Bundle Trust Board Meeting in Public Session 5 September 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

2.1 Ward Accreditation
Jaisun Kadalikkattil from Johnson Ward (Bronze)
Sarah Baker (Ward Sister) from Lincoln Cardiac Short Stay Unit (Bronze)

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5.1 Minutes of the meeting held on 4 July 2023
Chair
Item 5.1 Public Board Minutes July 2023v1

5.2 Matters arising from the previous meeting/action log
Chair
Item 5.2 Public Action log July 2023

6 Chief Executive Horizon Scan Including ICS
Chief Executive
Item 6 Group CEO Update, 050923

6.1 CQC Children and Young People Inspection Report
Item 6.1 CQC Aug 2023 - CYP Inspection Report - Exec Summary
Item 6.1 - Appendix 1 - INS2-15740436541 - RWDDA Lincoln County Hospital - 2023-07-27 - PDF
Item 6.1- Appendix 2 - CYP Inspection Action Plan in Response - Aug 23

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

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

8.1 Assurance and Risk Report from the Quality Governance Committee (Jul/Aug)
Item 8.1 QGC Upward report July 2023
Appendix 1 Ward to Board Quality Accreditation front sheet July 2023
Appendix 2 Ward to Board Quality Acreditation Update position July 23 Final
Appendix 3 Copy of Quality Accreditation Overview Updated to May 2023 Data Set
Appendix 4 IPC Annual Report 2022.23 Final Draft June 23
Item 8.1 QGC Upward report August 2023
Appendix 1 Eastern European report July 2023 FINAL
Appendix 2 SBL 3 MNOG July 23
Appendix 3 PPH Report July 2023
Appendix 4 Maternity Neonatal Safety Assurance Report for July 2023 MNOG Final
Appendix 5 Quarterly Perinatal Mortality Review Report January
Appendix 6 MatSIP Headline Report July 2023 MNOG
Appendix 7 NED report MayJune 2023

8.2 CQC Action Plan

Item 8.2 Board CQC Update - Aug 2023 - Public Board v.1.0 (new template) CQC Improvement Action Plan

Item 8.2 Appendix 1 - CQC Improvement Action Plan

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 Workforce and Organisational Development Committee (Jul/Aug)

Item 9.1 POD - Upward Report - July 2023v1

9.2 Workforce Race Equality Standards and Workforce Disability Equality Standards Action Plans

Item 9.2 Workforce Disability Equality Standards (WDES) Action Plan Front Sheet

Item 9.2 Workforce Disability Equality Standard Report and Action Plan 2023

Item 9.2 Workforce Race Equality Standards (WRES) Action Plan front sheet

Item 9.2 Workforce Race Equality Standard Report and Action Plan 2023

9.3 Responsible Officer Revalidation Annual Report

Item 9.3
B1844-framework-of-quality-assurance-for-responsible-officers-and-revalidation-22-23

Item 9.3 People and OD Committee - Revalidation Annual Report 2023

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 (Jul/Aug)

Item 10.1 FPEC Upward Report July 2023

Item 10.1 FPEC Upward Report August 2023

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

Item 12 IPR Trust Board August 2023

13 Risk and Assurance

13.1 Risk Management Report

Item 13.1 TB - Strategic Risk Report - July-August 2023

Item 13.1 Appendix A - TB Active risks rated 15-25 - July -August 2023

13.2 Board Assurance Framework

Item 13.2 BAF 2022-23 Front Cover September 2023

Item 13.2 BAF 2023-2024 24.08.23

13.3 Audit Committee Upward Report

Item 13.3 Audit Committee Upward Report July 23

Item 13.3 Audit Committee Annual Report 2022-23

Item 13.3 LCFS Annual Report 2022-23

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 7 November 2023

EXCLUSION OF THE PUBLIC

In accordance with Standing Order 3:1 and Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960: To resolve that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 4 July 2023

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Professor Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Mr Paul Dunning, Medical Director
Mrs Rebecca Brown, Non-Executive Director
Ms Michelle Harris, Chief Operating Officer
Ms Dani Cecchini, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Mr Barry Jenkins, Director of Finance and Digital
Mr Neil Herbert, Non-Executive Director

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Lindsay Shankland, Deputy Director of People and Organisational Development
Mrs Kathryn Helley, Deputy Director of Clinical Governance – Item 8.3
Mr Craig Ferris, Deputy Director of Safeguarding – Item 8.2
Mrs Angie Davies, Deputy Director of Nursing – Item 8.4
Jane Thompson-Burt, Patient Experience and Engagement Manager – Item 7
Fiona Hamer, Divisional Lead Nurse, Medicine – Item 7

Apologies
Mr Andrew Morgan, Chief Executive
Dr Colin Farquharson, Medical Director
Dr Chris Gibson, Non-Executive Director
Ms Claire Low, Director of People and Organisational Development

935/23	**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.
936/23	**Item 2 Public Questions** **Q1 from Vi King** **Please can I submit a question to the Trust Board for 4th July 2023.** **To help with poor communication when patients are in hospital when will patient's notes be electronic.** **Communication is being lost between staff and relatives when asking questions or making enquiries about patients.** **It is either not being passed on or not being escalated appropriately. Surely in this day and age it should be in place.** **Would it not be possible to have system 1 in place so joint networking with NHS and GPs and services is more effective.**
937/23	The Director of Finance and Digital responded: The Trust is on a journey to purchase an Electronic Patient Record (EPR) and over the past 2 years the Trust had been working to build the IT infrastructure to be able to go to market to buy an EPR. In the coming months options of EPRs available would be assessed with the Trust then moving to purchase one. This is a costly and labour-intensive exercise however there is every confidence that an EPR will be in place in the next 2 years.
938/23	**Item 3 Apologies for Absence** Apologies were received from Dr Colin Farquharson, Medical Director, Mr Andrew Morgan, Chief Executive Officer, Ms Claire Low, Director of People and Organisational Development and Dr Chris Gibson, Non-Executive Director
939/23	**Item 4 Declarations of Interest** There were no new declarations of interest.
940/23	**Item 5.1 Minutes of the meeting held on 6 June 2023 for accuracy** The minutes of the meeting held on 6 June 2023 were agreed as a true and accurate record.
941/23	**Item 5.2 Matters arising from the previous meeting/action log**

	613/23 – Assurance and Risk Report from the Quality Governance Committee – The Chair noted that the action pertained to the Head of Midwifery attending the Board to present the outcome of the review of the maternity 3-year plan however noted that consideration had been given to how this would be brought forward. It was noted that a Board Development session would be utilised in order to hold a more in-depth session with the maternity team – close
942/23	**Item 6 Chief Executive Horizon Scan including ICS** The Deputy Chief Executive/Director of Nursing presented the report to the Board noting that the Trust continued to operate as an organisation as part of a system under significant pressure.
943/23	All organisations had plans in place to ensure resilience of services, particularly due to managing the junior doctor strikes of which there were 3 days over June and more planned for July. The system was working through the plans for this period of action.
944/23	It was noted that the ballot for industrial action by consultants had been undertaken and had met the threshold meaning that action would now be taken and had been confirmed for 20 and 21 July. This would mean that the system would, in effect, be working through 7 days of action.
945/23	The recent ballot for the Royal College of Nursing (RCN) had concluded but did not meet the threshold for action.
946/23	The Deputy Chief Executive/Director of Nursing advised of the system financial position with a month 2 deficit of £10.1m reported. This took in to account the month-on-month savings which were on track for the system year end deficit of £15.4m.
947/23	There was a system financial recovery plan (FRP) in place and at month 2 the system had overdelivered at £6.8m against a plan of £5.3m, this was a positive position to be in.
948/23	The reported position had supported the recent system financial delivery plan meeting with NHS England where a range of metrics, associated with the FRP were considered. The outcome of the meeting was positive with NHS England delighted by the delivery of the system in months 1 and 2. This supported the continued confidence of the system with the Trust contributing to this.
949/23	The Deputy Chief Executive/Director of Nursing noted that NHS England were also pleased to note that the system had a recovery plan in place and understood the significant pressures being faced, predominantly associated with excess inflation but also the impact of industrial action. This had an impact on both the recovery activity position and a financial impact.
950/23	The system had received the operational plan close down letter which summarised the key targets and deliverables that the system was committed to deliver.

951/23	The Trust continued to contribute to improvement work with the Deputy Chief Executive/Director of Nursing noting the work being undertaken with Lincolnshire Police to develop the Right Care Right Person Policy.
952/23	This was a national programme to ensure people in crisis and need were signposted to the most appropriate agency, as an acute provider the Trust would care for people in crisis particularly those with mental health and medical issues.
953/23	The Deputy Chief Executive/Director of Nursing advised that, following the outcome of the Acute Services Review (ASR) the Trust would run the Urgent Treatment Centre at Grantham with the Integrated Community and Acute Medicine beds, at Grantham, to be delivered in collaboration with Lincolnshire Community Health Services NHS Trust (LCHS). Work was underway amongst the teams on mobilisation plans for these services.
954/23	The Board was advised that, over recent months, NHS providers had been considering how to develop integrated services. Staff in respective organisations had been informed of the work across the system to improve Primary Care Networks (PCNs) and community partnerships for stakeholders to come together to deliver services in a different way.
955/23	Therefore, a group arrangement was being established between the Trust and LCHS with engagement of other NHS partners and regional colleagues who were in support of this. This would mean that the Trust and LCHS would work more closely in the future with shared decision making, governance and joint posts, such as the current Director of Nursing post which was a step in the journey.
956/23	The Deputy Chief Executive/Director of Nursing noted that there would be better use of shared expertise, experience and services and enable consideration of how support functions worked. This would look more widely at areas where delivery could provide the best quality and value for money.
957/23	The Board was advised that the current Chief Executive of LCHS would be leaving and from 1 August, the Trust Chief Executive would take up the Group Chief Executive role of both United Lincolnshire Hospitals NHS Trust (ULHT) and LCHS on a temporary basis until a substantive appointment was made.
958/23	The Deputy Chief Executive/Director of Nursing noted the NHS 75th anniversary with the NHS assembly having produced a report called The NHS in England at 75. This considered the future of the NHS and covered preventing ill health, the personalisation agenda, tailoring care to the person and coordinating care close to home. The report would be considered by the system and strategies and plans would be drawn up to demonstrate how progress would be made in the future.
959/23	From a Trust perspective the Deputy Chief Executive/Director of Nursing advised of the month 2 financial position with a reported year to date deficit position. There was a positive variance of £13k against this with a full planned deficit of £20.8m. A full savings plan was in place at £28.1m which was on track and currently ahead of plan against month 1 and 2.

960/23	It was noted that the Junior Doctors strikes in June had resulted in the cancellation of 39 operations and 371 outpatient appointments. This was in addition to cancellations as a result of previous strikes.
961/23	Most patients had now been rebooked however it should be noted that there was also a financial impact as a result of the strikes which had cost the Trust circa £330k for additional staffing costs and £455k in lost activity income.
962/23	It was hoped that the activity could be recovered later in the year however there was a need to work through the staffing cost impacts and how this was covered from other savings and budgets.
963/23	The Board noted that the public consultation for paediatric services had launched on the 12 June and would run until the 4 September with the proposal to make the current service provision permanent. The Trust would continue to engage with the public and stakeholders before the decision was put to the Board.
964/23	The Trust had celebrated armed forces week in June, ahead of Armed Forces Day on the 24 June. There had been a number of events which staff had been able to join to celebrate and learn about the experiences of veterans.
965/23	The Trust had also celebrated national estates and facilities day across the organisation which had included hero awards to staff which had been well received.
966/23	The National Freedom to Speak Up report had been issued and listed the Trust as one of the top 10 most improved organisations for speaking up which clearly demonstrated the impact that the Freedom to Speak Up Guardian was having in the organisation.
967/23	The Deputy Chief Executive/Director of Nursing was pleased to note Martyn Staddon was the winner in the Future NHS category and Howard Straughen-Simpson the winner in the Lifetime achievement category of the NHS Parliamentary Awards in the Midlands.
968/23	Finally, it was noted that the decision had been taken by the Board that the Trust would move away from holding public Board meeting on a monthly basis. The meetings would move to bi-monthly however the Board would continue to meet but move to strategic development discussions to continue the improvements the organisation had made over the past 2-3 years. The next meeting of the Board would be the 5 September.
969/23	The Chair noted the level of celebration items within the report and reflected on the Freedom to Speak Up results which supported the staff survey results which had indicated an improvement in the culture of the organisation and the workforce being willing to speak up and be involved in improvements.
970/23	The congratulations of the Board were offered to Martyn Staddon and Howard Straughen-Simpson with the hope that they would be similarly successful in the national awards.

971/23	The Chair noted the importance of the engagement in the paediatric consultation and encouraged stakeholders to engage and contribute to the process.
972/23	In respect of Grantham, the Chair was pleased to note the final decision by the Integrated Care Board (ICB) regarding the ASR noting that the organisation was mobilising the establishment of the urgent treatment centre and also the acute medical beds. There was an intent to do this at pace.
973/23	The provider review work regarding service delivery was an exciting opportunity and one which that Trust Board had actively contributed to. This would significantly enhance the way in which care was delivered to benefit the patients and population of Lincolnshire, regular reports would be received by the Board.
974/23	It was noted that industrial action was impacting on both the cost to patient care and treatment but financially as well with the appreciation of the Board expressed to all staff in the Trust who were working to mitigate the impact of the action.
975/23	Mrs Brown offered thanks in addition to the Executive Team for the way in which the strikes had been managed and demonstrated exemplar leadership to keep patients safe at such a challenging time.
976/23	The Chair wished the NHS a happy birthday and noted that, despite the challenges being faced, the Chief Executive would say this was one of the greatest organisations in the world. The Board, in the Chief Executive's absence, endorsed this view.
977/23	The Trust Board: • **Received the report and significant assurance provided**
978/23	**Item 7 Patient Story** The Deputy Chief Executive/Director of Nursing introduced the patient story advising that the story was about a patient attending the emergency department and raising issues about how the Trust failed to provide nutrition and hydration.
979/23	The Trust had learnt a lot from the experience, and it was noted that some of the initial story was uncomfortable in terms of what the Trust did not do to support the patient but goes on to show what is being done to support those patients with longer stays in the emergency departments than would be wanted.
980/23	The Trust board watched the video of Fran's experience noting the difficult situation that had arisen when there was a lack of appropriate hydration and nutrition available to her during her stay in the emergency department.
981/23	The Chair apologised to Fran and would offer a letter of apology and express appreciation for the feedback offered which had enabled the Trust to improve patient experience.
982/23	The Deputy Chief Executive/Director of Nursing echoed the sentiments of the Chair and apologised to Fran noting that food and drink were a basic human necessity which should have been available to those in the department.

983/23	Thanks were offered to Fran for taking the time to work with the patient experience team to offer her experience as it was important that the Trust understood from people who needed the Trust's services, at a time of illness and vulnerability, what their experience had been.
984/23	Through the feedback other areas had been raised as concerns which were being considered by the clinical and patient experience teams, such as the concern about the transmission of Covid-19, through the use of a communal water jug.
985/23	The Deputy Chief Executive/Director of Nursing noted that it was good that actions were taking place and that this had not only been focused at Lincoln but considered across all 3 sites ad asked how it would be known that there changes of nutritional rounding and patients receiving the right level of food and drink were continued in 3-6 months' time and onward.
986/23	The Divisional Lead Nurse noted that it would be necessary to continue to monitor what was happening noting that this would be part of the quality metrics and audit process throughout the day and night. This was also about visible leadership and ensure patients were talked to so that provisions remained in place. This would also ensure other issues could be raised and addressed.
987/23	Mrs Wells reflected on the 'ping' meals mentioned in the video and asked how long a patient would need to be waiting before being able to have one of these and also sought to understand, with the summer months approaching, when the water fountains would be in place.
988/23	The Divisional Lead Nurse noted that there had been some difficulties with the water fountains at Pilgrim due to the new build and whilst these had been delayed there was a continued push to have these in place. Whilst this was being worked through alternative provisions were being considered.
989/23	In respect of the 'ping' meals, there were available for any patient with a longer wait due to the flow in the department and noted that hot meals were offered to these patients with volunteers supporting this. It was however known that, for those patients waiting in chairs, these meals may not always be suitable if there was nowhere for this to be placed safely. If they were wanted by the patient, they were available.
990/23	Professor Baker echoed how important it was that these issues were discussed by the Board in public and thanked all of those involved for raising the issue and taking measures to address the concerns raised.
991/23	The Patient Experience and Engagement Manager noted that Fran had been a patient in April of last year and reflected that this had taken some time to progress however as a result other patients had benefited from the feedback offered with a significant amount of work taken forward.
992/23	The Divisional Lead Nurse reflected that the experience described was not one that was expected by any member of the Board or Trust and there was now an opportunity to work more closely with the patients and public to build services for what they needed not what was needed for the Trust.

993/23	The Chair offered thanks for the story and to the Divisional Lead Nurse and Patient Experience and Engagement Manager for bringing the story to the Board and enabling the Trust to make the changes.
994/23	As a Board one of the purposes was to understand what was happening in the organisation, from ward to Board, to ensure that standards were being met and where these were not to ensure action was taken.
995/23	The Trust Board: • **Received the patient and staff story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
996/23	**Item 8.1 Assurance and Risk Report Quality Governance Committee (inc MNOG appendices)**
997/23	The Chair of the Quality Governance Committee, Mrs Brown, provided the assurances received by the Committee at the 20 June 2023 meeting.
998/23	Mrs Brown informed the Board that the Committee had endorsed the proposal to step down the Clinical Harm Oversight Group, which was supported by the ICB. The Committee was assured that the appropriate mechanisms were in place to review harm and reporting was taking place through Datix. This had been a positive decision taken about the utilisation of the time of clinical teams.
999/23	The Committee had been pleased to note that there continued to be no never event actions outstanding as well as seeing continued improvement in Duty of Candour reporting. The Committee had recognised actions open as a result of other incidents however expected to receive a closure trajectory to the next meeting and noted that this was in line with the more to the patient safety incident response framework.
1000/23	Mrs Brown noted the concern of the Committee due to the continued reporting below trajectory for Venous Thromboembolism (VTE) however it was recognised that the roll out of electronic prescribing and medicines administration (eMPA) this should improve. Further assurances on what actions would be taken before this rollout were sought by the Committee.
1001/23	The Committee noted that the Trust remained an outlier for the National Early Inflammatory Audit with a request made to receive a copy of the action plan to enable further assurances to be gained.
1002/23	The Committee was pleased to note improvement in medicines management, particularly around training and the successful recruitment of 15 staff however there was significant concern at the loss of dedicated support from the improvement team. This had been an area of concern for some time and Board support was sought to ensure project support was put back in place.
1003/23	Mrs Brown noted that the Committee received the never event summit action plan with the Committee assured of the progress and many of the actions being closed.

1004/23	Focus would remain on the plan due to the concerns however there had not, since the never event summit, been a further never event within the surgical division.
1005/23	A number of attachments were offered to the Board from the Maternity and Neonatal Oversight Group including the revised terms of reference for the group and the achievement of the Clinical Negligence Scheme for Trusts (CNST). Mrs Brown was pleased to be able to advise the Board that the Trust was one of 2 in the region that had met all 10 criteria to achieve CNST.
1006/23	A detailed deep dive into the maternity provision for Black, Asian and Minority Ethnic (BAME) women had been received with Committee noting that overall women received good outcomes. The deep dive would not be extended to Eastern European women and the outcome offered to the Committee.
1007/23	The staffing report was encouraging with a positive position reported against the required staffing levels and a verbal update was received in respect of version 2 of saving babies lives. Benchmarking of version 3 was taking place.
1008/23	The Committee received the final version of the Quality Account which summarised the huge achievements in the quality agenda over the past 12 months.
1009/23	The mixed sex accommodation statement was received and should be placed on the Trust website with Mrs Brown noting that this had been recommended by the Committee for the approval of the Board.
1010/23	The Committee also received 3 annual reports, patient experience, complaints and safeguarding, these would be considered by the Board in separate items however the Committee noted the excellent work and quality of the reports.
1011/23	The Chair noted the hight levels of assurance being received by the Board through the report noting this was due to the significant attention and focus paid to all of the issues in the Committee. Thanks were offered to Mrs Brown, Executive and Non-Executives on the Committee for the work undertaken.
1012/23	The Chair sought an update on the dedicated support issue for medicines management.
1013/23	The Director of Improvement and Integration advised that a process had been completed to map out the medicines management programme noted that some actions were business as usual and others required dedicated improvement support. As this was worked through, if any further actions were required the relevant level of support would be put in place.
1014/23	The Chair noted that the Committee would continue to pay close attention to this given that medicines management was not yet offering the required levels of assurance. This would be considered outside of the meeting and an update presented back to the public meeting in due course. **Action: Medical Director, 7 November 2023**

1015/23	The Deputy Chief Executive/Director of Nursing took the opportunity to offer thanks to the Deputy Director of Safeguarding, Deputy Director of Clinical Governance and Deputy Director of Nursing for each of the annual reports being offered to the Board. Year on year there are improvements in the processes and mechanisms in place culminating in excellent annual reports.
1016/23	The Chair noted that the Quality Account represented the Trust and demonstrated achievements across the year. The Board was pleased to note the achievement of CNST recognising this was not always something that the Trust had been able to achieve.
1017/23	There was a clear impact on mothers, babies and families by the Trust with the achievement of saving babies lives and the staffing report demonstrated the fortuitous position of the Trust, compared with others. This was thanks for the leadership within the service and division.
1018/23	The Chair sought the confirmation of the Board for the approval of the mixed sex accommodation statement to be published on the Trust website.
1019/23	The Trust Board: • **Received the assurance report** • **Approved the Mixed Sex Accommodation statement for publication on the Trust website** • **Received the maternity reports**
1020/23	**Item 8.2 Safeguarding Annual Report** The Chair welcomed the Deputy Director of Safeguarding to the Board noting the quality and positive comments made in relation to the report.
1021/23	The Deputy Director of Safeguarding was always grateful for the positive comments and noted that the improvements and production of the report were a team effort.
1022/23	The Deputy Director of Safeguarding offered and overview of the report noting that the team and Trust were now more engaged and involved in the system being vocal and offering input at system level.
1023/23	Child protection and children in care numbers remained stable however it was noted that following an internal audit further work was required in respect of Child Protection Information Sharing (CP-IS). Actions were in place being led by the medicine division and supported by safeguarding.
1024/23	It was recognised that training figures had declined however this had been due to IT issues which, now resolved, would mean that training figures across the organisation would improve.
1025/23	There had been the removal of Independent Domestic Violence Advocates (IDVA) from the Trust due to changes in funding for EDAN Lincs. As a result of this change the team was now developing a business case to directly employ IDVAs.

1026/23	The Chair noted that the annual report brought a depth and breadth to the Board and how this impacted so many people in so many settings. It was good to hear that the Trust was responding to the change to IDVAs.
1027/23	The report was comprehensive and offered significant detail with thanks offered to the Deputy Director of Safeguarding and the team.
1028/23	The Trust Board: • **Received and approved the annual report**
1029/23	**Item 8.3 Complaints Annual Report** The Chair welcomed the Deputy Director of Clinical Governance to the meeting noting the privilege to have recently met the complaints team.
1030/23	The Deputy Director of Clinical Governance was pleased to be able to present the 22/23 annual report noting that whilst receiving complaints was not a good thing it was important that when they were received there was learning from them.
1031/23	During the year the team had introduced the concept of meeting first, rather than a written response, in order to meet with both the clinical team and managers to discuss concerns.
1032/23	Often when a complainant received a letter there were further questions, the meeting process allowed questions to be responded to and a recording of the meeting was shared with the complainant to listen back to. Whilst letters were still offered this was a better process.
1033/23	The Deputy Director of Clinical Governance noted the recent opening of the complaints meeting room and reflected on research which noted that it can be distressing for people to come back into an environment where they had received care. Having the room off of the hospital site in a relaxing setting had had a big impact.
1034/23	The Senior Clinical Complaints Managers were in post and reviewed all complaints to determine which would be best suited to a meeting. They also dealt with a number of queries by telephone meaning there had been an improvement in response times.
1035/23	There had been a large reduction in the number of overdue complaints with 115 at the beginning of the year. This had now reduced to 11 with an additional 835 complaints received in year. The reduction was due to the hard work of the central team and divisions to ensure answers were provide in a timely manner to patients and relatives.
1036/23	The Deputy Director of Clinical Governance was proud of the team and the work that had been undertaken during the year and noted that some areas of work had been identified for the current year.
1037/23	A room at Pilgrim Hospital, to replicate Lincoln, was being explored and a target set to reduce the average response time from 50 to 35 working days.

1038/23	The Deputy Director of Clinical Governance noted that the Complaints Team received compliments with a number of these received throughout the year. This demonstrated how the team and process had moved forward over the past 2 years.
1039/23	The Chair noted the cultural shift to being open and where people were invited to talk to the Trust about where things had not gone right and the work to endeavour to resolve this. This was captured well in the report.
1040/23	The number of re-opened complaints was noted as having significantly reduced and was an indication of how thorough the team was being about the investigation and engagement with complaints. This was a good indicator of the impact of the new arrangements.
1041/23	Mrs Buik noted the personalisation of the responses to complaints and noted that the meeting room and face to face meeting was paying dividends. Through the public question the issue of communications was raised, and Mrs Buik asked if assurance could be offered on the involvement in the EPR project and if this would deal with communications issues or is gaps would still exist.
1042/23	The Deputy Director of Clinical Governance noted there were a number of strands with communications running throughout complaints. Work was taking place from both a staff and patient perspective to improve communications with the patient experience team having a programme of work with the complaints team to support in relation to this. Meeting with complainants was a helpful part of this process.
1043/23	The Trust Board: • **Received and approved the annual report**
1044/23	**Item 8.4 Patient Experience Annual Report** The Deputy Director of Nursing offered the report to the Board noting that this demonstrated the commitment to continue to build on patient experience and drive this forward as part of a cultural shift to doing with patient from doing to patients.
1045/23	The report detailed the wide variety of work undertaken to improve the experience of patients and carers receiving services from the Trust.
1046/23	The Deputy Director of Nursing was delighted to note the Patient Experience Network National Awards (PENNA) for which the Trust submitted 3 entries which made it to the final and achieved a first and second place award for the patient experience dashboard and patient panel.
1047/23	This had resulted in national interest in the Trust with other Trust's making contact in order to understand how these had been established.
1048/23	It was noted that communications remained one of the top 3 issues for patients in feedback and experiences that had been shared. Work was ongoing regarding communications, redesign and a training programme on communications.

1049/23	There had been a successful ‘what matters to you’ conference day which had allowed the team to start to roll out the ‘what matters to you’ approach in terms of communications.
1050/23	The Deputy Director of Nursing noted the roll out of the ‘you care we care to call’ campaign which offered focus and reminded staff that people were trying to get in touch to receive an update on patients. This was going to be an important campaign to embed as business as usual and was now included as a metric in the Integrated Improvement Plan.
1051/23	There would be a focus on ‘always events’ which would see work rolled out and embedded in the current year and a case was being developed for a new training programme for ‘hearing it my way’ to further develop and embed across the organisation.
1052/23	A patient story library had been built and was used throughout a number of forums and meetings across the organisation.
1053/23	The Deputy Director of Nursing noted the new visiting and carers policies which had been developed with staff and patient panel involvement and noted the continued involvement of the team in the national patient experience work around the national carer policy, for which the Trust was one of 13 pilot sites.
1054/23	During the coming year a children and young people’s patient panel would be established, and the mini-Patient Experience Group model would be embedded at divisional level.
1055/23	The Chair noted the work that had been undertaken and the work planned for the coming year noting in particular the establishment of the children and young people’s patient panel.
1056/23	The Trust Board: • **Received and approved the annual report**
1057/23	**Item 8.5 CQC Actions Quarterly Report** The Director of Nursing presented the report to the Board noting that this offered an update on the progress made in respect of actions identified following the Care Quality Commission (CQC) inspection from 2021.
1058/23	This included both the must and should do actions with a number of actions noted blue meaning these were both complete and embedded. This position had risen to over 21% with a number of actions rated green and evidence awaited of the embedding of these. Green actions were at 48% with a shift being seen in the right direction.
1059/23	The report outlined some achievements made including the work to support mitigations of risks around medicines being stored in hotter than ideal ambient room temperatures. Whilst this had been raised in respect of maternity this was being considered across the organisation with a draft standard operating procedure being

	approved by the obstetrics and gynaecology department to support staff in the areas identified. There had also been a move of the maternity ward, to a refurbished ward which, whilst improved, did not fully resolve the ambient room temperature issues.
1060/23	The Director of Nursing noted the continued challenges relating to sustaining improvements in appraisal rates and mandatory and statutory training. This had full oversight by the People and Organisational Development Committee.
1061/23	As reported by the Deputy Director of Safeguarding, the Child Protection Information Sharing (CP-IS) actions were largely complete with evidence of process and oversight having improved there was a need for audit to demonstrate the embedding and improvement of this.
1062/23	The Quality Governance Committee had focused on this in January, February and May with the divisional team attending the Committee and there being improved frequency of monitoring in the division to obtain the levels of assurance required.
1063/23	The Director of Nursing noted that the monthly executive led assurance meetings continued to be held to support and challenge the divisions to maintain improvements. The Committees continued to have oversight of the relevant actions through monthly updates offering progress on the actions.
1064/23	Improvements were being seen in all areas and updates offered to the CQC through the relationship meetings. The CQC had been pleased with the actions plan and continued to ask specific questions with the Trust providing evidence and ensuring the embedding of this along with holding audit information.
1065/23	The Chair noted the content of the report and the clarity offered on the areas requiring focus with the break down supporting sight of those areas.
1066/23	The achievements were noted along with the actions and future assurances required.
1067/23	The Trust Board: • **Received the report noting the moderate assurance**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1068/23	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker, provided the assurances received by the Committee at the 13 June 2023 meeting.
1069/23	The Committee considered the performance dashboard and was encouraged by the continued reduction in the vacancy rate however it was noted, as flagged by both the Committee and the Workforce, Strategy and Organisational Development Group, that issues continued around appraisal and training rates.

1070/23	The Committee received a referral from the Finance, Performance and Estates Committee regarding fire safety training with concerns relating also to the CQC action plan. This was an area of concern with the Committee having been patient whilst the directorate was satisfactorily staffed, and capability improved.
1071/23	It was noted now that the Committee could be more robust, and was doing so, as this was an area of significant scrutiny to ensure that appraisals and training rates started to move toward more acceptable levels.
1072/23	The fire safety training concern was echoed by the Committee, and it was noted that there were some additional issues around the availability of the provision of the training, but the Committee was also considering the ability to have adequate training and appraisal in place.
1073/23	Professor Baker noted the moderate assurance received in respect of the safer staffing report and the continue positive position. Work was being undertaken to ensure that the Committee received more up to date information to be discussed noting there was a timing issue with data availability.
1074/23	The Committee received and considered the annual report of the Guardian of Safe Working.
1075/23	Professor Baker noted that the Committee had commended the Equality, Diversity and Inclusion (EDI) annual report to the Board. This had highlighted the strength of work ongoing across the organisation as offered to members of the Board at the recent development session. This had also highlighted the good rating received by the Trust from NHS Employers on the EDI action plan.
1076/23	The Committee received an update from the Culture and Leadership Group with a positive Leading Together Forum having been delivered. There was also improved engagement with the System in respect of culture and leadership with the Trust in a more advanced position with some of these issues and able to take a leading role in the system.
1077/23	Professor Baker noted the medical school update that had been received with the continued successful delivery and the first cohort nearing the final year. There had been concerns around academic staffing, which was recognised as a national issue, but this presented challenge the move of the medical school to be led by the University of Lincoln, independent of the University of Nottingham,
1078/23	The Committee had considered research and innovation (R&I) and noted the concerns of the Clinical Research Network (CRN) around trial activity. There was a plan in place to address this with 7 clinical trials due to commence with the potential to recruit 1400 patients. This would move the Trusts annual number to circa 2000 which offered an indication of the current level of activity. The Committee would follow the trajectory and ensure the plan in place was supported and delivered.
1079/23	It was noted that a R&I forum was due to take place in July and it was hoped that there would be an increased emphasis on research across the Trust which would encompass all clinical colleagues, not just medical staff.

1080/23	Professor Baker advised the Board of the limited progress reporting through the University Teaching Hospital Group upward report around the financing of the model of the clinical academics. The efforts of colleagues to obtain a resolution to this were endorsed by the Committee.
1081/23	The Committee had considered the Savile action plan noting that not all actions had progressed with a need for progression at pace. The Committee would continue to seek further information on the progress against the plan at the next meeting.
1082/23	The Chair noted the comprehensive report covering all aspects of Committee business and was pleased that the Savile action plan had been noted by Professor Baker, particularly around the Disclosure and Barring Service (DBS) checks.
1083/23	It was encouraging that there was progress in many areas although the progress of the teaching hospital status was taking longer than was ideally wanted from a Trust perspective. R&I was clearly moving forward and there was also a clear focus on training compliance and appraisals going forward.
1084/23	The Chair noted the EDI annual report which was received to the Board with the approval of the Committee subject to some changes. This was presented to the Board and was comprehensive however it was noted that there should be consideration of the alignment to the Integrated Improvement Plan (IIP), on page 39 of the report.
1085/23	The Deputy Director of People and Organisational Development reflected on the areas of improvement needed and the issues raised by Professor Baker. Work was ongoing to provide assurance and it was noted that there was now a full education and learning team in place. The groundwork in respect of the issues was in place and it was hoped that this would now flow into the data to be reported to the Committee.
1086/23	Mrs Brown, through the MS Teams chat noted the need to ensure maternity and neonatal research was an area of growth as outstanding maternity units had strong research profiles.
1087/23	The Chair recognised this would be an area that would be overseen by the Committee.
1088/23	Subject to the consideration of the alignment to the IIP within the EDI annual report and required amendments made this was approved by the Board.
1089/23	The Trust Board: • **Received the assurance report** • **Approved EDI annal report subject to amendments noted**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1090/23	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee**

1091/23	The Chair of the Finance, Performance and Estates Committee, Ms Cecchini, provided the assurances received by the Committee at the 27 June 2023 meeting.
1092/23	Ms Cecchini confirmed that the Committee had not received any reports, as per the reporting schedule, on estates with an agreement to defer the green plan to the August meeting.
1093/23	As advised through the Chief Executive report the Committee had considered the financial position noting that the Trust was in a good position at month 2 and advised that the positive position on the delivery of the savings programme was mitigating some risks around non-pay inflation and the loss of income as noted through the junior doctor strikes.
1094/23	The Committee had noted some slippage on capital, largely in relation to the Community Diagnostics Centre and Pilgrim Emergency Department build however plans were in place for this to be brought back on track.
1095/23	Ms Cecchini noted that the Patient Level Information Costings (PLICS) report had been received which highlighted the potential for some significant efficiencies. It was recognised however that some of the efficiencies could only be delivered through significant transformational work.
1096/23	The Committee received the Digital Hospital Group upward report noting the progress underway to deliver the EPR business case. Some change to the outline business case had been noted and the Committee wanted to ensure this had been through the appropriate sign off process. Some early work had been done around the EPR and the transformation around delivering patient care that the EPR would support.
1097/23	Ms Cecchini advised the Board of the Data Security Protection Toolkit submission which had offered limited assurance. The Committee had previously been advised of the position and it was noted that 5 assertions were non-compliant. The Committee would continue to oversee delivery of the action plan to rectify this through the bimonthly reporting of the Information Governance Group.
1098/23	Delivery against operational performance continued to be challenging due to industrial action with Ms Cecchini offering thanks to the Chief Operating Officer and team for continuing to manage the pressures of this and minimising the number of cancellations as a result of the action.
1099/23	Improvements were being seen in performance however there were also challenges with the Trust not achieving the 78-week trajectory in March and April in respect of planned care. The Trust was now targeting to have no more than 125 patients over 78-weeks by the end of June with the team also trying to deliver against the 65-week trajectory by the end of the year.
1100/23	A deterioration in cancer performance was noted, specifically faster diagnosis for breast services with recovery actions in place and significant oversight of the service.

1101/23	Ms Cecchini noted that, more positively the action plans for echocardiograms was coming to fruition and good improvement was being seen.
1102/23	The Committee had received all of the report group terms of reference to support the governance improvement plan for the Committee over the financial year with the Estates Group being considered in detail at the August Committee.
1103/23	The regular topical update had been received with the Committee noting the Board checklist in respect of elective care priorities which was another level of scrutiny the regulator would like to apply to this area.
1104/23	Ms Cecchini noted the Integrated Improvement Plan and the number of programmes within this that had moved from amber to red. Focus was required for the team in this area to progress with the required transformational changes.
1105/23	Productive theatres was slightly behind plan although work was underway to determine if this would be recovered and was a financial issue rather than operational.
1106/23	The Committee had considered the deep dive into nurse agency spend with a turnaround and reduction in the spend proving helpful, good progress was being made.
1107/23	The CQC action plan was received with a comprehensive report associated with the estates elements of the plan. This described the assurances and how these had been received enabling the Committee to agree the closure of the specific outstanding actions, on the basis these would be monitored through estates assurances as business as usual.
1108/23	The Chair noted the comprehensive report across the breadth of the Committee noting that the finances were encouraging however there was some way to go to the end of the year.
1109/23	Operational performance was noted with the significant amount of scrutiny on the Trust from both a national and regional perspective. The position was noted, and it was reflected that this was being discussed and accepted through regulatory meetings.
1110/23	The Chair noted the sense of grip and control acknowledging that plans and trajectories were in place and if these were off plan it was known why with plans in place to rectify. This was offering assurance to the Board in terms of the actions being taken. The Trust Board: • **Received the assurance report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1111/23	No items

1112/23	**Item 12 Integrated Performance Report** The Chair noted the report presented to the Board and offered the Executive Directors the opportunity to draw out any areas not considered and the Non-Executives the opportunity to raise any questions.
1113/23	There were no other points to be raised or questions to be responded to with the Board taking the report as read, noting the position which continued to be challenged in regard to the emergency departments.
1114/23	The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
1115/23	**Item 13.1 Risk Management Report**
1116/23	The Director of Nursing presented the monthly risk report to the Board noting that there had been one very high risk, rated 20, added since the previous meeting.
1117/23	This had been discussed at the Risk Register Confirm and Challenge meeting and the risk was as a result of a nationwide shortage of suction catheters in paediatrics. Mitigations were in place as described in the report and work was taking place nationally to consider this. It was anticipated that a sense of the timescale of resolution to the shortages and the size of the issue should be known in the coming weeks.
1118/23	There had been agreement of the reduction of a very high risk to a moderate rating of 12 for the outpatient process in haematology meaning there were now 17 high to very high quality and safety risks.
1119/23	8 very high risks had been reported to the People and Organisational Development Committee and 6 very high risks reported to the Finance, Performance and Estates Committee. Detail of all strategic risks were offered in the appendix.
1120/23	The Chair noted that the Committees had reviewed the risks associated with areas of responsibility noting the live nature of the risk register. The risks associated with Pharmacy may need to be considered in further detail given that improvements in the service were not being seen as expected.
1121/23	The Trust Board: • **Accepted the risks as presented noting the significant assurance**
1122/23	**Item 13.2 Board Assurance Framework** The Chair was delighted to see the Board Assurance Framework (BAF) shaping up to be a more populated version noting there were some final updates to be made.
1123/23	The Trust Secretary advised that this has been received by each Committee during the month of June with no changes from the Committees to recommend ot the Board for approval.

1124/23	All assurance ratings remained the same as the previous month with work continuing with the executive leaders for the objective areas to strengthen the alignment of the BAF noting the changes reflected the Integrated Improvement Plan for 2023/24.
1125/23	The Trust Board: • **Received the report noting the moderate assurance**
1126/23	**Item 13.3 Audit Committee Upward Report** The Chair of the Audit and Risk Committee, Mr Herbert, presented the report to the Board form the meeting held on 20 June 2023 noting that this was the annual audit focus meeting.
1127/23	The Committee received the final internal audit reports from 2022/23 and was pleased to note the assurance, with some improvement required, in respect of the clinical governance follow up audit and core financial controls host ledger audit.
1128/23	Partial assurance had been received in respect of the payroll audit, with payroll being hosted by Lincolnshire Partnership NHS Foundation Trust (LPFT). A request had been made to the new Internal Auditors to undertake a comprehensive review of this area during the year.
1129/23	Mr Herbert noted that the annual Head of Internal Audit Opinion had been received from the outgoing auditors noting this offered partial assurance. It had however also highlighted the progress and improvement the Trust had made during the year in risk management, governance and the implementation of actions. Of the audits during the year 4 had given significant assurance with some improvement and 8 partial assurance.
1130/23	The Board noted that management continued to direct internal audits to areas of concern or where there would be benefit from the input.
1131/23	The Committee received the external completion report, form external audit, and the annual report which had no significant issues highlighted from the auditors. It was intended that the external auditors would give an unqualified audit opinion.
1132/23	The finance team were commended by the auditors and the Committee for the work and engagement undertaken during the audit process and for the improvements that had been made.
1133/23	Mr Herbert advised that the Committee had considered the Annual Account and Annual Report following the study of the drafts during an informal walk through.
1134/23	The Committee reviewed the final version and recommended approval to the Board. The Committee wished to pass thanks to the finance team for the work throughout the year but also for leading a well-managed audit process.
1135/23	The draft Internal Audit plan for 2023/24 was noted following the relatively recent appointment of the new internal auditors. It was recognised that there was a need for

	appropriate stakeholder input and as the plan was a living document this could change to meet circumstances in terms of risk and the need of the organisation.
1136/23	A request had been made for the inclusion of a review of procurement as this was an area the Board had recently had discussions and would like to seek additional assurance.
1137/23	The Committee had approved the reviews planned for the early part of the year and would review an updated version of the plan at the meeting in July.
1138/23	The Chair noted the positive report and move froward in relation to the audits. The recommendation to the Board of the final approval of the accounts and annual report was noted with thanks offered for the due diligence undertaken by the Committee.
1139/23	The engagement of the Committee influencing the audit plan demonstrated an effective Audit Committee which was alert to the business of the Trust with thanks offered for the leadership of this.
1140/23	The Trust Board: • **Received the report noting the significant assurance**
1141/23	**Item 14 Any Other Notified Items of Urgent Business** No items
1142/23	The next scheduled meeting will be held on Tuesday 5 September 2023 via MS Teams live stream

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

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
6 June 2023	925/23	Code of Governance – Update	Review of the Code of Governance and gap analysis to be reported to the Audit Committee through the quarterly compliance report	Trust Secretary	10/07/2023	Complete

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5 September 2023*
Item Number	*Item number 6*

Group Chief Executive's Report

Accountable Director	*Andrew Morgan, Group Chief Executive*
Presented by	*Andrew Morgan, Group Chief Executive*
Author(s)	*Andrew Morgan, Group 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*

OUTSTANDING CARE personally DELIVERED

Executive Summary

System Overview

a) All parts of the system continue to be under significant operational pressure. This has been compounded by the continued industrial action by the BMA relating to both junior doctors and consultants. Strikes took place during July and August and further action is planned by consultants in both September and October. The outcome of the junior doctor ballot, which closes at the end of August, will determine the extent of further junior doctor strike action.

b) Colleagues across the system have been shocked and upset by the appalling crimes of Lucy Letby. They are beyond belief for staff who are committed to saving lives and caring for those who put their trust in us. The national Inquiry will identify the lessons to be learned. In the meantime the local NHS will continue to ensure that we listen to patients, families and our people. It is also vital that colleagues feel able to speak up, if at any time, they feel something isn't right within the workplace and that they feel confident that it will be followed up with a prompt and thorough response. A message was sent out across all local NHS organisations to this effect shortly after the verdict in the Lucy Letby case.

c) At Month 4, the system financial recovery plan had delivered year to date savings of £15.1m against a plan of £12.2m, resulting in a positive variance of £2.9m. Work is continuing with a view to the system being able to exit the National Recovery Support Programme (RSP) based on the financial position at the end of Month 6. To be successful in an application to NHS England, the system will need to provide evidence relating to certainty around the delivery of the full-year financial recovery plan of £55m; the pipeline for future transformational schemes; and delivery of the in-year agency spend target. The application for exit from the RSP is being worked on and an update will be provided at the Board meeting.

d) Recruitment is underway for a new Chair for the Lincolnshire Integrated Care Board (ICB)

e) The work in relation to the four key workstreams of the Provider Services Review is continuing. A SRO for the workstream relating to the provision of more integrated care at PCN/locality level is being identified. The Group model between LCHS and ULHT is progressing, with a workshop being held on 4th September involving the two Boards at which discussions will be held about the degree of governance and decision-making integration between the two Trusts. The workstream relating to shared corporate services is at the scoping stage and is ensuring that there is alignment between the Provider Review and the Recovery Support Programme. The cultural change workstream will commence once further progress is made on the other workstreams.

f) Patients in Lincolnshire are to benefit from improved access to NHS diagnostic tests. This follows confirmation of £38m of additional funding for the development of two new Community Diagnostic Centres in Skegness and Lincoln. These will be run by ULHT. Services will commence in December 2023 with both sites planned to be fully operational by September 2024.

g) A new Fit and Proper Persons Test Framework has been issued by NHS England. The framework is designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a Board member. All Boards will now be working through how to implement the new framework.

h) NHS England has issued information about the Flu and COVID vaccination delivery programme for autumn and winter 2023/24. For adults the programme is due to start in

October and for children it is September. Action is now underway across the system to ensure the programme is delivered.

Trust Overview

a) At Month 4, the Trust reported a year to date deficit of £10.2m which is in line with the year to date plan. The full year plan is a deficit of no more than £20.8m. At Month 4, the Trust reported year to date financial savings of £8.8m compared to a year to date plan of £5.4m. This is £3.4m favourable to plan. The full year plan is for financial savings of at least £28.1m.
b) As of 1st August 2023 I became Group CEO of Lincolnshire Community Health Services NHS Trust and United Lincolnshire Hospitals NHS Trust. This is a temporary arrangement pending the recruitment of a substantive Group CEO. I still plan to give up full-time work at the end of March 2024.
c) As of 1st August 2023 I also became the NHS Trust partner member on the Board of the Lincolnshire ICB.
d) Claire Low, ULHT Director of People and OD is now the System SRO for People.
e) The Trust is part of the East Midlands Acute Provider collaborative (EMAP). This involves eight acute Trusts in the East Midlands. As part of the joint working arrangements for EMAP, the Trust has agreed to host the EMAP Managing Director role. This new role is currently out to advert.
f) The Trust's Annual Public Meeting (APM) takes place on Monday 18th September at 2.00pm. The meeting will be via Teams, with the opportunity for the public to submit questions in advance and to raise them on the day.
g) Nominations for the Trust's Staff Awards for 2023 close on 1st September. There are eleven award categories. The Awards ceremony will take place on the evening of 16th November.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 September 2023*
Item Number	*Item 6.1*

Childrens and Young Persons (CYP): CQC Inspection 31 May 23

Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Jeremy Daws, Head of Compliance*
Report previously considered at	*Quality Governance Committee (QGC)*

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	
3b Efficient use of our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c Becoming a university hospitals teaching trust	

Risk Assessment	Not Applicable
Financial Impact Assessment	Not Applicable
Quality Impact Assessment	Not Applicable
Equality Impact Assessment	Not Applicable
Assurance Level Assessment	Moderate

Recommendations/ Decision Required	• *note the final CQC inspection report following the 31 May unannounced visit within appendix 1;* • *note and approve the CYP team's action plan in response to the inspection visit, detailed within appendix 2.*
Executive Summary	

- The Care Quality Commission (CQC) carried out an unannounced inspection visit to Rainforest and Safari (CYP ward areas) on the 31 May 2023 in response to two Serious Incident (SI) / Divisional Incidents (DI) related to a common theme of medicines management.
- The CQC visit, which included a Pharmacy Professional Advisor as part of the visiting team, reviewed the evidence available that the actions from the SI/DI had been taken alongside speaking with members of staff from the areas.
- The Trust received a draft inspection report and submitted minimal factual accuracy challenges back in response.
- The report demonstrates that good evidence was located as part of the visit and submitted as part of the post visit information request. The visit did not result in any ratings changes.
- The CQC published the report onto it's website on Thursday 3 August 2023. A copy of the final draft report is attached for the attention of the Committee in **Appendix 1**.
- Proactive communication messages were prepared proactively to support the release by CQC of the report. Some media attention was attracted by the publication, resulting in the communications prepared being used.
- Whilst the CQC inspection report did not include any 'Should-do' or 'Must-do' actions, the Family Health Division have reviewed the report and taken into consideration the formal feedback provided to them by members of the CQC visiting team and in response have agreed 4 actions. A summary of these actions is outlined as follows:
    - Action 001: The Division have raised awareness of where to locate clinical guidelines on the Trust's intranet and how to use the search function. This has been incorporated for existing staff within CYP Governance meetings and for new medical staff, during their induction within August 2023.
    - In addition, to ensure consistency of printed information, a SOP/process to ensure printed materials are maintained in line with electronically published policy/SOPs.
    - Action 002: Feedback from the visiting team resulted in the Family Health division undertaking some additional scoping with staff members to determine if there were any concerns around relationships between disciplines that required targeted improvement work. The scoping work did not identify any concerns. Mechanisms are in place (i.e. incident analysis, matron's audits, listening events with staff etc.) within the division to identify from staff/teams/disciplines any concerns relating to relationships as part of the division's business as usual oversight processes.
    - Action 003: A bespoke piece of equipment to better enable a young child to shower within Rainforest Ward is in the process of being procured. This has taken longer than anticipated due to locating equipment from external providers that is suitable, in terms of IPC considerations, for use in a hospital environment.
    - Action 004: For completeness, whilst CQC examined the evidence available to them of the actions from the DI/SI having been taken at Lincoln, the division are reviewing the action plans from both incidents to ensure actions have been embedded at both hospital sites CYP services.
- **Appendix 2** provides the full action plan for the committee's attention.
- Once approved, these 4 actions will be included within the wider CQC reporting structure, under the CYP Core Service action plan. QGC will be the overseeing committee for these actions.

United Lincolnshire Hospitals NHS Trust

Lincoln County Hospital

Inspection report

Greetwell Road
Lincoln
LN2 5QY
Tel: 01522573982
www.ulh.nhs.uk

Date of inspection visit: 31 May 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**

Our findings

Overall summary of services at Lincoln County Hospital

Inspected but not rated

United Lincolnshire Hospitals NHS Trust (ULHT), situated in the county of Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 736,700 people. The trust provides acute and specialist services to people in Lincolnshire and neighbouring counties. The trust has an annual income of £447 million and employs 8,000 people.

In the last year, the trust had around 642,000 outpatient attendances, around 145,000 inpatient episodes and around 147,000 attendances at their emergency departments.

The trust provides acute hospital care for the people of Lincolnshire from their sites in Lincoln, Boston and Grantham and delivers services from community hospitals and centres in Louth, Gainsborough, Spalding, and Skegness.

We carried out a short notice unannounced focused inspection of the Children and Young People core service on 31 May 2023. We received information of concern about the safety and quality of the service.

During the inspection we focused on our safe questions relating to medicines and inspected Safari and Rainforest wards based at Lincoln County Hospital.

During the inspection we spoke with 1 relative and 12 staff including the ward manager, consultant, junior doctor, nurse in charge, band 4 and band 5 nurses. We also spoke with the Medicine Safety Officer and Associate Chief for Clinical Pharmacy.

We did not rate this service at this inspection. The previous rating of good remains:

We found:

The service had systems and processes to prescribe and administer medicines safely.

Staff learned from medicine incidents to improve practice. Action was taken and lessons were learnt.

The service had enough staff to care for children and young people and keep them safe.

However:

The service did not have specialist equipment to support children and young people to meet their individual needs.

Services for children and young people

Inspected but not rated

United Lincolnshire Hospitals NHS Trust (ULHT), situated in the county of Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 736,700 people. The trust provides acute and specialist services to people in Lincolnshire and neighbouring counties. The trust has an annual income of £447 million and employs 8,000 people.

In the last year, the trust had around 642,000 outpatient attendances, around 145,000 inpatient episodes and around 147,000 attendances at their emergency departments.

The trust provides acute hospital care for the people of Lincolnshire from their sites in Lincoln, Boston and Grantham and delivers services from community hospitals and centres in Louth, Gainsborough, Spalding, and Skegness.

We carried out a short notice unannounced focused inspection of the Children and Young People core service on 31 May 2023. We received information of concern about the safety and quality of the service.

During the inspection we focused on our safe questions relating to medicines and inspected Safari and Rainforest wards based at Lincoln County Hospital.

During the inspection we spoke with 1 relative and 12 staff including the ward manager, consultant, junior doctor, nurse in charge, band 4 and band 5 nurses. We also spoke with the Medicine Safety Officer and Associate Chief for Clinical Pharmacy.

We did not rate this service at this inspection. The previous rating of good remains:

We found:

- The service had systems and processes to prescribe and administer medicines safely.
- Staff learned from medicine incidents to improve practice. Action was taken and lessons were learnt.
- The service had enough staff to care for children and young people and keep them safe.

However:

- The service did not have bespoke equipment needed to meet the individualised needs of a child.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training.

Services for children and young people

After 2 incidents relating to children being administered too much medication had identified the need for further training, the trust had ensured all staff had received resuscitation training, in line with the action plan.

The department completed simulation training every week for staff to attend, this covered many different training sessions, and opened discussion for staff to ask questions and for the department to identify any lessons that can be learned.

