought to be viral when seen by ED Drs, once reviewed by paediatrics they were treated as sepsis.

Actions:
Sepsis training has been delivered for new Doctors starting in August.
Simulation training is to be reintroduced in ED areas.
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 which is the most common age for delayed treatment.

Mitigations:
There are ongoing meetings between the Sepsis team and ED which happen every 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.

Quality | Operational Performance | Workforce | Finance



Nov-22
74.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

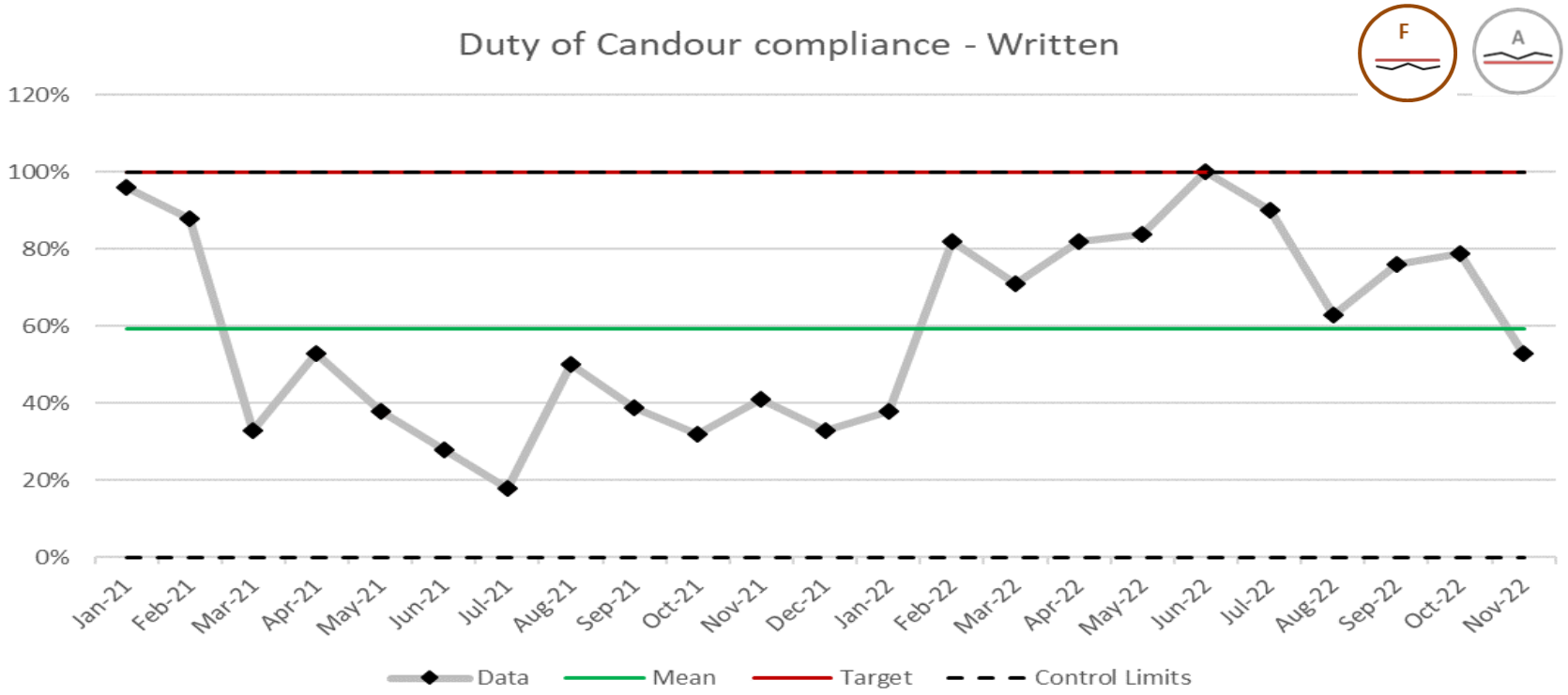
Background:
Compliance with the NHS requirement for verbal Duty of Candour, which applies to all patient safety incidents where harm is moderate or above, is a statutory requirement.

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 are now 5 cases outstanding 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.



Nov-22
53.00%
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 6 cases outstanding 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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-22	Nov-22	Dec-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.50%	0.39%	0.54%	0.31%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	59.76%	60.99%	42.36%	59.05%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1114	560	1034	7534	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	76.77%	78.00%	67.63%	79.33%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	7927	8204		54,476	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	47.84%	47.67%		49.44%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	71,962	72,281		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	46.27%	46.15%		49.49%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	60.30%	65.29%		59.25%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	32.76%	36.15%		26.28%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	88.36%	92.48%		90.71%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	97.35%	97.40%		97.68%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	83.33%	78.79%		72.20%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	92.08%	98.00%		95.99%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	56.00%	75.00%		67.41%	90.00%			

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PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-22	Nov-22	Dec-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	75.66%	69.67%		69.53%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	49.15%	52.19%	51.42%	52.81%	99.00%	F	B	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	2.17%	1.64%	1.74%	2.19%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	36	35	37	280	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	79.73%	85.71%	86.52%	75.06%	90%	F	B	
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	58.11%	68.83%	66.29%	55.63%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,859	3,906	3,614	3,823	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	1020	494	998	824	0	F		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	168	156	190	1,319	90	F	A	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.59	2.97	2.72	2.95	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	5.06	4.86	5.14	5.03	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	22,530	21,212	22,042	22,711	4,524	F	A	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	32.80%	33.41%	32.63%	36.04%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	37.45%	44.33%	43.60%	37.88%	45.00%	F		

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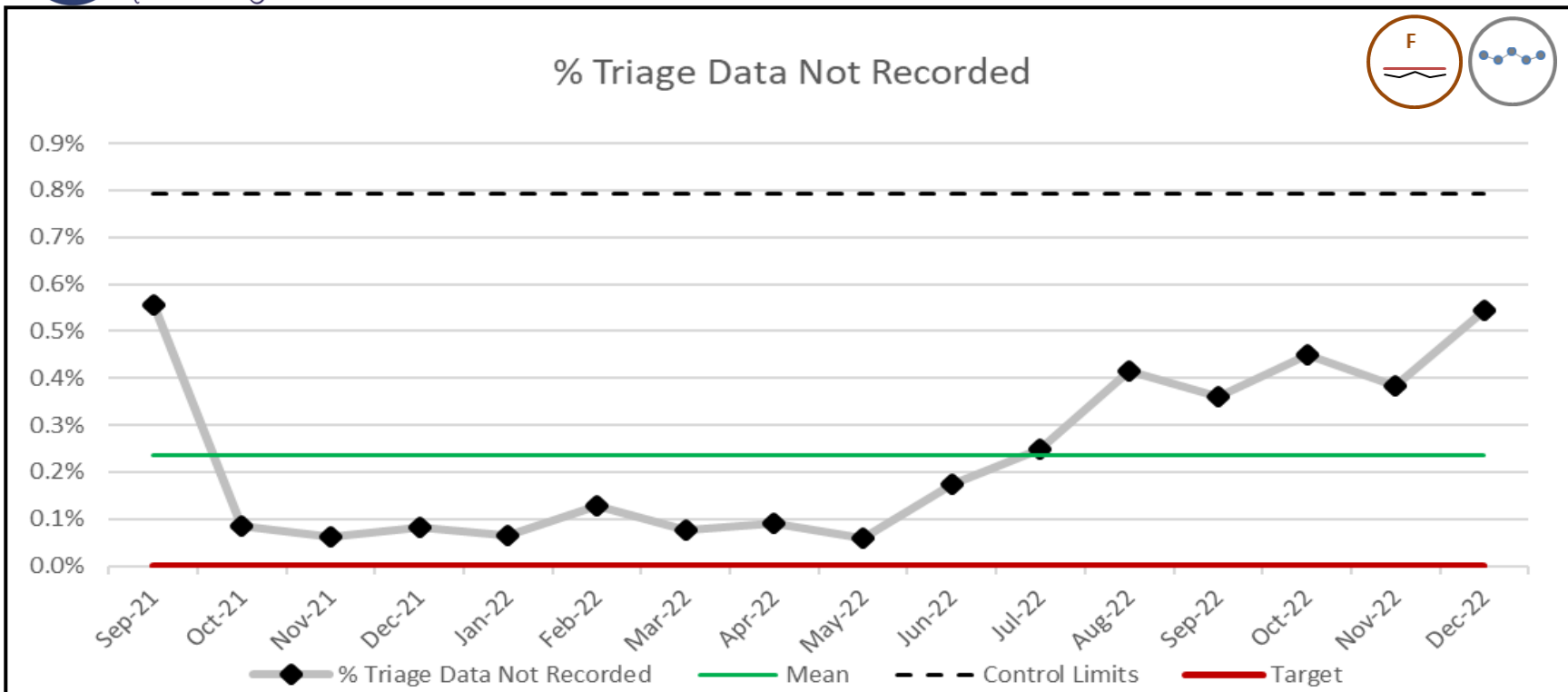


Dec-22
0.54%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

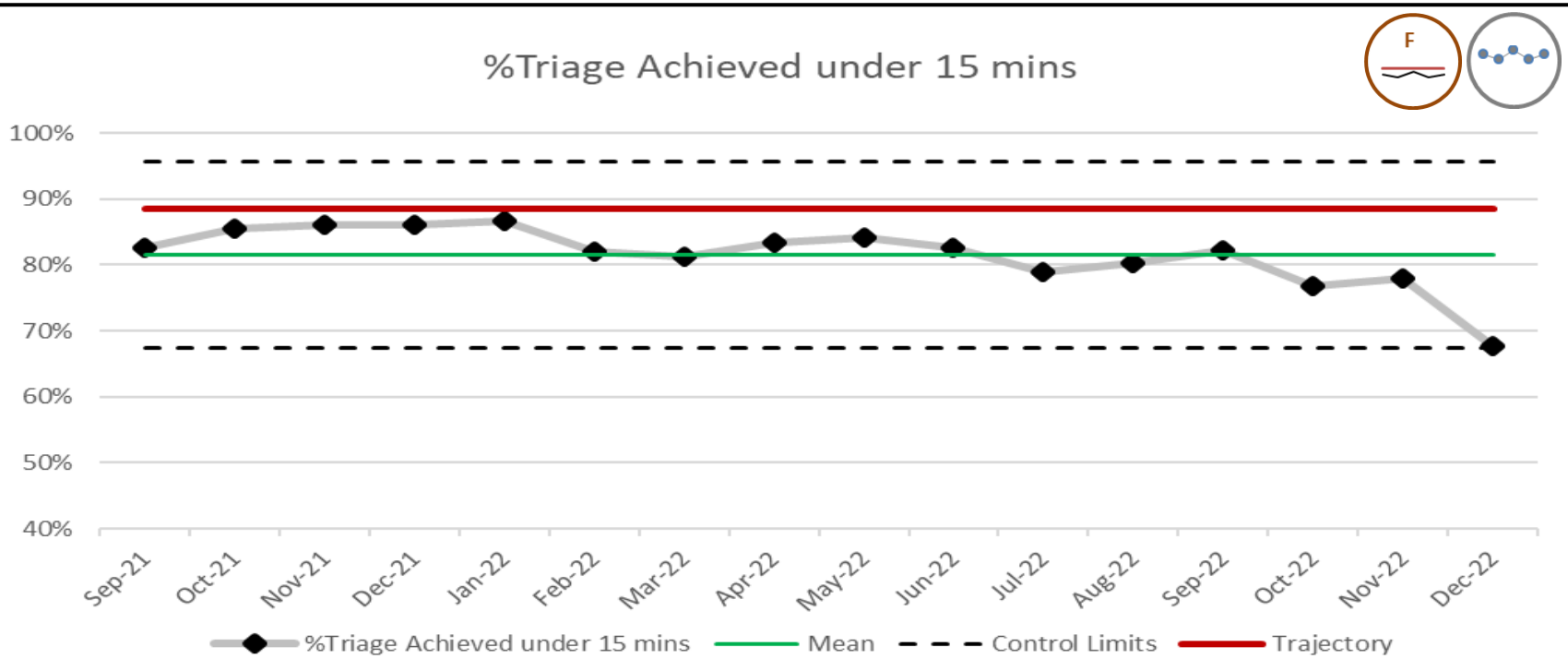
Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%.
December reported a non-validated position of 0.54% of data not recorded verses an October reported validated position of 0.39% data not recorded
December demonstrated a 0.15% negative variation compared with November
This will improve further once validation is complete
This metric is below target

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

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



Dec-22
67.63%
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 67.63% compared to 78.02% in November (validated).
This demonstrates a deterioration in performance of 10.39% compared with November and an 20.87% 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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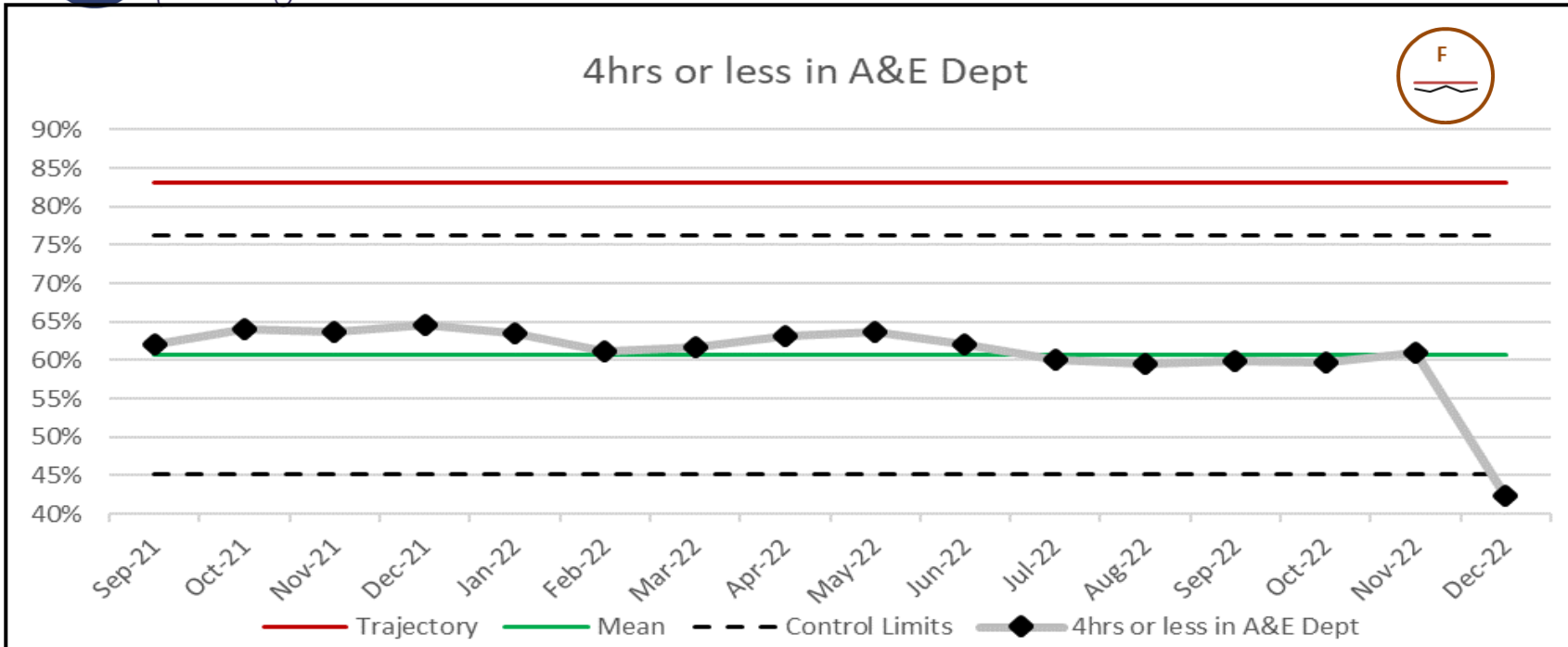
NHS United Lincolnshire Hospitals NHS Trust



Dec-22
42.36%
Variance Type
Metric is currently experiencing Special Cause Variation – outside the control limits
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 December was 42.36% compared to 60.99% in November, which is a deterioration of 18.63%. This the lowest performance ever recorded.
The target compliance is 83.12% and is an historic target that has been unchanged in 2 years.

