Bundle Trust Board Meeting in Public Session 4 April 2023

	PLEASE NOTE THAT ALL OF THE AGENDA TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE
1	Introduction, Welcome and Chair's Opening Remarks *Chair*
2	Public Questions *Chair*
3	Apologies for Absence *Chair*
4	Declarations of Interest *Chair*
5.1	Minutes of the meeting held on 7 March 2023 *Chair* Item 5.1 Public Board Minutes March 2023v1.docx
5.2	Matters arising from the previous meeting/action log *Chair* Item 5.2 Public Action log March 2023.docx
6	Chief Executive Horizon Scan Including ICS *Chief Executive* Item 6 CEO Update, 040423.docx
7	Patient/Staff Story *Director of Nursing* *Please be aware that sometimes our patient and staff stories can deal with very difficult subjects, which may affect you personally. If you are concerned about this the Trust Secretary can advise you of the subject to be discussed at the start of the meeting.*
7.1	BREAK
8	Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
8.1	Assurance and Risk Report from the Quality Governance Committee inc Committee Annual Report Item 8.1 QGC Upward report March 2023v1.doc Item 8.1 QGC Annual Report 2022-23v1.docx
9	Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
9.1	Assurance and Risk Report from the People and Organisational Development Committee inc Committee Annual Report Item 9.1 POD - Upward Report - March 2023.docx Item 9.1 POD Annual Report 2022-23v1.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 March 2023v1.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 March 2023.docx
13	Risk and Assurance
13.1	Risk Management Report Item 13.1 TB - Strategic Risk Report - April 2023.docx Item 13.1 Appendix A - Risks rated 15-25 - March 2023.pdf
13.2	Board Assurance Framework Item 13.2 Item BAF 2022-23 Front Cover April 2023.docx

Item 13.2 BAF 2022-2023 v28.03.2023.xlsx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 2 May 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.

Minutes of the Trust Board Meeting

Held on 7 March 2023

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Professor 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

Non-Voting Members:
Mrs Sarah Buik, Associate Non-Executive Director
Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration
Ms Claire Low, Director of People and Organisational Development

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mr Damian Carter, Divisional Managing Director
Mr David Smith, Advanced Care Practitioner, Parkinson's – Item 7
Mrs Jennie Negus, Head of Patient Experience – Item 7
Ms Rachel Wright, Sister/Charge Nurse, Neonatal Services – Ward Accreditation
Ms Katy Carr, Matron, Women's Health – Ward Accreditation
Mrs Angie Davies, Deputy Director of Nursing – Ward Accreditation

Apologies
Dr Colin Farquharson, Medical Director
Mrs Vicki Wells, Associate Non-Executive Director
Ms Michelle Harris, Chief Operating Officer

193/23	**Item 1 Introduction**

	The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream to the meeting.
194/23	**Item 2 Public Questions** **Q1 From Vi King** **Firstly I would like to thank Michelle Harris for giving me the opportunity to speaking to her regarding my question that I put forward to the Trust Board on 7th February 2023.** **Michelle dealt with my concerns very professionally and quickly.** **My question to the Trust Board is as part of the Consultation that the CCG held, that Grantham would become the centre of Excellence for Elective Orthopaedics please can you tell me what the take up is on elective operations.** **Also, please can you tell me what the percentage of operations that are being carried out at Grantham hospital.** The Divisional Managing Director responded: Uptake of orthopaedic operating at Grantham Hospital had been positive with excellent feedback from patients having been received. Overall, Trust wide activity for elective day cases had seen 14% of activity delivered at Grantham however 60% of all orthopaedic activity had been delivered at Grantham. It was recognised that continued progress was required in order to further increase activity however patient experience of the service, operations and treatment was very positive. The Trust was currently going through an accreditation process for Grantham to become a Get It Right First Time (GIRFT) recognised elective hub in order to strengthen the position. A significant reduction in on the day cancellations had been seen with the move to Grantham with the significant investment of 2 new theatres which had opened at the end of the previous calendar year. In the first 6-weeks of opening the Trust had successfully operated on 100 more patients than in the same period for the previous year. The Divisional Managing Director noted that there had been news in the media which had described this to the public and it was hoped that the uptake would continue to increase.
195/23	**Item 3 Apologies for Absence**

	Apologies were received from Dr Colin Farquharson, Medical Director, Ms Vicki Wells, Associate Non-Executive Director and Ms Michelle Harris, Chief Operating Officer.
196/23	**Item 4 Declarations of Interest**
	There were no new declarations of interest.
197/23	**Ward Accreditation Presentation**
	The Chair paused the Trust Board meeting in order to take a moment to celebrate the successes of the Trust and was delighted to welcome colleagues from Maternity and Neonatal Services for both Pilgrim and Lincoln to the Board to formally receive Bronze Diamond Ward Accreditation Awards.
198/23	The Board noted how hard the awards were to achieve and the high standards and expectations of achievement.
199/23	The Director of Nursing noted the huge honour in presenting 3 bronze diamond awards to maternity services noting the significant amount of work undertaken. The Director of Nursing had had the privilege and pleasure of chairing the accreditation panel in order to review the evidence.
200/23	The Director of Nursing welcomed Rachel Wright, Sister/Charge Nurse, Neonatal Services and Katy Carr, Matron, Women's Health to the Board to receive the accreditation awards.
201/23	The Deputy Director of Nursing offered an overview of the significant achievements for each of the services which had led to the success in achieving the Bronze Diamond Awards.
202/23	The Chair reflected the national high-profile narrative around maternity and neonatal services noting it was with great pleasure that the accreditations were awarded which reflected the high standards of care evidenced to the panel.
203/23	Thanks were offered for the highly effective leadership that had been demonstrated along with the effective teams in place noting that the services were leading the vanguard in relation to this.
204/23	The Chair and Board members offered congratulations on the significant levels of achievement and awarding of the Bronze Diamond Awards. These would be presented in person at a future date.
205/23	**Item 5.1 Minutes of the meeting held on 7 February 2023 for accuracy**
	The minutes of the meeting held on 7 February 2023 were agreed as a true and accurate record.
206/23	**Item 5.2 Matters arising from the previous meeting/action log**

	041/23 – Patient Story – The Director of Finance and Digital noted that the Director of Estates and Facilities was working through the areas for the Pets as Therapy, liaising with the Head of Patient Experience and Team. It was noted that there was a requirement for these areas to be in place by the end of March ahead of visits commencing in April.
207/23	The Chair was confident that this would be in place and noted that the Board would discharge the action on the basis that requirements were being worked through.
208/23	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board noting that there was an overlap between system and Trust issues that were included.
209/23	Since the report had been written there had been a number of changes, specifically regarding the ambulance strikes that had been due to take place. Negotiations had continued nationally around pay and had resulted in expected strikes being put on hold.
210/23	The Chief Executive noted that the Junior Doctor 72-hour strike was still due to take place with no agreed derogations which posed a significantly greater risk for business continuity and service provision.
211/23	Work was being undertaken across the system and Trust to ensure cover of other medical colleagues, senior doctors or other clinicians where possible. There was a significant amount of work being undertaken with an update to be offered to the Board in April on the outcome of this.
212/23	The Chief Executive advised the Board that the operational plan for the system had been produced and the first draft submitted to NHS England for quality assurance. The outcome, across the country, was that all plans required further work in terms of activity, finance and performance with a view that the final plan would be produced by the end of March.
213/23	Alongside operational planning was the joint forward plan being led by the Integrated Care Board (ICB) however involved all organisations. A planning session was due to take place on 8 March across the system with this effectively being the 5-year NHS plan, to be read alongside the Integrated Care Partnership (ICP) strategy and joint health and wellbeing strategy. These would all be informed by the joint strategic needs assessment. This would be reported back to the Board at the appropriate time.
214/23	The Chief Executive advised that the system was on course to deliver national expectations around the 78-week waits by the end of March. There was a risk to delivery however due to the Junior Doctor strike however the Trust was doing all possible to avoid having to cancel elective care. This would only be done as a last resort and the Trust would protect those with the most urgent clinical need, particularly cancer patients. Delivery of this would be a significant achievement for the system.

215/23	The Board noted that the system remained in the recovery support programme (RSP) given that not all of the regional criteria to exit had been met. Those not met related to the system finance position whereby there had not been 2 consecutive quarters where the financial plan had been achieved and therefore an application to extend the RSP time period had been made. This was due to be presented to the national panel on the 7 March.
216/23	The Chief Executive reminded the Board of the local elections at the beginning of May noting that the purdah period had commenced limiting public exposure of the public sector including the NHS to be involved in and limiting some communication activities such as high-profile issues which could be part of local political decisions. This would also be in place during the April Board.
217/23	The Chief Executive provided an update on the Trust position reflecting on the projected financial position. There was a £21m system deficit for which the Trust part would be £13.6m deficit. As well as contributing to the system operation plan the Trust was also in the process of finalising year 4 of the Integrated Improvement Plan (IIP).
218/23	The staff survey results were awaiting publication and would be published nationally on 9 March with the results being offered back to the Board at the appropriate time.
219/23	The Chief Executive reflected on the Trust estates noting delight at the opening of the new resus department at Lincoln which had seen a £5.6m investment for state-of-the-art care for the most seriously ill patients being treated in the best facility with the best equipment.
220/23	Thanks were extended to colleagues, both those in the estates and facilities team and on the frontline when there had been a full site electrical shut down at Lincoln. This had been a planned shutdown whilst essential maintenance work was undertaken on the high voltage system. Doing this and replying on generator power for 12-hours required significant planning and significant presence on the day in case anything had needed responding to. Colleagues were commended for the work done in both the planning and implantation.
221/23	The Chief Executive advised that the staff awards were now open with many months for people to make nominations with the ceremony due to be held in November. There were 2 new awards for rising stars and an Equality, Diversity and Inclusion Champion.
222/23	The Chief Executive was delighted that the Director of Nursing/Deputy Chief Executive had been made a visiting professor at the University of Lincoln noting the title change from Dr Dunderdale to Professor Dunderdale.
223/23	The Chair added the formal congratulations of the Board to the Director of Nursing on the prestigious appointment.
224/23	

	The Chair reflected on the Junior Doctor stroke noting clear concern however planning was underway in the Trust and nationally with the Trust well involved in its own arrangements.
225/23	Concern regarding planning was noted with the challenge for the Board to stay focused and understand how plans were aligned with a need to be clear with staff about what was important and what the Trust's key objectives were. The challenge would be the alignment and being satisfied that the plans were deliverable.
226/23	There was a need to consider how this would pull through into assurance at the Committees to allow the Board to have a full picture.
227/23	The Chair noted the nominations for the 2023 staff awards encouraging staff to submit applications and noting that the additional categories had been in response feedback from the previous year.
228/23	As one of the judging panel the Chair noted the great pleasure in reading all citations and nominations received with a desire to received as many as possible that reflected the great work taking place across the Trust. The Trust Board: • **Received the report and significant assurance provided**
229/23	**Item 7 Patient Story** The Director of Nursing introduced the Patient Story to the Board noting that this had originated from direct contact with the Chief Executive from Parkinson's UK, the support organisation for people with Parkinson's disease.
230/23	The story told of Mr Miles' admission to Grantham with pneumonia and his and his wife's experiences with a focus on medication and carers.
231/23	The Board was joined by Mr David Smith, Advance Care Practitioner (ACP) for Parkinson's and Mrs Jennie Negus, Head of Patient Experience.
232/23	The Board watched the video learning of Mr and Mrs Miles' experience following Mr Miles' admission to Grantham and the impact of this on his ability to take his Parkinson's medication at the appropriate times and for Mrs Miles to be able to be present on the ward to support her husband during his admission.
233/23	The Chair thanked Mr and Mrs Miles for raising the issue with the Trust and offering support to the Trust in order to take action to support others. It was one thing to read about this in paper however hearing it directly for patients and carers brought the message home. It had been unfortunate that Mr and Mrs Miles had had the experience described however it was pleasing to note that actions were being taken as a consequence of this.
234/23	The Head of Patient Experience had the privilege to speak with Mr and Mrs Miles and had the sense that they wanted to work with the Trust. This supported the work of the Trust to engage and work with patients and families with work currently underway

	around care partners and seeing carers as expert partners in care. It was evident how Mrs Miles was a critical part of Mr Miles' care.
235/23	Following contact with Mr and Mrs Miles the Head of Patient Experience joined with the ACP for Parkinson's with a number of actions already in train. Some progress had been made on actions with involvement of Mr and Mrs Miles which would be a legacy for them.
236/23	It was an important message to show how the Trust was listening and bringing in best practice such as the 'Get it on time' initiative.
237/23	The ACP for Parkinson's noted that if had been an unfortunate story however as the Head of Patient Experience had said work was underway on improving maters.
238/23	The ACP for Parkinson's advised of the expansion of the role and team in order to provider cover 5 days a week across the Trust however some aspects of this were now delivered by Lincolnshire Community Health Services NHS Trust (LCHS).
239/23	Additional staff were in place which would support the role out of the education programme across the Trust with an education day having been held, face-to-face, to support staff.
240/23	Dr Gibson was pleased with the way the story had been mapped to the Trust values and noted that wider dissemination of the principles would be beneficial across the Trust. This was about all staff across the organisation being aware of the change to support patients with medication.
241/23	The Director of Improvement and Integration noted the key questions was around medication education and the need to do more of this and bring staff on board. The key issue through the story was agency staff with the question raised as to how the Trust capitalised on this and embedded the ethos of what the organisation was about and how this was built on with agency staff.
242/23	The ACP for Parkinson's noted it was a fluid situation with the workforce and whilst as much education could be done as possible this would be impacted by the change in staff. The solution would be to run repeat session and offer other methods by having face-to-face sessions which were beneficial.
243/23	It was hoped that other Trusts doing the same thing and therefore agency staff would have access and exposure to the information and education. There was a need to capture as many staff as possible by doing repeat regular sessions.
244/23	Ms Cecchini noted how articulate patients were able to be heard and noted that this had been mostly about the expert carer not being allowed to support her husband and noted that having an expert carer sitting for an extended period of time on the ward would not only support the patient but also offer wider support in the hospital environment.

245/23	The Head of Patient Experience noted that the Trust was one of 13 national pilot sites to take forward the national car partners policy. Work was progressing on this with the Trust distinguishing between a visitor and a care partner.
246/23	Current proposals had been well received at the co-design workshops with the Patient Panel and Matron and Sisters Forum which would see no restrictions to care partners spending time on the wards.
247/23	Visitors would be defined as a neighbour, friend or work colleague and following an in-depth visiting audit a standardised approach to visiting hours had been welcomed. Currently there were a number of different visiting times across the organisation.
248/23	The Head of Patient Experience noted that Mrs Miles had acknowledged at the time of admission to Grantham that it was the tail end of the pandemic, and the Trust was just coming out of some of the restrictions which had been in place in respect of carers and visitors.
249/23	The ACP for Parkinson's noted that there had been reasons that Mrs Miles had been unable to stay due to Covid-19 however she was an empowered individual who was able to talk about this. As a Trust there was a need to support those individuals, including the most vulnerable, who did not have someone to advocate for them
250/23	It was noted that a piece of work, being led by Derby Hospitals regarding emergency departments and delivery of Parkinson's medicine was underway. The ACP for Parkinson's was exploring becoming involved and contributing to this.
251/23	The Director of Nursing referred to the Care Partners pilot noting this had been presented to the regional Directors of Nursing which had generated interest in the actions being undertaken.
252/23	It was noted that nursing had changed and was changing, particularly in the wake of the pandemic. The story described some of the changes and there was a need to ensure that change was positive. There was a need to embrace care partners and was why there was keenness to be engaged in the national pilot.
253/23	In respect of looking after the most vulnerable patients it was noted that there was a need to link with the Safeguarding team as well as linking to other neurological conditions to pull this together and avoid duplication.
254/23	The Director of Nursing offered thanks to the ACP for Parkinson's for the work being undertaken and to the Head of Patient Experience for the continued work that was forever growing through the Patient Experience Group.
255/23	Thanks were also offered to Mr and Mrs Miles for offering their story and the Director of Nursing stated that, given the opportunity, personal thanks would like to be offered to them.
256/23	The Chair endorsed all of the comments made noting that this had been mentioned at the regional Chairs meeting in respect of the work being undertaken for carers which was being recognised as good practice.

257/23	Apologies were offered to Mr and Mrs Miles for the experience they had had however thanks were offered for working with the Trust and continuing to advocate for patients in the way they were. The Trust Board: • **Received the patient story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
258/23	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair of the Quality Governance Committee, Mrs Brown provided the assurances received by the Committee at the 21 February 2023 meeting.
259/23	Mrs Brown noted the report from the Clinical Harm Oversight Group which had offered an update on the planning for the revised harm process. Once complete this would be received by the Executive Leadership Team and was hoped to be received by the Committee in March.
260/23	This would then offer assurance that the Trust had the most up to date process in place however it was recognised that whilst this was being developed the usual harm reviews were being undertaken with assurance received that there were no gaps in the process.
261/23	The Committee received the Patient Safety Group upward report noting the deep dive into patient harm as a result of delays in the emergency departments. Further work was ongoing to explore themes from this and the next steps with feedback due to the Committee at a future date.
262/23	Mrs Brown was pleased to be able to inform the Board that the Never Event Summit had taken place and had focused on culture and attitude aspects of the never event concerns. It was agreed that, to provide full assurance, the Committee would receive the final draft actions plan with appropriate and realistic timescales.
263/23	It was noted that assurance was received on duty of candour with positive improvement being seen.
264/23	The Committee received the claims and inquest report additional data had been requested which the existing system was unable to report, however it was encouraging to note the planned development to the system. This would allow the Committee to ensure, in the new financial year, that comparison data could be received alongside benchmarking and triangulation.
265/23	The Infection Prevention and Control (IPC) Group had reviewed the IPC Board Assurance Framework with the national IPC strategy with assurance gained in all areas with the exception for environmental factors. This was due to the condition of the Trust's estate and something that the Board was well sighted on.

266/23	It was noted that some actions were being taken to support this such as air flow however this would be an ongoing concern. A verbal update had also been received following the recent NHS England IPC regional visit which had resulted in no immediate actions with the formal letter due to be received and would be shared with the Board.
267/23	The Committee had been pleased to see the success of the electronic Prescribing and Medicines Administration (ePMA) as reported by the Medicines Quality Group with continued rollout throughout the remaining part of the year.
268/23	Improvements had been seen in the medicines management quality indicators for the second month in a row with Mrs Brown noting that this had been an area of concern for the Committee.
269/23	Whilst it was recognised that the improvement was down to the ward level commitment it was also recognised that there was increased oversight and governance led by the Medical Director and Deputy which had made a difference. It was hoped that the improvements would continue.
270/23	Mrs Brown advised the Board that the Medicine Division had attended the Committee due to the Child Protection Information Sharing (CPIS) issues which remained outstanding from a previous Care Quality Commission (CQC) visit. It was felt to be important that the division spoke directly to the Committee and whilst it was recognised that there were some green shoots of improvement there remained some way to go.
271/23	It was agreed that the Medicine Division would attend the Committee again in April with the envisaged hope and belief, due to the support in place, that the improvement would be seen.
272/23	As noted through the previous agenda item the Patient Experience Group was going from strength to strength with discussions held around the level of assurance being gathered from the group with many areas of improvement. As a result, the Committee would look to consider the assurance rating in the Board Assurance Framework going forward.
273/23	The Committee had reviewed all audit recommendations which were outstanding and was pleased to note this had reduced to a minimal level for the Committee noting that the outstanding actions had agreed plans in place meaning that these should be signed off in the coming months.
274/23	Mrs Brown advised the Board that the Committee had received, for the final time, the Savile Action plan update. Referrals were made however to the People and Organisational Development Committee and Finance, Performance and Estates Committee to request that the outstanding actions relevant were taken forward as required.
275/23	It had been agreed by the Committee that this would now be monitored by the Patient Experience Group which would feedback any concerns which may arise in respect of quality.

276/23	The Committee received an update in relation to the strike action that had taken place including cold and hot debriefs that had been held and was assurance of the actions taken by the Executives and Divisions to ensure the safety of patients. Thanks were offered to all involved.
277/23	The Chair noted the sense of increasing high levels of assurance on many of the topics across the Trust and where some improvements were being made clarity was being offered on the expectations going forward.
278/23	Professor Baker sought to understand how the learning from the Never Event Summit would be shared more widely with the organisation
279/23	The Director of Nursing noted that the summit had focused predominantly around theatres and so had been led by the surgical divisions with multiple stakeholders in attendance so that it was not an isolated event. All those supporting patients through a surgical pathway were included.
280/23	The event was a full day, off-site and facilitated and supported by the Governance Team with work looking at all never events not just those that had occurred in the current financial year. This meant that previous never events were considered to determine if there were any other themes over the period of the past few years.
281/23	The themes had been identified and workshops held to identify what actions had been taken, if they were appropriate and if there were any other elements which had not bee pulled out. The outcome of this was then developed into an action plan to not only support the surgical division and theatres but so that learning could be taken Trust wide.
282/23	The Committee had received the first output from the summit work and a follow up session would be held, including the quality improvement teams to support the actions going forward with a further review to be undertaken to confirm if anything else was required.
283/23	Ms Cecchini noted the discussions regarding patient harm as a result of delays noting recent media coverage which indicated that 50% of ambulance drivers asked felt there had been an impact on patient harm as a result of issues accessing emergency departments or due to delays in ambulance responses. Ms Cecchini sought to understand how this was reconciled with the report which had been received and the position presented.
284/23	The Director of Nursing noted that system work was underway in respect of considering this from a call to 999 through to discharge. The breaking the cycle initiative the Trust had put in place was as a result of this and recognising the risk presented as a result of issues with flow through the hospitals.
285/23	Breaking the cycle was about managing and moving the risk so that those waiting for a category 2 ambulance were able to receive these in a timely manner and when attending the emergency departments patients were treated in a timely way. Success had been seen through breaking the cycle which had been support by all

	teams and wards spreading the risk across the organisations in order to lessen the risk to ambulance colleagues.
286/23	The Director of Nursing noted that East Midlands Ambulance Service NHS Trust (EMAS) had experienced some of what was described in the media and what had led to the undertaking of breaking the cycle with a positive outcome seen from this.
287/23	The Director of Improvement and Integration noted that ambulance handover times in August of last year had a baseline of 24%, through breaking the cycle there had been a reduction of 11% in January down to 13%.
288/23	There were good improvement and interventions in place to ensure navigation of EMAS to direct services to support the ethos of patients being seen in the right place first time. This was being piloted in the emergency departments and urgent treatment centres to ensure specialties were in place to avoid waits.
289/23	The Chair noted that the terms of reference for the Committee had been reviewed and were offered for approval to the Board. The Trust Board: • **Received the assurance report** • **Terms of Reference received and approved**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
290/23	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker provided the assurances received by the Committee at the 23 February 2023 meeting.
291/23	Professor Baker reflected on the increased levels of assurance being offered from the Committee in large due to the increase in efficacy of the reporting groups. It was noted that there were plans to refocus the Workforce, Strategy and Organisational Development Group which were endorsed by the Committee to ensure that the group was more effective with appropriate representation.
292/23	The Committee received the report from the Guardian of Safe Working and offered thanks to Dr Chablani, who was stepping down, for the work undertaken in the role. The Committee considered out of hours medical cover, induction processes and locally employed doctor contracts.
293/23	There had been a focus on issues in orthopaedics and surgery with the Deputy Medical Director highlighting recent recruitment activity which was hoped to mitigate the issues described. The Committee would remain vigilant to the issues raised by the Guardian.

294/23	The Committee received the safer staffing report noting the increase in pressure ulcers however noted that the Quality Governance Committee would review this.
295/23	Professor Baker noted that the Equality, Diversity and Inclusion Group was highly effective noting that the Board would consider the Equality Delivery System and Gender Pay Gap reports directly. These had been considered by the Committee and advise provided on how best the data could be analysed to optimise this for the Trust.
296/23	The Committee considered reports from Research and Innovation and the University Teaching Hospitals Group with work continuing in a number of areas and optimism of the progress that would follow.
297/23	Statutory and mandatory training and appraisals had been considered which were key elements in the delivery of the Committee's objectives within the Integrated Improvement Plan. Work remained in progress with the Committee continuing to provide considerable attention on this however it was noted that better use of recording data through electronic methods would go some way in assisting progress.
298/23	The Chair noted the increasing maturity of the reporting groups and offered thanks for the clarity provided on the expectation of these and how information flowed to the Committee.
299/23	The update in respect of education funding was noted with the Chair keen to see how the updates offered would focus through into a more meaningful report to the Committee.
300/23	The focus on agency spend was noted along with appraisals and training compliance which was right given the concerns raised from the Finance, Performance and Estates Committee in respect of fire safety and information governance training.
301/23	The Chair noted the intention to write to Dr Chablani to offer thanks for the work undertaken as the Guardian of Safe Working and for the commitment given to the role. **Action – Chair, 4 April 2023**
302/23	The Chair noted that the terms of reference for the Committee had been reviewed and were offered for approval to the Board. The Trust Board: • **Received the assurance report** • **Terms of Reference received and approved**
303/23	**Item 9.2 Gender Pay Gap Report** The Chair noted that both the Gender Pay Gap and Equality Delivery System Reports were being received by the Board. These had been considered by the People and Organisational Development Committee with detailed discussions taking place. The reports were offered to be received formally by the Board.

304/23	The Director of People and Organisational Development noted that members of the Board would be aware that the Trust had a job evaluation process and national pay system in place with agenda for change and medical pay rates set for grades and jobs regardless of gender.
305/23	The report highlighted that in the Trust women earnt 83p for every £1 earnt by men with the medium gap, as at the end of March 2022, at 16.8%. This had widened, compared to 2021 data by 2.2%.
306/23	The Director of People and Organisational Development noted that it was important to state that the driver of the position remained the structure of the NHS workforce with a large majority of female colleagues comprising in lower paid roles and men featuring in higher paid roles.
307/23	There were a large number of actions identified within the action plan along with work being undertaken directly with the local women's network in respect of some of the identified actions.
308/23	Dr Gibson supported all of the actions being taken and noted that there was particular challenge around gender pay gap calculations within the NHS due to the attempt to bridge 2 populations. There was the agenda for change population with a 4:1 ratio female to male and medical population of nearly 1:2 female to male with the medical population earning twice as much.
309/23	Dr Gibson noted that when the 2 were considered together this resulted in Simpson's paradox whereby a larger overall distance in the Trust was seen when the 2 populations were considered together rather than considering these separately.
310/23	This would mean that, when setting targets to improve the ration, even if eutopia were achieved there would still remain and apparent gender pay gap. The Trust would need to remain mindful of this.
311/23	The Director of People and Organisational Development noted with interest the point raised recognising that reporting was set via the national system however the Trust could undertake an additional layer of due diligence in order to understand better the local dynamics of the gender pay gap. This would be taken forward and considered with the Equality, Diversity and Inclusion Group. **Action – Director of People and Organisational Development, 4 April 2023**
312/23	The Director of Nursing had attended a meeting with the chair of the women's staff network, as executive sponsor, noting that all recommendations and actions within the plan were supported with the staff network keen to support the work taking place in terms of actions that could be taken to reduce the gender pay gap.
313/23	Mr Herbert noted that whilst the data was key to this as well as part of action planning it would be necessary to break down processes such as recruitment, into steps, in order to understand the data as it flowed through. This would drive the actions for example in understanding if the Trust was not attracting more women for roles or if they were not supported during the process.

314/23	Mr Herbert reflected on the clinical excellence awards noting that these had to been applied for by individuals and noted that data demonstrated that women were less likely to apply. Whilst there was a desire to encourage more females to apply this would not improve the process and it was noted that there had been resistance from the BMA to change the process.
315/23	The Chair thanked Dr Gibson for the insight of the data analysis noting that whilst there was a need to report nationally if there was further work with the data to make this meaningful for the Trust this was encouraged. The Non-Executive Directors purpose was to add value for a range of reasons and noted that this was an example of that where further support could be offered.
316/23	The Chair expressed appreciation for the women's network in supporting the work and being actively involved to take this forward. This was challenging but a credit to the network for taking this on and working with the Trust to make improvements. The Trust Board: • **Received the report noting the moderate assurance** • **Approved publication of the report by 30 March 2023**
317/23	**Item 9.3 Equality Delivery System** The Director of People and Organisational Development presented the report to the Board noting that this had been approved by the Board in private session on the 7 February and was now being shared in public session for formal noting and to respond to any further questions which may arise.
318/23	The Chair noted that the report was comprehensive with a full action plan and intent for the Board to focus on equality, diversity and inclusion at a Board Development session. The Trust Board: • **Received the report noting the moderate assurance**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
319/23	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini provided the assurances received by the Committee at the 23 February 2023 meeting.
320/23	Ms Cecchini noted that the Committee had received the upward report from the Health and Safety Committee noting the ongoing maturity of the Committee however some concern was expressed due to the Committee not routinely receiving reports from the reporting groups however noted this was in hand.