Staff told us they had completed medication training and had their competency assessed, to ensure they were able to safely administer medications.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them.

The service did have enough suitable equipment to help meet individual needs of children and young people.

During the inspection we were informed that the service had access to a mobile hoist to support children and young people for non-weight bearing patients, the service also had handrails in the en-suite bathrooms situated in the rooms.

However, in one instance the service did not have bespoke equipment needed to meet the individualised needs of a child. For example, there was no space to keep their wheelchair on the ward and they had no access to a specialised shower chair. We shared these concerns with the leadership team who planned for the wheelchair to be stored safely on the ward. They also took action to identify suitable specialist equipment required for showering and are in the process of purchasing this equipment.

Nurse staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.

The service had enough nursing and support staff to keep children and young people safe.

The ward manager could adjust staffing levels daily according to the needs of children and young people.

The number of nurses and healthcare assistants matched the planned numbers.

The service had staff vacancies for the 2 wards this was 11.98% of staffing.

Nursing sickness rates for the month of April 2023, the service had 8 staff absences due to sickness this equated to 3.27% for Rainforest and 7.12% for Safari.

The service had reducing rates of bank and agency nurses.

The service used bank and agency staff to ensure there were enough staff to cover the shifts.

Services for children and young people

The service ensured that where possible they would use agency staff that were familiar with the wards, to ensure consistency for the children and young people.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep children and young people safe.

The medical staff matched the planned number.

The service had a 5.83% medical vacancy rate across the 2 wards.

There was 1 occurrence of medical staff absence in April 2023. This was the equivalent of 0.2% of the contracted medical staff full time equivalent, demonstrating the absence rate was low for the month.

The service used locum staff to cover vacancies within the service for the months of April and May 2023. During this time there had been 1 shift in May 2023 that was unfilled, however, this had been identified as unfilled sickness and was covered through a consultant on-call.

The service ensured that where possible that they used locums who were familiar to the service to ensure consistency for the child and young people.

The service always had a consultant on call during evenings and weekends.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

Information and policies for the administration of intravenous (IV) medicines were reviewed and kept up to date. These were accessible to staff in folders kept in medicine storage rooms and were also available electronically on the trust intranet. Although we were told that the electronic availability to these policies was not as easy as paper versions and was more time consuming for staff to quickly access.

Administration of IV medicines was undertaken by either a nurse and a doctor (not the prescriber) or 2 nursing staff who had undergone extra training and had been assessed as competent. This included an annual medicine management competency check. Staff we spoke with highlighted that there was a lot of training available which included simulation exercises in different scenarios, such as asthma, anaphylaxis, cardiac arrest, and seizures. A doctor commented that nurses double checked dose prescribing and calculations with a doctor if it was unusual.

Following a serious incident involving a high-risk medicine action was taken in the following areas:

Services for children and young people

- The trust guidance available on the prescribing and administration of the medicine was discussed at the Children and Young People Clinical Governance meeting. This involved reviewing all the available evidence on the most effective and safe form of administering the medicine. The British Thoracic Society guidelines were also reviewed for treating acute asthma. Following this further guidance, training and information was made available to staff. Staff said the updated information including calculations was helpful to ensure the correct dose was calculated.
- To take action to ensure staff have easy access to a paediatric emergency information card for the administration of adrenaline and infusion calculations. These were available on all the resuscitation trolleys.
- A flow chart for treating and assessing the severity of asthma was available in clinical treatment rooms including information on prescribing.
- A flow chart for treating anaphylaxis was available in clinical treatment rooms.

Staff completed medicines records accurately and kept them up to date.

Allergy statuses were routinely recorded on all medicine records seen. This meant that allergies were highlighted, and medicines could be prescribed safely.

Weights of patients were recorded on medicine administration records which was important for calculating weight-based medicines prescribing.

Staff stored and managed all medicines and prescribing documents safely.

High risk injectable medicines, which included adrenaline and magnesium sulphate, were stored on a separate shelf that was clearly marked as 'High Risk Medicines.'

Resuscitation trolleys were immediately available in the event of an emergency. These were sealed with tamper evident tags. This followed the guidance from the UK Resuscitation Council. Evidence of daily checks were recorded to ensure the medicines were available and safe to use.

Staff learned from safety alerts and incidents to improve practice.

The trust had systems in place for recording incidents and staff we spoke to were able to identify its use and how to access the system.

Staff told us they felt supported when there was a medicine incident with good de-briefing, as well as knowing where to go for advice if needed.

The trust has a Medicines Safety Officer (MSO) which was in line with NHS England directives. The MSO attended regional and national MSO networks to share and contribute to learning from safety incidents. They had shared the recent medicine safety incidents with the regional MSO network to ensure lessons learnt could be shared across other trusts. The MSO was involved and contributed to discussions concerning the recent investigations of medicines safety within the trust, however, they were not acknowledged on any of the investigation reports.

Services for children and young people

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave children, young people, and their families a full explanation when things went wrong.

The service held monthly governance meetings and duty of candour had been regularly discussed and monitored during these meetings.

Staff received feedback of incidents and when the senior leaders discussed patient journeys, they discussed the outcome and congratulated staff when the patient had received a good standard of care.

Managers investigated incidents thoroughly. Children, young people, and their families were involved in these investigations.

Managers investigated incidents and once completed findings were then shared with an independent panel within the senior leader's team, who held a discussion and agreed actions. An action plan would be implemented, and the department would work to address the actions in a timely manner and within agreed timescales. For example, for the 2 serious incidents we reviewed, the service had completed an action plan with set dates for completion. We found all actions had all been completed and staff were aware of any identified learning.

The senior leaders discussed risks monthly. These meetings identified the risks and any agreed actions implemented to mitigate future risk.

Staff told us that after a serious incident had occurred that they received support from local managers within the department.

Our inspection team

The team that inspected the service comprised of a CQC (Care Quality Commission) lead inspector, a CQC operations manager and CQC pharmacist inspector. The inspection team was overseen by a Deputy Director of Operations.

NHS
United Lincolnshire Hospitals
NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dundertale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 04/08/2023

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

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Context - Taken from the report (why was this identified as an issue)	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Status summary and update	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes:
CQC2023-001	Children and young people	Lincoln County Hospital	2023 Focussed Inspection of CYP at LCH	2023 'Interim Action'	A doctor told us that they struggled to locate guidelines relating to how to calculate the amount of medication that should be administered.	One of the doctors spoken to outlined how they struggled to find guidance on how to calculate medication. Given the feedback from SI was around calculation of medications, this was considered to be of concern and a gap. ULHT representatives felt this was likely as a result of a change in the location/process for hosting guidance documents on the intranet/hub.	CYP	Raise awareness with teams as to how to use the new Guideline repository on the new intranet: * Raise awareness at CYP Governance meeting; * Include quick reference guide to this as part of the Induction programme.	Dr Chingale (Clinical Lead)	31-Aug-23	05-Jul-23: Guidelines searching functionality discussed at CYP Governance meeting in June 2023 (need minutes as evidence). Discuss with Dr Chingale the inclusion of this as part of the induction programme in August with new medical staff. Raise with Dr Chingale to discuss with 2x College Tutors. In addition corporate action has been taken in respect of this already with the inclusion of additional help text/guidance on the guideline hub site, drawing attention to the search function. Cathy to review and determine if hardcopy guidelines are also available on the ward. 07-June-23: 7FAC: The guideline that was reported as not possible to find does not exist and Mr D confirmed nor should it. Suggested push back to CQC	Amber		(1) Evidence from CYP Governance of raising awareness about the search functionality on the Guidelines part of the intranet site. (2) Evidence of inclusion within the induction programme for new doctors. (3) Evidence of corporate action taken to make it easier for staff to make use of the search functionality of the intranet site.	N/A.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
							CYP	Agree and record process within a SOP document for gatekeeping printed medicines related policies stored in medicines rooms, to ensure these remain up to date and consistent with those available on the intranet.	David Speck (Education Team)	31-Aug-23	19-Jul-23: Whilst CQC noted positively that medicines management policies were available in medicines rooms for ease of access, the controls in place to ensure these printed documents remain timely and consistent with those available on the intranet could be strengthened.	Amber		(1) SOP document outlining process for ensuring printed policy information remains consistent and up to date.	N/A.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2023-002	Children and young people	Lincoln County Hospital	2023 Focussed Inspection of CYP at LCH	2023 'Interim Action'	Staff told us that there were concerns in relation to medical staff not listening to nursing staffs in relation to patient's care – example of this had been the incident last week where a doctor/consultant did not respond to a deteriorating child.	Staff spoken to mentioned concerns around medical staff and relationships, sometimes not listening to nursing staff. This supported one of the observations from the SI reports. This was underlined further by the incident on the 20 May, reported to CQC during conversations with staff, where a consultant refused to come on site when on call, when asked to do so 3 times. This raised concerns with CQC. ULHT colleagues on the call provided assurance that the individual concerned in the incident on the 20/05 has been spoken to and made clear the actions required. From self-reflection, the consultant concerned acknowledges they should have responded proactively and come onto site in response to being called. CQC questioned if this was a broader cultural theme around medical staff not listening to nursing colleagues. Simon fed back that this was not feedback he receives when he visits ward areas on a weekly basis. Family Health are currently undertaking some cultural work with HR/OD support. Simon will ask for this to be included within the scope of this piece of work to ascertain more information and to understand if this is a theme.	CYP	Scope out from staff within the service any concerns in relation to medical staff not listening to nursing staff.	Simon Hallion (Divisional Managing Director)	31-Jul-23	05-Jul-23: Jenny Devlin (People and OD) has undertaken some post staff survey focus groups. Using these already established events, Simon asked that this theme of medical staff not listening to nursing staff be included to understand if this was a recurring theme. Following these sessions, no feedback from staff was identified that related to this theme. Simon has also had seperate discussions with both CYP ward managers and not identified any specfic feedback. Evidence needed: Findings from Jenny Devlin; FH Cabinet slideset summarising feedback from staff. No real action to pick up themes like this in the future. Cathy to draw up trigger list to support improved consistency of incident themes requiring reporting via DATIX. As part of this and the investigation work to understand root causes, themes to do with relationships would be sought and any identification of issues between disciplines would be addressed. 15-June-23: Incident reviewed at SI panel. Not declared as an SI. 07-June-23: Incident CQC were aware of has been confirmed as a Divisional Investigation at SI panel that met today. Looking to manage via ROAG process. Amol email as evidence - of comms - come on site when called.	Green	05-Jul-23	(1) Outcomes following POD-C scoping of staff feedback following the staff survey. (2) Dr Chingale email to all staff about responsibilities when on-call.	N/A.	The NHS Staff Survey findings have been shared with the Family Health teams and following this, post survey focus groups with staff to understand greater specifics have been held, facilitated by the People and OD team. Feedback from these sessions did not highlight any concerns from nursing staff with respect to not being listened to. To ensure there is no confusion, the Clinical Lead for Acute Paediatrics has issued reminders to colleagues on responsibilities when on call and not being on site.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2023-003	Children and young people	Lincoln County Hospital	2023 Focussed Inspection of CYP at LCH	2023 'Interim Action'	Concerns around the facilities / equipment in place to care for her special needs son. The parent outlined that there was no room in the locality of the child for their wheelchair and no specialist equipment to support with showering.	Unrelated to their reason for visiting, CQC also fed back that during the visit a parent on Rainforest escalated their concerns around the facilities/equipment in place to care for her special needs son. The parent outlined that there was no room in the locality of the child for their wheelchair and no specialist equipment to support with showering. Parent has asked and spoken to Estates. 'Being looked into'. Concern that mobility for the child is hampered, mum needs to carry them, no potential for basic needs to be catered for. CQC need some assurance on this point.	CYP	Following collaboration with the young patient's family, procure the shower chair for use by the young patient and other patients on Rainforest, working with the Infection Prevention and Control team to ensure this is fit for purpose in a hospital setting.	Cathy Franklin (Lead Children's Nurse)	30-Sep-23	03-Aug-23: Working with procurement to purchase shower chair. 19-Jul-23: Therapies team involved and assisting to source from St Francis School an appropriate shower chair for use. Identified a gap also at PBH with this, who would use bed bathing as action. Review and make arrangements for same action at PBH. The chair/cover previously identified by the family, alongside Rainforest staff, is not suitable for use in a hospital environment as it does not meet IPC guidance which has complicated the procurement process. Hoping to have in place by the end of September. In the interim, the child concerned is able to shower with support. The new equipment will make this easier and result in a better patient experience. 05-Jul-23: Cathy to determine where we are with purchasing the shower chair identified by the patient's family and Carol. Get details and set achievable deadline.	Amber		(1) Evidence of shower chair being procured and ordered. (2) Evidence of shower chair being available in Rainforest Ward for use by patients.	N/A.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
							CYP	Ensure the CYP Admissions Document adequately includes as part of the plans to personalise care storage of patients equipment/mobility aids. Include this in the draft version of the document. (**NB:** In the case of this young patient, family confirmed that space outside the Ward Managers office is available for the storage of the wheelchair. The wider action is to ensure this is considered in other cases.)	Cathy Franklin (Lead Children's Nurse)	31-Jul-23	03-Aug-23: Update provided to CYP Board that document is in the process of being piloted. 19-Jul-23: Plan is to include additional question / detail within the draft Admissions Document by the end of July 23. Trial the document in August 23 and approve at APPG the document by the end of September 23. 05-Jul-23: Cathy to review CYP Admissions Document and determine if this adequately covers off storage of patient's own equipment/mobility aids to ensure personalised plans of care are considered on admission. Get details and set achievable deadline. (**NB:** Clinical adjacency meeting held that has considered the possibility of Lancaster ward being potentially reallocated to paediatrics. Timescales would be for FH to develop a strategy during this FY. This would link in with the Charitable Funds work and re-prioritise this to focus on LCH instead of Rainforest). 07-June-23: Scope out if this could be factored into the work to develop an admission document. Capture steps taken to keep equipment close at hand to meet individuals needs.	Green	31-Jul-23	(1) Evidence that the draft CYP admissions document has been reviewed and includes adequate aide memoir to support personalised care planning in relation to equipment / mobility needs and storage of these whilst on the ward.	N/A.	Draft Admissions document has been completed and is now being piloted.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
							CYP	Trial the CYP Admissions Document as part of a pilot.	Cathy Franklin (Lead Children's Nurse)	31-Aug-23		Amber		(1) Evidence that the draft CYP admissions document has been piloted and evaluated.	N/A.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
							CYP	Approve the CYP Admissions Document via APPG for use on CYP areas.	Cathy Franklin (Lead Children's Nurse)	30-Sep-23		Amber		(1) Evidence of APPG approval.	(1) Ongoing evidence that CYP Admissions document is in use and compliance is monitored (i.e. via Matrons audit)		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2023-003	Children and young people	Lincoln County Hospital	2023 Focussed Inspection of CYP at LCH	2023 'Interim Action'	The CQC visit was prompted in response to two incidents identified on CYP ward areas.	The CQC visit was prompted in response to two incidents identified on CYP ward areas relating to medicines management.	CYP	Undertake, for assurance purposes, a review of actions agreed in response to these incidents and ensure actions taken are consistent at both sites.	Kate Rivett (Divisional Head of Children and Young Peoples Nursing) Cathy Franklin (Lead Children's Nurse)	31-Aug-23	02-Aug-23: SIM training and Resus training. Question marks as to if this is in place. 19-Jul-23: Agreed for consistency to review actions from both incidents (DI and SI) and ensure evidence of completion available for both sites.	Amber		(1) Assurance evidence as detailed within each action plan from the two incident reports.	TBC.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	18 July 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 **Ward Accreditation Quarterly Report (appended)** The Committee received the report noting the areas which were achieving ward accreditation status and was pleased to note that this was now being extended into other areas. There have been significant periods of achievement in harm free certificates with some areas achieving up to a year of harm free care. This would be celebrated in the organisation through annual best practice days. Support continued to be in place for those areas requiring monitoring or enhanced monitoring with an annual review of the process also taking place. A digital solution for the audit tools was being considered and would be developed with the digital team. **Medicines Quality Group Upward Report** The Committee received the report noting ongoing concerns in respect of medicines management but recognised this would be part of the Patient Safety Incident Response Framework (PSIRF) going forward. It was noted that the Medicines Management Annual Report had been deferred to September due to, in part, the refocusing of the group and the additional support in place from the Improvement Team. The Committee noted a deep dive would take place at the August meeting in respect of medicines management to provide further assurance to the Committee on the actions being taken. The Committee was pleased to note that the additional support was now in place due to this being an

	area of concern. **Patient Safety Group Upward Report** The Committee received the report noting that the group had considered the harm report with the Committee noting that this demonstrated a robust process in place. As part of the ongoing development to implement PSIRF consideration was being given to investigation priorities going forward with the Committee endorsing the areas identified to date and which would be streamlined to 5 over the coming months. It was noted that the phase 4 close down report had been discussed. The group took receipt of the Human Tissue Authority report noting that regulatory intervention had been lifted however the Trust would continue to ensure actions were embedded to continue to reduce risk. **Infection Prevention and Control Group Upward Report** The Committee received the report noting the C-difficile position which continued to increase however it was noted that this was not isolated to the Trust with a national increase in infections of 25% compared to the previous year. A proactive approach was being taken to the management of C-difficile cases with hydrogen peroxide decontamination and deep cleaning in place to prevent future infections. The group had considered the IPC BAF which demonstrated that the Trust was compliant with 9 out of 10 conditions. The Committee noted the concerns raised in respect of ventilation in treatment rooms and medicine temperature management making a referral to the Finance, Performance and Estates Committee for consideration of capital funding to support areas requiring development. **Infection Prevention and Control Annual Report (appended)** The Committee received the annual report noting tat there were a significant number of achievements for the IPC team over the previous year including the expansion of the team and work taken forward by the IPC Group. The Committee noted the challenges that had been faced in respect of managing outbreaks such as Covid-19 however there had been robust management of this throughout the year. A system wide approach was being taken for IPC meaning that there was a joined-up approach across the system which was risk based. There had also been positive engagement and developments with the Estates and Facilities Team with the development of the Decontamination Lead role. The Committee noted the strong leadership within IPC which had

	supported internal work with the divisions developing strong relationships and allowing the service to be responsive. The Committee noted that antimicrobial stewardship had not progressed at the rate hoped however work continued for this to further develop over the coming year. **Serious Incident Summary Report inc Duty of Candour.** The Committee received the report noting the detailed paper and summary offered and was pleased to note the ongoing position of no outstanding never event actions. A closure trajectory was in place for SI actions along with a process for other open actions related in incidents. Work continued to progress in respect of PSIRF and the new review methodology which would come in to place once approved, this would see a reduction in SI reports as the new methodology was utilised. Compliance continued to remain high for duty of candour with this now being better embedded across the organisation as a result of the central team supporting the divisions. The Committee was pleased to note the intention of the central team to undertaken human factors training and whilst this was an overdue action this was positive decision. **High Profile Cases** The Committee received the report noting the content. **Claims and Inquests** The Committee received the report noting the position presented and was pleased to note the reduction in open inquests as a result of the coroner working through open cases resulting from delays during the Covid-19 period.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report and were pleased to note reports received by the group from the patient panel and Healthwatch and the actions being taken as a result of the feedback. The group had considered the national inpatient survey report headlines which demonstrated that the Trust had results in both the top and bottom 20% ranges, once the full report was received this would be considered by the group. It was noted that there had been improvement across the PLACE results in all 6 domains with this having been the first full assessment since the pandemic. Plans were being developed across a number of environments

	which would continue to improve patient experience and care. The Committee was also pleased to note the joint working with Lincolnshire Community Health Services NHS Trust in respect of the national consultation on visiting guidance.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting that there had been CQC colleagues in attendance at the meeting to observe the interactions between the professional groups present. The Committee was pleased to note the continued improvements in mortality reporting with the Trust benchmarking better than peers. Improvements were also being seen with National Confidential Enquires into Patient Outcome and Death (NCEPOD) with the Trust increasing from 7 to 14 fully compliant reports. Where areas of improvement were required the group had offered focus on the actions to be taken.
	Assurance in respect of other areas: **Terms of Reference and Work Programme 2023/24** The Committee received the terms of reference and work programme noting that discussions had taken place outside of the meeting which required reflecting within these. The work programme would be reviewed to consider reporting cycles for some areas to bi-monthly to support progress of work. **Integrated Improvement Plan** The Committee received the report noting the need for continued focus on medicine incidents resulting in harm and DKA incidents. Work was due to be undertaken in order to ensure that metrics continued to have traction and where necessary were brought back on track. The Committee was pleased to note the verbal update in respect of the support from the Improvement Team being put in place for medicines management with actions being considered for those which were business as usual and those requiring support. For those areas where metrics had not been populated the Committee was informed that there should be fully populated and reported from August. **Quality Impact Assessment (QIA) Quarterly Report** The Committee received the quarterly report noting that this offered the position for cost improvement programmes and the QIAs that had been completed against these.

	The Committee noted that monthly discussions which focused on ensuring impact for patients on the care offered. The Committee noted those QIAs which were closed, rejected or required further consideration. **Internal Audit Recommendations** The Committee received the report noting that the Improvement Team were now re-engaged in respect of Medicines Management which would provide focus on the FP10 action. The Committee requested update of the open recommendations and stated that plans should be offered to the Committee where these could not be closed. **CQC Action Plan** The Committee received the report noting that this also provided an update in respect of the move to the single assessment framework by the CQC. Work was underway to incorporate all actions associated with CQC inspections from previous reports to enable full sight of the action as well as the implementation of these. The Committee reflected on the actions which remained open and had been in place for some time however recognised that work was taking place to act on these and ensure actions were embedded. It was noted that the CQC remained sighted on the progress being made. **Committee Performance Dashboard** The Committee received the report noting the data and narrative presented which had been considered through the reports offered to the Committee with nothing further to be noted.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee referred to the Finance, Performance and Estates Committee the issue of ventilation in treatment rooms and medicine temperature management to seek support, through capital monies, for development of these issues.
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register.
Matters identified which Committee recommend are escalated to SRR/BAF	None

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

Attendance Summary for rolling 12-month period

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Quality Governance Committee*
Date of Meeting	*July 2023*
Item Number	*Item 8.1*
Ward to Board Quality Accreditation	
Accountable Director	*Professor Karen Dunderdale, Director of Nursing*
Presented by	*Angie Davies ,Deputy Director of Nursing*
Author(s)	*Angie Davies, Deputy Director of Nursing* *Sarah Addlesee, Assistant Director of Nursing.*
Report previously considered at	

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	
3b Efficient use of our resources	*X*
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	*X*
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	
Financial Impact Assessment	
Quality Impact Assessment	
Equality Impact Assessment	
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *To note the paper and the progression of the Quality Accreditation Programme including the diamond award application position*

Executive Summary

Ward to Board Quality Accreditation Update

The Quality Accreditation programme was developed as a further development of the pre-existing Ward Accreditation process that was in place from 2017 to pre-Pandemic 2019.

The revised model takes a continuous assessment approach using a multitude of data and information sources as well as observation and feedback from patients, staff, and learners.

The Quality Accreditation programme started in April 2021 as the data collection start date for the continuous assessment.

The current position (May 2023) is that there has been one area which has successfully achieved a SILVER diamond award.

The current position (May 2023) is that there have been six areas which have successfully achieved a BRONZE diamond award.

The current position (May 2023) is that there are two areas which have submitted an application for a BRONZE diamond award and have prepared their portfolio of evidence to present to Quality Accreditation Panels in June/July.

The current position (May 2023) is that there are six areas which are currently in the process of preparing their portfolio of evidence and completing an application for a BRONZE diamond award.

23 areas are on track to be able to apply for a BRONZE level diamond award from August 2023 if performance against the core criteria continues as is.

1 areas is on track to be able to apply for a SILVER level diamond award from August 2023 if performance against the core criteria continues as is.

Diamond Award applications will be approved by a Quality Accreditation Panel consisting of the Director of Nursing, the Medical Director, and a patient representative.

The Award itself will be presented by the Trust Chair at the public Trust Board, including a reward package for the clinical area.

All areas who have achieved a Diamond Award will be recognised at the annual Best Practice Day held by the Director of Nursing.

The diamond award Quality Accreditation programme provides a significant level of assurance to the Committee around safe and effective care for all areas included within the programme.

Quality Accreditation Diamond Award Position as of end May 2023		
Silver Diamond Award	**Ward/Department**	**Date Achieved**
Silver	GDH Surgical Unit	5th April 2023
Bronze Diamond Award	**Ward /Department**	**Date Achieved**
Bronze	GDH Surgical Unit	27th July 2022
Bronze	LCH Neonatal Unit	6th February 2023
Bronze	PHB Maternity Ward	6th February 2023
Bronze	PHB Labour Ward	6th February 2023
Bronze	LCH Theatres	5th April 2023
Bronze	Navenby Ward	3rd May 2023

Position update paper July 2023.

1.0 Introduction

The Quality Accreditation programme re-started as a new model based on a continuous assessment process, in April 2021. Any area within the Trust can join the programme and work towards achievement of a diamond award as part of the programme as detailed for the Committee in previous papers.

The revised model focuses on empowering leaders and engaging staff to improve standards in the clinical areas. It is based on the continuous improvement principle of standardisation, recognising, sharing and adhering to best practice in the interests of patient care and the basics of getting it right.

The aim of the Quality Accreditation Programme is to:

- Strengthen leadership
- Standardise care at ward and department level
- Objectively define and track the quality of care delivered by nursing staff
- Recognise and incentivise high standards of care
- Provide assurance that regulatory requirements (CQC fundamental standards) are being met
- Identify areas of good practice and where improvements are required
- Provides a strong focus to leadership team
- Improves Patient Experience

This paper provides an update of achievements against the 3 elements that make up the core requirements of the programme namely:

- Ward / Dept. weekly spot check audit
- Matron monthly audit
- Annual unannounced ward / Dept. inspection visit

This shows the current position regarding the state of readiness of potential award applications from the wards and Departments across the Trust. Appendix 1* shows a summary of those areas in the programme which have successfully achieved a diamond award.

2.0 Quality Accreditation programme

2.1 Weekly Ward / Department Spot Check Audits

Each week, every area that is part of the Quality Accreditation Programme must undertake a weekly spot check audit that assesses elements of care and environmental factors against 8 domains. Of the 8 domains in the tool, a default position to overall RED is applied for the following reasons:

- Nil return = overall RED week
- Inadequate numbers of audits returned (unless by prior DoN approval) = overall RED week
- Red IPC section = overall RED week

Achievement against the 8 domains results in the following:

- Achievement of 4 green domains or less = overall RED week
- Achievement of 5/6 green domains = overall AMBER week
- Achievement of 7/8 green domains = overall GREEN week

To achieve accreditation, the area must achieve a minimum criterion of 'green' weeks out of the 52 weeks within a rolling 12-month period for each level of accreditation.

Gold	**46 green weeks**
Silver	36 green weeks
Bronze	26 green weeks

The previous position at the end of February 2023 was 68 areas had achieved 24 or more green weeks in the previous 12 rolling months (March 22 – February 23). The position at the end of May 2023 is 75 areas have achieved 24 or more green weeks in the previous 12 rolling months (June 22- May 23). This reflects both an increase in the number of ward and departments which are now actively participating in the quality accreditation programme and an improvement in the consistency of weekly spot checks being undertaken and the standards being achieved.

At the end of May 2023, areas that have achieved 30 or more green weeks in the previous 12 rolling months (June 22-May 23):

Ward / Dept.	Achieved number of green weeks	Ward / Dept.	Achieved number of green weeks	Ward / Dept.	Achieved number of green weeks
LCH Clinic 7	52	**PHB Dermatology**	43	**Bostonian**	37
6A	50	**Johnson**	43	**Clayton**	37
GDH Surgical Unit	49	**GDH Eye Clinic**	42	**Hatton**	37
PHB Maternity M1	48	**LCH OPD**	42	**1B**	37
LCH Dermatology	48	**PHB ENT**	42	**MEAU A**	36
LCH Rheumatology	48	**5B**	42	**Burton**	36
CHL OPD	48	**GDH ED**	42	**PHB SDEC**	35
AMSS	47	**GDH Hospice**	40	**Neustadt Welton**	34
LCH UIS	46	**PHB ANC**	41	**LCH SDEC**	34
LCH MDU	46	**Ingham**	41	**6B**	33
LCH Clinic 11	46	**PHB Fracture Clinic**	40	**Bardney**	32
PHB Neonatal Unit	45	**ACU**	40	**LCH Neonatal Unit**	32
LCH Clinic 8	44	**Greetwell**	40	**Cardiac Short Stay**	31
SEAU	44	**LCH Audiology**	39	**PHB ICCU**	31
PHB Theatres	44	**Branston**	39	**Shuttleworth**	30
GDH OPD	44	**Witham**	39	**Lancaster**	30
MEAU B	44	**CHL Theatres**	38		
PHB OPD	43	**LCH Clinic 9**	38		

2.2 Matron Monthly Audit

The Matron audit is aligned to the same 8 domains of care assessment and environmental factors; a rag rating is applied per domain as above and then an overall rag rating is applied monthly. A default position to overall RED is applied for the following reasons:

- Nil return = overall RED
- Inadequate numbers of audits returned (unless by prior DoN approval) = overall RED
- Red IPC section = overall RED.

Achievement against the 8 domains results in the following:

- Achievement of 4 green elements or less = overall RED month
- Achievement of 5/6 green elements = overall AMBER month
- Achievement of 7/8 green elements = overall GREEN month

In order to achieve accreditation, the area must achieve a minimum criterion of 'green' months out of the 12 months, in a rolling 12 month period, for each level of accreditation.

Gold	**10 months**
Silver	8 months
Bronze	6 months
White	5 months or less

The position at the end of February 2023 was that 44 areas had achieved 5 or more green months in the previous 12 rolling months (March 22 – February 23). The position at the end of May 2023 is that 47 areas have achieved 5 or more green months in the previous 12 rolling months (June 22 – May 23).

At end of May 2023 areas that have achieved 5 or more green months in the previous 12 rolling months (June 22 – May 23):

Ward / Dept.	**Achieved number of green months**	**Ward / Dept.**	**Achieved number of green months**	**Ward / Dept.**	**Achieved number of green months**
PHB Neonatal Unit	12	**PHB ICCU**	9	**Waddington**	6
Ward 1	12	**GDH EAU**	8	**Cardiac Short Stay**	6
GDH Theatres	12	**PHB Dayward**	8	**LCH SDEC**	6
CHL Theatres	12	**Johnson**	8	**7A**	6
LCH Theatres	12	**Saxon Suite**	8	**LCH Stroke**	6
CMDU	12	**Vulcan Suite**	8	**SAL**	6
Cardiac Catheter Suite	11	**Harrowby**	8	**IAC**	5
PHB Theatres	11	**LCH ICCU**	7	**SEAU**	5
GDH Surgical Unit	11	**Ashby**	7	**1B**	5
Shuttleworth	11	**Navenby**	7	**MEAU B**	5
PHB Labour Ward	11	**Greetwell**	7	**1B**	5
PHB Maternity	10	**Branston**	7	**LCH UIS**	5
AMSS	10	**LCH ANC**	6	**ACU**	5
PHB SDEC	9	**Bostonian**	6	**LCH UIS**	5

GDH Hospice	9	**5A**	6	**8A**	5
PHB ANC	9	**LCH Neonatal Unit**	6		
PIU	9	**PHB Stroke**	6		

Although a number of Diagnostic and Outpatient areas have already been undertaking the weekly spot checks and Matrons audits, further non-ward areas have now formally commenced undertaking quality assurance audits as part of the Quality Accreditation Programme. Areas that have not traditionally been included within Quality Accreditation programmes including Occupational Therapy, Physiotherapy and Dietetics have been supported to develop and test out a quality metric tool relevant to their specialties and have now started to participate formally in the accreditation programme. This provides an increased level of assurance for areas which would not have previously been routinely monitoring the quality of care in a formalised and structured way. The number of Diagnostic and Outpatient areas now achieving 30 or more green weekly spot checks audits and/or achieving 5 or more green months in Matron audits, demonstrates that value is being placed on the Quality Accreditation framework and it is being owned and embedded by the clinical teams at a local level

The teams involved continue to feedback positively about being part of the process and have reported it has provided new learning and development opportunities.

Monthly Quality Metrics Dashboard meetings chaired by the Deputy Director of Nursing continue to review all areas both inpatient and non-ward areas.

2.3 Ward / Dept. Review Visits

Ward/Department quality review visits are an unannounced inspection visit with a multi-disciplinary team. Those areas most likely to apply for diamond accreditation based on their weekly and monthly audit results are being visited first in order for the 3 core components to have been met. ICB Quality Lead Nurses continue to support the visit schedule. A Patient Safety Partner representative is now scheduled to support as a member of the visit team for a number of ward visits. Work will continue with the Patient Experience team to invite and include patient representatives as members of the visit team wherever possible.

A Quality Matron, Senior Nurse or AHP leads every review visit and a weekly validation meeting is held with the Assistant Director of Nursing for Quality and Safety to ensure consistency of standards. A rag rating is applied to the visit and a written report provided to the clinical area. Areas that are on enhanced monitoring will not have a review visit undertaken until they have had opportunity to progress and a decision made that enhanced monitoring is no longer required.

There have been 53 ward/department review visits undertaken as at the end of May.

The position at the end of February 2023 was 25 areas had achieved a green visit in the previous 12 rolling months (March 22 – February 23). The position at the end of May 23 is 32 areas have achieved a green visit in the previous 12 rolling months (June 22- May 23).

At end of May 2023 for areas that have achieved green status in the previous 12 rolling months (June 22 – May 23):

Ward	Ward
Johnson	Burton
Bostonian	Cardiac Short Stay
AMSS	Harrowby
ACU	GDH EAU
LCH Neonatal Unit	5A
LCH ANC	PHB Labour Ward
PHB Neonatal Unit	PHB Theatres
SEAU	PHB Maternity M1
Navenby	GDH Hospice
6A	Ingham
LCH Theatres	Medical Day Unit
GDH Theatres	GDH Chemotherapy Suite
PHB Chemotherapy Suite	Waddington
MEAU B Side	Branston
Ward 1	6B
1B	GDH Surgical Unit

The remaining wards/departments (visit undertaken June 22–May 23) all achieved amber status and will therefore require a further visit to achieve a green status as part of their application for a diamond award.

Cancellation of a quality review visit will happen by exception and with prior discussion with the Deputy Director of Nursing. There have been a number of quality review visits which have been rescheduled due to the episodes of industrial action.

2.4 Harm Free Certificates

Wards/departments receive Harm Free Certificates as part of the Quality Accreditation process to acknowledge and celebrate when they have achieved a specific number of days harm free for falls, pressure ulcers and IPC. A roll call was presented at Best Practice Day in May.

At end of May 2023 for areas that have achieved harm free certificates. There has been an increase in the number of Falls and Pressure Ulcer harm free awards achieved compared to the previous 12 rolling months (March 22-February 23).

(some wards have received more than one level(s) certificate within the year):

Falls Harm Free Award	Number of Wards/Departments
Emerald (1 year)	6
Sapphire (250 days)	9
Ruby (150 days)	19
Gold (100 days)	18
Silver (60 days)	30
Bronze (30 days)	60

Pressure Ulcers Harm Free Award	Number of Wards/Departments
Emerald (1 year)	4
Sapphire (250 days)	10
Ruby (150 days)	16
Gold (100 days)	22

Silver (60 days)	42
Bronze (30 days)	58

IPC Harm Free Award	Number of Wards
One year	21

As new non-ward areas join the accreditation programme they are being supported to identify other measures of harm free care that they feel would be a more relevant indicator of quality and safety in their clinical area of work so that harm free certificates can be awarded, to enable them to evidence all of the essential criteria required to apply for diamond accreditation status.

Staff recognise the value of celebrating harm free care and positively receive the harm free certificates.

2.5 Themes for Improvement

The monthly quality metrics dashboard meetings chaired by the Deputy Director of Nursing provide oversight and allow early identification of any themes, which require a focus to improve. Current themes being observed are around:

- Indwelling Devices
- Missed medication doses
- Fluid Balance management
- Risk Assessments

Divisional teams continue to take an A3 thinking approach when presenting their improvement work and present Divisional themes and programmes of work in addition to those being undertaken locally at ward level. Areas continue to work collaboratively to share learning and are facilitating a number of Divisional forums established to provide a focus on themes, for example, falls and fluid balance management which have been identified through the dashboard metrics as areas to improve. This demonstrates a developing culture of shared learning through collaboration and teams being empowered to drive their own improvements.

2.6 Enhanced Monitoring

Wards/departments that require a level of enhanced monitoring due to their overall performance not improving are identified through the monthly quality metric meetings with the Deputy Director of Nursing. The length of time an area stays under enhanced monitoring is reviewed through the monthly meetings. Additional support is identified which includes Quality Matrons, training and education, corporate nursing teams. Current areas requiring an enhanced level of monitoring are across the Divisions:
CYP x2 LCH; x1 PHB
Surgery x1 LCH
Medicine x1 LCH
CSS X1 LCH

(Areas that are under enhanced monitoring are identified in blue per area on the dashboard).

There are areas where a clinical summit with the Director/Deputy Director of Nursing is undertaken, the requirement for this depends on the risks identified. Several areas have been subject to a Clinical Risk Summit over the last year and this has proved invaluable in understanding the detail which in turns has helped the clinical area to understand the root cause(s) of the identified issues. In one case this led to a Trust wide Oversight Group established to provide a further level of support to the clinical team, as well as developing assurance for the team and upwardly to the DoN.
Ward/departments that do not require enhanced monitoring but still require an additional level of monitoring and support are identified for Divisional monitoring and will have regular review meetings to monitor their overall performance and progress with the Divisional Nurse. Current areas requiring a divisional level of monitoring are across the Divisions:
Surgery x2 LCH
Medicine x3 LCH; x3 PHB.

(Areas that are under divisional monitoring are identified in amber per area on the dashboard).

At the end of May 2023, eleven areas which had been under enhanced monitoring have had this requirement discontinued following evidence of positive progress against quality and safety metrics being demonstrated through the monthly dashboard meetings. Twelve areas which had been under divisional monitoring have had this requirement discontinued. This provides assurance that the framework and mechanisms in place to support areas are having a positive impact and are driving improvements.

4.0 Accreditation Award summary position

The current position (May 2023) is one area has been successful with their application for a SILVER diamond award namely: GDH Surgical Unit. They have demonstrated further progress since achievement of their BRONZE award.

The current position (May 2023) is there are six areas which have been successful with their application for a BRONZE diamond award namely:
GDH Surgical Unit, LCH Neonatal Unit, PHB Labour Ward, PHB Maternity MI, LCH Theatres and Navenby Ward.

Appendix 1 provides an overview of the Quality Accreditation Award Position.

The current position (May 2023) is that there are 2 areas which have submitted an application for a BRONZE diamond award and have prepared their portfolio of evidence to present to present to Quality Accreditation Panels in June/July namely:
Cardiac Short Stay and Johnson Wards.

The current position (May 2023) is that there are five areas which are currently in the process of preparing their portfolio of evidence and application for a BRONZE diamond award namely: Bostonian, PHB Neonatal, GDH Theatres, AMSS, Ward 1.

The current position (May 2023) shows that 23 areas are in a position within the next three months submission of evidence to be able to apply for a BRONZE diamond award namely:

CHL Theatres, Waddington, Ashby, Branston, 1B,Cardiac Catheter Suite, Harrowby, 5A, PHB ICCU, LCH ICCU, PHB Theatres, GDH OPA, LCH SDEC, PHB SDEC 6B, LCH ANC, ,PHB ANC,GDH Hospice,8A,Shuttleworth,MEAU B ,Vulcan Suite and LCH Stroke.

The current position (May 2023) shows that 1 area is in a position within the next three months submission of evidence to be able to apply for a SILVER diamond award namely:
PHB Maternity Ward.

Six of these areas have previously been under enhanced monitoring and three have previously been under divisional monitoring demonstrating how the Quality Accreditation programme and supporting framework is helping to drive and achieve sustained improvement.

Support is provided to teams to prepare their applications and portfolio of evidence and in response to the increasing number of areas that are in a position to apply for a BRONZE diamond award there is a weekly Quality Accreditation clinic facilitated by the Assistant Director of Nursing for Quality and Safety.

Based on the amount of required evidence for an award application, this is a huge step forwards in the demonstration of safe quality care by the ward and departments within this programme.

An annual review of the accreditation audit tools is currently being undertaken which will support updates to be made in collaboration with subject matter experts and representatives from the clinical teams who undertake the audits. This will ensure the audit tool content is current, aligned to any recent changes in practice and will continue to support driving quality improvement at a local level.

A digital solution to the dashboards is currently being sought internally to further strengthen the process and reduce reliability on paper, streamlining the process and considering time efficiencies for all staff involved in the completion of the audits, collation and production of the results will continue to support the continuous improvement of the whole programme.

The Deputy Director of Nursing and Assistant Director of Nursing for Quality and Safety are representing ULHT at a newly formed Nursing and Midwifery Excellence Regional Network which has Ward Accreditation programmes as a focus and supports shared learning.

A detailed Quality Accreditation dashboard summary for each core component of the accreditation programme along with other variable components that are area specific such as FLO audit / Sepsis Audit results can be viewed in appendix 2

5.0 Summary

The Quality Accreditation system and Diamond Award programme provides a significant level of assurance to the Trust Board around the provision of safe quality care and the engagement and commitment of the team of staff within an area, in their efforts to do so.

The 3 elements of the programme are now embedded, with rich professional discussions occurring through the monthly quality metrics dashboard meetings. The clinical teams are able to focus on key areas of practice for improvement, and equally, provide a dynamic picture of assurance for their clinical areas.

When considering the following aims of the programme:

- *Strengthen leadership*
- *Standardise care at ward and department level*
- *Objectively define and track the quality of care delivered by nursing staff*
- *Recognise and incentivise high standards of care*
- *Provide assurance that regulatory requirements (CQC fundamental standards) are being met*
- *Identify areas of good practice and where improvements are required*
- *Provides a strong focus to leadership team*
- *Improves Patient Experience*

The Director of Nursing can offer a high level of confidence that the aims of the programme are being realised and the benefits of the quality accreditation programme are being delivered in practice.

Accreditation Progress Medicine - GDH & LCH

= Divisional Monitoring
= Enhanced Monitoring
= Escalation Area

Weekly Spot Check (Monthly)	GDH EAU	GDH Emergency Dept.	GDH Harrowby	LDH Burton	LDH Cardiac Cath Lab	LDH Cardiac Short Stay	LDH Clayton (Lancaster Team)	LDH Dixon [ULI735]	LDH ED MAJORS [ULI734]	LDH ED Chair 4 Treatment [ULI734]	LDH Johnson	LDH Lancaster [FAU Team]	LDH MEAU A	LDH MEAU B	LDH Nuvenity [L1023] (ex Carlton)	LDH Neustadt Welton	LDH RSU	LDH Scampton	LDH Stroke Unit	LDH Witham
Jun-21	Closed	LCHS	Closed	Amber		Amber	Red	Amber	Red	Red	Green	Red	Green	Green	Amber	Amber		Amber	Amber	
Jul-21	No Set	No Set	No Set	No Set	No Set	Red	Amber	Red	Amber	Amber	Green	Red	Amber	Amber	Amber	Green	Red	Red	Amber	Red
Aug-21	NC	NC	NC	NC	NC	Green	Green	NC	NC	NC	Amber	NC	NC	NC	NC	Amber	Amber	Red	Red	Amber
Sep-21	Red	Red	Red	Red	Red	Amber	Red	Green	Red	Red	Green	Amber	Amber	Amber	Green	Green	Red	Red	Red	Red
Oct-21	Amber	Red	Red	Amber	Red	Green	Amber	Amber	Red	Red	Green	Green	Amber	Amber	Green	Amber	Green	Red	Amber	Green
Nov-21	Red	Red	Red	Red	Amber	Green	Green	Amber	Red	Red	Green	Amber	Green	Green	Green	Amber	Amber	Red	Amber	Amber
Dec-21	Red	Red	Green	Green	Green	Green	Green	Amber	Red	Red	Green	Amber	Green	Green	Amber	Green	Amber	Red	Amber	Amber
Jan-22	Amber	Green	Amber	Amber	Amber	Green	Green	Amber	Red	Red	Amber	Amber	Green	Green	Amber	Green	Amber	Amber	Amber	Amber
Feb-22	Green	Amber	Amber	Amber	Green	Green	Green	Red	Red	Red	Amber	Amber	Green	Green	Green	Green	Amber	Amber	Amber	Amber
Mar-22	Red	Green	Amber	Amber	Amber	Amber	Green	Red	Red	Red	Amber	Green	Green	Green	Green	Amber	Amber	Amber	Amber	Amber
Apr-22	Green	Red	Red	Red	Red	Red	Red	Red	Red	Red	Green	Amber	Amber	Amber	Red	Amber	Amber	Green	Red	Red
May-22	Amber	Green	Amber	Red	Amber	Amber	Green	Red	Red	Red	Red	Amber	Green	Green	Amber	Red	Amber	Red	Red	Amber
Jun-22	Red	Green	Green	Amber	Red	Red	Red	Red	Red	Red	Red	Red	Green	Green	Amber	Red	Red	Amber	Red	Red
Jul-22	Red	Red	Red	Red	Green	Green	Red	Red	Red	Red	Green	Red	Green	Green	Red	Amber	Green	Amber	Red	Amber
Aug-22	Red	Green	Red	Green	Green	Green	Green	Red	Red	Red	Green	Green	Red	Red	Amber	Green	Amber	Red	Amber	Green
Sep-22	Red	Green	Green	Green	Green	Green	Amber	Red	Red	Red	Green	Red	Red	Red	Green	Amber	Red	Amber	Red	Amber
Oct-22	Red	Green	Red	Amber	Green	Green	Green	Red	Amber	Amber	Green	Red	Green	Green	Green	Red	Green	Green	Green	Green
Nov-22	Red	Green	Green	Red	Green	Green	Green	Red	Red	Red	Green	Red	Amber	Green	Green	Green	Green	Amber	Amber	Green
Dec-22	Red	Green	Green	Green	Green	Amber	Green	Red	Amber	Amber	Green	Green	Amber	Green	Green	Green	Green	Amber	Amber	Green
Jan-23	Red	Green	Red	Amber	Red	Green	Green	Red	Red	Red	Green	Red	Green	Green	Red	Green	Green	Red	Green	Green
Feb-23	Red	Green	Red	Green	Red	Red	Green	Red	Red	Red	Green	Red	Green	Green	Red	Green	Green	Green	Green	Green
Mar-23	Red	Red	Red	Green	Green	Amber	Green	Red	Amber	Amber	Green	Green	Amber	Green	Red	Green	Red	Red	Red	Green
Apr-23	Red	Green	Red	Green	Red	Amber	Green	Red	Red	Red	Green	Green	Green	Green	Red	Green	Red	Red	Red	Green
May-23	Red	Red	Red	Green	Red	Green	Amber	Amber	Red	Red	Green	Green	Green	Green	Red	Red	Red	Red	Red	Green

Weekly Spot Check (Weekly)	GDH EAU	GDH Emergency Dep	GDH Harrowby	LDH Burton	LDH Cardiac Cath Lab	LDH Cardiac Short Stay	LDH Clayton (Lancaster Team)	LDH Dixon	LDH Emergency Dept MAJORS	LDH ED Chair 4 Treatment	LDH Johnson	LDH Lancaster [FAU Team]	LDH MEAU A	LDH MEAU B	LDH Nuvenity [L1023] (ex Carlton)	LDH Neustadt Welton	LDH RSU	LDH Scampton	LDH Stroke Unit	LDH Witham
Jun-21	CLOSED		CLOSED																	
Jul-21		LCHS																		
Aug-21																				
Sep-21																				
Oct-21																				
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Nov-22																				
Dec-22																				
Jan-23																				
Feb-23																				
Mar-23																				
Apr-23																				
May-23																				

Matron Audit	GDH EAU	GDH Emergency Dept.	GDH Harrowby	LDH Burton	LDH Cardiac Cath Lab	LDH Cardiac Short Stay	LDH Clayton (Lancaster Team)	LDH Dixon [ULI735]	LDH ED MAJORS [ULI734]	LDH ED Chair 4 Treatment [ULI734]	LDH Johnson	LDH Lancaster [FAU Team]	LDH MEAU A	LDH MEAU B	LDH Nuvenity [L1023] (ex Carlton)	LDH Neustadt Welton	LDH RSU	LDH Scampton	LDH Stroke Unit	LDH Witham
Jun-21	Closed	LCHS	Closed	Amber	Green	Green	Green	Amber	Red	Red	Green	Red	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber
Jul-21	Amber	Amber	Amber	Amber	Green	Green	Amber	Amber	Amber	Amber	Green	Amber	Amber	Amber	Green	Green	Amber	Green	Amber	Amber
Aug-21	Amber	Amber	Amber	Amber	Green	Green	Red	Amber	Amber	Amber	Amber	Red	Amber	Amber	Green	Amber	Amber	Amber	Amber	Amber
Sep-21	Green	Amber	Green	Amber	Green	Amber	Red	Amber	Red	Red	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber
Oct-21	Amber	Amber	Green	Amber	Green	Green	Red	Amber	Red	Red	Green	Red	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber
Nov-21	Amber	Amber	Amber	Amber	Green	Green	Red	Amber	Red	Red	Green	Amber	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber
Dec-21	Amber	Green	Amber	Amber	Green	Green	Red	Red	Red	Red	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber
Jan-22	Amber	Amber	Green	Amber	Green	Amber	Red	Amber	Red	Red	Green	Amber	Red	Red	Amber	Amber	Amber	Amber	Amber	Amber
Feb-22	Amber	Amber	Amber	Amber	Green	Green	Amber	Amber	Red	Red	Green	Amber	Red	Red	Amber	Amber	Red	Amber	Red	Red
Mar-22	Green	Amber	Amber	Amber	Green	Green	Amber	Green	Amber	Amber	Green	Amber	Green	Green	Green	Amber	Amber	Amber	Amber	Amber
Apr-22	Amber	Amber	Green	Amber	Green	Green	Amber	Red	Red	Red	Green	Amber	Amber	Amber	Green	Amber	Amber	Amber	Red	Amber
May-22	Amber	Amber	Amber	Amber	Green	Green	Amber	Red	Red	Red	Green	Green	Amber	Amber	Green	Green	Amber	Amber	Amber	Amber
Jun-22	Green	Amber	Green	Amber	Green	Green	Amber	Amber	Amber	Amber	Green	Amber	Amber	Amber	Amber	Green	Amber	Green	Green	Green
Jul-22	Amber	Amber	Amber	Amber	Green	Green	Amber	Amber	Red	Red	Green	Amber	Amber	Amber	Amber	Green	Amber	Green	Amber	Amber
Aug-22	Amber	Green	Green	Amber	Green	Amber	Amber	Red	Red	Red	Green	Amber	Amber	Amber	Green	Amber	Amber	Amber	Green	Amber
Sep-22	Green	Green	Green	Green	Green	Amber	Red	Amber	Red	Red	Green	Amber	Amber	Amber	Amber	Amber	Amber	Red	Amber	Amber
Oct-22	Amber	Amber	Green	Amber	Green	Amber	Amber	Red	Red	Red	Green	Amber	Green	Green	Green	Red	Green	Green	Green	Red
Nov-22	Green	Green	Amber	Green	Green	Amber	Green	Red	Red	Red	Green	Amber	Green	Green	Amber	Amber	Green	Amber	Amber	Red
Dec-22	Green	Amber	Green	Amber	Green	Amber	Red	Amber	Red	Red	Green	Amber	Amber	Amber	Amber	Green	Amber	Amber	Amber	Amber
Jan-23	Amber	Amber	Red	Amber	Green	Green	Amber	Red	Red	Red	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber
Feb-23	Green	Amber	Amber	Amber	Green	Green	Green	Amber	Red	Red	Green	Red	Amber	Green	Amber	Amber	Amber	Green	Green	Amber
Mar-23	Green	Amber	Green	Green	Green	Green	Red	Red	Red	Red	Green	Red	Green	Red	Amber	Red	Amber	Amber	Amber	Red
Apr-23	Green		Green	Green	Green	Amber	Red	Amber			Amber	Green	Red	Red	Amber	Amber	Amber	Amber	Amber	Red
May-23	Green		Green	Green	Green	Green	Green	Amber			Green	Green	Red	Green	Green	Green	Green	Green	Green	Amber

Count of GREENS	14	42	24	36	32	31	37	9	4	4	43	30	36	44	21	34	27	21	22	39

Ward/Dept. Review Visit	GDH EAU	GDH Emergency Dept.	GDH Harrowby	LDH Burton	LDH Cardiac Cath Lab	LDH Cardiac Short Stay	LDH Clayton (Lancaster Team)	LDH Dixon	LDH ED MAJORS	LDH ED Chair 4 Treatment	LDH Johnson	LDH Lancaster [FAU Team]	LDH MEAU A	LDH MEAU B	LDH Nuvenity [L1023] (ex Carlton)	LDH Neustadt Welton	LDH RSU	LDH Scampton	LDH Stroke Unit	LDH Witham
Jun-21	Closed	LCHS	Closed	Amber											Amber				Amber	
Jul-21																				
Aug-21																				
Sep-21																				
Oct-21											Amber						Amber			Amber
Nov-21	Amber					Green														
Dec-21			Amber					Amber												
Jan-22																				
Feb-22													Amber	Amber						
Mar-22																				
Apr-22																				
May-22					Green															
Jun-22																				
Jul-22															Green					
Aug-22																				
Sep-22																				
Oct-22	Green																			
Nov-22			Green								Green	Amber								
Dec-22																				
Jan-23																				
Feb-23								Amber												
Mar-23														Green						
Apr-23													Amber			Amber				Amber
May-23							Amber													