Issues:

The Emergency Departments experienced an increase attendance in December of 1,304 patients compared to November. 19,023 combined attendances (in ED and UTC) compared to 17,719 combined attendances (ED and UTC) in November
Of the 19,023 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 12,856 and type 3 accounted for 6,167.
Inadequate daily 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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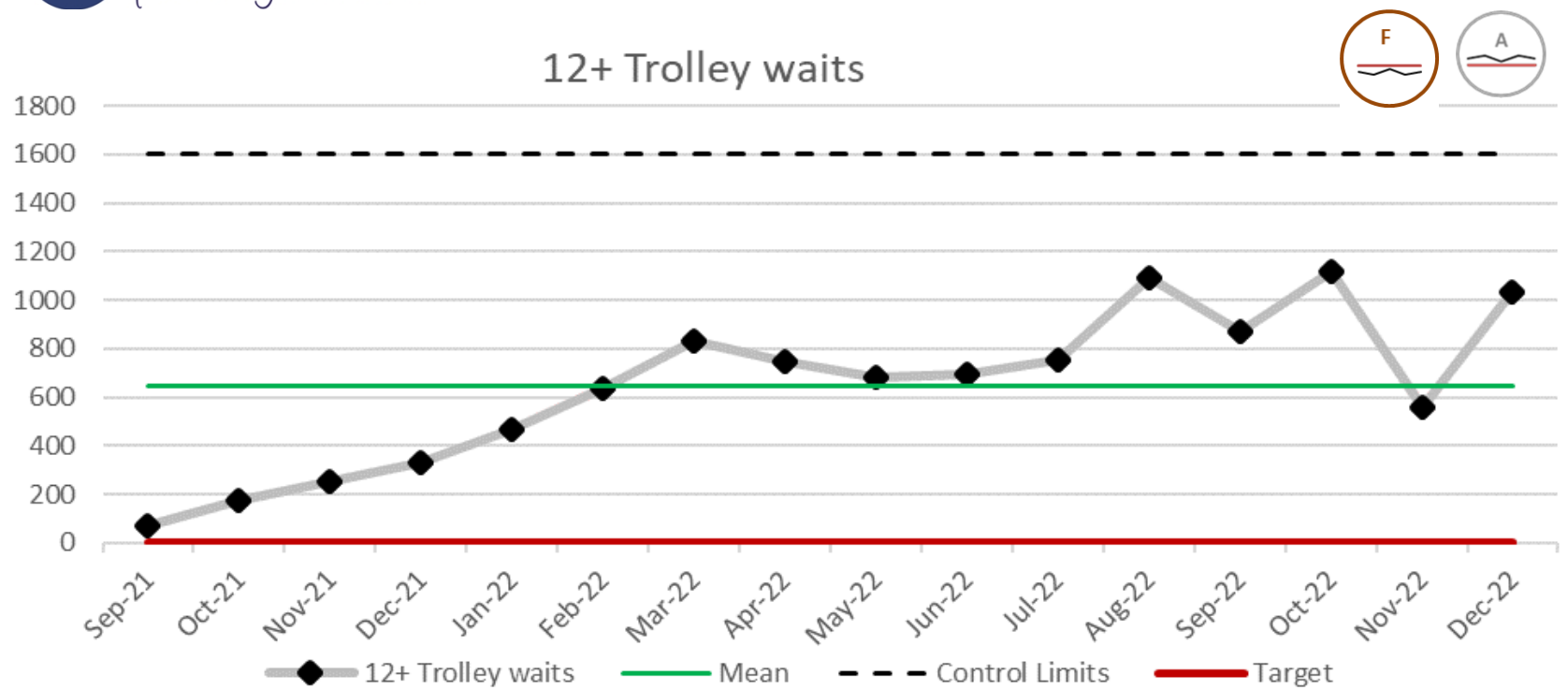
NHS United Lincolnshire Hospitals NHS Trust



Dec-22
1034
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
December experienced 1034 12-hr trolley wait breaches. This is the unvalidated position. This is an increase of 744 12-hr trolley wait breaches compared to November. This represents an increase of 45.85%. This equates to 8.04% of all type 1 attendances for December.
What the chart does not explain is the internal decision to move from 12hr DTA to total time in ED to minimise exposure risk.

Issues:

Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings. The actual number of 12hr trolleys wait breaches, whilst anticipated against flow predictions, exceeded actual expectations.
December has experienced increased attendances for respiratory viruses such as RSV, Influenza A and Covid.
The Trust has made the safety and risk-based assessment to move to total time in ED as opposed to the 12hr DTA standard.

Actions:

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

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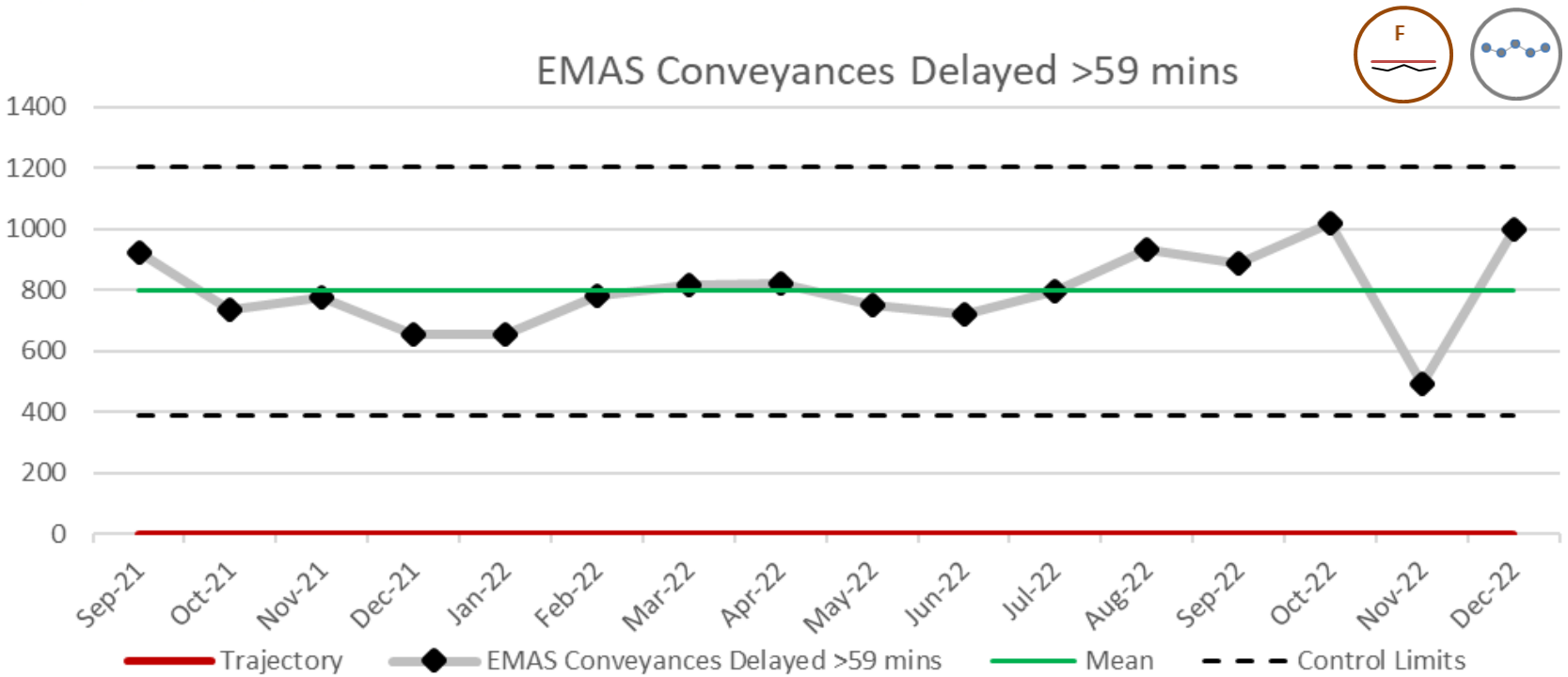

Dec-22
998
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

December demonstrated an increase in greater than 59 minutes' handover delays. 998 in December compared to 494 in November. This represents a 50.51% increase.

What the chart does not tell us is the total increase of >2hrs in December 2022 which is recorded as 634 compared to 219 for November. >2hrs but <4hrs accounts for 367 in December compared to164 in November and >4hrs accounts for 267 in December compared to 55 in November.

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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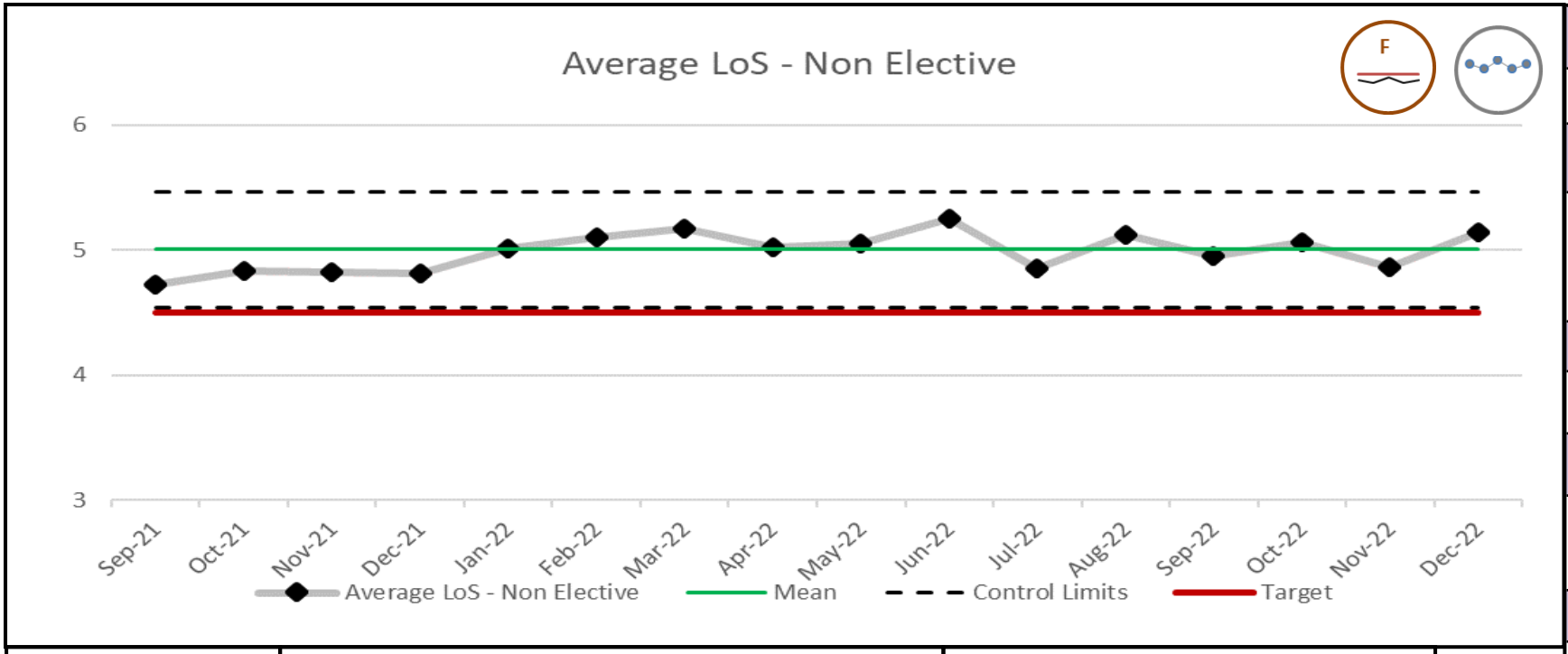

Dec-22
5.14
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 5.14 days in December vs 4.86 days in November.
This is an increase of 0.28 days
compared with November.
This is a 0.64-days negative variance against the agreed target.

Issues:

Numbers of stranded and super stranded patients have increased 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.
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.
Pathway 0 patient discharging remains slow to show improvement in December but is making a marked upward move now.

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

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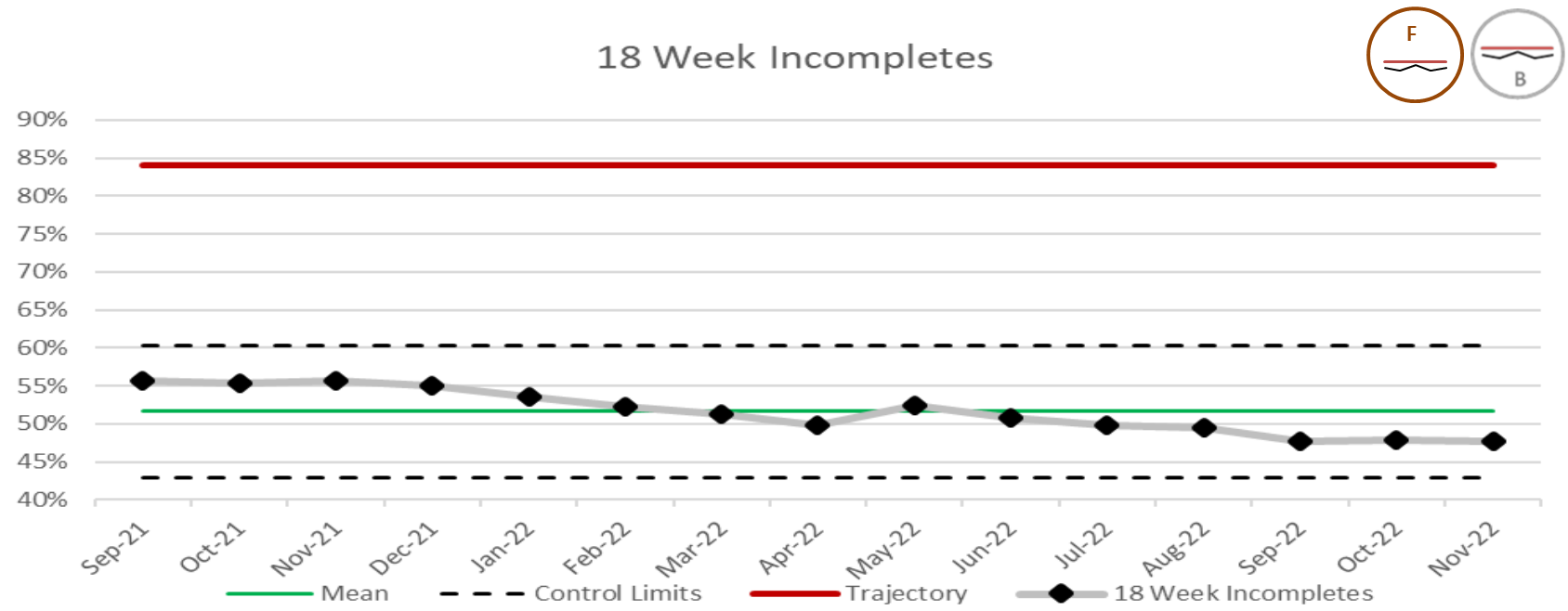

Nov-22
47.67%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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. November saw RTT performance of 47.67% against a 92% target, which is 0.18% down from October.

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 – 5794 (decreased by 115)
- Gastroenterology – 3885 (decreased by 52)
- Dermatology – 3297 (decreased by 69)
- Respiratory Medicine – 2781 (increased by 109)
- General Surgery – 2628 (increased by 28).

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 >67 as these have the potential to be >78 weeks in March 2023. Recent schemes to address backlog include;

1. Validation programme
2. Outpatient utilisation
3. Tertiary capacity
4. Outsourcing/Insourcing
5. Use of ISPs
6. 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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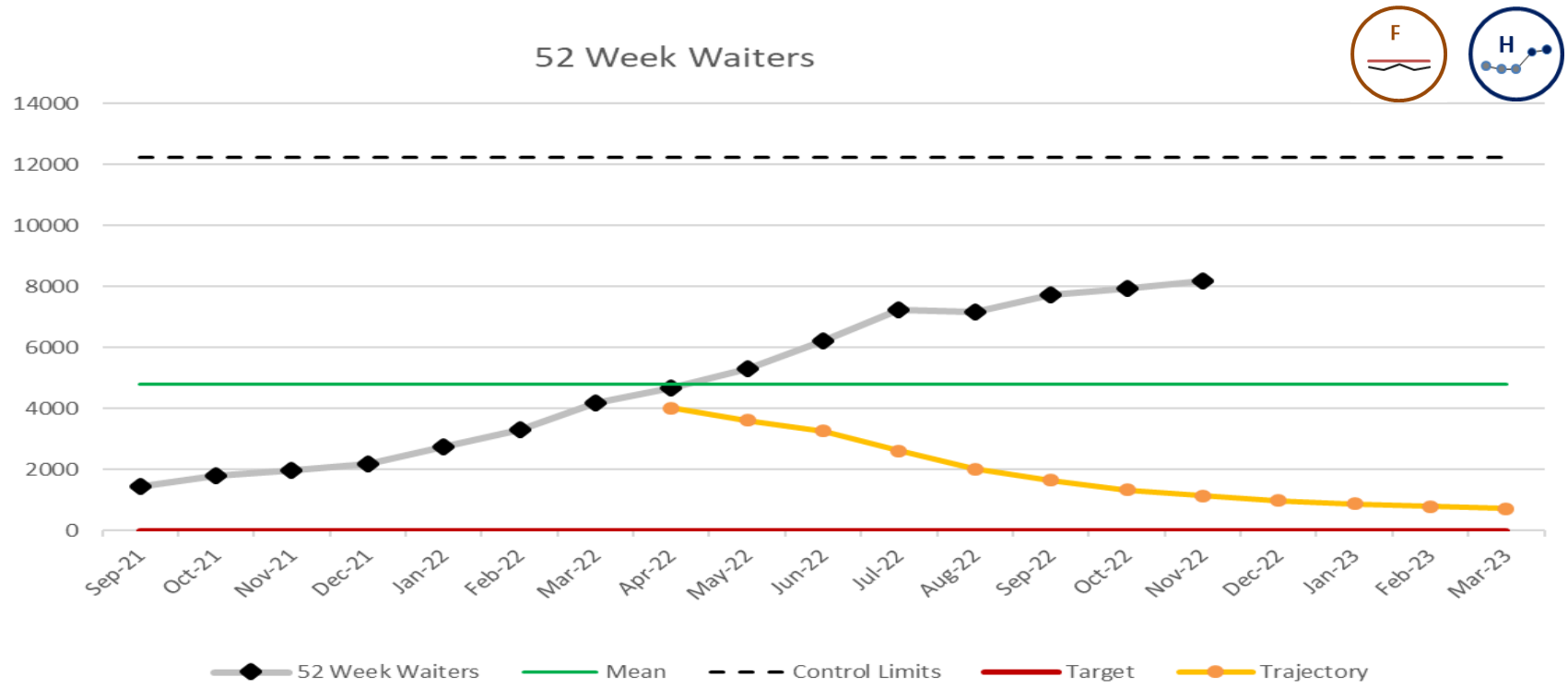