321/23	The Committee had noted that the Radiation Protection Group had not met since October however meetings had now been arranged. Discussions had been held regarding the health and safety enforcement notices regarding confined spaces and was assured that this was a standing item on the Health and Safety Committee agenda.
322/23	As previously agreed at the Committee the new policy in respect of how the Trust managed confined spaces would be received.
323/23	Ms Cecchini noted again the concerns regarding fire safety and compliance with statutory training noting that this had led to a wider conversation by the Committee around ensure mandatory training regarding information governance was also completed. The Committee considered the position with an escalation to be formally made to the People and Organisational Development Committee.
324/23	Assurance was received in respect of emergency planning however the Committee noted ongoing issues with business continuity plans (BCPs) with a lack of assurance in surgery and medicine. Work was ongoing to ensure services had up to date BCPs in place which were tested.
325/23	Ms Cecchini noted that the Chief Executive had referred to the financial position and advised the Board of the forecast outturn of £13.6m deficit which was an agreed position in the system. Significant assurance was received that the Trust would deliver to the final year end position, albeit assurance was limited in delivering the statutory breakeven position.
326/23	The Committee discussed the increasing concern regarding cash, due to arrangements around Covid-19 this had not presented as an issue until this point. The Committee considered the need for there to be more scrutiny into the next year and much closer management of all working balances.
327/23	Limited assurance was received in respect of the Cost Improvement Programme (CIP) with delivery of £17m against the required £29m and £33m plan in place. The process for identifying and delivering CIP was moving towards transformational and assurance was received that progress was being made. The Committee would continue to provide focus on this.
328/23	The Committee noted that contracting discussions for the coming year were ongoing and moderate assurance was received regarding delivery of the capital programme. This had been well managed for the past few years putting the Trust in good standing with thanks offered to the teams for the continued focus.
329/23	Ms Cecchini noted that there remained some way to go to deliver operational performance targets but noted positive discussions with an upturn seen in the past few months. It was believed that, despite the Junior Doctor strike, the Trust would achieve the 78-week target with Professor Briggs having visited the elective hub at Grantham which had resulted in a positive outcome and feedback.

330/23	The Committee discussed planning, recognising this was currently ongoing and a deep dive had been received into the progress made on the productive theatres improvement plan.
331/23	Good assurance had been received on the progress of the workstreams and the Committee had agreed to receive on a monthly and rotational basis, deep dives into some of the initiatives.
332/23	Ms Cecchini noted that the Integrated Improvement Plan continued to offer limited assurance with discussions being held around the realism of some of the targets set. Whilst these needed to be challenging, they also needed to be realistic. The Committee had requested an annual review of the position of the improvement plan but recognised this would be seen in the Trust annual report.
333/23	The Committee noted the Improvement Steering Group report which was maturing well noting the difficult start at the beginning of the year to establish the group and receive regular reporting. Progress had been noted, particularly around agency spend with a reduction being seen and theatre productivity. There was however a need to escalate the medicines management workstream and the lack of traction with the Committee considering a deep dive into the driver of this.
334/23	The Chair noted the wide-ranging report and business of the Committee noting the point about the maturity of the groups influencing the quality of the debate and quality in the Committee.
335/23	This reflected the previous position of both the Quality Governance and People and Organisational Development Committees, but it was clear improvements were being made in the same way as had been done for the other Committees.
336/23	The Chair offered thanks to Ms Cecchini for being clear on the expectations of the groups and for driving the agenda forward.
337/23	The escalation to the Board regarding the failure to achieve traction with the medicines manage programme was noted and a response was requested from the Medical Director.
338/23	The Medical Director noted that this programme of work was being taken forward by the Deputy Medical Director noting the awareness of the issues and indicated that these were being discussed at the Medicines Optimisation Group and Patient Safety Group. Improvement in traction on this was expected in the coming months however this would remain under review.
339/23	The Chair noted the need to be clear that the Committee would continue to monitor this to ensure delivery of the programme and the Quality Governance Committee would consider this from a quality and safety perspective.
340/23	An update on medicines management to the Board was requested in 3 months' time in order to ensure sight was not lost to due this having been an issue for some time. **Action – Medical Director, 7 June 2023**

341/23	The Chair also noted the escalation to the People and Organisational Development Committee regarding fire safety and information governance training noting the fit with the broader concern of the People and Organisational Development Committee in respect of mandatory training compliance.
342/23	Concern was noted regarding BCPs, particularly with surgery and medicine, with reflection that this was possibly being done on a daily basis but needed to be written down to ensure a greater understanding and assurance.
343/23	The financial position was noted and whilst the original trajectory was not going to be met there was clear grip and control in place with the current difficult operating environment in which the Trust was working recognised by the Board.
344/23	The Chair noted that the terms of reference for the Committee had been reviewed and were offered for approval to the Board. The Trust Board: • **Received the assurance report** • **Terms of Reference received and approved**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
345/23	No items
346/23	**Item 12 Integrated Performance Report** The Chair noted that each of the Committees had considered the relevant aspects of the Integrated Performance Report and noted discussions had taken place where required.
347/23	Mrs Brown noted that the Quality Governance Committee had not addressed the variation in pressure ulcers during the February meeting but would ensure this was addressed at the next meeting. There was also a need to consider the 52-week trajectory on the SPC chart as this was believed to be out of date and consideration was also needed for 78-weeks.
348/23	The Chair noted the need to ensure this was not just about populating data but was updated where needed.
349/23	The Director of Finance and Digital would ensure that the report was updated ahead of the commencement of reporting for 2023/24. The Trust Board: • **Received the report noting the limited assurance**

	Item 13 Risk and Assurance
350/23	**Item 13.1 Risk Management Report** The Director of Nursing presented the risk report to the Board noting that 2 new risks had been added since the Board had met in February.
351/23	There was 1 new quality and safety risk related to gaps in tertiary advice and support for young people with complex epilepsy. It was noted that there were mitigations in place.
352/23	The second new risk related to subject access requests and compliance with regulations, access to health records and statutory regulations.
353/23	A number of changes had been noted in the report and would be taken to the Risk Register Confirm and Challenge Meeting for validation prior to formal reporting to the Board.
354/23	A risk was also present in respect of demand and capacity in the emergency departments, ambulance handover delays, unexpected surges in emergency departments and reliance on bank and agency workforce, particularly in urgent and emergency care.
355/23	The Director of Nursing noted that as a result there were 13 high and very high risks related to quality and safety, 3 high and very high workforce risks and 6 related to finance, performance and estates.
356/23	All of the risks had been received by the Committees and as described all risks had clear mitigations in place which had been reviewed at the relevant Committees and should be recognised by Board members as the top risks presented.
357/23	The Director of Nursing advised that the report was offered with a significant level of assurance having previously been offered with moderate assurance. This was due to the internal audit report being received which offered a significant level of assurance.
358/23	The Chair noted the internal audit commentary which was well deserved following the significant amount of work undertaken to revise the risk register, this had been great work.
359/23	Dr Gibson sought clarity on risk 4789 regarding echocardiographic staffing noting that this was a national issue. Health Education England had responded by offering a training programme which was custom designed and allowed for local recruitment. This was supernumerary funded and developed in conjunction with the professional body. Confirmation was sought that the Trust was engaging with the process as a potential solution for some of the long-standing issues experienced by the Trust.
360/23	The Chair noted that a detailed response would be offered to Dr Gibson outside of the meeting which would also be captured within the minutes of the Board. **Action: Director of Nursing, 4 April 2023**

361/23	Mr Herbert noted the changes taking place within the Executive team and sought to understand if this should be captured as a risk.
362/23	The Chief Executive noted that risk 4991 related to recruitment and retention but reflected that it would be helpful to flag this either within the current risk or as a new risk to be able to add mitigations. A risk reduction plan had been received by the Executive Leadership Team which was now being acted upon however this did need to be captured as a risk.
363/23	The Chair thanked Mr Herbert for raising the concern noting that whilst there were plans in place the risk needed to be captured in order for it to be responded to and requested this be added to the risk register. **Action: Chief Executive, 4 April 2023** The Trust Board: • **Accepted the risks as presented noting the significant assurance**
364/23	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the Board Assurance Framework (BAF) to the Board noting that all Committees had considered the BAF during the February meetings.
365/23	It was noted that some significant updates had been made for objectives 3e and 3f however further work was required, at the request of the Finance, Performance and Estates Committee, to ensure alignments of the updates to the correct areas.
366/23	The Trust Secretary noted that there were no changes to the RAG ratings and advised on the continued work to link to the work of the Board and Divisions on the refresh of the Integrated Improvement Plan for 2023/24 to ensure the BAF was aligned.
367/23	At the April Board meeting the close down of the 2022/23 BAF would be presented alongside the 2023/24 version to move forward.
368/23	The Chair noted that the BAF presented a true and accurate representation of the position of the objectives. The Trust Board: • **Received the report noting the moderate assurance**
369/23	**Item 14 Any Other Notified Items of Urgent Business** No items
370/23	The next scheduled meeting will be held on Tuesday 4 April 2023 via MS Teams live stream

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

Agenda item: 5.2

PUBLIC TRUST BOARD ACTION LOG

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
7 February 2023	041/23	Patient Story	Follow up of plans for dog friendly outside space ahead of scheduled visits commencing April 2023	Director of Finance and Digital	07/03/2023	Work in place between Director of Estates and Facilities and Head of Patient Experience – Close
7 March 2023	301/23	Assurance and Risk Report People and Organisational Development Committee	Letter of thanks to be sent to Dr Chablani for work undertaken in the role as Guardian of Safe Working	Chair	04/04/2023	
7 March 2023	311/23	Gender Pay Gap Report	Consideration of additional layer of data to be utilised to better understand the local dynamics of the gender pay gap to be taken forward with the Equality, Diversity and Inclusion Group	Director of People and Organisational Development	04/04/2023	
7 March 2023	340/23	Assurance and Risk Report from the Finance, Performance and Estates Committee	Update on medicines management to be offered to the Board in 3 months' time in order to ensure sight was not lost to due this having been an issue for some time	Medical Director	07/06/2023	
7 March 2023	360/23	Risk Management Report	Clarity on risk 4789 regarding echocardiographic staffing to be offered to Dr Gibson in respect of the Trust engaging in the Health Education England process as a potential solution for the long-standing issues experienced by the Trust.	Director of Nursing	04/04/2023	

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

7 March 2023	363/23	Risk Management Report	Risk to be captured within the risk register in respect of current changes in the Executive Team	Chief Executive	04/04/2023	

Meeting	*Public Trust Board*
Date of Meeting	*4 April 2023*
Item Number	*Item number 6*

Chief Executive's Report

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

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to be under operational pressure due to service demand. Alongside this, plans have been developed for ensuring service resilience over the four day Easter period, recognising that health and care staff will also want to take annual leave over this holiday period.
b) Planning is underway for the junior doctor strike, which is for the four-day period from 07.00 on Tuesday 11th April to 07.00 on Saturday 15th April. This will affect all parts of the system, particularly as it comes straight after Easter. At the time of writing, it looks unlikely that there will be a negotiated agreement between the Government and the junior doctors, such that the industrial action can be called off.
c) At Month 11, the system has improved its forecast year-end deficit by £4m due to receiving additional income in relation to prescribing volume and price concessions. This means that the system should end the year with a £17m deficit.
d) The system operational plan for 2023/24 remains in draft form whilst further work is undertaken to improve the financial forecast in the plan. The current forecast is for a system deficit of £52m in 2023/24. NHS England will not sign off a forecast deficit at this level. An update will be provided at the Board meeting on the latest forecast.
e) As reported at the last Board meeting, the Lincolnshire system remains in the national Recovery Support Programme. This will be for a further twelve months up to the end of March 2024, with the possibility of applying for an earlier exit if the system financial recovery plan is delivered in line with trajectories for six consecutive months. A Financial recovery Plan has been produced and the trajectories have been agreed with NHS England. The Financial Recovery Plan contains full-year savings of £55m in 2023/24.
f) NHS England has confirmed the Quarter 3 2022/23 NHS Oversight Framework segmentation ratings. The Lincolnshire system remains in NOF segment four, ULHT in segment three, LCHS, and LPFT in segment one.
g) The next Quarterly System Review Meeting (QSRM) with NHS England takes place on 31st March. An update of the key issues arising from the meeting will be provided at the Board meeting

Trust Overview

a) At Month 11, the Trust reported a year to date deficit of £13.4m against a year to date plan of breakeven. This position is aligned to the previously agreed decision that the Trust would end the year with a £13.6m deficit.
b) Grantham and District Hospital has been nationally accredited as an elective surgical hub. This is part of a scheme run by the Getting It Right First Time (GIRFT) programme and the Royal College of Surgeons. Surgical hubs are a key part of the national plans to increase capacity for elective care and thus reduce waiting lists and waiting times.
c) The Trust submitted its Workforce Race Equality Standard (WRES) action plan to NHS England in October 2022. NHS England has confirmed that the Trust provided a comprehensive plan, which they have reviewed and have rated as 'Good'. This is using the same scale as that used by the CQC, namely, Inadequate, Requires Improvement, Good, and Outstanding.
d) Members of the Executive Leadership Team have signed up to the NHS Midlands Staff Networks Executive Sponsors programme. This is a development and support programme to enable sponsors to champion equality and empower staff networks to

be their best. The launch event for the programme was held on 22nd March and there will be four further sessions throughout 2023.

e) As part of the ongoing work around improving the Trust's culture and leadership, 16 Cultural Ambassadors have been appointed from colleagues across the Trust to help shape this work. These Cultural Ambassadors will engage with staff to inform, design and implement changes in the Trust. A training and development programme is being put in place for the Ambassadors. The role is for two years and involves two days of input per month.

f) An interim Director of Finance and Digital has been selected to cover the role when Paul Matthew leaves at the end of April. A formal announcement of the appointment will be made once all the pre-employment checks have been completed. The selection panel included the Directors of Finance from the NHS Lincolnshire ICB and NHS Midlands.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	21 March 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 (CHOG) Upward Report inc proposed changes to harm reviews** The Committee received the report noting the position of planned care and potential harm which was reflected in progress against the 78-week target however it was noted that there may be some impact as a result of the Junior Doctor strike. Any harm as a result would remain under scrutiny. Progress was noted in the action being taken for missing outcomes form outpatients however it was noted that a substantial backlog remained. The Committee noted the disbanding of the Clinical Harm Delivery Group, as agreed by the Clinical Harm Oversight Group, as a result of the agreement to the changes in the Clinical Harm Monitoring process were agreed by the Executive and Trust Leadership Teams which would see use of DATIX to monitor all harm to patients. Reporting of clinical harm reviews would be incorporated within the incident analysis report presented to the Patient Safety Group with the Committee noting that a review of the purpose and remit of the Clinical Harm Oversight Group would be undertaken going forward. **Patient Safety Group Upward Report** The Committee received the Chairs report as a result of the meeting being stood down due to operational pressures. It was noted that a number of papers were not submitted from the divisions however the corporate central team papers had been reviewed.

	It was noted that there had been improvements in incident management reporting with an increase in those being closed in 20 working days which was positive given the impact of the strikes and operational pressures. The Committee noted that a number of Central Alerting System (CAS) Alerts were outstanding however support was being put in place to ensure these were closed. The completed final action plan from the Never Event Summit had been received along with an update on the next steps. **Serious Incident Summary Report inc Duty of Candour** The Committee received the report noting the position presented which demonstrated an increase in the number of completed actions with no overdue actions resulting from never events. The Committee noted that the improvements being seen reflected the improvements in governance and processes across the organisation. The Committee considered duty of candour and the time lag in reporting of this noting that there were a number of factors which would impact the requirement of this as well as the timing of reporting. **High Profile Cases** The Committee received the report noting the content. **Safeguarding Group Upward Report** The Committee received the report noting that there had been some slippage on the completion of the internal audit actions. The Medicine Division would be taking over the audit of Child Protection Information Sharing (CPIS) from April and would be monitored by the Medicines Group and reported to both the Safeguarding and Children and Young People's Group. There was some concern highlighted around the ability to maintain the actions however support would be offered to immediate actions if necessary. Progress was being made with DMI training with a review to be conducted to identify 800-900 staff who would be mandated to undertake the training. The Committee noted the concerns raised around the ability of the Medicine Division to deliver the CPIS implementation however noted that an Emergency Department Oversight Meeting would be established in order to progress. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report noting that the Trust remained above trajectory for Clostridioides difficile and a further 2 cases of MSSA had been reported however this remained under trajectory.

	The Committee noted the establishment of the Peripheral Line Task and Finish Group as a result of a number of concerns identified in relation to peripheral line care and management. It was noted that the draft letter following the NHSE IPC visit had been received with the Trust offered an opportunity to comment on factual accuracy before the final letter was issued. **Medicines Quality Group Upward Report** The Committee received the report noting the medicines management IIP update which reflected the pressures being faced alongside the workforce pressures in pharmacy which was impacting on the ability to provide a 7-day service. The Committee noted the improvement in Controlled Drug Management and the positive feedback and progress of the ePMA rollout which had proved successful during the Junior Doctor strike. It was noted that there had been substantial progress against a number of areas of the divisional actions however some areas remained off track which related to the funding of self-administration of medication lockers. It was hoped this would be resolved through funding by the Integrated Care Board.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the upward report noting the number of positive items presented with particular note to the ambition to grow the number of volunteers in the Trust to 1000. Currently there were 300 volunteers in post with a view to increase this to 500 by the end of the year and the overall ambition to have a volunteer on every ward. The Committee noted the developments of the One Chaplaincy Model and the innovative way of working to further develop the service offer. The Committee approved the Patient Experience Group Terms of Reference.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the presentation of the high-volume lox complexity work and 78-week trajectory noting there was further work required to deliver. The Committee was pleased to note the achievement of the Elective Hub

	Accreditation for the Grantham site. The Committee considered the position in relation to completed national audits and the 53 audits had been signed up to for 2023/24. The Committee noted the CQUIN update for Q3 with concern raised regarding flu vaccination uptake which was believed to be lower than previous years due to the reduced number of peer vaccinators. As a result, the Committee noted the need to refer to the People and Organisational Development Committee to seek an understanding of the impact of flu vaccination and sickness levels to identify if there was a potential impact on quality and patient experience. Success was also noted with the Get It Right First Time (GIRFT) programme noting that this would support productivity moving in to the new financial year. **Clinical Audit Forward Programme** The Committee received and noted the proposed clinical audit plan for 2023/24 supporting the proposed audits.
	Assurance in respect of other areas: **Committee Effectiveness – Final Annual Report** The Committee received and approved the final report noting that this offered a fair reflection of the Committee business over the past 12 months. **Topical, Legal and Regulatory Update** The Committee received the update and considered the items reported noting in particular the Healthcare Safety Investigation Branch (HSIB) item in respect of harm caused by delays in patient however to emergency care. It was felt that the update provided would be more beneficial for the People and Organisational Development Committee to be sighted on due to the evidence on staff wellbeing. **Integrated Improvement Plan and KPIs for 2023/24** The Committee received the report noting that at the end of month 11 steady progress was being made on the patient objectives with moderate assurance offered. It was noted that moving forward discussions were taking place regarding priorities and actions in order to move in to the 2023/24 year. Work was taking place jointly with the Clinical Governance Team in order to support the development of metrics. **Audit Recommendations** The Committee received the audit recommendations and reflected the

	need for work to continue to progress so that actions could be closed. It was anticipated that actions related to safeguarding would be closed ahead of the April meeting. **CQC Action Plan (Quarterly Update)** The Committee received the quarterly update of the CQC action plan noting the progress that had been made in respect of the actions. It was noted that work had commenced on the single assessment framework with the divisions which would replace the current inspection regime with the Trust taking a proactive approach to this. It was anticipated that a number of workshops would be held, and information reported to the Trust Leadership Team prior to reporting to the Committees. **Committee Performance Dashboard** The Committee received the report noting that the items had been covered through the reports to the Committee. Concerns was noted against the SPC chart for pressure ulcers noting that there was a need to review how the data was presented. **Industrial Action – Final Action Plan** The Committee received the final action plan noting the recommendations in place along with those that had been completed. It was recognised that further work was required on a number of the recommendations however there had been significant learning as a result of the industrial action taken. The Committee noted the commendations received, both internally and externally, on the Trust's management of the industrial action.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee wished to refer to the People and Organisational Development Committee the HSIB Bulletin on Harm linked to delays in patient transfer. The Committee wished to refer to the People and Organisational Development Committee the impact of flu vaccination and sickness levels.
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. The Committee agreed that Objective 1b Improve Patient Experience should, as a result of the review undertaken against assurance, be uprated to Green.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

Annual Report to the Trust Board from the Quality Governance Committee 2022/23

ROLE OF THE COMMITTEE

In 2022/23, in line with all other Committees of the Board, the Terms of Reference were reviewed, amended. Under the agreed terms of reference, the Quality Governance Committee was tasked as follows:

The Quality Governance Committee will:

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

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

- Developing a safety culture
- Ensuring early detection and treatment of deteriorating patients
- Ensuring safe surgical procedures
- Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff
- Maintaining HSMR and improving SHMI
- Delivering on all CQC Must Do actions and regulatory notices
- Ensure continued delivery of the hygiene code and achievement of Infection Prevention and Control (IPC) BAF
- Improve patient safety by learning from incidents, specifically:
    - Maternity services (personalised care)
    - Medication Management

    - Diabetes Management (DKA)
    - Infection Prevention and Control
    - Urgent and Emergency Care

Improve patient experience:

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

Improve clinical outcomes:

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

MEETINGS

The Committee met monthly during the year and after each meeting provided an assurance report to the Trust Board.

Following the period of working during the Covid-19 pandemic the Committee, in 2022/23 returned to business-as-usual working to full agendas and length of meeting.

During times of pressure during December 2022, resulting in the declaration of critical incidents, the Committee, being cognisant of the pressures being faced by the Trust, worked to a reduce agenda and meeting length.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 202/23 the Committee was chaired by Dr Chris Gibson until the appointment of Mrs Brown who commenced with the Trust in August 2022 and took over chair of the Committee in October 2022.

Details of the Committee's membership and attendance during 2022/23 is set out below:

- Non-Executive Director (Chair) (Maternity and Neonatal Safety Champion)

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

Voting Members	19 Apr 2022	24 May 2022	21 June 2022	19 July 2022	23 Aug 2022	29 Sept 2022	18 Oct 2022	22 Nov 2022	20 Dec 2022	24 Jan 2023	21 Feb 2023	21 Mar 2023
Non-Executive Director (Mrs Brown, Chair)					X	X	X	X	X	X	X	X
Non-Executive Director (Dr Gibson)	X	X	X	X	X	X	X	A	X	X	X	X
Non-Executive Director (Mrs Dunnett)	X	X	X	A	X	A						
Medical Director	X	X	X	X	X	D	D	D	D	D	D	D
Director of Nursing	X	X	X	X	X	X	X	X	X	D	X	X
Chief Operating Officer	X	D	D	A	X	X	X	X	A	X	X	X

A denotes Apologies given
D denotes Deputy in attendance
C Director supporting response to Covid-19
X denotes attendance

External members including representation from the Integrated Care Board also attend the Committee to provide external challenge and review.

The Committee is regularly attended by the Deputy Director of Clinical Governance and Trust colleagues are co-opted onto the Committee to offer expert opinion and assurance when required, such as Deputy Director of Safeguarding, Head of Patient Experience, Deputy Medical Director.

A rolling programme of reporting group chair attendance at the Committee on a monthly basis is in place allowing the Chairs to offer upward reports and raise escalations to the Committee as appropriate.

REVIEW OF BUSINESS

The Quality Governance Committee work programme for 2022/23 is set out as an appendix (1) to this report.

The Quality Governance Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2022/23:

- Objective 1a Deliver high quality care which is safe, responsive and able to meet the needs of the population
- Objective 1b Improve Patient Experience
- Objective 1c Improve Clinical Outcomes

During 2022/23 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF.

The strategic objectives at the beginning of the year were rated as follows:

Objective 1a – **GREEN**
Objective 1b – **AMBER**
Objective 1c – **AMBER**

Through the year the Committee continued to receive reports offering assurance against the strategic objectives resulting in the objectives being rated as follows at the end of the year:

Objective 1a – **GREEN**
Objective 1b – **GREEN**
Objective 1c – **GREEN**

In May 2022 the Committee considered and revised the assurance rating of Objective 1c from amber to green due to the improved assurance being presented by the Clinical Effectiveness Group and as a result of the significant assurance achieved following the internal audit of the clinical audit programme.

OVERVIEW

The Quality Governance Committee has continued to, over the last twelve months, improve the assurance it can give to the Board that there is an effective system of quality governance and internal control across the clinical activities of the Trust. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan, as defined by the terms of reference through this annual report.

The Committee continues to receive monthly assurance/exception reports from the reporting groups offering assurance on effective quality governance within the Trust. A further review of the outcome of the Clinical Governance Review was conducted and recommendations put forward to the Committee. The acceptance of the recommendations will continue to strengthen assurance processes.

Following the Committee working to reduced agendas in 2021/22 in order to support the response to Covid-19 there has been a return of patient stories to the Committee enabling Committee members to hear first hand the work of clinicians and others within the Trust. Stories presented have been of both a positive and negative nature to demonstrate where the Trust does things well and where improvements are required.

There has also been an increase in the levels of assurance received in respect of Patient Experience with positive progress being made in respect of activity within the Trust and assurances provided to the Committee.

The Committee has been well attended by members during the year with a rolling programme in place for the Chair's of the reporting groups to attend the Committee and offer assurance on the relevant aspects of work.

The Chair and Executive Lead meet monthly to agree the forthcoming committee agenda in line with the work programme.

Key areas of focus of the Committee have included:

- CQC Inspection reports and outcomes
- Mortality
- Harm Reviews
- Never Events
- Serious Incident Reviews
- Quality Impact Assessments
- Infection, Prevention and Control
- CNST Maternity Scheme
- Maternity and Neonatal
- Medicines management
- Safeguarding arrangements

The Committee continued to have a focus on Maternity and Neonatal services following the introduction of the Maternity and Neonatal Oversight Group in 2021/22 which continues to be attended by the Non-Executive Director Maternity Safety Champion.

Due to the national focus on maternity and neonatal services the Committee continued to receive detailed upward reporting which was also offered to the Board alongside supporting documents and reports where necessary.

The Trust, during the course of 2022/23, continued to be part of the Maternity Safety Support Programme however due to the progress made during the course of the year the Trust exited the programme on 25 October 2022.

The Committee continued to receive detailed reports in relation to harm reviews and during the year received upward assurance/exception reports from the Clinical Harm Oversight Group. The Committee was able to receive assurance on the process in place to review clinical harm with a number of developments in the process undertaken during 2022/23 including the introduction of an Artificial Intelligence System to support clinicians.

During the course of the year assurances continued to be received in respect of Infection Prevention and Control with positive movement following a site visit in April 2022 by NHS England/Improvement which saw the Trust move from an Amber to Green rating.

The Committee continued to receive a lack of assurance in respect to Medicines Management however during the course of the year was able to start to receive increased levels of assurance through the Medicines Management Task and Finish Group and Medicines Quality Group upward reports.

Progress on the internal audit and CQC actions had been seen towards the end of 2022/23 with rationalisation of the functioning groups responsible for Medicines Management Oversight undertaken to provide increased focus and responsiveness.

The Committee was pleased to received notification in December 2022 of the removal of Section 31 Conditions from the Trust's CQC registration meaning that the Trust now holds unconditional registration with the CQC.

During the course of the year the Clinical Effectiveness Group continued to make progress with both local and national audit achievement alongside improved assurances being offered to the Committee, which had supported the change to objective 1c of the Board Assurance Framework RAG rating.

Risks

The BAF and Corporate risk register have been updated and reviewed at the committee on a monthly basis identifying where updates have been required based on assurances received at the Committee.

The Committee was pleased to note the full completion of the review of the risk register and the revision of the report which has enabled the Committee to be more clearly sighted on the relevant risks due to the dynamic nature of the register.

Performance Review

The Committee reviews performance against the agreed quality Key Performance Indicators and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover harm free care, improving patient experience and improving clinical outcomes.

The Committee have actively ensured that the KPIs requiring monitoring by the Committee were reported. At each of the meetings during 2022/23 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

During the course of the year the Committee was pleased to note the progress that had been made in the identification of a trajectory to reduce the time taken to respond to complaints and the delivery of this.

Work had been undertaken in respect of open serious incident actions with the Committee noting the significant improvements that had been seen as a result. During 2022/23 the Committee was advised to the change in incident reporting noting the introduction of the Patient Safety Incident Response Framework and was pleased to note the actions underway in year to prepare the Trust for the rollout in 2023/24.

On a monthly basis, along with all Board Committees the CQC Action plan was received and reviewed with positive progress noted on actions being closed and embedded. The Committee also received, on a quarterly basis, full reports to provide governance and assurance.