Storm Free Certificate	GDH EAU	GDH Emergency Dept.	GDH Harrowby	LDH Burton	LDH Cardiac Cath Lab	LDH Cardiac Short Stay	LDH Clayton (Lancaster Team)	LDH Dixon [ULI735]	LDH ED MAJORS [ULI734]	LDH ED Chair 4 Treatment [ULI734]	LDH Johnson	LDH Lancaster [FAU Team]	LDH MEAU A	LDH MEAU B	LDH Nuvenity [L1023] (ex Carlton)	LDH Neustadt Welton	LDH RSU	LDH Scampton	LDH Stroke Unit	LDH Witham
Jun-21						G - Skin		B - Skin				G - Falls						G - Skin	B - Skin	
Jul-21		B - Falls				B - Skin		S - Skin				B - Skin							S - Skin	
Aug-21	B - Skin	B - Skin		B - Skin B - Falls							B - Skin	B - Skin			B - Skin					
Sep-21		B - Skin		B - Falls			S - Skin	G - Skin							S - Skin	B - Skin	B - Falls			B - Falls
Oct-21	B - Skin	B - Skin B - Falls	S - Falls	B - Skin				B - Skin			S - Skin						S - Skin		B - Skin	S - Skin
Nov-21		G - Falls				B - Skin					B - Falls G - Skin									
Dec-21				B - Falls		S - Skin											B - Falls S - Skin	B - Skin	B - Skin	B - Falls S - Skin
Jan-22			B - Skin					B - Skin			B - Skin				B - Skin					
Feb-22	B - Falls	B - Skin									S - Falls	B - Skin				B - Skin				
Mar-22			S - Skin					B - Skin												
Apr-22	B - Skin		G - Skin	B - Skin IPC		B - Skin IPC		IPC			IPC									
May-22	S - Skin	B&S - Falls Sapphire - Skin																B - Skin	B - Skin	
Jun-22			B - Skin	B - Skin		B - Skin		B - Skin			B - Skin	B - Skin								
Jul-22	B - Falls	B - Falls	B - Falls	B - Falls			B - Skin	B - Falls B - Skin			B - Falls B - Skin							B - Skin B - Falls		
Aug-22	B - Skin	S - Falls	B - Skin			B - Falls B - Skin		B - Skin							B - Falls					
Sep-22			B - Falls					S - Skin	S - Skin B - Skin				B - Falls					B - Skin S - Skin	B - Skin	
Oct-22			S - Falls		B - Falls B - Skin															
Nov-22						S - Skin	B - Falls									B - Skin		G - Skin		
Dec-22		G - Falls	S - Falls					B - Falls				B - Skin					B - Falls B - Skin		B - Falls	B - Falls B - Skin
Jan-23		R - Falls															B - Falls			B - Falls
Feb-23			B - Skin			B - Falls		S - Skin				B - Skin					B - Skin	B - Skin		B - Skin
Mar-23			B - Skin			B - Skin					B - Falls	B - Falls B - Skin			B - Falls		B - Falls	B - Skin	B - Skin	B - Falls S - Skin
Apr-23							B - Falls					B - Skin		B - Falls			B - Falls	S - Skin		
May-23		S - Skin Sapphire - Falls	B - Falls	B - Skin		B - Skin B - Falls		B - Skin			B - Falls	S - Skin B - Falls			B - Falls		B - Skin			B - Skin

FLO	GDH EAU	GDH Emergency Dept.	GDH Harrowby	LDH Burton	LDH Cardiac Cath Lab	LDH Cardiac Short Stay	LDH Clayton (Lancaster Team)	LDH Dixon [ULI735]	LDH ED MAJORS [ULI734]	LDH ED Chair 4 Treatment [ULI734]	LDH Johnson	LDH Lancaster [FAU Team]	LDH MEAU A	LDH MEAU B	LDH Nuvenity [L1023] (ex Carlton)	LDH Neustadt Welton	LDH RSU	LDH Scampton	LDH Stroke Unit	LDH Witham
Jun-21	Closed	LCHS	Closed	G		G	G	A	R	R	G	R	G	G	G	G		G	G	
Jul-21	G	G		R		G	G	R	A	A	G	R	G	G	G	G		R	A	
Aug-21	A	G		A		G	G	G	R	A	G	R	R	R	G	G		A	A	
Sep-21	A	G	G	A		G	G	G	R	R	G	G	R	R	A	G		G	G	
Oct-21	R	G	G	A	G	G	G	R	A	A	G	G	G	G	R	G	G	R	G	G
Nov-21	R	G	G	G	A	G	G	R	A	A	G	G	G	G	G	G	G	G	G	A
Dec-21	R	G	G	G	G	G	G	A	G	G	R	G	G	G	G	G	A	G	G	R
Jan-22	A	G	G	R	G	G	G	A	A	A	G	G	G	G	G	G	G	G	G	G
Feb-22	G	G	G	G	G	G	G	G	A	A	A	G	G	G	G	R	G	G	G	G
Mar-22	G	G	G	G	A	G	G	A	A	A	G	G	G	G	R	G	G	G	G	G
Apr-22	A	G	G	G	A	G	G	G	A	A	A	G	G	R	G	G	G	A	G	G
May-22	A	G	G	G	G	G	G	G	A	R	A	G	R	A	A	G	G	G	G	G
Jun-22	G	G	G	A	G	G	G	G	G	R	R	G	A	A	A	G	G	G	G	G
Jul-22	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	Closed	G	G	G	G
Aug-22	G	G	G	G	G	G	G	R	A	A	A	G	G	A	G	G	G	R	G	G
Sep-22	G	G	G	G	G	R	G	A	G	G	G	G	G	G	G	G	A	G	G	A
Oct-22	R	G	G	G	G	G	A	R	G	G	G	G	G	G	G	G	A	A	R	A
Nov-22	A	G	G	G	G	A	G	N/A	G	G	G	N/A	G	G	G	G	G	G	A	A
Dec-22	A	G	G	G	A	G	A	A	G	R	A	G	G	G	G	G	G	N/A	A	A
Jan-23	A	G	G	G	G	G	A	A	A	A	G	G	G	G	G	G	G	G	G	A
Feb-23	A	G	G	G	G	R	A	A	N/A	N/A	N/A	G	G	G	G	G	R	G	A	A
Mar-23	A	G	G	G	G	G	A	A	A	A	G	G	G	G	G	G	A	R	G	G
Apr-23	G	G	G	G	G	R	G	A	N/A	N/A	G	G	G	G	G	G	G	R	N/A	G
May-23	G	G	G	G	G	G	G	A	A	A	G	G	G	G	G	G	G	G	G	G

SEPSIS	GDH EAU	GDH Emergency Dept.	GDH Harrowby	LDH Burton	LDH Cardiac Cath Lab	LDH Cardiac Short Stay	LDH Clayton (Lancaster Team)	LDH Dixon	LDH ED MAJORS	LDH ED Chair 4 Treatment	LDH Johnson	LDH Lancaster [FAU Team]	LDH MEAU A	LDH MEAU B	LDH Nuvenity [L1023] (ex Carlton)	LDH Neustadt Welton	LDH RSU	LDH Scampton	LDH Stroke Unit	LDH Witham
Apr-21	Closed	LCHS	Closed	G		G	G	G	G	G	R	A	G	G	R	G		A	A	
May-21	Closed	LCHS	Closed	G		G	A	G	G	G	G	R	G	G	A	G		G	G	
Jun-21	Closed	LCHS	Closed	G		G	G	R	G	G	G	R	G	G	A	G		A	G	
Jul-21	R	A		G		G	R	A	G	G	G	A	G	G	R	R		G	G	
Aug-21	R	G		A		A	G	R	G	G	G	R	G	G	G	A		G	R	
Sep-21	A	G	N/A	A		G	A	G	G	G	R	G	G	G	G	R	G	R	A	A
Oct-21	A	G	G	G		G	A	A	G	G	G	G	G	G	G	G	A	G	A	A
Nov-21	A	G	G	A		G	N/A	R	G	G	G	A	A	G	G	A	G	G	G	A
Dec-21	A	A	R	R		G	A	A	R	R	G	R	G	G	A	G	A	G	A	G
Jan-22	A	A	G	R		A	A	R	A	A	G	G	A	A	G	G	G	G	A	G
Feb-22	G	A	G	A		R	A	A	A	A	G	G	G	G	A	A	R	R	G	A
Mar-22	A	G	G	A		R	R	R	A	A	G	G	G	G	A	A	R	G	A	R
Apr-22	G	G	N/A	A		G	A	G	A	A	G	G	G	G	A	G	R	G	A	R
May-22	A	A	G	R		A	G	G	A	A	G	R	G	G	A	G	A	G	A	A
Jun-22	A	A	G	G		G	G	G	G	G	G	A	A	G	G	G	G	G	A	G
Jul-22	R	G	R	G		G	G	G	G	G	G	A	A	G	G	R	G	G	G	G
Aug-22	R	G	R	G		A	A	N/A	G	G	G	A	A	G	R	G	G	R	G	G
Sep-22	R	G	G	G		G	G	G	G	G	G	G	G	R	G	G	R	G	R	G
Oct-22	A	A	R	G		R	G	A	A	A	G	G	A	G	G	R	G	G	G	G
Nov-22	G	G	G	G		A	G	R	A	A	G	R	G	G	G	G	A	G	G	G
Dec-22	R	G	G	G		R	G	A	A	A	G	R	G	R	G	R	G	R	G	G
Jan-23	R	G	G	G		A	G	R	G	G	G	R	G	A	G	R	G	G	G	G
Feb-23	R	G	R	G		R	G	G	G	G	G	R	G	A	G	A	G	G	G	A
Mar-23	A	G	R	G		R	A	R	G	G	G	G	G	G	G	G	R	A	G	A
Apr-23	G	G	N/A	G		A	G	A	G	G	G	R	R	G	G	R	G	G	G	A
May-23	G	A	G	G		R	G	G	G	G	G	R	G	G	G	R	G	G	G	G

Accreditation Progress Medicine - PHB

= Divisional Monitoring
= Enhanced Monitoring
= Escalation Area

Weekly Spot Check [Monthly]	PHB ACU	PHB AMSS	PHB ED Majors	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7B	PHB 8A
Jun-21	Red	Green	Red	Red	Red	Red	Red	Amber	Amber	Red	Red
Jul-21	Green	Green	Red	Red	Red	Red	Green	Amber	Red	Red	Amber
Aug-21	Red	Green	Red	Red	Red	Red	Green	Red	Red	Red	Red
Sep-21	Red	Green	Red	Red	Amber	Red	Red	Amber	Green	Red	Red
Oct-21	Green	Green	Red	Red	Red	Red	Amber	Green	Green	Amber	Amber
Nov-21	Red	Green	Red	Red	Amber	Red	Red	Amber	Green	Green	Amber
Dec-21	Red	Green	Red	Red	Red	Red	Green	Green	Green	Green	Amber
Jan-22	Red	Green	Amber	Amber	Red	Amber	Amber	Green	Green	Amber	Amber
Feb-22	Amber	Green	Red	Red	Red	Amber	Green	Green	Green	Green	Amber
Mar-22	Amber	Amber	Red	Red	Green	Red	Amber	Green	Green	Green	Amber
Apr-22	Green	Amber	Red	Red	Amber	Red	Red	Green	Green	Green	Amber
May-22	Amber	Amber	Red	Red	Amber	Amber	Red	Green	Green	Amber	Green
Jun-22	Red	Green	Red	Red	Green	Amber	Red	Green	Green	Red	Amber
Jul-22	Red	Green	Red	Red	Red	Red	Red	Green	Amber	Red	Green
Aug-22	Amber	Green	Red	Red	Red	Red	Amber	Green	CLOSED	Red	Amber
Sep-22	Green	Green	Red	Red	Red	Amber	Green	Green	Green	Green	Amber
Oct-22	Green	Green	Red	Red	Red	Red	Amber	Green	Green	Amber	Red
Nov-22	Green	Red	Red	Red	Red	Red	Amber	Green	Red	Red	Amber
Dec-22	Green	Green	Red	Red	Red	Amber	Green	Green	Red	Red	Amber
Jan-23	Green	Green	Red	Red	Red	Red	Amber	Green	Green	Red	Green
Feb-23	Green	Green	Amber	Amber	Amber	Red	Amber	Green	Green	Red	Green
Mar-23	Green	Green	Red	Red	Red	Red	Red	Green	Green	Green	Green
Apr-23	Green	Green	Red	Red	Amber	Red	Amber	Green	Amber	Red	Amber
May-23	Green	Green	Amber	Amber	Red	Amber	Amber	Green	Green	Red	Green

Weekly Spot Check (Weekly)	PHB ACU	PHB AMSS	PHB ED MAJORS	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7B	PHB 8A
Jun-21	R G R R	G G G G	R R R R	R R R R	R R R R	R R R R	R G R R	A A A A	A A A A	R R R R	R R R R
Jul-21	R G G G	G G G G	R R R R	R R R R	R R R R	R R R R	G R G G	A A A A	R R R R	A A A A	A A A A
Aug-21	R R R G	R G G G	R R R R	R R R R	R R R R	R R R R	R G G G	G R R R	A R R A	G R A R	R R R R
Sep-21	R R R A	G G G G	R R R R	R R R R	G G R R	R R R A	A R R A	R R G G	G G G G	A R R A	R R R R
Oct-21	G G R G	G G R G	R R R R	R R R R	A R R G	R A R G	R A R G	G G G R	G G G G	R G A G	R A G A
Nov-21	R R R A	G G R G	R R R A	R R R A	G R G G	R R R A	R G R R	G G R G	A G G R	G G R G	A R A G
Dec-21	R R R A	G G R G	A A R R	A A R R	R R R R	R A R R	G G R G	G R G G	G G G A	G G R G	A A G R
Jan-22	R R G R	A G G G	R R A A	A R R A	R A A A	R A G A	R A G R	G G G G	G G G G	G R G R	G A A G
Feb-22	G R G A	R G G G	R R R R	R R R R	G R R R	A G R R	A G G R	G G G G	G G G G	G G G G	A G R A
Mar-22	G A G A	G A R R	R A R A	R A A A	G G A G	A R R A	G R R G	G G G G	G G G R	G G G G	A A G A
Apr-22	R G G G	G R G A	A R R R	A R R R	G R G R	R R R R	R R R R	G G G G	G G G A	G G R G	G A R G
May-22	G A G G A A R A G A	R R R R R	R R R R R	G A A G G	A A A R A	R R R R	G R R R R	G G G G G	G G A G G	R G R G G	G G G G A
Jun-22	G A A R	G A G G	R A A G	A G G G	A G G G	G R A A	G R R R	G G G G	G R G G	A G G A	A G G A
Jul-22	A G R R	G G G G	G R G A	G R G A	R R R R	R R R R	R A A A	G G G G	A G G A	G R R G	A G G G
Aug-22	G G R R G	G G G G	R R R G	G R G A	R R G G	A R A R	A G R R	G A G G	A G G G	CLOSED	G R R G
Sep-22	G G G A	G G G G	R A G R	R A G R	R A G R	G R A R	R A G A	A G G A	G G G G	G G A G	G G G G
Oct-22	G G G G G	G G G A	A A R A	A A R A	R A A A	R G A A	G A A R	G A G A	G G G G	G G G G	A R G R
Nov-22	G G G G	A G R G	A A R R	R A A G	G R R R	G A A R	G G A A	G G G G	G R A G	R F G G	G A G A
Dec-22	G R G G	G G G G	G A R A	G A R A	R A A G	A R R R	A G G G	G G G G	R G G A	R G A G	G A A A
Jan-23	G G A G	G G G G	A R R A	A R R A	A R R A	G R A R	G G A A	G R G G	G G G A	G R R G	R G G G
Feb-23	R G G G	G G A G	A A R A	A A A R	A A A R	A A R G	A R R G	A A A A	G G G G	G G G A	G R R R
Mar-23	G G G G	G G G G	A A R A	A A R A	R A A R	G A A R	A G A A	G R G G	G G G G	G A G G	G A G G
Apr-23	G G G G	G G G G	A A R A	R A R A	R A A R	G A A R	G A G A	G G A G	G A G G	G R G G	G G R R
May-23	G G G G	G G G G	A A A R	A A A R	A A A R	A A R G	A G G G	A G G G	G A G G	G R R R	R G R G

Count of GREENS											
	40	47	8	8	10	12	22	50	33	24	28

Matron Audit	PHB ACU	PHB AMSS	PHB ED Majors	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7B	PHB 8A
Jun-21	Amber	Green	Amber	Amber	Amber	Amber	Green	Amber	Amber	Amber	Red
Jul-21	Amber	Amber	Red	Red	Amber	Amber	Amber	Amber	Red	Amber	Green
Aug-21	Red	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber
Sep-21	Amber	Amber	Red	Red	Amber	Amber	Green	Amber	Green	Amber	Amber
Oct-21	Red	Green	Amber	Amber	Amber	Red	Green	Amber	Amber	Amber	Amber
Nov-21	Amber	Amber	Red	Red	Amber	Amber	Green	Amber	Amber	Amber	Amber
Dec-21	Amber	Red	Amber	Amber	Amber	Amber	Green	Amber	Amber	Amber	Amber
Jan-22	Amber	Amber	Amber	Amber	Red	Amber	Amber	Amber	Amber	Amber	Amber
Feb-22	Amber	Amber	Amber	Amber	Amber	Amber	Green	Green	Amber	Amber	Amber
Mar-22	Amber	Green	Amber	Amber	Amber	Amber	Green	Amber	Amber	Green	Amber
Apr-22	Red	Amber	Amber	Amber	Red	Amber	Green	Green	Amber	Amber	Amber
May-22	Amber	Amber	Red	Red	Amber	Amber	Green	Green	Amber	Green	Amber
Jun-22	Amber	Green	Red	Red	Red	Green	Green	Amber	Amber	Amber	Amber
Jul-22	Green	Green	Amber	Amber	Amber	Green	Green	Green	Amber	Amber	Amber
Aug-22	Green	Amber	Red	Red	Amber	Amber	Green	Amber	CLOSED	Amber	Amber
Sep-22	Green	Green	Red	Red	Amber	Green	Green	Red	Red	Amber	Green
Oct-22	Green	Green	Red	Red	Amber	Green	Green	Amber	Amber	Amber	Red
Nov-22	Red	Green	Red	Red	Amber	Amber	Green	Green	Green	Amber	Amber
Dec-22	Amber	Green	Red	Red	Green	Amber	Green	Amber	Amber	Amber	Green
Jan-23	Amber	Green	Red	Red	Green	Amber	Green	Amber	Green	Amber	Green
Feb-23	Amber	Green	Red	Red	Green	Amber	Green	Amber	Green	Green	Green
Mar-23	Red	Amber	Red	Red	Amber	Amber	Green	Amber	Green	Red	Green
Apr-23	Amber	Green	Red	Red	Green	Green	Green	Amber	Green	Red	Amber
May-23	Green	Green			Green	Green	Green	Red	Green	Amber	Amber

Ward/Dept. Review Visit	PHB ACU	PHB AMSS	PHB ED Majors	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7B	PHB 8A
Jun-21											
Jul-21	Amber					Amber					
Aug-21											
Sep-21											
Oct-21											
Nov-21		Amber									
Dec-21											
Jan-22					Amber						
Feb-22											
Mar-22									Amber		
Apr-22											Amber
May-22											
Jun-22								Green			
Jul-22											
Aug-22										Amber	
Sep-22											
Oct-22											
Nov-22											
Dec-22											
Jan-23		Green									
Feb-23	Green										
Mar-23											
Apr-23							Green		Green		
May-23											

Harm Free Certificate	PHB ACU	PHB AMSS	PHB ED Majors	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7B	PHB 8A
Jun-21	S - Skin										
Jul-21									B - Skin		
Aug-21	B - Skin					B - Skin			S - Skin		
Sep-21	B - Falls					B - Skin					
Oct-21	B - Falls B - Skin	B - Skin				S - Skin	B - Skin				B - Skin
Nov-21	S - Skin										
Dec-21	G - Skin						B - Skin				
Jan-22								B - Skin	B - Skin		
Feb-22			B - Falls	B - Falls					B - Falls	B - Falls	
Mar-22	B - Skin						B - Skin				
Apr-22	IPC						IPC		B - Skin	B - Skin	
May-22						B - Skin			S - Skin		
Jun-22											
Jul-22	B - Skin									B - Skin	
Aug-22	S - Skin								B - Falls		
Sep-22						B - Falls					
Oct-22	B - Skin										
Nov-22					B - Falls	B - Skin			B - Skin		
Dec-22	B - Falls B - Skin									B - Falls	
Jan-23	S - Skin					B - Falls					
Feb-23			B - Falls	B - Falls							B - Skin
Mar-23	G - Skin						B - Falls				S - Skin
Apr-23	B - Falls										
May-23	B - Skin	B - Falls	B - Skin	B - Skin		B - Skin		B - Skin			B - Skin

FLO	PHB ACU	PHB AMSS	PHB ED Majors	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7B	PHB 8A
Jun-21	R	G	R	R	R	R	G	G	A	R	G
Jul-21	A	G	R	R	R	R	G	G	A	R	G
Aug-21	R	G	A	A	R	R	G	G	R	G	G
Sep-21	G	G	R	R	R	G	G	G	G	G	G
Oct-21	G	G	R	R	R	G	A	G	G	G	G
Nov-21	G	G	R	R	G	G	G	G	A	G	G
Dec-21	G	G	R	R	A	A	G	G	G	G	G
Jan-22	A	G	R	R	A	G	G	G	G	R	G
Feb-22	A	G	R	R	A	R	R	G	G	G	G
Mar-22	G	G	R	R	R	G	G	G	G	G	G
Apr-22	G	G	G	G	G	G	G	G	G	G	G
May-22	G	A	R	R	G	G	G	G	G	G	G
Jun-22	G	A	A	A	A	G	G	G	G	G	
Jul-22	G	G	R	R	N/A	G	G	N/A	G	A	G
Aug-22	G	G	R	R	A	G	G	G	CLOSED	A	G
Sep-22	G	G	R	R	G	A	G	R	A	G	A
Oct-22	G	G	A		G	G	G	G	R	A	G
Nov-22	G	G	A		R	N/A	G	G	A	N/A	G
Dec-22	G	N/A	A	A	A	G	G	G	R	N/A	G
Jan-23	G	G	A	A	A	G	A	G	G	A	G
Feb-23	A	G	A	A	A	G	A	G	G	R	G
Mar-23	G	G	G	G	G	G	A	G	N/A	A	G
Apr-23	G	G	G	G	A	G	G	A	A	G	G
May-23	G	G	G	G	G	G	G	G	G	G	G

A

SEPSIS	PHB ACU	PHB AMSS	PHB ED Majors	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7B	PHB 8A
Jun-21	G	G	G	G	G	G	G	G	R	G	G
Jul-21	G	A	G	G	G	R	G	R	G	G	A
Aug-21	R	G	G	G	R	G	R	G	A	G	G
Sep-21	G	A	G	G	G	R	G	A	G	G	G
Oct-21	G	G	G	G	R	A	G	G	G	G	G
Nov-21	R	R	G	G	A	N/A	A	G	G	G	R
Dec-21	G	G	G	G	R	R	G	G	R	G	G
Jan-22	G	R	G	G	A	G	G	G	G	G	A
Feb-22	G	G	G	G	A	G	R	R	R	G	G
Mar-22	R	R	G	G	G	A	G	G	R	G	G
Apr-22	G	R	G	G	A	R	G	G	G	G	G
May-22	G	G	G	G	A	A	G	G	A	R	G
Jun-22	G	G	G	G	R	R	G	G	G	G	G
Jul-22	G	G	G	G	A	A	R	G	G	G	G
Aug-22	G	R	G	G	G	R	G	R	CLOSED	G	A
Sep-22	G	R	G	G	G	R	G	G	R	G	R
Oct-22	G	R	G		G	A	G	R	G	G	G
Nov-22	G	G	G		G	R	G	G	R	R	G
Dec-22	A	G	G	G	G	R	G	R	R	A	R
Jan-23	G	G	G	G	G	R	G	A	G	G	A
Feb-23	G	A	G	G	G	G	N/A	G	G	G	A
Mar-23	G	G	G	G	G	G	G	A	G	G	A
Apr-23	R	R	G	G	A	R	G	G	G	R	R
May-23	R	A	G	G	R	G	G	G	G	G	G

Accreditation Progress Surgery - Wards:

= Divisional Monitoring
= Enhanced Monitoring
= Escalation Area

Weekly Spot Check	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB SA	PHB SB	PHB 7A	PHB 9A
Jun-21												
Jul-21	Green			Green					Red	Red		
Aug-21	Green	Amber	Amber	NC	NC	NC	NC	NC	Red	Amber		
Sep-21	Green	Red	Amber	Green	Red	Amber	No Return	No Return	Red	Green		Amber
Oct-21	Green	Amber	Green	Amber	Red	Green	No Submission	Red	Red	Green		Amber
Nov-21	Green	Red	Red	Red	Green	Red	Red	Red	Red	Green		Red
Dec-21	Green	Red	Amber	Green	Red	Green	Red	Green	Red	Red		Amber
Jan-22	Green	Red	Green	Green	Red	Amber	Red	Amber	Red	Amber		Amber
Feb-22	Green	Red	Green	Green	Amber	Amber	Red	Amber	Red	Amber		Red
Mar-22	Green	Amber	Green	Green	Amber	Green	Red	Green	Amber	Green		Red
Apr-22	Green	Red	Green	Green	Amber	Green	Red	Green	Red	Green		Red
May-22	Green	Amber	Green	Green	Amber	Green	Red	Amber	Amber	Green		Red
Jun-22	Green	Amber	Green	Green	Green	Red	Red	Green	Amber	Amber	Green	Red
Jul-22	Green	Red	Green	Green	Green	Green	Red	Red	Amber	Green	Green	Red
Aug-22	Green	Red	Green	Amber	Amber	Red	Red	Red	Red	Amber	Green	Amber
Sep-22	Green	Red	Green	Green	Green	Amber	Amber	Red	Amber	Green	Red	Green
Oct-22	Green	Red	Green	Amber	Green	Green	Red	Red	Red	Green	Red	Green
Nov-22	Green	Red	Green	Amber	Green	Red	Red	Red	Red	Green		Green
Dec-22	Green	Red	Green	Amber	Green	Green	Red	Amber	Red	Green	Red	Green
Jan-23	Green	Red	Amber	Red	Green	Red	Red	Red	Amber	Green	Red	Amber
Feb-23	Green	Red	Green	Red	Green	Green	Red	Red	Red	Green		Green
Mar-23	Green	Amber	Amber	Amber	Green	Red	Green	Amber	Amber	Green	Green	Amber
Apr-23	Green	Amber	Green	Green	Green	Amber	Red	Red	Green	Green	Green	Green
May-23	Green	Green	Amber	Green	Green	Green	Red	Amber	Amber	Green	Red	Red

Weekly Spot Check (Weekly)	GDH Surgical Unit				LCH Digby				LCH Greetwell				LCH Hatton				LCH SEAU				LCH Shuttleworth				LCH SAL				PHB Day Ward				PHB SA				PHB SB				PHB 7A				PHB 9A			
Jun-21	G	G	G	G	R	R	R	R	A	A	A	A	G	G	R	G	R	R	R	R	R	A	R	R	A	A	A	A	G	G	G	G	R	R	R	R	G	G	G	G					R	A	R	R
Jul-21	G	G	G	G	R	R	R	R	R	R	R	R	G	G	G	G	R	A	R	R	G	R	G	G	A	A	A	A	R	R	R	R	G	G	G	G	R	R	R	R					R	R	R	R
Aug-21	G	G	G	G	G	G	G	R	G	G	R	A	A	R	R	G	G	G	R	A	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R					R	A	R	A
Sep-21	G	K	G	G	R	R	R	K	A	K	G	G	G	G	G	G	R	A	R	G	A	G	G	R	R	R	R	R	R	R	R	R	R	R	R	R	G	G	G	G					A	A	G	R
Oct-21	G	G	G	G	R	G	G	R	G	R	R	G	R	G	R	A	G	R	A	R	G	R	G	R	R	R	R	R	R	R	R	R	G	R	R	R	R	R	R	R					A	G	G	R
Nov-21	G	G	R	G	G	R	R	R	R	R	K	A	R	R	R	R	A	R	R	R	G	G	G	A	R	R	R	R	G	G	G	R	G	G	G	R									G	R	A	G
Dec-21	G	G	G	G	G	R	R	R	A	A	A	G	G	G	G	R	R	R	R	R	G	O	G	A	R	R	R	R	G	R	G	C	R	R	R	R									A	G	R	R
Jan-22	G	G	G	G	R	A	R	R	G	A	G	G	G	G	R	G	G	R	R	R	A	R	G	G	A	R	G	G	R	R	R	R	G	R	G	G									G	G	R	G
Feb-22	G	G	G	G	G	R	R	A	R	G	G	G	G	G	G	G	G	A	R	A	G	R	A	G	R	R	R	R	G	G	G	G	R	R	R	A									R	R	R	A
Mar-22	G	G	G	G	A	G	G	R	G	O	G	R	G	G	G	G	A	R	A	R	G	R	G	A	R	R	R	R	G	G	G	C	R	A	A	A									R	R	R	R
Apr-22	G	G	G	G	R	G	G	G	A	G	G	G	A	G	G	G	A	A	A	G	G	R	G	G	R	R	R	R	G	R	G	G	R	R	G	R									R	R	R	R
May-22	G	G	R	G	G	R	G	R	A	G	G	G	G	G	G	G	G	A	R	A	G	R	G	G	R	R	R	R	G	G	G	G	R	R	G	R									R	R	R	R
Jun-22	G	G	G	G	A	A	A	A	G	G	G	R	G	G	G	G	G	G	G	G	G	R	A	G	R	R	R	R	G	G	R	G	A	G	A	A									G	R	R	R
Jul-22	G	G	G	G	R	G	R	R	G	G	G	G	G	G	G	G	G	G	G	G	G	R	G	G	R	R	R	R	R	G	G	R	A	A	A	A									G	A	G	G
Aug-22	G	G	G	G	G	R	R	R	R	G	G	G	G	G	G	A	A	R	G	A	G	G	G	G	R	O	R	R	G	G	G	R	A	R	A	R									A	G	G	G
Sep-22	G	G	G	G	R	R	R	G	R	G	G	R	G	G	R	G	G	G	G	R	A	G	G	A	G	R	R	R	R	R	R	G	A	A	R	A									G	R	R	R
Oct-22	G	G	G	G	R	R	R	G	R	G	G	G	A	A	G	A	A	G	G	G	G	G	R	G	R	R	R	R	R	R	R	G	R	A	R	A									R	R	R	R
Nov-22	G	G	G	R	O	A	G	R	A	G	G	O	G	G	A	A	G	G	G	R	R	R	A	G	R	R	R	R	R	R	G	G	R	A	R	A									R	R	R	R
Dec-22	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	A	G	G	G	A	G	G	G	R	R	R	R	R	R	R	R									R	R	R	R
Jan-23	A	A	G	G	G	A	R	G	G	G	A	R	G	G	G	A	A	G	G	G	A	R	G	G	A	A	G	G	A	R	G	G	G	A	R	A									A	R	A	R
Feb-23	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G									G	R	R	A
Mar-23	G	G	G	G	A	A	A	A	G	A	G	A	A	G	G	A	A	G	G	G	A	G	G	G	A	R	A	G	R	G	G	G	G	A	A	A									G	G	G	A
Apr-23	G	G	G	G	A	A	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	A	G	G	R	G	G	G	G	G	G	G	G									G	G	G	A
May-23	G	G	G	G	G	G	G	G	G	G	G	G	G	R	G	A	G	G	A	G	G	G	G	R	G	G	G	G	A	G	R	G	R	G	R	G									R	G	R	A

Count of GREENS	49	25	40	37	44	30	20	28	19	42	21	23

Matron Audit	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB SA	PHB SB	PHB 7A	PHB 9A
Jun-21	Green	Red	Amber	Green	Green	Red	Green	Green	Amber	Red		Amber
Jul-21	Amber	Red	Red	Amber	Amber	Amber	Green	Green	Red	Amber		Red
Aug-21	Amber	Amber	Amber	Amber	Amber	Red	Amber	Amber	Red	Amber		Amber
Sep-21	Green	Red	Amber	Amber	Amber	Amber	Amber	Green	Red	Green		Red
Oct-21	Green	Red	Amber	Amber	Amber	Amber	Amber	Green	Amber	Green		Red
Nov-21	Green	Red	Red	Amber	Amber	Red	Amber	Amber	Amber	Amber		Red
Dec-21	Green	Amber	Red	Amber	Amber	Amber	Amber	Green	Red	Amber		Amber
Jan-22	Amber	Red	Amber	Amber	Amber	Red	Amber	Amber	Amber	Green		Red
Feb-22	Green	Amber	Amber	Amber	Amber	Red	Amber	Green	Red	Amber		Amber
Mar-22	Green	Amber	Green	Green	Green	Green	Amber	Green	Green	Green		Amber
Apr-22	Amber	Amber	Amber	Green	Green	Amber	Amber	Green	Amber	Amber	Amber	Green
May-22	Green	Amber	Green	Green	Green	Amber	Green	Amber	Green	Green	Green	Amber
Jun-22	Green	Green	Amber	Green	Green	Green	Amber	Amber	Green	Green	Green	Amber
Jul-22	Amber	Amber	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Aug-22	Green	Amber	Green	Red	Amber	Green	Green	Green	Green	Amber	Green	Amber
Sep-22	Green	Red	Green	Amber	Amber	Green	Green	Green	Green	Amber	Amber	Amber
Oct-22	Green	Amber	Amber	Red	Red	Green	Amber	Amber	Amber	Amber	None	Green
Nov-22	Green	Amber	Amber	Red	Amber	Green	Amber	Amber	Green	Amber	Amber	Amber
Dec-22	Green	Red	Red	Red	Amber	Green	Amber	Green	Red	Amber	Amber	Amber
Jan-23	Green	Red	Amber	Red	Green	Green	Green	Amber	Amber	Amber	Amber	Green
Feb-23	Green	Amber	Green	Amber	Green	Green	Amber	Green	Amber	Green		Amber
Mar-23	Green	Red	Green	Red	Green	Amber	Green	Green	Amber	Amber	Green	Amber
Apr-23	Green	Green	Amber	Amber	Amber	Green	Amber	Green	Amber	Amber	Green	Amber
May-23	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green

Ward/Dept. Review Visit	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB SA	PHB SB	PHB 7A	PHB 9A
Jun-21	Green				Amber							
Jul-21												
Aug-21												
Sep-21												
Oct-21										Amber		
Nov-21							Amber	Amber				
Dec-21				Amber								
Jan-22												
Feb-22			Amber									
Mar-22												
Apr-22												
May-22												
Jun-22					Green							
Jul-22												
Aug-22												
Sep-22												
Oct-22			Amber									
Nov-22						Amber	Amber		Green			
Dec-22												
Jan-23								Amber				
Feb-23												
Mar-23	Green											
Apr-23												
May-23												

Harm Free Certificate	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB SA	PHB SB	PHB 7A	PHB 9A
Apr-21		S - Skin IPC	B - Falls	S - Skin S - Falls	S - Skin	B- Skin IPC	B- Falls IPC					IPC
May-21			B - Skin	G -Falls	G - Skin		S - Falls		B - Skin			
Jun-21				G - Skin			G - Falls			B - Falls		
Jul-21				B - Falls								
Aug-21		B - Skin	B - Skin									
Sep-21	B - Falls	S - Skin	B - Skin		B - Skin	B - Falls		S - Falls				
Oct-21		B - Skin		B - Skin B - Falls	S - Skin		B - Falls		B - Skin			B - Skin
Nov-21	B - Falls				G - Skin B - Falls	B - Skin						S - Skin
Dec-21		B - Falls	S - Skin	B - Falls			B - Falls			B - Skin		
Jan-22	B - Falls			B - Falls			S - Falls S - Skin	B - Falls	B - Skin			
Feb-22	S - Falls					B - Skin	G - Skin					
Mar-22	G - Falls	B - Skin	B - Skin	B - Skin						B - Skin		
Apr-22		IPC	S - Skin IPC		B - Falls B - Skin	IPC			B - Skin IPC			
May-22	R - Falls				S - Skin		B&S - Skin	B - Falls			B - Falls	
Jun-22			B - Skin	B - Skin	G - Skin				B - Skin			
Jul-22	B - Skin		S - Skin	B - Skin			G - Skin	B - Falls			B - Falls	
Aug-22	S - Falls		B - Falls		R - Skin	B - Skin	G - Falls					
Sep-22		S - Falls	B - Falls	B - Falls			B - Falls				B - Falls	
Oct-22		B - Skin					S - Falls					
Nov-22	B - Skin		S - Skin		B - Skin		B - Skin		B - Falls			
Dec-22		R - Falls					S - Skin					
Jan-23		B - Skin	B - Skin	B - Falls			G - Skin					
Feb-23	B - Falls S - Skin		B - Falls S - Skin	B - Skin				B - Falls				
Mar-23	S - Falls G - Skin		B - Falls G - Skin	S - Skin			R - Skin					
Apr-23	B - Skin						B - Falls		B - Falls			
May-23	G - Falls B - Skin		B - Skin	S - Falls	B - Skin			B - Skin	B - Falls B - Skin			

FLO	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB SA	PHB SB	PHB 7A	PHB 9A
Apr-21	G	A	G	G	G	G	R	R	A	G		A
May-21	G	G	G	R	G	G	R	G	R	G		A
Jun-21	G	R	A	G	A	G	G	G	G	G		A
Jul-21	R	G	G	G	R	G	R	G	A	R		R
Aug-21	G	G	G	G	A	G	R	R	A	G		G
Sep-21	G	G	G	G	A	G	G	R	G	G		G
Oct-21	G	G	G	R	G	G	G	G	A	G		G
Nov-21	G	G	G	G	G	G	G	G	A	G		G
Dec-21	G	R	G	G	G	R	G	G	A	G		G
Jan-22	G	G	G	G	G	R	G	A	A	G		A
Feb-22	G	G	G	G	G	G	G	G	G	G		G
Mar-22	G	G	G	G	G	G	G	G	A	G		A
Apr-22	G	G	G	G	G	G	G	G	A	G	N/A	G
May-22	G	G	G	G	G	A	G	G	G	G	G	G
Jun-22	G	G	G	G	G	G	G	G	A	A		G
Jul-22	G	G	G	G	G	G	G	G	A	G	A	G
Aug-22	G	G	G	G	G	G	G	G	G	A	B	G
Sep-22	G	A	G	G	G	G	G	G	G	G	N/A	G
Oct-22	G	G	G	G	G	G	G	G	G	G	N/A	G
Nov-22	G	G	G	A	G	A	G	G	G	G	N/A	G
Dec-22	G	G	G	G	G	A	G	G	A	G	N/A	G
Jan-23	G	G	G	A	G	A	G	N/A	R	G	G	G
Feb-23	G	G	G	G	G	N/A	G	G	G	G	G	G
Mar-23	G	A	G	G	G	A	G	G	G	G	G	G

Apr-23	G	G	G	G	G	A	G	G	G	G	G	G
May-23	G	G	G	G	G	G	G	G	A	A	G	G

SEPSIS	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB 5A	PHB 5B	PHB 7A	PHB 9A
Jun-21	G	G	G	G	G	G	G	N/A	G	A		G
Jul-21	N/A	G	G	G	A	G	R	N/A	G	G		A
Aug-21	G	G	G	G	G	A	G	N/A	A	R		R
Sep-21	N/A	G	G	A	R	G	G	R	G	G		G
Oct-21	G	G	A	R	G	G	N/A	R	G	G		R
Nov-21	G	G	G	G	R	G	G	A	G	G		G
Dec-21	A	R	G	G	G	A	N/A	G	A	G		G
Jan-22	R	G	G	G	R	G	R	G	G	G	G	G
Feb-22	R	R	G	A	G	A	N/A	A	G	G	G	R
Mar-22	G	R	G	G	G	G	N/A	R	G	G	G	A
Apr-22	G	G	G	G	G	G	R	N/A	G	G	G	A
May-22	G	G	G	G	G	A	G	G	A	G	G	G
Jun-22	G	G	G	G	A	G	N/A	G	A	G	G	A
Jul-22	G	R	G	G	G	A	G	N/A	G	G	G	G
Aug-22	G	R	G	R	G	G	R	N/A	A	G	G	G
Sep-22	G	G	G	G	G	G	R	G	G	G	G	G
Oct-22	G	G	G	G	G	G	G	A	G	A	N/A	G
Nov-22	G	G	G	A	G	G	G	G	G	G	N/A	A
Dec-22	G	G	G	R	A	G	R	G	A	G	G	G
Jan-23	G	G	G	G	G	R	G	G	G	G	R	G
Feb-23	G	G	G	G	A	G	G	N/A	G	G	N/A	A
Mar-23	G	G	G	G	A	G	N/A	G	A	G	R	A
Apr-23	N/A	G	G	G	G	G	R	G	G	G	G	G
May-23	G	G	G	G	A	G	G	G	G	G	N/A	A

Accreditation Progress: Surgery Theatres & ICU

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check (Monthly)	CHL Theatres	GDH Theatres	LCH Theatres	PHB Theatres	LCH ICU	PHB ICU
Apr-21	Red	Green	Amber		Red	Amber
May-21	Red	Green	Red		Red	Green
Jun-21	Red	Green	Red		Red	Amber
Jul-21	Red	Green	Amber		Amber	Amber
Aug-21	Red	Red	Red	Red	Red	Red
Sep-21	N/C	N/C	N/C	N/C	Red	N/C
Oct-21	N/C	N/C	N/C	N/C	Red	N/C
Nov-21	Red	Green	Red	Red	Red	Red
Dec-21	Red	Green	Red	Red	Amber	Red
Jan-22	Red	Green	Red	Green	Green	Red
Feb-22	Green	Green	Red	Green	Amber	Red
Mar-22	Red	Green	Amber	Green	Amber	Amber
Apr-22	Amber	Amber	Amber	Green	Amber	Green
May-22	Amber	Red	Green	Green	Amber	Red
Jun-22	Green	Red	Red	Green	Amber	Amber
Jul-22	Red	Green	Red	Green	Amber	Green
Aug-22	Green	Green	Red	Amber	Red	Amber
Sep-22	Green	Green	Red	Green	Red	Amber
Oct-22	Green	Green	Amber	Green	Red	Green
Nov-22	Green	Red	Green	Green	Green	Red
Dec-22	Red	Red	Red	Green	Green	Red
Jan-23	Green	Red	Red	Green	Green	Red
Feb-23	Red	Red	Red	Green	Green	Green
Mar-23	Red	Red	Red	Green	Green	Red
Apr-23	Green	Red	Green	Green	Green	Green
May-23	Green	Red	Red	Red	Amber	Green

Weekly Spot Check (Weekly)	CHL Theatres					GDH Theatres					LCH Theatres					PHB Theatres					LCH ICU					PHB ICU				
Apr-21	R	R	R	R		G	G	G	G		A	A	A	A							R	R	R	R		A	A	A	A	
May-21	R	R	R	R	R	G	G	G	G	G	R	R	R	R	R						R	R	R	R	R	G	G	G	G	G
Jun-21	R	R	R	R		G	G	G	G		R	R	R	R							R	R	R	R		A	A	A	A	
Jul-21	R	R	R	R		G	G	G	G		A	A	A	A							A	A	A	A		A	A	A	A	
Aug-21	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Sep-21	R	R	R	R		R	R	R	R		R	R	R	R		R	R	R	R		R	R	R	R		R	R	R	R	
Oct-21	R	R	R	R		R	R	R	R		R	R	R	R		R	R	R	R		R	R	R	R		R	R	R	R	
Nov-21	R	R	R	R	R	R	G	G	G	G	R	R	R	R	R	R	R	G	G	G	R	R	R	A	R	R	R	G	R	R
Dec-21	R	G	R	R		G	G	G	R		G	R	R	R		R	R	R	G		A	A	R	A		R	R	G		
Jan-22	R	R	R	R	G	G	G	G	G	G	R	R	R	G	G	G	G	G	G	G	A	G	G	G	G	R	R	R	R	G
Feb-22	R	G	G	G		G	G	G	R		R	G	R	R		G	G	G	R		G	A	G	A		R	R	R	R	
Mar-22	R	G	R	R		R	G	G	G		R	G	G	R		G	G	G	R		R	A	G	A		A	R	G	A	
Apr-22	R	G	G	R		G	R	R	G		G	R	G	R		G	G	G	G		A	A	G	R		G	G	A	G	
May-22	G	R	G	G	R	G	R	G	R	R	G	G	G	G	R	G	G	G	G	G	G	A	G	G	R	G	R	R	R	R
Jun-22	G	G	G	R		R	G	R	R		G	R	G	R		G	G	G	G		A	G	G	R		R	A	G	G	
Jul-22	R	R	G	R		G	R	G	G		R	G	G	R		G	G	R	G		G	A	G	R		G	G	G	R	
Aug-22	G	G	G	G	G	G	G	G	R	G	G	G	R	R	R	R	R	G	G	G	G	A	A	A	R	R	G	G	R	G
Sep-22	R	G	G	G		G	G	G	G		R	G	R	R		G	G	G	G		A	R	R	A		G	R	R	G	
Oct-22	G	G	G	G	G	G	G	G	G	G	G	G	R	G	R	G	R	G	G	G	R	R	G	A	G	G	G	A	G	G
Nov-22	G	G	G	G		G	R	G	R		G	G	G	R		R	G	G	G		A	G	G	G		G	G	A	R	
Dec-22	R	R	R	R		R	G	R	R		G	G	R	R		G	G	G	G		R	G	G	G		R	G	G	R	
Jan-23	G	G	G	G	G	R	R	R	G	R	G	G	R	G	R	G	G	G	G	G	A	G	G	G	G	R	R	G	A	G
Feb-23	R	G	G	R		G	R	R	G		G	R	G	R		G	G	G	G		G	G	R	G		R	G	G	G	
Mar-23	R	G	R	G		G	R	R	R		R	G	G	R		G	G	G	G		G	G	G	R		A	R	R	G	
Apr-23	G	G	G	G		R	R	G	R		G	R	G	G		R	G	G	R		G	A	G	G		G	G	A	G	
May-23	G	R	G	G	G	R	R	G	R	R	R	G	G	R	R	R	R	G	G	G	G	G	G	A	A	G	G	R	G	G

Count of GREENS	38	26	27	44	29	31

Matron Audit	CHL Theatres	GDH Theatres	LCH Theatres	PHB Theatres	LCH ICU	PHB ICU
Apr-21	Green	Green	Amber	Green	Red	Amber
May-21	Green	Green	Amber	Green	Red	Green
Jun-21	Red	Green	Green	Amber	Red	Amber
Jul-21	Amber	Green	Amber	Red	Amber	Amber
Aug-21	Green	Green	Amber	Green	Red	Amber
Sep-21	Green	Green	Amber	Green	Red	Amber
Oct-21	Green	Green	Green	Amber	Red	Green
Nov-21	Green	Green	Green	Green	Amber	Green
Dec-21	Green	Green	Green	Green	Amber	Green
Jan-22	Green	Green	Green	Green	Amber	Green
Feb-22	Green	Green	Amber	Amber	Amber	Amber
Mar-22	Green	Green	Green	Green	Amber	Green
Apr-22	Green	Green	Green	Green	Green	Green
May-22	Green	Green	Amber	Amber	Green	Green
Jun-22	Green	Green	Green	Green	Green	Green
Jul-22	Green	Green	Green	Green	Green	Green
Aug-22	Green	Green	Green	Green	Green	Green
Sep-22	Green	Green	Green	Amber	Green	Green
Oct-22	Green	Green	Green	Green	Amber	Amber
Nov-22	Green	Green	Green	Green	Green	Amber
Dec-22	Green	Green	Green	Green	Amber	Amber
Jan-23	Green	Green	Green	Green	Amber	Green
Feb-23	Green	Green	Green	Green	Amber	Green
Mar-23	Green	Green	Green	Green	Green	Green
Apr-23	Green	Green	Green	Green	Amber	Green
May-23	Green	Green	Green	Green	Green	Green

Ward/Dept. Review Visit	CHL Theatres	GDH Theatres	LCH Theatres	PHB Theatres	LCH ICU	PHB ICU
Apr-21						
May-21						
Jun-21						
Jul-21						
Aug-21						
Sep-21						
Oct-21						
Nov-21						
Dec-21						
Jan-22						
Feb-22						
Mar-22						
Apr-22						
May-22		Green				
Jun-22			Green			
Jul-22						
Aug-22						
Sep-22						
Oct-22				Green		
Nov-22						
Dec-22						
Jan-23						
Feb-23						
Mar-23						
Apr-23						
May-23		Green				

Harm Free Certificate	CHL Theatres	GDH Theatres	LCH Theatres	PHB Theatres	LCH ICU	PHB ICU
Apr-21						IPC
May-21						
Jun-21						
Jul-21						
Aug-21						
Sep-21						B - Falls
Oct-21						S - Falls
Nov-21						G - Falls
Dec-21					1 Yr - Falls	
Jan-22						
Feb-22					B - Skin	
Mar-22						
Apr-22						B - Falls
May-22						
Jun-22						
Jul-22						B - Skin
Aug-22					B - Falls	B - Falls
Sep-22					S - Falls	S - Falls
Oct-22						G - Falls
Nov-22						
Dec-22					R - Falls	R - Falls
Jan-23						
Feb-23			B - Skin			
Mar-23	B - Skin		S - Skin			
Apr-23	S - Skin			E - Skin		
May-23		E - Skin			B - Skin	

FLO	CHL Theatres	GDH Theatres	LCH Theatres	PHB Theatres	LCH ICU	PHB ICU
Jun-21	R	G	R	R	G	G
Jul-21	R	G	G	G	G	G
Aug-21	R	A	R	R	G	G
Sep-21	R	G	G	R	G	G
Oct-21	G	G	G	G	G	G
Nov-21	G	G	G	G	G	G
Dec-21	G	G	G	G	G	G
Jan-22	G	G	G	R	R	G
Feb-22	G	G	R	G	G	G
Mar-22	G	G	G	G	G	G
Apr-22	G	G	G	R	G	G
May-22	G	G	G	G	G	G
Jun-22	G	G	G	G	G	G
Jul-22	G	G	G	G	G	G
Aug-22	G	G	G	G	G	G
Sep-22	G	G	G	G	G	G
Oct-22	G	G	G	N/A	G	G
Nov-22	G	N/A	G	G	G	G
Dec-22	G	G	G	G	G	G
Jan-23	G	G	G	G	G	G
Feb-23	G	N/A	G	G	G	G
Mar-23	G	G	G	G	G	G
Apr-23	G	G	G	G	G	G
May-23	G	G	G	G	G	G

Accreditation Progress: Family Health Wards

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check [Monthly]	LCH Bardney [L4535]	LCH Branston [L4635]	LCH Nettleham [L4536]	PHB Labour Ward [P4535]	PHB 1B [P4635]	PHB M1 Maternity [P4536]
Sep-21	Red	Red	Red	Red	Red	Red
Oct-21	Red	Red	Red	Red	Green	Amber
Nov-21	Red	Red	Red	Red	Amber	Amber
Dec-21	Red	Red	Green	Amber	Red	Green
Jan-22	Red	Amber	Green	Amber	Red	Green
Feb-22	Red	Red	Green	Green	Red	Green
Mar-22	Amber	Amber	Green	Amber	Green	Amber
Apr-22	Amber	Amber	Amber	Amber	Amber	Amber
May-22	Amber	Red	Amber	Amber	Red	Amber
Jun-22	Green	Red	Red	Green	Red	Green
Jul-22	Green	Green	Red	Red	Red	Green
Aug-22	Amber	Amber	Green	Amber	Red	Green
Sep-22	Red	Amber	Red	Red	Amber	Green
Oct-22	Red	Amber	Red	Amber	Green	Green
Nov-22	Green	Green	Green	Green	Red	Green
Dec-22	Red	Green	Red	Red	Red	Green
Jan-23	Green	Green	Red	Green	Green	Green
Feb-23	Green	Green	Green	Red	Green	Green
Mar-23	Red	Green	Red	Green	Green	Green
Mar-23	Red	Green	Red	Green	Green	Green
Mar-23	Green	Green	Red	Red	Green	Amber