Nov-22
8204
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

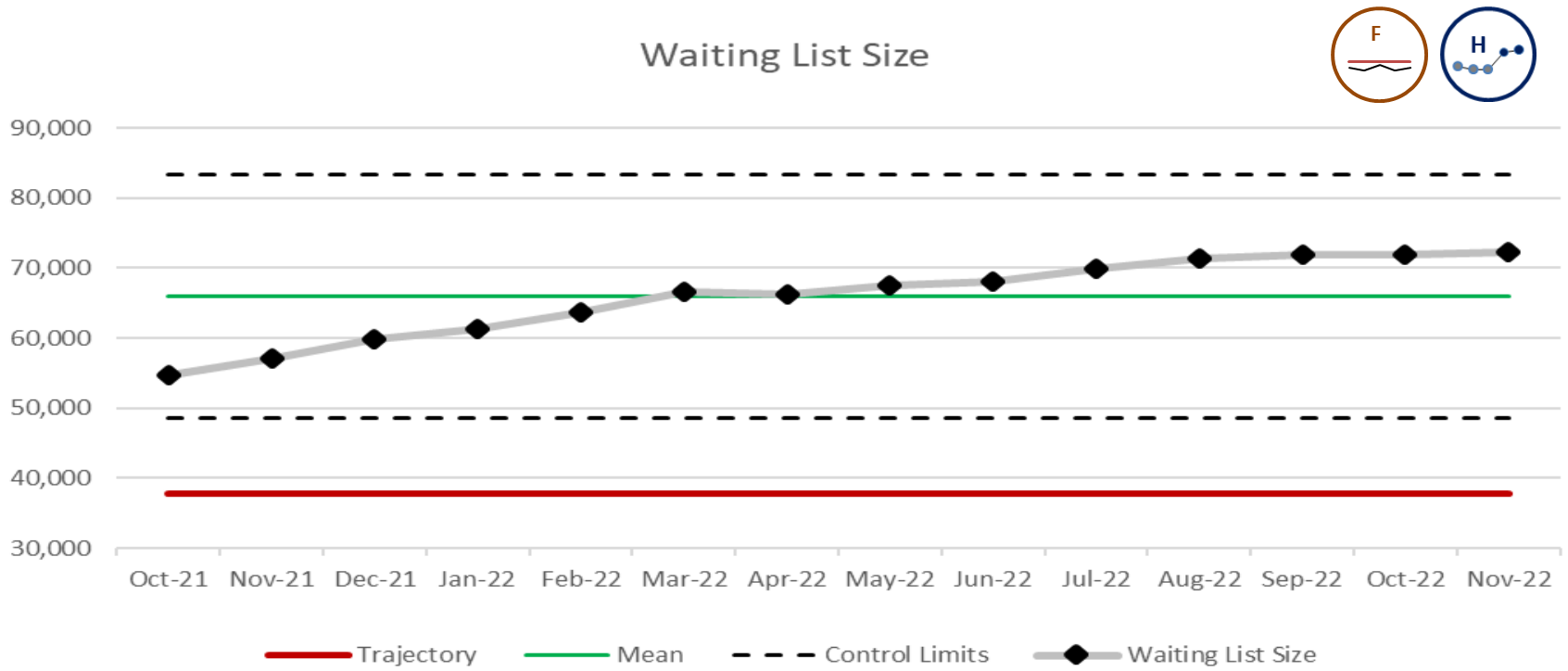
Background:
Number of patients waiting more than 52 weeks for treatment.

What the chart tells us:
The Trust reported 8204 incomplete 52-week breaches for November, an increase of 277 from October.

Issues:
Whilst ULHT's position is strong with 104 week wait patients, performance is less assured with 52 week waiters. Both admitted and non-admitted patients sit within this backlog, however, the most significant pressure sits 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 working in some specialties that have lower numbers of patients; however, it is making slow progress in many, 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.



Nov-22
72,281
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 October, with November showing an increase of 319 to 72,281
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 – 8646
- Ophthalmology – 5967
- Gastroenterology – 5742
- Dermatology – 5437
- General Surgery - 5337

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 Dermatology, ENT and Gastroenterology.

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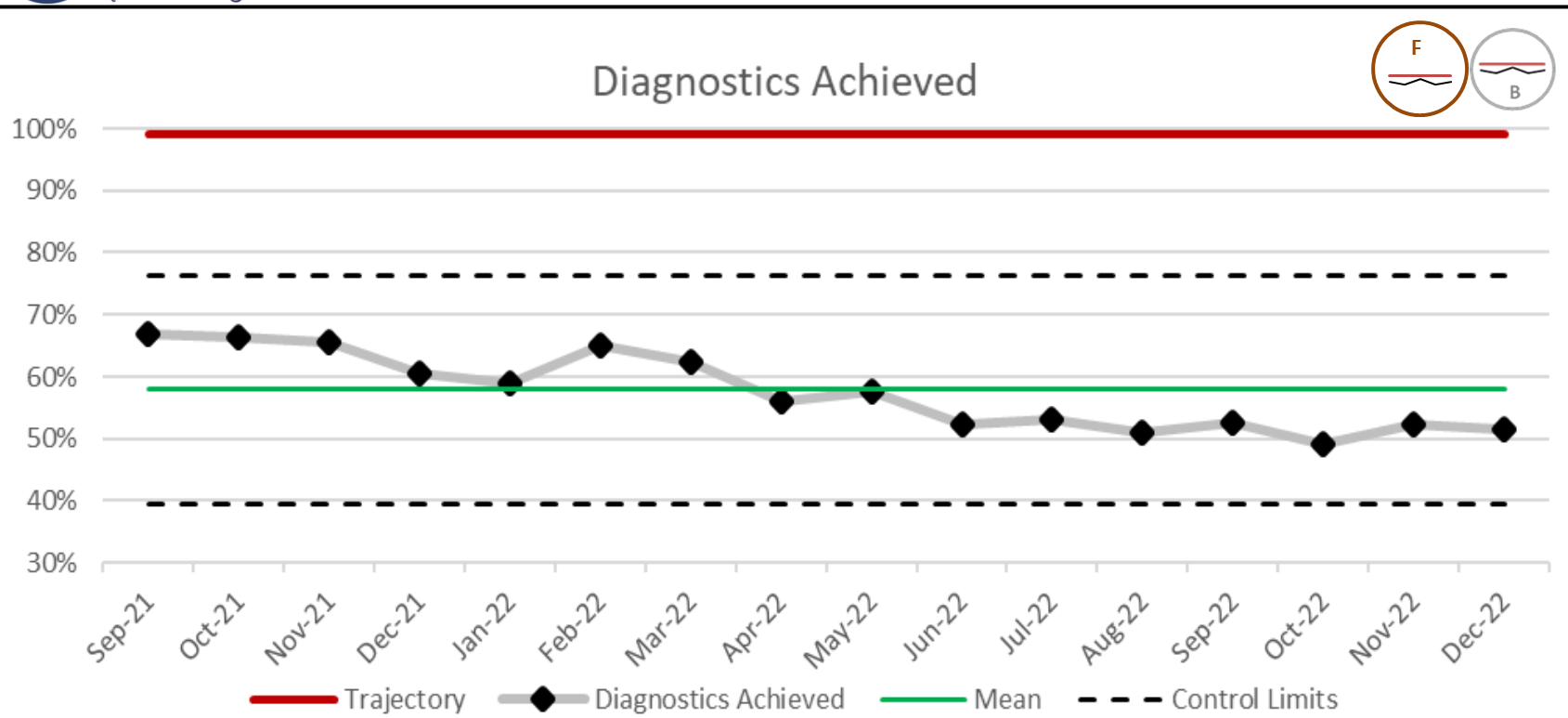

Dec-22
51.42%
Variance Type
Metric is currently experiencing Special Cause Variation – below the trend
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 51.42% against the 99.00% target.

Issues:
The majority of diagnostic breaches sit in Cardiac Echo with 6316 breaches recorded in December. MRI has 1798 breaches. Additional outsourcing to help reduce the backlog from January 2023 hopefully reducing breaches to within limits by April
There are 1439 Dexa Breaches as the scanner is not up and running we should see a reduction of around 250 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.

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.

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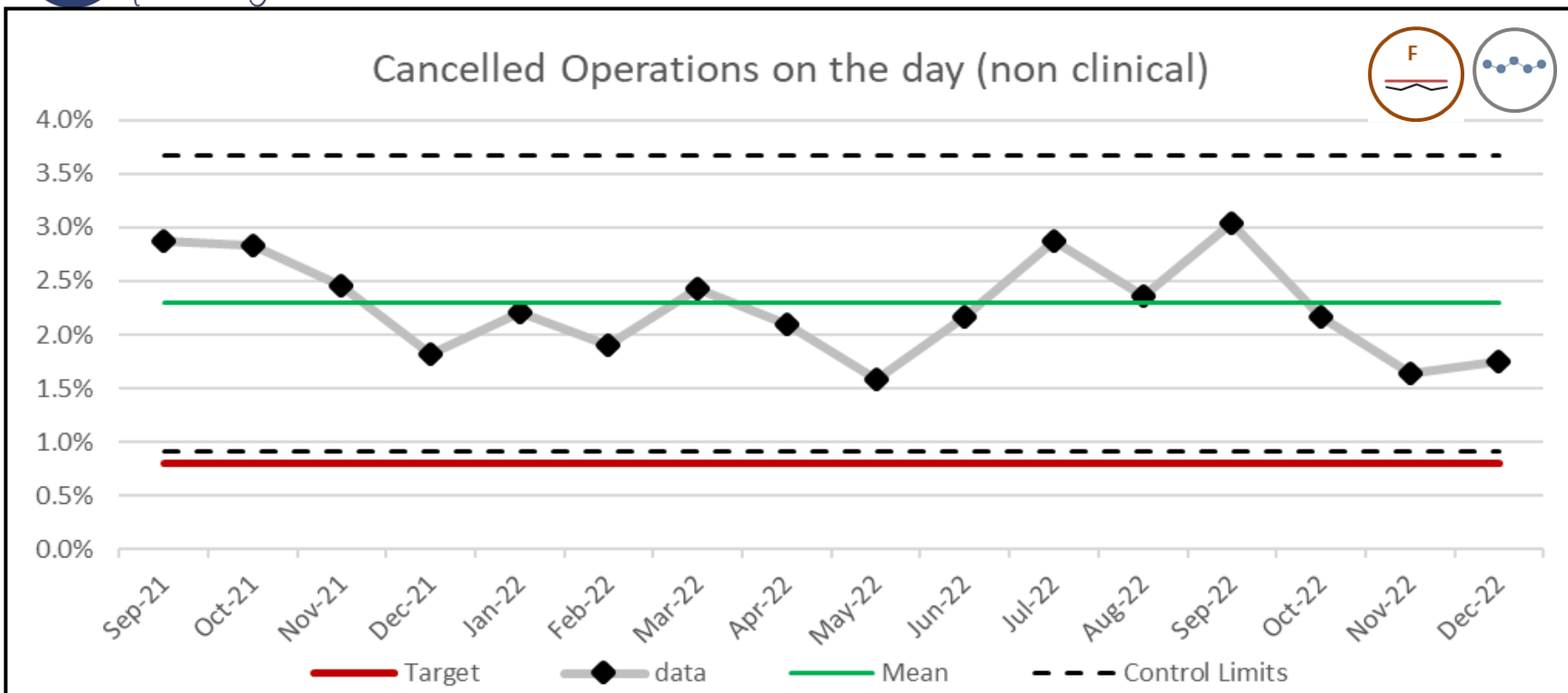


Dec-22
1.74%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us
There was a slight increase of patients cancelled on the day from to 1.64% in November to 1.74% in December and this remains above the agreed trajectory of 0.8%

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

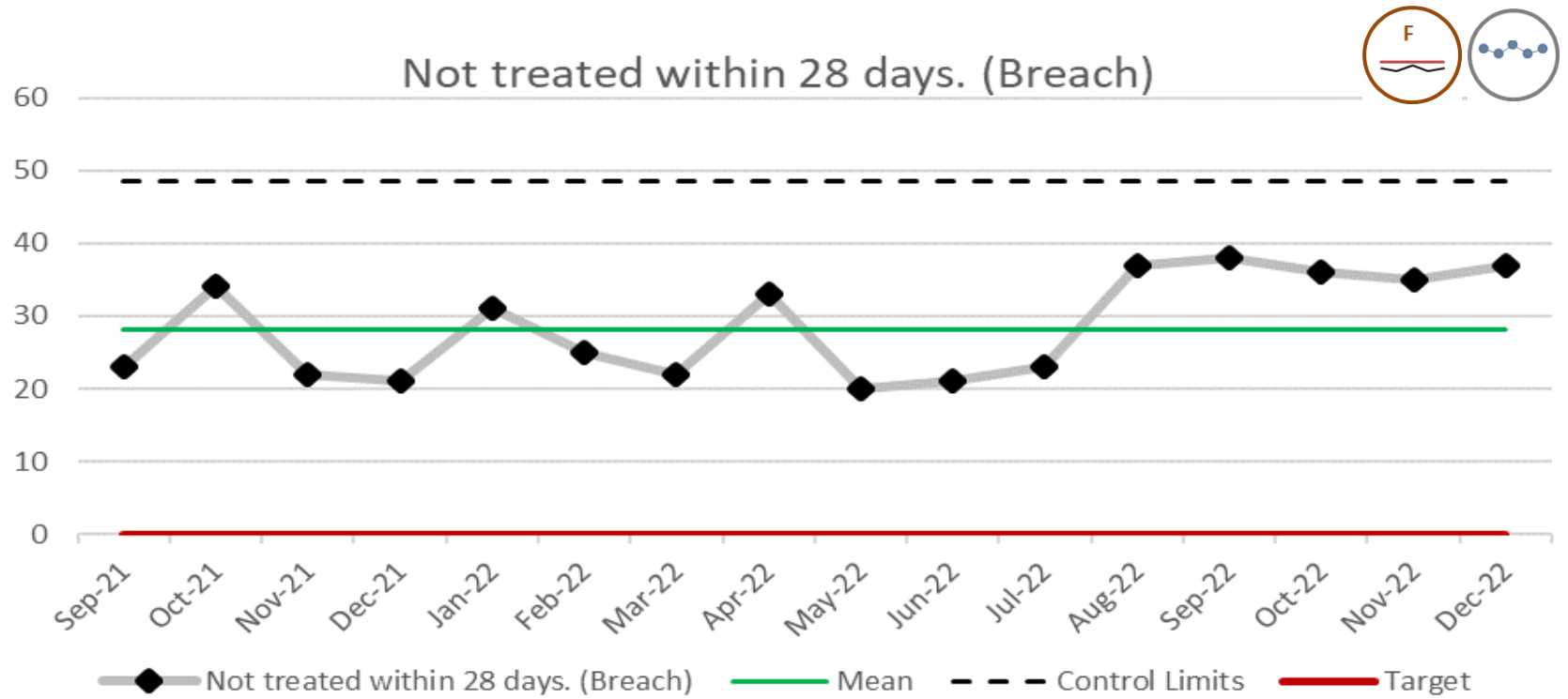
1. Lack of time
2. No theatre staff
3. No equipment available

Actions:
Productive Theatre Oversight Group has focussed on making improvements across those areas accounting for highest number of on the day cancellations.

The Super Sprint starts on 16th January and one focus will be starting on time which should show a reduction in the number of cancellations due to lack of time

Mitigations:
Sickness, and inability to backfill gaps, across all theatres has had a significant impact on cancellations on the day.

Increased ICU capacity on both larger sites has been the cause of 5 cancellations due to lack of Level 2 beds in December.



Dec-22
37
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
This chart shows the number of breaches during December 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 December is 37, which is an increase of 2 from 35 in November, though the agreed target of zero has not been achieved.

Issues:
Poor list uptake across all sites due to leave/vacancy provides reduced capacity for booking patients.

Additionally, the extended Christmas break has reduced availability of lists

This has been further exacerbated by the ongoing site capacity issues and subsequent bed shortages, particularly at the two larger sites.

Actions:
Waiting List teams to ensure planned list activity is at a minimum of 90% for all appropriate lists.

CBUs to work with clinicians to identify lists that can be relocated to Grantham to ensure full utilisation of the new theatre availability. This is still ongoing, particularly due to clinical commitments of surgeons for the other part of the working day

Mitigations:
The ongoing bed pressures at the larger sites means reduced capacity for inpatient activity. Additionally, the ICU pressures and reduction in L3 equivalent beds at Lincoln is having some impact on their ability to admit patients post operatively.
642 is running well with professional challenge in place which supports improved utilisation of lists.