Performance of the Trust was also monitored through the Commissioning for Quality and Innovation (CQUIN) framework with the Committee receiving reports on performance from quarter 2. There had been agreement by the Integrated Care Board that non-achievement of the CQUINs in year would see a reinvestment of the income to the Trust. This was to support the Trust following NHS England declining an application for the Trust to be excluded from reporting for the year 2022/23.

The Committee continued to receive direct reporting in respect of Duty of Candour noting that there had been fluctuation in performance across the year, recognising that performance has improved overall. Reporting would continue directly to the Committee in order that oversight be maintained, and it was noted that there was a need for consistent monitoring and support to the divisions.

Performance of Venous Thromboembolism (VTE) had varied during the course of the year with some improvements seen however the Committee was mindful of the need for additional VTE assessment support in order for consistent improvement to be achieved.

During 2022/23 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals to the Committee and from the Committee were made during the year offering opportunities for the Quality Governance Committee to seek further assurances.

The Quality Governance Committee is an essential element of the Trust's corporate governance structure. It works closely with the Audit Committee and the Chair of the Quality Governance Committee is also a member of the Audit Committee. The Committee received all internal audits relevant to its remit for consideration of the actions and oversight of the completion of these.

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	21 March 2023
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2022/23 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Lack of Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Workforce Strategy and Organisational Development Group (WSODG) Upward Report** The Committee received the report noting the updates offered in respect of the key performance indicators with the Committee considering the revised datasets presented which were approved. It was noted that attendance and quoracy remained of concern noting that the group needed appropriate attendance in order to provide assurance to the Committee. The terms of reference would be submitted to the Committee in April for approval. **Committee Performance Dashboard** The Committee considered the performance dashboard noting the long-term upward trend in sickness absence and exploring support in place to staff. It was noted that a review of the occupational health service was underway to ensure that this was delivered as a preventative model rather than reactive to better support staff. **Safer Staffing** The Committee received the report noting this offered an update on the January position and reflected the need to ensure aligned reporting to avoid the time lag. Whilst it was recognised that January had been a challenging month operationally there had been improvements in staffing as a result of redeployment being managed in a structured way.

	Triangulation of the quality metrics demonstrated a positive position resulting in moderate assurance being offered. **NHS and System People Plan update** The Committee received the update noting that this offered an overview of quarter 3 progress with the Committee noting the steady rise in substantive staff in post and noted the target for cost savings in the 2023/24 year. Use of agency staff was explored by the Committee with the culture of agency staff use discussed noting that work continued to address both the use and culture of use of agency staffing.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **National Staff Survey** The Committee received the report for information. **Culture and Leadership Group Upward Report** The Committee received the report noting the update offered and was pleased to note that 16 Cultural Ambassadors had been recruited with a training schedule in place. The Committee noted that consideration had been given to this as a joint role with Freedom to Speak Up ambassadors however was noted that a joint role would not be undertaken at this time however would be further explored.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Medical School Update** The Committee received a verbal update noting that progress was being made in a number of areas with work being undertaken to finalise the AP2 module which was due to commence in August 2023. The Committee was pleased to note that the official opening of the Education Centres would take place at Lincoln and Pilgrim on the 28 June and 5 July respectively. **Research and Innovation Governance Group Upward Report** The Committee received the report and continued to note concern in the progress of research and innovation however recognised the presentation that had been made to the Trust Leadership Team in order to make further progress.

	It was noted that the Research and Innovation Team were planning research away days in order to support staff to undertaken and be involved in research. **University Teaching Hospital Group Upward Report** The Committee was pleased to note recent positive discussions which had taken place with the University and recognition of the strategic importance of joint activity with further discussions due to take place in due course.
	Assurance in respect of other areas: **Committee Effectiveness – Final Annual Report** The Committee received and approved the final report noting that this offered a fair reflection of the Committee business over the past 12 months. **Topical, Legal and Regulatory Upward** The Committee received the report noting the content which offered useful updates to the Committee. The Committee noted the need to consider at a future date the NHS Pension Scheme and Workforce Race Equality Standards as detailed within the report. **Integrated Improvement Plan and KPIs for 2023/24** The Committee received the report noting that at month 11 limited assurance was offered due, in the main, to the continued challenge with achievement of appraisal and mandatory training figures. It was recognised that work continued to ensure there was a clear emphasis of the responsibility of leaders in the organisation to ensure that training and appraisals were complete. Trajectories were in place alongside the review of these to enable progress. **Risk Appetite** The Committee considered risk appetite which would inform a wider Board discussion **Audit Recommendations** The Committee received the audit recommendations noting the overdue actions for which extensions had been requested in order to ensure these could be responded to. **Savile Action Plan** The Committee received the action plan noted that the paper offered an overview of the progress made with specific focus on the Disclosure and Barring Service (DBS).

	The Committee noted the intention to commence consultation with staffside colleagues in respect of the change to process for currently employed staff and the completion of DBS checks. These were in place for new starters. **CQC Action Plan** The Committee received the action plans and sought a greater understanding of some of the actions assigned to the Committee and recognised that whilst these appeared to be clinical issues they were driven by recruitment and retention. The Committee noted the intention for a review of the action plan which would be discussed through the Trust Leadership Team and presented back to the Committee.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the 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	A	M	J	J	A	S	O	N	D	J	F	M
Philip Baker (Chair)	X	X	No meeting held	X	No meeting held	X	X	X	X	X	X	X
Gail Shadlock	X	A		A								
Karen Dunderdale	D	X		X		X	X	D	A	D	A	D
Paul Matthew	X	X		X		X	X					
Claire Low								X	X	X	X	X
Colin Farquharson	A	X		X		D	D	D	D	D	D	D
Chris Gibson						X	X	X	X	X	X	X
Vicki Wells						A	A	X	X	X	A	X

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

Annual Report to the Trust Board from the People and Organisational Development Committee 2022/23

ROLE OF THE COMMITTEE

In 2022/23, in line with all other Committees of the Board, the Terms of Reference were reviewed and amended. Under the agreed terms of reference the People and Organisational Development Committee was tasked as follows:

The People and Organisational Development Committee will:

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

A modern and progressive workforce:

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

Making ULHT the best place to work

- Address the concerns around equity of treatment and opportunity within ULHT, so that the Trust is seen to be an inclusive and fair organisation

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

Becoming a University Teaching Hospital

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

MEETINGS

The Committee met monthly during the year, with the exception of June and August 2022. The Committee did not meet in June 2022 due to a requirement for the Executive Directors to attend a System meeting which meant that the Committee would not be quorate. Where the Committee did not meet as a result of the summer period in August 2022 reports scheduled to be received were, where required, deferred to September 2022.

Following the period of working during the Covid-19 pandemic the Committee, in 2022/23 returned to business-as-usual working to full agendas and length of meeting.

The Committee, after each meeting held provided an assurance report to the Trust Board.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2022/23 the Committee was chaired by Professor Philip Baker.

Details of the Committee's membership and attendance during 2022/23 is set out below:

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

Members	12 April 22	10 May 22	14 June 2022	14 July 22	16 Aug 22	13 Sept 22	11 Oct 22	15 Nov 22	13 Dec 22	17 Jan 23	14 Feb 23	14 Mar 23
Non-Exec Director Philip Baker (Chair)	X	X	Committee meeting not held	X	Committee meeting not held	X	X	X	X	X	X	X
Non-Executive Director (Ms Shadlock)	X	A		A								
Non-Executive Director (Dr Gibson)						X	X	X	X	X	X	X
Associate Non-Executive Director (Mrs Wells)						A	A	X	X	X	A	X
Director of People & Organisational Development	X	X		X		X	X	X	X	X	X	X
Medical Director	X	X		X		D	D	D	D	D	D	D
Director of Nursing	D	X		X		X	X	D	A	D	A	D

A denotes Apologies given
D denotes Deputy in attendance
C Director supporting response to Covid-19

REVIEW OF BUSINESS

The People and Organisational Development Committee's work programme for 2022/23 is set out as an appendix to this report.

The People and Organisational Development Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2022/23:

- Objective 2a A modern and progressive workforce
- Objective 2b Making ULHT the best place to work
- Objective 4b Becoming a University Hospitals Teaching Trust

During 2022/23 the Committee has utilised the Board Assurance Framework (BAF) to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. The strategic objectives at the beginning of the year were rated as follows:

Objective 2a – **RED**
Objective 2b – **RED**
Objective 4b – **RED**

Through the year the Committee had continued to receive reports offering assurance against the strategic objectives resulting in the objectives being rated as follows at the end of the year:

Objective 2a – **AMBER**
Objective 2b – **AMBER**
Objective 4b – **RED**

OVERVIEW

The People and Organisational Development Committee has continued to, over the last twelve months, offer a level of assurance to the Board on people and organisational development. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan as defined by the terms of reference, through this annual report.

The work programme for the Committee has focused on the continued workforce challenges faced by the Trust and considered and supported the review and revision of the structure of the People and Organisational Development Directorate.

The Committee has been well attended by members throughout the year and the Chair has been actively involved in the agenda setting alongside the Director of People and Organisational Development.

Other key areas of focus of the Committee have included:

- Freedom to Speak Up
- Guardians of Safe Working
- Safer Staffing
- International Recruitment
- Medical School
- University Hospital Teaching Status
- Culture and Leadership Programme

During 2022/23 the Committee had requested a focus and further development of the subgroups in order to streamline reporting and improve assurance. As a result, the Workforce, Strategy and Organisational Development Group has been established and continues to develop in order to fully function as a subgroup of the Committee.

The Committee has noted the strengthened reporting and refocus of the Culture and Leadership Group. This has enabled the Committee to receive further assurances on the programme of work in place and the actions being taken within the Trust in order to support staff and the organisation to further develop and improve leadership behaviours.

Reporting continued to be received from both the Freedom to Speak Up Guardian and Guardian of Safe Working to the Committee which demonstrates the Trusts' commitment to supporting staff to be able to raise concerns to be addressed.

Regular reports are received by the Committee with attendance at the Committee meetings by both Guardians to ensure that appropriate assurances are received and where necessary escalations made. Through the reports the Committee was pleased to note the levels of reporting from staff within the organisation and also noted the positive response to the anti-racism campaign that ran during 2022/23.

Following the review and revision of the terms of reference of the Equality, Diversity and Inclusion Group the Committee has been pleased to note the progress being made and the improvements in reports being offered to the Committee. Regular reporting has been received from the subgroup offering a level of assurance to the Committee.

Progress had been made in respect of medical workforce and recruitment activity with a reported 110WTE reduction in the vacancy position for medics in year. It was noted that reports for nursing, AHP and clinical support staff was not as positive however assurances received that plans were in place for this to be rectified by year end.

During the course of 2022/23 the Committee remained concerned with the progress in respect of research and innovation requesting additional reporting to the Committee on the strategy for improvement. The Committee supported and approved a revised meeting structure in order to enable further development of research and innovation across the organisation, linked to the University Teaching Hospital aspiration.

Risks

The BAF and Corporate Risk Register have been reviewed at the Committee on a monthly basis identifying where updates have been required based on assurances received at the Committee.

The Committee was pleased to note the completion of the review of the risk register and the revision of the report which has enabled the Committee to be more clearly sighted on the relevant risks.

Performance Review

The Committee reviews performance against the agreed Key Performance Indicators (KPIs) and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover a modern and progressive workforce and making ULHT the best place to work. The metrics presented to the report have been reviewed to ensure that the information presented offers a clear position on the performance of the Trust.

At each of the meetings held during 2022/23 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

The Committee, through the Workforce, Strategy and Organisational Development Group, have an increased level of scrutiny of the KPIs as these are considered by the group prior to reporting to the Committee where escalations and areas of concern are highlighted.

Discussions were held in relation to safer staffing where assurance continued to be offered that there was no correlation between staffing levels and patient harm. The Committee noted that ongoing triangulation of nursing and quality metrics to ensure the quality of care being offered to patients.

The Committee provided a focus on mandatory training and appraisal completion rates noting that performance was a concern. Task and finish groups had been established towards the end of 2022 in order to provide specific focus to these areas. On a monthly basis the CQC Action Plan was also considered by the Committee with the actions included relating to both mandatory training and appraisal.

The People and Organisational Development Committee is an essential element of the Trust's corporate governance structure. It works closely with the Audit Committee and the Chair of the People and Organisational Development Committee is a member of the Audit Committee, which helps provide additional assurance on the adequacy of the Trusts workforce. The Committee received all internal audits relevant to its remit for consideration of the actions and oversight of the completion of these.

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	23 March 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 Group Upward Report** The Committee received the report noting that update offered in respect of the high voltage shut down that had been undertaken for essential maintenance to be carried out. The Committee commended the work that had been undertaken by all teams involved in the shutdown noting the level of collaborative working in order to ensure issues were managed as they arose. Slippage in respect of the Pilgrim Emergency Department capital project was noted however actions were in place to continue to progress. **Entonox Update** The Committee received the update noting that the issue had been discussed by the Board in March with the update offered following correspondence from the Royal College of Nursing whereby this was suggested to be an estates and Health and Safety issue, not clinical. The Committee noted that retesting was being undertaken of the environments and staff working due to the levels of exposure currently reported. More accurate monitoring systems would be required in order to monitor throughout the days and identify any spikes which should be explored. Work was in progress, and it was noted that Health and Safety would be supporting and monitoring staff within maternity in order to ensure best practice was being followed to ensure this was not a contributing factor. Long term solutions, such as changes to the gases used were being explored.

	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts and CIRG Upward Report** The Committee received the report noting the month 11 position and noted the high confidence levels in delivering the system agreed forecast outturn of £13.6m deficit. The Committee noted the limited assurance in respect of efficiency noting that this was received due to the delivery reported to date which would impact on the 23/24 underlying position. Contracting discussions were progressing and moving on with both national and system expectations with the Committee noting that the signing of contracts was linked to financial, activity and workforce planning. The Patient Level Costing Information was received with the Committee noting the work underway in the Trust to use the information to support delivery of the financial position with the Divisions against activity. The Capital position was noted with the Trust on track to deliver a capital spend of £46.5m by year end with additional funding having been received during March. There was a high level of confidence of delivery as had been achieved in previous years. **Better Payment Practice Code** The Committee took the report as read noting the limited assurance offered however recognised the action plan in place which was at the request of NHSE. The Committee was keen to see delivery of the action plan. **Procurement Update** The Committee received the update taking the report as read however had not yet received the procurement pipeline that had been requested in order to ensure sight of upcoming contracts.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting that the Trust had received contact from the Information Commissioners Officer (ICO) to inform that the audit revisit would take place at the end of May. The Committee noted that the group had reviewed the ICO actions and plans were in place to ensure engagement with the divisions and corporate teams to progress further. A working group had been established, meeting on fortnightly basis, in order to progress ICO actions and the data security and protection toolkit.

	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received and noted the moderate assurance offered against the operational performance report. The Committee noted a slight decrease in urgent care performance noting that there had been a slight increase in patients waiting greater than 12 hours. It was noted however that there had been a reduction in ambulances waiting greater than 59 minutes. A comprehensive review of planned care was being undertaken in order to progress with 65 and 78 week waits with new metrics being put in place nationally. It was noted that the Trust was not likely to achieve 78 week wait target due to the impact of the Junior Doctor strike however there had been a significant reduction in the number of patients waiting. The Committee noted the 62-day cancer backlog which was now in line with or better than trajectory with the biggest risk remaining in colorectal services. Significant reductions were also being seen in the 104-day backlog with those remaining being disengaged patients and work underway, alongside the ICB to determine what support was required for those patients to receive treatment.
	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 **Outpatients Deep Dive** The Committee received the deep dive with it noted that the reports were beneficial to the Committee as strong assurances of progress were received. The programme of work and key projects in the programme were noted with the Committee raising the question of sustainability of some of the delivery. It was noted that the target was set nationally with a need to maintain momentum with a joint approach and clinical leadership. **Planning Update**

	The Committee noted that planning was underway for the 23/24 year with work progressing. It was noted that planning currently represented a significant deficit across the Midlands region with clear direction nationally of the need to reconsider plans and work to reduce the position. The Committee noted the submission of the second draft due at the end of March and the final plan to be submitted in April.
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review No reports
	Assurance in respect of other areas: **Committee Effectiveness – Final Annual Report** The Committee received and approved the final report requesting that further detail be included in respect of the levels of assurance received across the year. **Topical, Legal and Regulatory Update** The Committee received the paper noting that the content was a useful guide to areas of interest and to direct discussions at relevant points on the agenda. **Risk Appetite** The Committee considered risk appetite which would inform a wider Board discussion **Audit Recommendations** The Committee received the audit recommendations report noting that there were a number overdue however most were anticipated to be resolved by 31 March 2023. **CQC Action Plan** The Committee received the update noting that actions were covered through other reports received by the Committee and noted that a group would be established to support progress of urgent care associated actions. The Committee also noted the need to receive assurance on the delivery of actions through the reporting groups. **Integrated Improvement Plan and KPIs for 2023/24** The Committee noted the month 11 position which offered limited assurance on progress overall however there had been some sustained improvements across the patient programmes of work. It was noted that there had been positive discussions regarding stretch targets and how this would progress in 23/24.

	Whilst limited assurance was received the Committee noted the increasing assurance received in respect of the infrastructure supporting the IIP. It was hoped that this would place the Trust in good stead moving in to 23/24. **Improvement Steering Group Upward Report** The Committee received the report noting the positive position reported and reflected that whilst there had been some impact on progress during February there was a good structure in place to support delivery. The Committee was delighted to note the achievement of the Elective Hub Accreditation at Grantham noting that it was anticipated targets would be set for delivery as a result. The Committee was pleased to note some reduction in agency spend and the progress made in respect of the medical workforce and improvement benefits from the outpatient work. **Committee Performance Dashboard** The Committee received the report noting the content and reflecting discussions held throughout the course of the meeting had considered all relevant items. **PRM Upward Report** The Committee received the report for information noting that due to the change in structure of the PRM meetings that the report was no longer required to be received by any of the Committees of the Board.
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	A	M	J	J	A	S	O	N	D	J	F	M
Dani Cecchini, Non-Exec Director	X	X	X	X	X	X	X	X	X	X	X	X
Gail Shadlock, Non-Exec Director	X	A	A	X								
Director of Finance & Digital	X	X	X	X	X	D	X	X	X	X	X	X
Chief Operating Officer	X	D	X	X	X	X	X	X	X	X	X	X
Director of Improvement & Integration	X	X	D	X	D	X	X	X	D	X	X	X
Sarah Buik, Associate Non-Executive Director					X	X	X	X	X	X	A	X

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

Meeting	*Trust Board*
Date of Meeting	*4th April 2023*
Item Number	*Item 12*

Integrated Performance Report for February 2023

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

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

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

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

Executive Summary

Quality

Venous Thromboembolism Risk Assessment

Compliance against this metric has slightly increased for the month of February and is currently at 94.03%.

Medications

For the month of February, the number or incidents reported in relation to omitted or delayed medications has increased from the previous month at 31% with medication incidents causing harm decreased at 11.8%. A number of work programmes through the IIP continue and are currently being monitored through the Medicines Quality Group.

Patient Safety Alerts

There are currently 4 patient safety alerts with actions outstanding, 2 relate to medication, 1 to medical gases and 1 to ophthalmology. The number of National Patient Safety Alerts issued each month is usually very small, meaning that there are frequently none or very few that are due in any particular month, and there are often multiple actions required (for example, in February 2023 there was 1 Alert due, in which there was 1 of 6 actions not completed on time relating to the ophthalmology alert).

SHMI

The Trust SHMI has slightly increased this month and is currently at 103.12. 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 89.3% with sending eDDs within 24 hours for February 2023 against a target of 95%. A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric at their monthly Performance Review Meeting.

Sepsis compliance – based on January data

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

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

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

Duty of Candour (DoC) – December Data

Verbal compliance for January was at 94% against a 100% target and 90% for written against a target of 100% within the reporting period. The Clinical Governance team continue to notify clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

Operational Performance

At the time of writing this executive summary (11th March 2023), the Trust has 34 positive COVID inpatients. There is 1 patient requiring Intensive Care intervention. The February peak was 41 patients. The current Influenza inpatients are 1 with the peak in February being recorded at 6 patients. There are currently 9 patients requiring Norovirus prevention/intervention at LCH.

This report covers February's performance, and it should be noted the demands of Wave 7 have now decreased with the number of positive COVID cases remaining static. The teams across the organisation continue to transition to 2022/23 and the recovery of waiting times and continues to return pre-Covid access.

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

A & E and Ambulance Performance

Whilst the summary below pertains to February's data and performance, the proposed revised Urgent Care Constitutional Standards are now in question and the reporting will be adjusted to reflect any new changes including the new 4-hour performance target of 76% and Bed occupancy expectations.

4-hour performance was incompliant against the 4-hour target with a reduction in performance at 58.21%. Which is a 2.46% negative variance against January's position.

There were 702 12-hr trolley waits, reported via the agreed process in February. This represents an increase of 55 patients from January 2023 (647). Sub-optimal discharges/timely recognition to meet emergency demand remains the root cause of these delays.

Performance against the 15 min triage target demonstrated an improvement of 0.55%. 78.62% in February verses a target of 88.50%. A deeper review is required of patients who leave the department or refuse treatment that compromise this performance target.

There were 316 >59minute handover delays recorded in February, a decrease of 184 from January, representing a 57.27% decrease. This is the first time ULHT has recorded a value under 400 since June 2021. February also experienced a decrease of 67.11% in >120mins handover delays compared with January and a 95% decrease in >4hrs handover delays. With the ambition to now focus on 15 and 30min handover delays as per new constitutional standards.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 4.89 days against an agreed target of 4.5 days an improvement compared to January. The average bed occupancy for February against "Core G&A" was in excess of 98%, with PHB demonstrating the highest level of occupancy against core. February saw the highest number of acute beds open at 1059 verses funded core G&A of 968 acute beds.
System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3. Pathway 1 saw a decreased length of stay by 2.4 days compared to January 23.

Elective Length of Stay increased further by 22.15% from 3.52 days in January to 4.30 days in February. This is a continuation from the sharp increased experience in December due to a number of cancellations/delay in treatment. Patient complexity has also increased.

Referral to Treatment

It is important to view Referral to Treatment standard in the context of the current National Recovery Agenda, and the move away from a focus on constitutional standards to the expectation of clinical urgency; a clinical risk-based patient selection process as opposed to selection based upon the longest waits. Whilst RTT was to be disregarded in the revised constitutional standards, this key metric has now been re-instated.

December demonstrated an improvement in performance of 2.27%. January outturn was 49.16%. This is highest improvement since August 2022. The Trust is now reporting patients waiting over 65 weeks as opposed to 52 weeks. The Trust reported 3,487 patients waiting over 65 weeks, which is a decrease of 229 on the reported December 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 February, the Trust reported zero patients waiting longer than 104 weeks. Discussions are taking place with NHSE weekly in regard to 104- and 78-week waiters with an expectation of zero patients over 78 weeks by end of March 2023 including first definitive treatment.

Waiting Lists

Overall waiting list size has increased since December. January reported 72,772 compared to December's position of 72,530 an increase of 242. Work continues between Outpatient department and the Clinical Business Units regarding returning better access to our bookable services for primary care and patients' choice.

The recovery plan for ASIs has been developed, including a recovery trajectory. As of 12th March, ASI recovery has demonstrated an improvement (564 in February verses 627 in January) and is more in line with 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 February reported 60.12% versus 55.33% in January compliance against the national target of 99%. A positive variation of 4.79% improvement on the January outturn but still a negative variance of 38.88% against the nationally agreed target. Whilst the main area of concern remains Echocardiography, they are signs of improvement, DEXA backlog has reduced to 1163 in February compared to 1311 in January. Endoscopy backlog due to outpatient recovery, in particular, colorectal. This will be supported by the utilisation of Medinet.

Cancelled Ops

The compliance target for this indicator is 0.8%. January demonstrated a 1.28% compliance. This is an improvement of 0.77% on January but a negative variance of 0.48% against the agreed target.

The target for not treated within 28 days of cancellation is zero. February experienced 22 breaches against the standard verses 32 in January.

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 41.23% (against 85.4% target.) This demonstrates a deterioration of 8.06% in performance since the last reporting period and is 44.17% below the nationally agreed compliance target. However, the position against the Trust recovery trajectory is just 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 127 patients waiting >104 days against a target of <10. The current figure is a further decrease of 35 patients since the last reporting period. The highest risk speciality is colorectal with 83 greater than 104 weeks, this a further reduction of 19 since the last reporting period. 3 times weekly meetings are in place to offer challenge and confirm.

Workforce

Mandatory Training – The mandatory training rate for February has dropped by 0.44% to 88.81%. Whilst the software issues were resolved in February 2023, this was not until towards the end of February, the transfer over to edge has resulted in some other training packages no longer being available discussion are taking place to look at actions that can be taken to resolve this. The Mandatory Training Action Plan

has now been approved and work is underway to improve our mandatory training compliance, including the review of all core and topics to ensure these are still required. A 6-month progressive compliance target has been agreed with the final target of 95% to be achieved by October 2023.

Sickness Absence – There has been a further increase this month by 0.02% to 5.61% which is still above the target of 4.5%. The continued recruitment campaigns to fully staff the new People and Organisational Development Teams within the new structure continues which will commit to the full support and management of all absence across the Trust. Work continues around the performance management process in regards to managers who are not using AMS to manage their team's absence. Work continues with the Health and Well-Being of our staff with the support of the Employee Assistance Programme.

Staff Appraisals – Ongoing service pressures and staffing challenges in the Trust continue to impact appraisal completion rates but month on month there is a slight improvement with an increase this month to 65.39% non-medical and 97.88% for medical; this giving a trust average of 81.64%. As we commence our action planning further to the results from the 2022 staff survey, every team member having an appraisal will be part of this action planning. An appraisal forms part of the basics brilliantly strategic work stream and how to have effective appraisals including the recording of these will be within our leadership fundamental training.

Staff Turnover – Turnover continues to see a small month on month reduction with February turnover being 13.55% against a Target of 12%. Operational pressures, staffing and culture challenges mean that a regular proportion of staff are looking for other avenues outside the Trust. The OD team previously offered face to face / Teams exit interviews to gather deeper insights on the reasons for leaving (in addition to ESR / EF3 form results), however this has not been available in recent months due to capacity. 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, planning currently underway for next year's system plan. The recent analysis illustrates that 17% of resignations could be avoided through better management, relationships, flexible working and career opportunities if offered in the Trust. It is anticipated that as well as addressing retention issues through the Culture and Leadership Programme and People Promise work increased recruitment activity will in time reduce workforce challenges and offer support to challenged clinical areas in reducing turnover.

Vacancies – We saw a 0.6% decrease in vacancy factor in February to 7.7%, this was due to us having a significant number of starters joining the Trust. We need to keep an ongoing focus on HCSWs and Nurses over the coming months, with a particular focus on International Nurses, as this supply route expands. We may see an increase in our vacancy factor in coming months due to sizeable business cases for Community Diagnostics and Housekeeping being signed off which will increase our funded establishment, however despite this due to significant recruitment our net staffing position will continue to grow.

Statistical Process Control Charts

Finance

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

The Trust delivered a deficit of £0.3m in February (£0.3m adverse to plan) and the Trust YTD delivered a deficit of £13.4m deficit (£13.4m adverse to plan).

CIP savings of £15.9m have been delivered YTD (£9.3m adverse to planned savings of £25.2m).

Capital funding levels for 2022/23, agreed through Trust Board & FPEC, show a plan of c£38.8m; capital expenditure incurred YTD equated to £22.1m.

The February 2023 cash balance is £31.9m, which is a decrease of £56.4m against the March year-end cash balance of £88.3m.