Weekly Spot Check (Weekly)	LCH Bardney [L4535]					LCH Branston [L4635]					LCH Nettleham [L4536]					PHB Labour Ward [P4535]					PHB 1B [P4635]					PHB M1 Maternity [P4536]				
Sep-21	R	R	R	R		R	R	R	A		R	R	R	G		R	R	R	R		A	R	G	R		R	R	R	R	
Oct-21	R	R	R	R		A	R	R	G		R	R	A	R		R	R	R	G		R	G	G	G		G	R	G	R	
Nov-21	R	R	R	R	R	R	A	R	R	R	R	R	G	R	G	R	G	R	R	G	G	R	G	R	G	G	G	R	R	G
Dec-21	R	R	R	R		R	R	A	R		G	G	G	G		G	R	G	R		R	R	G	R		G	G	G	G	
Jan-22	R	R	R	R	G	G	A	R	A	A	R	G	G	G	G	R	G	G	G	A	R	R	R	G	R	G	G	G	R	G
Feb-22	R	R	R	G		A	R	A	R		G	R	G	G		G	G	G	R		R	R	R	R		G	G	G	G	
Mar-22	G	R	G	R		R	G	A	G		G	G	G	R		R	R	G	G		G	G	R	G		G	G	G	G	
Apr-22	R	R	R	R		A	G	G	R		R	R	R	R		R	A	G	R		G	G	G	R		R	G	G	G	
May-22	G	R	G	R	G	R	A	A	A	R	R	R	R	A	G	G	G	R	G	G	R	R	R	R	G	G	G	G	G	G
Jun-22	G	G	G	G		R	A	R	G		R	G	R	G		G	G	R	G		R	G	G	R		G	G	G	G	
Jul-22	G	G	G	R		G	G	G	G		G	G	R	R		R	G	R	R		G	R	G	R		G	G	G	G	
Aug-22	G	G	R	G	G	G	G	G	A	A	G	R	G	G	G	R	G	G	G	R	G	R	R	R	G	G	G	G	G	G
Sep-22	R	R	R	R		G	G	R	R		R	R	R	G		G	R	R	R		R	G	G	G		G	G	G	G	
Oct-22	G	R	R	R	R	R	R	G	G	G	R	R	R	G	R	R	G	G	G	R	G	G	G	G	G	G	G	G	G	G
Nov-22	R	G	G	G		G	G	G	G		G	G	G	G		G	G	G	G		A	R	G	A		G	G	G	G	
Dec-22	R	G	R	G		G	G	G	A		R	R	R	G		R	R	R	R		G	R	G	A		G	G	G	G	
Jan-23	G	G	R	G	G	G	G	A	G	R	R	R	R	R	G	R	G	G	G	G	G	G	G	G	G	G	G	G	G	G
Feb-23	G	G	R	G		G	G	G	G		A	G	G	G		R	G	R	R		G	R	G	G		G	G	G	R	
Mar-23	G	G	R	R		G	G	G	G		G	R	R	R		G	R	G	G		G	G	G	R		G	R	G	G	
Mar-23	G	R	R	G		G	G	G	G		R	R	R	A		G	G	G	R		G	G	G	G		G	G	G	G	
Mar-23	G	G	G	R	G	G	G	G	A	G	R	R	R	R	A	G	G	R	R	R	G	G	G	G	G	A	G	R	G	G

Matron Audit	LCH Bardney [L4535]	LCH Branston [L4635]	LCH Nettleham [L4536]	PHB Labour Ward [P4535]	PHB 1B [P4635]	PHB M1 Maternity [P4536]
Sep-21	Green	Red	Red	Green	Red	Green
Oct-21	Amber	Red	Green	Green	Amber	Green
Nov-21	Green	Red	Green	Amber	Red	Green
Dec-21	Green	Amber	Amber	Red	Amber	Red
Jan-22	Amber	Red	Amber	Amber	Red	Green
Feb-22	Green	Amber	Amber	Green	Amber	Green
Mar-22	Amber	Red	Green	Green	Red	Green
Apr-22	Amber	Amber	Amber	Amber	Amber	Amber
May-22	Amber	Red	Amber	Amber	Red	Amber
Jun-22	Amber	Green	Amber	Green	Amber	Green
Jul-22	Amber	Green	Green	Green	Amber	Green
Aug-22	Amber	Green	Green	Green	Amber	Amber
Sep-22	Amber	Amber	Amber	Amber	Green	Green
Oct-22	Amber	Amber	Green	Green	Amber	Green
Nov-22	Amber	Amber	Amber	Green	Amber	Green
Dec-22	Red	Amber	Red	Green	Green	Green
Jan-23	Amber	Green	Amber	Green	Amber	Green
Feb-23	Green	Green	Red	Green	Green	Green
Mar-23	Amber	Green	Amber	Green	Green	Green
Apr-23	Red	Red	Red	Green	Red	Green
May-23	Amber	Green	Green	Green	Green	Amber

Count of GREENS						
	32	39	21	29	37	48

Ward/Dept. Review Visit	LCH Bardney [L4535]	LCH Branston [L4635]	LCH Nettleham [L4536]	PHB Labour Ward [P4535]	PHB 1B [P4635]	PHB M1 Maternity [P4536]
Sep-21						
Oct-21						
Nov-21						
Dec-21						
Jan-22						
Feb-22						
Mar-22						
Apr-22						
May-22						
Jun-22						
Jul-22						
Aug-22						
Sep-22						Green
Oct-22				Green		
Nov-22						
Dec-22						
Jan-23						
Feb-23						
Mar-23						
Apr-23		Green				
May-23					Green	

Harm Free Certificate	LCH Bardney [L4535]	LCH Branston [L4635]	LCH Nettleham [L4536]	PHB Labour Ward [P4535]	PHB 1B [P4635]	PHB M1 Maternity [P4536]
Sep-21			B - Falls			
Oct-21		B - Falls	S - Falls		B - Falls	
Nov-21		S - Falls	G - Falls		G - Falls	
Dec-21		B - Falls				
Jan-22		B - Falls			B - Falls B - Skin	
Feb-22		S - Falls			B - Falls S - Skin	
Mar-22	B- Falls				S - Falls	
Apr-22	S - Falls IPC	S - Falls IPC B - Skin	IPC		IPC	IPC
May-22		S - Skin				
Jun-22		G - Skin			B - Skin	
Jul-22	Ruby - Falls	S- Falls	B - Falls		B - Falls S - Skin	
Aug-22		R - Skin	B - Falls		B - Falls	
Sep-22			S - Falls		S - Falls	
Oct-22	Saph - Falls	B - Falls	S - Falls			
Nov-22			G - Falls	B - Falls B - Skin	B - Falls	
Dec-22		B - Falls B - Skin		S -Falls Sapphire - Skin	B - Falls	
Jan-23		S - Skin	Sapphire - Skin R - Falls	G - Falls	B - Skin	
Feb-23		B - Falls	B - Falls			
Mar-23		S - Falls G - Skin	B - Skin	R - Falls B - Skin	B - Falls	
Apr-23				S - Skin	S - Falls	E - Skin
May-23		B - Falls R - Skin	B - Falls G - Skin		B - Falls B - Skin	

FLO	LCH Bardney [L4535]	LCH Branston [L4635]	LCH Nettleham [L4536]	PHB Labour Ward [P4535]	PHB 1B [P4635]	PHB M1 Maternity [P4536]
Sep-21	G	G	G	G	G	G
Oct-21	G	A	G	G	G	G
Nov-21	G	A	G	G	R	G
Dec-21	G	G	G	G	G	G
Jan-22	G	A	G	G	G	G
Feb-22	G	A	G	G	G	G
Mar-22	G	R	G	G	R	G
Apr-22	G	G	G	G	G	G
May-22	G	A	R	G	G	G
Jun-22	G	G	G	G	G	G
Jul-22	G	G	G	G	N/A	G
Aug-22	G	G	G	G	G	G
Sep-22	G	G	G	G	G	G
Oct-22	G	G	G	G	G	G
Nov-22	G	G	G	G	G	G
Dec-22	G	G	G	G	G	G
Jan-23	G	A	G	G	G	G
Feb-23	G	G	G	G	G	G
Mar-23	G	G	G	G	G	G
Apr-23	G	G	G	G	G	N/A
May-23	G	G	G	G	G	G

SEPSIS	LCH Bardney [L4535]	LCH Branston [L4635]	LCH Nettleham [L4536]	PHB Labour Ward [P4535]	PHB 1B [P4635]	PHB M1 Maternity [P4536]
Sep-21	A	N/A	G	G	N/A	G
Oct-21	G	G	G	A	G	R
Nov-21	G	G	R	G	A	A
Dec-21	G	R	G	A	R	R
Jan-22	A	G	G	G	G	G
Feb-22	G	R	A	G	N/A	G
Mar-22	A	G	R	G	R	A
Apr-22	G	N/A	R	A	G	G
May-22	G	G	G	G	N/A	G
Jun-22	A	N/A	G	G	G	G
Jul-22	R	R	G	G	R	G
Aug-22	R	G	A	G	R	G
Sep-22	R	G	G	G	G	A
Oct-22	A	G	G	G	R	R
Nov-22	G	N/A	G	G	R	G
Dec-22	R	R	G	A	G	A
Jan-23	A	G	G	G	R	R
Feb-23	G	G	G	G	G	G
Mar-23	A	N/A	R	A	N/A	A
Apr-23	G	G	G	A	G	R
May-23	A	N/A	G	G	G	G

Accreditation Progress: FH CYP & NNU

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check [Monthly]	GDH Kingfisher [UG4737]	LCH Clinic 5 [UL4720]	LCH Rainforest [UL4735]	LCH Safari [UL4734]	PHB 4A [UP4736]	LCH NNU [UL4736]	PHB NNU [UP4735]
Jun-21			Amber	Amber	Red	Amber	Green
Jul-21			Red	Red	Red	Amber	Amber
Aug-21			Red	Red	Red	Green	Green
Sep-21			N/C	N/C	N/C	Green	Green
Oct-21			N/C	N/C	N/C	Green	Green
Nov-21			Red	Red	Red	Green	Green
Dec-21			Red	Red	Red	Amber	Green
Jan-22			Red	Red	Red	Green	Green
Feb-22			Red	Red	Red	Green	Green
Mar-22			Red	Red	Red	Green	Green
Apr-22			Red	Red	Red	Amber	Green
May-22			Red	Red	Red	Amber	Green
Jun-22			Red	Red	Red	Green	Green
Jul-22			Red	Red	Red	Green	Green
Aug-22			Red	Red	Red	Amber	Green
Sep-22			Red	Red	Red	Green	Green
Oct-22			Red	Amber	Red	Green	Red
Nov-22			Green	Green	Red	Amber	Green
Dec-22			Amber	Green	Red	Green	Green
Jan-23			Red	Red	Red	Amber	Green
Feb-23			Amber	Green	Red	Amber	Green
Mar-23			Green	Green	Red	Amber	Green
Apr-23			Green	Green	Red	Amber	Green
May-23			Amber	Green	Red	Amber	Green

Weekly Spot Check (Weekly)	GDH Kingfisher [UG4737]					LCH Clinic 5 [UL4720]					LCH Rainforest [UL4735]					LCH Safari [UL4734]					PHB 4A [UP4736]					LCH NNU [UL4736]					PHB NNU [UP4735]				
Jun-21											A	A	A	A		A	A	A	A		R	R	R	R		A	A	A	A		G	G	G	G	
Jul-21											R	R	R	R		R	R	R	R		R	R	R	R		A	A	A	A		A	A	A	A	
Aug-21											G	A	R	R	R	G	A	R	R	R	R	R	R	R	R	R	G	G	G	G	A	A	G	G	G
Sep-21											R	R	R	R		R	R	R	R		R	R	R	R		G	G	G	G		G	G	G	G	
Oct-21											R	R	R	R		R	R	R	R		R	R	R	R		G	G	A	A		G	G	G	G	
Nov-21											A	R	R	A	R	A	R	R	R	R	R	R	R	R	R	G	G	G	G	A	G	R	G	A	G
Dec-21											A	A	R	R		R	R	R	R		R	R	A	R		R	A	G	G		G	G	G	A	
Jan-22											A	R	A	R	R	R	R	R	R	R	R	R	R	R	R	G	G	G	G	G	G	G	G	G	G
Feb-22											R	R	R	R		R	R	R	R		R	R	R	R		A	G	A	G		R	G	G	G	
Mar-22											R	R	A	R		R	R	R	R		R	R	R	A		G	G	A	G		G	G	G	G	
Apr-22											R	R	R	R		R	R	R	R		A	R	R	A		G	A	A	G		G	G	G	G	
May-22											R	R	A	R	A	R	R	R	R	R	R	A	R	R	A	A	A	A	A	G	G	G	G	G	G
Jun-22											R	G	R	R		R	R	R	R		R	R	R	A		G	G	A	G		G	G	G	G	
Jul-22											R	R	R	R		R	R	R	R		R	A	R	R		G	G	G	A		G	G	G	G	
Aug-22											R	R	R	R	R	R	R	R	R	R	R	R	R	R	A	A	A	G	A	G	G	G	G	G	G
Sep-22											R	R	R	R		R	R	R	R		R	G	R	R		G	G	G	G		G	G	G	G	
Oct-22											R	R	R	G	G	R	G	R	G	G	R	R	R	A	R	A	G	G	G	G	A	G	G	A	R
Nov-22											G	G	R	G		G	G	R	G		R	R	R	R		G	G	A	A		G	A	G	G	
Dec-22											A	A	G	R		G	G	G	G		R	R	R	R		A	G	G	G		G	G	G	G	
Jan-23											G	R	G	G	R	R	R	G	R	G	R	R	R	R	R	A	G	A	G	G	G	G	G	G	G
Feb-23											A	G	A	G		R	G	G	G		R	R	R	R		G	A	G	A		G	G	G	G	
Mar-23											G	G	G	R		G	G	G	R		R	R	R	R		A	A	G	G		G	G	A	G	
Apr-23											G	G	G	G		G	G	G	G		R	R	R	R		G	A	R	G		G	G	G	G	
May-23											G	G	G	R	A	G	G	G	G	G	R	R	R	R	R	G	A	A	A	G	G	G	G	G	A

Matron Audit	GDH Kingfisher [UG4737]	LCH Clinic 5 [UL4720]	LCH Rainforest [UL4735]	LCH Safari [UL4734]	PHB 4A [UP4736]	LCH NNU [UL4736]	PHB NNU [UP4735]
Jun-21	Amber		Amber	Amber	Amber	Amber	Green
Jul-21	Red		Red	Red	Red	Amber	Amber
Aug-21	Green		Red	Red	Red	Amber	Amber
Sep-21	Green		Red	Amber	Amber	Amber	Green
Oct-21	Green	Green	Red	Red	Red	Amber	Amber
Nov-21	Green		Red	Red	Amber	Green	Amber
Dec-21	Red		Red	Red	Red	Amber	Amber
Jan-22	Red		Red	Red	Red	Amber	Amber
Feb-22	Green		Red	Red	Red	Green	Amber
Mar-22	Green		Red	Amber	Red	Green	Green
Apr-22	Green	Green	Red	Red	Amber	Green	Green
May-22	Green		Red	Red	Amber	Amber	Green
Jun-22	Green		Amber	Amber	Amber	Green	Green
Jul-22	Amber		Red	No submission	Red	Amber	Green
Aug-22	Red		Red	Red	Red	Green	Green
Sep-22	Red		Red	Red	Red	Green	Green
Oct-22	Amber		Red	Red	Red	Amber	Green
Nov-22	Red		Red	Red	Red	Green	Green
Dec-22	Red		Red	Red	Amber	Amber	Green
Jan-23	Red		Red	Red	Red	Green	Green
Feb-23	Red		Red	Red	Red	Green	Green
Mar-23	Amber		Red	Red	Red	Amber	Green
Apr-23	Amber		Amber	Red	Red	Amber	Green
May-23	Red		Red	Green	Red	Amber	Green

Count of GREENS							
	0	0	22	27	1	32	45	0

Ward/Dept Review Visit	GDH Kingfisher [UG4737]	LCH Clinic 5 [UL4720]	LCH Rainforest [UL4735]	LCH Safari [UL4734]	PHB 4A [UP4736]	LCH NNU [UL4736]	PHB NNU [UP4735]
Jun-21							
Jul-21							
Aug-21							
Sep-21							
Oct-21							
Nov-21							
Dec-21							
Jan-22							
Feb-22							
Mar-22							
Apr-22							
May-22							Green
Jun-22						Green	
Jul-22							
Aug-22							
Sep-22							
Oct-22							
Nov-22							
Dec-22							
Jan-23							
Feb-23							
Mar-23							
Apr-23							
May-23							Green

Harm Free Certificate	GDH Kingfisher [UG4737]	LCH Clinic 5 [UL4720]	LCH Rainforest [UL4735]	LCH Safari [UL4734]	PHB 4A [UP4736]	LCH NNU [UL4736]	PHB NNU [UP4735]
Jun-21							
Jul-21			B - Falls				
Aug-21			S - Falls				
Sep-21							
Oct-21			B - Falls				
Nov-21			S - Falls				
Dec-21			**G - Falls**				
Jan-22							
Feb-22							
Mar-22					B - Falls		
Apr-22	IPC				IPC	IPC	IPC
May-22			B - Falls				
Jun-22							
Jul-22			B - FallsS - Skin				
Aug-22			G - Skin		B - Falls		
Sep-22			B - SkinB - Falls		B - Falls	B - Skin	
Oct-22			S - FallsB & S - Skin			S - Skin	
Nov-22			G - Falls				
Dec-22			R - Falls		B - Falls	G - Skin	
Jan-23			B - Skin		S - Falls	R - Skin	
Feb-23			B - Falls		G - Falls		S - Falls
Mar-23			S - Falls				
Apr-23				E - Falls			
May-23			G - Falls	B - Falls		R - Falls	

FLO	GDH Kingfisher [UG4737]	LCH Clinic 5 [UL4720]	LCH Rainforest [UL4735]	LCH Safari [UL4734]	PHB 4A [UP4736]	LCH NNU [UL4736]	PHB NNU [UP4735]
Jun-21	R	R	G	G	R	G	G
Jul-21	R	R	G	G	G	R	G
Aug-21	R	R	A	G	G	G	G
Sep-21	R	G	G	G	G	G	G
Oct-21	R	R	G	G	G	R	R
Nov-21	G	G	A	G	G	G	R
Dec-21	A	G	G	R	G	G	G
Jan-22	G	R	G	G	G	G	G
Feb-22	G	G	G	G	R	G	G
Mar-22	G	G	G	G	R	G	G
Apr-22	G	G	G	G	R	G	G
May-22	G	G	G	G	G	G	G
Jun-22	G	G	G	G	G	G	G
Jul-22	G	R	G	G	G	G	G
Aug-22	N/A	R	R	R	R	G	G
Sep-22	G	G	G	G	G	G	G
Oct-22	G	G	A	G	G	G	G
Nov-22	N/A	G	G	G	G	G	G
Dec-22	G	G	G	G	N/A	G	G
Jan-23	G	G	G	G	G	G	G
Feb-23	G	G	G	G	N/A	G	G
Mar-23	G	G	G	G	G	G	G
Apr-23	A	G	A	G	G	G	G
May-23	N/A	G	G	G	A	G	G

SEPSIS	GDH Kingfisher [UG4737]	LCH Clinic 5 [UL4720]	LCH Rainforest [UL4735]	LCH Safari [UL4734]	PHB 4A [UP4736]	LCH NNU [UL4736]	PHB NNU [UP4735]
Jun-21			G	G	G		
Jul-21			A	R	G		
Aug-21			G	G	G		
Sep-21			A	A	G		
Oct-21			G	R	G		
Nov-21			A	R	A		
Dec-21			G	R	G		
Jan-22			G	A	R		
Feb-22			G	G	A		
Mar-22			R	R	G		
Apr-22			A	A	A		
May-22			A	A	R		
Jun-22			G	G	G		
Jul-22			R	A	G		
Aug-22			G	R	G		
Sep-22			A	G	A		
Oct-22			G	A	A		
Nov-22			R	A	G		
Dec-22			R	A	A		
Jan-23			R	A	G		
Feb-23			G	R	G		
Mar-23			A	G	G		
Apr-23			G	R	R		
May-23			A	A	G		

Accreditation Progress:

= Divisional Monitoring

= Enhanced Monitoring

Weekly Spot Check (Monthly)	LCH ANC	PHB ANC
Jun-21	X	X
Jul-21	X	X
Aug-21	X	X
Sep-21	Red	Red
Oct-21	Green	Green
Nov-21	Red	Amber
Dec-21	Amber	Amber
Jan-22	Amber	Amber
Feb-22	Amber	Amber
Mar-22	Red	Amber
Apr-22	Green	Green
May-22	Red	Green
Jun-22	Green	Green
Jul-22	Red	Amber
Aug-22	Red	Amber
Sep-22	Amber	Green
Oct-22	Amber	Amber
Nov-22	Red	Amber
Dec-22	Red	Green
Jan-23	Red	Green
Feb-23	Green	Green
Mar-23	Green	Green
Apr-23	Green	Green
May-23	Green	Green

Weekly Spot Check (Weekly)	LCH ANC					PHB ANC				
Jun-21										
Jul-21										
Aug-21										
Sep-21										
Oct-21										
Nov-21	R	R	G	R	R	R	R	R	G	G
Dec-21	G	R	G	R		G	R	G	R	
Jan-22	G	G	R	R	G	G	G	R	R	R
Feb-22	G	R	G	R		R	R	G	G	
Mar-22	R	R	R	R		R	R	G	G	
Apr-22	G	G	G	R		G	G	G	G	
May-22	R	G	G	R	R	G	G	G	G	G
Jun-22	G	G	G	R		G	G	G	G	
Jul-22	R	R	R	R		G	A	G	R	
Aug-22	R	R	R	R	R	A	G	G	A	G
Sep-22	R	G	G	R		G	G	G	G	
Oct-22	R	G	G	G	R	G	G	G	A	R
Nov-22	G	R	R	R		R	A	G	G	
Dec-22	R	R	G	R		G	G	G	R	
Jan-23	R	R	R	R	G	G	G	G	G	G
Feb-23	G	G	G	R		G	G	G	G	
Mar-23	G	G	G	R		G	G	G	G	
Apr-23	G	R	G	G		G	R	G	G	
May-23	G	G	G	G	R	G	G	G	G	R
Count of GREENS	24					41				

Matron Audit	LCH ANC	PHB ANC
Jun-21	Green	Green
Jul-21	Green	Green
Aug-21	Amber	Green
Sep-21	Amber	Green
Oct-21	Green	Green
Nov-21	Green	Green
Dec-21	Green	Green
Jan-22	Green	Green
Feb-22	Amber	Green
Mar-22	Green	Green
Apr-22	Amber	Green
May-22	Green	Green
Jun-22	Green	Green
Jul-22	Amber	Amber
Aug-22	Amber	Amber
Sep-22	Amber	Amber
Oct-22	Amber	Green
Nov-22	Amber	Green
Dec-22	Amber	Green
Jan-23	Green	Green
Feb-23	Green	Green
Mar-23	Green	Green
Apr-23	Green	Green
May-23	Green	Green

Ward/Dept Review Visit	LCH ANC	PHB ANC
Jun-21		
Jul-21		
Aug-21		
Sep-21		
Oct-21		
Nov-21		
Dec-21		
Jan-22		
Feb-22		
Mar-22		
Apr-22		
May-22		
Jun-22		
Jul-22		
Aug-22	Green	Amber
Sep-22		
Oct-22		
Nov-22		
Dec-22		
Jan-23		
Feb-23		
Mar-23		
Apr-23		
May-23		

Harm Free Certificate	LCH ANC	PHB ANC
Apr-21		
May-21		
Jun-21		
Jul-21		
Aug-21		
Sep-21		
Oct-21		
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		
Mar-23		
Apr-23		
May-23		

FLO	LCH ANC	PHB ANC
Jun-21	G	G
Jul-21	G	G
Aug-21	G	G
Sep-21	G	G
Oct-21	G	G
Nov-21	G	G
Dec-21	G	G
Jan-22	G	G
Feb-22	G	G
Mar-22	G	G
Apr-22	G	G
May-22	G	G

Jun-22	G	G
Jul-22	G	G
Aug-22	G	A
Sep-22	G	G
Oct-22	G	G
Nov-22	G	N/A
Dec-22	G	G
Jan-23	G	G
Feb-23	G	G
Mar-23	G	G
Apr-23	G	G
May-23	G	G

SEPSIS	LCH ANC	PHB ANC
Apr-21	G	G
May-21	G	G
Jun-21	G	G
Jul-21	G	G
Aug-21	G	G
Sep-21	G	G
Oct-21	G	G
Nov-21	G	G
Dec-21	G	G
Jan-22	G	G
Feb-22	G	G
Mar-22	G	G
Apr-22	G	G
May-22	G	G
Jun-22	R	N/A
Jul-22	G	N/A
Aug-22	G	N/A
Sep-22	G	N/A
Oct-22	G	N/A
Nov-22	G	N/A
Dec-22	G	G
Jan-23	G	R
Feb-23	R	G
Mar-23	G	G
Apr-23	N/A	G
May-23	G	R

Weekly Spot Check [Monthly]	GDH Comm Mid	LCH Comm Mid	PHB Comm Mid	SPALD Comm Mid	Skeg Cof C	SLE CofC	JCH CofC	Wolds CoCo
Sep-21								
Oct-21								
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								
Mar-23	Red	Red	Red	Amber	Red	Red	Red	Red
Apr-23	Red	Amber	Amber	Amber	Red	Amber	Amber	Red
May-23	Red	Green	Red	Red	Red	Red	Red	Red

Weekly Spot Check (Weekly)	GDH Comm Mid					LCH Comm Mid					PHB Comm Mid					SPAL Comm Mid					JCH CofC					SLE CofC					Skeg Cof C					Wolds CoCo				
Sep-21																																							
Oct-21																																							
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																																							
Mar-23	R	R	R	R		A	R	R	R		R	A	R	A		A	R	G	A		R	R	R	R		A	R	R	R		R	A	R	R		A	R	A	R	
Apr-23	R	R	R	A		A	A	A	G		A	A	G	G		R	A	G	G		R	A	A	G		A	A	A	A		R	G	R	R		R	A	A	R	
May-23	R	R	R	A	A	G	G	G	G	A	R	R	G	R	R	G	R	A	R	R	G	R	A	A	R	A	A	R	R	R	R	R	A	A	A	R	R	R	A	R

Matron Audit	GDH Comm Mid	LCH Comm Mid	PHB Comm Mid	SPALD Comm Mid	SLE CofC	Skeg Cof C	JCH CofC	Wolds CoCo
Apr-21	Green	Green	Green			Green	Green	Green
May-21	Amber	Amber	Amber			Amber	Amber	Amber
Jun-21	Amber	Amber	Amber			Amber	Amber	Amber
Jul-21	Amber	Amber	Amber			Amber	Amber	Amber
Aug-21	Amber	Amber	Amber			Amber	Amber	Amber
Sep-21	Amber	Amber	Amber			Amber	Amber	Amber
Oct-21	Amber	Amber	Amber			Amber	Amber	Amber
Nov-21	Red	Red	Red			Red	Red	Red
Dec-21	Red	Red	Red		Amber	Red	Red	Red
Jan-22	Amber	Amber	Amber		Amber	Amber	Amber	Amber
Feb-22	Amber	Amber	Amber		Amber	Amber	Amber	Amber
Mar-22	Green	Green	Green		Green	Green	Green	Green
Apr-22	Amber	Amber	Amber		Amber	Amber	Amber	Amber
May-22	Amber	Amber	Amber		Amber	Amber	Amber	Amber
Jun-22	Green	Green	Green		Green	Green	Green	Green
Jul-22	Amber	Amber	Amber		Amber	Amber	Amber	Amber
Aug-22	Green	Green	Green		Green	Green	Green	Green
Sep-22							Amber	Amber
Oct-22		Green						
Nov-22			Amber			Amber		
Dec-22	Amber				Amber			
Jan-23							Amber	Amber
Feb-23		Green						
Mar-23			Amber					
Apr-23	Red							
May-23	Amber							

Count of GREENS Rolling 12 Months	GDH Comm Mid	LCH Comm Mid	PHB Comm Mid	SPALD Comm Mid	SLE CofC	Skeg Cof C	JCH CofC	Wolds CoCo
	0	5	3	4	2	0	1	0

Ward/Dept Review Visit	GDH Comm Mid	LCH Comm Mid	PHB Comm Mid	SPALD Comm Mid	Skeg Cof C	SLE CofC	JCH CofC	Wolds CoCo
Apr-21								
May-21								
Jun-21								
Jul-21								
Aug-21								
Sep-21								
Oct-21								
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								
Mar-23								
Apr-23								
May-23								

Harm Free Certificate	GDH Comm Mid	LCH Comm Mid	PHB Comm Mid	SPALD Comm Mid	Skeg Cof C	SLE CofC	JCH CofC	Wolds CoCo
Apr-21								
May-21								
Jun-21								
Jul-21								
Aug-21								
Sep-21								

Oct-21								
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								
Mar-23								
Apr-23								

Accreditation Progress: CSS Wards

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check [Monthly]	GDH Chemo	GDH Hospice	LCH Ashby	LCH Ingham	LCH Waddington	PHB Bostonian	PHB Chemo
Nov-21		Green	Green	Red	Amber	Green	Green
Dec-21		Green	Amber	Amber	Green	Red	Green
Jan-22		Green	Green	Amber	Green	Green	Amber
Feb-22		Green	Amber	Green	Green	Green	Green
Mar-22		Green	Amber	Green	Green	Green	Green
Apr-22		Amber	Green	Amber	Red	Green	Amber
May-22		Green	Amber	Amber	Green	Green	Amber
Jun-22		Green	Green	Green	Red	Green	Amber
Jul-22		Green	Green	Green	Green	Green	Red
Aug-22		Red	Amber	Amber	Red	Amber	Green
Sep-22		Amber	Amber	Green	Red	Red	Green
Oct-22		Green	Red	Green	Red	Amber	Green
Nov-22		Red	Red	Green	Red	Red	Green
Dec-22		Green	Red	Green	Red	Green	Red
Jan-23		Red	Red	Red	Green	Red	Red
Feb-23		Green	Red	Green	Red	Green	Red
Mar-23		Green	Red	Green	Red	Green	Red
Apr-23		Green	Green	Red	Red	Green	Red
May-23		Green	Green	Red	Amber	Green	Red

Weekly Spot Check (Weekly)	GDH Hospice					LCH Ashby					LCH Ingham					LCH Waddington					PHB Bostonian					PHB Chemo				
Nov-21	G	G	G	G	R	G	G	R	G	G	R	R	G	R	R	R	G	G	R	G	R	G	G	G	G	G	A	G	G	A
Dec-21	G	R	G	G		G	R	A	R		R	G	G	R		G	G	G	R		G	R	R	R		G	G	G	G	
Jan-22	G	G	G	G	G	R	G	G	G	G	R	R	G	G	G	G	R	G	G	G	R	G	G	G	G	R	G	G	R	R
Feb-22	G	R	G	G		A	R	G	G		G	G	G	G		G	G	G	G		A	G	G	G		G	G	G	G	
Mar-22	G	G	R	G		R	G	G	A		G	G	G	G		G	G	G	R		G	G	R	G		G	G	G	R	
Apr-22	R	R	G	G		G	R	G	G		G	R	R	G		R	R	R	G		G	G	G	G		G	R	R	G	
May-22	G	G	G	G	R	A	A	G	R	R	R	G	G	G	R	G	G	G	G	G	G	G	G	G	G	G	R	G	G	G
Jun-22	G	G	G	G		G	R	G	G		G	R	G	G		R	G	R	G		A	G	G	G		G	G	R	G	
Jul-22	G	G	G	R		G	A	G	G		G	G	G	G		G	G	G	R		G	G	G	G		G	R	A	A	
Aug-22	R	R	R	R	G	G	A	A	G	G	G	G	R	G	R	R	R	G	R	G	G	A	G	G	R	G	G	G	G	R
Sep-22	G	R	R	G		R	R	A	G		G	G	G	G		R	R	G	G		G	R	G	R		G	G	G	R	
Oct-22	G	G	G	G	G	R	A	G	R	R	G	G	R	G	G	R	R	R	R	G	A	G	A	G	G	G	G	G	R	G
Nov-22	R	R	G	G		G	R	G	R		G	G	G	G		G	R	R	G		G	R	R	R		G	G	G	R	
Dec-22	G	R	G	G		R	R	R	R		G	G	G	R		G	R	R	R		G	G	G	G		G	R	R	R	
Jan-23	G	G	R	R	G	G	G	R	G	R	R	R	G	G	G	G	G	G	R	G	A	R	A	G	G	R	G	R	G	R
Feb-23	G	G	G	G		R	G	R	R		G	G	G	G		G	R	R	G		R	G	G	G		R	G	R	G	
Mar-23	G	G	G	G		R	R	G	G		G	G	G	G		R	R	R	R		G	G	R	G		G	R	R	R	
Apr-23	G	G	G	G		G	G	G	G		R	G	R	G		G	R	G	R		G	G	G	G		R	G	R	R	
May-23	G	G	G	G	G	G	R	G	G	G	R	R	G	G	G	R	G	G	A	G	G	G	G	G	G	R	R	R	R	G
Count of GREENS	40					27					41					24					37					26				

Matron Audit	GDH Chemo	GDH Hospice	LCH Ashby	LCH Ingham	LCH Waddington	PHB Bostonian	PHB Chemo
Nov-21	None	None	Amber	Amber	Amber	Green	None
Dec-21	None	Green	Green	None	Red	Amber	Green
Jan-22	None	None	Amber	Amber	Amber	Amber	None
Feb-22	None	None	Amber	None	Amber	Amber	Green
Mar-22	None	None	Amber	Green	Amber	Green	None
Apr-22	None	Green	Amber	None	Amber	Green	Green
May-22	Green	None	Green	None	Amber	Amber	None
Jun-22	None	None	Green	None	Amber	Green	None
Jul-22	None	None	Amber	None	Green	Green	Green
Aug-22	Green	None	Amber	None	Amber	Amber	None
Sep-22	None	Green	Green	Amber	Amber	Green	None
Oct-22	None	Green	Green	None	Green	Amber	Green
Nov-22	Green	Green	Green	None	Green	Amber	None
Dec-22	None	Green	Green	Amber	Green	Amber	None
Jan-23	None	Green	Green	None	Green	Amber	None
Feb-23	None	Green	Amber	None	Green	Green	Green
Mar-23	None	Green	Amber	Red	Red	Green	None
Apr-23	Amber	Green	Amber	None	Red	Red	None
May-23	Green	Green	Green	None	Amber	Green	Green

Ward/Dept. Review Visit	GDH Chemo	GDH Hospice	LCH Ashby	LCH Ingham	LCH Waddington	PHB Bostonian	PHB Chemo
Nov-21							
Dec-21						Green	
Jan-22					Green		
Feb-22							
Mar-22							
Apr-22							
May-22							
Jun-22							
Jul-22	Green			Green			Green
Aug-22		Green					
Sep-22			Amber				
Oct-22							
Nov-22							
Dec-22							
Jan-23							
Feb-23							
Mar-23					Green		
Apr-23							
May-23						Green	

Harm Free Certificate	GDH Chemo	GDH Hospice	LCH Ashby	LCH Ingham	LCH Waddington	PHB Bostonian	PHB Chemo
Nov-21			B - Skin				
Dec-21			S - Skin			B - Skin	
Jan-22			G - Skin B - Falls			B - Falls	
Feb-22		B - Skin	S - Falls			S - Skin	
Mar-22		B - Skin	B - Falls R - Skin			B - Skin	
Apr-22							
May-22			B - Falls				
Jun-22		B - Skin					
Jul-22			B - Skin				
Aug-22			S - Skin	B - Falls			
Sep-22		B - Falls	G - Skin	S - Falls		B - Falls	B - Falls
Oct-22		S - Falls	B - Falls	G - Falls			S - Falls
Nov-22			R - Skin				
Dec-22		G - Falls		R - Falls			

Jan-23							
Feb-23							
Mar-23	B - Skin						B - Skin
Apr-23	S - Skin						S - Skin
May-23			B - Falls		B - Skin		R - Falls

FLO	GDH Chemo	GDH Hospice	LCH Ashby	LCH Ingham	LCH Waddington	PHB Bostonian	PHB Chemo
Nov-21		G	G	G	G	A	G
Dec-21		G	G	G	G	G	G
Jan-22		G	G	G	G	G	G
Feb-22		G	G	G	G	G	G
Mar-22		G	A	G	G	G	G
Apr-22	G	G	A	G	G	G	G
May-22	G	G	G	G	G	G	G
Jun-22	G	G	G	G	G	G	R
Jul-22	R	G	G	G	G	G	G
Aug-22	G	G	A	G	G	G	G
Sep-22	G	G	G	G	G	A	G
Oct-22	G	G	G	G	G	G	G
Nov-22	G	G	G	G	G	G	G
Dec-22	G	G	G	G	G	A	G
Jan-23	G	G	G	G	G	A	G
Feb-23	G	G	G	G	G	A	N/A
Mar-23	G	G	G	G	G	N/A	G
Apr-23	G	G	G	G	G	G	G
May-23	G	G	G	G	G	N/A	G

SEPSIS	GDH Chemo	GDH Hospice	LCH Ashby	LCH Ingham	LCH Waddington	PHB Bostonian	PHB Chemo
Nov-21		G	N/A	N/A	G	G	N/A
Dec-21		G	N/A	N/A	G	R	G
Jan-22		G	R	G	G	G	N/A
Feb-22		G	G	G	G	G	G
Mar-22		G	G	N/A	G	G	N/A
Apr-22		N/A	G	G	G	A	N/A
May-22		N/A	G	G	G	A	N/A
Jun-22		N/A	G	G	G	G	N/A
Jul-22		N/A	G	G	G	A	G
Aug-22		N/A	G	G	G	R	N/A
Sep-22		N/A	G	N/A	G	A	G
Oct-22		N/A	G	N/A	G	G	N/A
Nov-22		N/A	N/A	N/A	G	G	G
Dec-22		N/A	G	G	G	A	G
Jan-23		N/A	R	G	G	G	R
Feb-23		N/A	G	G	G	G	G
Mar-23			G	R	G	G	G
Apr-23			N/A	R	A	A	G
May-23			G	G	G	A	G

Accreditation Progress: CSS Diagnostics

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check [Monthly]	CHL Endoscopy	GDH Endoscopy	GDH MRI	GDH Nuclear Medicine	GDH Radiology [X-Ray]	LCH Audiology	LCH Radiology CT & Xray	LCH Endoscopy	LCH Interventional Radiology	LCH MRI	LCH Neuro Physics	LCH Nuclear Medicine	LCH Resp Physics	LCH Ultrasound	PHB Nuclear Medicine	PHB Radiology [X-Ray]	PHB Radiology CT	PHB Interventional Radiology	PHB Endoscopy	PHB Ultrasound
Jun-21																				
Jul-21																				
Aug-21																				
Sep-21																				
Oct-21																				
Nov-21		S																		
Dec-21		S																		
Jan-22	S	A						S												
Feb-22	A	G						G												
Mar-22	A	G				R		G			R	R			R	A			R	R
Apr-22	R	A				R		G			R	R			R	R			R	R
May-22	S	G				A		G			A	R			G	G			G	R
Jun-22	S	G				G		G			G	G			G	G			G	R
Jul-22	S	G				G		G			G	G			G	G			G	R
Aug-22	S	A				A		R			G	A			G	G			R	R
Sep-22	R	G				G		R			G	R			R	R			R	R
Oct-22	R	G		R		R	R	R			R	R			R	R			R	R
Nov-22	R	G		R		G	R	G			R	R			R	R			R	R
Dec-22	G	G		R	R	G	R	R			R	R			R	R			R	R
Jan-23	R	G		R	R	G	R	R			R	R			R	R			R	R
Feb-23	R	G		R	R	G	A	R			R	R			R	R			R	R
Mar-23	R	G		R	R	G	R	R			R	R			R	R			R	R
Apr-23	R	G		R	R	R	R	R			R	R			R	R			R	R
May-23	R	G		R	R	R	R	R			R	G			R	R			R	R

Matron Audit	CHL Endoscopy	GDH Endoscopy	GDH MRI	GDH Nuclear Medicine	GDH Radiology [X-Ray]	LCH Audiology	LCH Radiology CT & Xray	LCH Endoscopy	LCH Interventional Radiology	LCH MRI	LCH Neuro Physics	LCH Nuclear Medicine	LCH Resp Physics	LCH Ultrasound	PHB Nuclear Medicine	PHB Radiology [X-Ray]	PHB Radiology CT	PHB Interventional Radiology	PHB Endoscopy	PHB Ultrasound
Jun-21										Amber										Red
Jul-21					Red						Amber						Red			
Aug-21	Amber			Amber																
Sep-21			Red					Amber								Red				
Oct-21		Green									Amber									
Nov-21						Amber			Red										Green	
Dec-21		Amber																		Green
Jan-22							Amber								Amber			Amber		
Feb-22								Amber								Green				
Mar-22					Red								Red				Red			
Apr-22	Amber			Green					Green											
May-22		Amber				Red					Amber									
Jun-22		Green								Red					Green					
Jul-22																			Amber	Green
Aug-22					Amber	Amber										Amber				
Sep-22							Amber	Green					Green							
Oct-22	Green			Green													Amber			
Nov-22			Amber			Amber			Amber											
Dec-22											Green	Green								
Jan-23						Amber				Amber	Green									
Feb-23					Amber											Amber				
Mar-23												Red							Red	
Apr-23				Amber				Green												
May-23			Amber			Amber														

Ward/Dept. Review Visit	CHL Endoscopy	GDH Endoscopy	GDH MRI	GDH Nuclear Medicine	GDH Radiology [X-Ray]	LCH Audiology	LCH Radiology CT & Xray	LCH Endoscopy	LCH Interventional Radiology	LCH MRI	LCH Neuro Physics	LCH Nuclear Medicine	LCH Resp Physics	LCH Ultrasound	PHB Nuclear Medicine	PHB Radiology [X-Ray]	PHB Radiology CT	PHB Interventional Radiology	PHB Endoscopy	PHB Ultrasound
Jun-21																				
Jul-21																				
Aug-21																				
Sep-21																				
Oct-21																				
Nov-21																				
Dec-21																				
Jan-22																				
Feb-22																				
Mar-22																				
Apr-22																				
May-22																				
Jun-22																	Amber			
Jul-22																				
Aug-22																				
Sep-22																				
Oct-22																				
Nov-22																				
Dec-22																				
Jan-23																				
Feb-23																				
Mar-23																				
Apr-23																				
May-23																				

Harm Free Certificate	CHL Endoscopy	GDH Endoscopy	GDH MRI	GDH Nuclear Medicine	GDH Radiology [X-Ray]	LCH Audiology	LCH Radiology CT & Xray	LCH Endoscopy	LCH Interventional Radiology	LCH MRI	LCH Neuro Physics	LCH Nuclear Medicine	LCH Resp Physics	LCH Ultrasound	PHB Nuclear Medicine	PHB Radiology [X-Ray]	PHB Radiology CT	PHB Interventional Radiology	PHB Endoscopy	PHB Ultrasound
Jun-21																				
Jul-21																				
Aug-21																				
Sep-21																				
Oct-21																				
Nov-21																				
Dec-21																				
Jan-22																				
Feb-22																				
Mar-22																				
Apr-22																				
May-22																B - Falls				
Jun-22																S - Falls				
Jul-22																G - Falls				
Aug-22																				
Sep-22							B - Falls									Ruby - Falls				
Oct-22							S - Falls													
Nov-22																				
Dec-22					B - Falls		S - Falls									Sapphire - Falls				
Jan-23							G - Falls													
Feb-23																				
Mar-23					B - Falls		R - Falls													
					B - Skin		B - Skin													
Apr-23					S - Skin		S - Skin												E - Falls	
May-23																				

FLO	CHL Endoscopy	GDH Endoscopy	GDH MRI	GDH Nuclear Medicine	GDH Radiology [X-Ray]	LCH Audiology	LCH Radiology CT & Xray	LCH Endoscopy	LCH Interventional Radiology	LCH MRI	LCH Neuro Physics	LCH Nuclear Medicine	LCH Resp Physics	LCH Ultrasound	PHB Nuclear Medicine	PHB Radiology [X-Ray]	PHB Radiology CT	PHB Interventional Radiology	PHB Endoscopy	PHB Ultrasound
Jun-21	R	G	G	R	G	G	R	G	G	G	G	A	R	R	G	A	G		G	G
Jul-21	R	G	G	R	G	G	R	R	G	G	G	A	R	R	R	G	R		G	R
Aug-21	A	G	G	R	R	G	R	G	G	G	G	G	R	G	A	G	R		R	R
Sep-21	A	G	G	R	A	G	G	G	G	G	G	A	R	G	G	G	G		G	G
Oct-21	G	G	G	R	G	G	G	R	G	G	G	A	R	G	G	G	R		G	G
Nov-21	G	G	G	R	R	G	R	A	G	G	G	A	A	R	G	G	R		G	G
Dec-21	G	G	G	R	R	G	R	A	G	G	G	G	R	R	A	G	R		R	G
Jan-22	G	G	G	R	G	G	G	G	G	G	R	R	A	R	G	G	R		G	R
Feb-22	G	G	G	R	G	G	G	G	G	G	G	R	R	R	G	G	R		G	R
Mar-22	R	G	G	G	G	G	R	G	G	G	G	R	R	R	G	G	G		G	G
Apr-22	G	R	G	R	G	R	A	G	G	R	G	R	R	G	R	G	R	R	G	G
May-22	G	G	G	R	G	G	R	G	G	G	G	G	R	G	R	G	R	R	G	G
Jun-22	G	R	R	R	G	R	G	A	G	G	G	G	R	G	R	G	R	R	G	G
Jul-22	G	G	G	R	G	G	G	G	G	R	G	G	R	G	R	G	R	R	G	G
Aug-22	G	G	G	R	G	G	G	G	G	G	G	G	R	G	R	G	R	R	G	G
Sep-22	G	G	G	R	G	G	G	G	G	R	G	G	R	G	R	G	R	R	G	G
Oct-22	G	G	G	G	G	G	G	G	G	R	G	G		G	G	G	G		A	G
Nov-22	G	G	G	R	G	G	G	G	G	R	G	G		R	G	G	R		G	G
Dec-22	G	G	G	N/A	G	G	G	G	N/A	N/A	G	G		N/A	G	G	N/A		G	G
Jan-23	G	G	G	R	G	G	G	G	G	N/A	G	G		G	N/A	G	N/A		G	G
Feb-23	G	G	G	G	G	G	G	G	G	G	G	G		G	N/A	G	G		G	G
Mar-23	G	G	G	G	G	G	G	G	G	G	G	G		N/A	N/A	G	G		G	G
Apr-23	G	G	G	G	G	G	G	G	N/A	G	G	G		G		G	G		G	G
May-23	G	G	G	G	G	G	G	N/A	G	G	G	G		G		G	G		G	G

SEPSIS	CHL Endoscopy	GDH Endoscopy	GDH MRI	GDH Nuclear Medicine	GDH Radiology [X-Ray]	LCH Audiology	LCH Radiology CT & Xray	LCH Endoscopy	LCH Interventional Radiology	LCH MRI	LCH Neuro Physics	LCH Nuclear Medicine	LCH Resp Physics	LCH Ultrasound	PHB Nuclear Medicine	PHB Radiology [X-Ray]	PHB Radiology CT	PHB Interventional Radiology	PHB Endoscopy	PHB Ultrasound
Jun-21		N/A						N/A											R	
Jul-21		N/A						G											R	
Aug-21		N/A						N/A											N/A	
Sep-21		N/A						G											G	
Oct-21		N/A						N/A											G	
Nov-21		N/A						G											G	
Dec-21		N/A						N/A											N/A	
Jan-22		N/A						N/A											N/A	
Feb-22		N/A						N/A											N/A	
Mar-22		N/A						N/A											G	
Apr-22		N/A						N/A											N/A	
May-22		N/A						N/A											N/A	
Jun-22		N/A						G											R	
Jul-22		N/A						N/A											N/A	
Aug-22		N/A						N/A											R	
Sep-22		N/A						N/A											N/A	
Oct-22		N/A						N/A											N/A	
Nov-22		N/A						N/A											G	
Dec-22		N/A						N/A											N/A	
Jan-23		N/A						N/A											N/A	
Feb-23		N/A						N/A											G	
Mar-23		N/A						G											R	
Apr-23		N/A						N/A											N/A	
May-23		N/A						N/A											N/A	

Weekly Spot Check [Weekly]	CHL Endoscopy	GDH Endoscopy	GDH Radiology [X-Ray]	GDH MRI	GDH Nuclear Medicine	LCH Audiology	LCH Radiology CT & Xray	LCH Endoscopy	LCH MRI	LCH Nero Physics	LCH Nuclear Medicine	LCH Resp Physics	LCH Ultrasound	PHB CT	PHB Endoscopy	PHB Nuclear Medicine	PHB Ultrasound	PHB X-Ray
Jun-21																		
Jul-21																		
Aug-21																		
Sep-21																		
Oct-21																		
Nov-21																		
Dec-21																		
Jan-22	R	S	G	R	R			R										
Feb-22	A	S	G	R	R			A										
Mar-22	R	G	G	R	R	A	A	R										
Apr-22	R	S	G	R	R	R	R	R										
May-22	R	S	G	R	R	R	R	R										
Jun-22	R	S	G	R	R	G	G	R										
Jul-22	R	S	G	R	R	G	G	R										
Aug-22	R	S	G	R	R	G	G	R										
Sep-22	R	S	G	R	R	G	G	R										
Oct-22	R	S	G	R	R	G	G	R										
Nov-22	R	S	G	R	R	G	G	R										
Dec-22	R	S	G	R	R	G	G	R										
Jan-23	R	S	G	R	R	G	G	R										
Feb-23	R	S	G	R	R	G	G	R										
Mar-23																		
Apr-23																		
May-23																		

Count of GREENS																				
	17	28	0	0	0	30	1	17	0	17	19	0	0	0	17	0	6	0	0	0

Non-Inpatient Areas CSS OPD - Accreditation Progress:

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check [Monthly]	CHL OPD	GDH Eye Clinic	GDH Fracture Clinic	GDH OPD	LCH Clinic 6	LCH Clinic 7	LCH Clinic 8	LCH Clinic 9	LCH Clinic 11	LCH Dermatology	LCH MDU	LCH OPD	LCH Rheumatology	LCH UIS	PHB Breast Clinic	PHB Dermatology	PHB ENT	PHB Fracture	PHB OPD	PHB Royle Eye Clinic
Apr-21																				
May-21																				
Jun-21																				
Jul-21																				
Aug-21	R			A		R			R	R			R	R		R	R	R	R	R
Sep-21	R		R	A		R			R	R			R	R		R	R	R	R	R
Oct-21	R	A	R	A		R			R	R			R	R		R	R	R	R	A
Nov-21	R	R	R	A		R			A	R			R	R		R	R	R	R	A
Dec-21	R	R	R	A		R			R	R			R	R		R	R	R	R	A
Jan-22	R	R	R	A		R			R	R			R	R		R	R	R	R	A
Feb-22	R	R	R	R		A			A	A	G	A	G	G		A	A	G	G	A
Mar-22	R	R	A	A		G			A	A	G	A	G	G		R	A	R	G	A
Apr-22	A	G	A	A		A			R	G	G	G	G	G		R	A	A	A	A
May-23	A	G	A	G		G			G	G	G	G	G	G		R	A	G	G	R
Jun-22	G	G	G	G		G			G	G	G	G	G	G		G	R	A	G	R
Jul-22	R	G	A	G		G			R	G	G	G	G	G		G	G	G	G	A
Aug-22	G	G	A	G		G			G	G	G	G	G	G		G	R	G	G	A
Sep-22	G	G	A	G		G			G	G	G	G	G	G		G	A	A	G	R
Oct-22	G	G	A	A		G			G	G	G	G	G	G		G	G	A	G	R
Nov-22	G	G	G	G		G			G	G	G	G	G	G	G	G	G	G	G	G
Dec-22	G	G	G	G		G			G	G	G	G	G	G	R	G	G	G	G	G
Jan-23	G	G	G	G		G			G	G	G	G	G	G	A	G	G	G	G	G
Feb-23	G	G	R	G		G			G	G	G	G	G	G	G	G	G	G	G	G
Mar-23	G	G	G	R		G			G	G	G	A	G	R	G	R	R	G	G	G
Apr-23	G	G	G	G		G			G	G	G	G	G	G	G	R	G	G	G	G
May-23	G	G	G	G		G			G	G	G	G	G	G	G	R	G	G	G	R

Weekly Spot Check (Weekly)	CHL OPD	GDH Eye Clinic	GDH OPD	LCH Breast Clinic	LCH Clinic 7	LCH Clinic 8	LCH Clinic 11	LCH Dermatology	LCH MDU	LCH OPD	LCH Rheumatology	LCH UIS	PHB Breast Clinic	PHB Dermatology	PHB ENT	PHB Fracture	PHB OPD	PHB Royle Eye Clinic
Apr-21																		
May-21																		
Jun-21																		
Jul-21																		
Aug-21	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Sep-21	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Oct-21	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Nov-21	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Dec-21	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Jan-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Feb-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Mar-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Apr-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
May-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Jun-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Jul-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Aug-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Sep-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Oct-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Nov-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Dec-22	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Jan-23	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Feb-23	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Mar-23	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Apr-23	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
May-23	R R R R R	A A A A	A A A A	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	R R R R R	A A A A	R R R R R
Count of GREENS: Rolling 12 Months	48		42		44		0		52		44		46		48		47	