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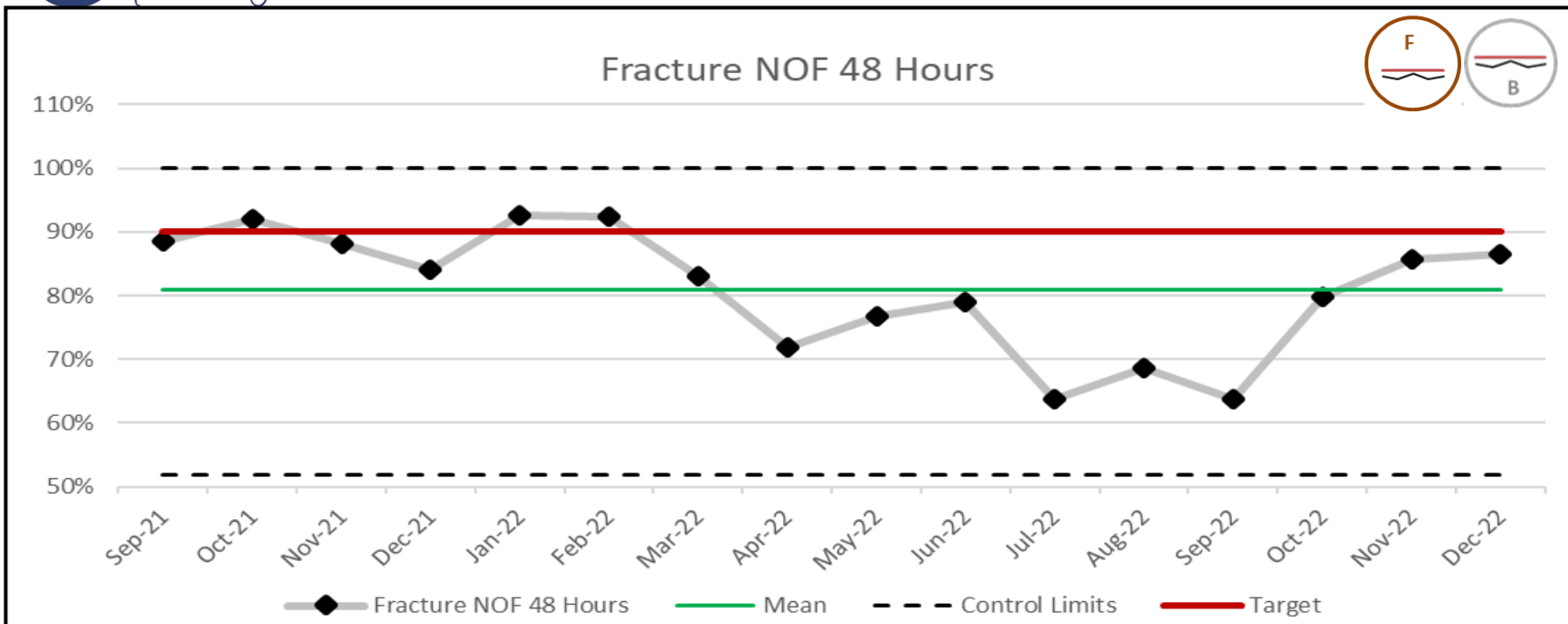


Dec-22
86.52%
Variance Type
Metric is currently experiencing Special Cause Variation – below the trend
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

December performance out turned at 86.52% against the agreed target of 90%.

LCH Site underperformed at 80.85% and PHB achieved 92.86%. However this is the highest % achieved overall this financial year.

Issues:

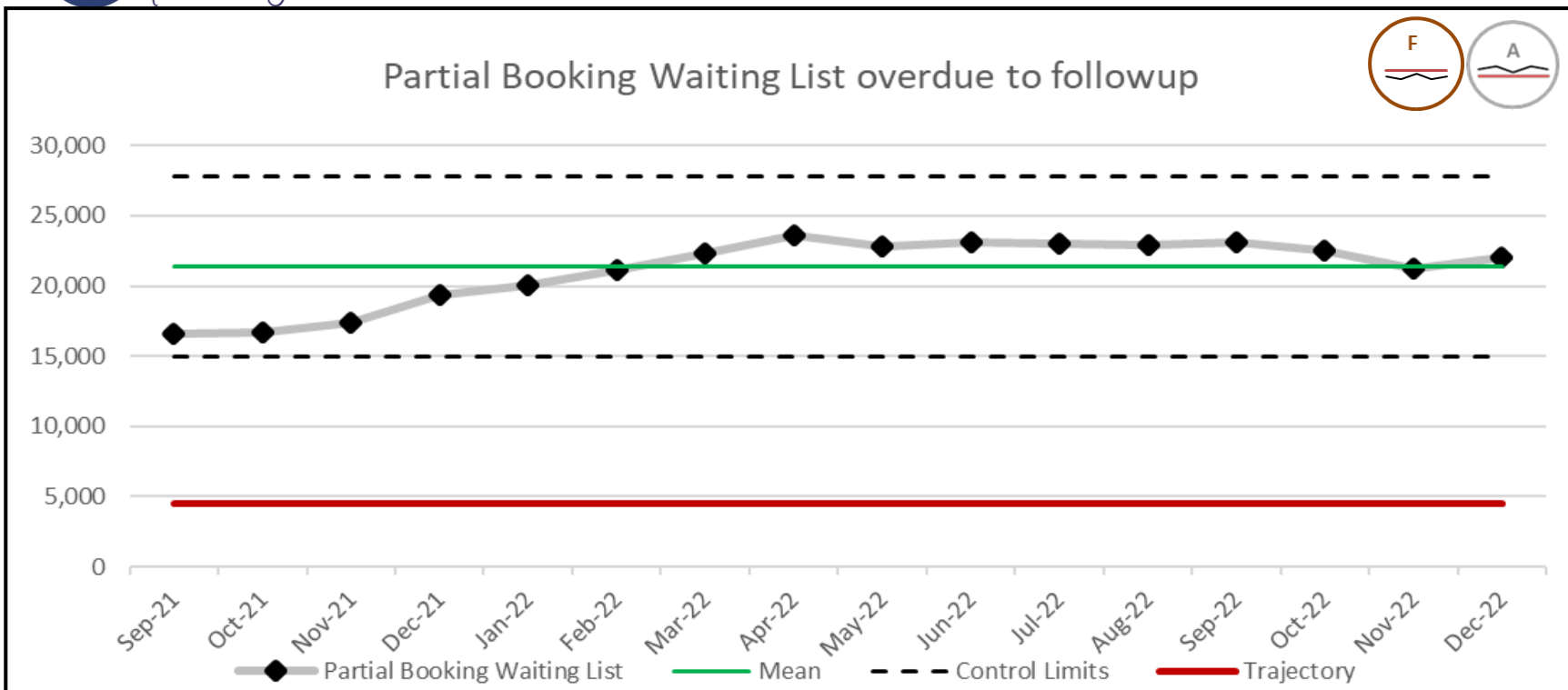
Increase in trauma demand over recent months.
High vacancy rate in theatres and anaesthetic sickness has severe impact on capacity for additional theatres.
Due to increase in trauma demand and the types of injuries seen, certain procedures have been clinically prioritised ahead of NOF patients.
Delays 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.

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 lists continue to be identified in periods of high trauma with escalation to Surgical MD when staffing proves challenging.
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.

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.



Dec-22
22,042
Variance Type
Metric is currently experiencing Special Cause Variation – Above the trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 22,042 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. With an increase in support required during the EMAS strike action. This has meant ED, ward and theatre cover has taken priority over outpatient cover. Matching clinic space and resources limits the amount of extra capacity available.

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

Mitigations:
Outpatients support organisational priorities in ED and urgent care cancelling outpatient clinics on an adhoc basis to free up resources when required. This was required for a number of clinics during the first EMAS strike date.

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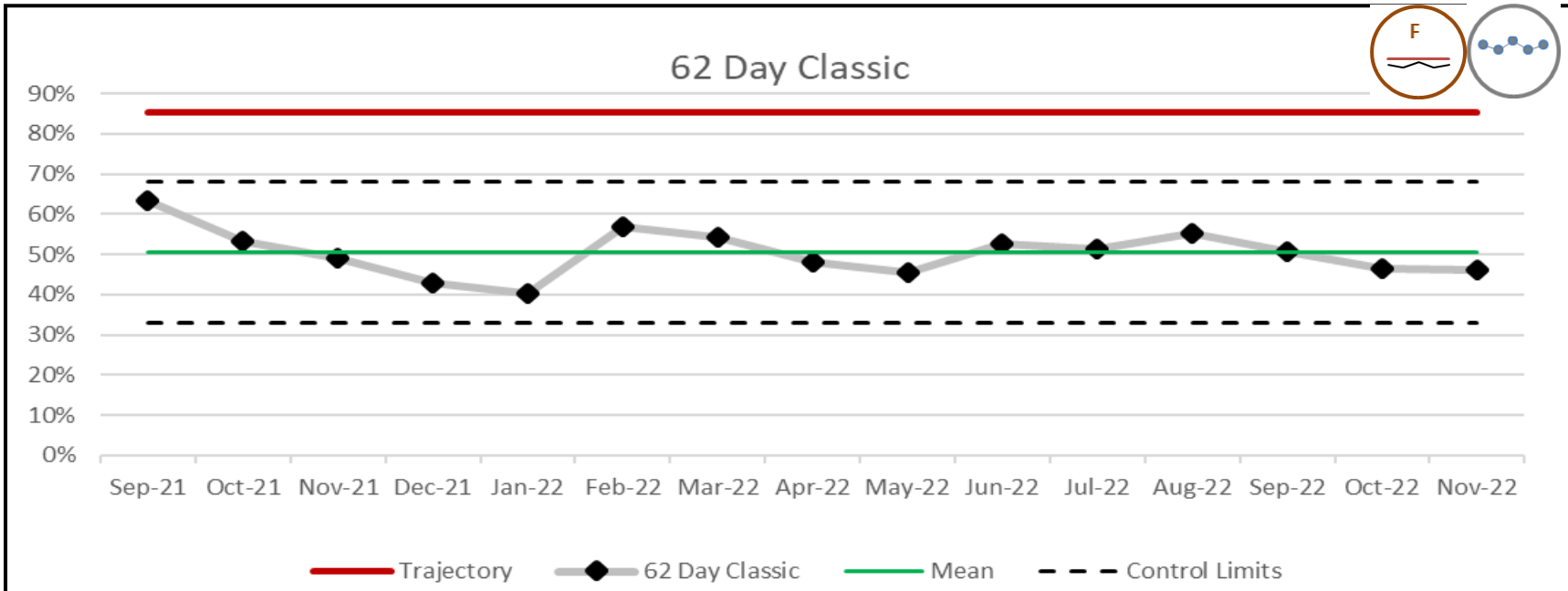


Nov-22
46.15%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 46.15% 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:

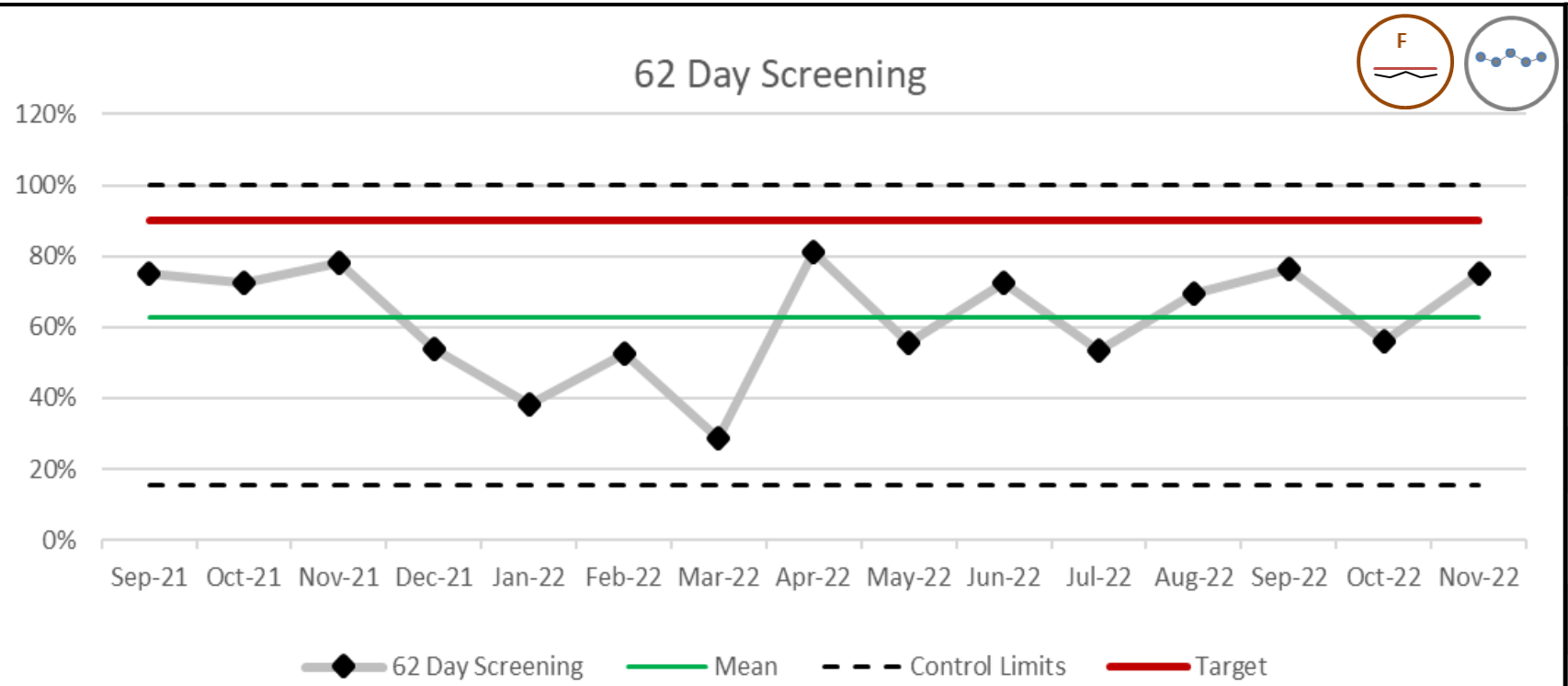
Recruitment in Oncology is ongoing to secure locums. There is a significant lack of consultants nationally and very few available from agency.
Theatre capacity is improving and will be further alleviated now that the new theatres have opened at GK. Robotic Lists are progressing well, though proving difficult 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:

Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work.
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



Nov-22
75.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

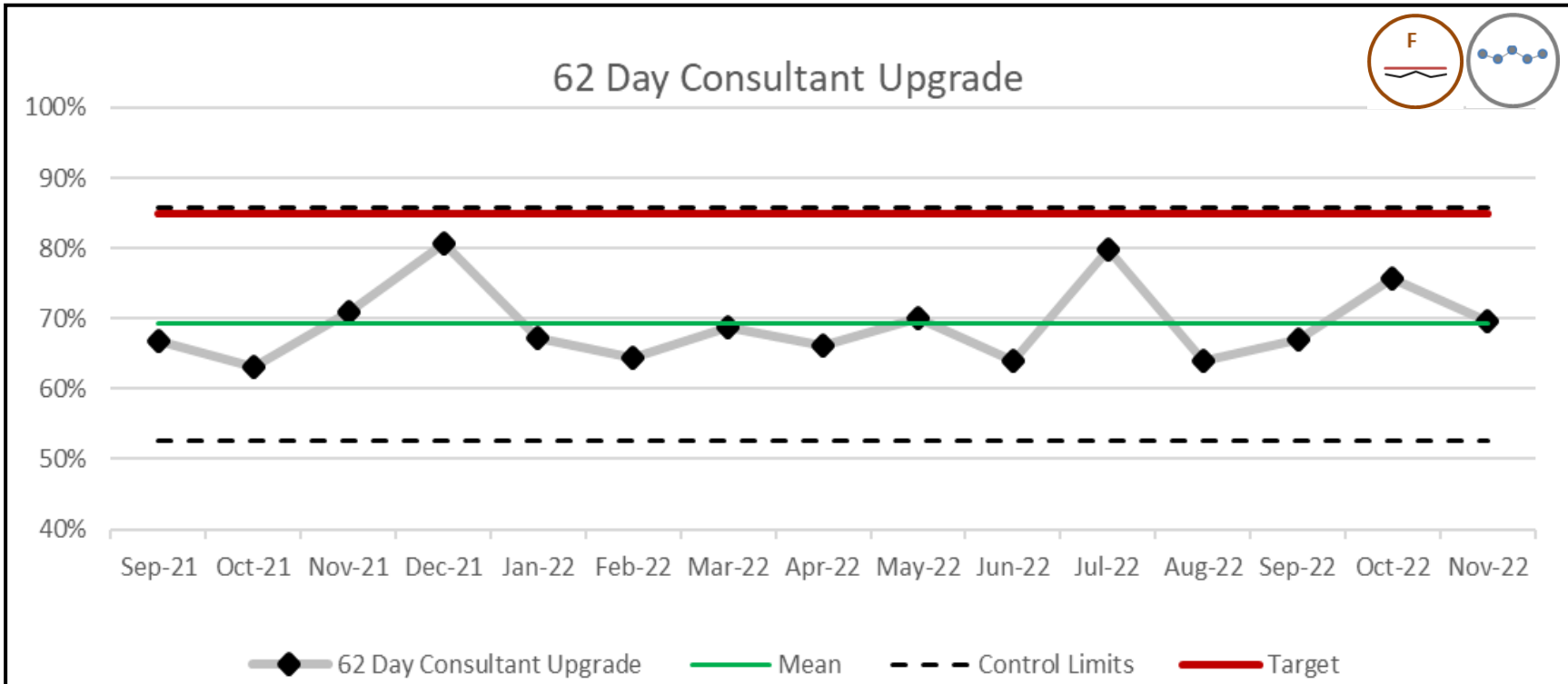
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 75.00% 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.