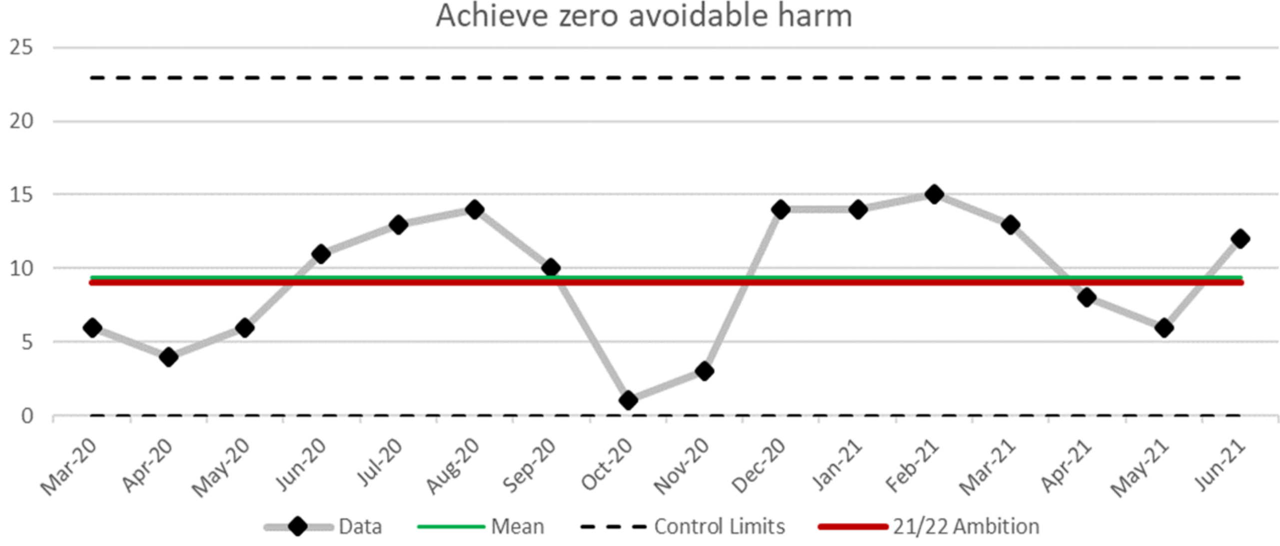
Paul Matthew
Director of Finance & Digital
February 2023

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:



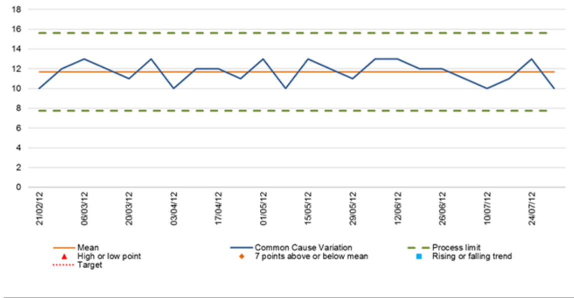
Statistical Process Control Charts

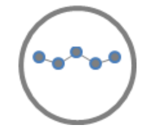
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

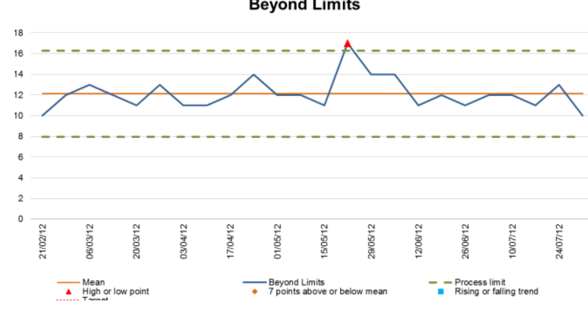
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful 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:





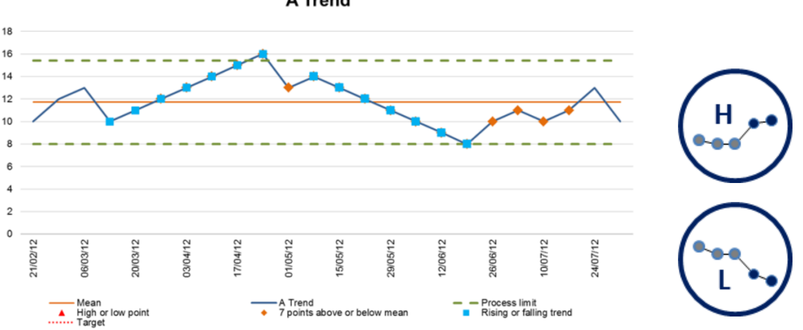
Extreme Values
There is no Icon for this scenario.



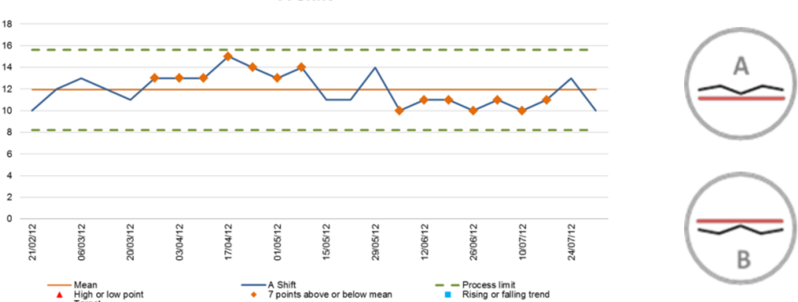
Quality | Operational Performance | Workforce | Finance

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.

EXECUTIVE SCORECARD

Measure ID	Domain	Measure	Measure Definition	SRO	2022/23 Ambition	Tolerance	£'000	Dec-22	Jan-23	Feb-23	Latest month pass/fail to ambition/ tolerance	Trend variation
1	Patients	Implementation of SAFER Bundle – LOS > 7 Days pathway 0	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients.	COO	10.00%	1.00%		12.87%	12.81%	11.68%	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 (103.16) (75th of 121)	3rd Quartile (102.68) (75th of 121)	3rd Quartile (103.12 (71st of 121)	P	B
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		0.33	0.39	0.06	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		0.08	0.03	0.09	F	
6	Patients	Reduction in DKA incidents resulting in moderate & severe harm or death	Total number of DKA incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	MD	TBD	TBD		0.03	0.03	0.03		
7	Patients	Achievement of the IPC BAF	% of green/compliant items from the IPC COVID BAF C1501 v1.8 (quarterly)	DoN	95.00%	1.00%					P	
8	Services	Financial Plan	Variance aganst plan (£'000)	DoF	£0	£0	£'000	(3,146)	(610)	(276)	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%		19.98%	13.88%	15.01%	F	
10a	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	COO	503	100		8,282	7,563		F	A
10b	Services	Patients waiting 65 weeks or more	Number of patients waiting 65 weeks or more (RTT pathways)	COO	TBD	TBD		3,716	3,487			
11	Services	28 days faster diagnosis	Number of patients diagnosed within 28 days or less of referral as a percentage of total Cancer pathways.	COO	75.00%	5.00%		59.56%	55.58%		F	A
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	DoPOD	9.00%	1.00%		8.98%	8.30%	7.72%	P	
13a	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	DoPOD	90.00%	2.00%		63.74%	64.24%	65.39%	F	A
13b	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	DoPOD	95.00%	2.00%		89.78%	89.25%	88.81%	F	
14	People	Improved Pulse Survey results (Quarterly staff survey)	Improvement in the % of people rating their likelihood of referring the Trust to Friends and Family (Agree & Strongly Agree)	DoPOD	55.00%	5.00%						
16	Partners	Increased recruitment/academic posts (across the ICS)	Number of posts appointed	DII	10	2						
18	Partners	Early Warning Discharge Indicators	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, for pathway 1-3 patients.	COO	50%	10.00%		78.83%	80.56%	75.83%	F	

Quality | Operational Performance | Workforce | Finance

Implementation of SAFER Bundle – LOS > 7 Days pathway 0

Feb-23
11.68%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
10% with 1% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Whilst not achieving the ambition of 10%, improvements are being realised. What the chart isn't telling is that the average time from medically Optimised to discharge for Pathway 0 in February was 1.1 days a further reduction of 0.1 days experienced in January.

Issues:
Numbers of stranded and super stranded patients has increased across all 3 Acute Sites.
Higher acuity of patients requiring a longer period of recovery post Winter Impact, and complexity of post hospital care.
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 now reduced.
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

Reduction in medication incidents leading to moderate & severe harm or death (per 1000 OBD)

Month	Data
Dec-21	0.20
Jan-22	
Feb-22	
Mar-22	
Apr-22	
May-22	
Jun-22	
Jul-22	
Aug-22	
Sep-22	
Oct-22	
Nov-22	
Dec-22	
Jan-23	0.03
Feb-23	0.09

Legend: Data, Mean, Control Limits, 2022/23 Ambition

Feb-23
0.09
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:
In the month of February the number of Medication incidents per 1000 bed days was 0.09. This is an increase from the January figure of 0.03.

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

Financial Plan - Varance against plan (£000)

£6,000
£4,000
£2,000
£0
-£2,000
-£4,000
-£6,000
-£8,000

Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

Data — Mean — Control Limits — 2022/23 Ambition — LCL

F

Feb-23
Variance to plan (£276) k
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
£0
Achievement
Metric is failing the target
Executive Lead
Director of Finance

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

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

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

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

Mitigations:
Continued focus upon the delivery of cost improvement, monitoring of the TLT action plan, agreement to transact the Risk and Gain Share in relation to Care Closer to Home (which has resulted in a contract variations for £8m in relation to the projected slippage), and agreement of a forecast deficit of £13.6m as part of a revised ICS forecast for 2022/23.

Percentage of patients spending more than 12 hours in Emergency Department

Feb-23
15.01%
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:
February experienced a slight increase in the numbers of patients with an aggregated time of arrival greater than 12 hours against total attendance. 1656 compared to 1652 in January. What this chart doesn't tell us also is that February saw a reduction of 279 patients into the department compared to January.

Issues:
February experienced a 2.29% decrease in Type 1 attendances to ED compared to January 23. This decrease in Emergency Department attendances resulted in 11.69% less non-elective admissions. However the main factor contributing to the delays still seen, is due to inadequate discharges from exit block/ timely recognition of discharges to meet the demand and flow. Increased number of patients experiencing an elongated LOS due to requiring non acute admission but requiring access to an alternative health care setting such as domiciliary care, transitional care, community hospital and Adult Social Care. The establishment of a joint health and social care off for domiciliary care is in place and capacity to access this is increasing.
Delays in time to first assessment contribute to the clear formulation of a treatment plan, especially out of hours.

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

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

Patients waiting 65 weeks or more

F H

6,000
5,000
4,000
3,000
2,000
1,000
0

Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23

Data — Mean — Control Limits — 2022/23 Ambition — LCL

Jan-23
3,487
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
2022/23 Ambition/Tolerance
TBD
Achievement
Executive Lead
Chief Operating Officer

Background:
Number of patients waiting more than 65 weeks for treatment.

What the chart tells us:
The Trust reported 3,487 incomplete 65-week breaches for January 2023, a decrease of 229 from December 2022's 3,716.

Issues:
Whilst ULHT's position is strong with 104 week wait patients, with 1 patient reported for January; performance is less assured with 65 week waiters. Both admitted and non-admitted patients sit within this backlog, however, the most significant pressure remains in the non-admitted pathways. The doctors scheduled industrial action will have a detrimental effect on performance.

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

Mitigations:
Theatre productivity and HVLC compliance are worked through by the theatres group to support admitted pathways. The Integrated Elective Care Co-Ordination Programme will provide a single, real time view of clinical prioritisation of our patients with reduced cancellations and increased efficiency of the 642 process
ORIG supports delivery of Outpatient improvements for the non-admitted pathways.

28 days faster diagnosis

Jan-23
55.58%
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 55.58% 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, breast and lung (see 2ww Suspect).
Diagnostic capacity challenges and clinical review capacity.

Actions:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program.
Recruitment to vacant CNP post focus on clinical reviews below 28 days is currently on hold until potential re-banding and substantive funding is in place.
Recruitment is underway in Respiratory, ENT and Haematology specialties to improve Consultant availability and clinical review capacity.
Theatre capacity for Urology diagnostics remains a challenge – work to increase this capacity and reduce bottlenecks is ongoing. Daily Diagnostic Huddles have been implemented within the Urology CBU and diagnostic capacity for TPGA and TPLA is being explored at Grantham.
Recruitment is underway in Respiratory, ENT and Haematology specialties to improve Consultant availability and clinical review capacity.

Mitigations:
A new electronic and streamlined admin process is in place in respiratory and being embedded at LCH – this is now also being reviewed for PHB too.
In gynaecology, the 90 minute standard has been introduced and is implemented daily.
A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention/support. However, the Pre-Diagnosis Team workload continues to be impacted by an increasing backlog.
All tumour site CBUs recently attended and engaged with the introduction of the Cancer Centre FDS Dashboard to understand their performance and explore areas to focus on improvement. The Dashboard went live on 06/02/2023.

Appraisal rates and training development (Appraisal Rates)

F A

Month	Data
Dec-21	
Jan-22	
Feb-22	
Mar-22	
Apr-22	
May-22	
Jun-22	
Jul-22	
Aug-22	
Sep-22	
Oct-22	
Nov-22	
Dec-22	
Jan-23	
Feb-23	

Y-axis: 100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0%

Legend: Data, Mean, Control Limits, 2022/23 Ambition

Feb-23
65.39%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
2022/23 Ambition/Tolerance
90% with 2% tolerance
Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
% completion is currently 65.39% **(non-medical)**

What the chart tells us:
We continue to be off track on this measure

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

Actions:
- Resources are being allocated to review these two key issues and report back to the Director of People and OD by 31/3/23
- Further areas of work are also scheduled to commence in March 2023 which will support the development of an Improvement Action Plan and realistic trajectories to eventually reach a compliance target of 90%
- Appraisal completion to be focussed on through FPAM
- Appraisal Training to become mandatory in the year 2023/24 for all our leaders

Mitigations:
See actions

Appraisal rates and training development (Core Learning)

Chart axis: 80% to 100%; months Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23, Feb-23

Legend: Data, Mean, Control Limits, 2022/23 Ambition

Feb-23
88.81%
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 People and OD

Background:
% completion is currently 88.81

What the chart tells us:
Mandatory training compliance has dropped and requires action

Issues:

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

Actions:

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

Mitigations:
Improvement Action Plan

Early Warning Discharge Indicators

Month	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23

Legend: Data, Mean, 0.02, 2022/23 Ambition, LCL

Feb-23
75.83%
Variance Type
Metric is currently experiencing Common Cause Variation
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 75.83% against a 50% 2022/23 ambition with a 10% tolerance. This is a decrease in performance of 4.73% compared to January 23.

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.

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Dec-22	Jan-23	Feb-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	1	8	5	65	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	0.00	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	0.01	0.01	0.02	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	0.08	0.13	0.13	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	1	0	5	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	3	2	9	F	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	7	11	4	63	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	93.68%	93.70%	94.03%	94.37%	F	
	Never Events	Safe	Patients	Director of Nursing	0	1	0	0	5	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	6.02	5.02	5.32	5.82	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	13.7%	21.0%	11.8%	13.34%	F	

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Dec-22	Jan-23	Feb-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	None due	100%	0%	52.67%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	94.89	93.98	93.79	94.44	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	103.16	102.68	103.12	105.59	F	L
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	100.00%	99.64%	P	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	89.20%	91.50%	89.30%	90.07%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	87.0%	90.0%		90.78%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	81.7%	84.8%		86.18%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	92.0%	94.0%		93.77%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	100.0%	100.0%		79.87%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	89.0%	92.0%		90.53%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	84.0%	90.0%		85.80%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	92.0%	96.0%		93.88%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	57.0%	89.0%		63.29%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.21	2.44	2.22	2.75	P	
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	93.00%	94.00%		86.50%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	81.00%	90.00%		79.80%	F	

Pressure Ulcers category 4

Month	Data
Jan-22	1
Feb-22	1
Mar-22	0
Apr-22	0
May-22	1
Jun-22	2
Jul-22	0
Aug-22	0
Sep-22	0
Oct-22	1
Nov-22	0
Dec-22	0
Jan-23	3
Feb-23	2

Legend: Data, Mean, Target, Control Limits

Feb-23
2
Variance Type
Metric is currently experiencing Common Cause Variation
Target
1.3
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Pressure Ulcers Category 4

What the chart tells us:
The Trust recorded 2 category 4 incidents against a target of 1 per month.

Issues:
There have been two Category 4 pressure ulcers reported in February. This is a decrease from 3 in January.

Following validation, it was evidenced that both incidents had deteriorated from existing skin damage, 1 from a Category 3 pressure ulcer and 1 from an Unstageable pressure ulcer.

Neither of these incidents related to device related pressure damage.

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

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

Mitigations:
The Patient Pressure Ulcer Incident Panel have sight of any other areas of concern that are not raised through the serious incident process.

Learning outcomes continue to be added to the overarching action plan, which is reviewed each month by the Quality Matron and Tissue Viability team, themes are discussed at the Skin Integrity Group (SIG) meeting.

Venous Thromboembolism (VTE) Risk Assessment

Feb-23
94.03%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is failing the target
Executive Lead
Medical Director

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

What the chart tells us:
VTE risk assessment 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.

Medication incidents reported as causing harm (low /moderate /severe / death)

Month	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23

Legend: Data, Mean, Target, Control Limits

Y axis: 0%, 5%, 10%, 15%, 20%, 25%, 30%, 35%

Feb-23
11.8%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10.7%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of February the number of incidents reported was 169. This equates to 5.32 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 11.8% 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:

Patient Safety Alerts responded to by agreed deadline

120%
100%
80%
60%
40%
20%
0%

Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

Data — Mean — Target — Control Limits

Feb-23
0%
Variance Type
Metric is currently experiencing Special Cause Variation – outside the control limits
Target
100%
Target Achievement
The metric has failed to target
Executive Lead
Medical Director

Background:
Percentage of patient safety alerts responded to by an agreed deadline

What the chart tells us:
There is considerable variance month to month in the completion of actions required from National Patient Safety Alerts (NatPSAs)

Issues:
The number of National Patient Safety Alerts issued each month is usually very small, meaning that there are frequently none or very few that are due in any particular month, and there are often multiple actions required (for example, in February 2023 there was 1 Alert due, in which there was 1 of 6 actions not completed on time).

Actions:
Details of all required actions are sent to the identified professional lead and responses coordinated by the Risk & Governance business partner for the lead division.

There are currently 4 Alerts with actions outstanding: 2 relate to medication; 1 to medical gasses; and 1 to ophthalmology.

Mitigations:
The response to National Patient Safety Alerts is coordinated by the Risk & Incident Team in Clinical Governance using the Medical Equipment Management System (MEMS).

Details of all outstanding Alerts are included in the monthly divisional Integrated Clinical Governance Report.

Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)

Chart axis: 95–120; months Jan-22 to Feb-23. Legend: Data, Mean, Target, Control Limits.

Feb-23
103.12
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
To remain in "as expected" range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
SHMI is at the lowest level for the Trust and is 'as expected'.

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

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

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

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

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

HSMR is 93.79 (rolling 12 months)

eDD issued within 24 hours

Feb-23
89.30%
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 89.3%.

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

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

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

Sepsis screening (bundle) compliance for inpatients (child)

Chart axes: 40% to 110%; months Jan-21 to Jan-23. Legend: Data, Mean, Target, Control Limits.

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

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

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

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

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

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

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

Legend: Data, Mean, Target, Control Limits

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

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

What the chart tells us:
The data this month shows that the IVAB compliance was 88.9%, which is 8 of 9 patients, and is below the 90% target. 1 patients was delayed in receiving antibiotics.

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

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

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

Duty of Candour compliance - Verbal

Jan-23
94.00%
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 achieving 100% compliance with Duty of Candour requirements consistently within 1 month of notification. However, in December 2022 and January 2023 it was above 90%

Issues:
Duty of Candour compliance is measured by extracting patient safety incident data from the Datix system, which may not always be updated promptly.

In addition, the chart above shows compliance within 1 month of an incident being reported. It does not show where Duty of Candour is completed after more than 1 month.

Actions:
Risk & Governance Coordinators are sighted on each day's notifiable incidents and are working closely with the Divisional teams to eliminate the backlog and improve the timeliness of completing Duty of Candour.

There is now only1 case outstanding for verbal Duty of Candour from 2022 and 2 from January 2023.

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

Duty of Candour compliance - Written

Chart: y-axis 0% to 120%; x-axis Jan-22 to Jan-23. Legend: Data, Mean, Target, Control Limits.

Jan-23
90.00%
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 achieving 100% compliance with written follow-up Duty of Candour requirements consistently within 1 month of notification. However, in January 2023 it was above 90%.

Issues:
Duty of Candour compliance is measured by extracting patient safety incident data from the Datix system, which may not always be updated promptly.

In addition, the chart above shows compliance within 1 month of an incident being reported. It does not show where Duty of Candour is completed after more than 1 month.

Actions:
Risk & Governance Coordinators are sighted on each day's notifiable incidents and are working closely with the Divisional teams to eliminate the backlog and improve the timeliness of completing Duty of Candour.

There is now only 1 case outstanding for written follow-up Duty of Candour from 2022 and 3 from January 2023.

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

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Dec-22	Jan-23	Feb-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.54%	0.26%	0.27%	0.30%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	58.12%	60.67%	58.21%	60.55%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1034	647	702	8883	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	67.63%	77.99%	78.62%	79.14%	88.50%			
	65 Week Waiters	Responsive	Services	Chief Operating Officer	TBC	3716	3487		26,232				
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	46.89%	49.16%		49.16%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	72,530	72,772		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	50.29%	41.23%		48.74%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	61.43%	66.95%		60.24%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	21.51%	14.41%		24.62%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	93.47%	89.97%		90.91%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	95.10%	99.31%		97.58%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	86.49%	83.33%		74.74%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	96.81%	92.39%		95.71%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	69.23%	44.00%		65.25%	90.00%			

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Dec-22	Jan-23	Feb-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	74.75%	56.32%		68.73%	85.00%			
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	51.42%	55.35%		53.07%	99.00%			
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.74%	2.05%	1.28%	2.09%	0.80%			
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	37	32	22	334	0			
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	86.52%	88.46%	65.56%	75.42%	90%			
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	66.29%	67.95%	37.78%	55.13%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,614	3,638	3,475	3,775	4,657			
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	998	497	316	748	0			
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	190	162	127	1,608	110			
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.72	3.52	4.30	3.12	2.80			
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	5.14	5.05	4.89	5.02	4.5			
	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	22,042	22,664	23,309	22,761	4,524			
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	32.63%	32.60%	31.35%	35.12%	70.00%			
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	43.60%	43.47%	43.87%	39.55%	45.00%			

% Triage Data Not Recorded

Month	% Triage Data Not Recorded
Nov-21	
Dec-21	
Jan-22	
Feb-22	
Mar-22	
Apr-22	
May-22	
Jun-22	
Jul-22	
Aug-22	
Sep-22	
Oct-22	
Nov-22	
Dec-22	
Jan-23	
Feb-23	

Legend: % Triage Data Not Recorded, Mean, Control Limits, Target

Y-axis: 0.0%, 0.1%, 0.2%, 0.3%, 0.4%, 0.5%, 0.6%, 0.7%

Feb-23
0.27%
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%.
February reported a non-validated position of 0.27% of data not recorded verses January reported validated position of 0.26% data not recorded
This will improve further once validation is complete
This metric is below target.

Issues:
- Recognition of patients that "Did Not Wait/Refused Treatment". 79.66% of those "triage data not recorded" were due to patients leaving the department prior to triage being conducted.
- Recognition of patients who were transferred from one site to another for continued emergency care/direct admission to specialty.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been less problematic at all three sites.
- Staffing gaps, sickness and skill mix issues

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

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

%Triage Achieved under 15 mins

Feb-23
78.62%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage achieved under 15 minutes.

What the chart tells us:
The compliance against this target is 88.50%.
February outturn was 78.62% compared to 78.07% in January (validated).
This demonstrates an improvement in performance of 0.52% and a 9.88% negative variance against the agreed target.

This target has not been met.

Issues:

- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 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.

4hrs or less in A&E Dept

Chart (Nov-21 to Feb-23): 90%, 85%, 80%, 75%, 70%, 65%, 60%, 55%, 50%, 45%, 40%
Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23, Feb-23
Trajectory — Mean — Control Limits — 4hrs or less in A&E Dept

Feb-23
58.21%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The 4-hour transit target performance for February was 58.21% compared to 60.67% in January, which is a decline of 2.46%.
The target compliance is 83.12% and is an historic target that has been unchanged in 2 years.

Issues:
ED saw a 2.29% decrease in Type 1 Attendances compared to January 2023 but 9.11% more than seen in February 2022. A large proportion of the decrease can be attributed to the remaining impact of Winter/Cold. High acuity of patients has required longer attendance in the department.

Ward Based Discharges were an average of 35 short to meet ED demand each day – this resulted in prolonged bed waits overnight. Early recognition of discharges also lead to the extended LOS within ED.

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.

12+ Trolley waits

Legend: 12+ Trolley waits; Mean; Control Limits; Target

Y-axis: 0 – 1600. X-axis: Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23, Feb-23

Feb-23
702
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
There is a zero tolerance for greater than 12-hour trolley waits. These events are reported locally, regionally, and nationally.
What the chart tells us:
February experienced 702 12-hr trolley wait breaches. This is an increase of 66 12-hr trolley wait breaches compared to January. This represents a decline of 8.5%. This equates to 5.78% of all type 1 attendances for February.
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 12hr trolleys were anticipated against flow predictions
There remains some complacency in terms of 12hr trolley waits following the winter peak of 84.64% increase seen.

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.

EMAS Conveyances Delayed >59 mins

Legend: Trajectory; EMAS Conveyances Delayed >59 mins; Mean; Control Limits

Feb-23
316
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:
February demonstrated a further improvement with decreased waits greater than 59 minutes'. 316 compared to 497 in January and 998 in December. This represents a 36.41% improvement.
What the chart does not tell us is that this is the first time ULHT has been under 400 for delayed EMAS conveyances since June 2021 and prior.
Also handovers <30mins improved by 3.09%

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.

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.

Average LoS - Elective

Feb-23
4.30
Variance Type
Metric is currently experiencing Common Cause Variation
Target
2.80
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for Elective inpatients.

What the chart tells us:
The average LOS for Elective stay has increased from 3.52 days in January to 4.30 days in February. This is an increase of 0.78 days and represents a negative variance of 1.50 days against the agreed target.

Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

Actions:
The reduction in waiting times is being monitored weekly.
Focus on speciality waiting lists where patients have been identified as having increased morbidity which will impact of increased LOS.
Timely ITU 'step down' of level 2 care to level 1 'wardable' care.
The complete review and allocation of 'P' codes. This is currently at c6weeks.
Work is in train to include an ALOS predictor against procedure normal LOS vs patient specific indicators when scheduling patients for theatre.

Mitigations:
6-4-2 weekly theatre scheduling meeting will identify those patients that will need an extended LOS and consideration for increased optimisation to reduce predicted LOS.
All elective areas are to now escalate pre-operatively any post-operative requirements that may lead to an extended LOS outside of the expected LOS.

Average LoS - Non Elective

6
5
4
3

Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

Average LoS - Non Elective — Mean — Control Limits — Target

Feb-23
4.89
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 4.89 days in February This is an improvement of 0.16 days and a 0.39-days negative variance against the agreed target.
What the chart doesn't tell us is that the improvement has shown most within Pathway 1 by 2.4 days less compared to January 23, and a further 0.3 less days once made medically Optimised to discharge LOS.

Issues:

Super –stranded patients has seen an increase from Januarys 137 to Februarys 145 daily average.

Weekend Discharges remain consistently lower than weekdays with an average of 40% less than required to meet Emergency Admission Demand.
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 Norovirus patients both internally and external in care providers causing closure has also lead to delayed discharge and impacted on improvement being realised with length of stay.

Actions:

These actions are repetitive but still appropriate
Focused discharge profile through daily escalations.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
The move to Lateral Flow Testing as opposed to PCR testing for access to onward non acute care is proving beneficial once Community and social care is secured.
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.
Line by line review of all pathway fully 0 patients who do not meeting the reason to reside.
A new approach to SAFER and P0 discharges is being considered via URIG

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.

18 Week Incompletes

Chart (monthly, Nov-21 to Jan-23; y-axis 40%–90%). Legend: Mean, Control Limits, Trajectory, 18 Week Incompletes.

Jan-23
49.16%

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. January 2023 saw RTT performance of 49.16% against a 92% target, which is 2.27% up from December 2022.

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 – 5728 (decreased by 159)
- Gastroenterology – 3729 (decreased by 172)
- Dermatology – 3007 (decreased by 249)
- Respiratory Medicine – 2682 (decreased by 77)
- Gynaecology – 2575 (increased by 17).

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

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

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

Waiting List Size

Jan-23
72,772
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 December 2022, with January showing an increase of 242 to 72,772
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 – 8781
- Ophthalmology – 6306
- Gastroenterology – 6173
- Gynaecology – 5172
- Dermatology – 5079

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:
The number of patients waiting over 78 weeks has decreased by 124 from December. There is a daily 78 week cohort meeting between the ICB and ULHT to monitor progress against target. Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced, with an established process for this now in place for several specialties.

Diagnostics Achieved

Feb-23
60.12%
Variance Type
Metric is currently experiencing Common Cause Variation
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 60.12% against the 99.00% target.

Issues:
Most diagnostic breaches sit in Cardiac Echo with 5800 breaches recorded in February
MRI has 1104 breaches. Additional outsourcing to help reduce the backlog from January 2023 hopefully reducing breaches to within limits by June
There are 1163 Dexa Breaches as the scanner is now up and running we should see a reduction of around 200 breaches each month
Additional to the 5800 cardiac echoes there are additional 96 Stress/TOES and 195 echo-paediatrics.

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 200 reduction each month as now up and running. Expecting a big reduction in March DMO1 as additional sessions placed.