Matron Audit	CHL OPD	GDH Eye Clinic	GDH Fracture Clinic	GDH OPD	LCH Breast Clinic	LCH Clinic 7			LCH Clinic 11	LCH Dermatology	LCH MDU	LCH OPD	LCH Rheumatology	LCH UIS	PHB Breast Clinic	PHB Dermatology	PHB ENT	PHB Fracture	PHB OPD	PHB Royle Eye Clinic
Apr-21				Red		Red								Red						
May-21	Amber																Green			
Jun-21																				Green
Jul-21						Green			Green								Amber			
Aug-21																Green				
Sep-21										Green	Green							Amber		
Oct-21				Amber						Green				Green						
Nov-21	Red																	Red		
Dec-21						Green														Red
Jan-22										Green							Amber			
Feb-22		Green							Amber							Green				
Mar-22	Green		Green							Green				Green				Green	Green	Green
Apr-22				Green					Green			Green								
May-22	Green													Green				Amber		
Jun-22			Green			Green														Green
Jul-22										Green				Green		Green				
Aug-22		Green							Green								Green			
Sep-22						Amber					Amber			Green					Green	
Oct-22				Green						Green				Amber						
Nov-22	Green									Green	Green		Green	Green				Green		
Dec-22			Green			Amber								Amber			Green	Green		
Jan-23									Amber											Green
Feb-23	Green	Green							Green				Green			Green	Green			
Mar-23						Green								Green	Green	Green	Green	Green		
Apr-23				Green						Green				Green						
May-23	Amber				Green						Amber								Green	

Ward/Dept. Review Visit	CHL OPD	GDH Eye Clinic	GDH Fracture Clinic	GDH OPD	LCH Breast Clinic	LCH Clinic 7			LCH Clinic 11	LCH Dermatology	LCH MDU	LCH OPD	LCH Rheumatology	LCH UIS	PHB Breast Clinic	PHB Dermatology	PHB ENT	PHB Fracture	PHB OPD	PHB Royle Eye Clinic
Apr-21																				
May-21																				
Jun-21																				
Jul-21																				
Aug-21																				
Sep-21																				
Oct-21																				
Nov-21																				
Dec-21																				
Jan-22																				
Feb-22																				
Mar-22											Green			Amber						
Apr-22																				
May-22																				
Jun-22																				
Jul-22																				
Aug-22																				
Sep-22																				
Oct-22																				
Nov-22																				
Dec-22																				
Jan-23																				
Feb-23														Amber						
Mar-23																				
Apr-23																				
May-23																				

Harm Free Certificate	CHL OPD	GDH Eye Clinic	GDH Fracture Clinic	GDH OPD	LCH Breast Clinic	LCH Clinic 7			LCH Clinic 11	LCH Dermatology	LCH MDU	LCH OPD	LCH Rheumatology	LCH UIS	PHB Breast Clinic	PHB Dermatology	PHB ENT	PHB Fracture	PHB OPD	PHB Royle Eye Clinic
Apr-21																				
May-21																				
Jun-21																				
Jul-21																				
Aug-21																				
Sep-21																				
Oct-21																				
Nov-21																				
Dec-21																				
Jan-22																				
Feb-22																				
Mar-22																				
Apr-22																				
May-22																				
Jun-22																				
Jul-22																				
Aug-22																				
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Nov-22																				
Dec-22																				
Jan-23																				
Feb-23																				
Mar-23																				
Apr-23																				
May-23																				

FLO	CHL OPD	GDH Eye Clinic	GDH Fracture Clinic	GDH OPD	LCH Breast Clinic	LCH Clinic 7			LCH Clinic 11	LCH Dermatology	LCH MDU	LCH OPD	LCH Rheumatology	LCH UIS	PHB Breast Clinic	PHB Dermatology	PHB ENT	PHB Fracture	PHB OPD	PHB Royle Eye Clinic
Apr-21	G	G	R	G		G			G	G	G	G	G				R	G	R	G
May-21	G	R	R	G		R			G	R	G	G	G				R	G	G	G
Jun-21	G	A	A	G		R			G	G	R	G	G				R	G	G	G
Jul-21	G	G	G	G		R			R	G	G	G	G				R	G	A	G
Aug-21	G	G	G	G		R			R	G	G	G	G				G	G	A	G
Sep-21	G	G	G	G		G			G	G	G	G	G				G	G	G	G
Oct-21	G	G	G	G		R			G	G	R	G	G				G	G	G	G
Nov-21	G	G	G	G		G			G	R	G	G	G	G			R	G	G	G
Dec-21	G	G	G	G		G			R	R	R	G	G	G			G	G	G	G
Jan-22	G	G	G	G		G			G	G	G	G	G	G			G	A	G	G
Feb-22	G	G	G	G		G			G	G	G	G	G	G			G	G	G	G
Mar-22	G	G	G	G		G			G	G	G	G	G	G			G	G	G	G
Apr-22	G	G	G	G		R			G	G	G	G	G	G	G	G	G	A	G	G
May-22	G	G	G	G		G			G	G	G	G	G	G	G	G	G	R	G	G
Jun-22	G	G	G	G		G			G	R	G	G	G	G	G	G	R	A	G	G
Jul-22	G	G	G	G		G			G	G	G	G	G	G	G	G	G	G	G	G
Aug-22	G	G	G	G		G			G	G	G	G	G	G	G	G	G	G	G	G
Sep-22	A	G	G	R		G			G	G	G	G	R	N/A	G	G	G	A	G	G
Oct-22	G	G	G	N/A		N/A			G	G	N/A	G	G	G	G	G	G	G	G	G
Nov-22	G	G	G	G		G			G	G	N/A	G	G	G	G	G	G	G	G	G
Dec-22	G	G	G	G		G			G	G	G	G	G	G	G	G	G	G	G	G
Jan-23	G	G	G	G		G			G	G	G	G	G	G	G	G	G	G	G	G
Feb-23	G	G	G	G		G			G	G	G	G	G	G	G	G	G	G	G	G
Mar-23	G	G	G	G	G	G			G	G	G	G	G	G	G	G	N/A	G	G	G
Apr-23	G	G	G	G	G	G			G	G	G	G	G	G	G	G	G	G	G	G
May-23	G	N/A	G	G	G	G			G	G	G	G	G	G	G	G	G	G	G	G

SEPSIS	CHL OPD	GDH Eye Clinic	GDH Fracture Clinic	GDH OPD	LCH Breast Clinic	LCH Clinic 7			LCH Clinic 11	LCH Dermatology	LCH MDU	LCH OPD	LCH Rheumatology	LCH UIS	PHB Breast Clinic	PHB Dermatology	PHB ENT	PHB Fracture	PHB OPD	PHB Royle Eye Clinic
Apr-21																				
May-21																				
Jun-21																				
Jul-21																				
Aug-21																				
Sep-21																				
Oct-21																				
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																				
Mar-23																				
Apr-23																				
May-23																				

Accreditation Progress:
OPD Medicine

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check [Monthly]	GDH AAU [SDEC]	LCH CMDU	LCH MDU	LCH Saxon	LCH SDEC	LCH Vulcan	PHB PIU	PHB SDEC
Jun-21								
Jul-21								
Aug-21								
Sep-21								
Oct-21								
Nov-21	R		A		R			R
Dec-21	R		G		R			R
Jan-22	R		R		R			R
Feb-22	R		G		R			R
Mar-22	G		G		R			R
Apr-22	G		G		R			R
May-22	G		G		A			R
Jun-22	R		G		G			G
Jul-22	A		G		R			R
Aug-22	A		G		A			G
Sep-22	G		G		A			R
Oct-22	A	R	G	R	G	R		G
Nov-22	G	G	G	G	G	G	G	G
Dec-22	R	R	G	R	R	G	R	R
Jan-23	R	R	G	R	R	G	R	G
Feb-23	R	R	G	R	R	G	G	R
Mar-23	G	R	G	G	R	G	R	R
Apr-23	R	R	G	R	A	G	R	G
May-23	R	R	G	R	R	A	R	G

Weekly Spot Check (Weekly)	GDH AAU(SDEC)					LCH CMDU					LCH MDU					LCH Saxon					LCH SDEC					LCH VULCAN					PHB PIU					PHB SDEC				
Jun-21																																							
Jul-21																																							
Aug-21																																							
Sep-21																																							
Oct-21	R	G	R	R							R	R	A	G	G																									
Nov-21	A	R	G	R	R						G	G	G	R							R	R	R	R	R										R	R	R	R	R
Dec-21	R	R	G	R							R	G	R	G	R						R	R	R	G											R	R	R	G	
Jan-22	R	A	R	R	R						G	G	G	G							G	R	R	A	R										G	R	R	R	R
Feb-22	R	G	G	G							G	G	G	G							R	R	R	R											R	R	R	R	
Mar-22	R	G	G	G							G	G	G	G							R	R	R	R											R	R	R	R	
Apr-22	R	G	G	G							G	G	G	G	G						R	R	R	G											R	R	G	R	
May-22	G	G	R	A	A						G	G	G	G							G	G	R	R	G										R	R	R	G	G
Jun-22	G	R	G	R							G	G	G	G							G	G	G	G											G	G	G	G	
Jul-22	G	G	R	A							G	G	G	G	R						R	G	R	G											R	G	R	G	
Aug-22	G	G	G	A	R						G	G	G	G							R	G	G	G	R										G	G	G	G	G
Sep-22	G	G	G	G							G	G	R	G	G						G	G	R	G											R	R	R	G	
Oct-22	A	G	A	R	G				G	G	G	G	R	G	G				R	A	G	G	G	G	G		R	G	G	R					G	G	R	G	G
Nov-22	G	G	G	G		G	G	G	G		G	G	G	G		R	G	G	G		G	G	G	G		R	G	G	A		G	G	R	G	G	G	G	G
Dec-22	A	R	G	R		R	R	R	R		G	G	G	G		A	R	R	R		R	G	R	R		G	G	G	G		R	R	R	R		G	G	R	R	
Jan-23	R	R	R	R	R	R	R	R	R	R	G	A	G	G	G	R	G	G	G	R	R	G	G	G	R	G	G	G	G	G	R	R	R	R	R	G	R	G	G
Feb-23	R	R	R	R		G	R	R	R		R	G	G	G		R	A	G	A		R	G	R	G		G	G	G	R		G	R	G	G		R	R	G	G	
Mar-23	G	R	G	G		R	R	G	R		G	G	G	G		A	G	G	G		G	R	G	R		G	G	R	G		R	R	R	G		R	R	R	G	
Apr-23	R	R	G	G		R	R	R	R		G	A	G	G	G	R	R	G	A		A	R	G	G		G	G	G	G		R	R	R	R		G	G	G	R	
May-23	R	G	R	A	G	R	R	R	R	R	R	G	G	G		R	R	R	G	R	A	R	G	G	G	G	G	A	A	G	R	G	G	R	G	R	G	G	G

Count of GREENS	25	8	46	12	34	26	10	35

Matron Audit	GDH AAU [SDEC]	LCH CMDU	LCH MDU	LCH Saxon	LCH SDEC	LCH Vulcan	PHB PIU	PHB SDEC
Jun-21								
Jul-21								
Aug-21								
Sep-21								
Oct-21								
Nov-21								
Dec-21								
Jan-22			Green					
Feb-22								
Mar-22					Green			
Apr-22		Amber			Green	Amber		
May-22		Amber		Green		Amber		Green
Jun-22	Green	Green				Amber	Green	
Jul-22		Green	Green	Amber	Green	Amber		
Aug-22		Green		Green		Green	Amber	Green
Sep-22		Green		Amber		Green	Amber	
Oct-22		Green		Green	Green	Green	Green	Green
Nov-22		Green	Green		Amber	Amber	Green	Green
Dec-22		Green		Green	Green	Amber	Green	Green
Jan-23		Green		Green	Amber	Green	Green	Green
Feb-23		Green		Green	Green	Green	Green	Green
Mar-23		Green		Green	Green	Green	Green	Green
Apr-23	Green	Green		Green	Green	Green	Green	Green
May-23	Green	Green		Green	Amber	Green	Green	Green

Ward/Dept. Review Visit	GDH AAU [SDEC]	LCH CMDU	LCH MDU	LCH Saxon	LCH SDEC	LCH Vulcan	PHB PIU	PHB SDEC
Jun-21								
Jul-21								
Aug-21								
Sep-21								
Oct-21								
Nov-21								
Dec-21								
Jan-22								
Feb-22								
Mar-22			Green					
Apr-22								
May-22								
Jun-22								
Jul-22								
Aug-22								
Sep-22								
Oct-22								
Nov-22								
Dec-22								
Jan-23								
Feb-23								
Mar-23								
Apr-23								
May-23			Green					

Harm Free Certificate	GDH AAU [SDEC]	LCH CMDU	LCH MDU	LCH Saxon	LCH SDEC	LCH Vulcan	PHB PIU	PHB SDEC
Jun-21								
Jul-21								
Aug-21								
Sep-21								
Oct-21								
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								B - Falls
Dec-22								S - Falls
Jan-23								
Feb-23								
Mar-23					B - Skin			B - Skin
Apr-23					S - Skin			S - Skin
May-23								

FLO	GDH AAU [SDEC]	LCH CMDU	LCH MDU	LCH Saxon	LCH SDEC	LCH Vulcan	PHB PIU	PHB SDEC
Jun-21			R		G	G		R
Jul-21			G		G	R		G
Aug-21			G		G	A		G
Sep-21			G		G	A		G
Oct-21			R		G	A		G
Nov-21			G		G	G		G
Dec-21			R		A	G	G	G
Jan-22			G		A	R	G	G
Feb-22			G		G	G	G	G
Mar-22		G	G	G	G	G	G	G
Apr-22	G	G	G	G	G	G	G	G
May-22	G	G	G	G	G	G	G	G
Jun-22	G	G	G	G	G	A	R	G
Jul-22	G	G	G	R	G	G	G	G
Aug-22	G	G	G	G	G	G	G	G
Sep-22	G	G	G	G	G	G	G	G
Oct-22	G	G	N/A	G	G	G	G	G
Nov-22	G	G	N/A	G	G	G	G	G
Dec-22	G	G	G	G	G	G	G	G
Jan-23	G	G	G	G	G	G	G	N/A
Feb-23	G	G	G	G	G	G	G	G
Mar-23	G	G	G	G	G	G	G	G
Apr-23	G	G	G	G	G	G	G	G
May-23	A	G	G	G	G	G	G	G

SEPSIS	GDH AAU [SDEC]	LCH CMDU	LCH MDU	LCH Saxon	LCH SDEC	LCH Vulcan	PHB PIU	PHB SDEC
Jun-21					N/A	G		R
Jul-21	R				G	R		N/A
Aug-21	G				N/A	A		N/A
Sep-21	G				N/A	R		N/A
Oct-21	A				N/A	R		R
Nov-21	A				G	A		G
Dec-21	A				G	R		G
Jan-22	A				N/A	R		N/A
Feb-22	G				N/A	A		N/A
Mar-22	A				N/A	A		G
Apr-22	G				N/A	A		G
May-22	A				N/A	R		G
Jun-22	G				N/A	G		G
Jul-22	G				N/A	G		N/A
Aug-22	N/A				N/A	G		N/A
Sep-22	G				N/A	G		N/A
Oct-22	G				N/A	G		G
Nov-22	N/A				N/A			N/A
Dec-22	G				N/A	G		N/A
Jan-23	G				N/A	G		N/A
Feb-23	G				N/A	G		N/A
Mar-23	G				N/A	G		N/A
Apr-23	G				N/A	G		G
May-23	N/A				G	G		N/A

Accreditation Progress: Surgery OPD

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check [Monthly]	GDH Max Fax Clinic	GDH Pre-Op Assessment	LCH Clinic 6	LCH Clinic 8 Opthalmology	LCH Clinic 9 Dental	LCH Colorectal & Stoma	LCH Head & Neck	LCH Orthoptists	LCH Pre-Op Assessment	PHB Colorectal & Stoma	PHB Max Fax	PHB Orthoptists	PHB Pre-Op Assessment	PHB Urology Clinic	PHB Vascular Clinic
Jun-21															
Jul-21															
Aug-21				R											
Sep-21				R											
Oct-21				R											
Nov-21				R											
Dec-21				R											
Jan-22			A	R	R										
Feb-22			A	A	A										
Mar-22			G	G	A										
Apr-22			G	G	G										
May-22			G	G	G										
Jun-22			G	G	G										
Jul-22			G	G	G										
Aug-22			G	G	G										
Sep-22			G	G	G										
Oct-22			G	G	G										
Nov-22			G	G	G										
Dec-22			G	G	A										
Jan-23			G	R	G										
Feb-23			G	G	G										
Mar-23			G	G	G										
Apr-23			G	G	R										
May-23			G	R	R										

Weekly Spot Check (Weekly)	GDH Max Fax Clinic	GDH Max Fax	GDH Pre-Op Assessment	LCH Head & Neck	LCH Orthoptists	LCH Pre-Op Assessment	LCH Clinic 8 Opthalmology	LCH Clinic 9 Dental	LCH Pre-Op Assessment	PHB Colorectal	PHB Max Fax	PHB Orthoptists	PHB Rpre-Op Assessment	PHB Urology Clinic	PHB Vascular Clinic
Jun-21															
Jul-21															
Aug-21							R R R R R								
Sep-21							R R R R								
Oct-21							R R R R								
Nov-21							R R R R R								
Dec-21							R R R G								
Jan-22							R R R R A	R R R A R							
Feb-22							R G A R	A A A A							
Mar-22							G G G A	R G R A							
Apr-22							G G G G	G G R G							
May-22							G G G G G	G G G G A							
Jun-22							G G G G	G G G G							
Jul-22							G G G G	G G G G							
Aug-22							A G G G G	G G G G G							
Sep-22							G A G G G	G G R G							
Oct-22							G G G G	G G R G G							
Nov-22							G G G G	G G G A							
Dec-22							G G G G	G R R G							
Jan-23							G R G G R	G G R G G							
Feb-23							G G G G	G G G G							
Mar-23							G G G R	G G G G							
Apr-23							A G G G	G R R R							
May-23							R R G G G	R R R R R							

Count of GREENS															
	0	0	0	0	0	0	44	38	0	0	0	0	0	0	0

Matron Audit	GDH Max Fax Clinic	GDH Pre-Op Assessment	LCH Clinic 6	LCH Clinic 8 Opthalmology	LCH Clinic 9 Dental	LCH Colorectal & Stoma	LCH Head & Neck	LCH Orthoptists	LCH Pre-Op Assessment	PHB Colorectal & Stoma	PHB Max Fax	PHB Orthoptists	PHB Pre-Op Assessment	PHB Urology Clinic	PHB Vascular Clinic
Jun-21															
Jul-21															
Aug-21				Red											
Sep-21															
Oct-21															
Nov-21															
Dec-21															
Jan-22			Amber												
Feb-22			Amber												
Mar-22	Green														Green
Apr-22															
May-22						Green	Green	Red		Green					
Jun-22	Amber	Amber							Amber			Green		Green	Green
Jul-22			Green					Red			Green		Amber		
Aug-22	Amber					Green	Green			Green		Amber			
Sep-22	Green	Green							Green				Green		
Oct-22								Green							
Nov-22	Green	Green				Amber			Green	Green		Green		Green	
Dec-22			Green		Green						Green				
Jan-23				Amber				Amber							
Feb-23	Green		Green		Green	Amber			Green	Green		Green	Green		
Mar-23			Red											Green	
Apr-23	Amber										Green				Green
May-23		Green	Amber		Amber	Green		Green		Green		Green	Amber		

Ward/Dept. Review Visit	GDH Max Fax Clinic	GDH Pre-Op Assessment	LCH Clinic 6	LCH Clinic 8 Opthalmology	LCH Clinic 9 Dental	LCH Colorectal & Stoma	LCH Head & Neck	LCH Orthoptists	LCH Pre-Op Assessment	PHB Colorectal & Stoma	PHB Max Fax	PHB Orthoptists	PHB Pre-Op Assessment	PHB Urology Clinic	PHB Vascular Clinic
Jun-21															
Jul-21															
Aug-21															
Sep-21															
Oct-21															
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															
Mar-23															
Apr-23															
May-23															

Harm Free Certificate	GDH Max Fax Clinic	GDH Pre-Op Assessment	LCH Clinic 6	LCH Clinic 8 Opthalmology	LCH Clinic 9 Dental	LCH Colorectal & Stoma	LCH Head & Neck	LCH Orthoptists	LCH Pre-Op Assessment	PHB Colorectal & Stoma	PHB Max Fax	PHB Orthoptists	PHB Pre-Op Assessment	PHB Urology Clinic	PHB Vascular Clinic
Jun-21															
Jul-21															
Aug-21															
Sep-21															
Oct-21															
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															
Mar-23															
Apr-23															
May-23															

FLO	GDH Max Fax Clinic	GDH Pre-Op Assessment	LCH Clinic 6	LCH Clinic 8 Opthalmology	LCH Clinic 9 Dental	LCH Colorectal & Stoma	LCH Head & Neck	LCH Orthoptists	LCH Pre-Op Assessment	PHB Colorectal & Stoma	PHB Max Fax	PHB Orthoptists	PHB Pre-Op Assessment	PHB Urology Clinic	PHB Vascular Clinic
Jun-21				G											
Jul-21				G											
Aug-21				R											
Sep-21				G											
Oct-21				R											
Nov-21				G											
Dec-21				G											
Jan-22				G								G			
Feb-22				G								G			G
Mar-22				G								G			G
Apr-22		G		G		G			G	G		R	G	G	G
May-22		G		G		G		G	G	G	G	G	G	G	G
Jun-22				G		G			G			G		A	G
Jul-22				G		A		G	G			G	G	A	G
Aug-22				G		G			G	G		G	G	A	G
Sep-22		G		G		A			G	G		G		A	G
Oct-22		G		G		N/A		G	G	G		N/A	G	N/A	G
Nov-22		G		G		N/A		N/A	G	G		G	G	G	G
Dec-22		G		G		N/A		N/A	G	G		G	G	G	G
Jan-23		N/A		G		G		N/A	G	G	G	G	G	N/A	G
Feb-23		G	G	G	G	N/A		G	G	N/A	G	G	G	G	G
Mar-23		G	G	G	G	G		N/A	G	G	G	G	G	G	G
Apr-23		G	G	G	G	G		G	G	G	N/A	G	G	G	G
May-23		G	G	G	G	G		G	G	G	G	G	G	G	G

NHS
United Lincolnshire Hospitals
NHS Trust

Director of Infection Prevention and Control Annual Report 2022-2023

OUTSTANDING CARE *personally* DELIVERED

Version Control

Version	1
Type	Annual Report
Directorate	Corporate
Author	Mrs Natalie Vaughan – Deputy Director Infection Prevention and Control
Contributors	Dr Bethan Stoddart - Consultant Microbiologist/Infection Prevention and Control Doctor Mrs Sandra Smirthwaite – Clinical Lead Infection Prevention and Control Mrs Joanne Bradshaw – Interim IPC Matron Mrs Vivien Duncanson – Senior Nurse Infection Prevention and Control Mrs Balwinder Bolla - Consultant Antimicrobial Pharmacist Mr Stuart Whitehead – Head of Estates Mr Paul Pattinson – Head of Estates , Compliance, Facilities Mr Wayne McIntosh – Head of Facilities - Estates and Facilities Engagement Lead Mrs Karen Bailey - Estates, Facilities and Decontamination Lead Nurse Mr Stephen Kelly – Head of Occupational Health Mrs Anita Pearson – Senior Occupational Health Advisor Mr Martin Bosworth - IPC Service Co-ordinator/Data Analysist
Approving Person	Mr Paul Dunning - Medical Director, Director Infection Prevention and Control
Approval Date	Infection Prevention and Control Group

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1. Summary and Highlights

The Director of Infection Prevention and Control (DIPC) Annual Report details infection prevention and control (IPC) performance activities within United Lincolnshire Hospitals Trust (ULHT) for the year 2022-2023.

The report outlines the Trust's continued zero tolerance approach to preventing and reducing the risk of avoidable healthcare associated infection (HCAI) as well as the process and interventions taken to mitigate risk. There is a strong commitment to lead on and support initiatives to prevent HCAI.

IPC practice is essential to ensure those who access the Trust's services receive safe care. Effective interventions require the hard work and diligence of all clinical and non-clinical staff, with a need for everyone to consistently apply a high level of practice.

The publication of this report is a requirement to demonstrate effective governance and public accountability. It highlights in addition the role, function and reporting arrangements of the DIPC and the IPC Team.

During the year there has been further development of the IPC Team in both number and skill mix to take forward the need for investment in strong, consistent clinical leadership and to continue to build a one team approach. New members have enhanced this approach and brought with them a wealth of experience and skills to take the service forward.

IPC key objectives provide a strategic and structured framework upon which to shape and develop IPC across the organisation.

The IPC Group receives quarterly Board Assurance Frameworks (BAF) for The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and until September 2022 related COVID19 guidance. There is a continued increase in compliance and commitment to sustain the required IPC key lines of enquiry.

Mandatory reported cases of HCAI has identified an increase in the cases of some infections. The pandemic effect has continued to impact, due to resuming clinical activity, treating a high number of very sick patients and the use of antibiotics.

The COVID-19 pandemic continued to pose a level of challenge with the continued implementation of a risk-based response and the gradual decreasing of the wearing of masks and testing for this infection. There was close monitoring of nosocomial cases and outbreaks of this infection, with a high number continued to be reported.

During the year, NHS England (NHSE) conducted 2 visits where significant improvements were observed, specifically relating to Estates and Facilities actions to achieve remedial work. Good IPC practice was recognised as well as the strengthening of governance arrangements. A decision was made to increase the Trust from an amber to a green rating. Staff were commended as being professional, caring and friendly. An identified issue was promptly dealt with in an efficient manner. There is a need to continue to focus on peripheral line management, waste disposal practices and the management of sharps.

The report furthermore offers an overview of activity and/or development of outbreaks of infection, policies and guidelines, audit programme, antimicrobial stewardship, laboratory service, occupational health and training.

The Estates and Facilities section makes reference to work relating to environmental cleanliness, water safety, ventilation and decontamination.

This report will make reference to the strong Lincolnshire system-wide partnership work to create and sustain consistent and proportionate approaches to the investigation and management of relevant infections.

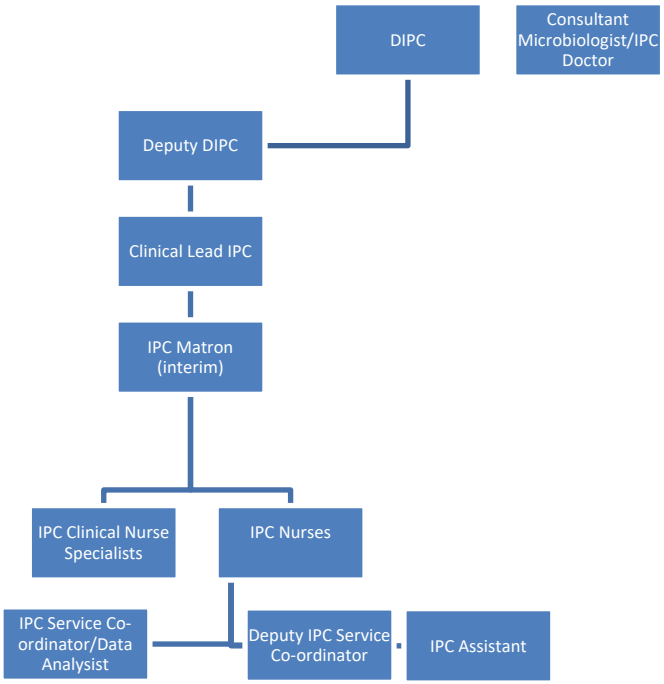
A forward plan details work and initiatives to be progressed through 2022-2023 in addition to updated IPC key objectives.

2. Infection Prevention and Control Arrangements and Team

The DIPC holds Board level responsibility for all matters relating to the safe delivery of IPC care and practice and is supported by the Deputy DIPC, who also provides operational leadership to the IPC Team.

During the year there has been further development of the IPC Team in both number and skill mix to take forward the need for investment in strong, consistent clinical leadership and to continue to build a one team approach. New team members have enhanced this approach and brought with them a wealth of experience such as ward management, clinical education and critical care skills to take the service forward. Existing team members have received career progression and an IPC Assistant twas welcomed to the team. Some cover over the weekend and bank holiday working has been implemented. Recruitment continues with interest in the posts advertised.

Diagram 1: Current Infection Prevention and Control Team Structure



3. Infection Prevention and Control Governance, Assurance and Reporting Structure

The IPC Group meets monthly and provides strategic direction for the prevention and control of HCAI. It performance manages the organisation against the Trust's IPC Key Objectives (Table 1) and ensures a risk-based and proportionate response to directives as well as national and local guidance. Upward reporting via a highlight report is to the Quality Governance Committee (QGC) and the Trust Executive Board.

Table 1: Infection Prevention and Control Key Objectives 2022-23

Number	Objective
1	Develop infection prevention and control organisational and Divisional Governance arrangements
2	Continue to progress assessment and gap analysis of The Health and Social Care Act 2008. Code of Practice on the prevention and control of infection
3	Further development of surveillance of healthcare associated infections and performance
4	Investigate and manage the risks posed by novel infectious diseases to promote patient safety and prevent and reduce the risk of cross transmission
5	Investigate and manage the risks posed by the emergence of multi-drug resistant organisms to promote patient safety and prevent and reduce the risk of cross transmission
6	Development of governance arrangements for appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
7	Implement and sustain standards of cleanliness in line with National Standards of Healthcare Cleanliness. Development and implementation of hydrogen peroxide total room decontamination
8	Progress water safety, ventilation and decontamination requirements as sub-groups of the Infection Prevention and Control Group to ensure patient safety requirements

Antimicrobial stewardship, water safety, ventilation and decontamination sub-groups report into the IPC Group with Divisions providing assurance and exception reporting in line with The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and related guidance (updated December 2022).

The Infection Prevention and Control Objectives and Programme of Work 2022-2023 utilises the IPC Key Objectives to provide a framework to devise, implement and evaluate initiatives and strategies to prevent and reduce the risks associated with and incidence of HCAI.

The focus of work has supported initiatives to further develop Divisional arrangements with an emphasis on clinical practices and the development of their IPC audit processes to further interrogate and analyse data.

A plan remains in place to develop surveillance of HCAI with a need to take forward some surgical site infection surveillance. This has again been impacted upon by the continued need to prioritise COVID-19 related work.

To promote patient safety and prevent and reduce the risk of cross transmission, work has continued to progress on the investigation and management of novel and multi-drug-resistant organisms. The development of governance arrangements for appropriate antimicrobial have also been a priority.

IPC expertise has supported the progression of further compliance with environmental cleanliness, water safety, ventilation and decontamination requirements and directives. Specific interventions have remained work to achieve hydrogen peroxide decontamination in occupied areas, as well as the roll of the L8 Guard water flushing compliance system.

This report will allude to the strong Lincolnshire system-wide partnership work to create and sustain consistent and proportionate approaches to the investigation and management of relevant infections.

3.1 Board Assurance Frameworks (BAF)

The IPC Group receives a quarterly BAF for The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and related guidance with the criterion wording detailed in Table 2. The COVID-19 BAF continued to September 2022, when it was superseded by a generic IPC framework document.

Table 2: The Health and Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related guidance

No	Criterion Description: what the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and others may pose to them
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance
4	The provision of suitable accurate information on infection to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion
5	That there is a policy for ensuring that people who have or are risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7	The provision or ability to secure adequate isolation facilities
8	The ability to secure adequate access to laboratory support as appropriate
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection prevention and control

The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and related guidance has described the organisation can respond in an evidence-based way to maintain the safety of our patients, services users, and staff. We have identified areas of risk and as a response put in place the required corrective actions. The BAF furthermore provided assurance to the Trust Board that organisational compliance has been systematically reviewed.

There are a wide range of systems, processes, policies and procedures to prevent and reduce the IPC risks posed to patients, visitors and staff. For example, in respect of a respiratory plan incorporating respiratory viruses that reported patients have been managed in line with Trust policy and procedure for testing, isolation/cohorting arrangements, outbreak investigation and management as well as multi-disciplinary working (Criterion 1).

Environmental cleanliness audit data has indicated very good overall compliance with prompt rectification of an issue of concern. Investment to support the required levels of clinical cleaning across the organisation was positively received by the IPC Group in respect of the prevention of HCAI (Criterion 2).

Plans contained within the BAF have addressed gaps in assurance such as ventilation systems within our ageing environmental infrastructure continue to score partial compliance (Criterion 2). The roll out of new hand hygiene products offered assurance that requirements are in place to achieve staff, patient and visitor hand hygiene compliance and awareness (Criterions 4 and 6).

Table 3: The Health and Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance: Board Assurance Framework Compliance Summary 2022-23

Compliant

Partial

Criterion	Theme
Criterion 1	Governance
Criterion 2	Environment
Criterion 3	Antimicrobial stewardship
Criterion 4	Information
Criterion 5	Management
Criterion 6	Engagement
Criterion 7	Isolation
Criterion 8	Laboratory support
Criterion 9	Policies
Criterion 10	Workforce

The final COVID-19 BAF highlighted overall very good systems and processes in place. A Lincolnshire –system wide approach has promoted a joined up way of working. Cleaning resources were aligned to achieve a risk-based and prioritised approach. Partial compliance remained for Criterion 2 pertaining to the challenges with poor environmental infrastructure and ageing ventilation.

Table 4: The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections: COVID-19 Board Assurance Summary: April - September 2022

Compliant

Partial

Criterion	Theme
Criterion 1	Governance
Criterion 2	Environment
Criterion 3	Antimicrobial stewardship
Criterion 4	Information
Criterion 5	Management
Criterion 6	Engagement
Criterion 7	Isolation
Criterion 8	Laboratory support
Criterion 9	Policies
Criterion 10	Workforce

4. Healthcare Associated Infection Performance

4.1 Mandatory Reporting

The following infections required by the mandatory surveillance programme facilitated by UK Health Security Agency (UKHSA) continued to be reported:

- Meticillin-resistant *Staphylococcus aureus* (MRSA) blood stream infections (bacteraemia)
- *Clostridioides difficile* infection
- Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia
- *Escherichia coli* bacteraemia
- *Klebsiella* species bacteraemia
- *Pseudomonas aeruginosa* bacteraemia.

4.2 Meticillin-Resistant *Staphylococcus aureus* Bacteraemia

Staphylococcus aureus is a bacterium commonly found on human skin which if there is an opportunity for the bacteria to enter the body can cause infection. In serious cases it can result in a bloodstream infection (bacteraemia). Meticillin-resistant

Staphylococcus aureus (MRSA) is a strain of these bacteria that is resistant to many antibiotics, making it more difficult to treat.

Many patients carry MRSA on their skin and this is called colonisation. It is important to screen some high risk patient groups when they come into hospital to identify if they are carrying MRSA.

In 2022-2023, there were 2 Trust acquired MRSA bacteraemia reported and nationally there remains a zero tolerance to such cases (Table 5). This was the same as the number of cases reported in 2021-2022.

For each case a root cause analysis (RCA) investigation was undertaken to identify areas of concern, ensure actions were taken to prevent recurrence and the lessons learnt and shared with the wider health care team.

The first case in June 2022, at Pilgrim Hospital Boston (PHB) was in the Surgery Division and due to the patient developing an infection (parotitis). This occurred in the community setting, but as the patient was discharged from our care within a 28 day period was attributed to the Trust. At the time of writing, the apportionment case is subject to an appeal process.

The second case at Grantham and District Hospital (GDH) was in the Medicine Division. The investigation the patient acquired MRSA that was deemed avoidable as there were discrepancies with peripheral line management.

Table 5: MRSA Bacteraemia by Site 2022-2023

Date → / Site ↓	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Louth	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln (LCH)	0	0	0	0	0	0	0	0	0	0	0	0
Pilgrim (PHB)	0	0	1	0	0	0	0	0	0	0	0	0
Grantham (GDH)	0	0	0	0	0	1	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	0	1	1	1	2	2	2	2	2	2	2

4.3 *Clostridioides difficile (C. difficile)* Infection

C. difficile is a bacterium found in the gut of around 3% of healthy adults. It seldom causes a problem as is kept under control by the normal bacteria of the intestine. It can however cause an infection of the large intestine (colon). Certain antibiotic can disturb the bacteria of the gut and *C. difficile* can then multiply and produce toxins which cause symptoms such as diarrhoea.

Table 6 describes 70 Trust attributable cases of *C. difficile* reported against a trajectory of not to exceed 56 cases. This compared with 59 Trust attributable cases reported in 2020-2021 (increase of 18%). For 4 cases, a review panel comprising ICB, UKHSA and IPC colleagues deemed no lapses in patient care and supported the readjustment of the end of year figure to a total of 66 cases. Nationally there has been a reported increase on this infection.

Table 6: Trust Attributable C. *difficile* Data 2022-2023

Date → Case Totals ↓	Apr 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Trajectory	4	4	4	4	5	5	5	5	5	5	5	5
Actual acute cases	4	6	5	7	8	11	6	4	1	8	5	5
+/- Trajectory	0	+2	+1	+3	+3	+6	+1	-1	-4	+3	0	0
Acute Cumulative actual	4	10	15	22	30	41	47	51	52	60	65	70

The increase in cases, especially in the Medicine Division alluded to patients that required multiple antimicrobial treatment which subsequently increased their risk of having this infection.

There were investigations into 3 periods of incidence (PII) defined as two or more cases of *C. difficile* (occurring > 48 hours post admission, not relapses) in a 28-day period on a ward. There was one PII at Lincoln County Hospital (LCH), 1 at PHB and 1 at GDH. IPC interventions such as patient isolation, enhanced cleaning, sending stool samples for ribotyping, weekly antimicrobial audits for a 3 week period as well as RCA investigation and holding PII meetings with clinical colleagues were instigated.

For the PII at LCH, the ribotyping indicated cross transmission which highlighted the need for prompt patient isolation upon taking the stool sample, review of antimicrobial prescribing and the importance of maintaining high standards of environmental cleanliness.

Cases of Trust acquired *C. difficile* were furthermore subject to a thematic investigation to facilitate a detailed review. Common themes requiring further work and development included recording of severity score, some suboptimal antimicrobial prescribing, i.e. long-term antimicrobials given without Microbiologist consultation as well as their advice not always followed. Patients were not always isolated when a stool sample was taken and in some cases samples were not taken appropriately. An action plan was compiled with assurance and monitoring by the IPC Group.

4.4 Meticillin-Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

MSSA is a strain of these bacteria that can be effectively treated with antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body and in serious cases it can cause blood stream infection (bacteraemia).

Table 7 details the 25 reported cases of Trust acquired MSSA bacteraemia during 2022-2023 and has increased when compared with 19 cases reported in the previous year, representing an increase of 31%. Contributory factors have included, an increase in post pandemic activity, patient acuity as well as higher risk factors, e.g. IV drug use. There has been an increased focus on the management of invasive devices.

Table 7: Trust Attributable MSSA Bacteraemia by Site 2022-2023

Date → / Site ↓	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Louth	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln (LCH)	0	4	1	1	2	0	1	1	2	0	1	3
Pilgrim (PHB)	0	0	1	1	1	0	1	1	2	0	1	0
Grantham (GDH)	0	0	0	0	0	0	1	0	0	0	0	0
Total	0	4	2	2	3	0	3	2	4	0	2	3
Cumulative Total	0	4	6	8	11	11	14	16	20	20	22	25

4.5 Gram Negative Bacteraemia

- ### *Escherichia coli (E. coli)* Bacteraemia

E. coli is a bacteria that normally lives in the intestines of both healthy people and animals to aid the digestion of food, but can cause urinary, biliary or gastrointestinal tract related infection leading to blood stream infection (bacteraemia).

Some *E. coli* are enzyme producers known as extended spectrum beta lactamase (ESBL) which increase the resistance to multiple antibiotics.

Attention to insertion and care of urinary catheters, auditing, education and reporting of catheter associated urinary tract infection were the interventions directed to further reduce HCAI and *E. coli* blood stream infection.

For 2022-2023 there was a total Trust and community trajectory of not to exceed 107 cases of this bacteraemia and within this period 61 were Trust attributed. There were 54 cases reported in the previous year, representing an increase of 13%.

- ### *Klebsiella* species Bacteraemia

Klebsiella species belong to the family enterobacteriaceae. They are commonly found in the environment and human intestinal tract and do not normally cause disease. These species however can cause a range of HCAIs, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis. There can also be resistance to a wide range of antibiotics.

For 2022-2023 there was a total Trust and community trajectory of not to exceed 37 cases and in this period there were 29 Trust attributed cases. There were 24 cases reported in the previous year, representing an increase of 21%.

- ### *Pseudomonas aeruginosa* Bacteraemia

Pseudomonas is a type of bacteria commonly found in the environment, including soil and in water. Of the many different types of *Pseudomonas*, the one most often causing infection is an opportunistic pathogen called *Pseudomonas aeruginosa*. It takes advantage of a weakened immune system, produces tissue-damaging toxins and can cause bloodstream infection, pneumonia, or infection in other parts of the body following surgery.

For 2022-2023 there was a total Trust and community trajectory of not to exceed 13 cases and in this period there were 12 Trust attributed cases. There were 8 cases reported in the previous year, representing an increase of 50%. An investigation alluded to the likely contributory factor was extremely medically vulnerable patients

with an increased susceptibility to infection. A water associated link was not identified.

4.6 COVID-19

Through 2022-2023 the COVID-19 pandemic continued to pose a high level of challenge. Nosocomial rates and outbreaks of COVID-19 were closely monitored with measures in place to prevent and reduce the spread of the virus.

Outbreak of infection meetings continued to be held twice weekly to offer support, guidance, implementation of IPC policy and practice relating to COVID-19, management of outbreaks and provided assurance to the IPC Group and QGC.

The updated COVID-19 BAF (Section 3.1) supported the process and moreover until superseded by the IPC BAF provided a framework for assurance and monitoring.

The Lincolnshire system-wide approach offered a review and interpretation of national and regional principles sand standards to accommodate living with COVD-19. Back in April 2022 this concentrated on interventions to support ambulance hand over delays and improve patient flow into and out of our hospitals. This resulted in changes to COVID-19 testing and associated patient management protocols. Protection of our most vulnerable patient groups remained a priority.

Throughout the year, upon the direction of national IPC guidance COVID-19 precautions and interventions have gradually been decreased, via a proportionate and rational approach taking into account local demographics and prevalence. This has included decreasing the wearing of a face mask as well as relaxing social distancing. There was furthermore a commitment to reinstating visiting arrangements when it was safe to do so.

Clinical and Divisional colleagues have remained focused on and engaged with COVID-19 IPC requirements. Cleaning teams continued to provide an exceptional level of support to ensure there was enhanced cleaning in areas caring for positive patients, contacts and for outbreak wards.

The COVID-19 designated wards at the LCH and PHB sites remained in situ and provided a high level of patient care and IPC precautions to achieve patient safety and maximise the use of single room accommodation.

Trust wide communications have disseminated relevant, up to date and consistent key messages to ensure an informative and proportionate approach.

4.7 Carbapenemase Producing Enterobacterales (CPE)

CPE are a strain of the enterobacteriaceae bacteria family, which live naturally in the gut and help to digest food. This is called colonisation as it causes no harm and requires no treatment, however if these bacteria get into other areas other areas of the body such as the bladder, bloodstream or wounds, they can cause infection. CPE bacteria are resistant to carbapenam antibiotics, which makes an infection very difficult to treat. Last year there was an increase in cases of CPE with a contributory factor being the increased use of antibiotics. There were also 2 reported outbreaks of this infection (Section 4.12).

4.8 Group A *Streptococcus* (GAS)

GAS is a bacteria also known as *Streptococcus pyogenes* which can live harmlessly in the throat and nose, and is usually associated with throat infection more common in younger children. Most infections are mild and can be easily treated with an antibiotic. Rarely the infection can cause a blood stream infection that is more serious and is referred to as invasive group A *Streptococcus* (iGAS).

UKHSA reported an unusual national rise in cases from December 2022- March 2023, affecting all ages. This meant seeing a higher number of cases compared to a typical year. There were no associated outbreaks with this organism.

There was again Lincolnshire system-wide discussion and collaboration that ensured a joined up approach of compliance with national requirements. In December 2022 a local directive issued pertaining to the management of children with suspected and/or confirmed scarlet fever/GAS was issued.

4.9 Influenza A

Influenza A virus causes a highly contagious respiratory illness with influenza A and B the most common strains that can lead to outbreaks of this infection. The viruses circulate in the community with new strains emerging each winter.

It was reported the likelihood of viral co-infections may have been greater last winter, due to several respiratory diseases peaking at the same time, rather than sequentially as happened pre-pandemic.

There was therefore the expected increase in cases this winter from December 2022- March 2023, compared to the previous year.

The Lincolnshire system-wide approach promoted a good level of consistency with the requirements for risk considerations such as mask wearing, testing, patient isolation and cohorting along with outbreak declaration and management.

4.10 Norovirus

Norovirus causes diarrhoea and/or vomiting, is highly contagious and can easily spread through contact with someone with the infection or with contaminated surfaces.

There was an increase in cases with 4 outbreaks of this infection reported in our hospitals. This was also reflected nationally, where the increase in norovirus laboratory reports increased across all age groups, most notably in those aged 65 years and over, being reported by UKHSA as the highest number of cases in over a decade.

4.11 Monkeypox (Mpox)

The national outbreak of this infection was subject to national directives and guidance that via a Lincolnshire system-wide approach were interpretated and implemented at a local level. This included the management of suspected cases, providing a cohesive approach to the implementation of operational actions. This collaborative work promoted a greater understanding of roles and responsiblities to achieve a process for the safe management of this infection.

4.12 Outbreaks of Infection

An outbreak of infection is defined as an episode of infection where there is spread of sufficient seriousness to demand immediate action and the year's outbreaks of infection are located in Table 8.

Table 8: Outbreaks of Infection 2022-23

Organism	Number of Outbreaks	Number of Patients	Number of Staff	Number of Closed Bed Days
Influenza A	3	9	0	0
Norovirus	4	35	15	0
C. difficile	1	3	0	0
CPE	2	9	0	58
Totals	**10**	**56**	**15**	**58**

- Influenza A

There was a general increase in the number of cases of Influenza A and 3 outbreaks were declared. Full ward closure did not take place, as patient segregation in bays with the doors kept closed was successful to reduce transmission. The ward areas were subsequently deep cleaned and re-opened.

- Norovirus

Norovirus cases and 4 outbreaks of this infection across several wards accounted for an increase in cases during February- March 2023. IPC measures included closing the wards to new admissions and a deep cleans before being reopened.

- *C. Difficle*

In July 2023, an outbreak was declared on a ward at LCH following identification of 3 hospital onset cases, associated with an 8 bedded bay. The patients were isolated in single rooms and received the appropriate treatment. The ward was decanted, deep cleaned and curtains changed. There was the same Ribotyping (020) for the 3 cases indicated cross transmission had taken place. The IPC Team reviewed practice and provided education.

- CPE

This was the first time the Trust had declared outbreaks of CPE. The first in June 2022 on a ward at LCH where 2 patients affected patients were cared for in opposite beds in the same bay. The cases were identified as *Klebsiella pneumoniae* OXA type Carbapenemase detected. Contacts were screened and the ward was decanted to facilitate a Microbiology and IPC review, as well as total ward hydrogen peroxide decontamination and associated remedial work.

Environmental sampling in this bay identified CPE in a hand wash basin drainage outlet in this bay. The basin was replaced and the taps decontaminated. Reiteration that hand wash basins must be used solely for washing hands was progressed as a likely cause was possibly due to the incorrect disposal of patient wash water into this basin. Surveillance identified no further cases.

The second outbreak in July 2022 was on a ward at PHB affecting a total of 7 patients. The related cases were predominantly identified as *Klebsiella oxytoca* OXA type carbapenamase detected. The ward was closed to admissions and patient screening was undertaken in line with policy as well as screening of all patients transferred from PHB to the LCH and GDH sites.

Enhanced cleaning was instigated with assurance and monitoring ascertained via audit processes. Integrity of equipment was reviewed with replacement as required along with a review of cleaning methods, e.g. the cleaning of hand wash basins to negate the risk of transference of micro-organisms. Refresher hand hygiene and cleaning training were also delivered. The ward was decanted to allow Estates works to be carried such as hand wash basin replacement as well as total ward hydrogen peroxide decontamination.

- ## COVID-19 cases of nosocomial infection and outbreaks

During the year there were 892 reported cases of nosocomial (probable and definite) COVID-19 and 132 outbreaks of this infection (Table 9).

Table 9: COVID-19 Nosocomial Cases and Outbreaks of Infection 2022-23

Number of Cases/Outbreaks → Date ↓	Number of Cases of COVID-19 : Probable (8-14 days)	Number of Cases of COVID-19: Definite (15+ days)	Number of Outbreaks of COVID -19
Apr 22	38	37	7
May 22	8	29	9
Jun 22	28	39	10
Jul 22	42	77	19
Aug 22	36	49	6
Sept 22	53	76	25
Oct 22	55	59	9
Nov 22	18	19	6
Dec 22	24	26	10
Jan 23	15	19	8
Feb 23	27	38	9
Mar 23	51	29	14
Totals	**395**	**497**	**132**

As described above the continued high prevalence of COVID-19 led to increased cases and outbreaks of this infection. The twice weekly IPC outbreak meetings had oversight of each outbreak and received assurance regarding the investigation of cases, patient isolation, IPC precautions and the monitoring of positive patients and contacts in line with national guidance. There was timely patient and staff screening with good co-ordination by Occupational Health colleague. Visiting was restricted as appropriate as well as the deployment enhanced cleaning and increased auditing of the affected areas.

Contributory factors that may have led to onward transmission included limited single room accommodation (and with en suite facility), the number of patients cohorted in an area due to bed capacity constraints, ageing environmental infrastructure, especially ventilation systems and repeated critical incident status due to very high bed capacity. Further exacerbations were the increased number of COVID-19 related admissions as well as some decreased staffing capacity due to COVID-19 related illness.

5. Policies and Guidelines

Through 2022-2023 the policies to comply with the requirements set out in The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and related guidance continued to be published with existing documents reviewed and updated.

The Guidance at a Glance quick reference documents for key IPC practice have remained popular as a very good quick reference guide.

In July 2022 there was the launch of the National Infection Prevention and Control Manual for England (NHSE) that offered an evidence-based practice resource to ensure a consistent approach to IPC with the premise that it should be adopted in NHS settings with the principles applied in all care settings. Publication of local polices has progressed by utilising the manual as a reference guide to align IPC principles and practice as appropriate

Pan-organisation communication was an important means for the provision of a raft of key information and directive updates to busy staff.

6. Audit Programme

The IPC programme of audit monitored and assured IPC practice standards across the organisation as well as putting forward additional COVID-19 related assurance.

The Front Line Ownership (FLO) audit programme has remained the standardised IPC audit tool for all wards and departments by focussing on key areas of practice including hand hygiene, general and patients' immediate environment, patient isolation, dirty utility / linen and waste disposal, ward kitchen, sharps safety, storage areas, clean utility and treatment room, patient equipment decontamination and clinical practice.

The audits were undertaken by Divisions on a monthly basis with results, themes and actions reported to the IPC Group. Senior Divisional staff have provided a

detailed overview of IPC practice in their clinical environments reflecting responsibility, accountability and engagement to achieve a good range of predominantly high standards. The IPC Team has conducted a programme of validation audits with collaborative work taken forward when the results highlighted discrepancies.

Thematic analysis as in past years highlighted the need to focus on the impact of poor environmental infrastructure and continued programmes of enhancement and refurbishment. There has been a focus on peripheral cannula management as well as safe sharps practices in respect of activating the container temporary closure mechanism.

A summary of Divisional FLO audit results is located in Table 10.

Table 10: Divisional Front Line Ownership Audit Scores (%) 2022-2023

Site	Division	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Pilgrim	CSS	93.63%	93.37%	94.00%	95.83%	95.12%	96.19%	96.53%	96.61%	96.94%	96.88%	96.89%	97.50%
Lincoln	CSS	96.22%	96.81%	96.56%	95.71%	96.89%	96.31%	96.48%	97.30%	97.52%	97.00%	96.88%	97.21%
Grantham	CSS	96.73%	95.58%	97.50%	98.11%	98.60%	98.22%	98.40%	98.33%	97.83%	98.21%	98.29%	99.15%
Louth	CSS	98.29%	98.14%	98.25%	98.25%	97.50%	96.75%	98.29%	98.83%	97.17%	97.57%	97.88%	98.13%
Pilgrim	Family Health	96.86%	96.88%	97.38%	96.80%	96.00%	97.13%	97.43%	98.40%	96.71%	96.17%	95.60%	96.50%
Lincoln	Family Health	96.44%	96.33%	97.00%	96.86%	97.60%	96.67%	96.50%	97.44%	97.50%	95.75%	96.88%	96.33%
Grantham	Family Health	93.50%	99%	99%	100%	N/A	98%	99%	N/A	97%	96%	95%	96%
Louth	Family Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pilgrim	Medicine	96.17%	93.75%	94.10%	94.60%	92.83%	90.50%	92.75%	92.60%	92.92%	92.00%	93.92%	94.46%
Lincoln	Medicine	94.06%	94.47%	93.88%	96.61%	94.33%	95.05%	93.95%	93.58%	93.89%	94.19%	93.14%	92.10%
Grantham	Medicine	95.50%	95.00%	93.50%	95.00%	95.75%	96.00%	95.75%	95.50%	93.25%	93.50%	94.25%	93.50%
Louth	Medicine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pilgrim	Surgery	95.44%	96.92%	94.75%	94.27%	95.50%	96.20%	97.38%	98.09%	97.27%	96.58%	97.23%	97.31%
Lincoln	Surgery	93.18%	94.54%	94.36%	94.42%	95.09%	94.73%	95.00%	95.11%	95.70%	95.18%	95.23%	93.82%
Grantham	Surgery	99.25%	99.50%	98.33%	98.33%	97.33%	96.75%	97.25%	97.67%	97.67%	98.67%	96.67%	97.75%
Louth	Surgery	94.00%	96.50%	97.00%	97.00%	97.00%	98.00%	97.50%	98.00%	97.50%	97.50%	98.50%	97.50%

(≤ 84% = red; 85-90% = amber; 91–100% = green)

Effective hand hygiene is one of the most effective measures to prevent the spread of infection and this has been especially important throughout the pandemic. The results in Table 10 described overall high compliance with the requirements of the 5 moments of hand hygiene.