Nov-22
69.67%
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 69.67% against an 85% target.

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

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

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

OUTSTANDING CARE personally DELIVERED

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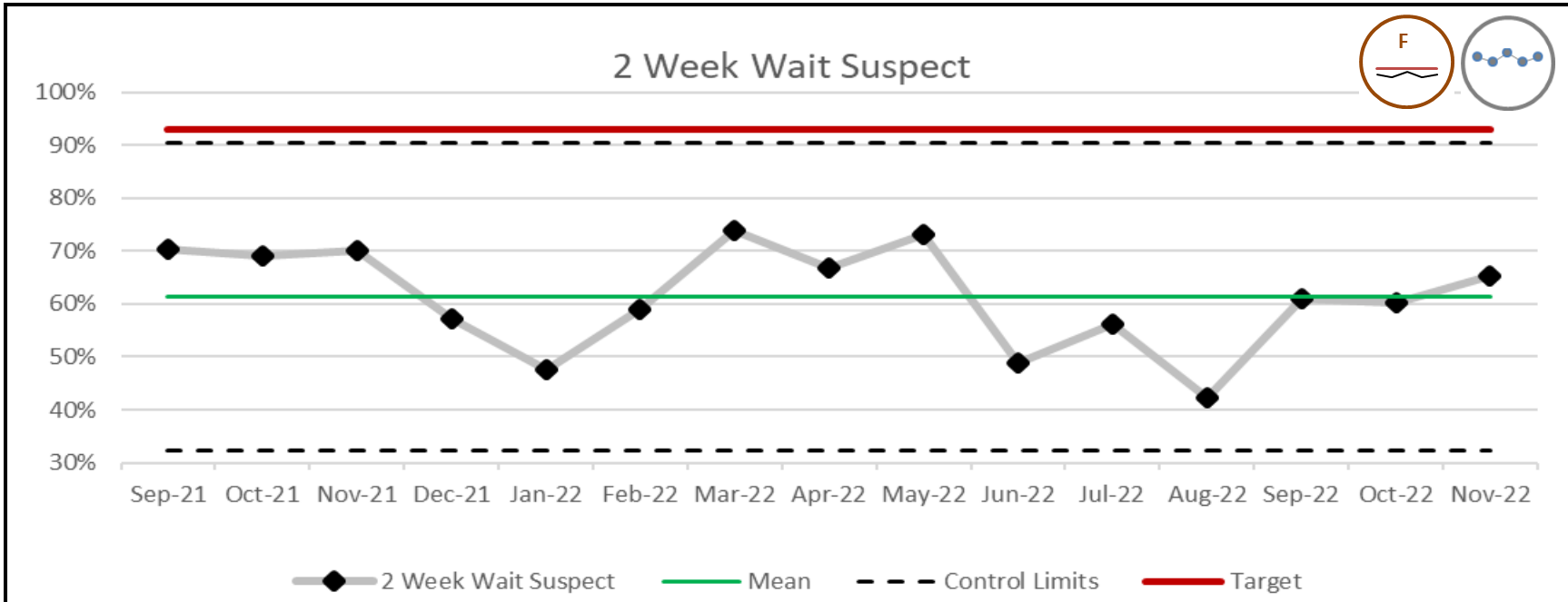


Nov-22
65.29%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 65.29% against a 93% target.

Issues:

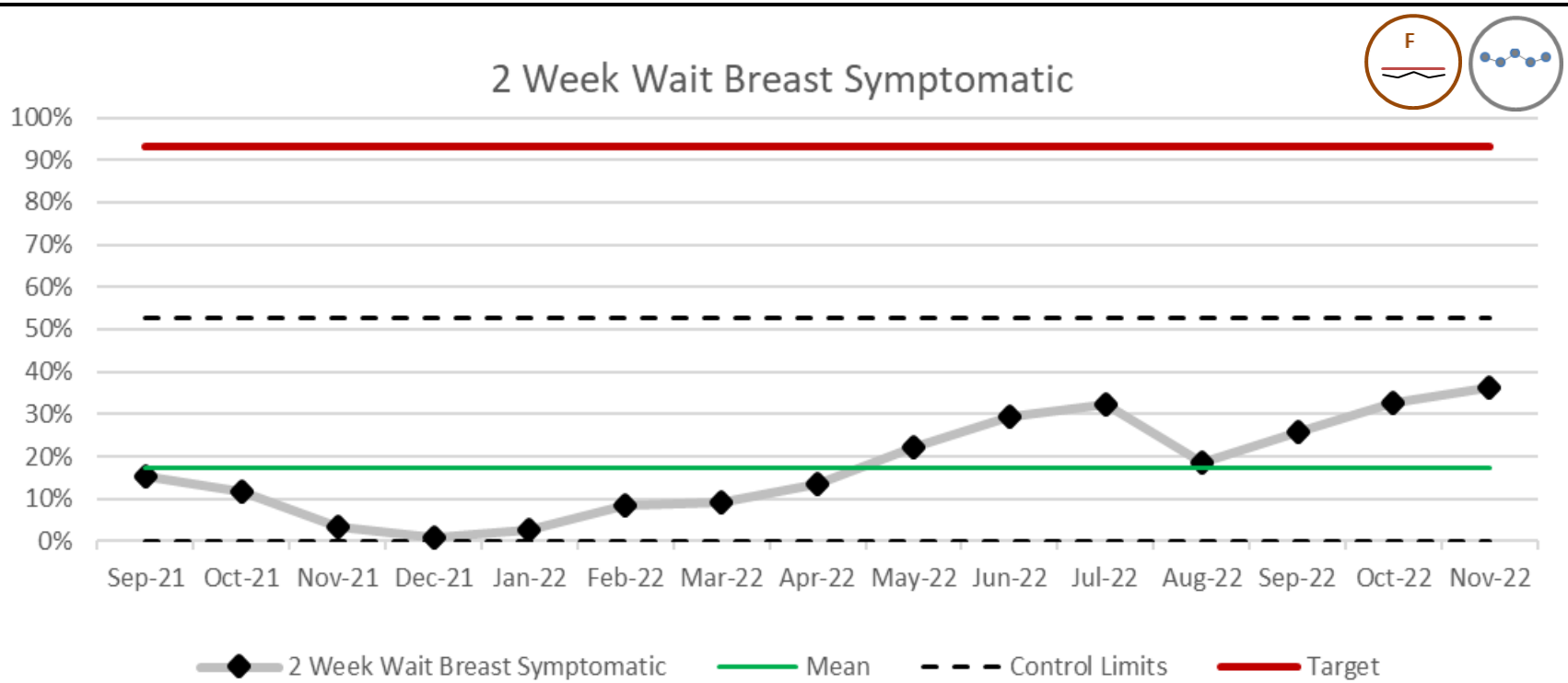
Patients not willing to travel to where our service and/or capacity is available.
Nurse Triage / CNP capacity issues in colorectal specialty.
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with 25% of the Trust's November 14 Day breaches within that tumour site.
Of greater concern in November was skin performance which accounted for 36% of the Trust's 14 day breaches. Capacity has been limited due to clinical, nursing and administrative staff sickness.

Actions:

A follow-up Gynae oncology strategy meeting date is scheduled for 03/02/2023. Referral triage by the Gynae CNS team and referral redesign work is underway to address 1st OPA capacity challenges.
UGI Referral and Triage processes are being reviewed and a Gap Analysis was supported by the ICB has been completed. A bid is being developed for UGI CNS to triage at the start of UGI pathway.
Haematology is in fragile services due to vacancy/capacity. EMAP work has started. Delays in booking and utilisation of 2ww slots are being addressed and C&A training continues.
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.
Increased referrals over the summer, along with unprecedented staff sickness levels impacted Dermatology performance.

Mitigations:

Within the respiratory specialty, work is ongoing to move Spirometry into Community Diagnostic Centres.
3 Respiratory consultant posts have been recruited to across LCH and PHB with start dates TBC. An ongoing BC for increase in consultant workforce to 10-15 consultants is underway.
A Demand and Capacity deep dive has been completed with a number of improvements having been undertaken to smooth out Dermatology booking processes.



Nov-22
36.15%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 36.15% against a 93% target.

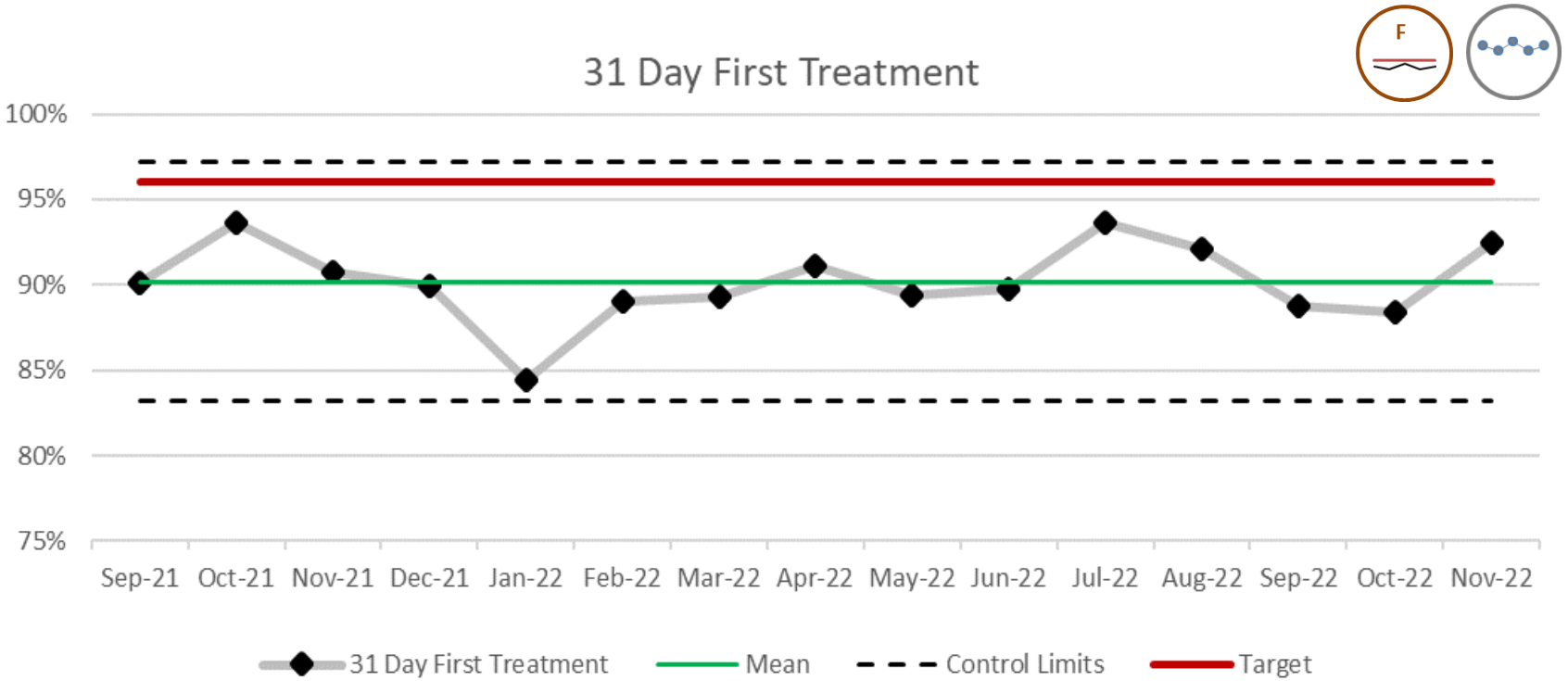
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Nov-22
92.48%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

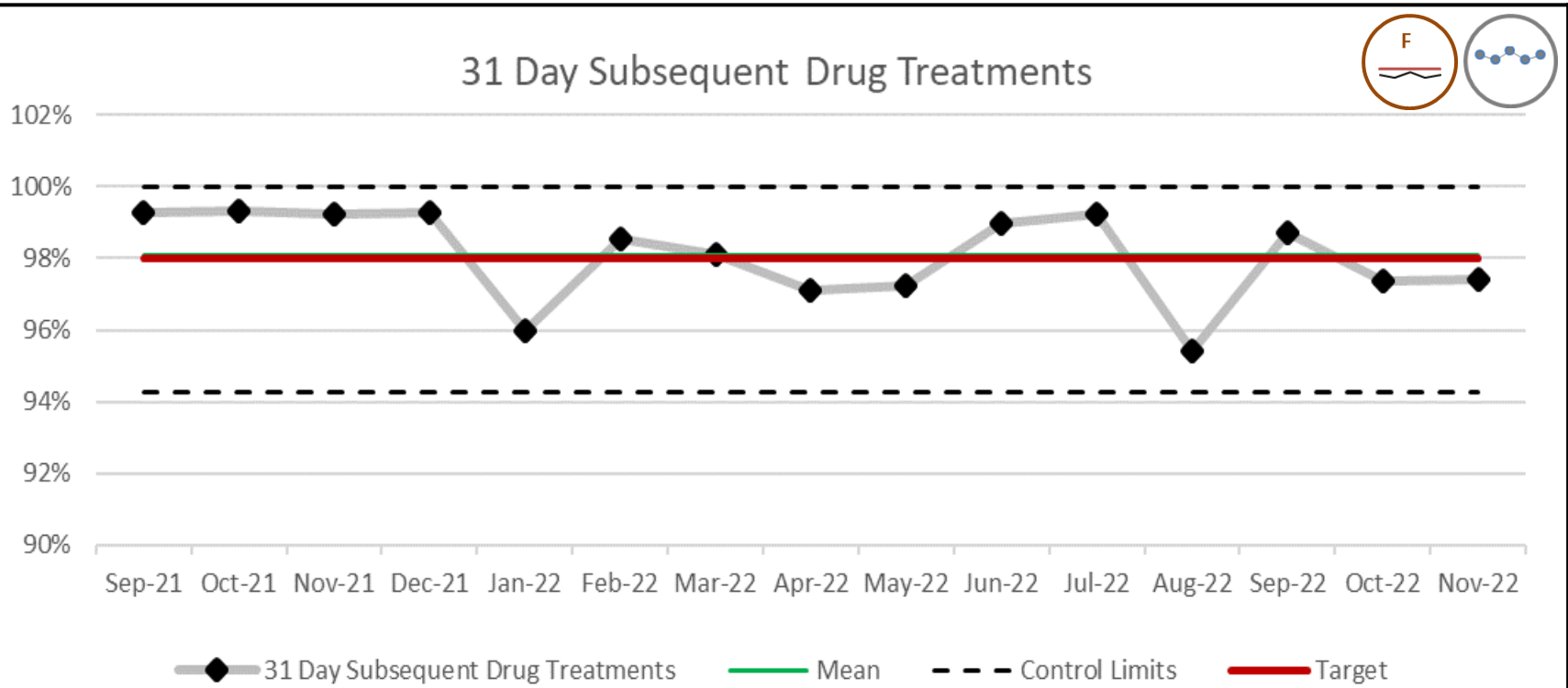
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 92.48% 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.
Work has commenced on building the new theatres at Grantham.
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity.
For Colorectal, a Deep Dive and pathway analysis is underway, supported by ICB colleagues. The subsequent work streams emerging from this are ongoing.

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.



Nov-22
97.40%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

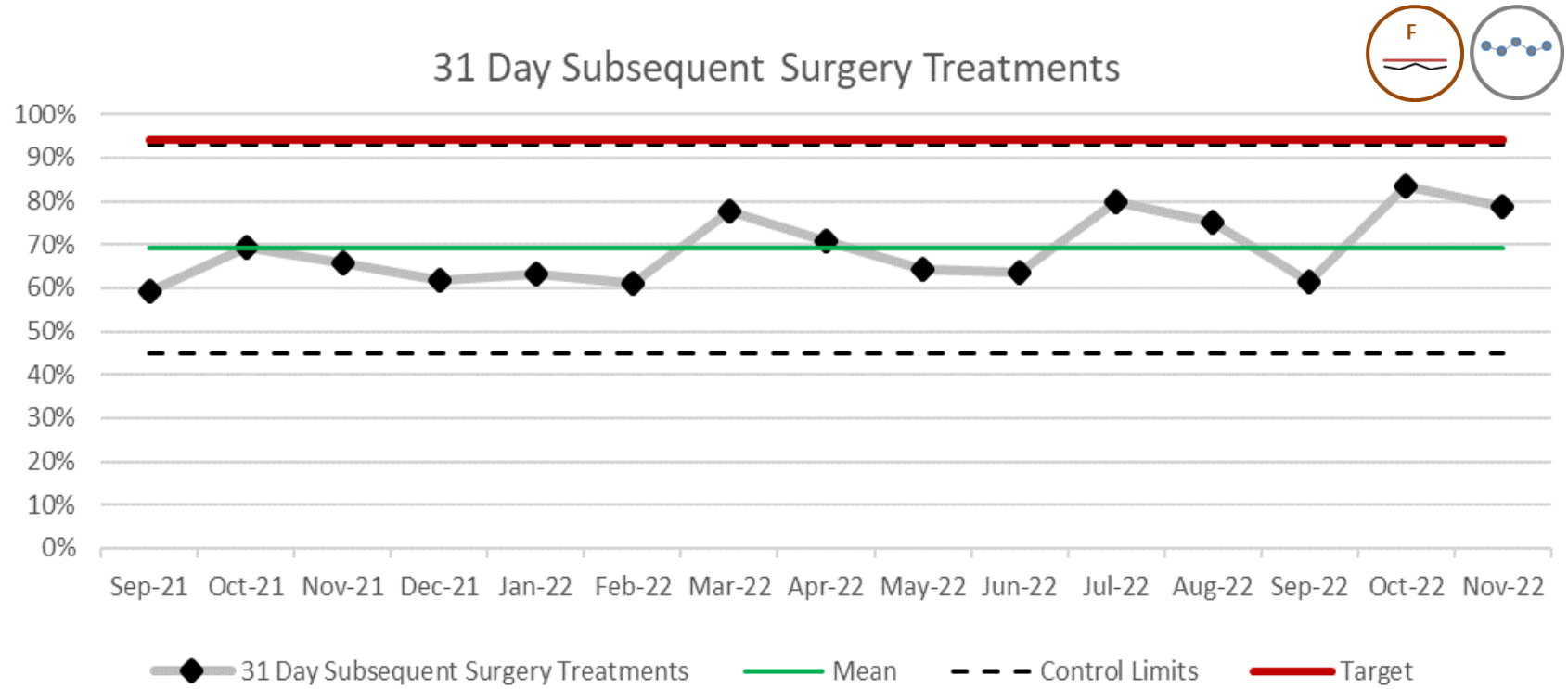
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was drugs.