Mitigations:
All waiting lists are being monitored. Going forward every new referral will have a D code assigned to each patient. This will make sure all patients are seen in clinical urgency. Additional list for ultrasound and echo.

Cancelled Operations on the day (non clinical)

4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%

Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

Target — data — Mean — Control Limits

F

Feb-23
1.28%
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 February.

What the chart tells us
There was a significant decrease of patients cancelled on the day from 2.05% in January to 1.28% in February, though this remains above the agreed trajectory of 0.8%

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

- Lack of time
- No surgeon
- No L2 beds/No equipment

Actions:
The Super Sprint started on 16th January and one focus is the NiNE approach (Needle In at Nine Every time) which has shown a static number of patients being cancelled due to lack of time from at 9 however a reduction on the Grantham site from 4 to 2 in February.
A text reminder service is currently in design with IT colleagues in order to reduce the number of DNAs.

Mitigations:
Short notice surgeon sickness played a significant part in on the day cancellations although, in February, these were all attributed to one high volume list on one day.

Not treated within 28 days. (Breach)

Chart data (read from plot):

Month	Not treated within 28 days. (Breach)
Nov-21	22
Dec-21	21
Jan-22	31
Feb-22	25
Mar-22	22
Apr-22	33
May-22	20
Jun-22	21
Jul-22	23
Aug-22	37
Sep-22	38
Oct-22	36
Nov-22	35
Dec-22	37
Jan-23	32
Feb-23	22

Legend: Not treated within 28 days. (Breach) — Mean — Control Limits — Target

Feb-23
22
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There have been further reductions in February, with the total number of breaches at 22 against 32 in January, though the agreed target of zero has not been achieved.

Issues:
There were reduced orthopaedic lists during February due to both concentration on outpatient activity and high levels of trauma activity.

Additionally to this, increased levels of annual leave have given reduced list availability.

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

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

Mitigations:
The Productive Theatre/Super Sprint initiative has meant more focus on list utilisation and therefore this has supported ensuring lists are fuller, providing ability to reduce breaches which is evident in the reduction of breaches.

Fracture NOF 48 Hours

Chart: Fracture NOF 48 Hours, Nov-21 to Feb-23 (y-axis 50% to 110%). Legend: Fracture NOF 48 Hours, Mean, Control Limits, Target.

Feb-23
65.56%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
February performance out turned at 65.56% against the agreed target of 90%. This is a deterioration on January's position

LCH Site underperformed at 61.11% and PHB at 72.22%. Both of which were significant deterioration on performance

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.
Reduction in specialty trauma lists on Boston and Lincoln sites.
Lack of anaesthetic or theatre staff to provide additional trauma capacity.
Elective patients given priority over trauma 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 and reduction of electives over winter months to ensure optimal trauma flow.
Current involvement with LCHS in T&F Group for improving outcomes, particularly neck of femur length of stay.
Review of additional trauma lists through job planning process
Band 7 Trauma Lead advertised to ensure streamlining of processes and utilisation of lists.

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.

Partial Booking Waiting List overdue to followup

Chart: Partial Booking Waiting List, Nov-21 to Feb-23 (y-axis 0 to 30,000). Legend: Partial Booking Waiting List, Mean, Control Limits, Trajectory. Icons: F; common cause variation.

Feb-23
23,309
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 23,309 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased and has continuously increased until April 2022. Since then the PBWL has remained reasonably stable with small decreases / increases per month.

Issues:
The organisation is continually pressured in a number of areas especially in urgent / emergency care, requiring patient flow to be prioritised. Activity is reduced against pre-covid activity levels with resources being the main driver to the reduced activity.
Rehab medicine have added an additional cohort of patients to the Trust PBWL.

Actions:
PBWL meeting has been relaunched with a new agenda and template to improve attendance and focus with PBWL. PIFU implementation has been refreshed and will be rolled out to the relevant specialties with PIFU schedules replacing PBWL schedules in March / April.
Personalised Outpatient Plan is still being worked on to maximise validation, clinical triage, and technological solutions.
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 when required. The priority has been to ensure patients waiting in the over 78 week cohort get an appointment and are seen as soon as possible.

62 Day Classic

Chart legend: Trajectory; 62 Day Classic; Mean; Control Limits. Y-axis 0%–90%; X-axis Nov-21 to Jan-23.

Jan-23
41.23%
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 41.23% 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:
In Oncology, recruitment is ongoing to secure locum, NHS locum or substantive posts. 3 Medical Oncologist posts are out to advert as locums. A 6 month Oncology SpDr post went out to advert from which we have 2 appointable candidates. Confirmation as to whether both can be appointed is awaited.
Theatre capacity is improving and will be further alleviated now that the new theatres have opened at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.

Please also see Actions on accompanying pages.

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

Please also see Mitigations on accompanying pages.

62 Day Screening

Jan-23
44.00%
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 44% 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.

62 Day Consultant Upgrade

Jan-23
56.32%
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 56.32% 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.

2 Week Wait Suspect

Chart legend: 2 Week Wait Suspect — Mean — Control Limits — Target

Y-axis: 100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%

X-axis: Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23

Jan-23
66.95%
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 66.95% 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 44% of the Trust's January 14 Day breaches within that tumour site.
Also of concern, although an improving picture in January, was skin performance which accounted for 19% of the Trust's 14 day breaches.
The Gynae tumour site accounted for 17% of January breaches.
Lung accounted for 7% of the Trust's breaches and over 45% of 2ww referrals did not have their first OPA until after day 28 of the pathway.

Actions:

In Gynaecology, a number of work streams have been identified following the follow-up oncology strategy meeting which took place on 03/02/2023. Referral triage by the CNS team and referral redesign work is still underway to address 1st OPA capacity challenges.
The Radiology Recruitment Strategy is in place to address the Breast Service One-Stop appointment alignment issues. In addition, 2 x Registrars are undergoing assessments that will allow them to hold their own clinics thereby improving capacity, and another new Specialty doctor who commenced in Feb '23 is also in their assessment period.
Respiratory consultant capacity is a continuing issue alongside an increased number of referrals. ICB Analysis of the FReD Referrals is in progress and an ongoing BC for an increase in consultant workforce to 10-15 consultants is underway.
UGI Referral and Triage processes are being reviewed and a Gap Analysis supported by the ICB has been completed. A bid is being developed for UGI CNS to triage at the start of UGI pathway.
These and other key action progress are tracked through the Urgent Care Cancer group chaired by the Medical Director and run with full system partner involvement.

Mitigations:

In Urology, a Deep Dive, supported by the ICB, commenced on 23/01/2023 to identify and address pathway improvements including the quality of primary care referrals as well as capacity and flagging issues.
Haematology is in fragile services due to vacancy/capacity. EMAP work has started but the next EMAP meeting has been pushed back from Jan to March. ICB colleagues will now be involved in future meetings. Ongoing issues with inappropriate referrals and GP engagement continue to be escalated, as are the delays in the booking and utilisation of appointment slots which are still being addressed with C&A.
In Dermatology, a Demand and Capacity deep dive has resulted in a number of improvements being adopted to smooth out booking processes.

2 Week Wait Breast Symptomatic

Jan-23
14.41%
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 14.41% against a 93% target.

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

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

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

31 Day First Treatment

Jan-23
89.97%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 89.97% against a 96% target.

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

Actions:
Recruitment in Oncology is ongoing to secure locums, NHS locum or substantive posts. 3 Medical Oncologist posts are out to advert as locums. A 6 month Oncology SpDr post went out to advert from which we have 2 appointable candidates. Confirmation as to whether both can be appointed is awaited.
In Head and Neck, Surgeon recruitment required. Locum consultant currently taking on non-cancer Thyroid cases to release capacity for cancer.

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.
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity.

31 Day Subsequent Surgery Treatments

Month	Value
Nov-21	
Dec-21	
Jan-22	
Feb-22	
Mar-22	
Apr-22	
May-22	
Jun-22	
Jul-22	
Aug-22	
Sep-22	
Oct-22	
Nov-22	
Dec-22	
Jan-23	83.33%

Legend: 31 Day Subsequent Surgery Treatments, Mean, Control Limits, Target

Jan-23
83.33%
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 83.33% against a 94% target.

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

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

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

31 Day Subsequent Radiotherapy Treatments

105%
100%
95%
90%
85%
80%

Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23

31 Day Subsequent Radiotherapy Treatments — Mean — Control Limits — Target

F

Jan-23
92.39%
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 radiotherapy.

What the chart tells us:
We are currently at 92.39% against a 94% target.

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

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

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

104+ Day Waiters

Chart: 104+ Day Waiters, Nov-21 to Feb-23, with Mean, Control Limits and Target. Y-axis: 0, 50, 100, 150, 200, 250. X-axis: Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23, Feb-23.

Feb-23
127
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 9th March the 104 Day backlog was at 127 patients. The agreed target is <10.

There are three tumour sites of concern
Colorectal 83 (majority awaiting diagnostics, outpatients and clinical review)
Urology 16
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 26% 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	Dec-22	Jan-23	Feb-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	89.78%	89.25%	88.81%	89.58%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	8.98%	8.30%	7.72%	9.83%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.52%	5.59%	5.61%	5.38%		F	A	
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	13.79%	13.67%	13.55%	14.43%		F		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	63.74%	64.24%	65.39%	61.00%		F	A	

See Executive Scorecard section for relevant failing metrics above.

Sickness Absence (Rolling Year %)

F A

6.0%
5.8%
5.6%
5.4%
5.2%
5.0%
4.8%
4.6%
4.4%
4.2%
4.0%

Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

All days lost as a percentage of those available — Mean — Control Limits — Target

Feb-23
5.61%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
5.61 % of sickness absence rolling year.

What the chart tells us:
The rate has increased by a further 0.2% to 5.61% which is above the target of 4.5%.

Issues:

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

Actions:

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

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

Staff Turnover

Feb-23
13.55%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
12%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

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

What the chart tells us:
Turnover rates have stabilised and decreased slightly month on month but are still higher than 12% target

Issues:
Recent Analysis of exit survey data shows reasons as follows
- 20% retirement age
- 16% lack of work life balance
- 13.5% relocation
- 10% lack of development opportunities
- 7% incompatible work relationships
- 6.5% promotion
- 5% ill health

Actions:
- A People Promise Manager dedicated to ULHT who is focussing on retention issues including career conversations and flexible working
- 16 Culture Ambassadors have been recruited with on boarding sessions booked for 24.03 and 03.04
- CLP has support from Tim Whitworth, Associate Consultant working with NHSE CLP

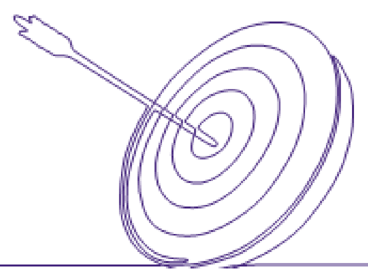
Mitigations:
See actions

Financial Position Month 11 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

OUTSTANDING CARE
personally DELIVERED

Quality | Operational Performance | Workforce | Finance

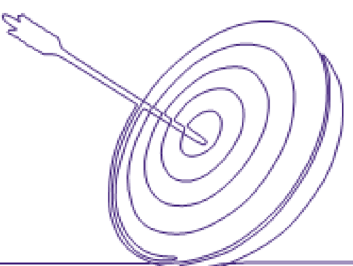
Finance Spotlight Report (Headlines)



Adjusted financial performance	Current Month			Year to Date		
	£'000	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	52,450	57,567	5,117	577,105	605,885	28,780
Other operating income	3,537	5,268	1,731	34,151	40,977	6,826
Employee expenses	(37,238)	(38,857)	(1,619)	(402,154)	(434,044)	(31,890)
Operating expenses excluding employee expenses	(18,164)	(23,887)	(5,723)	(202,763)	(221,990)	(19,227)
OPERATING SURPLUS / (DEFICIT)	**585**	**91**	**(494)**	**6,339**	**(9,172)**	**(15,511)**
NET FINANCE COSTS	(640)	(365)	275	(7,014)	(4,818)	2,196
Other gains/(losses) including disposal of assets	0	(54)	(54)	0	74	74
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(55)**	**(328)**	**(273)**	**(675)**	**(13,916)**	**(13,241)**
Remove capital donations/grants/peppercorn lease I&E impact	55	52	(3)	675	549	(126)
Adjusted financial performance surplus/(deficit)	**0**	**(276)**	**(276)**	**0**	**(13,367)**	**(13,367)**

- The table above shows that the Trust delivered an adjusted deficit of £0.3m in M11 (£0.3m adverse to plan) and YTD delivered an adjusted deficit of £13.4m (£13.4m adverse to plan).
- After M09, the Trust agreed a forecast outturn position of a £13.6m deficit in support of a revised ICS forecast outturn position of a £21m deficit forecast; the Trust's M11 position is aligned to delivery of it's revised forecast deficit of £13.6m.
- In M11, the ICS has improved its forecast by £4m to a deficit of £17m by reflecting additional income in relation to its allocation for prescribing volume and price concessions.
- CIP savings of £15.9m have been delivered YTD, or £9.3m (37.0%) adverse to planned savings of £25.2m.

Finance Spotlight Report
(Key areas of focus - Income)

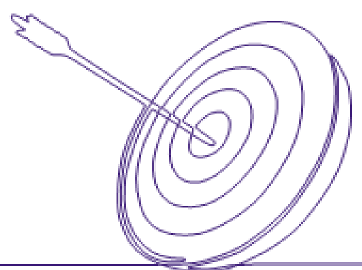


The Income position is £35.6m favourable YTD to plan; this includes:

- **NHS Patient Care income contract - favourable variance of £27.8m**; this includes £8.8m pay award funding (net of NI reduction), over performance of £4.6m re Variable Drugs (Lincs and NHSE) for which there will be an offset in Non Pay, £1.1m of NHS England prior year income for the true-up, £0.5m mutual aid income for working being undertaken for Leicestershire ICB in T&O and £300k of other variable charges to providers and devolved administrations). In addition, the YTD position now includes £7.0m of funding to compensate the Trust for beds that have not yet closed as a result of the CC2H scheme, £1.7m of winter funding, £1.3m of digital and cyber funding, £1m funding in respect of delayed discharges, £538k EPR funding, £441k validation and another £400k of other allocations across a number of schemes. £666k has also been assumed from Lincolnshire ICB in relation to variable diagnostics. Settlements have been reached with Lincolnshire ICB for variable elements to the contract and with Leicestershire ICB regarding mutual aid in order to remove year end risk.

- **NHS Patient Care - additional 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
- **Education & Training - favourable variance of £3.1m** including £0.5m notional income re the apprenticeship levy.
- **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).
- **Income in respect of employee benefits accounted for on a gross basis – favourable variance of £1.3m.**
- **Non-Patient Care services - favourable variance of £0.5m.**
- **Bad debt provisions - favourable variance of £0.2m**; this reflects a one off change which offsets an adverse variance in Non Pay.
- **Research & Development – favourable variance of £0.2m**
- **Other miscellaneous movements – favourable variance of £0.9m**.

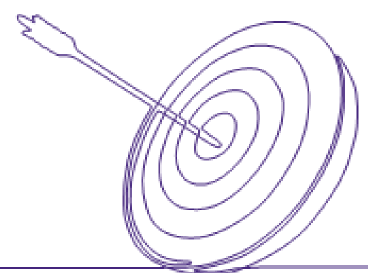
Finance Spotlight Report
(Key areas of focus - Pay)



- **The YTD pay position is £31.9m adverse to plan including under delivery on Pay CIP of £8.6m.**
- Actual pay expenditure in February of £38.9m was £1.0m lower than £39.8m in January.
- The £1.0m decrease in Pay expenditure in February reflects the fact that January included an accrual of £0.2m for Bank Holiday enhancements, three fewer days in the month, and a decrease in Bank Pay in relation to the cost of the extra contractual rate card increase.

  - **Substantive pay is £3.7m adverse to plan (inclusive of £1.5m of technical CIP delivery)**
    - Expenditure of £31.0m in February is £0.1m higher than expenditure of £30.9m in January.
  - **Agency pay is £21.9m adverse to plan**
    - Expenditure of £3.5m in February is £0.4m lower than expenditure of £3.9m in January.
    - YTD efficiency savings of £3.9m in Agency Pay are £12.8m adverse to plan; the YTD position also reflects higher than planned bed numbers, sickness levels & vacancies.
  - **Bank Pay is £6.3m adverse to plan**
    - Expenditure of £4.3m in February is £0.7m lower than expenditure of £5.1m in January; Medical bank expenditure was higher in January driven by the retrospective inclusion of shifts worked in December.
    - The extra contractual rate card increase is estimated to have increased Medical Extra Duty costs by £1.25m since it was implemented on 12 December.

Finance Spotlight Report
(Key areas of focus - Other)



Non Pay

- The YTD Non-Pay position is £19.2m adverse to plan including under delivery on CIP of £2.2m; £2.9m 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, £1.3m re System Digital & Cyber, £0.5m re mutual aid, £0.4m re validation and £0.2m re a one off adjustment re Bad Debt.
- Non Pay expenditure in February of £23.9m was £2.7m higher than £21.2m in January; this is driven by the inclusion of a £2.4m provision for future removal/destruction costs associated with the medical record storage contract.

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 £25.2m by the end of M11; actual savings of £15.9m (63.0%) have been delivered, such that YTD delivery is £9.3m (37.0%) adverse to plan.

Capital

- Capital funding levels for 2022/23 agreed through Trust Board & FPEC show a plan of c£38.8m; Capital spend incurred YTD equates to c£22.1m.

Finance Spotlight Report

(Key areas of focus – Cash & BPPC)

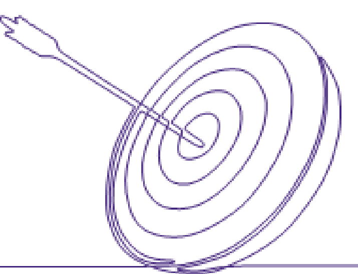
Cash

- The February 2023 cash balance is £31.9m; this is a decrease of £56.4m against the March year-end cash balance of £88.3m.
- The Trust will be drawing capital PDC of £19.9m in March, the majority of which is unlikely to be utilised until April / May. The year end cash position is therefore expected to increase to circa £60m.
- Whilst current cash levels remain comfortable; the position will narrow as we move into 2023/24 and will require careful management of cash and working capital.

BPPC

- The BPPC performance for the year to February was 79% / 70% by value / volume of invoices paid (appendix 5d); this compares to the full year performance in 2021/22 of 89% / 83%.
- Performance during February itself was 86% / 76%. This is comparable to the period prior to the August Cyber attack, but remains below levels before the finance system migration in December 2021.
- The Trust has received a letter from Julian Kelly re-iterating the 95% target and directing the Trust to improve performance from April.

Finance Dashboard



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

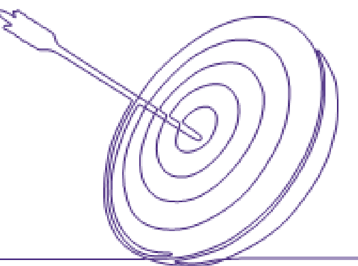
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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	FEB 2023
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.16
Capital service cover rating	4	4	4	1	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(9.75)
Liquidity rating	4	4	1	1	3
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(2.07%)
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%	(2.07%)
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



	31-Mar-22	28-Feb-23		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Intangible assets	7,675	6,153	6,214	6,086
Property, plant and equipment	267,753	285,206	273,559	288,834
Right of use assets	12,468	11,796	12,034	11,831
Receivables	1,848	1,848	1,859	1,848
Total non-current assets	**289,744**	**305,003**	**293,666**	**308,599**
Inventories	6,006	6,006	6,514	7,000
Receivables	15,520	23,673	39,550	36,000
Cash and cash equivalents	88,297	46,204	31,858	61,282
Total current assets	**109,823**	**75,883**	**77,922**	**104,282**
Trade and other payables	(89,017)	(65,455)	(68,685)	(94,113)
Borrowings	(2,552)	(3,290)	(3,145)	(2,847)
Provisions	(8,774)	(4,895)	(10,484)	(13,525)
Other liabilities	(1,130)	(1,130)	(7,708)	(1,130)
Total current liabilities	**(101,473)**	**(74,770)**	**(90,022)**	**(111,615)**
Total assets less current liabilities	**298,094**	**306,116**	**281,566**	**301,266**
Borrowings	(13,751)	(12,069)	(12,378)	(12,566)
Provisions	(3,182)	(3,071)	(2,401)	(2,401)
Other liabilities	(11,572)	(11,110)	(11,111)	(11,069)
Total non-current liabilities	**(28,505)**	**(26,250)**	**(25,890)**	**(26,036)**
Total assets employed	**269,589**	**279,866**	**255,676**	**275,230**
Financed by				
Public dividend capital	704,178	715,191	704,180	724,043
Revaluation reserve	29,294	28,656	28,642	28,587
Other reserves	190	190	190	190
Income and expenditure reserve	(464,072)	(464,171)	(477,336)	(477,589)
Total taxpayers' equity	**269,589**	**279,866**	**255,676**	**275,230**

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 £31.8m has reduced £6.4m from January but is expected to increase before the year end with the drawdown of £19.9m capital PDC in March.

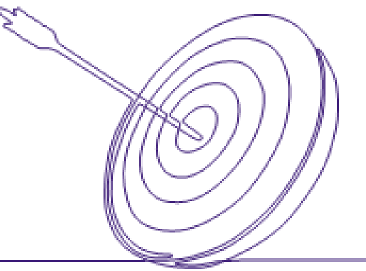
Note 3: Receivables have increased in recent months but continue to be supressed below pre-pandemic levels and will remain so throughout the remainder of 2022/23 with the continuation of block contract payments.

Note 4: The overall level of Trade and other payables at £68.7m remains above historic levels by circa £5-10m. This includes Annual leave (£6m) and other pay accruals.

Note 5: The capital programme for 2022/23 will result in asset additions of £38.8m. This is to be funded through internal cash resources but with an injection of £19.9m PDC capital. A significant proportion of the additions (16.7m) will be during the March meaning the level of year end capital creditors is forecast to be increase.

Note 6: The year end valuation is underway, this is likely to result in movements in the value of non-current assets and the revaluation and I&E reserves.

Cashflow reconciliation – April 2022– March 2023



	31-Mar-22	28-Feb-23		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Operating surplus / (deficit)	549	6,339	(9,173)	(9,009)
Depreciation and amortisation	15,736	17,629	17,959	19,781
Impairments and reversals	7,340	-	-	-
Income recognised in respect of capital donations	(27)	-	(30)	(50)
Amortisation of PFI deferred credit	(503)	(462)	(461)	(503)
(Increase) / decrease in receivables and other assets	11,261	(8,153)	(23,934)	(20,430)
(Increase) / decrease in inventories	504	-	(508)	(994)
Increase/(decrease) in trade and other payables	9,745	(9,910)	(4,274)	10,416
Increase/(decrease) in other liabilities	(457)	-	6,578	-
Increase / (decrease) in provisions	5,860	(3,960)	968	4,009
Net cash flows from / (used in) operating activities	**50,008**	**1,483**	**(12,875)**	**3,220**
Interest received	34	220	1,036	1,185
Purchase of intangible assets	(994)	-	(60)	(60)
Purchase of property, plant and equipment	(35,132)	(48,184)	(38,718)	(42,740)
Proceeds from sales of property, plant and equipment	148	-	155	155
Net cash flows from / (used in) investing activities	(35,944)	(47,964)	(37,587)	(41,460)
Public dividend capital received	26,610	11,011	-	19,863
Other loans repaid	-	(403)	(403)	(403)
Capital element of finance lease rental payments	-	(2,206)	(2,140)	(2,250)
Interest paid	(1)	-	-	-
Interest element of finance lease	-	(108)	(111)	(108)
PDC dividend (paid)/refunded	(6,418)	(3,901)	(3,324)	(5,872)
Net cash flows from / (used in) financing activities	20,191	4,388	(5,978)	11,225
Increase / (decrease) in cash and cash equivalents	34,255	(42,093)	(56,440)	(27,015)
Cash and cash equivalents at 1 April - brought forward	54,042	88,297	88,297	88,297
Cash and cash equivalents at period end	88,297	46,204	31,857	61,282

Note 1: Cash held at 28 February was £31.9m against a plan of £46.2m. This represents a decrease of £56.4m against the March year-end cash balance of £88.3m.

Note 2: The variance against plan of £14.3m is being driven predominantly by a combination of the I&E deficit £(15.5m), Capital purchases £9.6m and PDC receipts £(11.0m)

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

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

Note 4: Despite pressures / risks associated with the in-year financial position, no immediate cash pressures are anticipated. The forecast year end cash position is anticipated to be in the region of £60m, due in large part to the level of capital creditors forecast.

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

Meeting	*Trust Board*
Date of Meeting	*4 April 2023*
Item Number	*Item 13.1*

Strategic Risk Report

Accountable Director	*Dr Karen Dunderdale, Director of Nursing & Deputy Chief Executive*
Presented by	*Dr Karen Dunderdale, Director of Nursing & Deputy Chief Executive*
Author(s)	*Paul White, Head of Risk and Governance*
Report previously considered at	*Lead assurance committees for each strategic objective*

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

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

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

Executive Summary

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

- There were 12 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month:
- 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;
- Learning lessons from previous patient safety incidents.
- Recovery of children's community diabetes service
- Epilepsy service provision in Paediatrics – **New Validated Risk**
- Gaps in tertiary advice and support for children and young people with complex epilepsy
- Since the last report two Very High risks have been discussed at the February RRC&C meeting with the following outcome:

    - Ambulance handover delays – Reduced from a Very High (20) to Moderate (12)
    - Unexpected surge in emergency demand – Closure of risk agreed and will be incorporated within a single demand and capacity risk.

- There were 3 Very high risks (20-25) reported to the People & Organisational Development Committee this month:
- Recruitment and retention of staff (Trust-wide)
- Workforce culture (Trust-wide)
- Disruption to services due to potential industrial action (Trust-wide)

- There were 5 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month:
    - Potential for a major fire;
    - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
    - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
    - Reliance on agency / locum medical staff in Urgent & Emergency Care
    - SAR's Compliance and access to Health records in accordance with statuary requirements – **New Validated Risk**
- In February it was agreed by RRC&C members to approve the reduction of the following risk from a Very High (20) to a High Risk (16)
    - Cost of reliance on bank and agency staff for nursing workforce in U&EC

- There are also several High and Very high risks that are awaiting review and validation from the Risk Register Confirm & Challenge Group (RRC&CG), including:
- Cancer Services service configuration, staffing capacity and appointment delays

- Pharmacy service provision, staffing capacity and medicines reconciliation
- ICU capacity for elective surgery
- Recruitment and retention processes Trust-wide
- Processes to support learning from patient safety events

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

1. Introduction

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

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

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

2. Trust Risk Profile

2.1 There were 343 active and approved risks reported to lead committees this month. This is 20 more than were reported last month.

2.2 There were 20 risks with a current rating of Very high risk (20-25) and 23 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)
5 (1%)	**61** (18%)	**234** (68%)	**23** (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 9 Very high risks and 5 High risks recorded in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (25)	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	21/02/2023
5016	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding. This may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Very high risk (25)	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED.	22/02/2023
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Very high risk (20)	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10-week period to enable a deep dive and improvement plan to be implemented for the service.	27/01/2023
5073	Safety risk from inability to source tertiary advice and support for children and young people with complex epilepsy	Very high risk (20)	1. Liaison with tertiary centres via ICB and specialist commissioning representatives to aid establishment of referral pathway. 2. Liaison with tertiary centres via ICB and specialist commissioning representatives to aid establishment of contracts.	13/02/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	13/01/2023
5051	Quality and safety risk from inadequate capacity within the children's community diabetes nursing team.	Very high risk (20)	1. Prioritisation of which services can be provided with focus on those that are essential to maintaining safety; 2. Liaison with ICB CYP Programme Manager (one priority of this role is to support delivery of national priorities, which includes CYP diabetes). 3. To create satellite clinic for diabetes patients in Boston team due to geographical location. Could increase amount of patients able to be seen. "	07/02/2023
4877	If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	26/01/2023
4622	If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients.	Very high risk (20)	- Establishment of Patient Safety Improvement Team - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previoulsy called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ - Prepare for implementation of new Patient safety Incident Response Framework (PSIRF) in 2022 (replacement for Serious Incident Framework)	07/03/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	06/03/2023

Strategic objective 1b: Improve patient experience

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

Strategic objective 1c: Improve clinical outcomes

2.5 There were 3 Very high risks and 2 High risk recorded in relation to this objective. A summary of the Very high risks is provided below:

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

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 from mid Oct.	02/02/2023
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.	06/03/2023

Closure of Pilgrim Hospital Theatre 8

2.6 Following the discovery on Friday 17 February 2023 of a gas leak into Theatre 8 on the Pilgrim Hospital, Boston site and the lack of an appropriate ventilation system, the risk was such that a decision was taken to close the theatre whilst awaiting confirmation it was safe to use. As a result there was no functioning operating theatre on the Labour Ward and in order to manage the residual patient safety risk women who required transfer to theatre had to transfer to a ground floor theatre.