Work progressed to review hand hygiene facilities as the current system required updating and replacement. The new GOJO hand hygiene system is now in place across the majority of the organisation (further work required at the Louth site).

Table 11: Divisional Hand Hygiene Audit Scores (%) 2022-2023

Site	Division	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Pilgrim	CSS	96.88%	99.62%	97.07%	98.13%	98.78%	98.78%	96.44%	96.94%	99.88%	99.81%	99.88%	99.81%
Lincoln	CSS	99.70%	99.54%	99.27%	98.44%	99.72%	99.72%	99.52%	99.61%	99.90%	98.72%	99.35%	99.63%
Grantham	CSS	99.75%	100.00%	99.67%	99.73%	99.78%	99.78%	100.00%	99.55%	100.00%	99.86%	100.00%	99.85%
Louth	CSS	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Pilgrim	Family Health	100.00%	99.57%	99.38%	100.00%	100.00%	100.00%	99.71%	99.00%	98.83%	99.50%	95.40%	99.63%
Lincoln	Family Health	99.78%	99.78%	99.44%	99.86%	100.00%	100.00%	100.00%	100.00%	99.75%	100.00%	99.75%	99.89%
Grantham	Family Health	99.00%	100.00%	95.00%	100.00%	100.00%	100.00%	99.00%	N/A	100.00%	100.00%	100.00%	100.00%
Louth	Family Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pilgrim	Medicine	98.50%	95.00%	98.00%	96.00%	97.00%	97.00%	97.50%	97.80%	95.67%	96.64%	97.00%	96.67%
Lincoln	Medicine	96.12%	97.39%	97.93%	98.47%	96.61%	96.61%	93.74%	97.17%	98.32%	96.71%	97.32%	97.50%
Grantham	Medicine	98.25%	99.00%	98.25%	98.50%	97.00%	97.00%	98.75%	98.25%	98.50%	99.00%	99.25%	98.75%
Louth	Medicine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pilgrim	Surgery	94.13%	98.00%	98.17%	98.30%	97.91%	97.91%	95.75%	98.82%	97.18%	95.45%	96.50%	95.62%
Lincoln	Surgery	99.44%	99.15%	98.70%	99.42%	99.50%	99.50%	98.18%	97.67%	98.40%	99.18%	99.31%	99.36%
Grantham	Surgery	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.66%	100.00%
Louth	Surgery	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

(≤ 84% = red; 85-90% = amber; 91–100% = green)

- ## Compliance Assessment Tool (CAT) Audits

The IPC Team has carried out compliance assessment tool (CAT) audits on a patient upon identification of an organism of clinical significance, including MRSA, *C. difficile*, CPE and ESBL. Themes focussed on the need for prompt and correct patient isolation, a focus on commode cleanliness, a clutter-free environment, prompt taking of MRSA repeat swabs along with the correct wearing of PPE.

Further developments included timely commencement and completion of IPC related care pathways and documentation of a *C. difficile* infection severity assessment. Support and education was instigated to assure future compliance.

- ## Sharps Mangement External Audit

In March 2023, an external sharps audit was carried out on all sites. There was a good overall level of compliance, Divisions were however asked to ensure inappropriate items were not disposed of in the sharps containers and to complete the label with the date and time the container was assembled. As previously reported, there was a focus on using the temporary closure mechanism, ensuring correct assembly and making sure of the correct lid and container to avoid a mismatch. There was also monthly sharps auditing in place via the FLO audit programme as well as a plan for education and refresher training.

- Infection Prevention and Control Internal Audit: Grant Thornton

The COVID-19 BAF has been subject to an internal audit undertaken by Grant Thornton. There was a review of IPC and associated policies as well as visits to 30 randomly selected clinical services across 3 sites (LCH, PHB and GDH). Significant assurance was obtained that the organisation has monitored and reported progress against the BAF with appropriate escalation. There was moreover sufficient recorded evidence to support the assurance provided to demonstrate mitigating actions were implemented. There was significant assurance with some further work required to ensure staff were aware of and compliant with the actions contained within the framework. Partial assurance was awarded for staff demonstrating evidence of the implementation of actions to achieve compliance.

A follow up audit to LCH concluded progress in addressing many of the recommendations relating to IPC arrangements and the National Standards of Healthcare cleanliness 2021 star ratings were well embedded with good adherence to hand hygiene practice. A recommendation was for the IPC Group to continue to monitor compliance concerning the use of cleaning schedules, understanding the cleaning of bed spaces following a patient discharge as well as the correct use of clean stickers on commodes.

7. External Inspections and Visits

The first NHSE visit of the year was in April 2022, as a follow up to LCH outpatient areas, as a previous visit had identified number of IPC practice and environmental issues requiring immediate attention. Significant improvements were observed specifically relating to Estates and Facilities actions to achieve decluttering and remedial work.

Good IPC practice was observed as well as the strengthening of governance arrangements, for example audit development and review. A good level of work was evidenced in respect of further embedding practice to achieve sustainability, especially in relation to sharps practices and some waste disposal processes.

In July 2022 a letter from the regional NHSE Assistant Director of IPC documented a decision to increase the Trust from an amber to a green rating.

A further visit in February 2023 took place over 2 days to the GDH, PHB and LCH sites, with verbal feedback giving much positive assurance that as an organisation we have achieved the progression of improved IPC standards. It was encouraging this was also apparent in the unannounced areas that were visited. Staff were

commended as being professional, caring and friendly. An identified issue was promptly dealt with in an efficient manner.

There was a need to continue to focus on waste disposal practices with the reporting of good overall progress to ensure consistent compliance with the required directives. Sharps management has remained a Divisional focus with auditing and training in place.

Aspects of peripheral line non-compliance coincided with the progression of a Peripheral Line Task and Finish Group, chaired by the Deputy DIPC, was established due to a number of concerns identified in relation to peripheral line care and management and furthermore in the context of 2 cases of HCAI (reported in section 4). Work has focused on documentation, policy, procedure and competency as well as the peripheral line patient pathway practices. There has been a review of audit and validation processes along with education and the role of the Clinical Educators. There is to be reinstatement of the Vascular Access Group.

Through the year, there have been quarterly supportive visits from the Senior Health Protection Nurse at the Integrated Care Board (ICB). The review of IPC compliance in clinical areas has been overall positive with areas being clean. Summary reports made reference to the ageing and in some cases poor infrastructure and as previously reported sharps practices and peripheral line management.

8. Antimicrobial Stewardship (AMS)

The set up and development of NHSE Antimicrobial Resistant Leads has brought about much insight and development in acute NHS Trusts, with participation in several key work streams, including penicillin allergy and intravenous (IV) to oral switch.

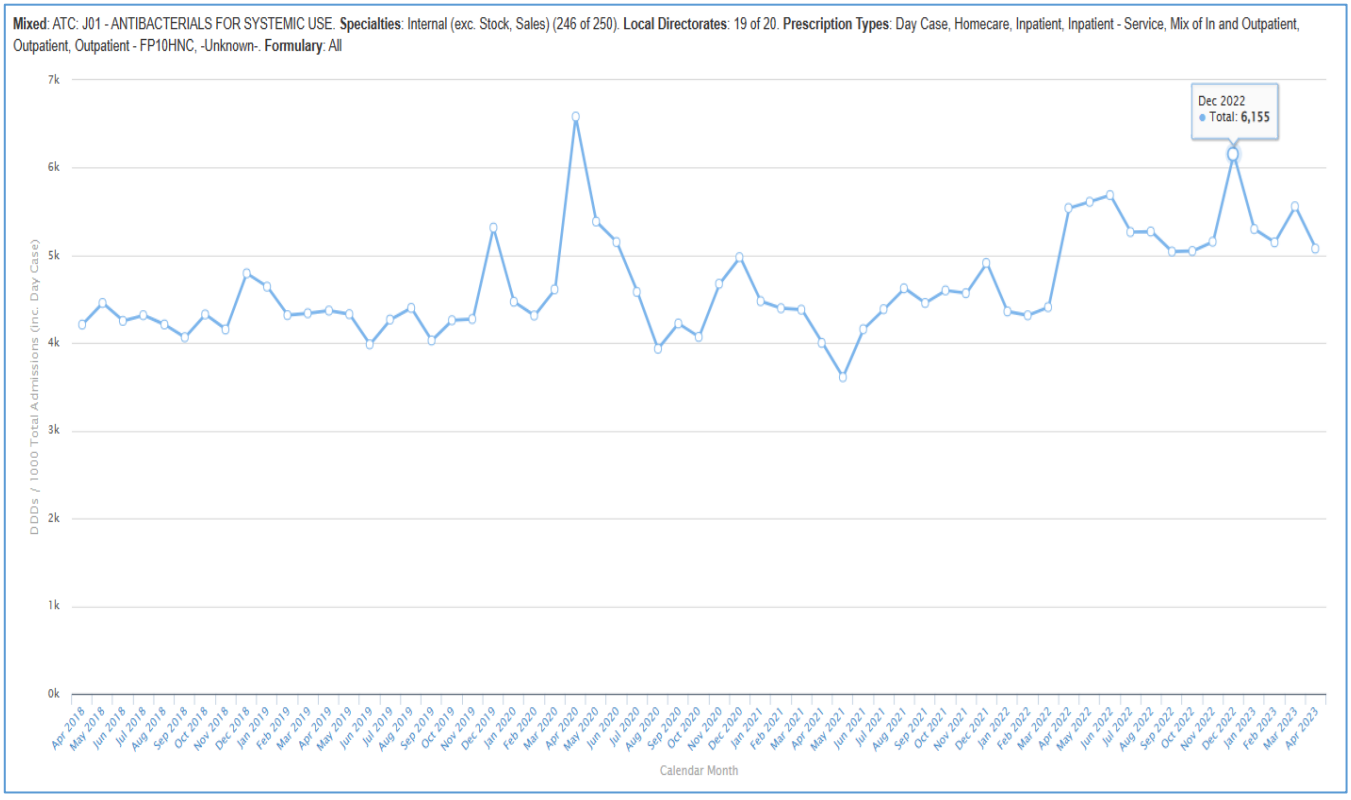
Last year the Trust Antimicrobial Stewardship Strategy Group (ASSG) focussed on guiding development of antimicrobial stewardship via the new electronic prescribing system, and increasing Divisional Nurse representation. A primary aim was to disseminate lessons learned from relevant Divisional audits and take a fresh approach to speciality accountability and input into understanding antimicrobials surveillance, to provide organisational management insight.

National and regional benchmarking against other acute NHS providers has indicated a challenging organisational position and being significantly off track for the 10% reduction in ‘high risk’ antimicrobials required by the NHS Standard Contract.

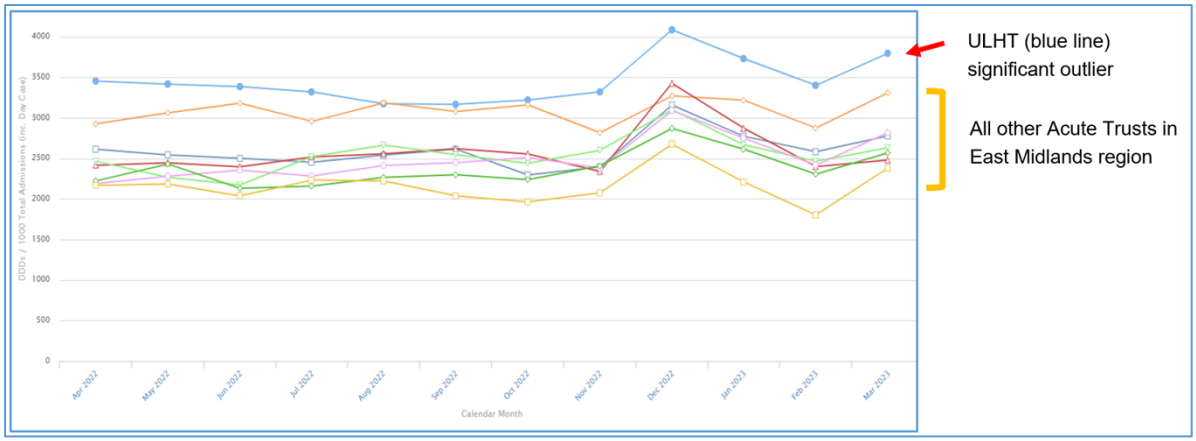
There has been increasing usage from the set baseline of 2018 data, with a background of increased overall antimicrobial use (Graph 1). Some may have be attributed to the set up and capacity of the Outpatient Parenteral Antibiotic Therapy (OPAT) service, but would only explain the position in part. Data from neighbouring Trusts with greater antimicrobial resistance has indicated less use compared with ULHT (Graph 1).

Ward Pharmacy Teams and specialty governance meetings have previously monitored antibiotic prescribing to curb inappropriate use had been impacted upon by severe departmental staffing shortages, resulting in a loss of some essential support. This specifically put forward a reduction in therapeutic drug monitoring stewardship support, increased antimicrobial queries to the specialist team as well as less policing of high risk and restricted antimicrobials, due to diminished capacity or presence to challenge prescribing. Benchmarking moreover emphasised a need to strengthen AMS and embed in all clinical areas.

Graph 1: Total Consumption of All Antimicrobials. Monthly Trend since 2018 (Adjusted to Trust Activity Levels)



Graph 2: Consumption of High Risk Antimicrobials (All Watch and Reserve Antimicrobial as per National Definition England AWaRe - Adapted from World Health Organisation) and Adjusted to Trust Activity Levels

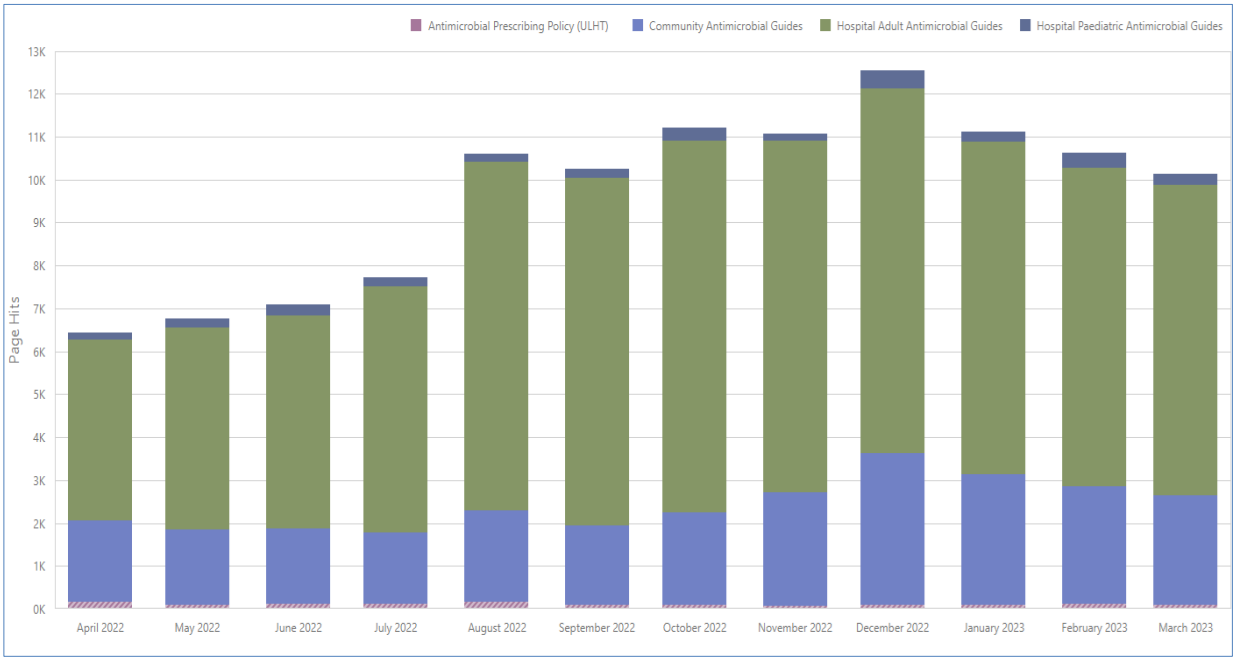


Further insights (Graph 2) in relation to specific antimicrobials demonstrated that approximately 50% usage is Co-amoxiclav, with correlating peaks and troughs. Piperacillin-tazobactam use cited 30% reduction over the year, ending in 4% contribution. Carbapenem use reduced by 9%, ending in 3% contribution. Clarithromycin use increased by around 20% and although partly influenced by the increase in cases of GAS and related drug shortages, audit data revealed a prior concern.

Last winter, the OPAT service underwent a rapid expansion to support A&E delays and bed flow. This new care delivery model, included hospital based nurses and OPAT junior doctors to increase capacity to 16 beds (from a baseline of 6). This resulted in a transfer of same-day suitable cases from a clinic setting to support admission avoidance. This service utilises all high risk antimicrobial agents that have contributed to the upward trend described in Graph 2.

The AMS Lincolnshire Microguide App utilisation (Graph 3) has shown adult antimicrobial guidelines were accessed about 250 times per day. Approximately 80% of access is via the webviewer option and indicated the effectiveness of the links and QR codes displayed on various platforms. Microguide awareness was shown to increase in the months where there was communication to highlight changes or new features. This is now a planned intervention, along with being regularly featured in induction programmes and teaching sessions. The sepsis and IV to oral switch clinical decision tools received national recognition and have been shared.

Graph 3: Lincolnshire Microguide Usage 2022-23



Progression of a wider system working via AMS Lincolnshire has included sharing via the Future NHS platform. Lessons learned from the urinary tract infection (UTI) Commissioning for Quality and Innovation (CQUIN) initiative (achieved overall 53%). They have been translated into actions and educational resources to be shared across the Trust, and Lincolnshire ICS, as a recognised area for improvement in both primary and secondary care settings. This was to improve diagnosis and management of patients, and where possible avoid hospitalisation.

Antimicrobial guidelines have continued to be aligned with the National Institute for Health and Care Excellence (NICE) recommendations with a ‘Start Smart then Focus’ emphasis, further iterated in educational sessions. The AMS Antimicrobial strategy and actions have secured support via Medicines Quality Group, Drug and Therapeutics Committee, IPC Group along with other relevant key forums.

The 5 Antimicrobial Prescribing Key Performance Indicators (KPIs) have been a significant measure of stewardship standards. Key themes were shared with Divisions for dissemination of lessons learned. AMS audits have played an important role in increasing awareness, engagement and improving clinical practice, with examples described in Table 12.

Table 12: Antimicrobial Quality Improvement Audits 2022-2023

IV to Oral switch Audit: Ascertained the impact of raising awareness of the clinical decision tool developed at ULHT and shared nationally, being shortlisted for national awards. Further actions and improvements identified and in good time for the 2023-24 CQUIN initiative, with outcomes anticipated to improve bed flow, patient recovery and reduce carbon footprint.
UTI Audit: As part of the national CQUIN has identified and progressed development of a raft of actions which will be shared across Lincolnshire primary and secondary care settings.
Surgical KPIs audit: To understand real terms prescribing issues in general surgery ward areas. Shared insights with Division and on various platforms. Actions taken include ward stock changes, change in layout of microguide pages for easier navigation, and directed teaching sessions. Will also guide a set of general surgery specific initiatives (reduce metronidazole use, IV to oral switch campaign to highlight the relevant indications along with improved awareness of guidelines for those indications).

The Antimicrobial Pharmacy Team has remained a well-utilised and respected service for clinical advice and support. Prescribers have received induction and training in prudent antimicrobial use and regular antimicrobial resistance along with stewardship reminders. The set up and rollout of electronic prescribing in the Trust is anticipated to bring many benefits and opportunities for improvements.

9. Laboratory Service

A standard is for patient/service user testing for infectious agents to be undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.

The microbiology service is provided by Path Links which is the NHS pathology partnership between ULHT and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Path Links microbiology laboratories process clinical diagnostic and screening samples, and endoscopy waters. Potable water and other environmental samples are submitted to external laboratories by Estates and Facilities.

Path Links has United Kingdom Accreditation Service (UKAS) accreditation and has been preparing for imminent surveillance visits. Standard operating procedures (SOPs) have continued to be consistent with the national standards for microbiology investigations (SMI) and NICE guidelines, and were regularly reviewed and monitored using the Q-pulse document management system.

The percentage of Registered Biomedical Scientists (BMS) and Medical Laboratory Assistant (MLA) staff undertaking mandatory and statutory training, competencies and personal appraisal development review (PADR) was monitored monthly with gaps challenged and addressed. The laboratories have undertaken regular scheduled horizontal and vertical audits, and participated in quality assurance

scheme including internal quality assessment (IQA) and external quality assessment (EQA) through national external quality assessment scheme (NEQAS) and other providers.

There is requirement for early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.

Path Links microbiology has continued to operate a 24/7 service that has allowed early processing of samples and minimised turnaround times. Interim results have been communicated where necessary, for example a blood culture Gram stain before formal identification and sensitivity testing results were available. Definitive results could have been produced more quickly if suitable analysers had been made available, for example MALDI-TOF and rapid automated sensitivity systems. Cost containment has meant that for now more traditional methods were employed, within the parameters of the SMI.

SOPs have included methods for screening and detection of antimicrobial resistance and HCAI. All specimens were examined at the appropriate laboratory containment level once identified, although the request for clinical details highlighting the need for such precautions often goes unheeded. Significant results were communicated either by BMS staff or the clinical microbiologists where further advice was needed. A 24/7 clinical microbiology rota had the provision of IPC advice as required.

A further standard is for protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times to be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.

Path Links microbiology provides services to several organisations with the appropriate service level agreements in place. Turnaround times for key investigations have been monitored and were subject to internal and external KPIs and monitored during the monthly technical working group and Directorate meetings, alongside contracting meetings as needed. Standard turnaround times were published in the laboratory users' handbook, available on the Trust intranet.

There is a stipulation for patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.

Information about testing protocols is available in the microbiology users' handbook available on the Trust intranet. Diagnostic testing has continued to be undertaken at the discretion of the admitting clinician in line with clinical protocols. Screening advice found in the IPC guidelines on the intranet site remains consistent with

national guidance. Where there have been significant changes, for example COVID-19 testing advice, the new protocols have been widely communicated with the help of the Communications Team. Microbiology results have been made available electronically on the relevant system as soon as they have been validated.

There is a need for patients/service users who develop symptom of infection to be tested / retested at the point symptoms arise and in line with national guidance and local protocols. Diagnostic testing has been undertaken at the discretion of the clinician in line with clinical protocols and with the advice of a clinical microbiologist where needed.

There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.

Path Links is part of the ME2 laboratory network, and where capacity is exceeded, work can be sent to a partner laboratory. Likewise, Path Links can also receive samples to support other laboratories in similar times of need. UKHSA laboratories unfortunately have been unable to support Lincolnshire with outbreak investigation during the COVID-19 pandemic due to limited capacity. Samples requiring detection of unusual pathogens have been sent to the appropriate reference laboratory, as were isolated as needing further specialist work. The laboratory communicated results to UKHSA via the second generation surveillance system (SGSS), or notification by phone or email in a more urgent situation.

A standard is to have protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance. Transport of specimens has been covered by a local SOP which was compliant with current legislation. The laboratory has provided transport containers as required.

10. Estates and Facilities

The Estates and Facilities Team has continued to progress work streams to further support and provide assurance to the IPC Group. Notable changes have included the clear approach to planned preventative maintenance (PPM), decontamination and environmental cleanliness. Reporting mechanisms have been clear and consistent with concerns being escalated where required as well as providing assurance reports in a timely manner.

10.1 Environmental Cleanliness

During 2022-23, The National Standards of Healthcare Cleanliness 2021 have been fully implemented, along with updating relevant cleaning standards documents and Control of Substances Hazardous to Health (COSHH) data. Cleaning Services has undergone a full review and a successful business case achieved funding to ensure compliance with the required standards as well as provision of the following:

- Further housekeeping staff on wards at the LCH and PHB sites
- Housekeeping staff for new developments such as emergency departments and specialist units
- Additional evenings and weekend deep clean services
- Night time cleaning services 7 days per week at LCH and PHB sites
- Increased number of supervisors and auditors
- Covering of costs to include relief, bank and agency personnel for ward-based housekeeping

The official Patient-Led Assessments of the Care Environment (PLACE) inspections were carried out in the autumn and for Cleaning Services demonstrated clear improvement from the previous inspection back in 2019 (PLACE suspended during the pandemic), as well as achievement of scores meeting the national average for acute Trusts.

The environmental cleanliness auditing tool was updated to reflect the National Standards of Healthcare Cleanliness 2021 with a move away from a percentage score to a star rating for each function risk (FR) category. Each FR category has its own target score with FR1 being for the highest risk areas such as intensive care and Theatres down to FR6 that represents the lowest risk areas such as offices and training centres.

A robust remedial process was in place to rectify concerns if an audit achieves a 3 star or below rating with deep clean staff assigned to promptly rectify elements of failure.

Tables 13-15 illustrate the average star rating across all in audits in the relevant FR category.

Table 13: Environmental Cleanliness Star Ratings Grantham and District Hospital (GDH) 2022-23

Date	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Category	**Star Rating**											
FR1 (98%)	5	5	5	5	4	5	4	5	5	5	5	5
FR2 (95%)	5	5	5	5	5	5	5	5	5	5	5	5
FR3 (90%)	5	5	5	5	5	5	-	5	-	5	-	5
FR4 (85%)	5	5	5	5	5	5	5	5	5	5	5	5
FR5 (80%)	-	-	5	-	-	-	-	-	-	-	5	-
FR6 (75%)	-	-	-	-	5	5	-	-	-	-	-	-

Table 14: Environmental Cleanliness Star Ratings Lincoln County Hospital (GDH) 2022-23

Date	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Category	**Star Rating**											
FR1 (98%)	4	4	4	4	3	4	4	4	4	4	4	4
FR2 (95%)	5	4	5	5	4	4	5	5	4	5	5	5
FR3 (90%)	5	5	5	5	4	5	5	5	5	5	5	5
FR4 (85%)	5	5	5	5	4	5	5	5	4	5	5	5
FR5 (80%)	-	5	-	5	5	-	-	5	-	5	5	-
FR6 (75%)	5	5	5	5	5	5	5	5	5	5	5	5

Table 15: Environmental Cleanliness Star Ratings Pilgrim Hospital Boston (PHB) 2022-23

Date	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Category	**Star Rating**											
FR1 (98%)	4	4	4	4	4	4	4	4	4	4	4	4
FR2 (95%)	5	4	4	4	4	4	4	5	4	4	4	4
FR3 (90%)	3	4	5	4	2	5	5	5	5	-	5	-
FR4 (85%)	5	5	5	5	4	5	5	5	5	5	5	4
FR5 (80%)	-	-	-	5	-	-	-	-	-	5	-	5
FR6 (75%)	5	4	-	5	4	5	5	-	-	-	5	-

10.2 Water Safety

Work has continued to progress and ensure identified actions were addressed with systems and personnel in place to deliver a compliant and managed approach.

There has been streamlining and therefore a reduction in the number of contractors providing services via a tendering process and the subsequent awarding of a water hygiene contract to provide sampling, thermostatic mixer valve (TMV) maintenance and showerhead replacement etc. Training and appointing staff has been progressed to ensure compliance with the required health technical memoranda (HTM) management structure guidance. Work has continued to address outstanding actions identified through Legionella risk assessments and Authorised Engineer (AE) audits. Asset identification has included the progression of migration from bar code to QR codes.

Much work has been carried out to achieve a revised approach to water flushing with the procurement of the L8 Guard system to go live in the summer of 2023. This will allow effective management and identification of infrequently used outlets. By automating the flushing regime, it will reduce human error, act as a timely reminder and provide an escalation route on a department-by-department basis.

The escalation of water safety concerns has been to the Water Safety Group (WSG) along with the provision of detailed plans of action to manage and address risk. There has been upward reported to the Health and Safety and Finance, Performance and Estates (FPEC) Committees to offer further assurance.

Water audits led by the AE were undertaken in January 2023 and identified progress in the management and approach towards water safety. At this time, there was also an assessment by the AE of the Estates Maintenance Officers at all 3 sites with letters

of appointment issued to the Head of Estates recommending appointment as Responsible Persons (RP) -Water, based on assessments as per the HTM approval route.

Water risk assessments were finalised in accordance with HTM 04/HSG274 and were triggered due to a change in management and significant progress since the previous risk assessments (2019). The aim was to have the service tendered and awarded and this should come to fruition in the summer of 2023 and is to moreover include producing schematics for all water systems.

PPM performance has been measured on a monthly basis (Table 16), with the updates issued to the Site Operational Managers and the Authorised Person (AP) /RP to oversee, capture and address any omissions. At LCH this has been particularly challenging due to the number of vacancies and this is being addressed.

Table 16: Water Safety Completed Planned Preventative Maintenance May 2022 – April 2023

	Grantham			Lincoln			Pilgrim		
Row Labels	PPMs Created	Completed PPMs	Completed %	PPMs Created	Completed PPMs	Completed %	PPMs Created	Completed PPMs	Completed %
May-22	34	32	94.1%	56	50	89.3%	28	27	96.4%
Jun-22	31	29	93.5%	60	37	61.7%	25	22	88.0%
Jul-22	36	32	88.9%	50	41	82.0%	26	25	96.2%
Aug-22	34	21	61.8%	49	26	53.1%	22	13	59.1%
Sep-22	34	29	85.3%	54	46	85.2%	24	14	58.3%
Oct-22	36	31	86.1%	49	36	73.5%	26	24	92.3%
Nov-22	33	30	90.9%	49	36	73.5%	26	20	76.9%
Dec-22	36	28	77.8%	55	44	80.0%	25	23	92.0%
Jan-23	36	21	58.3%	46	31	67.4%	25	20	80.0%
Feb-23	36	29	80.6%	57	32	56.1%	26	23	88.5%
Mar-23	33	32	97.0%	48	45	93.8%	24	21	87.5%
Apr-23	33	32	97.0%	48	37	77.1%	23	17	73.9%
Grand Total	**412**	**346**	**84.0%**	**621**	**461**	**74.2%**	**300**	**249**	**83.0%**

By continuing these works, the organisation will be in a position to demonstrate compliance to prevent and reduce Trust and patient risk from potential water system harm.

10.3 Ventilation

A number of the ventilation systems across the Trust, are of an age installed to the guidance at that time which has been superseded a number of times and may not meet the expected standard of clinical environmental factors i.e. procedural Theatre activity. It has been recognised by the Trust Board that significant investment is required for the refurbishment/replacement of ventilation systems across all sites and this has been included in the 5 Year capital plans.

Following training and assessments there has been the appointment of an AP-Ventilation. Personnel changes led to the appointment of a new AE-Ventilation as the exemplar approach to management as detailed in HTM 00. This person in this role has responsibility for undertaking site audits to be presented to the IPC Group.

The Ventilation Steering Group has in place a process for AE, APs, as well as Health and Safety Team support to escalate concerns to the group and provide detailed plans of action to manage and address risks associated. These reports have then been upwardly reported to the IPC Group and FPEC for further assurance.

Asset capture and QR code migration has continued. PPM performance has been monitored on a monthly basis, with the updates issued to the Site Operational Managers as well as the AP to oversee, capture and address any missed maintenance.

An area to note was the escalation of workplace exposure limits exceeded within Maternity at the PHB and LCH sites in relation to Entonox. Estates work has improved ventilation at PHB to achieve HTM03-01 Part B parameters with further work being progressed at the LCH site.

10.4 Decontamination

The Decontamination Lead has developed into the role and successfully completed the Decontamination Lead Roles and Responsibilities course at Eastwood Park.

The Decontamination group meetings have been well embedded with good dialogue taking place. Issues have identified discussed and addressed as appropriate. An action log has been in place with discussions taking place with the governance team to take forward a decontamination risk dashboard.

The Trust has not yet appointed to the AE Decontamination role to support the wider decontamination risks across the Trust. This is required to ensure that the Trust complies with the HTM 01 for items that require decontamination and machines that requiring validation. There is however an AE Decontamination for the Endoscopy service.

Decontamination work streams have concentrated on the Institute of Healthcare Engineering and Estate Management (IHEEM) recent audit results with an action plan. The Endoscopy Matron and Business Support Manager have supported the Decontamination Lead Nurse with any identified issues of concern. In the LCH unit upgrade work has been progressed in respect of the environment and ventilation as part of a new build project. Ventilation at the Louth site and achieving a drying cabinet with compliance against HTM01 06 at the GDH site, progressing a permit to work process and as previously reported the appointment of a Trust wide AE Decontamination are all being taken forward. A Decontamination of Endoscopes Policy has been further developed and published.

There was an incident at the LCH site that involved a peracetic acid chemical leak. Chemical monitors (ChenDAQ) have been installed within Endoscopy dirty utility areas. This technology has been supported by a SOP to ensure the correct actions

are undertaken if the alarm sounds to enable those in the vicinity to take the appropriate to protect themselves and others.

Work has progressed to achieve a validation process for a small number of essential in house washing machines where it has not been possible to outsource the laundering of some items.

11. Occupational Health

The Occupational Health Service (OHS) has supported the health and wellbeing of staff as well as delivering a programme of staff health assessment to ensure protection against infectious disease by vaccination and on employment screening.

11.1 Healthcare Worker Vaccination

The OHS is responsible for staff influenza and COVID-19 vaccination programmes and last year the campaign ran from September 2022 to 2023. Data described 51.29% of staff received an influenza vaccination with 39.84% of frontline staff taking up the offer of COVID-19 vaccination. The campaign offered flexibility and it was helpful this took into account all shift patterns, weekend working, the option of simultaneous vaccination as well as drop in and the continuation of Complex COVID-19 clinics. There was however a reduction in Peer Vaccinators that impacted upon the campaign delivery.

The OHS has provided a very good level of support to the Trust and IPC Team to undertake COVID-19 staff tracking, tracing and testing and implementing changes to guidance as necessary. This has additionally facilitated the investigation and management of outbreaks of this infection.

There had continued to be a robust service for the delivery of other healthcare worker advised vaccinations, e.g. Hepatitis B, Measles, Mumps and Rubella, Chickenpox as well as the control of Pulmonary Tuberculosis in NHS employees. Staff non-attendance has been subject to a follow up process with escalation to line managers.

Written instructions for occupational vaccinations have been aligned to in line to the rest of the East Midlands. An update of the Occupational Health records system has been taking place to further inform vaccine intelligence.

Plans for the relocation of LCH and PHB sites OHS have been taken forward, vaccination clinics however will largely remain at on site premises with the option of off-site to meet staff convenience.

11.2 Inoculation Injuries

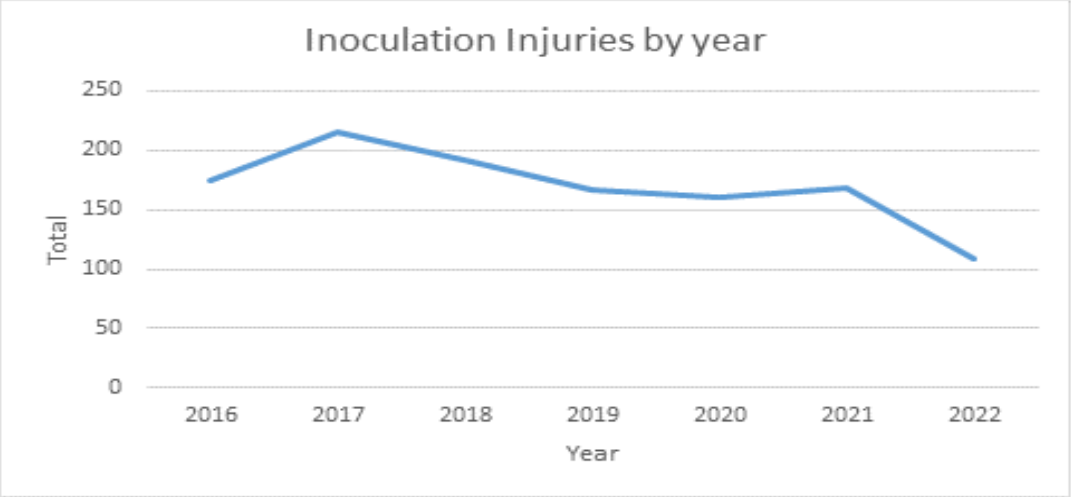
The OHS has led on the management of the safe handling and disposal of sharps, as well as the management of inoculation injury and exposure to bodily fluids. The aim has remained to prevent and reduce the incidence of such injuries and promote the requirement to use safer sharps devices.

Table 17 and Graph 4 offer the number of reported inoculation incidents from 2016 to 2023. It has been encouraging to demonstrate last year's 35 % reduction with the use of safer sharps devices being the main contributory factor. There has however remained a focus on correct disposal following use and being able to activate the safe sharp mechanism.

Table 17: Reported Inoculation Incidents 2016-2023

Year	Number of Inoculation Incidents
2016	175
2017	215
2018	192
2019	167
2020	160
2021	169
2022	109

Graph 4: Reported Inoculation Incidents 2016-2023



12. Training

Through 2022-2023, Divisional IPC mandatory training compliance has been reported (Table 18) and this is predominantly unchanged from the previous year data.

Table 18: Divisional Infection Prevention and Control Mandatory Training Compliance (%) 2022-2023

Division	IPC Mandatory Training Compliance (%)
Medicine	84.72%
Surgery	88.03%
Family Health	90.02%
Clinical Support Services	92.46%
Corporate	91.32%
Estates and Facilities	84.62%
Overall Compliance	88.53%

Trust-wide communication and bulletins had an educational emphasis to communicate pertinent and current information, e.g. promoting rational glove usage.

A month-long Focus on Fundamentals initiative concentrated on updating IPC information boards (CPE and MRSA) with the IPC Team undertaking promotional

visits to clinical areas. Daily microbe bulletins highlighted a daily organism e.g. MRSA, *C. difficile*, norovirus and Tuberculosis. There was a week of emphasis on cleanliness and hand hygiene, followed by an initiative in collaboration with Occupational Health that promoted staff protection such as vaccination.

In May, there was support for the World Hand Hygiene Day yearly initiative and was an opportunity to promote and refresh all aspects of hand hygiene with a specific emphasis on the implementation of the Gojo products. Colleagues were engaged and enjoyed a visit to the colourful stand showcasing information and product samples.

13. Forward Plan 2023-2024

The following forward plan details work and initiatives to be progressed through the next year:

- Progress the IPC Key Objectives (Table 19) to provide assurance and monitoring of the overarching IPC requirements
- Continue to develop compliance with the components of the IPC BAF
- Support Divisional development of their IPC interventions and next steps to be taken
- Prevent and reduce HCAI, and instigate measures to achieve the allocated trajectories, for example *C. difficile*
- Progress some aspects of surgical site infection surveillance
- Enhanced focus on clinical practice, e.g. sharps practice and peripheral line management to achieve and sustain the required level of compliance
- Promote patient safety, governance and risk mitigation processes
- Support the development and implementation of antimicrobial stewardship initiatives
- Advancement of education activities with an emphasis on the post pandemic reinstatement and development of the IPC Link Practitioner network
- Expand IPC social media activity
- Support the progression of laboratory-based interventions to achieve enhanced diagnostic and clinical applications for the identification of micro-organisms for medical diagnosis
- Provide IPC expertise to progress further compliance with environmental cleanliness, water safety, ventilation and decontamination requirements and directives
- Progress the continued expansion and growth of the IPC Team to invest in furthering the scope of the clinical IPC service

- Continue Lincolnshire-wide partnership work to further create and sustain consistent and proportionate approaches to the investigation and management of relevant infections

It is anticipated the above forward plan will offer a range of IPC work to further develop the prevention and reduction of HCAI to achieve a high level of patient safety, governance and mitigation of risk.

Table 19: Infection Prevention and Control Key Objectives 2023-2024

Number	Objective
1	Develop infection prevention and control organisational and Divisional Governance arrangements
2	Continue to progress assessment and gap analysis of The Health and Social Care Act 2008. code of Practice on the prevention and control of infections and related guidance
3	Further development of surveillance of healthcare associated infections and performance
4	Investigate and manage the risks posed by novel infectious diseases to promote patient safety and prevent and reduce the risk of cross transmission
5	Investigate and manage the risks posed by the emergence of multi-drug resistant organisms to promote patient safety and prevent and reduce the risk of cross transmission
6	Development of governance arrangements for appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
7	Implement and sustain standards of cleanliness in line with National Standards of Healthcare Cleanliness
8	Progress water safety, ventilation and decontamination requirements as sub-groups of the Infection Prevention and Control Group to ensure patient safety requirements

14. Conclusion

2022-23 has been another year dominated by COVID-19 but also provided an opportunity to concentrate on other micro-organisms and reinstate much pre pandemic work and practice.

A wide range of strategic and operational IPC interventions and initiatives are in place and continue to be developed to prevent and reduce HCAI and promote a high level of risk-based patient safety.

There is much commitment to progress development of the IPC service and Team to continue the journey to achieve IPC excellence at all levels in the organisation.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	22 August 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 **Infection Prevention and Control Group Upward Report** The Committee received the report noting the increase in prevalence of C-Difficile cases with 12 cases over trajectory reported, this was in line with the nationally reported position. It was noted that there had also been an increase in other target organisms with relevant actions being taken alongside support being offered from Estates and Facilities. Whilst increases were being seen the Committee was assured that all relevant actions were being taken with appropriate evidence in place to demonstrate this. The Committee noted the ongoing work in respect of engagement with Estate and Facilities to support safe storage of waste with an increase in the scope of corrective measures having been put in place. **Serious Incident Summary Report inc Duty of Candour.** The Committee received the report noting the detailed paper and summary offered and was pleased to note the ongoing position of no outstanding never event actions. The Committee recognised that reporting would develop and change as a result of the implementation of the Patient Safety Incident Response Framework however there would be a period of dual reporting whilst current investigations were completed. There continued to be positive progress and compliance with Duty of

	Candour as a result of the support offered from the Clinical Governance Team. **High Profile Cases** The Committee received the report noting the content. **Children and Young People Oversight Group Upward Report** The Committee received the report noting that a number of areas considered by the Group had been directly considered by the Committee during the course of the meeting. It was noted that the report considered outstanding work on assurances provided for Child Protection Information Services (CP-IS) with traction being seen. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the report and associated appendices (attached) from the group noting the continued detailed work being undertaken by the teams. Of note the Committee recognised the deep dive into the care outcomes for Eastern European women along with the post-partum haemorrhage which demonstrated the groups proactive approach to considering important issues. The Committee noted the issue raised around the IT system for maternity services, specifically the need to complete the procurement of the new system to support the year 5 requirements of CNST and Saving Babies Lives v3. It was noted that for the 3-year delivery plan, Saving Babies Lives v3 and CNST there would be challenges to delivery due to current pressures and timescales associated with these however work was underway. The Committee also noted the active engagement with staff due to the recent outcome of the Letby trial noting that regional and system letters had been shared with staff to provide support and encourage speaking up where staff felt there were issues. **Medicines Quality Group Upward Report** The Committee received the report noting the continued compliance with NICE TAs. Progress was noted in relation to the ePMA rollout however some delays to this had been noted in relation to acute medical areas. Actions were however in place to address this. **Pharmacy Deep Dive** The Committee considered in detail, along with representatives of the Pharmacy Team and Clinical Support Services Division the outcome of the deep dive.

	It was noted that work was underway to address actions resulting from previous CQC inspections and internal audits with positive actions being taken in respect of recruitment, particularly the success of the recent international recruitment. The Committee noted the movement of the actions described, noting that phase 1 of the improvement journey was underway. The Committee was keen to understand the further phase which would come online as phase 1 completed to see the full extent of the intended actions. The Committee requested that all actions were offered through a single action plan to provide clarity on the actions required and the current position of these. It was noted that the service now had support in place from the Improvement Team however recognised that further support may be required to continue with the progress being seen. **Medicines Management Improvement Programme Update** The Committee received and noted the update provided as part of the Pharmacy Deep Dive discussions with the Pharmacy Team and Clinical Support Services Division. **Patient Safety Group Upward Report** The Committee received the report noting the content and receiving the draft Patient Safety Improvement Plan and Patient Safety Policy, ahead of these being in place in October. The Committee noted that the improvement plan now included 5 local themes for investigation through the Patient Safety Incident Response Framework, these being Inpatient Falls, Medication, Diagnostics, End of Life Care and ReSpect and DKA. Further work would be undertaken on both the plan and policy, with Committee members requested to provide feedback, ahead of the approval of the Board being sought, prior to implementation. **Safeguarding Group Upward Report** The Committee received the report noting the month-on-month improvement in training figures. The Committee was pleased to note the positive group model working that was taking place with Lincolnshire Community Health Services NHS Trust which was strengthening services across both organisations. Improvements were also reported in respect of the internal audit actions and it was noted that, whilst the official Oliver McGowan mandatory training was not yet available, the Trust had implemented training to educate and support staff ahead of this being available.

	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report noting there were no escalations from the group however noted the assurance received from the Surgery Division offered through the patient story demonstrating changes being made to support patients. An organisational response had been submitted regarding the Department of Health and Social Care consultation on visiting with the group pleased to note that this would be considered as a line of enquiry through CQC regulations. Initial work had commenced on data analysis in order to triangulate patient experience data against ward accreditation data and would continue to develop. **Patient Experience Quarter 1 Report** The Committee received the quarter 1 reporting noting that this provided an overview of patient experience activity as presented through the upward reports. Concern was noted in the uplift in communication concerns being raised however the Committee noted that this would be considered and addressed moving into quarter 2. Work was underway with the Communications Improvement Group with work presented to the ICB Quality Group which was well received. **Palliative and End of Life Care Group Upward Report** The Committee received the report noting that this was the first meeting of the group and recognised that there were no escalations. The Committee would consider the report in further detail at the September meeting.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the continued 100% compliance with national audits although recognised that the Trust was an outlier in a number of audit areas. Action would be taken with increasing engagement with consultant bodies in order to see improvement. The Committee noted a risk to achievement of 2 CQUINs however again plans were in place to address this through electronic systems and addressing data input issues.

	The Committee noted the annual report on audit noting how this demonstrated the volume of audits being completed and areas which required further development. There was improved discussions taking place at the Clinical Audit Group to support audits and shared learning.
	Assurance in respect of other areas: **Terms of Reference and Work Programme 2023/24** The Committee received the terms of reference and work programme noting the amendments which had been made and confirmed approval of these. **Integrated Improvement Plan** The Committee received the report noting that there was good progress being made on the programmes of work and associated actions. The Committee sought an understanding as to the reason for the change in reporting of incidents causing potential harm noting that this had been updated to reflect the previous year indicator for consistency and to enable regional and national benchmarking to take place. **Internal Audit Recommendations** The Committee noted that updates were being made by internal audit with an updated report due to be offered to the Committee in September. **Progress against CP-IS must do action plan** The Committee welcomed members of the Medicine Division Quadrumvirate to the meeting in order to receive an update on progress against the CP-IS action. The Committee was pleased to note the significant progress that had been made in both training and embedding of recording CP-IS. It was noted that there had been an improvement in training completion however there remained the need to continue to conduct audits in respect of data capture. The Division was committed to continue to push forward with the action to ensure this was fully embedded due to the wishing to ensure the best care and patient safety was delivered to patients. Whilst there had been a small number of areas of non-compliance recorded there had been swift action and discussions with staff to resolve this. The Committee noted that, due to the progress seen at this time, that the Quadrumvirate would not be asked back to present progress to the Committee however the Committee would retain oversight of the data to ensure continued progress. **CQC Action Plan** The Committee received the report noting that this would be offered directly to the Board to in September.

	The Committee noted the volume of information presented which offered a clear update on the improvements that had been made. **CQC Final Report Children and Young People Inspection Visit** The Committee received the report noting the outcome of the CQC inspection which had taken place within Children and Young People's services noting the positive outcome and also the immediate improvements made where required. **Committee Performance Dashboard** The Committee received the performance dashboard noting the content and the continued improvement in mortality indices. The Committee reflected that reports received during the course of the meeting had also considered the information contained within the performance dashboard. The Chair expressed her sincere thanks for the excellent job the Deputy Medical Director has undertaken in the Medical Directors absence.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports, which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	S	O	N	D	J	F	M	A	M	J	J	A
Chris Gibson Non-Executive Director	X	X	A	X	X	X	X	X	A	X	X	X
Sarah Dunnett Non-Executive												

Director (Maternity Safety Champion)												
Karen Dunderdale Director of Nursing	X	X	X	X	D	X	X	D	X	X	D	X
Simon Evans Chief Operating Officer	X	X	X									
Colin Farquharson Medical Director	D	D	D	D	D	D	D	D	D	D	D	X
Rebecca Brown, Non-Executive Director (Maternity Safety Champion)	X	X	X	X	X	X	X	X	X	X	X	X
Vicki Wells, Associate Non-Executive Director	A	X	X	X	X	X	X	X	X	X	X	X
Michelle Harris, Chief Operating Officer				A	X	X	X	X	D	X	X	D

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Maternity Report

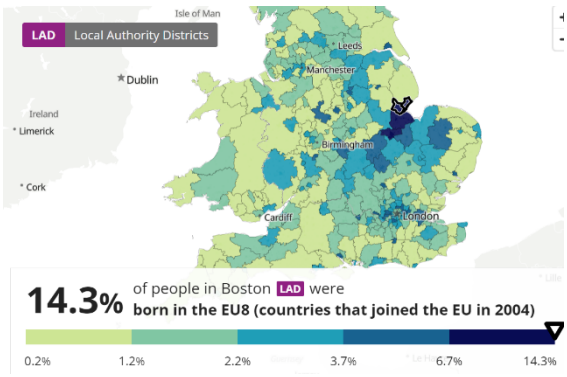
Care and outcomes for women from Eastern European ethnic minority groups

Amy Garratt- Patient Safety Midwife

July 2023

Since the European Union expansion in 2004, the UK has experienced significant immigration from Eastern Europe. Recent focus has been on established minority ethnic pregnant groups; however, Eastern European pregnant women are a relatively under-researched group in the current evidence base. A recent review (REF) of 2198 relevant publications examining Eastern European migrants demonstrated that the most common barriers to accessing and using healthcare were limited understanding of how the system works within the UK and language difficulties. A cross-sectional national survey in 2018 compared recent maternity experiences of recent migrant mothers to women who were born in the UK or had resided in the UK for a longer period. The results showed that all migrant women experienced poorer care than UK-born women did. Furthermore, migrant women felt they were not spoken to in a way they could understand and, unfortunately, felt that they were not treated with kindness or respect (REF)

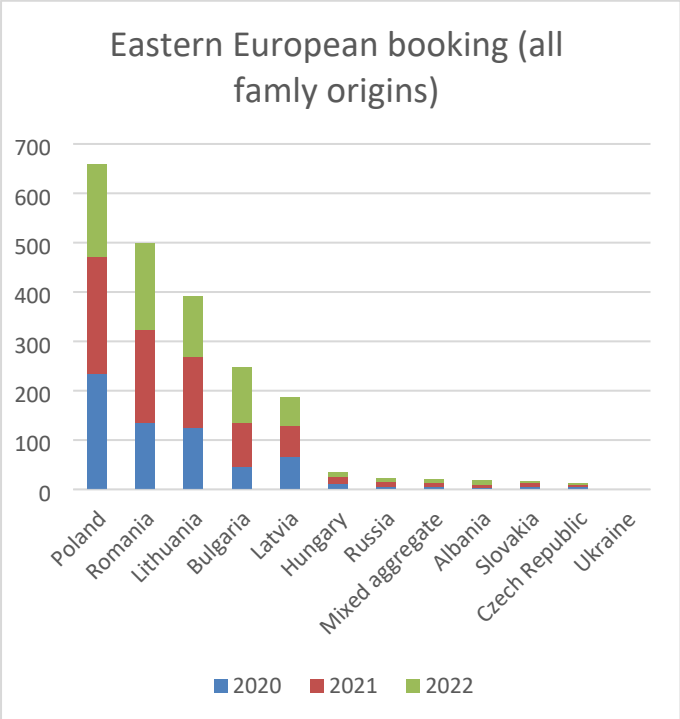
Whilst the national focus is predominantly on outcomes for women and babies of BAME backgrounds, which has been reviewed locally (BAME REPORT), ULHT is in the unique position of having a very large Eastern European population. This group is largely localised to the Boston region with recent ONS Census data indicating that on average, 18.1% of Boston residents were born in EU8 and EU2 countries with a density of around 30% in some areas of Boston town, the highest concentration of people originating from Eastern Europe in the UK.