What the chart tells us:
We are currently at 97.40% 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.



Nov-22
78.79%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

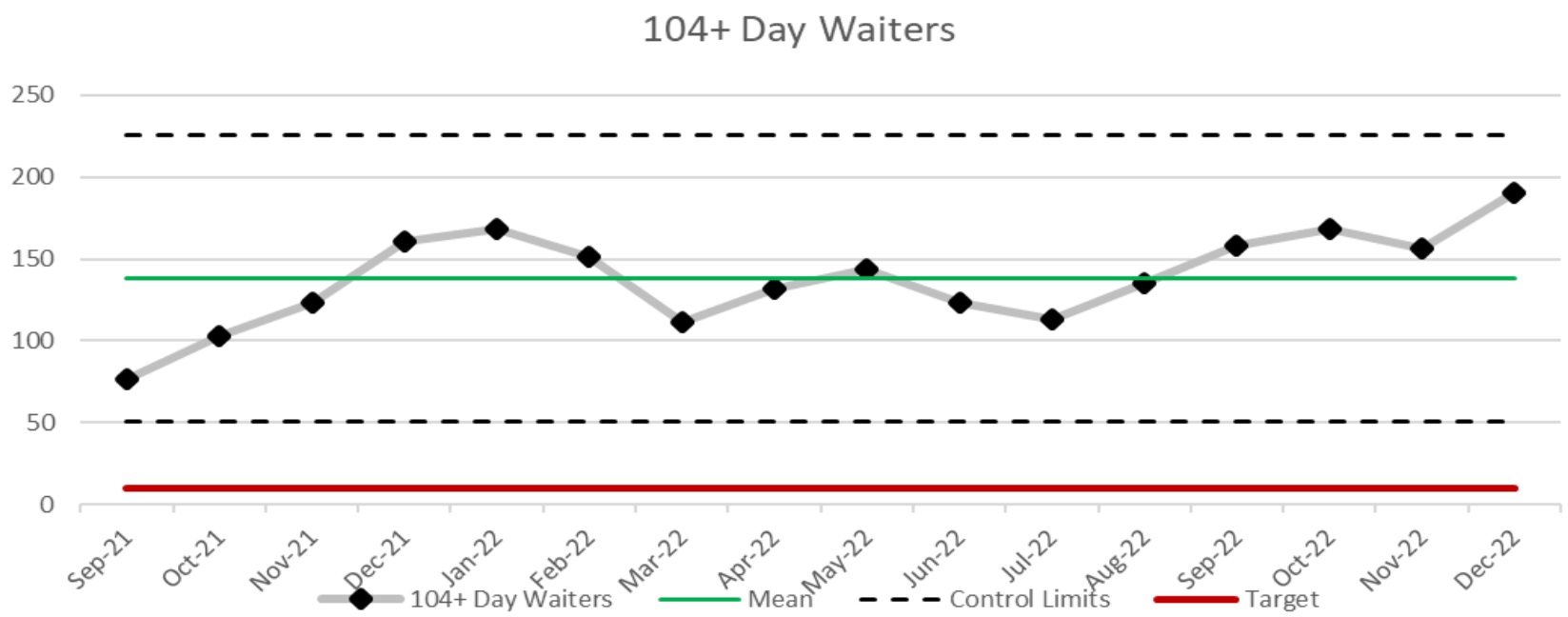
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was surgery.

What the chart tells us:
We are currently at 78.79% 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.



Dec-22
190
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 12th December the 104 Day backlog was at 190 patients. The agreed target is <10.

There are four tumour sites of concern
Colorectal 126 (majority awaiting diagnostics, outpatients and clinical review)
Urology 23
Upper GI 17
Lung 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 19% 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

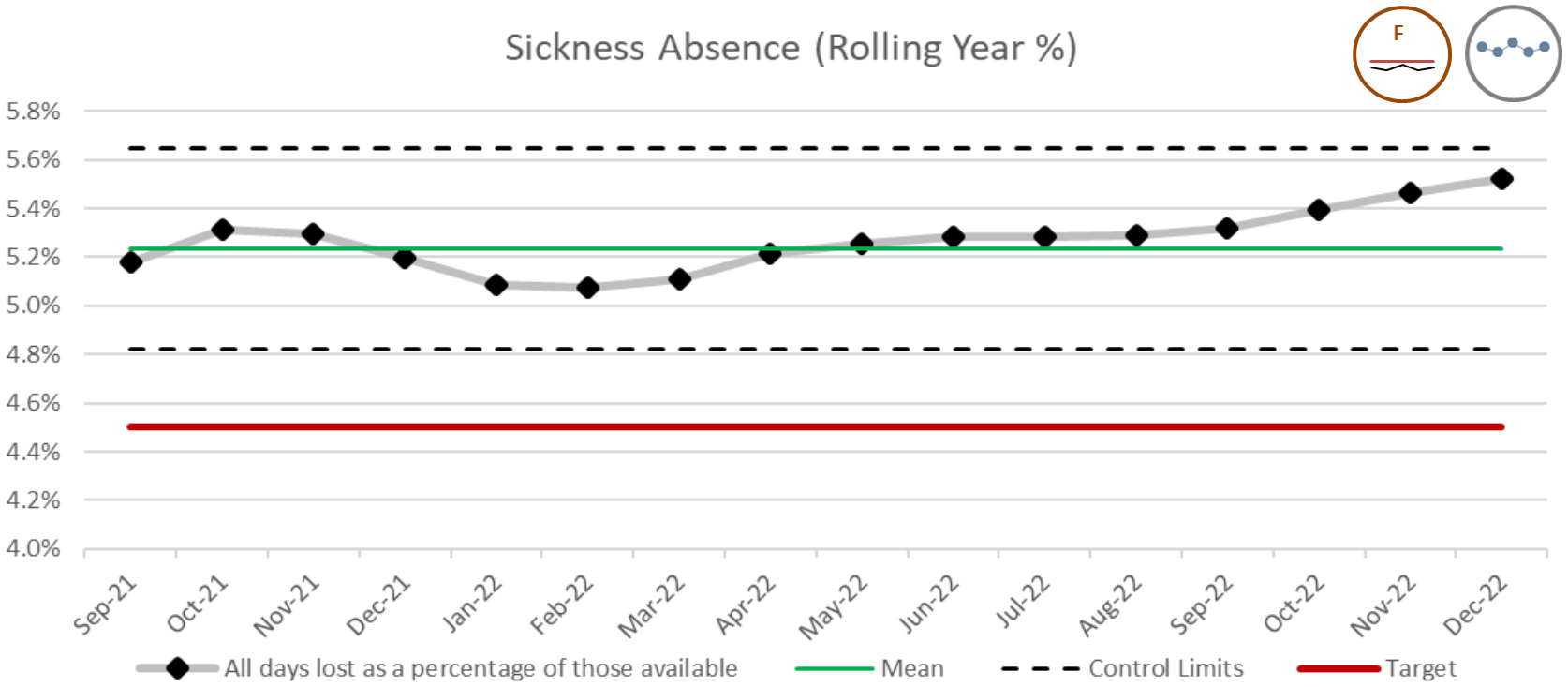
PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-22	Nov-22	Dec-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	89.09%	90.01%	89.78%	89.71%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	9.31%	8.77%	8.98%	10.23%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.39%	5.46%	5.52%	5.34%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	14.48%	14.18%	13.79%	14.61%		F	A	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	62.05%	63.26%	63.74%	60.15%		F		

See Executive Scorecard section for relevant for narrative failing metrics above.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-22
5.52%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The rate has increased by 0.13% to 5.52% which is still above the target of 4.5%.

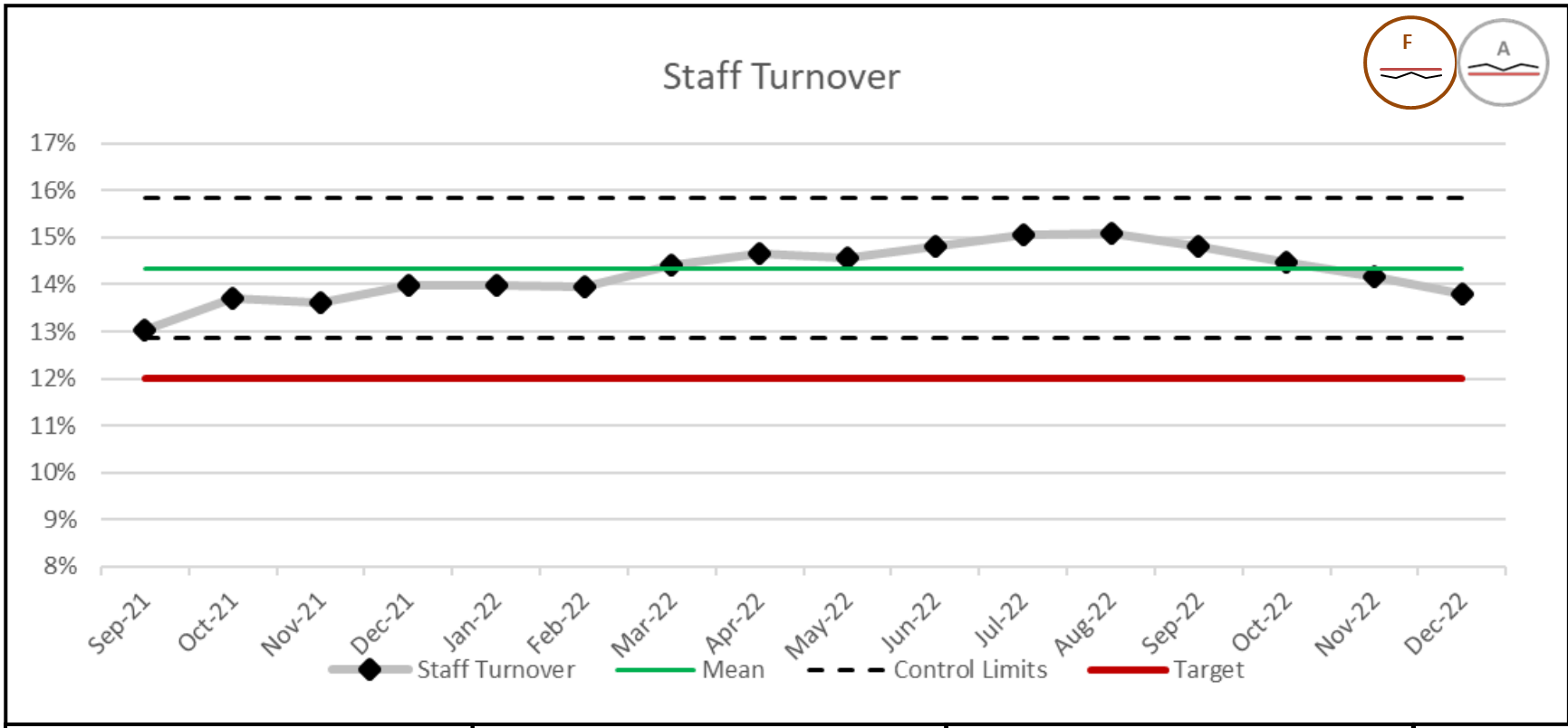
Issues:

- We have experienced an increase in the number of Covid absences during this winter period alongside the flu virus. This continues to be monitored daily.
- Stress & Anxiety still remains the top reason for absence, followed by other MSK problems.

Actions:

- Extensive support has been provided during the Critical Incident periods by the ER and AMS Teams completing call backs on behalf of managers, to support the return to work of absent staff and in providing daily absence data reports to the Gold Command Team. This has resulted in a positive impact on the absenteeism numbers across this period.
- Recruitment is continuing at pace within the new Divisional HR Teams which will have a positive impact in supporting the management of all absence moving forwards across the Trust.

Mitigations:
See actions
NB: Gaining full engagement in the use of AMS means we will see an increase in the absence rate before we see an improvement due to accurate, full reporting.



Dec-22
13.79%
Variance Type
Metric is currently experiencing Special Cause Variation – above the trend
Target
12%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

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

What the chart tells us:
Whilst turnover rate has fluctuated there has been a decrease from 15.6% in July 2022 to 13.79% in December 2022

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:

- The Culture and Leadership Programme has recruited and is currently training a number of Cultural Ambassadors
- A People Promise Manager dedicated to ULHT is focussing on retention
- A large-scale piece of work around flexible working is being delivered under the People Promise
- Leadership and management training programmes specific to divisions started in July 22

Mitigations:
See actions

Financial Position Month 09 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

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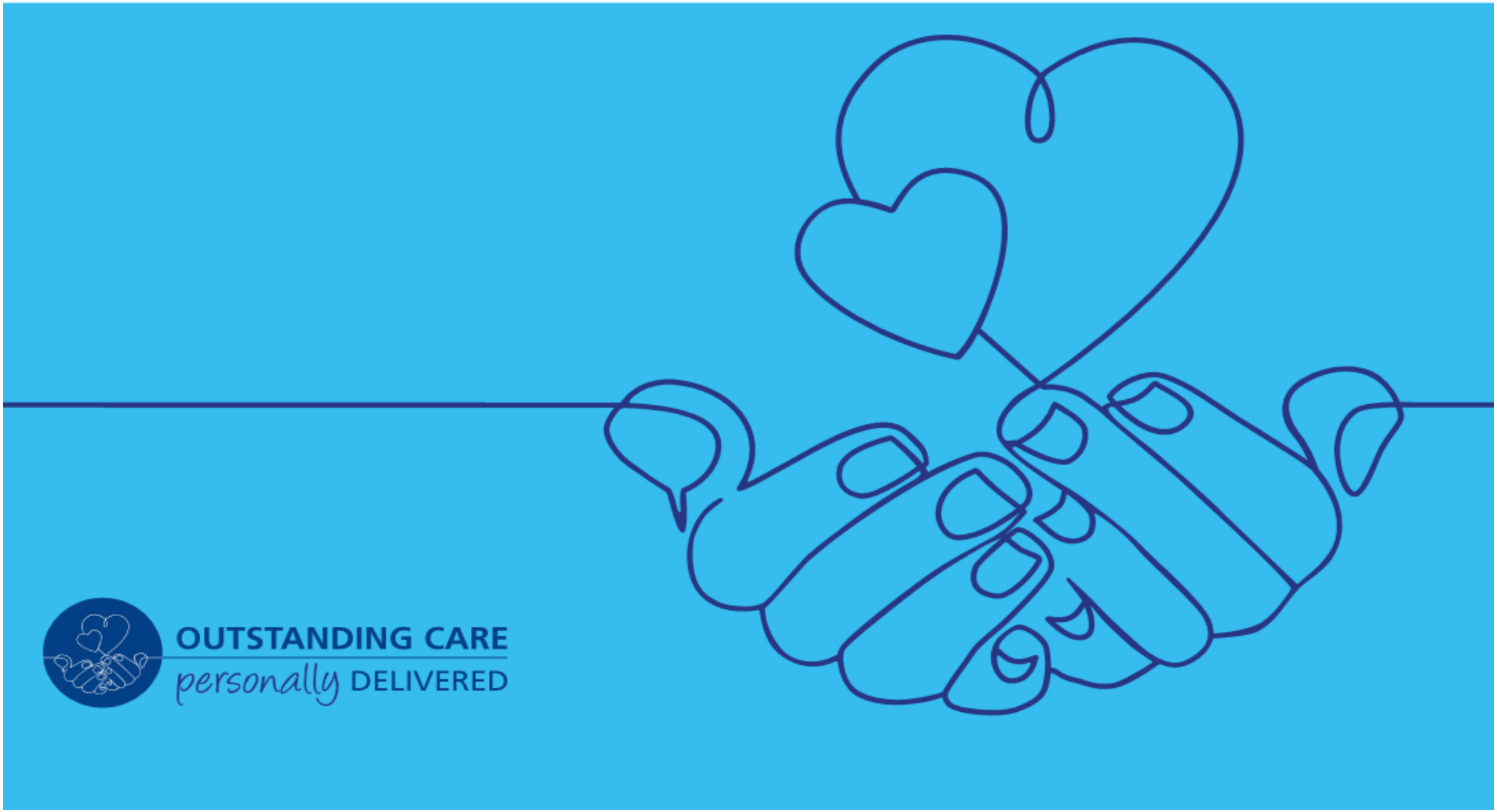
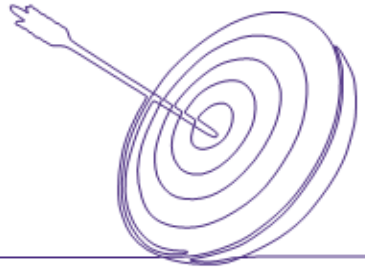


Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)

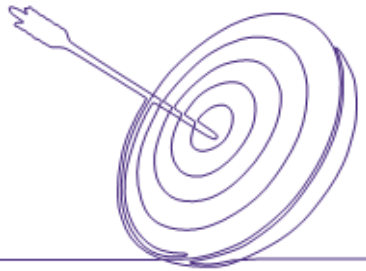


United Lincolnshire Hospitals NHS Trust

Adjusted financial performance	Current Month			Year to Date		
	£'000	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	52,455	54,528	2,073	472,202	491,483	19,281
Other operating income	2,808	2,946	138	27,209	31,784	4,575
Employee expenses	(36,999)	(39,314)	(2,315)	(327,308)	(355,360)	(28,052)
Operating expenses excluding employee expenses	(17,678)	(20,916)	(3,238)	(166,936)	(176,951)	(10,015)
OPERATING SURPLUS / (DEFICIT)	**586**	**(2,756)**	**(3,342)**	**5,167**	**(9,044)**	**(14,211)**
NET FINANCE COSTS	(641)	(433)	208	(5,732)	(4,030)	1,702
Other gains/(losses) including disposal of assets	0	(1)	(1)	0	128	128
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(55)**	**(3,190)**	**(3,135)**	**(565)**	**(12,946)**	**(12,381)**
Remove capital donations/grants/peppercorn lease I&E impact	55	44	(11)	565	465	(100)
Adjusted financial performance surplus/(deficit) including PSF as per accounts	**0**	**(3,146)**	**(3,146)**	**0**	**(12,481)**	**(12,481)**
Less gains on disposal of assets	0	0	0	0	(144)	(144)
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**0**	**(3,146)**	**(3,146)**	**0**	**(12,625)**	**(12,625)**

- The table above shows that the Trust delivered an adjusted deficit of £3.1m in M9 (£3.1m adverse to plan) and YTD delivered an adjusted deficit of £12.5m (£12.5m adverse to plan).
- The table also shows that after removing gains from disposals of £0.1m, the Trust delivered a YTD deficit of £12.6m in relation to system achievement (£12.6m adverse to plan).
- The M8 position included funding of £5.0m in relation to the YTD slippage on CC2H and £0.6m in relation to the YTD excess cost of the pay award; excluding this funding the position would have been a deficit of £2.4m which was in line with the most likely case forecast for M8.
- The Trust's Most Likely Case forecast is for a deficit of £17.4m; the deficit of £3.1m in Month 9 is £0.4m higher than expected by the most likely case forecast and means that YTD the Trust is £0.3m adverse to forecast.
- CIP savings of £9.8m have been delivered YTD, or £8.1m (45.0%) adverse to planned savings of £17.9m.

Finance Spotlight Report
(Key areas of focus - Income)



United Lincolnshire Hospitals NHS Trust

The Income position is £23.9m favourable YTD to plan; this includes:

- **NHS Patient Care income contract - favourable variance of £19.0m**; this includes £7.5m pay award funding (net of NI reduction), over performance of £2.7m re Variable Drugs (Lincs and NHSE) for which there will be an offset in Non Pay, £1.1m of NHS England prior year income for the true-up, and £0.5m mutual aid income for working being undertaken for Leicestershire ICB in T&O and £115k of other variable charges to providers and devolved administrations). In addition, the ytd position now includes £5m of funding to compensate the Trust for beds that have not yet closed as a result of the CC2H scheme, £668k of winter funding, £800k of digital and cyber funding, and another £382k of other allocations across a number of schemes. £401k 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 £1.6m to plan** including £0.3m notional income re the apprenticeship levy.

- **Income in respect of employee benefits accounted for on a gross basis – favourable variance of £0.5m.**

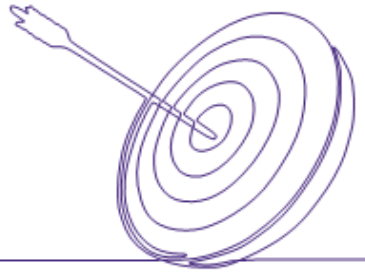
- **Non-Patient Care services - £0.5m favourable to plan.**

- **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 £0.1m**

- **Other miscellaneous movements – favourable variance of £0.4m**.

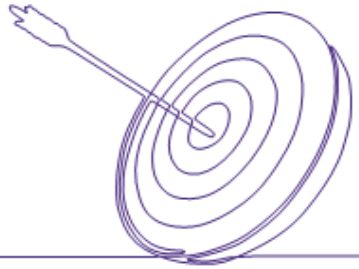
Finance Spotlight Report
(Key areas of focus - Pay)



United Lincolnshire Hospitals NHS Trust

- **The YTD pay position is £28.1m adverse to plan including under delivery on Pay CIP of £7.5m.**
- Actual pay expenditure in December of £39.3m was £0.5m higher than £38.8m in November inclusive of an accrual of £0.6m for Bank Holiday enhancements.
- The increase in actual pay expenditure in December was driven by the accrual for Bank Holiday enhancements.
    - **Substantive pay is £4.5m adverse to plan (inclusive of £1.2m of technical CIP delivery)**
        - Expenditure of £31.1m in December is £0.1m higher than expenditure of £31.0m in November; the impact on substantive Pay of an accrual of £0.5m for Bank Holiday enhancements was largely mitigated bottom line by the fact November included a number of non recurrent items i.e. APA arrears in November of £0.3m and other arrears in November of £0.1m.
    - **Agency pay is £18.3m adverse to plan**
        - Expenditure of £4.0m in December is £0.1m higher than expenditure of £3.8m in November; November, though, included £0.3m non recurrent benefit as a result of data cleansing.
        - YTD efficiency savings of £1.7m in Agency Pay are £10.6m adverse to plan; the YTD position also reflects higher than planned bed numbers, sickness levels & vacancies.
    - **Bank Pay is £5.2m adverse to plan**
        - Expenditure of £4.2m in December is £0.3m higher than expenditure of £3.9m in November; Medical bank was £0.2m higher driven by the rate card increase implemented from 12 December.

Finance Spotlight Report
(Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

Non Pay

- The YTD Non-Pay position is £10.0m adverse to plan including under delivery on CIP of £1.6m; £1.9m 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, £0.8m re System Digital & Cyber, £0.5m re mutual aid, and £0.2m re a one off adjustment re Bad Debt.
- Non Pay expenditure in December of £20.9m was £1.1m lower than £22.0m in November; this favourable movement was mainly driven by a reduction of £1.2m in High Cost Drugs expenditure.

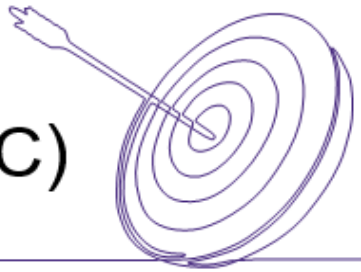
CIP

- The original financial plan assumes that the Trust will deliver CIP savings of £25m (3.6%) in 2022/23; the plan resubmission increased the total CIP savings requirement by £4.0m.
- The financial plan assumed CIP savings delivery of £17.9m by the end of month 9; actual savings of £9.8m (55.0%) have been delivered, such that YTD delivery is £8.1m (45.0%) adverse to plan.

Capital

- Capital funding levels for 2022/23 agreed through Trust Board & FPEC show a plan of c£37.5m; this represents a £5.7m increase compared to the plan reported last month; this increase comprises of additional allocations of c£5.3m from Frontline Digitisation for ePR and c£0.4m from NHSE Diagnostic for Mammography; Capital spend incurred YTD equates to c£15.7m.

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



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Cash

- The November 2022 cash balance is £41.3m; this is a decrease of £47.0m against the March year-end cash balance of £88.3m. Significant inroads have now been made into creditor backlogs following the August cyber attack. Average monthly payments of £40m were made between October - December, compared to an average of £25m in the 12 months pre-cyber attack.

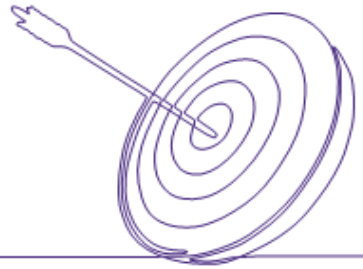
- Whilst current cash levels remain comfortable and will remain so through to 31 March 2023; the position will narrow as we move into 2023/24 and will require careful management of cash and working capital.

BPPC

- The BPPC performance for the nine months to December was 77% / 70% by value / volume of invoices paid (appendix 5d); this compares to the full year performance in 2021/22 of 89% / 83%.

- Performance during December itself was 85% / 75%. 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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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

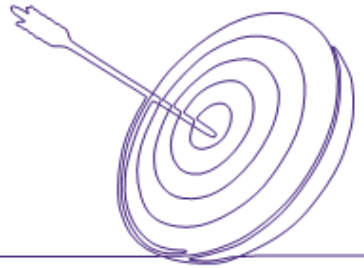
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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	DEC 2022
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	0.92
Capital service cover rating	4	4	4	1	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(8.22)
Liquidity rating	4	4	1	1	3
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(2.39%)
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%	(2.39%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	4

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

Balance Sheet



United Lincolnshire Hospitals NHS Trust

	31-Mar-22	31-Dec-22		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Intangible assets	7,675	6,395	6,459	6,080
Property, plant and equipment	267,753	280,280	271,745	288,806
Right of use assets	12,468	12,222	10,833	11,193
Receivables	1,848	1,848	1,861	1,848
Total non-current assets	**289,744**	**300,745**	**290,898**	**307,927**
Inventories	6,006	6,006	6,878	6,500
Receivables	15,520	23,708	36,716	29,000
Cash and cash equivalents	88,297	43,990	41,322	64,213
Total current assets	**109,823**	**73,704**	**84,916**	**99,713**
Trade and other payables	(89,017)	(62,460)	(72,530)	(83,842)
Borrowings	(2,552)	(3,290)	(2,975)	(2,847)
Provisions	(8,774)	(5,695)	(8,059)	(5,359)
Other liabilities	(1,130)	(1,130)	(9,943)	(1,130)
Total current liabilities	**(101,473)**	**(72,575)**	**(93,507)**	**(93,178)**
Total assets less current liabilities	**298,094**	**301,874**	**282,307**	**314,462**
Borrowings	(13,751)	(12,483)	(11,367)	(11,775)
Provisions	(3,182)	(3,121)	(3,099)	(3,087)
Other liabilities	(11,572)	(11,194)	(11,195)	(11,069)
Total non-current liabilities	**(28,505)**	**(26,798)**	**(25,661)**	**(25,931)**
Total assets employed	**269,589**	**275,076**	**256,646**	**288,531**
Financed by				
Public dividend capital	704,178	710,291	704,180	723,558
Revaluation reserve	29,294	28,772	28,761	28,587
Other reserves	190	190	190	190
Income and expenditure reserve	(464,072)	(464,177)	(476,485)	(463,803)
Total taxpayers' equity	**269,589**	**275,076**	**256,646**	**288,531**

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 £41.3m has remained at a similar level to November.

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.

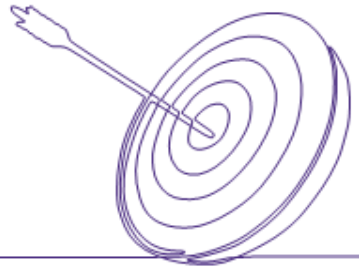
Note 4: The overall level of Trade and other payables at £72.5m remains above historic levels by circa £5-10m. This includes Annual leave (£6m) and other pay accruals.

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

Note 6: The capital programme for 2022/23 will result in asset additions of £36.4m. This is to be funded through internal cash resources but with an injection of £19.4m 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.

The PDC capital cash will be drawn down during February / March.

Cashflow reconciliation - April 2022 – March 2023



NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-22	31-Dec-22		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Operating surplus / (deficit)	549	5,167	(9,044)	4,820
Depreciation and amortisation	15,736	14,503	14,558	19,191
Impairments and reversals	7,340	-	-	-
Income recognised in respect of capital donations	(27)	-	(9)	(50)
Amortisation of PFI deferred credit	(503)	(378)	(377)	(503)
(Increase) / decrease in receivables and other assets	11,261	(8,188)	(21,138)	(13,430)
(Increase) / decrease in inventories	504	-	(872)	(494)
Increase/(decrease) in trade and other payables	9,745	(10,588)	1,299	(4,522)
Increase/(decrease) in other liabilities	(457)	-	8,813	-
Increase / (decrease) in provisions	5,860	(3,110)	(759)	(3,471)
Net cash flows from / (used in) operating activities	**50,008**	**(2,594)**	**(7,530)**	**1,541**
Interest received	34	180	755	1,103
Purchase of intangible assets	(994)	-	(38)	(38)
Purchase of property, plant and equipment	(35,132)	(41,817)	(34,893)	(37,566)
Proceeds from sales of property, plant and equipment	148	-	151	151
Net cash flows from / (used in) investing activities	(35,944)	(41,637)	(34,025)	(36,350)
Public dividend capital received	26,610	6,111	-	19,378
Other loans repaid	-	(403)	(403)	(403)
Capital element of finance lease rental payments	-	(1,792)	(1,611)	(2,250)
Interest paid	(1)	-	-	-
Interest element of finance lease	-	(88)	(82)	(119)
PDC dividend (paid)/refunded	(6,418)	(3,901)	(3,324)	(5,873)
Net cash flows from / (used in) financing activities	20,191	(76)	(5,420)	10,725
Increase / (decrease) in cash and cash equivalents	**34,255**	**(44,307)**	**(46,975)**	**(24,084)**
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**	**43,990**	**41,322**	**64,213**

Note 1: Cash held at 31 December was £41.3m against a plan of £44.0m. This represents a decrease of £47.0m against the March year-end cash balance of £88.3m. Significant inroads have now been made into creditor backlogs following the August cyber attack. Average monthly payments of £40m were made between October - December, compared to an average of £25m in the 12 months pre-cyber attack.

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 £6.9m has largely been offset by the new outflow of cash linked to the income and expenditure deficit and working capital movements.

Note 3: Underlying cash balances remain significantly increased on 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 exceed £50m, 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	*7 February 2023*
Item Number	*Item 13.1*

Audit Committee Upward Report

Accountable Director	*Neil Herbert, Audit Committee Chair*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

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

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

Executive Summary

The Audit Committee met via MS Teams on the 13th January 2023. The Committee considered the following items:

External Audit

The Committee received the external audit progress report. The Committee were advised that detailed planning for the year end audit had taken place and the audit would commence in February. The audit strategy and risk profile for the Trust remained as per last year. The Committee were alerted that the audit would be led by a new Audit Manager.

The Committee received the Trust annual accounts and year end timetable. The Committee were alert to changes in the leadership of the Finance team and asked for assurance that this had been reflected in the timetable and planning. The Director of Finance and Digital confirmed that resilience would be built into the planning to allow for changes in personnel and handovers.

Internal Audit

The Committee noted good progress from the Trust's Internal Audit providers on the delivery of the agreed audit plan. 225 days of the 350 day plan had been delivered. The Committee received eight published audit reports. Four further reviews were in progress due for completion by year end.

The Trust Internal Audit Provider confirmed the resourcing was in place to meet the requirements of the remaining audit plan despite the continuing changes in the team.

The Committee noted the changes to the audit plan which meant that reviews of training and appraisals had been removed and replaced by a review of CAS and data quality. This had been agreed in recognition of the timing alongside the ongoing People and OD restructure. The decision was supported by the chair of the People and OD Committee. The Committee supported the proposed changes to the plan.

In reviewing follow up of audit recommendations the Committee noted that 11 actions had been implemented since the last Committee. There were 20 live actions with 19 overdue of these 1 high risk, 10 medium risk and 8 low risk. This remained an emphasis for management, and it was important that ownership was maintained despite changes in personnel. The Committee would continue to seek assurance on the level of grip and control over progressing agreed actions through the assurance received from the monitoring by the Executive Leadership Team and Assurance Committees. There was a focus on moving the number of outstanding audit recommendations to single digits and bringing updates on all high rated risks and those over six months overdue.

The Committee was pleased to note significant improvements in the two follow-up reviews.

The Committee discussed the Safeguarding Audit and the Chair of the Quality Governance Committee confirmed that the committee had received an action plan and assurances in response to the recommendations.

Counter Fraud

The Committee reviewed and approved the Local Counter Fraud Specialist's Progress report.

The Committee noted that the Trust were currently amber in relation to the fraud metrics and the recommendation from the Local Counter Fraud Specialist was that these would move to green at year end.

The work on the fraud risk register was noted.

Compliance Report

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

The Committee noted the removal of the final CQC section 31 condition. The Committee recognised the work in achieving this and the progress this reflected of the Trust.

The Trust position in relation to waivers of standing orders was much improved with lower volume and value of waivers.

Risk Management

The Committee have continued to request assurance on actions being taken to strengthen controls over risks and received a progress report on the risk register reconfiguration to support improvement.

The rigour being brought to risk management through the Risk Register confirm and challenge group was noted. The output of the Risk Management internal audit was noted with significant assurance with some improvement required confirming the progress made with risk management.