2.7 Other options that were considered:

- Continued use of Theatre 8 – this was not possible as the theatre is not a suitable place to perform the required surgical procedures.
- Closure of unit – the distance for women to travel would be significant. Mutual aid availability was unknown due to the increased pressure on all maternity services at that time. On occasion women do not alert the service of their attendance so the service needs a plan to support those women.

2.8 After considering the above options and completing a comprehensive risk assessment involving senior stakeholders from Maternity services, Estates & Facilities and Clinical Governance, utilising the ground floor theatre was deemed to be the safest option. This was an interim option for 72 hrs whilst longer term plans were being reviewed and arrangements put in place.

2.9 Details of this incident were provided to the QGC for assurance purposes, in order to demonstrate the risk-based decision making process and action taken. Work is ongoing to address the strategic risk around nitrous oxide.

Strategic objective 2a. A modern and progressive workforce

2.10 There was 1 Very high risk and 3 High risks recorded 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.	14/03/2023

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

2.11 There were 2 Very high risks and 2 High risks (a reduction of one) recorded 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	14/03/2021

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	14/03/2023

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

2.12 There were 2 approved Very high risks (20-25) and 1 High risk (15-16) recorded in relation to this objective, the same position as reported last month. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4648	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk. - Fire safety protocols development and publication. - Fire drills and evacuation training. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Planned preventative maintenance programme by Estates	03/03/2023
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - PPM reporting for FEG and FSG By Estates Teams - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk	03/03/2023

Strategic objective 3b: Efficient use of our resources

2.13 There were 2 approved Very high risks (20-25), 1 less than was in last month's report; and 4 High risks (15-16), 1 more than reported last month (due to the reduction of one risk from Very high to High), recorded in relation to this objective,. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4664	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	Very high risk (20)	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	02/02/2023
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.	09/02/2023

Strategic objective 3c: Enhanced data and digital capability

2.14 There was 1 approved Very high risk (20-25) recorded in relation to this objective, this is an increase of 1 from the previous report that was validated by the Risk Register Confirm & Challenge Group in February. There were also 3 High risks (15-16), the same as in the previous report. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements.	Very high risk (20)	"Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process.	01/03/2023

	Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."		Early identifications of chasers and urgent requests to reduce the likelihood of complaints."	

Strategic objective 3d: Improving cancer services access

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

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

2.16 There were no approved Very high risks (20-25) or High risks (15-16) to this objective.

Strategic objective 3f: Urgent Care

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

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

2.18 There were no approved Very high risks (20-25) or High risks (15-16) to this objective.

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

2.19 There are currently no Very high or High risks recorded in relation to this objective. However, the Director of Improvement and Integration has asked for the risk to delivery of this objective to be assessed and added to the risk register this month.

2.20 A comprehensive review and update of the People & OD directorate risk register is currently taking place, with support from the Clinical Governance risk team. This work is likely to result in a more detailed breakdown of specific workforce risks, providing clearer links between the risk register and planned work on workforce planning; leadership and management; and equality and inclusion.

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

2.21 There were no approved Very high risks (20-25) or High risks (15-16) to this objective.

2.22 There are several High and Very high risks that are awaiting review and validation from the Risk Register Confirm & Challenge Group (RRC&CG), including:

- Cancer Services service configuration, staffing capacity and appointment delays
- Pharmacy service provision, staffing capacity and medicines reconciliation
- ICU capacity for elective surgery
- Recruitment and retention processes Trust-wide
- Processes to support learning from patient safety events

3. Conclusions & recommendations

3.1 There were 12 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month:

- 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;
- Learning lessons from previous patient safety incidents.
- Recovery of children's community diabetes service
- Epilepsy service provision in Paediatrics
- Gaps in tertiary advice and support for children and young people with complex epilepsy

3.2 There were 3 Very high workforce risks (20-25) reported to the People & Organisational Development Committee this month:
- Recruitment and retention of staff (Trust-wide)
- Workforce culture (Trust-wide)
- Disruption to services due to potential industrial action (Trust-wide)

3.3 There were 5 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month:
- Potential for a major fire;
- Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
- Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- Reliance on agency / locum medical staff in Urgent & Emergency Care
- SAR's Compliance and access to Health records in accordance with statuary requirements

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

Appendix A - Quality and safety risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective							**1a. Deliver Harm Free Care**																			
4789	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl	Patient Safety Group	Clinical Effectiveness Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01	27/01/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	[27/01/2023 10:16:42 Charles Smith] 27/01/23 - Charles Smith DGM - CDC work had to go via tender, expected to start ~01/02/23. Delivery of 3000 from backlog. Midlands visit action plan/meridian recommendations largely implemented. R&R has preliminary sign-off from trust. Trajectories have total WL eradication in 2024 if no changes, 6w and 13ww cohorts within 12/12. FUrther workforce challenges with Mat leave and new resignations. Position remains difficult in terms of capacity and fragility of workfoce. [01/12/2022 10:58:41 Carl Ratcliff] New working group in place lead by COO Plans being worked up to open CDC when contract agreed	4	31/03/2022	31/03/2023	20/04/2023
5073	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Group	Clinical Effectiveness Group	12/01/2023	20		Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Safety risk from inability to source tertiary advice and support for children and young people with complex epilepsy	1. None - ULHT is currently treating patients with complex epilepsy that should be referred into tertiary services for specialist input. Tertiary services cite lack of contract and/or lack of capacity as reason for declining to offer advice and assistance. This increases the risk of children and young people developing complications that have short, medium and long-term consequences.	1. Number of declined referrals	13/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Liaison with tertiary centres via ICB and specialist commissioning representatives to aid establishment of referral pathway. 2. Liaison with tertiary centres via ICB and specialist commissioning representatives to aid establishment of contracts.	[13/02/2023 14:07:10 Jasmine Kent] For review at governance for possible merge with other epilepsy risk.	4	12/01/2024		13/03/2023
4879	Physical or psychological harm	Harris, Michelle	Lynch, Diane	Patient Safety Group		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU			If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	13/01/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[02/03/2023 08:41:30 Maddy Ward] Risk lead changed to Diane Lynch as Lucy Rimmer has left the trust as of 02/02/2023. DL is the new interim DMD until early June [13/01/2023 15:07:01 Paul White] Closed in error - re-opened. [17/11/2022 12:24:41 Rose Roberts] 4736 can be closed as Estates have investigated everything they can and Paula is launching an education and poster campaign. Trust comms have already gone out. [16/11/2022 15:54:57 Rose Roberts] Ongoing 4/8/22 Confirmed it is an ongoing corporate risk being managed at divisional level. Ongoing	8	31/03/2023	31/03/2023	28/02/2023
5016	Physical or psychological harm	Wall, Mrs Tracey	Thomson, Cheryl	Workforce Strategy Group	Patient Safety Group	02/09/2022	25		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	22/02/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	[22/02/2023 12:01:19 Paul White] Present at Confirm & Challenge by TW, reduction in score from 25 to 20 discussed and agree along with incorporation of details from previously separate 'surge in demand' risk. [27/01/2023 11:17:57 Helen Hartley] Risk reviewed and updated. [23/11/2022 11:28:16 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed. [10/11/2022 13:40:59 Helen Hartley] No change at governance [07/11/2022 07:03:00 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:20:43 Helen Hartley] No changes made at governance	10	02/09/2023	31/03/2024	22/03/2023
5051	Physical or psychological harm	Rivett, Kate	Flatman, Deborah	Workforce Strategy Group		31/10/2022	20		Family Health	Children and Young Persons CBU	Children's Community Services	Community	Quality and safety risk from inadequate capacity within the children's community diabetes nursing team	1. Team leader currently supporting provision of clinical duties across all 3 sites. 2. Prioritisation of workload to help match against available nursing capacity; 3. Support from OD team to help optimise team working and dynamics; 4. Business case in development to support expansion of diabetes services.	1. Complaints; 2. Compliance with National guidance; 3. Feedback from Peer Review audits; 4. Ability to provide Best Practice Tariff services; 5. Health and wellbeing of nursing workforce.	07/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Prioritisation of which services can be provided with focus on those that are essential to maintaining safety; 2. Liaison with ICB CYP Programme Manager (one priority of this role is to support delivery of national priorities, which includes CYP diabetes). 3. To create satellite clinic for diabetes patients in Boston team due to geographical location. Could increase amount of patients able to be seen.	[21/02/2023 10:42:37 Rachael Turner] Risk validated at Confirm and Challenge 25/01/2023. [07/02/2023 14:21:16 Kate Rivett] 07/02/2023 - KR 1. Risk to remain as is.... full time Band 6 post remains vacant despite recruitment effort. Impending retirement will also create Team Leader vacancy. [20/01/2023 11:24:42 Alison Barnes] Mitigation in place. SBAR case reviews. [20/12/2022 13:21:55 Jasmine Kent] No change, Matron to add some more information re: risk reduction. [08/12/2022 12:32:07 Paul White] Rating increased on review.	3	31/10/2023		07/03/2023

Appendix A - Quality and safety risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4622	Physical or psychological harm	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group		09/04/2018	20	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	If the Trust doesn't have an effective approach to learning lessons when things go wrong with patient care it may result in missed opportunities to significantly improve patient safety and potentially to serious harm.	National Policy: - NHS National Patient Safety Strategy - NHS National Reporting and Learning System (NRLS) ULHT Policy: - Incident Management Policy & Procedures - Complaints Policy & Procedures - Patient Safety Improvement Team (Clinical Governance) - Patient Safety Specialists - Patient Safety Partners ULHT governance: - Trust Board assurance through Quality Governance Committee (QGC) / Patient Safety Group (PSG)	- Recurring themes in patient safety incidents, complaints, PALS & claims - Recurring themes in audits / reviews of risk / incident / complaints / claims management - Monitoring implementation of the National Patient Safety	23/01/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	National Patient Safety Strategy implementation plans, including: - Preparations for introduction of the new national Patient Safety Incident Response Framework (PSIRF) - Upgrade to Datix CloudIQ to enable information upload to the new national Learning from Patient Safety Events (LFPSE) system - Recruitment and induction of Patient Safety Partners (PSPs) - Establishment of Patient Safety Improvement Team within Clinical Governance	[01/03/2023 15:52:56 Rachael Turner] Risk amended to a score of 20 (v High) until validation of reduction of a score to 12 (Moderate) at RRC&C Meeting in March. [23/12/2022 15:00:10 Paul White] Risk reviewed alongside 4958 (Delivery of the National Patient Safety Strategy). Updated and combined into a single risk of potential missed opportunities to take action to improve patient safety. Also updated to take into account progress with PSIRF implementation and Datix CloudIQ upgrade. Rating amended from High (20) to Moderate (12) based on improved quality of SI investigations and wide range of methods for sharing lessons. Evidence from SIs indicates there remain some significant risk, being addressed as part of PSIRF preparation and also reflected in separate risk register entries for specific clinical risks. [06/12/2022 09:56:41 Rachel Thackray] Full review of risk to be completed and presented to the next Risk Confirm and Challenge Group [14/10/2022 10:30:38 Rachael Turner] Risk reviewed-no change. - Patient Safety Improvement Team now established within Clinical Governance - Datix CloudIQ has been approved for connection to the new national learning system - Business case for Datix CloudIQ approved and final sign off undertaken September; plan will be to roll out over the next 6 months Directorate review (May 2022) - agreed that this would remain Very high (20) subject to learning	4	31/01/2019	23/04/2023	31/03/2023
4624	Physical or psychological harm	Davies, Angela	Addlesee, Sarah	Patient Falls Steering Group	Nursing, Midwifery and AHP Forum	08/11/2021	16	Aggregation of Incident/Claims & Complaints/PALS	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	National policy: - NICE Clinical Guideline CG161: Assessment and prevention of falls in older people (2013) - PHE Falls and fracture consensus statement: Resource pack (2017) ULHT policy: - Falls Prevention and Management Policy (approved April 2021, due for review March 2023) ULHT governance: - Lead Quality Matron - Weekly Falls Investigation Panel / Training package tiered approach / Weekly spot check audits / Monthly Quality Metrics Dashboard meetings /ward review visits - Patient falls steering group / Nursing, Midwifery & AHP Forum / Quality Governance Committee	Frequency, location and severity of patient falls incidents reported: - The numbers of reported falls incidents are demonstrating an increasing upward trend therefore will not achieve the strategic objective to achieve harm free care. - Operational pressures have resulted in patients having prolonged periods sitting in Emergency Departments whilst waiting assessment and for inpatient beds to become available. This may contribute to an increase in some patients overall frailty level and subsequent deconditioning which increases the vulnerability to an individual falling. - Longer length of stays have demonstrated a correlation to risk of a patient falling whilst in the care of the Trust.	06/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious	[06/03/2023 09:35:09 Sarah Addlesee] •Update Feb 2023 Falls incidents continue to be analysed and trends and themes identified organisationally which will continue to be areas of focus to improve. •The new Adult Inpatient Risk Assessment documentation has been rolled out, this includes a daily assessment for falls which prompts preventative actions to be implemented and escalation processes. Regular training and support is being provided by the Quality Matron and Clinical Education teams post introduction. There has been a reduction in the overall number of falls in February 2023- (129) ,there continues to be severe –(2) and moderate –(2) reported in February. •Collaborative working continues with Quality, Divisional and Improvement teams to ensure an integrated approach to falls prevention improvement work. A revised Falls Prevention working group has been formed and will provide updates to the Falls Prevention Steering Group (FPSG) who will provide oversight and monitoring of progress being made. •The Falls Prevention and Management Policy and Enhanced Care Policies are being reviewed. [14/10/2022 10:29:24 Rachael Turner] Risk reviewed-no change. • Weekly Falls Investigation Panel embedded / Falls Prevention Steering Group meets monthly / Falls improvement work ongoing across the Trust and focused pieces of work identified through the	4	31/12/2021	31/03/2023	09/02/2023
4878	Physical or psychological harm	Harris, Michelle	Carter, Mr Damian	Patient Safety Group	Outpatient Improvement Group	28/03/2022	20	Risk assessments	Corporate	Operations		Trust-wide	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care non-admitted pathway & booking systems / processes (outpatients) - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Outpatient Recovery Group; Reports through Divisional PRMs (for performance), and FPEC and System Planned Care Group - Clinical Harm Oversight Group	2ww first O/Ps back within national target Urgent 1sts 90% <13 weeks by 31.03.23 Time critical follow ups (452/2657 overdue) – target to eliminate (mainly neurology, cardiology, rheumatology) by 31.03.23 RTT non-admitted: Clear >104wws by 31.03.22 Clear >78wws by 31.03.22 (with few remaining by 30.06.22) Clear >65wws by 30.09.22 Clear >52wws by 31.12.22	21/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[21/02/2023 17:44:30 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen in Outpatients and subsequently patients are not waiting so long. Recent Outpatient Sprint to improve DNAs, missing outcomes etc. have also seen fewer patients waiting. The trust is on track to clear all incomplete patient pathways >78 weeks by the end of March 2023, with the exception of patient choice. [13/12/2022 13:31:41 Rachel Thackray] As per previous update, no change to risk grading [21/10/2022 09:42:00 Rachel Thackray] Work continues on the Outpatient Improvement Programme (ORIG) to improve clinic utilisation, reduce demand and increase activity back to 19/20 levels and above. Key progress since last update includes; 1.Contract awarded for Validation contract – Start date November 2022 2.Commencement of personalised Outpatient plan – Start date December 2022 3.Super September completed and yielded 40% reduction in non-admitted pathways that were validated 4.Plan to reinstate tertiary clinics to increase capacity 5.Dedicated support to reduce missing outcomes 210622 No change due to major pressure on the system due to covid backlog. 230922 An externally procured validation team have been identified and they are due to start end of October. Risk transferred to Operations from Outpatients following discussion re ownership.	8	31/03/2023	31/03/2023	22/05/2023
4877	Physical or psychological harm	Harris, Michelle	Carter, Mr Damian	Patient Safety Group		28/03/2022	20	Risk assessments	Corporate				If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care admitted pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	26/01/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[02/03/2023 18:51:14 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen and subsequently patients are not waiting so long. Recent Theatre Productivity work has started to yield improvements and led to a significant reduction in late starts. This is particularly evident at Grantham through the SuperSprint and has seen lost minutes due to late starts reduce by 50% [26/01/2023 15:06:57 Corporate Dashboards] Risk moved from Surgery to Corporate as this is an operational risk, not divisional. [21/10/2022 09:40:36 Rachel Thackray] Work continues on three main improvement programmes to address capacity for Surgery 1.HVLC/GIRFT – Looking at best use of theatres by ensuring HVLC procedures are completed as daycases rather than Electives. This maximises productivity of lists and reduces length of stay to ensure bed availability for surgery. Compliance with HVLC has started to increase over recent weeks 2.Theatre efficiency/productivity – The trust deployed a company called Foureyes insight to work with the surgical division and implement a 16 week improvement programme around best use of theatres	8	31/03/2023	31/03/2023	02/06/2023

Appendix A - Quality and safety risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4984	Physical or psychological harm	Sanz Torres, Aurora A	Cawley, Martin	Radiation Protection Group	Patient Safety Group	28/07/2022	16	Risk assessments	Clinical Support Services				Not reporting over exposures to CQC. Patient being over exposed and not knowing Not optimising dose for Radiotherapy on-board imaging, IR(ME)R. Recording of radiological exposure on the linear accelerators. Version 2.5TB does not create automatic dose reporting. Relies on manual collection of total. Risk recording of total exposures. Not optimising of imaging dose from data analysis."	Exposure properties stored within record and verify system (ARIA) which has appropriate governance. Manual review of patients concomitent exposures on completion of their treatment. Audit related to process	Retrospective assesment of patients imaging can identify over exposures to report to CQC. Reliant on robust transcription methods.	20/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Take case of need 2021_37V2 to CRIG for: Upgrade of Linear accelerators to version 2.7 Version 2.7 creates dose reports that can be sent to analysis/storage system currently ULHT use OpenREM.	[14/03/2023 11:07:54 Rachael Turner] Risk submitted for closure by Division, this will be reviewed at the RRC&C Group in March. [20/02/2023 09:48:39 Martin Cawley] Truebeam upgraded to 2.7. Fully accepted. Consider this risk mitigated. [16/01/2023 08:56:19 Martin Cawley] No change [21/12/2022 11:46:13 Martin Cawley] Dates for upgrading linacs now set as. LA2 H192652 Tuesday 31st January 2023 LA4 H192138 Tuesday 7th February 2023 LA1 H192457 Tuesday 14th February 2023 [15/12/2022 13:43:18 Alex Measures] ongoing [21/11/2022 11:04:43 Martin Cawley] Assessment of linear accelerator tolerances, which are tighter on TB 2.7, have identified a small amount of remedial work that needs to be carried out before the upgrade. This is planned out of hours otherwise there is too much of an impact on clinical time. This will delay the upgrade slightly. Now expecting to complete early January.	4	27/01/2023		31/03/2023
4935	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha	Workforce Strategy Group	Patient Safety Group, WORK	26/05/2022	16	Workforce Metrics	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care		Patient being over exposed and not knowing	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Reliant on robust transcription methods.	09/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		09/02/2023
4779	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl		Clinical Effectiveness Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Not optimising dose for Radiotherapy on-board imaging, IR(ME)R.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	27/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[27/01/2023 10:23:30 Charles Smith] 27/01/23 - CS DGM - Ongoing area of concern due to workforce and ACP gaps (being recruited to but time required to train). TIA still a concern but stable numbers. [16/12/2022 14:35:47 Carl Ratcliff] Additional work in palce to find external support / validate PWL and push patients through system [22/11/2022 17:25:10 Carl Ratcliff] Aim to have outliers back in right place and work continues to improve OPD work. Limited consultant numbers still mean there is a risk to OPD planned care work Plans in place to address backlogs across all areas. Significant area of risk for TIA. 23.08.22 Remains an issues although noting covid cases have dropped. Will be resolved once the improvement work on wards in completed to remove outliers and pts are in the correct place with appropriate bed numbers	4	31/03/2022	31/03/2023	28/01/2023
4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Maternity & Neonatal Oversight Group	Medicines Quality Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Recording of radiological exposure on the linear accelerators. Version 2.5TB does not create automatic dose reporting. Relies on manual collection of total. Risk recording of total exposures.	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	05/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Use of tamper proof boxes/trays being purchased. 2. The only control to prevent the risk is to prepare the injections prior to administration (within 30 minutes) as per guidance (National and Trust). 3. If the practice is to continue, the prepared products should be labelled to include the recommended information. A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day.	[21/02/2023 08:53:55 Paul White] Note from Risk Register Confirm & Challenge Group - risk to be reviewed from Family Health perspective, including current rating and where responsibility for the risk should belong. [05/01/2023 14:08:19 Lisa-Marie Moore] To be raised again at MQG and action to be taken agreed Following a Datix (ref no: 255637), it has been identified that intravenous medication required for a Lower Segment Caesarean Section (LSCS) is being prepared in advance of the procedure in case of an emergency. The Lead Obstetric Anaesthetist has discussed the practice with the team and the consensus is that for safety the drugs need to be prepared in advance for potential emergencies. The team has sourced tamper proof drug trays to store the drugs once prepared. This risk assessment has been done for Pilgrim Hospital, Boston. However, the practice seems to replicate at Lincoln County Hospital. Full risk assessment is attached to Datix. 17/5/22 No change	4	30/09/2022	31/03/2023	09/02/2023
4974	Physical or psychological harm	Hallion, Simon	Naydeva-Grigorova, Tanya	Children & Young Persons Oversight Group	Clinical Effectiveness Group, Patient Safety Group	14/07/2022	9	Professional Guidance	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Not optimising of imaging dose from data analysis."	1. Two Consultant Paediatricians (TN-G and AB) are currently managing all children with diabetes;	1. Audit of compliance with NICE guideline NG18 - Diabetes (Type 1 and Type 2) in Children and Young People: Diagnosis and Management and Adults and NICE quality standard QS125 - Diabetes in Children and Young People.	12/12/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Business case being developed to address resources shortfall (e.g. dietitian, psychologist, admin support, additional nurses) - agreed in principle at CRIG meeting. 2. Increase in clinic capacity to meet demand as per consultants database	[13/12/2022 14:42:45 Alison Barnes] No change. [18/11/2022 11:43:21 Alison Barnes] We are already scoring this highly. The mitigation has been reliant on funding to support an uplift of nursing, doctor time, psychology, dieticians etc. This funding whilst provisionally approved has not been forthcoming, with no clear plan in sight. We need to adjust mitigation to a position of reducing general service and prioritising those children most in need, and in doing so accept that we will not meet BPT or audit requirements. The score therefore needs to be reviewed. Recommend to change to 20. cabinet to escalate, agree at governance. 09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR	3	31/07/2023		12/03/2023
4646	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Clinical Effectiveness Group	NIV Working Group	14/12/2021	20	Policy/Protocol Issues, Risk assessments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	13/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[13/01/2023 13:14:40 Donna Gibbins] Case of need agreed and SFBC being written following approval at establishment review for staffing establishment. Recruitment complete for LCH Respiratory wards with minimal vacancies once all staff in place. Task and finish group arranged for phase 2 of the respiratory project to review NIV standards at PHB and additional areas of focus including domiciliary NIV. To commence end of January 23. Monthly NIV audit continues-Timeliness of the commencement of NIV is improving, issues relating to availability of NIV bed and appropriate referrals a current issue to bed pressures. Escalated and reported through escalation structure. Agreed risk remains high but reduced, requires to remain at 16 until for confirmation of Trust wide achievement of BTS standards. New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB are on hold with provisions in place to allow NIV to be delivered in the bay where there are x 4 monitored beds (IPC agreed) Risk discussed at Risk Register Confirm & Challenge Group in May 2022. Still inconsistencies with timeliness against BTS standards, particularly at Lincoln, and inability to ring-fence beds but an improving position. Agreed that risk remains high but has reduced. Recommendation for rating to change from 20 to 16.Overall compliance monitored with a monthly NIV report. Case of need for funding of ward nurses in new environment agreed to ensure BTS standards are delivered, SFBC now required- commenced and in process, ew costings awaiting due to agreed pay rise on agenda for change	4	30/09/2022	31/12/2022	07/04/2023

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ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective							1b. Improve patient experience																			
4985	Reputation	Sanz Torres, Aurora A	Cawley, Martin	Trust Leadership Team	Clinical Effectiveness Group	28/07/2022	16	Professional Guidance	Clinical Support Services	Cancer Services CBU	Radiotherapy		Not meeting NHSE/Service specification. Not being able to offer complete SABR technique.	Shared MDT with Nottingham Patient transferred to Nottingham if unable to treat	Number of patients of patient referred to Nottingham.	20/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Take case of need 2021_37V2 to CRIG for: Upgrade of Linear accelerators to version 2.7 Version 2.7 enables upgrade of the AlignRT system for improved functionality in motion management of SABR.	[21/02/2023 08:52:00 Paul White] Note from Risk Register Confirm & Challenge Group - risk description to be expanded to include cause / event / effect and rating to be agreed at division level prior to presentation at RRC&CG for validation. [20/02/2023 10:04:15 Martin Cawley] Still awaiting AlignRT upgrade. [16/01/2023 08:58:16 Martin Cawley] No change [21/12/2022 12:18:40 Rose Roberts] Teams message from Martin Cawley: "case of need written, not suitable for CRIGs current acceptance criteria therefore will be presented in April". I think this should be on 5062 which is the staffing for SABR. 4985 is the equipment which is already going ahead." [15/12/2022 13:44:30 Alex Measures] case of need written, not suitable for CRIGs current acceptance criteria therefore will be presented in April [21/11/2022 11:06:17 Martin Cawley] This is linked to 4984 please refer to that risk for updates. MGC PO for TB 2.7 has been raised. The upgrade to AlignRT will be scheduled once the TB2.7 is settled. Expect this can happen in December or early January depending on availability of engineers from VisionRT. This is now work in progress ____ Awaiting case of need to be presented to CRIG.	8	17/07/2023	27/01/2023	31/03/2023
4701	Reputation	Grooby, Mrs Libby	Upjohn, Emma	Estates Investment and Environment Group	Patient Experience Group	13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	23/01/2023	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	[23/01/2023 17:04:59 Jasmine Kent] Included within capital allocation bids for next financial year. Agreement from trust board that works will take place in next financial year. Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15 26/09/2022 - Unchanged	6	31/03/2025	31/03/2025	24/04/2023
4724	Physical or psychological harm	Rimmer, Lucy	Bradley, Mrs Lesley	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	15/12/2022	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients. Prioritisation tool helps to identify patients with greatest acuity or importance which will directly impact patient flow and current bed situation.	[13/01/2023 12:51:48 Lesley Bradley] 13/1/23 NHSE reviewed Ashby ward this month-await recommendations for staffing levels [15/12/2022 09:53:21 Alex Measures] No update [30/11/2022 10:04:52 Rose Roberts] Neuropsychology bid is still awaiting CRIG approval as CRIG has been stood down. Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	30/11/2021	31/03/2023	31/03/2022
Strategic Objective							1b. Improve patient experience																			
4972	Physical or psychological harm	Hallion, Simon	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/07/2022	9	Clinical Audit Reports	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Safety risk from an inability to provide a fully funded epilepsy service that complies with relevant NICE guidance.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition.	Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People.	13/02/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	1. Development of business case to enable establishment of fully funded epilepsy service.	[13/02/2023 14:05:26 Jasmine Kent] For discussion at governance for possible merge with other epilepsy risk and to duplicate onto community paeds risk reg. B7 unable to start but B6 is still due to start. [13/12/2022 14:48:22 Alison Barnes] Appointed 2 x epilepsy nurses. Steps in right direction. [18/11/2022 11:44:07 Alison Barnes] Agreement for spending, close advert for b7 and b6 due to be appointed epilepsy workshop with ICB. Gaps identified, work in progress. [11/10/2022 13:22:37 Alison Barnes] Adverts out for b6 and b7 epilepsy nurses, with interest, cost pressure whilst sorting funding. 09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR 1. Risk discussed at Risk Register Confirm and Challenge meeting - risk and grading agreed as appropriate. 12/09/2022 - Risk Register Review. Risk remains the same, now have permission to recruit. In process of sorting funding.	3	11/07/2023	11/07/2023	13/03/2023
4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	Patient Safety Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	02/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Planned introduction of an auditable electronic prescribing system across the Trust. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct	[02/02/2023 14:18:48 Lisa Hansford] Expected end date of implementation 31/03/23 [05/01/2023 14:07:02 Lisa-Marie Moore] Pilot phase in Cardio LCH complete. Roll out to begin on Stroke w/c 9th January [08/12/2022 12:43:26 Lisa-Marie Moore] Pilot still underway in cardiology at LCH. No update received to date on when roll out will occur. Issues external to pharmacy may hinder roll out e.g staff to add patients on careflow on admission/transfer [14/10/2022 16:05:51 Rachel Thackray] Pilot being undertaken in cardiology w/c 10 October 2022 which will take place over the next month. This will then be reviewed following completion. Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. 17/5/22 No change 150622 Discussed that a further risk is to be added concerning accurate medicines reconciliation as defined in NICE medicine and optimisation guidance NG5. And connection to staffing. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct.	4	31/12/2023	29/12/2023	09/02/2023