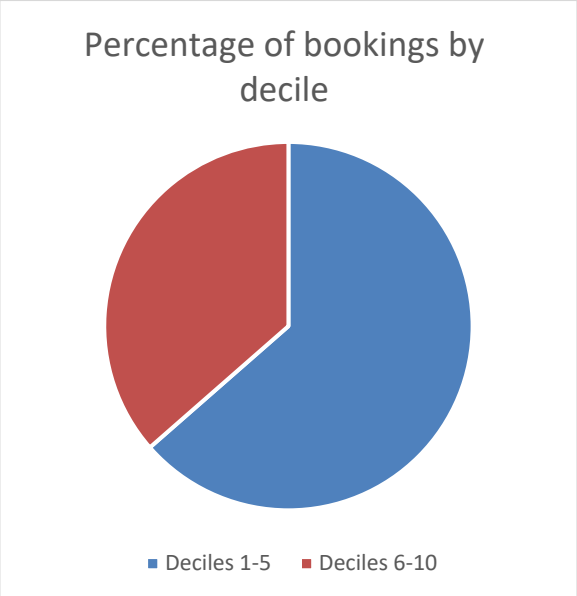


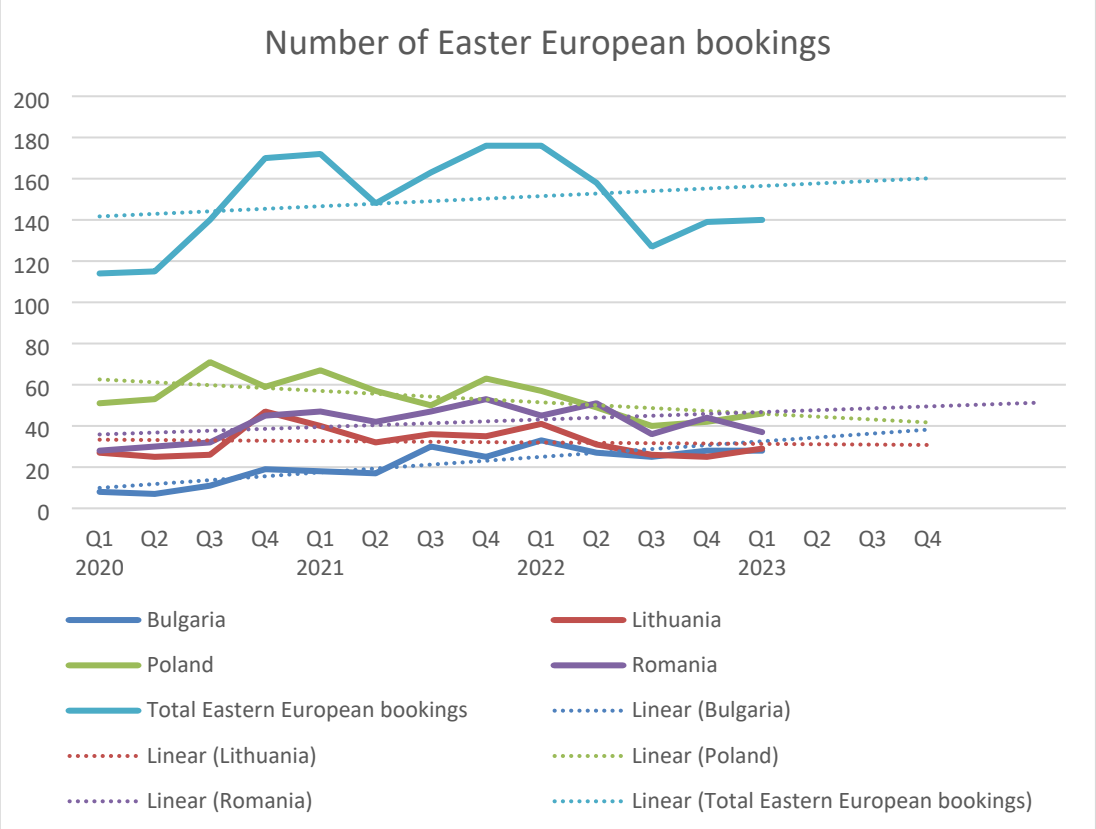
UK confidential enquiries into maternal mortality and morbidities (MBRRACE-UK) as well as perinatal reviews of infant mortality have consistently identified that stillbirth and neonatal death rates increase with deprivation across **all** ethnic groups. Nationally there is a drive to identify populations at risk and reduce mortality and morbidity through the Equity & Equality Framework for Maternity Services. Locally, this is managed through our Better Births Transformation Team.

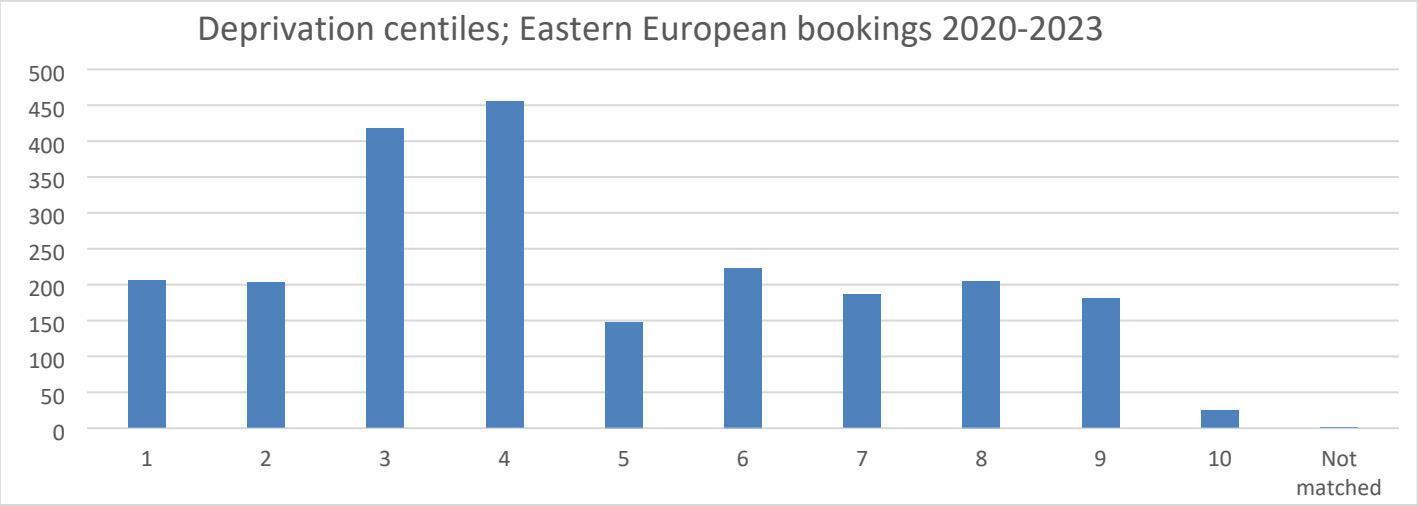
The current landscape

Based on bookings from 2020 to date, 64% of Eastern European women reside within the five lowest deciles of deprivation. Furthermore, this is pattern is replicated in the income and employment profiles. Due to the variation in data input around maternal and paternal occupation it is difficult to interpret the data as a whole. On initial review, it appears a significant proportion of employment is within factory settings. This reflects the findings from the Better Births team and ongoing streams of work.



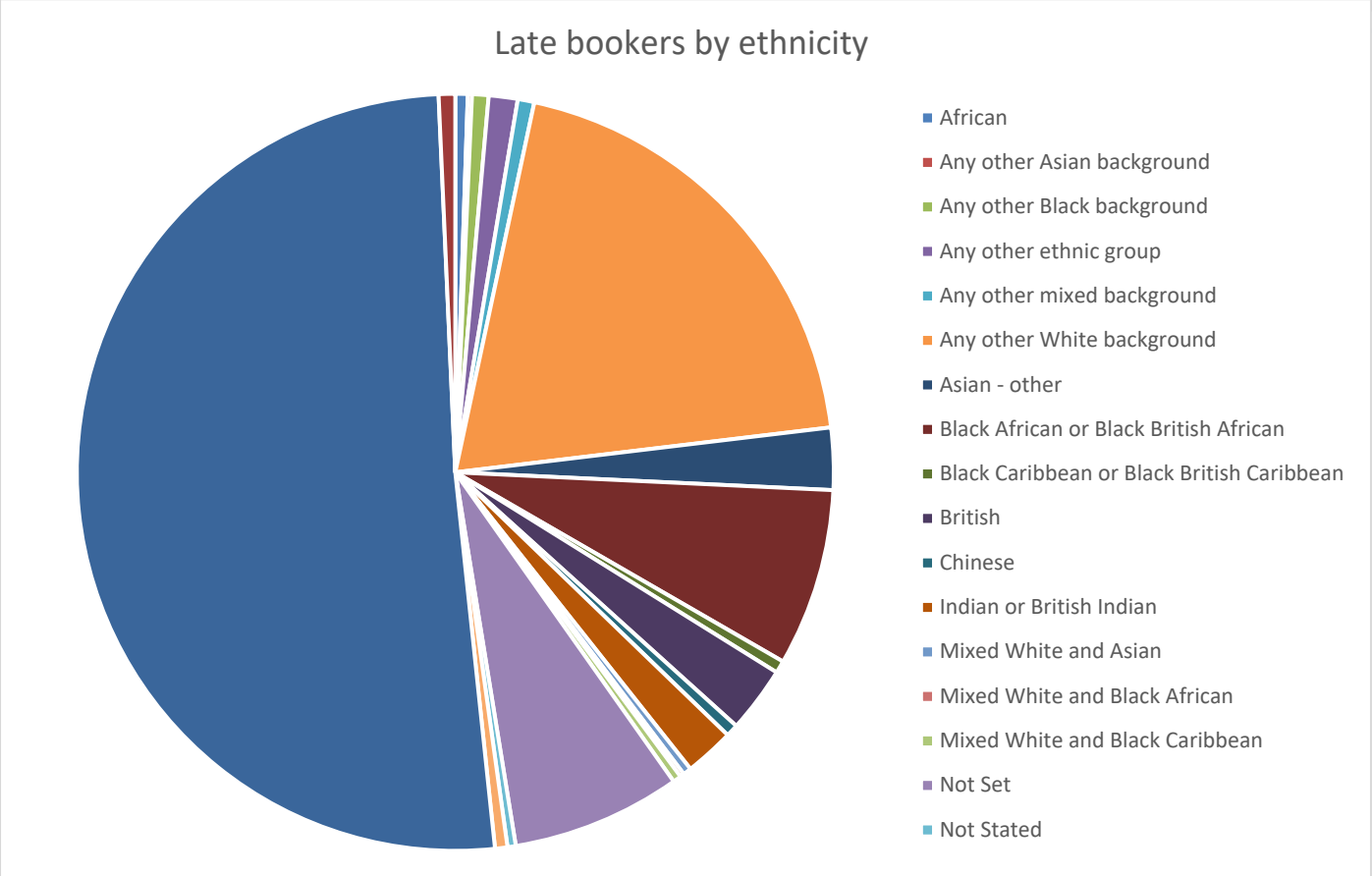




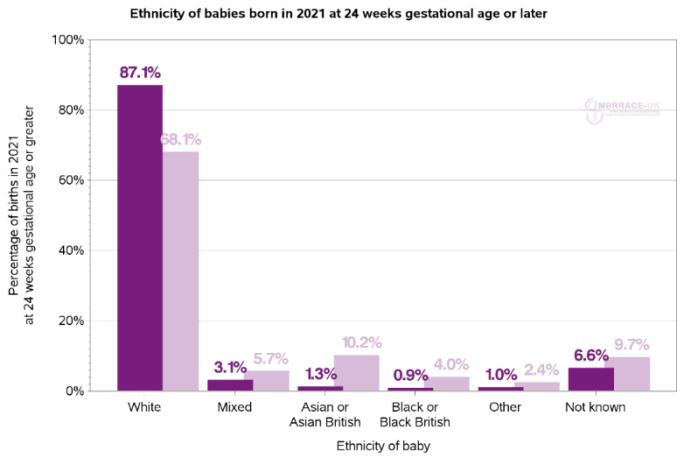


58% of Eastern European women book by 9+6 weeks, which is higher than for women from Black, African/any other Black backgrounds (42-48%) however this is below the target of 67.5%. Of note, 71% of White British women booked by 9+6 weeks. These same groups of women are less likely to receive first trimester screening by the 13+6 week target. 18% of women booked late (after 12+6). Eastern European women made up 14% of late bookers across all ethnic origins; 68% of these women booked between 13 and 20 weeks, 22% between 20-30 weeks and 10% between 30-40 weeks. Local data on late bookers reflects national data and the limited evidence base. On exploration of recent research, barriers to earlier initiation of antenatal care appear multi-faceted including; lack of fixed residence, lack of knowledge about available services and entitlement to care, a negative perception of the health-system and individual cultural beliefs.

Some women booking late within the Trust appear to have had some antenatal care in their home country including scans, however, this information is not transferable or consistent so requires all offers of screening to be repeated when booking within the Trust. The previous BAME reported identified that large numbers of BAME women who moved to Lincoln later in pregnancy, coincided with the start of the academic university year and women had had previous antenatal care elsewhere. Eastern European women, and their partners, are more likely to hold blue-collar, industrial jobs in the Boston area and the current data set does not provide detail as to whether women had previous antenatal care elsewhere. Further review of rationale for late booking may be a worthwhile consideration. Improving both initiation and engagement with local services should be explored locally, with lived experience at the centre of service planning. Furthermore, qualitative and quantitative data on women booking late in pregnancy should be monitored regularly.



Our most recent Perinatal Mortality Reporting Tool report published to Trusts by MBRRACE on 5th May 2023 (and available to the public on 11th May 2023) indicates we have a much lower than average rate of late fetal loss, stillbirth and neonatal death across all BAME groups. However, the report does highlight that 6.6% of PMRT cases do not have a recorded ethnicity. In addition, a regional quality improvement project has also highlighted a lack of recorded ethnicity when incidents are reported to STEIS. Ensuring our data collection is robust is a key action of the CNST year 5 standards; there is a need to continue improvement work to have a recorded ethnicity for all patients in ULHT and to ensure learning for all staff groups includes a focus on equity and equality.



Pregnancy

At the booking appointment 9% of Eastern European women reported English as their first language. Of the women for whom English was not their first language 61% told us that they were fluent in English, while 22% had difficulty understanding in English and 17% had no understanding of English.

All women should be asked about domestic violence at every opportunity and on average, a woman will disclose abuse only when they have been asked around 13 times. Of the data reviewed, 56% of women were not asked this question at booking. This may be likely due to partners being present at the first appointment. Of women who were both 'asked' and 'not asked' the question on domestic violence the percentage of women fluent in English was similar (92% and 93%). Eastern European women, when asked both questions made up a large proportion of the women who reported difficulty or no understanding of English. In the 'asked' group 82% of the women who reported no understanding of English or a difficulty in understanding English were Eastern European, this was slightly less in the not asked group (70%).

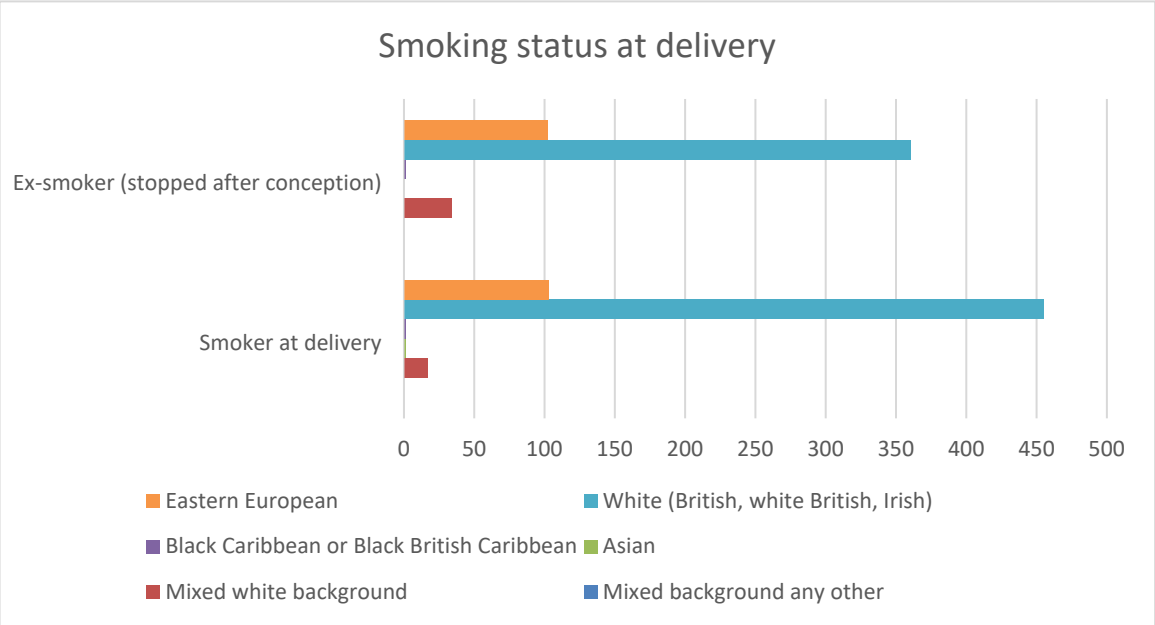
Limited English proficiency and low health literacy is a key barrier to healthcare and increases the chance of poor health and outcomes. The World Health Organisation describe an association with financial, social and educational deprivation and low levels of health literacy. Furthermore, immigration status can be another social determinant linked to low health literacy owing to language and social barriers affecting integration into society. A recent study suggested that in Bulgaria, low health literacy was identified in 62% of the population. Addressing gaps within our patient information provision as well as the ability to communicate effectively with women remains a priority to the Trust and the Better Births team. Problems with the Trusts current language interpretation service has been escalated and should be seen as a priority with such a number of women requiring language support during their maternity journey.

It is recommended that all women, prior to becoming pregnant, take Folic Acid and Vitamin D daily. 1014 women were recorded as taking both these vitamins prior to pregnancy, which would imply high levels of health literacy and motivation. Only 5% of these women were Eastern European, compared to 83% that were White British.

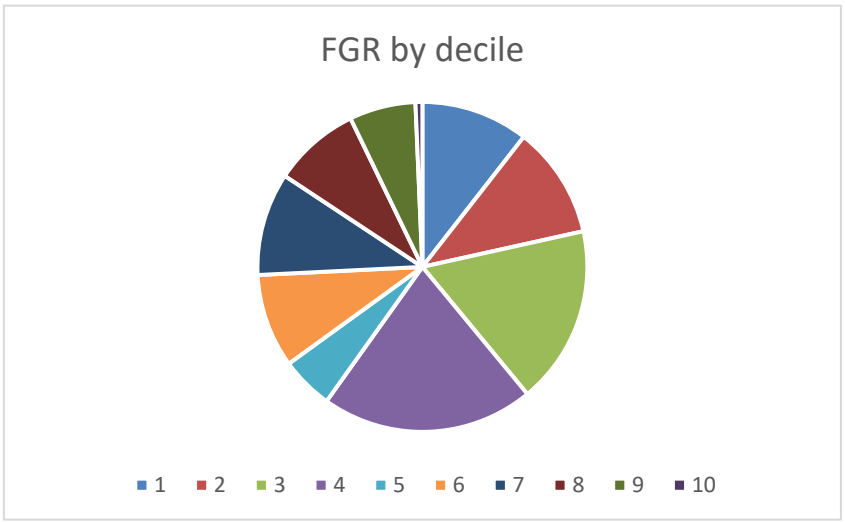
Birth

Smoking during pregnancy has serious consequences on the health of the child and can lead to an increased risk of miscarriage, premature birth, stillbirth and low birth weight babies which lead to a higher infant mortality rate. A pregnant woman has multiple contacts with healthcare professionals throughout her pregnancy; labour and postnatal period, providing many opportunities to help a mother to stop smoking.

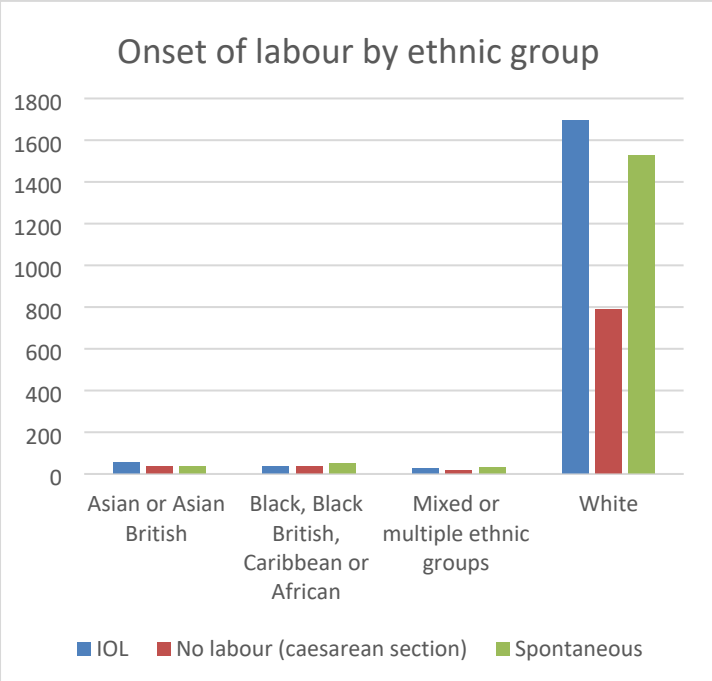
At the point of birth, Eastern European women made up 18% of the current smoker cohort of women and 21% of women who had stopped smoking after conception. 78% of women who remained a smoker at time of delivery were from a white background. ULHT also have a specialist tobacco dependency midwife to provide ongoing monitoring, assurance and quality improvement aimed to reduce the numbers of women smoking during pregnancy and at birth. Inclusion of the specialist midwife should be considered in any equity and equality work streams at local or transformational level.

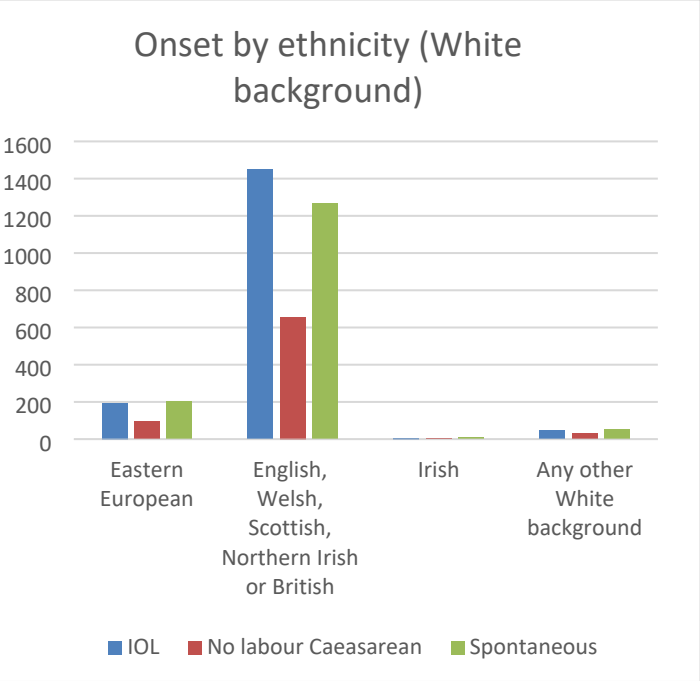


The vast majority of babies across all ethnicities were born at term, however of all the FGR babies born to Eastern European mothers, 65% were born to mums residing in the 5 most deprived deciles. There is strong evidence linking undiagnosed FGR to stillbirth; it may be beneficial to review undetected FGR data by ethnicity at a local level.

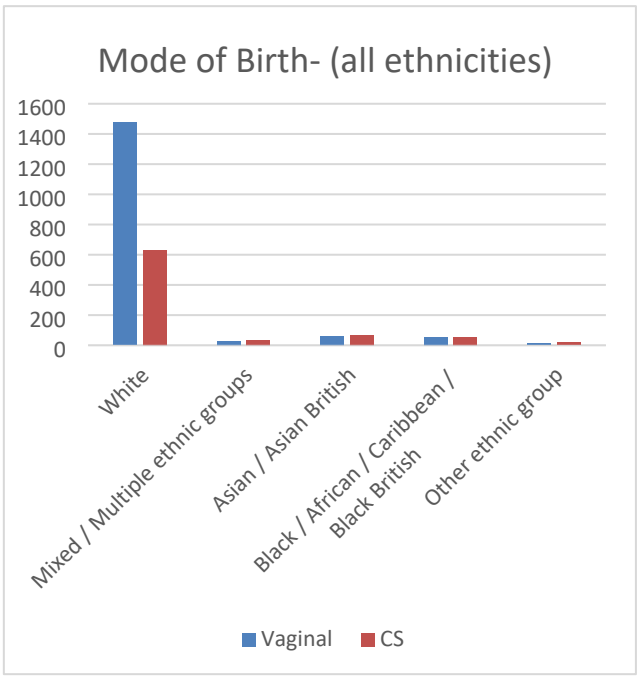


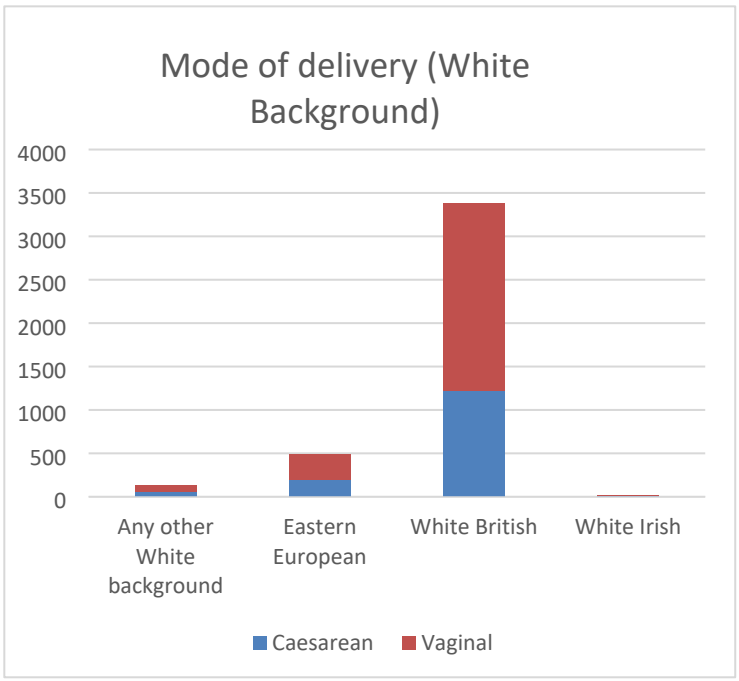
As reflected nationally with rising induction of labour(IOL) rates, at a local level IOL (mechanical, medical, surgical and combinations of all) is the most common onset across all ethnic groups, however in the Black, Black British, Caribean or mixed group, IOL and no labour ceasarean are equal. 49% of Eastern European women had their labour



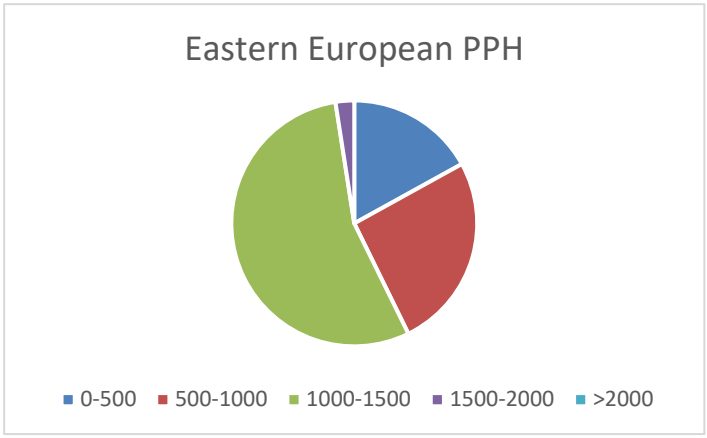


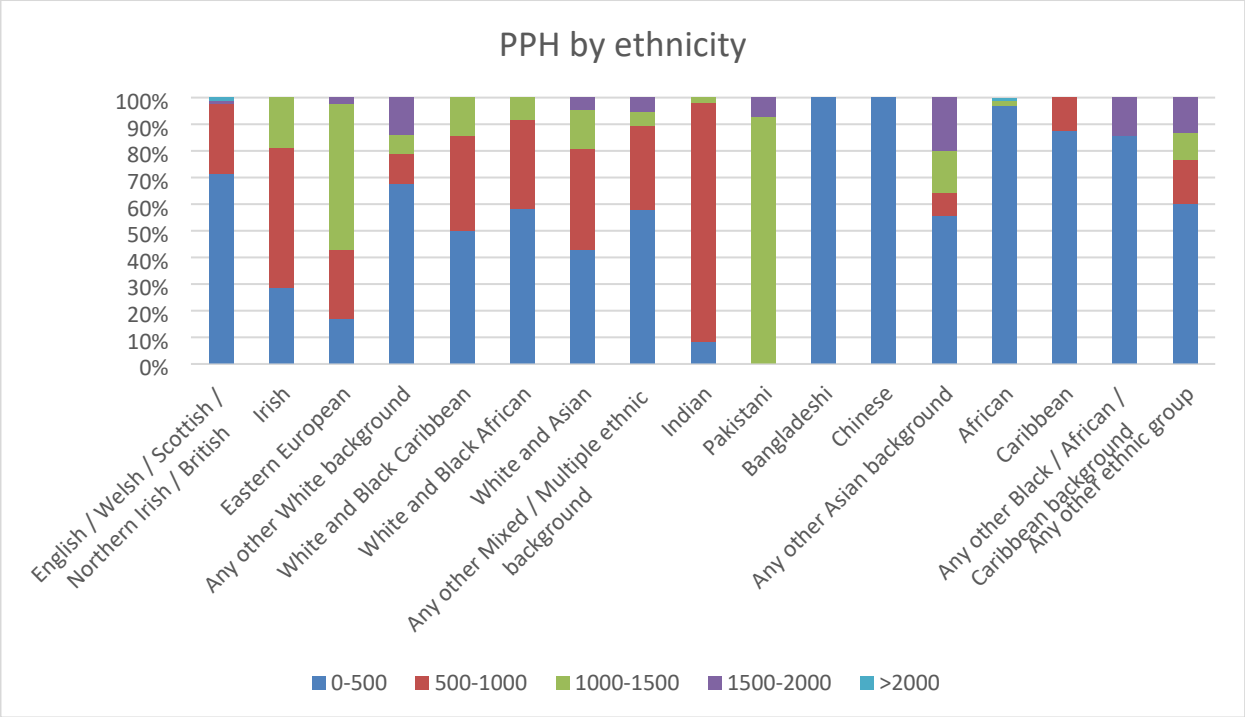
induced compared with 53% of British women. Vaginal birth was achieved in 61% of births by Eastern European women. In comparison 63% of British women went on to deliver a baby vaginally. The need for assisstance at birth (ventouse or froceps) was around 14% for both British and Eastern European women. While quantitaive data , taken from the electronic patient record, is useful, there is a need to better understand the qualitative data and women's lived experiences surrounding onset of labour and their birth experience. Referral to Birth Afterthoughts demonstrates minimal variation in ethnic origin; since January this year. At Pilgrim, 92% of referrals were from White British women with only one woman from an Eastern European background. The PMA team have added ethnicity to their database and have already identified a need for some quality improvement in this area.





A further report is currently in progress on post-partum haemorrhage (PPH) over 2L, however findings related to ethnicity and blood loss can be seen below. Women from Eastern Europe have a much higher percentage of blood loss over 1L than compared to the majority of other ethnicities (57% of women lost over 1L). In comparison, 2% of British women lost over 1L. Although the total number of Pakistani women are small, 100% experienced a total blood loss of over 1L.





Personalised care, social prescribing and patient activation measures

Central to Better Births and a key part of the NHS Long Term Plan is the principle that maternity care should be personalised and safe. Care should be centred on the woman, her baby and her family; based around her needs and decisions, where there has been genuine choice informed by unbiased information. This is essential to ensuring that women receive the best care possible. A whole system approach enables a variety of services across the health, social care, public health and community spectrum to be integrated around the individual in order to deliver better outcomes and experiences. Research has shown that when patients have the opportunity to be involved in decision making around personalised healthcare, there are generally better outcomes and experiences and reduced health inequalities.

Moving towards a more personalised approach has led to the creation of extra roles including that of a social prescriber. The World Health Organisation describes social prescribing as a means of connecting patients to a range of non-clinical services in the community to improve their health and well-being. It builds on the evidence that addressing social determinants of health such as socioeconomic status, social inclusion, housing, and education is key to improving health outcomes. Exploration of the role of a care navigator for these women will also help to reduce inequalities.

Patient Activation Measures (PAMS) is a validated, licensed tool that measures people's knowledge, skills and confidence in managing their own wellbeing. It is expected that by understanding a patient's activation level, care can be planned appropriately with the individual, leading to improved wellbeing and fewer episodes of unplanned and emergency care. This may include longer appointments, a named social prescriber, patient information in a format that can be understood and tools to help the individual support themselves.

Social prescribing, personalised care and shared decision-making have been shown to reduce health inequalities, improve health literacy and increase activation and motivation in care. From the evidence within this report and based on the localised demographic of Easter European women in certain areas of Lincolnshire, the use of social prescribing and patient activation measures should be explored as a matter of urgency.

Considerations and recommendations

- Sharing of both BAME and Eastern European reports with all staff via intranet to increase knowledge and understanding of the wider context and implications for these groups.
- Sharing of both reports with the Better Births team leading on Equality and Equity workstream as part of co-production.
- Comms plan for increasing uptake of 'shared decision making' and 'personlised care' training modules facilitied by ICB personalised care team including utilisation of patient safety midwife trained trainer to deliver specific maternity training.
- Inclusion of ethnicity data on all survey's/reports/incident reviews/audits.
- Review if ethnicity is captured in FGR/SGA data.
- During procurement of Badgernet, explore if ethnic origin can be specific and standardised to enable robust audit.

Saving Babies Lives v3

MNOG Report

13 July 2023

Karen Ludkins

Background

Saving Babies Lives V2 (SBL) launched in March 2019. It aims to provide detailed information for service providers and commissioners of maternity care on how to reduce to reduce perinatal mortality across England. The second version brought together five different elements of care which are all widely recognised as evidence based and or / best practice.

Elements

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction.
3. Raising awareness of reduced fetal movement.
4. Effective fetal monitoring during labour.
5. Reducing preterm birth.

The implementation of SBL v2 is one of the standards required for CNST. Much of the evidence achieved was with an agreed manual audit process due to the immaturity of the current maternity IT system.

Saving Babies Lives (SBL) V3 was launched in **June 23**, with some significant changes to the previous 5 elements and the addition of element six.

6. Management of pre-existing Diabetes in Pregnancy.

Current practice

ULHT implemented and achieved green for all five elements in April 23, and was able to provide all the evidence needed to achieve CNST year 3 and 4. Even with the challenges presented to service provision during COVID 19. Full improvement trajectory for all **six elements by March 2024** is recommended. **CNST year 5** requires to demonstrate implementation of 70% of intervention across all six elements overall, and implementation of at least 50% in each individual element.

Overseeing of implementation for SBL V3 has also changed with the national implementation surveys stepped down. The use of the new national implementation tool will track and demonstrate compliance to both the Trust Board and ICBs. Oversight has now changed and achieved by holding quarterly quality improvement discussions with the ICB with element specific improvement work undertaken

including evidence generation within the tool. Tool launched **1 July 23** in the process of population of evidence.

Findings

Overall ULHT is in a good positon for SBL V3, the majority of our guidelines are in bedded into practice are in line with the care bundle. However, the amount of evidence and scrutiny to demonstrate compliance is challenging.

Challenges

- IT system still does not allow for data extraction for many evidence audits, manual audits are required.
- IT system will not report on gestation information.
- Evidence year 4 CNST not current, all audits need to repeated.
- MIS system providing accurate data for MSDS duplicates'.
- Staff training still challenging for Fetal monitoring needs to 100% for all staff groups, action plan developed and trajectory to achieve CNST year 5 and SBL compliance, all other elements 90% of all staff groups.
- Increased scan capacity and sonography services.
- Electronic medicines management to track steroid and mag sulphate administration for pre term.
- Guidelines need a review for each element.
- Need of a diabetes dietitian within the MDT one stop clinic for both sites.
- Grow 2.0 customised growth charts are not aligned with SBL v3
- Suboptimal fetal growth guidance will require discussion and derogation, waiting for RCOG guidance on charts.

Recommendations.

- Improved IT system for data collection, providing required evidence, and reporting. Funding secured for Badgernet system, however the funding for the project team for implementation still needs confirmation.
- Increased staffing to assist with manual data collection.
- Sonography service requires a review of the service level agreement.
- Electronic medicines management service for maternity.
- To continue to work with ICB to provide up to date evidence of compliance.
- Very Brief Advice about smoking NCSCT added to ESR for evidence of compliance.

OUTSTANDING CARE personally DELIVERED

Maternity Report

Postpartum Haemorrhage >2000ml 2022/23

Jules Bambridge – Consultant Midwife

July 2023

Following the introduction of statistical process control charts within the maternity dashboards, we have identified a shift above the mean in the rate of postpartum haemorrhage (PPH) over 2000mls at Pilgrim Hospital Boston. This report is a summary of the identified factors, themes and recommendations.

The SPC chart was triggered due to a run of 7 sequential months above the mean, this indicates only a 0.8% chance of this being common cause (expected) variation, the trigger indicates that this is special cause variation and requires review. For more information on SPC charts click here.

Demographics

In total 23 women between Dec 22 and May 23 lost >2000mls at birth

<table>
<tr><td>Onset of labour
• 13/23 (56%) IOL
• 6/23 (26.1%) LSCS
• 4/23 (17.4%) spontaneous
Parity
• 11/23 (47.8%) Primiparous
• 12/23 (52.2%) Multiparous</td><td>Route of birth
• 5/23 (21.7%) Cat 2 LSCS
• 2/23 (8.7%) Cat 3 LSCS
• 4/23 (17.4%) Cat 4 LSCS
• 5/23 (21.7%) Forceps
• 6/23 (26.1%) SVB with IOL
• 1/23 (4.3%) SVB no IOL</td><td>Reason for PPH
• 10/23 (43.4%) Tone
• 3/23 (13.0%) Trauma
• 5/23 (21.7%) Tissue
• 0/23Thrombin
• 3/23 (13.0%) Surgical loss (2 x fibroids, 1 x hysterectomy 1 x vascular lower segment)</td></tr>
<tr><td>Gestation
• 1/23 (4.3%) <30 weeks
• 1/23 (4.3%) 30-36+6 weeks
• 5/23 (21.7%) 37 – 38+6
• 16/23 (69.6%) >39 weeks</td><td>Time of Day
• 7/23 00:00 – 06.00
• 5/23 06:00 – 12:00
• 7/23 12:00 – 18:00
• 5/23 18:00 – 00:00
5 of the cases occurred in the hour between 18.00 and 19.00</td><td>PPH Volume
• 14/23 (60.9%) 2000-2499mls
• 6/23 (26.1%) 2500-2999mls
• 3/23 (13.0%) >3000mls
2 of the three cases >3000mls were multiple pregnancies</td></tr>
<tr><td>Vaginal Births
• 2/23 (%) 10iu oxytocin IM</td><td>Birthweight
• 4/23 (17.4 %) <3000g</td><td>Ethnicity and MDI
• 1/23 (4.35%) Middle East</td></tr>
</table>

• 4/23 (%) 5iu oxytocin IV • 0/23 (%) Syntometrine IM **Two women who had 10iu IM were eligible for 5iu IV**	• 17/23 (17.4%) 3000 – 4000g • 2/23 (8.7%) >4000g	Asian • 1/23 (4.35%) Mixed White/Black Caribbean • 16/23 (69.6%) White British • 5/23 (21.7%) Eastern European

Women being induced were most likely to have a PPH >2000ml at 56%, however it should be remembered that our current IOL rate is 39%, this means a significant proportion of women at ULHT are induced and therefore are likely to be over represented in reviews. Women who went on to have a non-instrumental vaginal birth following IOL were the group most likely to have 2000ml PPH, when reviewing these cases 4/6 were well managed with 5iu oxytocin IV given, however 2/4 had 10iu IM oxytocin despite 5iu being both indicated and possible due to having a cannula in situ. The PPH risk assessments launched as part of the new PPH guideline in February 2023 give clearer guidance on the pathways of third stage management and aim in to crease use of 5iu IV oxytocin for those women who are suitable.

The group least likely to have PPH>2000mls were spontaneous onset with vaginal birth.

The reasons for PPH were predominantly related to atony, MROP and surgical loss. Of note were a run of particularly complex cases including

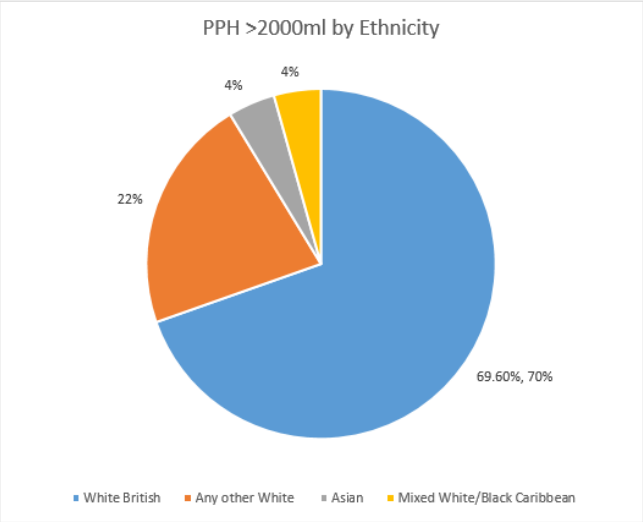
- one woman with known placenta percreta requiring preterm hysterectomy
- one undiagnosed morbidly adherent placenta
- two twin caesarean births (one noted to have an extremely vascular lower segment),
- two women with undiagnosed fibroids, one also with a left angle extension
- five women required manual removal of placenta(MROP),

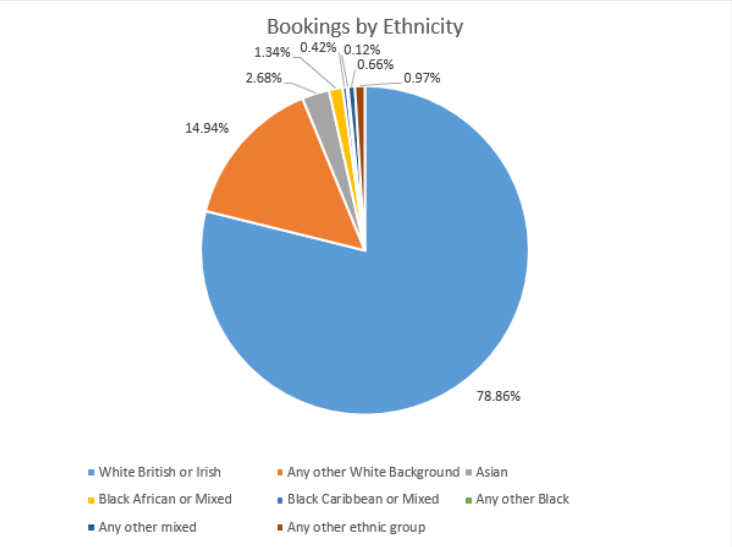
Usual practice would be for women with abnormally invasive placentas (AIP) e.g. percreta, increta and accreta to give birth a tertiary unit with access to specialist surgical services. Of the two delivered at PHB one was a preterm labour who did not have time to transfer to the tertiary unit, the other was undiagnosed until after birth. As the population sees an increase in the number of caesarean births we are likely to see in an increase in rates of AIP, both diagnosed and potentially undiagnosed at time of delivery.

Of the three cases with a blood loss over 3000ml, two were twin births

There was no significant difference or over-representation of any particular group related to ethnicity or MDI. Ethnicity is generally representative of the population within the local area with a slightly higher proportion of

Eastern European women, however Pilgrim Boston Hospital has a higher proportion of these women booking than the Trust as a whole. Deprivation deciles 1, 2, 7, 8 and 9 were more likely than the average population to have increased blood loss but as the numbers in each group are very small this is not generalizable.





Human factors

- When reviewing time of day, it was noted that 5 of the 23 cases took place in the last hour of the day shift between 6pm and 7pm, this correlates with previous reviews which indicate incidents are more likely to occur immediately before and during handover.
- In one case it was identified that there was situational awareness with the Registrar declining help when the blood loss was approaching two litres and ongoing.
- In a number of cases reviewed in the PPH IR2 meeting there were concerns that liqor volume wasn't always differentiated from blood loss.
- 67% of cases did not have a Massive Haemorrhage Protocol initiated

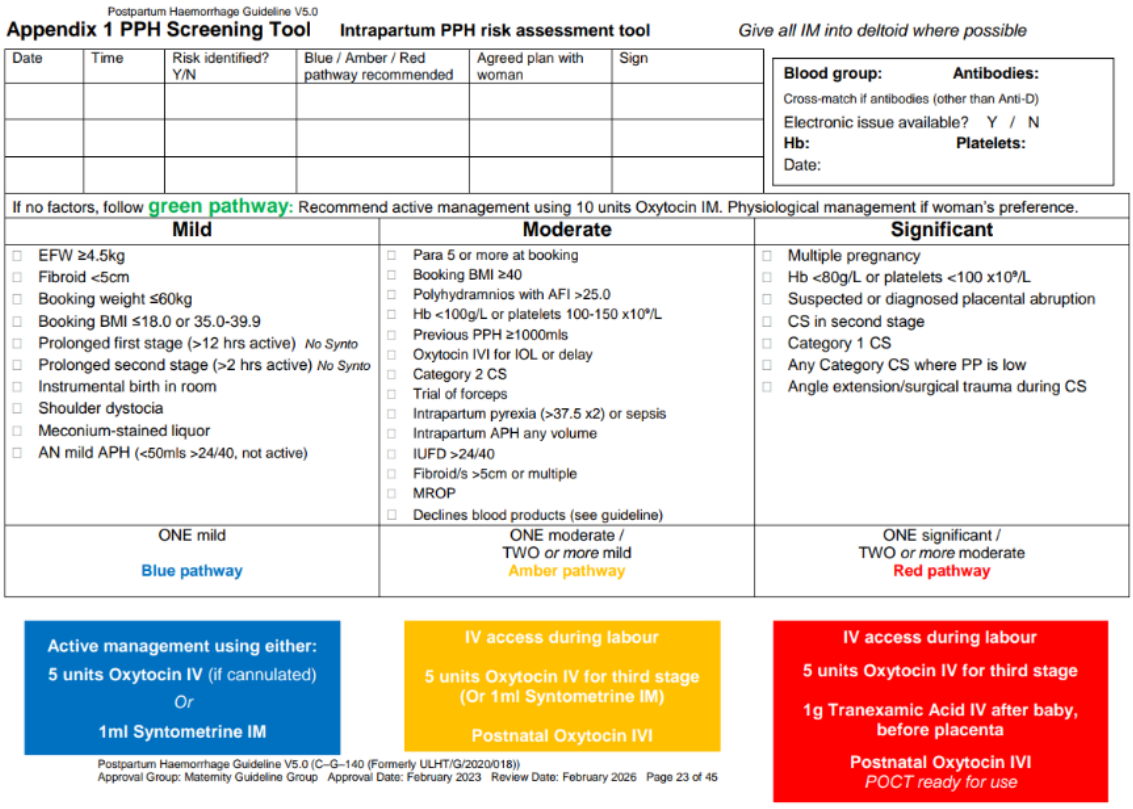
Conclusion

Whilst there may be an association with the unusually high number of very complex cases there is no room for complacency and it is prudent to review all these cases and identify areas for improvement. IOL, multiple pregnancies and women giving birth between 6pm and 7pm are over-represented in this group. There are also human factors associated with these increased blood losses which would benefit from an MDT approach to quality improvement.

Recommendations

- Audit 20 sets of notes for completion of new PPH risk assessment (Appendix 1)
- Review availability and use of cell salvage in maternity cases for women at high risk (e.g. multiple pregnancies)
- Education to ensure liqor volume is documented and deducted from total loss
- Continue with human factors training for the MDT with a focus on psychological safety to ensure staff feel able to ask for assistance, from seniors and also with the MHP
- Implement Team of the Shift element of Each Baby Counts Learn + Support Toolkit to improve MDT working and escalation processes
- Continue to promote 5iu IV oxytocin or IM Syntometrine for women on the blue PPH risk assessment pathway
- Review rates of AIP within the Trust and ensure a mitigating plan is in place in situations were women with AIP are not in a position to be transferred to a tertiary unit.

Appendix 1 PPH Risk Assessments



Postpartum Haemorrhage Guideline V5.0

Appendix 1 PPH Screening Tool **Intrapartum PPH risk assessment tool** *Give all IM into deltoid where possible*

Date	Time	Risk identified? Y/N	Blue / Amber / Red pathway recommended	Agreed plan with woman	Sign

Blood group: **Antibodies:**
Cross-match if antibodies (other than Anti-D)
Electronic issue available? Y / N
Hb: **Platelets:**
Date:

If no factors, follow **green pathway:** Recommend active management using 10 units Oxytocin IM. Physiological management if woman's preference.