Policies Update

The Committee received an update in relation to the policy management project that offered limited assurance.

The Committee noted the resource that was in place and improved progress, offering a clearer understanding of the position. The Committee noted the lack of progress from escalation to the Divisional Performance Review Meetings. The Committee agreed actions which they expected to be advised of progress against at their next meeting.

Board Assurance Framework

The Committee confirmed that the Board Assurance Framework remained relevant and effective for the Trust with focus on the appropriate risks. The Committee noted the assurance ratings and the reviews which had been completed through Assurance Committees.

Objective 2c – Well Led Services was the remit of the Audit Committee and after discussion and despite noting some progress it was agreed the amber rating for the objective would remain.

The Committee noted that the Trust had been subject to an internal audit review of the Board Assurance Framework during the 2022/23 financial year and that this had resulted in an audit conclusion of significant assurance with some improvement required confirming the progress made in the design and effectiveness of the BAF.

Internal Audit Tender

The Committee noted progress with the tender for internal audit services to be contracted from April 2023. The tender was being offered for all three provider organisations in Lincolnshire and the ICB.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*Tuesday 7 February 2023*
Item Number	*Item 13.2*

Strategic Risk Report

Accountable Director	*Dr Karen Dunderdale, Director of Nursing & Deputy Chief Executive*
Presented by	*Kathryn Helley, Deputy Director of Clinical Governance*
Author(s)	*Paul White, Head of Risk & Governance*
Report previously considered at	*Trust Leadership Team (TLT)* *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	*Moderate*

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 risk profile remains the same as per the previous report due to the cancellation of the Risk Register Confirm & Challenge meeting in December, due to the impact of operational pressures and planning for industrial action on members' availability, and are as follows:

- The highest rated quality and safety risks 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.

- The highest rated workforce risks within the Trust at present relate to:
    - Recruitment and retention of clinical staff;
    - The impact of organisational culture on behaviours;
    - Potential for significant service disruption due to the threat of large-scale industrial action.

- The highest rated finance, performance, information and estates risks within the Trust at present relate to:
    - Potential for a major fire;
    - Compliance with fire safety regulations;
    - 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

- There are several new or increased Very high and High rated risks due to be presented to the Risk Register Confirm & Challenge Group for validation this month

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. **The meeting scheduled for December 2022 was cancelled due to the impact of operational pressures and planning for industrial action on members' availability.**

2. Trust Risk Profile

2.1 There were 321 active and approved risks reported to lead committees this month. This is 67 more than were reported last month, due primarily to the completion during the month of work to align all active risks to the appropriate strategic objectives and lead committee.

2.2 There were 20 risks with a current rating of Very high risk (20-25) and 22 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%)	**58** (18%)	**220** (68%)	**22** (7%)	**20** (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 8 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
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 appropriate for patient care for example the in the back of an ambulance or patients receiving care in the designated 'fit 2 sit' area, resulting in potential serious harm.	Very high risk (25)	Estates increase at Lincoln County ED will support the reduction in handover delays. System work to reduce the number of ambulance conveyances to EDs. Work within ULHT to support alternate destinations to ED for ambulance conveyances e.g. SEAU / Paeds / SDEC.	20/12/2022
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 (25)	Estates increase at Lincoln County ED. 'Breaking the Cycle' approach in place to manage high levels of demand.	20/12/2022
5016	If there is not sufficient flow through the Trusts Emergency Departments due to demand outstripping capacity and insufficient availability of beds in the hospitals it may result in increased likelihood of long waits in the departments for patients, increase likelihood of patient harm, delays in care and poor patient experience	Very high risk (25)	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	20/12/2022
4877	If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (non-admitted / outpatients) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	21/11/2022

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 potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	21/11/2022
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	21/11/2022
4624	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	Very high risk (20)	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents, monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	05/12/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm and a poor clinical outcome	Very high risk (20)	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	20/12/2022
4622	If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients.	Very high risk (20)	- 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)	19/12/2022 (Proposed reduction to 12 Moderate)

Strategic objective 1b: Improve patient experience

2.4 There were no Very high risks and 2 High risks reported in relation to this objective.

Strategic objective 1c: Improve clinical outcomes

2.5 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
4828	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust. Update 4th July 22- 26th July, ePMA functionality version 10.21 will be upgraded. ePMA pilot from 13/09/22, full Trust wide roll out- mid Oct.	05/01/2023

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.	15/12/2022
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.	12/12/2022

2.6 The following QGC-aligned risks are awaiting confirmation from the Risk Register Confirm & Challenge Group (RRC&CG) in order to be reduced in rating below High / Very high risk:

- Learning lessons to improve patient safety (20, Very high to 12, Moderate).
- Radiology support for symptomatic and breast screening services (15, High to 12, Moderate)
- Grantham Hospital MRI scanner patient transfer risk (15, High to 8, Moderate)

2.7 There are also several new or increased High and Very high risks awaiting validation by the RRC&CG, before being included in reports to the committee. This includes the provision of epilepsy services in Paediatrics, which was reported to the committee in December but requires discussion at the RRC&CG. With the cancellation of the December RRC&CG meeting due to operational pressures, these have now been included on the January 2023 agenda and any updates will be presented through the relevant subcommittees in February.

Strategic objective 2a. A modern and progressive workforce

2.8 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.	09/11/2022 (currently under review by the Director of People)

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

2.9 There were 2 Very high risks and 3 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	09/11/2022 (currently under review by the Director of People)
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.	07/11/2022 (currently under review by the Director of People)

Strategic objective 2c: Well-led services

2.10 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

2.11 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.	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 - 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

2.12 There were 3 Very high risks (20-25) and 4 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	01/11/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	20/12/2022
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.	20/12/2022

Strategic objective 3c: Enhanced data and digital capability

2.13 There were no Very high risks (20-25) and 2 High risks (15-16) reported in relation to this objective.

Strategic objective 3d: Improving cancer services access

2.14 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

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

Strategic objective 3f: Urgent Care

2.16 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

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

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

2.18 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

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

2.20 There were also 3 FPEC-aligned risks with a provisional rating of High (15-16) that are awaiting validation by the Risk Register Confirm & Challenge Group (RRC&CG) prior to being included in report to the committee and Trust Board. However, because the December meeting was cancelled due to operational pressures and preparations required for industrial action these will be included on the agenda in January and any updates will be presented through the relevant subcommittees in February.

2.21 The RRC&CG also plans to carry out a review of High and Very high risks which will include giving consideration to the realignment of some existing risks to strategic objectives 3d, 3e and 3f.

3. Conclusions & recommendations

3.1 The highest rated quality and safety risks 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.

3.2 The highest rated workforce risks within the Trust at present relate to:

- Recruitment and retention of clinical staff;
- The impact of organisational culture on behaviours;
- Potential for significant service disruption due to the threat of large-scale industrial action.

3.3 The highest rated finance, performance, information and estates risks within the Trust at present relate to:

- Potential for a major fire;
- Compliance with fire safety regulations;
- 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

3.4 There several new or amended risks that are provisionally rated as High or Very high and are awaiting discussion at the Risk Register Confirm & Challenge Group before being included in regular reports to the appropriate lead committee.

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*7 February 2023*
Item Number	*Item number 13.3*

Board Assurance Framework (BAF) 2022/23

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

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure* • *Confirm the proposed Amber rating of objective 2b – Making ULHT the best place to work*

Executive Summary

The relevant objectives of the 2022/23 BAF were presented to all Committees during November and the Board are asked to note the updates provided within the BAF.

Updates provided to the Committees and offered to the Board are identified by green text.

Following review through the Committees, the People and Organisational Development Committee is proposing that objective 2b – Making ULHT the best place to work be rated from Red to Amber.

The Committee took the decision at the December Committee meeting and continued to review and rate the objective as Amber in January whilst awaiting confirmation of the change by the Board.

The following assurance ratings have been identified:

Objective		Rating at start of 2022/23	Previous month (December)	Assurance Rating (January)
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	**N/A**	**Amber**	**Amber**

	diagnostics to constitutional standards			
3f	Urgent Care	**N/A**	**Red**	**Red**
4a	Establish collaborative models of care with our partners	**Amber**	**Amber**	**Amber**
4b	Becoming a University Hospitals Teaching Trust	**Red**	**Red**	**Red**
4c	Successful delivery of the Acute Services Review	**N/A**	**Amber**	**Amber**

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2022/23 - January 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 Failure to manage radiation safely	5016 4804 5057 4624 4877 4878 4879 4789 4935 4750 4779	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.		

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			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	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 Estares and Facilites 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		
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG) One central monitoring process now in place.	Review of compliance metrics required.	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads(CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		

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						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		
						Quality Accreditation and assurance programme which includes weekly and monthly audits which include feedback on patient experience from patients in the clinical areas.(PEG)	Further development of alignment of findings in audit data to patient experience surveys overarching plan and other sources of patient experience information. Annual Ward / Dept quality review visits may be paused due to operational pressures in times of extremis.	Head of pt experience can access the audit date. Deep dives into areas of concern as identified in quality metrics dashboard meetings Update reports to PEG and QGC as required. Weekly and monthly audits continue to take place including during times of extremis.	Reports to PEG and upwardly to QGC	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year, which include the patient experience team as part of the visit team. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support.		

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	4701 4724	CQC Caring	Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging. 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	Quality Governance Committee	**Amber**
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting. 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.		
						Clinical Audit Group in place and meets monthly (CAG) with quarterly reports to QGC (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed and workshops planned with leads, led by the Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates meaning that reporting to QGC is not as up to date as expected.	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate Meeting to take place with Medical Director and Audit Leads to discuss role and expectations, however attendance has been impacted by operational pressures.		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4731 4828 4972 4905	CQC Responsive CQC Effective	National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable	Quality Governance Committee	**Green**
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	Not applicable		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down although this is due to recommence.	National reports to be presented at Governance Meetings once produced		
						Specialised services quality dashboards (SSQD)	SSQD data collection now commenced again post Covid. Areas with outliers identified with some plans for improvement, however not all required areas currently have plans.	Continued support from the Clinical Effectiveness Team and requirement to attend CEG and provide update on progress.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	Actions plans not yet received for all necessary areas.	Continued requirement to attend CEG to provide updates.		
						Process in place for implementing requirements of the CQUIN scheme.	Plans now in place for delivery of 2022/23 CQUINs, although assurances not yet received that these are fully implemented.	CQUIN delivery group commenced again.	Quarterly reports to CEG and upwardly reported to QGC	Some gaps identified in reporting processes.	Being dealt with via the CQUIN delivery group		
						Process in place for ensuring high quality of record keeping including Medical Records Group.	Medical Records Group not meeting regularly.	Refocus of the Medical Records Group planned by the new Chair.	Programme of record keeping audits taking place.	Audits do not demonstrate compliance with record keeping standards.	Divisional governance leads to pick up within each area.		
						Process in place for monitoring of and implementation of NCEPOD requirements.	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.				
						Enhance clinical effectiveness by ensuring that care delivered to patients is based on evidence based, best practice leading to improved clinical outcomes			Implementation of the SAFER bundle				

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SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
					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 required to be submitted at the end of January 23.		
						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			

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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		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, paper presented at December POD Committee to provide update on this and the on-going appraisal review.	People and Organisational Development Committee	**Amber**
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff - To be discussed following review of development offer (on hold)					
						Reducing sickness absence - 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.	The introduction of LTS Absence meetings with HRBP's, ER Advisers, Divisional Leads and Occ Health have commenced. E&F and Medicine Divisions has start the learning journey through a People Management Essentials (PME) sessions. This covers a section on AMS and management responsibilities. AMS project lead with present at January 2023 TSSG and Nursing/AHP Workforce Transformation Group. The AMS audit November 2022 has presented key findings on accountability of managers and changes to the absence policy are required to improve reporting of sickness and absence follow up. Due to critical incident status the HR team have supported clinical managers with making call backs to staff who report being absent through the AMS system.		
						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			

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						Creation of robust Workforce Plan •Values based recruitment and retention •Maximising talent management opportunities •Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn' 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			
						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	CQ workshops continue to be delivered however due to critical incident status non essential training has been paused including CQ. First cut of the staff survey results are under embargo at the moment however early indicators show a huge improvement in the Trust engagement scores. First review to be tabled at next PODC meeting.		

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.			Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care			People and Organisational Development Committee	**Amber**
						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.		
						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			

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2c	Well led services	Chief Executive	Risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes 4 sessions during Oct / Nov 21 Risk Register Confirm and Challenge Group ToRs Upgrade to datix system Full Risk Register review	Policy and Strategy document updated	Complete	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**
						Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6			
						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy management reviewed and updated	Move of policies in to SharePoint reliant on progress with Trust intranet. Timeline delayed through Covid Divisional breakdown of policies requiring review being shared with PRMs	Review of document management processes - Complete New document management system - SharePoint - In place Reports generated form existing system - Complete All policies aligned to division and directorates - Complete Single process for all polices clinical and corporate - Complete	Fortnightly ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
						Ensure system alignment with improvement activity							

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SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4648 - Fire Safety 4647 - Fire Safety 4858 - Water	CQC Safe	Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.	Finance, Performance and Estates Committee	**Amber**
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments PLACE Full assessments starting in September 22	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response. With PLACE Full assessments starting in September gaps will be closed further.		
						Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID	Improvement teams have started in 2022/23 working through value for money and financial efficiency schemes included development of Housekeeping, Security and Portering Business Cases for future models	MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Groups will report through to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not with Annual Reporting providing assurance and gap analysis on all AE domains.		

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						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report Letter from British Safety Council on External Review				
						Implement Year 1 of our Estates Strategy	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	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 - Meidcal 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				
						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		

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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 opportunites with Northampton General Hospital who provide RPA Services					
						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 (Daily reviews) of key concern specialties increase the scrutiny of reporting and pathway performance led by COO	Finance, Performance and Estates Committee	**Red**

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3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer	Insufficient clinical or physical capacity, insufficiently optimised pathways		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Planned Care Integrated Improvement Programme and Assoc Governance System Planned Care and Diagnostic Group	Recovery post COVID and risk of further waves Specialty strategies not in place Elective Theatre Programme Transformation team not yet established.	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 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			Finance, Performance and Estates Committee	**Amber**
3f	Urgent Care	Chief Operating Officer	Insufficient clinical capacity or expertise, inefficiently configured services, failure of system partners to provide capacity or reduce demand to pathway and excessive demand above capacity available		Emergency Care Clinical Indicators (12hr, 4 hour CRTP, 60 minute decision and 15 minute triage)	Daily System control meetings in collaboration with 3x daily internal capacity meetings. Integrated Improvement plan for urgent care and Urgent Care improvement Group. System Urgent Care Partnership Board. LHCC Improvement Programme Board and LHCC Board	Recovery post COVID and risk of further waves Internal professional standards not embedded External dependencies lack of visibility of capacity and system control to move risk/capacity between services. E.g. community care hours, care home ,assessment capacity etc.	External reviews used to identify gaps in services and assess capacity shortfalls. Emergency Care Intensive Support Team, IMPOWER specialist consultants and Dr Ian Sturgess specialist consultant reviews identify control and process and capacity gaps. 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)	Gaps in Early Warning Dashboard Pathway 1 capacity admission avoidance impact, waits and capacity for primary care.	LHCC Programme Board reviewing Early Warning Dashboard - additional reports on progress LHCC Programme Board reviewing progress Weekly CEO Forum review where evidence is and any gaps	Finance, Performance and Estates Committee	**Red**
SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
			Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and		COC Caring	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority specialities for service reviews by July 2022.		
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements in 22/23- (1) continued improvements in patient safety and experience (2) reduce long waiting times for treatment (3)make our people feel valued and supported by improving our culture and leadership	Embedding and sustaining cultural change when we remain operationally challenged with staffing issues etc. Ability to demonstrate quick impact on the cultural change due to various interventions as part of our Outstanding Care Together programme will be limited (as these are multi year/multi factorial projects)	ELT/TLT oversight Board / system reporting	Updated IIP reported at relevant Board Committees	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh		

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4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	Operational pressures and other planning priorities puts an added constraint on time, capacity and headspace to engage with the ICS agenda. Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor institutions		CQC Caring CQC Responsive CQC Well Led	Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain ULHT anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS	Finance, Performance and Estates Committee	**Amber**
						Developing a business case to support achievement of University Hospital Teaching Trust Status	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee	Further understanding of the costs involved to increase size of R&I department and also to develop an R&I facility	R&I team reworking business case with a phased approach		
						Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increase clinical academics by 20 and RCF funding worth £200k within the last 2yrs Further clarification and implications of the changed guidance on univ hospital status required. Funding for Clinical Academic posts and split with UOL to be agreed	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Contract agreed with UOL for Clinical academic posts. UoL have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - linked to roadmap and Research Event to identify specialties. RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position - now amalgamated into the monthly Steering Group with ad hoc meetings between SRO's where needed to discuss funding for Clinical Academics. ULHT have a recruitment roadmap in place which will include some pump prime from vacancies. Additionally a joint Research Event is being planned for Q3 of 2022/23 with the University to identify future areas of collaboration with research and Clinical Academic recruitment.		

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4b	Becoming a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Improve the training environment for students	Understanding of our offer of the facilities required for a functioning clinical academic department	Revision of the library and training facilities to ensure that facilities are fit for purpose for all staff who will require access to training facilities, library, ICT equipment to be able to perform their role. This will be aligned to the UHA Guidance, and will include those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unknown timescales of completion	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.	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