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ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4731	Physical or psychological harm	Harris, Michelle	Parkin, Mr Lee	Medical Records Group	Clinical Effectiveness Group, Digital Hospital Group, Information Governance Group, Patient Experience Group, Patient Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Draft policy produced further discussion with changes required with Divisional Clinical Lead - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	02/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	[02/02/2023 15:31:12 Rose Roberts] KB going to ask crg meeting if the new policy has been signed off. [15/12/2022 14:24:51 Madeline (Maddy) Ward] Ongoing, issue raised with clinical records meeting with control of health records for resolution, further meeting to be held mid-December [29/11/2022 11:04:59 Rose Roberts] Policy still awaiting final ratification so please extend by 1 month. [27/10/2022 12:08:42 Rose Roberts] Ongoing OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Digital Hospital Group. 120522 - Review of policy is underway – sent to h/recs managers for amendments before being sent for sign off to Lee and via the CRG 210622 Now further update until Nov. In Nov expect to get preferred bidder for it. Updates will come from Electronic records system project. 23/09/2022 - No further updates	4	30/06/2018	31/03/2023	31/03/2023
4928	Service disruption	Ratcliff, Carl	Smith, Charles	Patient Safety Group	Clinical Effectiveness Group	28/04/2022	16	Professional Guidance	Medicine	Cardiovascular CBU	Cardiology		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across Cardiology arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	27/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[27/01/2023 10:20:57 Charles Smith] 27/01/2023 - CS - DGM - Further 2x Cons departures (Ads out). C&A not able to support PIFU implementation yet. Further loss of agency Cons at PHB to remove reliance on agency (cost). NHS national ask is to reduce FU work, this will have negative impact so currently negotiating via D&C process. [16/12/2022 14:40:47 Carl Ratcliff] Work underway to fill all clinics but no major concerns with perf [22/11/2022 17:29:18 Carl Ratcliff] RTT for cardiology starting to improve, however backlogs still place and risk not yet reduced. Specialty review work will lead t plan to bring RTT performance back into line but could take 6/12 Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Additional details to be added to risk reduction plan. 10.08.2022- New consultant starting September 2022- 2 x clinics per week for new patients only Existing new patients currently being validated by support manager. TOE list capacity being utilised for PBWL patients. Plans in plan for PIFU for cardiology (next meeting end of August 2022).	8	30/06/2022	31/07/2023	27/04/2023
4905	Physical or psychological harm	Cooper, Mrs Anita	Bradley, Mrs Lesley		Clinical Effectiveness Group, Workforce Strategy Group	22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on acute wards, delayed discharges, delayed referral to response times. Patient reviews delayed for botox treatment. Paediatric services-delayed response to new diabetes referrals and unable to see current diabetes patients in clinic-could lead to patient harm.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Prioritisation guidelines help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff-(normally B6 N&D staff)	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service.	15/12/2022	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Getting locums and bank staff in place. Good use of relocation allowance. Actively managing the waiting lists and dealing with urgent cases to avoid harm eg telephone contact with patients. Case of need for GDH orthopaedic staffing. Case of need for rehabilitation consultant post. Case of need for upper GI dietician. Case of need for Neuro Psychology staff on Ashby. Case of need for OT staff at PHB and LCH in ITU. Over recruitment of band 5s in dietetics. Competency frameworks and preceptorship.	[13/01/2023 12:54:24 Lesley Bradley] 13/01/2023 Continue to review staffing levels, vacancies and reasons for sickness on a monthly basis [15/12/2022 09:55:40 Alex Measures] still looking at models of how to measure safe staffing levels, just asking each team to provide there funded establishment, what they would expect on a usual day and what is the minimum level of staffing, then we can start measuring whether we are falling below safe staffing levels, we have no method of recording that at the moment [30/11/2022 10:07:42 Rose Roberts] Continuing to look at staffing. Currently have a lot of sickness. Looking at levels of staffing so able to report whether staffing levels fall below a safe level. 130622 Looking at staffing vacancies and looking at line by line post analysis. OT IR 8 posts KPI's for Integration include reduce vacancies Promotional Commms for AHP week and Trac being produced to attract staff Improved recruitment strategies.	9	30/06/2023	31/03/2023	31/03/2022
Strategic Objective							**1c. Improve Clinical Outcomes**																			
4932	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Workforce Strategy Group	Clinical Effectiveness Group	24/05/2022	16	Risk assessments	Clinical Support Services	Cancer Services CBU		Trust-wide	Services will be stopped and/or disrupted due to non-recurrent funding (Macmillan/RDC/SDF funding streams). These include CNS, CCC, Waiting List Clerk, Trainee ACP's/ACP's, Advanced Practitioner Radiographer, PTL administrator, PTL Tracker, Deputy nurses-leadership roles.	List of job roles provided to Finance. CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology.	Via job roles list	22/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology. Risk reduction plan escalated to ICB as it is a system wide impact.	[14/03/2023 11:21:33 Rachael Turner] Division has reviewed and have proposed that risk score is increased to a rating of 20 (Very High). This risk will be raised at RRC&C Meeting in March for validation. [30/01/2023 16:12:51 Rose Roberts] Contracts end March 2023, if not in receipt of further funding non specific symptom (NS pathway will have to stop. Pre diagnosis service will have to stop. Currently we have a tick box on all 2 ww referrals which allows complex and vulnerable patients to be identified for support from this team, circa up to 40 pt per week. The other contracts that end end of March for transitional care specifically for colorectal and urology, would stop. [15/12/2022 13:32:54 Alex Measures] case of need completed for all four divisions within the trust, paper submitted to CRIG awaiting date for presentation Reduced to moderate as finance are now fully aware of the situation. Ongoing	8			31/03/2023
Strategic Objective							**2a. A modern and progressive workforce**																			

Appendix A - Quality and safety risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4991	Service disruption	Low, Claire	Shankland, Lindsay	Workforce Strategy Group		08/08/2022	20		Corporate	People and Organisational Development	Operational HR	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience.	ULHT policy: - Workforce planning processes - Recruitment & Selection Policy & Procedure - Rota management systems & processes - Locum temporary staffing arrangements - Workforce management information - Core learning / Core+ programmes? ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Vacancies & turnover rate. Staff survey results relating to job satisfaction / retention. Core learning compliance rates?	14/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	[14/03/2023 13:54:10 Rachael Turner] Increase in headcount, 7.7% now and plans to get this even lower. Roughly 4% improvement. 450 more staff increase and cicra 300 net extra are clinical. Agency providers are now across 4 key areas. Talent acquisition team are now in place to help recruit to difficult to recruit roles. Refugee doctor project still in place. Due to work taking place, proposal for the risk score to be reduced to a score of 12 (moderate). This will go to RRC&C meeting for validation. [31/01/2023 15:11:35 Rachel Thackray] Developing workforce planning report to be submitted to HEE by 31 March 2023, this has a monthly breakdown of anticipated recruitment plans across staff groups with an aim to take us to a vacancy factor of approx 2%. This will be monitored at an organisational and system level monthly. Staff survey results from November 2022 show increased positive scores across all factors which should influence retention issues. Risk reduction plan - Presentation to ELT on 10/11/22 to update international recruitment plan, revised projection on increasing nurse recruitment to get to zero vacancy position by March 2023 Currently 250 nurse vacancies - task and finish group created by Head of Recruitment to work in conjunction with divisional leads to pull together a recruitment activity plan for the remainder of 2022/23 and 2023/24. Plan for recruitment of 285 nurses by the end of the financial year. 1. New to care recruitment being extensively used for HCSW role with 14 appointed & a further 40 offered. 2. Nursing associate recruitment embedded 3. Medical Support Worker role now looking to be embedded as business as usual. 4. Agency providers increased to a minimum of three for key roles, rather than 1 previously. 5. Restructure process started within wider HR team will result in significant greater capacity for recruitment activities and overall oversight and proactivity.	4	31/03/2023	31/03/2023	14/04/2023
4741	Service disruption	Cooper, Mrs Anita	Chester-Buckley, Sarah	Workforce Strategy Group		13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung Clinical oncology - head and neck, skin, upper GI (RT only). Lack of cover for leadership roles (Chemotherapy lead and clinical lead)	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements	Monitoring tumour site performance data	22/02/2023	Extremely likely (5) >90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	[16/01/2023 12:13:46 Sarah Chester-Buckley] Interviews being set up for leadership role. [15/12/2022 13:42:46 Alex Measures] leadership posts out to advert [16/11/2022 15:56:34 Rose Roberts] Posts being mitigated by employing high cost locums, risk with this mitigation is that locums need only give one weeks notice. Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements. 220622 Agency Clinical oncologists recruited. So improved cover for Head and neck and melanoma. Ongoing	4	31/03/2023	31/03/2023	22/03/2023
4862		Ratcliff, Carl	Rumble, Callum	Workforce Strategy Group	WORK	22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting. We do not have the substantive staff nor the locum or agency bookings, to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The Business Unit have this week (06/09) put a bid in to the EMCA to gain funding of 250K to support a General Medicine to work in Respiratory so that our Substantive teams can be released to support Respiratory Cancer Capacity - This bid is currently being reviewed. We have worked in the background to book x 2 Agency Locum General Medicine Consultants 1 at Boston and 1 at Lincoln which will take us over budget, but supports the respiratory patients of lincolnshire and the welfare of consultant staff.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	24/02/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Close working with Agency to try and recruit agency locums to temporarily fill gaps. Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff. Additional funding applied for from Cancer alliance/ICB for Gastro and Resp to allow for additional Gen Med Locum to reduce burden on current workforce. Remote working in place to support outpatients where possible. Agency spend supporting out of hours workload - for example, covering the substantive consultants on calls to allow them to focus on Cancer work instead of on call - supporting patient care.	[24/02/2023 13:48:15 David Marsh] Recruitment in progress, 5 substantive consultants in post (3 x Lincoln, 2 Boston). Agency locums in place covering a variety of roles/sites. New NHS Trust Locum Respiratory Consultant from overseas started in January at Lincoln. Now working independently. Division looking at developing ACP roles and Nodule Nurse post. [01/12/2022 11:15:13 Carl Ratcliff] plan for 3 consultants now being on boarded New plan to develop ACP nodule role Most recent update: Dear Carl, Following the catch up earlier, Claudia, Ashley and I have compiled our thoughts on what could go down to support the services..... OptionTake down:BenefitsRisks: 1 Do Nothing None • Cancer patients continue to wait prolonged periods for care. • Inpatient services at LCH and PHB continue to become extremely depleted • Welfare of current consultant workforce continues to suffer, potentially leaving to sickness / prolonged absence • Boston have only x2 Consultants, currently utilising support from already depleted LCH Team. (If annual leave / sickness, we have only 1 consultant on the Pilgrim site) 2 Grantham inpatient respiratory services (Preferred) • Releases x1 Agency Locum Consultant who can ?potentially? go over to Lincoln (as per previous agreement) • Releases a consultant to cover the rota to a 'safe' level • Non-compliance with ASR due to taking out inpatient respiratory services at GDH • 1 consultant from the Acute on Call rota at Grantham. • Dr E could decide to leave ULHT due to not agreeing with request 3 Respiratory to come off the outlier rota for General Medicine • Capacity to support the ward referrals / CT triage • Impact on other specialties / or risk for outliers not to be seen daily (sick and new only)	4	30/12/2022	01/04/2023	01/03/2023
4762	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	Nursing, Midwifery and AHP Forum, WORK	14/01/2022	15	Risk assessments	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	09/01/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[09/01/2023 14:29:40 Caroline Donaldson] Staffing position remains the same - still an issue. Advert out for posts. Second Clinical Educator post has been recruited to. Level 3 beds still capped at 8 (both sites). [29/11/2022 15:15:09 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. No change to previous progress note. [20/10/2022 14:04:40 Caroline Donaldson] 20/10/2022 Discussed with Lead Nurse. Still ongoing workforce issues. Interviews are in progress for additional clinical educator post and approach has been made to the Clinical Education team to support with that. Individualised action plans are being drawn up and put in place for new members of nursing staff in order to support them. 16/09/2022 Skill continues to be an issue. Additional clinical educator to be appointed to support training needs of team. Level 3 beds still capped at 8. Risk continues and includes skill mix as well as numbers of staff. Mitigation - ongoing recruitment, block booking of Agency staff, daily review of staffing undertaken, liaison with University of Lincoln to support new starters. 13/06/22- Beds are currently capped at 8 level 3 due to insufficient medical staffing. We are able to meet numbers but skill mix remains a concern.	6	30/06/2021	30/09/2022	09/02/2023

Appendix A - Quality and safety risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective							**2b. Making ULHT the best place to work**																			
4990	Reputation	Low, Claire	Shankland, Lindsay	Workforce Strategy Group		08/08/2022	20		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally.	1. National and local lessons learnt for engaging staff effectively with surveys 2. Dedicated 'staff experience/engagement' role proposed to lead programme of work (including corporate and local action planning)	1. Pulse Staff Survey response rate (quarterly) 2. NHS Staff Survey response rate (annual)	14/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. National mandate for NHS organisations to run Pulse Survey every quarter (1,2&4) 2. Comprehensive and robust positioning to complement NHS Staff Survey and part of a wider staff listening and engagement plan 3. You said campaign to drip feed/communicate how staff intelligence is improving working environment and services - now live	[14/03/2023 14:01:55 Rachael Turner] Staff survey results demonstrate significant improvement, the Trust are now second nationally in improving. Update to be provided at next reviews [31/01/2023 15:15:19 Rachel Thackray] Staff survey responses from November 2022 indicate a perceptible positive shift across most questions. Improvement evident in position within our group on Picker moving from last place to 57/65. [09/11/2022 14:55:58 Rachel Thackray] Staff survey currently live with a good uptake and comms on a daily basis. HRBPs working with divisional leads to promote areas with low uptake. Promise Manager now in post from September 2022 working on staff retention. 1. Pulse Staff Survey - Q2 (July'22) 2. Reset approach (communication, engagement of and management) for sign off - ELT (June'22) 3. Local action planning process - now live 4. 7 Big Ticket Priorities proposed following NHS Staff Survey	4	31/03/2023	31/03/2023	14/04/2023
4439	Service disruption	Low, Claire	Shankland, Lindsay	Emergency Planning Group	WORK	16/11/2018	20		Corporate	People and Organisational Development	Operational HR		If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Workforce plans & rota management procedures. Temporary staffing arrangements. Business Continuity Policy with associated procedures & guidelines. Local service-specific business continuity plans & recovery procedures. Executive oversight (Chief Operating Officer) through Emergency Planning Group.	Frequency of industrial action events. Publicised staff polls / surveys by professional bodies on possible industrial action.	10/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	[10/03/2023 11:46:11 Rachael Turner] No change. Work currently in progress to provide an update in April. [31/01/2023 15:18:02 Rachel Thackray] Current risk assessment in place and working group set up to prepare for potential ongoing industrial action, links in with operational planning to ensure a joined up approach. [07/11/2022 11:13:23 Rachel Thackray] There is a likelihood that there will be some form of industrial action before the Christmas period in 2022. Therefore, it is necessary to increase the likelihood of this risk from low to extremely likely. As such he Associate Director of Workforce is working with the Emergency Planning team to revise the current action plan in place involving staff side reps and the Senior Management Team. The communications team will also be involved. There is a meeting taking place on the 8 November 2022 to implement a Task and Finish group. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review).	4		31/03/2023	10/04/2023
4993	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	WDES (Workforce Disability Equality Standard): limited awareness and implementation of reasonable adjustments and other forms of support which results in limited equality and equity of opportunity for staff classified as having a 'disability'; impedes Trust's ambitions to create an inclusive culture and foster belonging; difficulties in attracting as well as retaining talent	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	[31/01/2023 15:22:04 Rachel Thackray] WDES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. WDES action plan prioritised for engagement, development and delivery 2. July 2022: ULHT review datasets, declaration rates (from 1/7/22 ULHT required to submit metrics and narrative data via the DCF online platform by Aug'22). 3. End October 2022: deadline for ULHT to publish WDES 2022 annual report (include metrics report and WDES action plan)	4	31/03/2023	31/03/2023	28/04/2023
4992	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	WRES (Workforce Race Equality Standard): low compliance/ limited improvement and action to address indicators i.e. increase senior representation and better lived experience of BAME staff working in ULHT. Risk is this results in low number of applications for vacancies which then remain unfilled (difficulty attracting talent); poor turnover rates (difficulty in retaining talent) and a poor employer brand locally, regionally, nationally and overseas. This will impact on the culture of the organisation and the ability to recruit with increased turnover. Wider risk with regards to broader protected characteristics linked to the delivery of the EDI objectives.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	[31/01/2023 15:23:43 Rachel Thackray] WRES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. EDI Group and regular reporting established (for assurance) 2. Anti racism strategy and delivery plan socialised with stakeholders and live 3. NHS Staff Survey results - deep dive and analysis of lived experience of staff with protected characteristics 4. Draft EDI objectives 2022-25 - socialised and ready for sign off (end June) 5. ULHT workstream lead - addressing BAME disciplinary gap (Lincs Belonging Strategy) 6. People Promise Manager successfully appointed from end May'22	4	31/03/2023	31/03/2023	28/04/2023
Strategic Objective							**3a. A modern, clean and fit for purpose environment**																			

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specalty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4647	Reputation	Harris, Michelle	Davey, Keiron	Fire Safety Group	Fire Safety Group	14/12/2021	20	External Inspections	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees	- Compliance audits against fire safety standards - Progress with fire safety improvement plans - PPM compliance assurance (current lack of required detail for internal and regulator assurance)	03/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	[03/03/2023 13:44:13 Rachael Turner] Fire safety team currently working with estates colleagues to identify any areas of lower assurance are included within PPM schedule. Fire Drills commencing non clinical areas March 2023 No change, risk grading remains the same [06/12/2022 14:55:09 Rachel Thackray] Fire safety team currently working with estates colleagues to identify any areas of lower assurance are included within PPM schedule [02/11/2022 12:40:28 Rachel Thackray] No change, risk grading remains the same LFR previously served ULH with an Enforcement notice and action plan (since removed) in which the storage of items within corridors was highlighted: "Article 14(2) Emergency Routes and Exits There are combustible materials and items that pose an ignition risk are located on escape routes within the hospital. It required that Corridors and stairways that form part of an escape route should be kept clear of obstruction and hazard free at all times. Items that maybe a source of fuel or pose an ignition risk should not normally be located on any corridor or stairway that will be used as an escape route." In light of identified storage issues and subsequent non-compliance with these requirements, there is now a high potential for immediate enforcement notice with a view to prosecution in accordance with the regulator's compliance code. Task & finish group set up to address storage issues at local and at senior levels. Fire Safety Advisors working with local managers; IR1s reported when storage issues are identified, with escalation to divisional leads where necessary. Lack of PPM assurance identified - escalated to Estates management team for action, including improvements to the Micad system.	4	30/06/2022	31/03/2024	03/04/2023
4648	Physical or psychological harm	Harris, Michelle	Davey, Keiron	Fire Safety Group	Emergency Planning Group, Health and Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	03/03/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[03/03/2023 13:47:32 Rachael Turner] Compartmentation survey commenced with remedial actions identified for inclusion within capital plan 23/24/25, Fire drills commenced in non clinical areas March 2023. [06/12/2022 14:53:59 Rachel Thackray] New security provider undertaking internal patrol routes with escalation to porters when storage discovered. [02/11/2022 12:39:13 Rachel Thackray] Regular audits conducted by fire safety team by Fire Safety team within corridors, and IR1s being submitted to line managers for action. Escalation to matrons has now begun via IR1s. Rating increased on review to 20 - combustible storage in common areas frequently found (including life lobbys); emerging lessons learned from recent arson incident at LCH (including spread of smoke beyond the room of origin). Actions undertaken recently - IR1s issued to local managers and owners of storage risk, including escalation to senior managers. Setting up task & finish group to look at storage issues. Reviewed all fire risk assessments in Diagnostics across all 3 sites; other FRAs for public areas have also been reviewed. Reviewed all external security patrols and implemented alterations to routes to ensure possible higher risk areas are also patrolled. New tagging points added to patrol routes. Implementation of further required actions continues to progress.	10	31/03/2022	31/03/2025	03/04/2023
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	21/10/2022	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	[21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB-is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	21/01/2023

Strategic Objective	3b. Make efficient use of our resources

Appendix A - Quality and safety risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4664	Finances	Matthew, Mr Paul	Young, Jonathan	Workforce Strategy Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	National policy: - Agency spending cap set by Government ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Annual budget setting process cascades and apportions the Trust temporary staffing spend limits to the Divisions and Directorates. - Monthly financial management & monitoring arrangements are in place to identify variation temporary staffing financial plans at all levels of expenditure from department up to Trust. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Financial Review Meeting (FRM)	02/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	[02/03/2023 10:14:50 Rachel Thackray] No update this month. [02/02/2023 14:17:26 Rachel Thackray] The Trust is forecasting a 52.8m agency usage in 22/23 this is driven by increased volume requirements due to the number of beds open and significant breach of the agency price caps due to market conditions. The Trust has significant oversight and plans to control and manage in a phased and safe way agency reductions in Q4 22/23 and into 23/24. [02/11/2022 11:06:31 Rachel Thackray] The Trust agency spend continues on a similar trajectory driven by significant and increased demand for patient services – primarily in the NEL pathway and pressures in ED. This has resulted in additional beds being required above those planned and subsequently a need to staff the beds with temporary and high cost nursing and medical staff to remain safe. The Trust has introduced a financial improvement plan that is heavily focused on increased agency oversight across all staff groups with a number of Exec lead schemes. The Trust has exited the 21/22 financial year with an agency spend of c£44m. This has in part been driven by COVID pressures and a large number of escalation beds open increasing the requirement for temporary staff. The Trust has agreed an ambitious CIP programme that is heavily focused on agency reductions through the recruitment of staff and reducing the number of NEL beds required. This will take time to embed. Reviewed at RRC&CG - score increased from 16 to 20.	8	31/03/2023	31/03/2023	03/04/2023
5020	Finances	Wall, Mrs Tracey	Thomson, Cheryl	Workforce Strategy Group	WORK	02/09/2022	20		Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	09/02/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[27/01/2023 11:36:10 Helen Hartley] Reviewed today, will be discussed further on 6 Feb to potentially lower. [23/11/2022 11:25:30 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed but may be reduced on next review taking account of mitigating controls. [10/11/2022 13:40:37 Helen Hartley] No change at governance [07/11/2022 07:03:07 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:24:16 Helen Hartley] No changes made at governance	10	02/09/2023		09/03/2023
4957	Finances	Young, Jonathan	Young, Jonathan			28/06/2022	16	Professional Guidance	Corporate	Finance and Digital	Finance	Trust-wide	The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. The national planning assumption is that all COVID costs incurred in Acute settings in relation to COVID will cease from 1st June 2022 aligned to the anticipated reduction in COVID patients to extremely low levels.	National policy: - Government financial planning assumptions due to COVID ULHT policy: - Financial plan set out the Trust Budget allocations in respect of COVID spend - Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). ULHT governance: - Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. - Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FRM.	02/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Alignment of the Directorate and Divisional budgets to the national strategy for the removal of COVID costs from 1st June 20222. By exception reporting of all COVID costs not removed from financial positions.	[02/02/2023 14:25:19 Rachel Thackray] The Trust is forecasting £5.8m COVID related costs for 22/23. This is a much improved position from the 21/22 spend however this is still a pressure, although much reduced, in the financial position. All schemes that have been reduced or ceased have been through a QIA assessment. Risk to be reassessed in April 2023. The Trust incurred c£13m of direct costs in relation to COVID with a further indirect cost e.g. staff sickness. The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	8	31/03/2023	31/03/2023	03/04/2023
4665	Finances	Matthew, Mr Paul	Young, Jonathan	Financial Turnaround Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £25m CIP target for 22/23. If the Trust fails to deliver The CIP Plan it will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to achieve their financial plans.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial plan inclusive of CIP. (Transformational) - Establishment of the service framework to prioritise Speciality improvement reviews. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process from 1st April. (Transactional) ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process - Programme Management Office (PMO) & dedicated Programme Manager. - Introduction of the Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes - Refresh of the FRMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I The Trust monitors internally against its CIP targets inclusive of specific Divisional and Scheme targets Divisional focus against Transactional schemes is reviewed at the relevant FRM Trust focus against Targeted and Transformational schemes is reviewed at the Improvement Steering Group	02/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Refresh of the CIP framework and training to all stakeholders. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust IIP and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	[02/02/2023 14:13:16 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme for 22/23 a shortfall of £11m against its revised plan, which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. [02/02/2023 14:12:00 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. The Trust has delivered its CIP plan for the past 3 years, albeit a reduced requirement during the 2 financial years that cover COVID. The Trust is embedding a new Improvement framework with CIP included within it and is also working with system partners to make financial improvements due to pathway changes. This will take time to embed and alongside the operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the CIP target. Reviewed at RRC&CG - agreed score of 16.	4	31/03/2023	31/03/2023	02/05/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5019	Finances	Wall, Mrs Tracey	Spendlove, Mrs Clare			02/09/2022	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is a continued reliance on bank and agency staff for nursing workforce in Urgent & Emergency Care there is a risk that there not sufficient fill rate in each department which will impact on patient safety and have a negative impact on the CBU budget	Robust nursing plan for every post meetings Daily operational matrons identified for Lincoln and Pilgrim Daily safer staffing lead identified for escalation Establishment review DON Monthly roster clinics / workforce dashboard Daily staffing meetings 3x day Monthly director of nursing quality dashboards. Temporary staffing solutions group - purpose is to reduce agency spend attendance.	Plan for every post meetings Budget reports	22/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Robust recruitment plan International recruitment	[06/03/2023 13:55:09 Rachael Turner] RRC&C members in agreement of risk score reduction to a High Risk (16). [22/02/2023 16:47:51 the reporter] -Establishment reviews have taken place -Fill rates have improved into temporary staffing therefore the likelihood of not having nursing staffing in both Pilgrim and Lincoln is reduced -The organisation has taken ownership that a rapid handover is available. -Divisional approval of risk reduction confirmed. -Email sent to RCRC&C members for approval of risk score reduction. [22/02/2023 14:03:50 Paul White] Improvement in fill rates when shifts are put out. Reduced likelihood because of existing mitigations in place affecting staffing and there is a proposed end . Presented at Confirm & Challenge meeting 22 Feb by TW. Agreed in principle with reduction in score from 20 to 16. Group members to be given until 1 March to raise any concerns.	8	02/09/2023		22/05/2023
4965	Finances	Hallion, Simon	NIC (Deleted User)	Workforce Strategy Group	WORK	11/07/2022	9	Workforce Metrics	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Financial risk due to reliance upon temporary staff (nursing and medical) to cover vacancies in Paediatrics.	1. Scrutiny of rosters to ensure optimal use of existing staffing resources; 2. Review of all shifts that are placed with either Nursing or Medical Bank to ensure these are required; 3. Use of bank staff in preference to agency staff in view of potential cost savings; 4. Utilisation of tier 1 and 2 agencies in view of potential cost savings; 5. Use of long line agency in view of potential cost savings and increased assurance that shifts are safely staffed.	1. Reviewed via temporary staffing expenditure and safe staffing metrics; 2. Agency spend reviewed via at FPAM	12/12/2022	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1. Robust recruitment and retention plan for nursing and medical staff across Children and Young People Clinical Business Unit.	[13/12/2022 14:40:14 Alison Barnes] No change [18/11/2022 11:42:37 Alison Barnes] Positive feedback around nursing recruitment. Start dates for medical staff currently delayed beyond predictions impacting on higher than anticipated use of agency staff. Agency spend closely monitored at trust level. 09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR Discussed at Risk Register Confirm and Challenge meeting. Confirmed that risk is solely financial as there is mitigation in place to ensure quality and safety are maintained (eg long line booking of regular agency staff). Some discussion about whether this risk should sit on the divisional risk register or whether it is captured in the corporate risk that focuses on the impacts of vacancies. To discuss at forthcoming risk meeting.	3	31/07/2023		12/03/2023
Strategic Objective							**3c. Have enhanced data and digital capability**																			
4657	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team.	Monthly reporting completed. Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	01/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[01/03/2023 16:45:25 Fiona Hobday] Risk updated following Confirm and Challenge meeting. Meeting with ICO 6/2/22 with Trust Secretary, SIRO and Head of IG- overall regulator were comfortable with position explained to them and work ongoing to resolve backlog issue. Staff resource has been reallocated to split between backlog and new requests- performance being monitored between both and resource will be redirected as needed. Backlog has reduced over last month and oldest request now dates back to July 22 as opposed to May 22 which was the position at the start of Feb 23. Action plan documented- to be sent to ICO imminently as part of an update. Awaiting formal response from ICO following meeting. [02/02/2023 09:01:03 Fiona Hobday] Risk taken to Confirm and Challenge meeting in Jan 23- agreed score should increase to 20. [30/01/2023 14:01:47 Rachael Turner] Risk requested to be increased to a score of 20 at Confirm and Challenge group as we are not meeting statuary requirements and continue to have a large backlog. This risk also impacts on Complaints and PALS. Agreed at C&C group for risk score to be increased. [06/12/2022 15:51:15 Maria Dixon] Ongoing communications with ICO. Changes to clinical review part of process. Some additional temporary resource brought in. This is a significant ongoing piece of work that is going to take at least 12 months to overcome. Office 365 implementation Trust-wide in progress, to enable search of emails / systems. Still has limitations & requires staffing capacity to manage demand for SARs. Discussed at Risk Register Confirm & Challenge Group, 23 March 2022. Agreed recommendation that current rating should potentially be increased from 12.	6	30/06/2023	30/06/2023	03/04/2023
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the required data protection / privacy impact assessment process and subsequent contractual requirements is not followed consistently at the start of a system/ process change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach or third-party incompliance that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	National policy: - Data Protection Act 2018 & General Data Protection Regulation - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy and supporting appendices ULHT governance: - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group - Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles	Monitoring of IG project tracker into IG Group. Internal audit review of data protection / PIA processes	06/12/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process. Work to review and implement a formal process with procurement/ contracting. Work to develop and implement the IAO strategy.	[06/12/2022 15:00:16 Maria Dixon] Developed new template to go live this month. Strategy is drafted going to IGG for escalation in Jan 2023. Interim Head of IG currently in post. Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues. Reference to DPIAs in Data Security and Awareness mandatory training. Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required. Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data.	4	31/03/2024	30/06/2023	28/02/2022

Appendix A - Quality and safety risks rated 15 - 25

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4658	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework it runs the risk of not meeting national best practice. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management.	02/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments.	[02/02/2023 14:17:13 Fiona Hobday] Revise score approved at Confirm and Challenge meeting in Jan 23. [06/12/2022 15:09:53 Maria Dixon] DPO & Interim Head of IG raised with SIRO as part of O365 discussion. Development of health records retention & disposal policy in progress. Discussed at Risk Register Confirm & Challenge Group, 23 March 2022. Currently the Trust is storing paper records for longer than it should and there remains a lot of unknowns as to where records are stored. Likelihood should be increased, severity may possibly be lower.	4	28/06/2024	28/06/2024	02/05/2023
4641	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	Emergency Planning Group	23/11/2021	16	Risk assessments	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	19/05/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	Risk reviewed, description amended to reflect broader range of threats to the digital infrastructure. Current score increased to 16. Have purchased a significant number of Radios, to allow communication in the event of failure. We've completed a Network Core Switch replacement at Pilgrim new Data (DC3) at Pilgrim to provide resilience at site backup across site has been improved. Recovery Vault is in the process of implementation The Metro-Cluster is in the process of implementation.	4	31/03/2023	31/03/2023	18/08/2022

Meeting	*Public Trust Board*
Date of Meeting	*4 April 2023*
Item Number	*Item number 13.2*

Board Assurance Framework (BAF) 2022/23

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

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure* • *Confirm the proposed GREEN rating of objective 1b – Improve patient experience*

Executive Summary

The relevant objectives of the 2022/23 BAF were presented to all Committees during March 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 Quality Governance Committee are proposing that objective 1b – Improve patient experience be rated green from amber.

The following assurance ratings have been identified:

Objective		Rating at start of 2022/23	Previous month (February)	Assurance Rating (March)
1a	Deliver harm free care	Green	Green	Green
1b	Improve patient experience	Amber	Amber	Green
1c	Improve clinical outcomes	Amber	Green	Green
2a	A modern and progressive workforce	Red	Amber	Amber
2b	Making ULHT the best place to work	Red	Amber	Amber
2c	Well led services	Amber	Amber	Amber
3a	A modern, clean and fit for purpose environment	Amber	Amber	Amber
3b	Efficient use of resources	Amber	Red	Red
3c	Enhanced data and digital capability	Amber	Amber	Amber
3d	Improving cancer services access	N/A	Red	Red
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	N/A	Amber	Amber
3f	Urgent Care	N/A	Red	Red

4a	Establish collaborative models of care with our partners	**Amber**	**Amber**	**Amber**
4b	Becoming a University Hospitals Teaching Trust	**Red**	**Red**	**Red**
4c	Successful delivery of the Acute Services Review	**N/A**	**Amber**	**Amber**

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamination and other estates- related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		
						Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). Infection Prevention and Control BAF in place and reviewed monthly IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	Non-compliance with some aspects of the Hygiene Code.	Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC. IPC policies have been updated / developed / written in line with the timetable. •Estates and Facilities/Decontamination Lead has made good progress with estates and facilities work and is awaiting a place on a specialist decontamination course. • Good progress with achieving and sustaining standards of environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve Very good progress with work to achieve compliance with new National Standards of Cleanliness directive and this continues to be taken forward via a Task and Finish Group with monthly monitoring by the IPCG • Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		

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1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care	5016 4624 4877 4878 4879 4789 4935 4779 4868 4974 4646 5073 5051 4622 4984	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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			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			Medicines Quality Group in place with a focus on improving medication safety / appropriate prescribing / appropriate management of drugs and controlled drugs Robust medicines management policies and procedures in place Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit. The Medicines Management Action group in place to oversee the programme of works from the IIP programme. MQG will retain oversight of the relevant IIP programme of work (MQG)	Lack of e-prescribing leading to increase in patient safety incidents due to medication errors Gaps identified within the recent internal audit undertaken by Grant Thornton Lack of adherence to Medicines management policy and procedures Lack of 7 day clinical pharmacy service	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Deputy Medical Director led Action / Delivery Group in place and meeting fortnightly to progress actions and reporting to the MQG.	Upward Report from the Medicines Quality Group to QGC Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group Omitted doses audit Prescribing Quality reports Robust Divisional reporting and attendance into MQG monthly IIP upward report into MQG monthly Internal Audit report	Medicines Quality Group have not been receiving reports regarding progress with the medicines management IIP however this is planned to commence from November; Lack of upward reporting from the DTC and the Medical Gas Audit Pharmacy audits only occurring in areas they are providing a clinical service to.	Divisional representation at Medicines Quality Group reinforced by Medical Director and Director of Nursing and template for divisional reporting of BAU medication safety activities in to Medicines Quality Group developed and in place		
						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training occurs through MNOG.		

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						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA (Ensuring early detection and treatment of deteriorating patients) (PSG)	Work required to develop the maturity of the group. New Chair identified and full review of membership and remit required. Maturity of some of the sub-groups of DPG not yet realised. This will be considered as part of the review of DPG.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE; DKA	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas Number of incidents occurring regarding lack of recognition of the deteriorating patient	DPG meeting not meeting as frequently due to loss of Chair. New Chair identified and commenced in post October 2022.			
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	Paper presented to CRIG and funding agreed - currently sat in reserves and awaiting drawdown by Estates and Facilities who will manage the trainers	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting to Mental Health, Neuro Diversity and Autism group	DMI training to commence delivery in November 2022. PETS roles will be in post End May 2023	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. All PETS roles being interview this month. Security lead appointed and in post, Deputy lead interviews on14th MArch. PETS to be in post by end May 2023		
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG) One central monitoring process now in place.	Review of compliance metrics required.	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						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)		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				

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						Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG) Patient Experience Group - the group has developed its maturity. The annual scheduled workplan is embedded, the meeting has consistent quoracy, the ToR are reviewed annually and relfect the purpose and work of the group. If PEG is stood down due to operational pressures, the Chair / Vice Chair review the papers and provide upward report to QGC.			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. An overarching action plan has been developed which captures the themes from surveys and other surces of information / audits, Access to this is available to all Divisions for regular updating and use through theier own Divisional PEG's and governance meetings.	Themes from the Divisional assurance reports and the Complaints reports and others sources of information such as the national patient surveys are triangulated, so issues and learning across the themes is clear, this is work in progress, and will be ongoing so that oversight is maintained.	The overarching action plan is monitored through PEG.		
						Patient and Carer Experience (PACE) plan 2022 - 2025 (PEG)	The PACE Delivery Plan to be actioned and embedded over the life of the delivery plan.		Patient Experience & Carer Plan progress report to Patient Experience Group as per schedule.	Ongoing assurances provided to PEG re: actions. Assurance is variable due to the number of actions being delivered. But overall oversight of the plan = moderate assurance	The delivery plan will be monitored through PEG		

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						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 data. Deep dives into areas of concern as identified in quality metrics dashboard meetings. patient experience data collected through the audits is referenced in the overarching action plan, so that the data is triangulated. Update reports to PEG and QGC as required. Weekly and monthly audits continue to take place including during times of extremis. Audit tools are refreshed at least annually or sooner, to reflect current practice. quality accrediation now embedded with a number of ward areas acheiving Diamond Award status, the award panel has a patient representative on the Panel.		Reports to PEG and upwardly to QGC Ward / Dept review Visits are cancelled when the organisation is in extremis. However, weekly spot check audits and monthly matron audits continue. Scheduled review visits for the year, which include the patient experience team as part of the visit team. Pt Experience team 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 4985 4972 4828 4731 4928 4905	CQC Caring	Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG) Working with Hard to Reach groups. Diversity of representation at the patient panel Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging You Care - We Care to Call (YCWCC) Campaign being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. You Care - We Care to Call (YCWCC) Campaign being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. Experts by Experience group gaining traction and engagement, working with the QI Team to identify a patient E by E group who they can work with as part of codesign / service redesign. LD E by E practitioner about to be recruited.	Reaching out project (Hard to Reach groups) still being developed but linking in with Healthwatch in the meantime		Upward reports and minutes to the Patient Experience Group Sensory Loss group upwardly reports to Patient Panel.	Diversity of patient engagement and involvement is limited.		Quality Governance Committee	Green
						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. New Visting Policy being written, incorporating feedback and steer from national team around visitors /	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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									team around visitors / carers / Head of Pt Exp part of this natonal work and spo bringing back the infomration to ULHT. B31:E40				
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Pt Equalities Lead role being discussed at Trust level re potential for this new role into the Trust. Both Pt experience managers will be Cultural Ambassadors as part of the Trust culture change workstream. Head of Pt Exp is a member of the EDI group and works with the EDI lead on pt issues.	EDI 1/4rly report to PEG;	EDI Reports still developing in maturity regarding patient experience	Head of Pt Experience working with EDI lead to ensure data is relevant and triangulated.		
						Robust process for monitoring Mixed Sex Accommodation Breaches in place.	No control gaps identified.	No control gaps identified.	Regular reporting to Patient Experience Group and Quality Govenance Committee.	No assurance gaps identified.	No assurance gaps identified.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)			PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme recommenced September 22. Annual report will go to TB and then to PEG.	PEnding first formal issue of the outputs on the National Staff Survey early link in with Comms will be required to share the outputs with all Trust Staff before general release on the 9th March.		
						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. Staff experience surveys - Pulse survey quarterly and annual staff survey			Discharge experience reports to PEG quarterly staff experience reports and updates received at PEG. Patient Experience Team working with Lead Nurse for Discharge to support and ensure experience data is collected, analysed and acted upon.	Lead Nurse for discharge to attend PEG in October. Deferred to Nov. Deferred to Dec. Attending in April. Annual staff survey results to April PEG	Staff experience data will be used to identify thems and triangulate to pt experience data / complaints.		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4932	CQC Responsive CQC Effective	Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust.	Acknowledged that there is good engagement from nursing and AHPs. Although improving, 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.		Quality Governance Committee	Green
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports have begun to demonstrate changes in practice as a result of GIRFT work. The committee want to see further evidence of this before removing this gap.	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.		
						National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable		
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	Not applicable		

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						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) Regular reports to CEG with relevant owners in attendance where improvements are required.	None identified	None identified	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	None identified	None identified		
						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	None identified.	None identified.		
						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.				
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)			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			

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						Workforce planning and workforce plans	Overall vacancy rate declining	A new pillar for workforce planning and transformation is being created as part of the People Directorate restructure. The Trust have an Associate Director of Transformation and Workforce planning in post who is leading workforce planning in conjunction with HRBP's, finance and improvement team. This is established and regular reviews are now in place.	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend.	Some areas remain hard to fill however full and comprehensive workforce plans are in place 'plan for every post' and workforce scorecards are in place and are reported through to the Operational Workforce and Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board.	Work continues with the regional roll out of the KPMG workforce tool and from a ULHT perspective a group has been created to support the submission of the Q4 workforce planning submission. First draft of the workforce submission has been submitted with further work now been undertaken on the final submission which is due to our system colleagues on 13.03.23. Intensive work has been undertaken to triangulate the workforce requirements coupled with capacity and finanical reductions on temporary staffing required from a ULHT perspective contributing to the system cost improvement plan.		
						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			
						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 paper was tabled at PODC in February to outline the plan to progress review of what constitutes mandatory and role specific training with focused work to commence when the Head of Education commences employment at the beginning of April. Recommendations were approved by PODC.		

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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	4991 4741 4862 4762	CQC Safe CQC Responsive CQC Effective	Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural change when the ability of the ULHT teams to engage when we are operationally challenged Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects)	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations Working with each improvement programme and Divisions to develop identify and align improvement plans	Internal training reports produced by Improvement academy Improvement programmes identifying personalised training needs for ULHT staff Divisions training plan (aligned to the IIP) presented at FPAM	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams.	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement)	People and Organisational Development Committee	Amber
						Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Support and training from HRBPs External consultancy briefings with divisional leads	Sickness/absence data	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. Stats are reported through FPAM.		
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service (pending P&OD restructure)	Training and Development department	Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education Recruitment to Head of Education and Training infrastructure. Interim resource in place	System LEAD (Learning, Education and Development) Board to provide system oversight (agreed) Apprenticeship uptake and utilisation of levy through WSODG	None identified			
						Creation of robust Workforce Plan •Values based recruitment and retention •Maximising talent management opportunities •Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn' Promote benefits and opportunities of Apprenticeships	Vacancy of accountable officer	Appointed post holder due to commence March 2023. Interim cover in place. Task and Finish Group established	Improved vacancy rates reported through WSODG and escalated as required through the scorecard to PODC.	None identified			

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						Improve the consistency and quality of leadership through:- Reset leadership development offer and support (Leadership SkillsLab and PME) •Improved mandatory training compliance •Improved appraisals rates using the WorkPal system •Developing clear communication mechanisms within teams and departments	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	Trust wide communications were issued on the 9th March in relation to the results of the staff survey with follow up work being undertaken by Head of OD working with the Head of HR and separate Directorates to highlight the 'top three' areas of improvement and the plan to address these.		
			Further decline in demand			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				

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2b	Making ULHT the best place to work	Director of People and Organisational Development	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	4990 4439 4993 4992	CQC Well Led	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.	People and Organisational Development Committee	Amber
						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							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												

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3a	A modern, clean and fit for purpose environment	Director of Finance and Digital	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4648 - Fire Safety 4647 - Fire Safety 4858 - Water	CQC Safe	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 - Medical 4965 - Reliance on temp staff paeds	CQC Well Led CQC Use of Resources	Inflation - The Trust is working to actively manage its contracts and to flag excess inflation due to market conditions as part of the national collection process in relation to this spend area	Impact of unstable market conditions led to the Trust forecasting excess inflation of £5.8m in its 2022/23 financial plan, primarily in relation to Utility costs but also impacts in other non-pay contracts. As prices continue to rise may be unable to mitigate these cost increases.	Financial plan set out the Trust expectation in respect of inflation aligned to the national allocations Annual budget setting process cascades and apportions the Trust inflation allocation to Divisions and Directorates. Monthly financial management & monitoring arrangements are in place to identify variation of excess inflation against financial plans at all levels of expenditure from department up to Trust. The Trust actively manages its external contracts to ensure value for money.	The Trust is monitored externally against the inflation impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific inflation forecasts Divisional focus against specific contracts (e.g. Utilities) is reviewed at the relevant FPAM	Forward view of market conditions.	Internally through FPAMs and upwards into FPEC. Externally through greater dialogue with suppliers and proactive contract management	Finance, Performance and Estates Committee	Red
						Agency - Financial Recovery Plan schemes: Recruitment improvement; Medical job planning; Agency price reduction; Workforce alignment	Reliance on temporary staff to maintain services, at increased cost Management within staff departments and groups to funded levels. Maximisation of below cap framework rates Rapid ability to on-board temporary staff to substantive contracts	Proposed centralised agency & bank team. Workforce Groups to provide grip Improvement Steering Group to provide oversight Non-Clinical Agency sign off process	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans. Rota and job plan sign off in a timely manner Large scale recruitment plans to mitigate vacancies.	The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups		
						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 104%. National steer is to not clawback under delivery in H1	Maximisation of the Trust Resources - Theatre and Outpatient productivity. Impact of the COVID patients and flow on availability of beds to provide capacity. Ability to recruit and retain staff to deliver the capacity.	Divisional ownership and reporting Improved counting and coding, including data capture and missing outcome reductions. Shared risk and gain share agreements for the Lincolnshire ICS.	Delivery of the 104% target	The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 104% activity target.	The Trust is monitored externally against the Trust activity target through the monthly activity returns The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns		

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

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3c	Enhanced data and digital capability	Director of Finance and Digital	Approval of OBC for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure	4641 - Digital infrastructure 4661 - DPIA	CQC Responsive	Rollout of PowerBI as Business Intelligence Platform during 2022/23			Delivering improved information and reports Implement a refreshed IPR Rollout increasing, having replaced QlikView dashboards. New dashboards in place to support Vaccination reporting and HR EF3 processes. Work underway to automate IPR production for Trust Board and Committees, as well as Divisional PRMs.	IPR refresh for 22/23. Completed for Jan 2022	Steady implementation of PowerBI through specific bespoke dashboards and requests.	Finance, Performance and Estates Committee	Amber
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues	Skilling up internal resource. Exploring opportunities with Northampton General Hospital who provide RPA Services LCHS and ULHT contracts being migrated to one at next renewal.					
						Improve end user utilisation of electronic systems	Business case for additional staff under development	Digital team providing advice and guidance hoc to address pressure points					
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Additional metrics have been added and reviewed, and a work plan and deadlines associated with completion is being drawn up. These will be shared with the Director of Finance & Digital for sign off.		
3d	Improving cancer services access	Chief Operating Officer	Insufficient clinical capacity, insufficiently optimised pathways, Dependency on services (primary care, pathology) that are unable to deliver required access or level of service		Cancer Standards 62 day, 14 day and 28 Day FDS	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Cancer Care Integrated Improvement Programme and Assoc Governance System Cancer Improvement Board	Recovery post COVID and risk of further waves Specialty Capacity strategies not in place Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) East Midlands Cancer Alliance Increased Oversight	Cancer board assurance and performance reports Deep Dive information and reports on gap analysis Routine Performance and pathway data provided by Sommerset system	Process information below the cancer stages are not always captured Some digital systems are not linked and not all wait information is recorded e.g. MIME system	Targeted Improvement (3 x weekly) of key concern specialties increase the scrutiny of reporting and pathway performance led by COO Colorectal now seeing a well managed recovery and the Surgical Division is now reviewing the Prostate Cancer Pathway. Breast continues to see improvement. The 62 day backlog continues to be aligned to the agreed recovery trajectory.	Finance, Performance and Estates Committee	Red

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3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer	Insufficient clinical or physical capacity, insufficiently optimised pathways		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Planned Care Integrated Improvement Programme and Assoc Governance System Planned Care and Diagnostic Group	Recovery post COVID and risk of further waves Specialty strategies not in place Elective Theatre Programme Transformation team not yet established.	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Recovery plans at specialty level. To date have delivered required reductions in 104 week waits Outpatient Improvement Group Foureyes Theatre Improvement Programme GiRFT and High Volume Low Complexity Programme Group	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and NHSE Review data	Inconsistent approach to waiting list validation CBUs do not have traction or insight into the non admitted or admitted waiting lists Maximum Outpatient and theatre capacity not apparent as yet. Demonstration of change at pace is lacking.	National edict to see and treat all patient waiting greater then 78 weeks by 31 March 2023 in place. Twice daily monitoring and reporting is now in place. The largest DM01 risk is Echo Cardiology. A plan is now in place to offer and recruitment and retention premium. The recommendations and action plans suggested following the Regional Diagnostic Team external review is realising some benefits. Local, System, Regional and national assurance meetings in place to monitor progress and delivery. Use of independent sector, mutual aid and insourcing/outsourcing providers to ensure delivery. ICB and COO holding the Trust to account for delivery against national deadline. Internal design, development and agreement of a 'production plan'. Review of all consultant Job Plans is in train.	Finance, Performance and Estates Committee	Amber
						Outpatient Recovery & Improvement Programme (ORIG)	Focused on 3 activities to support outpatient specialties to be able to reduce backlogs and provide enough capacity to meet demand 1. Clinic slot utilisation key metric being tracked to drive up access to outpatient services and reduce the backlogs 2. e-RS -All directory of services (DOS) reviewed and services to be uploaded to ensure polling for primary care 3. Missing outcomes backlog addressed and reduced with sustainable plans OP Sprint above completed - next phase of OP work in Q4 to continue to address slot utilisation, improve Patient Initiated Follow Up , no patients waiting over 78 week & root cause issues of missing outcomes & DNA in Trauma & Orthopaedics	ORIG working with division to get back to pre-covid clinic templates and develop recovery plans Specialty based capacity and demand modelling to ensuring outpatient resource focused in correct areas-focus on division specific areas of improvement required	OP Data Activity tacker from Performance Team reviewed weekly monthly in divisional FPAM	Escalations & issues through ISG when required	Reporting through Improvement Steering Group & FPEC		

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						HVLC/GIRFT Programme - Theatre productivity and efficiency	Ability of the ULHT teams to engage in the programme. Emergency pressures resulting in elective cancellations. Culture mindset change takes time.	Full robust Theatre programme with focus on KPIs now meeting weekly to oversee and drive changes	Theatre dashboard has been created and reviewed by operational teams for booking & scheduling - aim for 90% 6-4-2/scheduling now in place Weekly Capacity meetings held to ensure theatre utilisation	Increased in NEL demand may impact staffing levels, elective bed capacity, and therefore could impact on elective activity. KPIs potentially impacted: OTD cancellations and actual utilisation against planned levels	Reporting through Improvement Steering Group/FPEC/HVLC		
						Clinical prioritisation Group	Ability to list appropriate mix of P2/3/4 due to effective preop Unnecessary on the day cancellations Increased non-admitted waiting list waiting to convert to admitted	Preop workstream via FEI Review and management through prioritisation group and Surgical PRM Management through ORIG/HVLC/Surgical PRM	Reporting through FPEC/HVLC				
						Daily System control meetings in collaboration with 3x daily internal capacity meetings. Integrated Improvement plan for urgent care and Urgent Care improvement Group. System Urgent Care Partnership Board. LHCC Improvement Programme Board and LHCC Board	Recovery post COVID and risk of further waves Internal professional standards not embedded External dependencies lack of visibility of capacity and system control to move risk/capacity between services. E.g. community care hours, care home ,assessment capacity etc.	External reviews used to identify gaps in services and assess capacity shortfalls. Emergency Care Intensive Support Team, IMPOWER specialist consultants and Dr Ian Sturgess specialist consultant reviews identify control and process and capacity gaps. Development of clinical vision for Urgent and Emergency Care	Improvement against strategic metrics Suite of performance metrics and benchmarking % of patients in Emergency Department >12 hrs (Total Time) Reports produced by ECIST IMPOWER and Improvement Consultants Breaking the cycle updates (as delivery of the clinical vision) A revised 4hr transit target of 76% agreed nationally and improvement trajectories being confirmed.	Gaps in Early Warning Dashboard Pathway 1 capacity admission avoidance impact, waits and capacity for primary care. Clear Treatment plans for P0 patients to support exit. Assurance in regard to Bed closure plan.	LHCC Programme Board reviewing Early Warning Dashboard - additional reports on progress. The System have now adopted SHREWD as the method of actual position and early warning LHCC Programme Board reviewing progress Weekly CEO Forum review where evidence is and any gaps supplemented with twice weekly CEO and COO calls.		

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3f	Urgent Care	Chief Operating Officer	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)	Urgent Care Recovery Improvement Steering Group which oversees a programme of work linked to increase capacity, flow and discharge through the Trust Wide Emergency Departments, Urgent Treatment Centres and Same Day Emergency Care Breaking the cycle launched in November - 60 day trial of new way of working including the full cacpaity protocl , using SDEC, care naviagation to ensure right care right time principals Improve access for patients by reducing unwarranted variation in service delivery through transformation of Urgent Care Breaking the cycle piolt has now ended and lesson learnt document shared and agreed recommendations for embedded changes agreed at UCRIG. UEC - sprint work on has now commenced front door realting to EMAS direct access, therapies at front door & pedaitric pathway review . Productive ward programme now has sprint focus on discharge lounge, web V completion & Predictive discharge dates	Large complex programme which required system working to reduce pathway 0 waits and deliver right care right time principals	Large programme of work so additional resource has been provided through a consultancy Impower & ECIST to assist in identification of areas to improve and on the ground support	Metrics dashboard developed for discharge and flow linked to bed reductions trajectory	Data metrics to demonstrate impact on of the interventions is being developed. There is a risk to the delivery of non-elective length of stay target and increase in daily discharges due to the reliance of other specialties and external agencies outside of the control of the hospital There is a risk that winter pressures and will outstrip length of stay and occupancy gains preventing delivery of discharge/ bed closures.	Reporting through Urgent Care Improvement& Recovery Steering Group and Improvement Steering Group monthly	Finance, Performance and Estates Committee	Red
						Recovery Support Plans	Risk of further waves, increased emergency demand and covid related sickness	Urgent and Emergency Care Board.	Daily review via Capacity and performance meetings Weekly reporting to ELT Fortnightly reporting to				
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			Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority specialities for service reviews by July 2022. Heat Map finalised and used to identify the Specialties that were to be prioritised first for Specialty Review. Initial 17 data packs completed in readiness for Specialty Reviews during Feb/Mar 2023. Pilot within Cardiology undertaken in Nov 2022.		

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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	Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements in 22/23- (1) continued improvements in patient safety and experience (2) reduce long waiting times for treatment (3)make our people feel valued and supported by improving our culture and leadership	Embedding and sustaining cultural change when we remain operationally challenged with staffing issues etc. Ability to demonstrate quick impact on the cultural change due to various interventions as part of our Outstanding Care Together programme will be limited (as these are multi year/multi factorial projects)	ELT/TLT oversight Board / system reporting	Updated IIP reported at relevant Board Committees	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh - completed. Year 4 IIP under development and due to be completed within Mar 2023 following a robust Business Planning Session in Q4 of 2022/23 (including Divisional IIP completions).	Finance, Performance and Estates Committee	**Amber**
						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain ULHT anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) The process of building the Trust Clinical Strategy has commenced taking information from Specialty Reviews to inform accordingly, and building on outputs from the Business Planning process.		
						Developing a business case to support achievement of University Hospital Teaching Trust Status	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee	Further understanding of the costs involved to increase size of R&I department and also to develop an R&I facility	R&I team reworking business case with a phased approach		

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4b	Becoming a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increase clinical academics by 20 and RCF funding worth £200k within the last 2yrs Further clarification and implications of the changed guidance on univ hospital status required. Funding for Clinical Academic posts and split with UOL to be agreed	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Contract agreed with UOL for Clinical academic posts. UoL have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - linked to roadmap and Research Event to identify specialties. RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position - now amalgamated into the monthly Steering Group with ad hoc meetings between SRO's where needed to discuss funding for Clinical Academics. ULHT have a recruitment roadmap in place which will include some pump prime from vacancies. Additionally a joint Research Event is being planned for Q3 of 2022/23 with the University to identify future areas of collaboration with research and Clinical Academic recruitment. Event planned for Q3 of 2022/23 cancelled by the University as they wanted to review outputs from a previous event they hosted in August 2022 to understand if there was any potential alignments that could be made for onward joint collaborations.	People and Organisational Development Committee	Red
						Improve the training environment for students	Understanding of our offer of the facilities required for a functioning clinical academic department	Revision of the library and training facilities to ensure that facilities are fit for purpose for all staff who will require access to training facilities, library, ICT equipment to be able to perform their role. This will be aligned to the UHA Guidance, and will include those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unknown timescales of completion	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		
						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		

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

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

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

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

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

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

Rating	Description
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