Mild	Moderate	Significant
☐ EFW ≥4.5kg ☐ Fibroid <5cm ☐ Booking weight ≤60kg ☐ Booking BMI ≤18.0 or 35.0-39.9 ☐ Prolonged first stage (>12 hrs active) *No Synto* ☐ Prolonged second stage (>2 hrs active) *No Synto* ☐ Instrumental birth in room ☐ Shoulder dystocia ☐ Meconium-stained liquor ☐ AN mild APH (<50mls >24/40, not active)	☐ Para 5 or more at booking ☐ Booking BMI ≥40 ☐ Polyhydramnios with AFI >25.0 ☐ Hb <100g/L or platelets 100-150 x10⁹/L ☐ Previous PPH ≥1000mls ☐ Oxytocin IVI for IOL or delay ☐ Category 2 CS ☐ Trial of forceps ☐ Intrapartum pyrexia (>37.5 x2) or sepsis ☐ Intrapartum APH any volume ☐ IUFD >24/40 ☐ Fibroid/s >5cm or multiple ☐ MROP ☐ Declines blood products (see guideline)	☐ Multiple pregnancy ☐ Hb <80g/L or platelets <100 x10⁹/L ☐ Suspected or diagnosed placental abruption ☐ CS in second stage ☐ Category 1 CS ☐ Any Category CS where PP is low ☐ Angle extension/surgical trauma during CS
ONE mild **Blue pathway**	ONE moderate / TWO *or more* mild **Amber pathway**	ONE significant / TWO *or more* moderate **Red pathway**

Active management using either:
5 units Oxytocin IV (if cannulated)
Or
1ml Syntometrine IM

IV access during labour
5 units Oxytocin IV for third stage
(Or 1ml Syntometrine IM)
Postnatal Oxytocin IVI

IV access during labour
5 units Oxytocin IV for third stage
1g Tranexamic Acid IV after baby, before placenta
Postnatal Oxytocin IVI
POCT ready for use

Postpartum Haemorrhage Guideline V5.0 (C–G–140 (Formerly ULHT/G/2020/018))
Approval Group: Maternity Guideline Group Approval Date: February 2023 Review Date: February 2026 Page 23 of 45

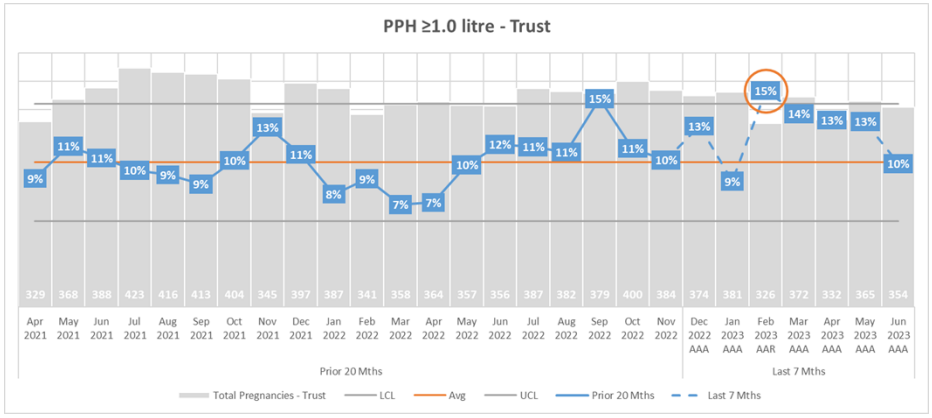
Planned Caesarean Section PPH risk assessment tool

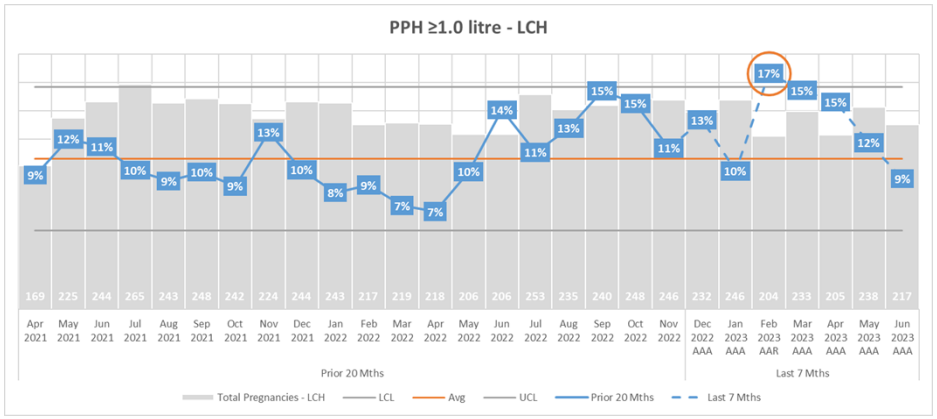
Date	Time	Risk identified? Y/N	Blue / Amber / Red pathway recommended	Agreed plan with woman	Sign

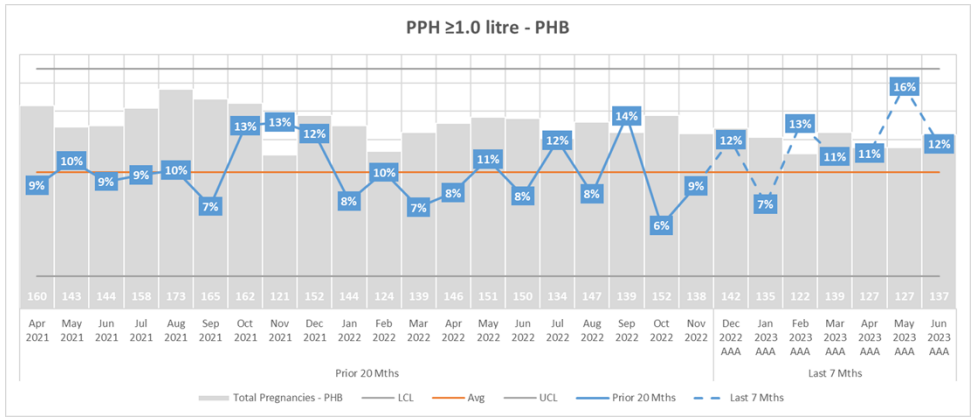
Blood group: **Antibodies:**
Cross-match if antibodies (other than Anti-D)
Electronic issue available? Y / N
Hb: **Platelets:**
Date:

Standard	☐ All planned Caesarean births	**5 units Oxytocin IV** **PN Oxytocin IVI**
Moderate	☐ Booking BMI ≥40 ☐ EFW >4.5kg ☐ Polyhydramnios with AFI >25.0 ☐ Hb <100g/L or platelets 100-150 x10⁹/L ☐ Booking weight <60kg ☐ Low anterior placenta (at incision site) ☐ Two previous CS or any previous T/classical incision ☐ Declines blood products ☐ Previous angle extension ☐ IUFD >24/40	**5 units Oxytocin IV** **PN Oxytocin IVI** **1g Tranexamic Acid IV given after uterine incision or birth** *but before delivery of placenta*
Significant	☐ Multiple pregnancy ☐ Three or more previous CS ☐ Hb <80g/L or platelets <100 x10⁹/L ☐ Known complete placenta praevia ☐ Known abnormally invasive placenta ☐ Angle extension/surgical trauma during current CS	*Pre-CS Cross Match 2-4 units* *POCT ready for use. Consider cell savage if available.* **5 units Oxytocin IV** **PN Oxytocin IVI** **1g Tranexamic Acid IV given after uterine incision** **250 micrograms Carboprost IM ~5 minutes after placenta** (check with surgeon)

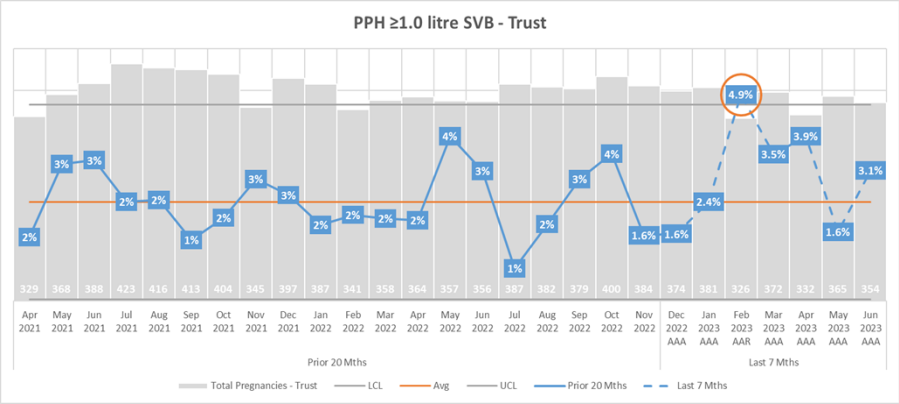
PPH >1.0 litre – all births

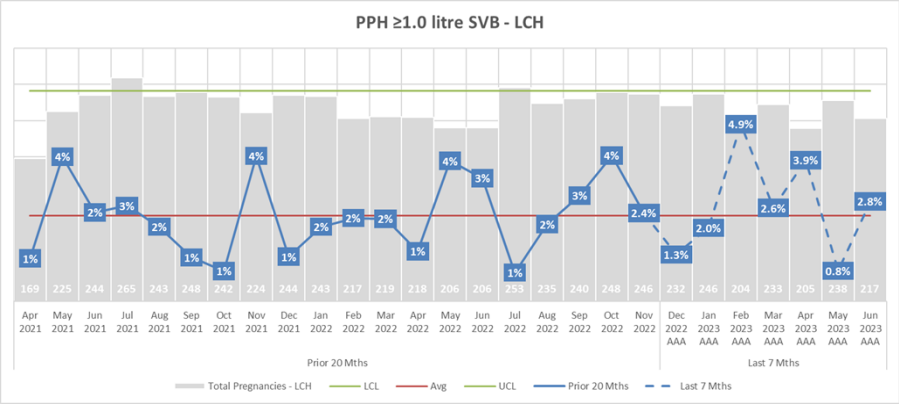


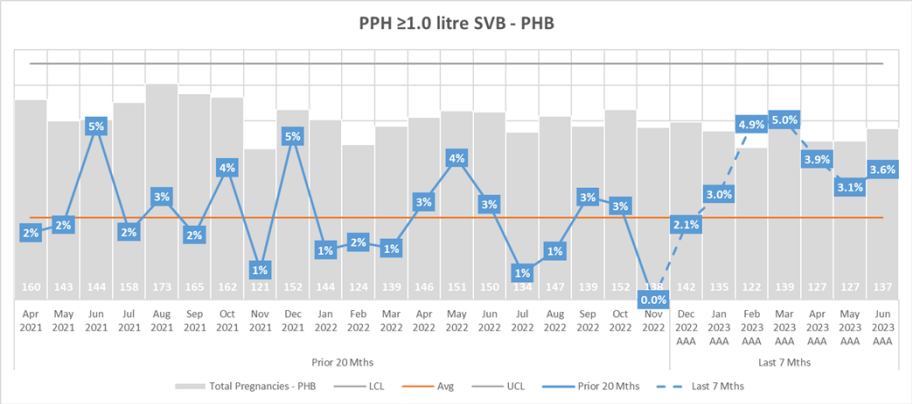


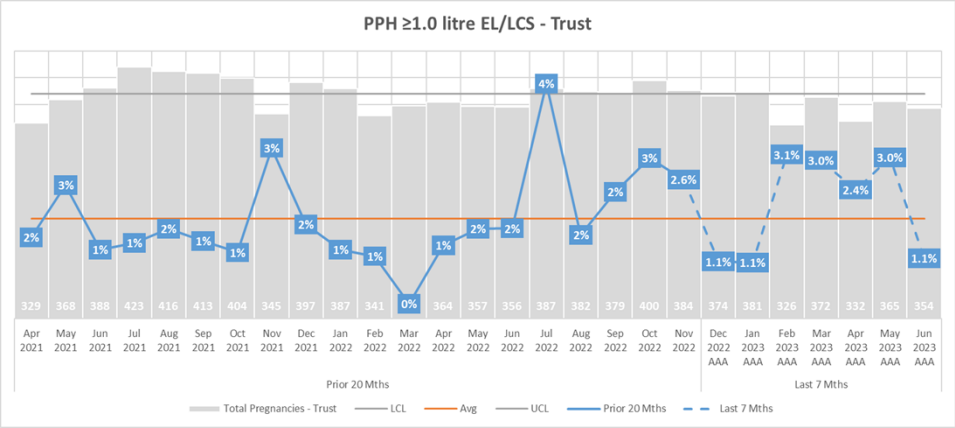


PPH >1.0 litre – SVB

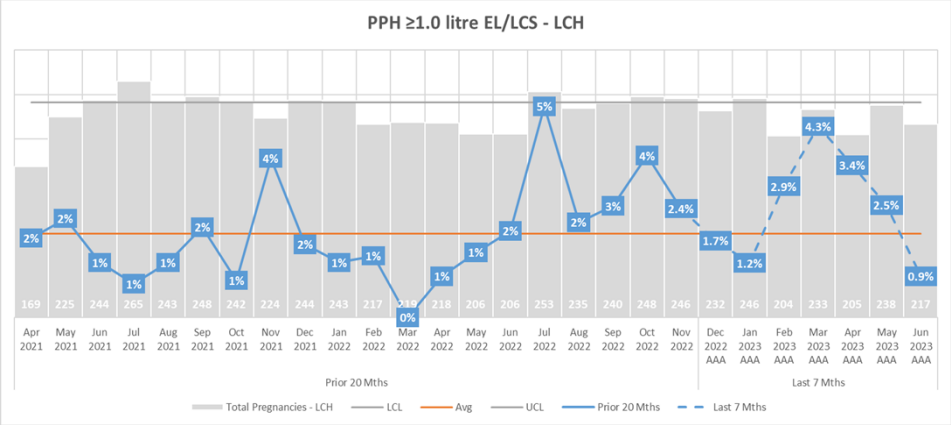


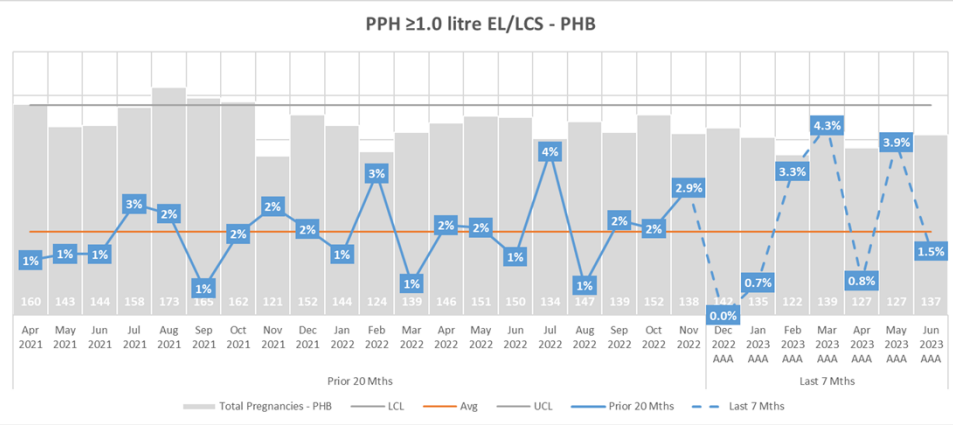


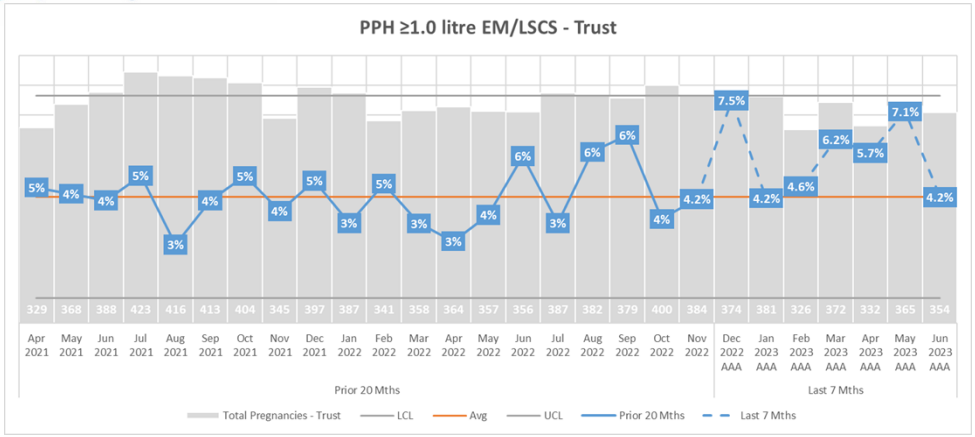




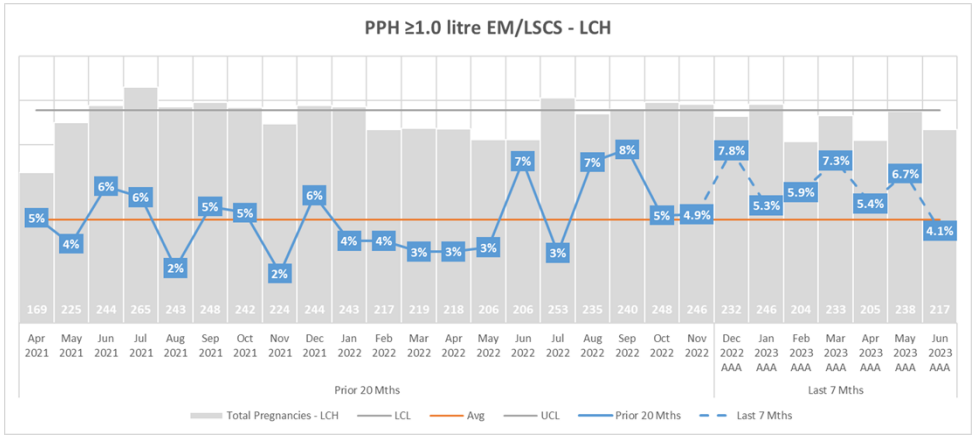
PPH >1.0 litre – ELLSCS

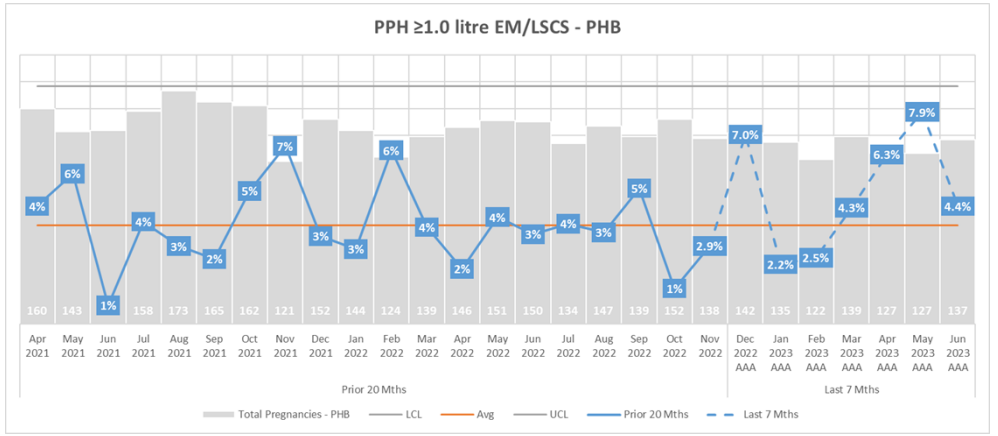


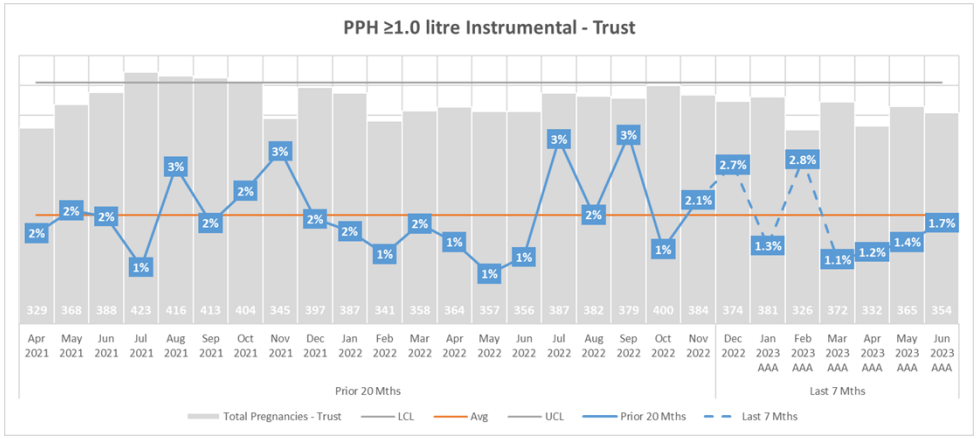




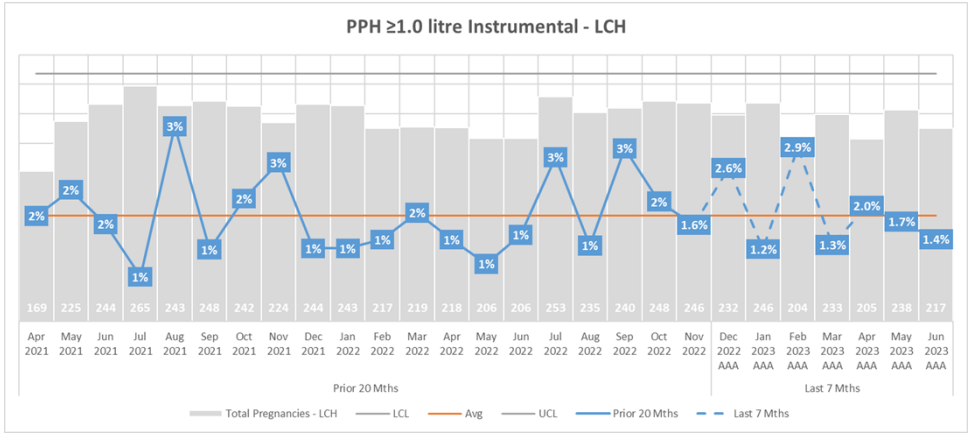
PPH >1.0 litre – EMLSCS

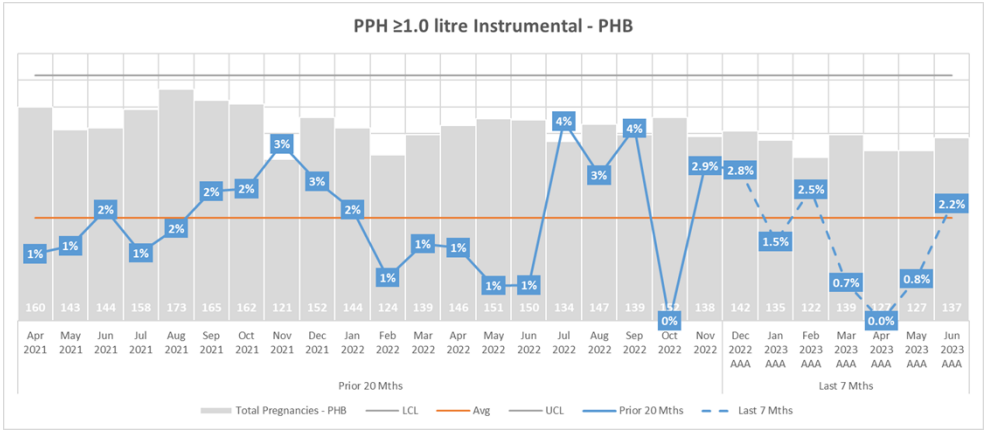




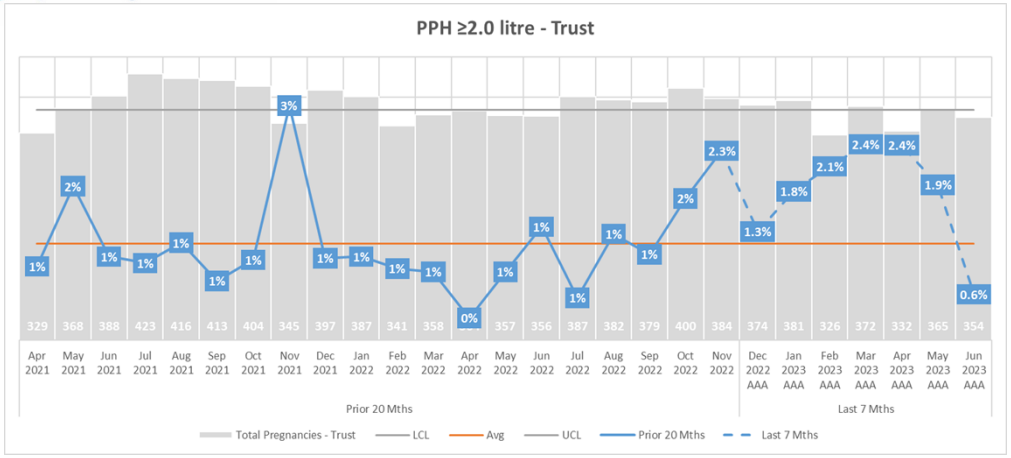


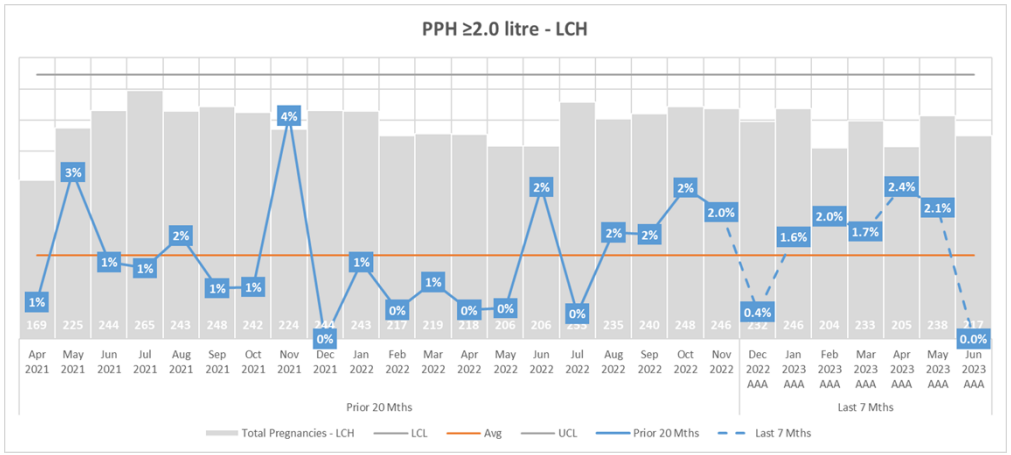
PPH >1.0 litre – Instrumental

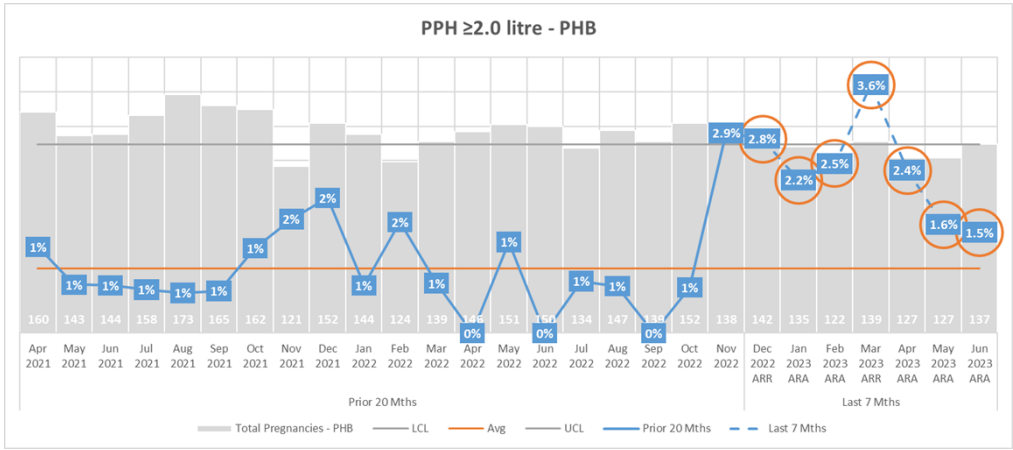




PPH >2.0 litre – all births







United Lincolnshire Hospitals NHS Trust

Maternity & Neonatal Safety Assurance Report

Libby Grooby, Divisional Head of Midwifery

As at 17 July 2023

Maternity & Neonatal Safety Assurance Report – Key Highlights

Trust: United Lincolnshire Hospitals NHS Trust **Date:** As at 17 July 2023 (June data)

Executive Summary:
This report outlines progress against the maternity and neonatal transformation work. The full Maternity & Neonatal Dashboard is provided at **Appendix A**. Other relevant in-month developments & updates are also included in a separate section of the highlight report.

CNST Yr 5: 10 Steps-to-Safety

No	Safety Action	Predicted RAG	Comments / Actions Being Taken
1	National Perinatal Mortality Review Tool		On track, evidence in file
2	Maternity Services Data Set (MSDS)		At risk due to ethnicity data compliance – most recent 81%. Data retrospectively updated. BAME report shared with staff
3	Transitional Care Services		Action plan to review
4	Clinical Workforce Planning		Need support and engagement from neonatal and anaesthetic medical colleagues
5	Midwifery Workforce Planning		On track, evidence in file
6	SBLCB V3		Audit plan in place
7	Service User Feedback / Co-produced Services		Meeting in place to discuss next steps
8	Training Plan		Awaiting confirmation of standard details from NHSR
9	Safety Champions		On track, evidence in file
10	HSIB / Early Notification Scheme		On track, initial benchmarking highlighted no concerns

Saving Babies Lives Care Bundle (SBLCB) V3

CNST required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. T

No	Requirement	RAG	Comments / Actions Being Taken
1	Reducing Smoking		Benchmarking undertaken and work ongoing. Need to update evidence
2	Fetal Growth Restriction		Benchmarking undertaken and work ongoing Need to update evidence Will need to understand increase need for scan capacity
3	Reduced Fetal Movements		Benchmarking undertaken and work ongoing Need to update evidence
4	Fetal Monitoring During Labour		Benchmarking undertaken and work ongoing Need to update evidence. Staff training needs to be 100% across all staff groups
5	Reducing Pre-term Birth		Benchmarking undertaken and work ongoing Need to update evidence
6	Diabetes		Benchmarking undertaken and work ongoing Need Diabetes dietician within the MDT

Maternity & Neonatal Dashboard Highlight Report

Maternity dashboard now has support of SPC charts to understand data more effectively.

ULHT dashboard is showing Blue (good) on SPC chats for smoking at time of delivery. This metric remains red rag rated however the SPC chart shows that we have had a definite decline in smoking rates on the Pilgrim site over the last 7 months. This co insides with the new Smoking QIP.

Stillbirth rate is also showing blue and demonstrates a consistently low still birth rate over the last 7 months. Could be attributed to the full implementation of SBLv2.

NND rate is flagging as amber on SPC charts although the rag rating remains green. This demonstrates an increase in NND over the last 7 months. This could be to do with reporting as we are now notified of NND within the community. The guidance has also changed and we are seeing more NND in extremely premature babies (< 24 week gestation) where it is documented that there were signs of life at delivery. Will continue to monitor.

‘Deep Dives’

This section of the report provides high level reporting on specific ‘Deep Dives’ arising from either incidents or outliers: red flags including as requested by the Maternity & Neonatal Oversight Group.

- See agenda items for discussion

Learning Lessons

Overview for the reporting period:

As at 1 July 2023, there were 81 (97 last report) open incidents for Obstetrics & Community Midwifery, 39 (47 last report) of which are overdue.

There were 10 (13 last report) open incidents in Neonates, 5 (10 last report) of which are overdue.

As at 1 July 2023, there was one (308286) Serious Incidents (SI) open in Obstetrics and none in Neonates.

5 open cases being investigated by HSIB - IDs 295891, 294094, 305131, 309592, 307455, with 2 being overdue.

There was no closed SI for Obstetrics or Neonates and no closed HSIB cases.

ULHT SI Update – see below

LMNS report July.docx

SPC Charts to demonstrate data relating to Datix and SI actions

Worksheet in C Users grayner AppD

Specific Requirements	Number	Details	Learning / Actions Taken
Number of incidents graded as moderate or above (reported June 2023)	3 – Obstetrics 0 - Neonates	1. 314606 – Patient consented to tubal ligation at EI LSCS which was subsequently not performed, the patient was not informed until it was discovered at postnatal discharge that this hadn't occurred. 2. 315207 – 22/40, delivered in the car on the way to hospital, signs of life seen by the paramedic and the patient. No signs of life on arrival to the hospital. 3. 315512 – EI LSCS for previous LSCS, raised BMI and GDM diet controlled, baby sustained a fractured humorous at delivery due to difficult extraction.	1. Rapid Review completed and with Lincoln obstetric risk lead to discuss what process of investigation needs to be undertaken. 2. Agreed at review panel that this did meet the criteria for a SI to be declared. Care issues identified around the certification of the NND and also as to why she wasn't advised to come in for assessment earlier when she contacted AAC with abdo pain and brown loss. Cannot rule out that this wither this would have had an impact on the patient outcome. 3. Rapid Review completed and shared with the wider MDT, no care issues identified and decided that no further investigation was required.
Other Incidents considered at SI / Rapid Review Panel (June 2023)	2 – Obstetrics 0- Neonates	07.06.2023 – **312949** – 34+4 abruption, IUD, agreed no care issues identified to follow PMRT process 21/06/2023 – **314512** – 39+2 IUD, agreed no care issues identified to follow PMRT process	
Serious Incidents - New – declared June	0 - Obstetrics 0 – Neonates		
Serious Incidents – Closed (June 2023)	0 – Obstetrics 0 – Neonates		

HSIB Investigations	5 current	1. 294094 – Breech birth at home - To go back to SI panel with HSIB report for sign off. 2. 305131 –- Term IUD - HSIB report back for factual accuracy 3. 295891 – HIE confirmed - Family meeting 1/8/23, final action plan with LMNS for comments. 4. 309592 – Baby out for cooling - HSIB interviews currently ongoing, initial action plan with LMNS for comments. 5. 307455 – Intrapartum stillbirth - Awaiting HSIB report.	
Key themes & trends Identified from the above incidents and any additional actions being taken		Clinical oversight Lack of placental histology – Patient safety midwives to perform a review of how we can improve storage and compliance. Delay in recognition and management of deteriorating patient Failure to follow guidelines when certifying NND Failure of documentation on Medway Ongoing review of all open SI/DI/HSIB actions.	
Number of overdue actions from incidents / SIs / HSIB and actions being taken		As at 1 July 2023, in Obstetrics, there were 71 (95 last report) ongoing actions – 47 of these are overdue. In Neonates there were no outstanding actions. Weekly action plan meetings continue- teams/leads to identify any actions that may require support/resources or date extensions if unachievable.	

Service User Voice Feedback

Brief overview for the reporting period:

As at 1 July 2023, there were 6 open complaints in Obstetrics & Community Midwifery, none of which are overdue. There is one open complaint in Neonates.

There was one PALS contact received in Obstetrics in May and one open PALS contacts.

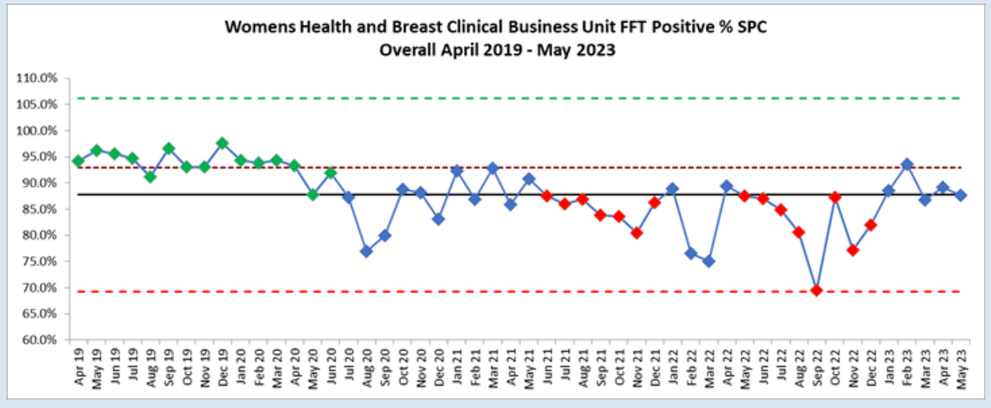
What matters to you event held in Gainsborough 15.6.23 - Extremely positive event hosted by the Better Births Team with multiple staff attendance from services appropriate to pregnancy and families with children under the age of 5. Well attended by over 50 families. Women reported how safe they felt in the care of the COCO Gainsborough Team and how much they and their families have benefited from Continuity of Carer. The team are continuing to do a fabulous job at supporting women throughout antenatal, intrapartum and postnatal care and it was clear to see the positive impact this had on the team and families. One family detailed their own home birth experience and how supported the team were to enabling them to have the birth they hoped for.

Birth Afterthoughts noticeboard for mums and dads to be created

Progress Neonatal Afterthoughts

PMA pilot of a new pathway to identify any postnatal PTSD symptoms, working with LPFT Perinatal Trauma and Loss Care Services and the Lincolnshire Talking Therapies, making sure we are doing the right thing for women and directing them for appropriate care and support.

Specific Requirements	Number	Details	Learning / Actions Taken
Number of complaints received in June	4 - Obstetrics 0 - Neonates	1. L37463 2. P37717 3. L37821 4. L37758	
Number of PALS received in May	1 – Obstetrics 0 - Neonates		
Number of compliments* ***Information taken from SUPERB (Single Unified Patient Experience Reporting Board)***	33 – Obstetrics 23 – Neonates	For April and May	
Feedback received by Maternity & Neonatal Voices Partnerships			
Key themes & trends identified from the above activity and any additional actions being taken		Continues to be appointments and communication	
Number of overdue actions from complaints / PALS and actions being taken		As at 1 July, there were no open Obstetric complaint actions. There are 0 open Neonatal complaint actions.	
Friends and Family Test		The highlight report for May 2023 shows a National average recommended rate of 93%, a Trust average of 89% and Maternity have achieved 100%. No data for NNU as same cohort of women. Further highlight reports are not available currently.	



We see a consistently low number of negative stories from the ‘Care Opinion’ ranging from 0-1 a month. However there is inconsistency in the positive stories ranging from 2 – 25 a month

Staff Experience & Feedback

Overview for the reporting period including staff feedback from frontline champions and walkabouts:

- Please also refer to the separate report from the Maternity NED ‘Safety Champion.
- Staff highlighted the need to avoid meetings over lunch times and try to start 10 minutes later to provide break between meetings where possible.
- Expanding PNAs through peer nominations.
- Ideas for staff engagement boards, suggestion boxes, “you said/we did” with a view to progressing to engagement sessions.

Other in month Developments & Updates

For May/June

- Birth Rate Plus Review – received Quote and have responded asking for review Dec/Jan

  Quote QU0206.pdf

- Outcome of Ockenden Insight Visit – Report not received as yet but initial feedback was good.

Risk register report

There are 31 risks on the risk register relating to Maternity and Neonatal Service

1	12	17	1	0

I high risk
17 moderate
12 low risk
1 very low risk

Highest risks
For Maternity Services and this is due to the clinical environment on both sites which is currently rated as a 16.

Moderate Risks

Maternity - Medway is highlighted for several reasons, connectivity, inability to pull data and its functional use for midwives. Community midwives on escalation and CTG interpretation are also highlighted.
Neonates – Highlight inadequate pharmacy support, lack of QIS and inability to fill the ANNP rota.

All risks have been reviewed in the last quarter and monthly meetings are in place to review.

- Quarterly PMRT Report – Jan-Mar 2023 & Newsletter

  Quaterly (Qu 4) PMRT Report January

  PMRT Newsletter - Issue 1.docx

- In an effort to better understand the culture within the maternity unit ULHT engaged with the Workforce Innovation team for a period of 9 months. This work has now completed although we still have the change champions working with the in house PMO team on ongoing projects around the antenatal clinic pathway. We still also have ongoing staff engagement sessions and are re launching the staff shared decision making counsel who are focusing on working with staff to improve working lives. Members of the senior leadership team began the Perinatal Culture and Leadership programme in December 2022. There were two teams of 3 that attended ,however, 1 of the team left the trust so the work is now continuing with the remain 5 members a one team. This work is going well and no support is currently requested from the Trust Board.

- SBLv2 Compliance Table/Sign Off

  Copy of Copy of Copy of ULHT SBLCB

  Copy of ULHT Compliance table M

- Compliance with NICE Guidance in Maternity & Neonatal

  NICE Maternity and Neonates Report V1

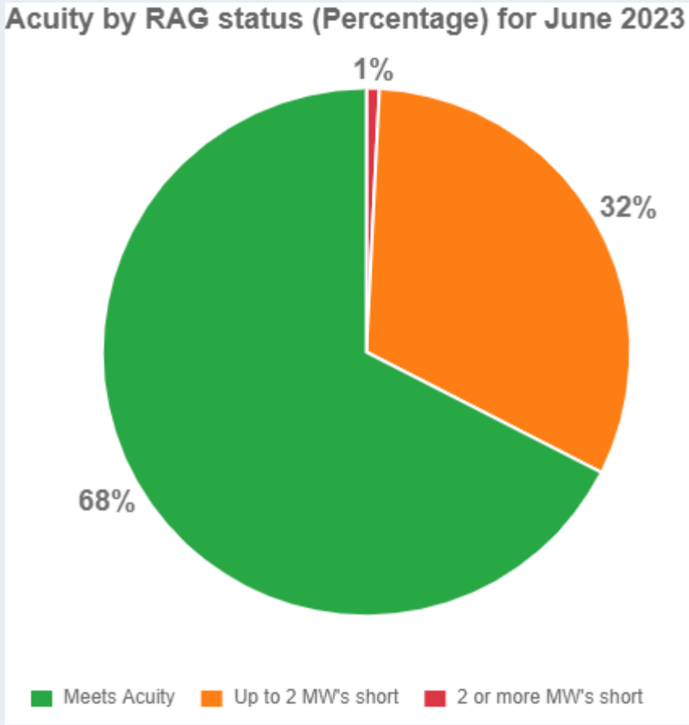
- Aromatherapy - The Senior Team have made a difficult decision to pause the aromatherapy service. This was disappointing to many staff but following review of the NICE guidance and a regional directive we have reviewed our aromatherapy service against provided benchmarking. Unfortunately we do not meet the requirements and so, at this time, we are unable to continue to offer an aromatherapy service.

  The plan going forward is to review our training and guidelines with the aim to re-instate the service.

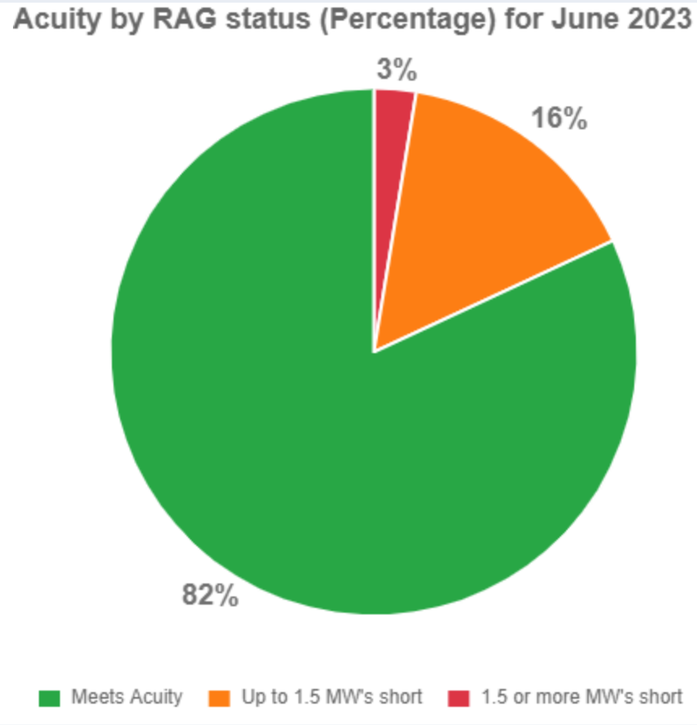
Staffing:

Staffing templates for labour ward are 7 midwives for Lincoln and 5 for Pilgrim. This is worked out on average acuity and is flexed with redeployment in times of increased acuity. If staffing falls below template an assessment is made on the birth acuity tool to assess if there are enough midwives to meet the demand. The acuity tool is completed 4 hourly.

Lincoln



Pilgrim



The above shows that, in the month of June, the number of midwives on duty met the acuity 68% of the time at Lincoln and 82% of the time at Pilgrim.
At time when the acuity is amber midwives are redeployed from other areas to support the labour ward. If this is not achievable, specialist midwives and managers are redeployed and community midwives are called to support. This happens 24 hours a day.
At times when acuity is red redeployment again takes place and if needed services are suspended on that particular site and activity is supported on the other site. During the month of June this only occurred 1% of the time at Lincoln and 3% of the time at Pilgrim.
Obstetric staffing is reported daily through the maternity sit rep and both the Trust ops team and the ICB are sited. No escalations needed for board.

Update from Neonates –

Recruitment:

- Lincoln

  B5 – currently sitting on 4.72 vacancy factor.
  Forward trajectory: 5 NQN/NQM commencing September 23.
  Vacancy factor reduces to 1.69wte. RAD completed to go to advert.

  B6 – currently 1.84wte vacancy factor.
  Forward trajectory – 0.84 advertised internally for one year secondment (Ward Manager currently seconded)
  1wte – RAD completed – to go to advert

  B2 HCSW – 0.64wte – appointed. Commencing in post shortly on completion of employment checks.

Trainee ANNP – Looking to recruit a further trainee to commence January 2024. One fully qualified ANNP leaving Sept 23.

Data Clerk – appointed. Awaiting employment checks

QIS –

- Currently 48% at LCH. Two staff complete training Oct 23 which would take percentage to 53 % however with all new starters figures diluted further giving 40% QIS in post. Nottingham University currently reviewing course offered and therefore modules in Feb 24 restricted to those staff currently on course.
- Scoping course availability from other providers.
- Using Ward Manager and Educators to support rota and staff.
- Boston – 72% QIS – diluted when starters commence in post. To update next month.

PDN 0.6 WTE B7 and Risk Gov Lead 0.6 WTE B7 - has been secured by NHSE – JD and PS in process. Case of need to be completed and presented at CRIG.

Boston:

B5 – 3.75wte appointed – commencing in post July – September 23
B4 – 0.6wte vacancy – to go to advert for role of Nursing Associate

Equipment:

- Cooling equipment update – quote received and cost in the region of £38k. The equipment would be needed on both sites. Case of need to be completed and presented via CRIG. This will depend upon the competing priorities within the division. To discuss at Divisional Cabinet meeting in July. Further update next month.
- X-ray – Testing of use of trays for all x-rays in process. Radiography team leading on the project. Current guidance in place until testing completed.

NNAP:

- ANNPs leading on NNAP – deep dives undertaken where parameters not met. Quarterly report to be produced for governance

Family Integrated Care:

- Still awaiting correspondence from the local charity to contribute to snack trolley

Update from Maternity & Neonatal Safety Collaborative (Improvement Delivery Group) Meeting:

Escalations from Maternity & Neonatal Safety Collaborative –

- Concerns around the CNST timelines and the tight deadlines
- Concerns relating to the MSDS data, particularly around ethnicity but a lot of work is ongoing to address this.
- Concerns in relation to fetal monitoring training/training generally
- CCF – concerns around the uplift to the head room – working through it
- SBLv3 – massive piece of work. There are concerns around ability to monitor BP on the equipment stipulated.
- SBLv3 – increased oversight from the LMNS
- Huge increase in the referrals for BFI consultations and the impact on the capacity of the team to progress projects, work to support L3 accreditation etc. Consultant Midwife will approach the LMNS to identify any potential funding
- Connectivity is now a major concern in children's centres. Midwives unable to plug into LAN lines for information governance reasons and the trial dongles do not work.
- Two impending CRIG applications – Physiology and one for MSDS project support.

Appendix A

ULHT Maternity & Neonatal Quality Dashboard 2023/24

Activity Indicators ULHT																					
Metric	Threshold			Data Source/ Standard	Link to Tab	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Total Number of bookings				Careflow Maternity (CM)	Bookings	421	464	475										1360			Updated May 23
Women booked by 9+6 weeks	<67.50%		>67.50%	CM/HES Data 2021	BookedBy9+6	68.88%	72.84%	69.05%											70.26%		Updated May 23
Women booked onto Continuity Pathway	<22%		>22%	CM/ULHT default plan	BookedToCoCo	21.62%	26.72%	21.68%											23.34%		
BMI >25 at Booking				CM/PHE 2018	BMIBooking	58.19%	57.54%	57.89%											57.88%		
BMI >35 at Booking				CM/PHE 2018		16.63%	11.64%	11.16%											13.14%		
BMI >40 at Booking				CM/PHE 2018		7.60%	5.39%	4.42%											5.80%		
Total number of Births				CM	BirthNumbers	335	372	358										1065			
Total Number of Live Births				CM		334	370	358										1062			
Unassisted Vaginal Birth Rate				CM/HES Data 2020	NVB	53.43%	50.81%	51.68%											51.97%		
Home Birth Rate	<2.40%		>2.40%	CM/ONS 2020	HomeBirth	2.09%	3.49%	2.51%											2.70%		
Forceps and Ventouse				CM/HES Data 2020	Forcep&Ventouse	9.85%	7.26%	10.06%											9.05%		
Total Caesarean Section Rate				CM	Caesarean	35.82%	40.05%	36.31%											37.40%		
Emergency Caesarean Section				CM		24.78%	25.00%	20.11%											23.30%		
Elective Caesarean Section				CM		11.04%	15.05%	16.20%											14.10%		
Women booked on Continuity Pathway received care in labour/birth by continuity Team	<70%		>70%	CM/NHSIE	ContinuityCare	37.68%	38.81%	29.87%											35.45%		
Induction of Labour Rate	>40%		<40%	CM/HES Data 2021	IoL	42.77%	34.25%	35.59%											37.54%		
Smoking at Booking				CM/MSDS 2021	SmokingBooking	12.83%	12.72%	13.68%											13.08%		
Smoking at the time of Delivery	>9.6%		<9.6%	CM/NHSD 2021	SmokingDelivery	11.45%	14.25%	14.12%											13.27%		

Maternal Morbidity Indicators ULHT

Metric	Threshold R	A	G	Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
PPH ≥1.0 litre	>8.60%		<8.60%	CM/Obs CYMRU	PPH>1l	13.25%	13.15%	10.17%											12.19%		
PPH ≥1.0 litre SVB	>4.90%		<4.90%	CM/Obs CYMRU	PPH>1lSVB	3.92%	1.64%	3.11%											2.89%		
PPH ≥1.0 litre Instrumental	>18.40%		<18.40%	CM/Obs CYMRU	PPH>1lInstrumental	1.20%	1.37%	1.69%											1.42%		
PPH ≥ 1.0litre EL/LCS	>8.50%		<8.50%	CM/Obs CYMRU	PPH>1lEL/LSCS	2.41%	3.01%	1.13%											2.18%		
PPH ≥ 1.0litre EM/LSCS	>19.80%		<19.80%	CM/Obs CYMRU	PPH>1lEM/LSCS	5.72%	7.12%	4.24%											5.69%		
PPH ≥2.0 litre	>1.30%		<1.30%	CM/Obs CYMRU	PPH>2l	2.41%	1.92%	0.56%											1.63%		
3rd and 4th degree Tear	>3%		<3%	CM/OASI post-bundle stats	3rd4thDegTears	1.51%	0.82%	1.69%											1.34%		
Admission to ITU	>1		0	Inpatient Matron	ITU	0	1	0										1			
No of PN Readmissions up to 42 days of birth	>3.40%		<3.40%	Self serve NMPA 2021	PNReadmissions	2.41%	5.48%	6.78%											4.89%		

Neonatal Mortality & Morbidity Indicators ULHT

Metric	Threshold R	A	G	Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
Unexpected Term admissions to the NICU (based on Term births)	>5%		<5%	NNU/NHSIE ATAIN project	UnexpectedNICU	4.84%	5.65%												5.25%		Reports 1 month behind
No. of babies transferred for therapeutic cooling	>1		0	NNU	Cooling	2	0	0										2			
Pre-Term Birth 23+0-36+6 wks	>6%		<6%	CM/SBL	PreTerm	4.78%	9.68%	7.82%											7.42%		
No. of Antenatal stillbirths	≥1			CM	AntenatalSB	1	1	1										3			
No. of Intrapartum stillbirths	≥1			CM	IntrapartumSB	0	0	0										0			
Rolling stillbirth rate (12 months)	>3.8 per 1000		<3.8 per 1000	CM/ONS 2020	RollingSB	2.23	2.45	2.67													
No. of NND	≥1			CM and NNU	NoNND	0	0	1										1			
Rolling NND rate (12 months)	>2.2 per 1000		<2.2 per 1000	CM and NNU/ONS 2020	RollingNND	0.45	0.44	0.67													
AN Steroids Eligible / Full course Administered	<100%		100%	NNU	ANSteroids	33.33%	50.00%	57.14%											46.83%		
AN Magnesium Sulphate Eligible / Administered	<100%		100%	NNU	ANMagSulph	50.00%	50.00%	50.00%											50.00%		
SGA detection rate	< 41.2%		>41.7%	ANC/SBL Perintatal Institute	SGA	54.24%	59.57%	50.00%											54.60%		

Workforce Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Midwife to Birth Ratio (funded)	01:27		01:26			01:26	01:26	01:26													
Midwife to Birth Ratio (Actual)	01:27		01:26			01:23	01:25	01:24													
1-1 in labour	<99%		>99%	CM/CNST	1-1Labour	100.00%	100.00%	99.68%											99.89%		
Sickness Rate	>4.3%		<4.3%	Workforce Intelligence	Sickness	4.47%	4.80%	4.92%											4.73%		
Co-ordinator Supernumerary	<96%		>99%	Inpatient Matron/CNST	Co-ordinator	96.94%	99.00%	99.75%											24.64%		
Prompt Training Compliance	<90%		≥90%	CE team/ CNST	PROMPT	88.13%	88.91%	89.44%											88.83%		
Mandatory Training Compliance	<90%		≥90%	CE team/ CNST	MMTD	83.39%	86.55%	90.07%											86.67%		

***PROMPT Training (includes CTG training) – all staff groups as at the end of June 2023**

		Trained	Possible	%
PROMPT	Lincoln MW	155	169	91.72
	Lincoln Drs	26	32	81.25
	Lincoln Anaes	20	22	90.91
	Lincoln HCSW/MSW	36	45	80.00
	LCH Prompt	237	268	**88.43**
	Bank Only MW (Trustwide)	17	21	**80.95**
	Pilgrim MW	95	103	92.23
	Pilgrim Drs	26	26	100.00
	Pilgrim Anaes	18	22	81.82
	Pilgrim HCSW/MSW	22	26	84.62
	PHB Prompt	161	177	**90.96**
	Trust Compliance Prompt	415	466	**89.06**

Postnatal Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Skin to Skin Contact at Birth	<80%		>80%	CM/HES 2021	SkinToSkin	81.14%	76.76%	77.93%											78.61%		
Breastmilk at first feed	<68%		>68%	CM/HES 2021	FirstFeed	67.50%	71.51%	65.12%											68.04%		

Risk Management Indicators ULHT																				
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
No. of unit closures	≥1		0	Inpatient Matron		3	0	1										4			
No. of SI's Maternity	≥1		0	Risk (Datix)		0	0	0										0			
No. of Never Events	≥1		0	Inpatient Matron		0	0	0										0			
No. of HSIB cases	≥1		0	Risk (Datix)		1	0	0										1			
PMRT commenced within CNST timeframe	<95%		≥95%	Bereavement Midwife		100.00%	100.00%	100.00%											100.00%		
PMRT completed within CNST timeframe	<50%		≥50%	Bereavement Midwife		100.00%	100.00%	100.00%											100.00%		
No of current coroners cases / inquests pending				Legal		0	0	0										0			
No of coroners Regulation 28 (prevention of future death reports) made direct to the trust)				Legal		0	0	0										0			
No of Formal Complaints				Complaints		5	3	3										11			

Perinatal Mortality Reports

May 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	MBRRACE Notified	CNST Standards draft deadline date	DATIX Panel SI
PHB	Misc	02/05/23	19/40	P2, smoker, BMI 50.2	N/A	N/A	N/A	No
LCH	MTOP	05/05/23	20+1	P0, APH 10/40, SROM 19+1. MTOP 20+1	N/A	N/A	N/A	No
LCH	MTOP	12/05/23	16+4	Multiple abnormalities	N/A	N/A	N/A	No
LCH	MTOP	17/05/23	18+6	P0, smoker. SROM 18+3. MTOP 18+6	N/A	N/A	N/A	No
PHB	SB/MTOP	21/05/23	25+5	P0+15, Failed MTOP 10/40. Unaware of on-going pregnancy. Clause 'B' MTOP-Maternal mental health	87599	N/A	N/A	Gynae Yes ?
LCH	Misc	23/05/23	18+4	P2, un-booked. concealed pregnancy, misc in A&E	N/A	N/A	N/A	No
PHB	SB	25/05/23	34/40	P2, low risk pregnancy. Abruption	87679	30/05/23	No standards set	312949 Due ?
LCH	Misc	27/05/23	19+6	P2, No FH on anomaly USS	N/A	N/A	N/A	No
PHB	MTOP	27/05/23	21+4	Bi-lateral multi cystic kidneys.	N/A	N/A	N/A	No

June 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	MBRRACE Notified	DATIX Panel SI
LCH	MTOP	13/06/23	34/40	P1, Thought to be early pregnant, attended for TOP with EPAU. Found to be @32+6. Baby diagnosed with Anencephaly.	87986	15/06/23	No
LCH	SB	15/06/23	39+2	P1, BMI 36.9. Stopped smoking in pregnancy. h/o pre-eclampsia last pregnancy, GDDM, attended ELCS @39+2, no FH on admission	88052	20/06/23	314512 Yes No
LCH	NND	23/06/23	22+1	P0, BMI 33.5 @booking, IUI pregnancy donor egg. Contacted labour ward reporting tightening @ 22+1, gave birth in transit. Baby born alive and passed way less than an hr of age. RIP.	88151	28/06/23	315207 5/7/23 ?

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Lincoln County Hospital

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit	Live Births	2909	2925	2812	242.4	243.8	234.3	233.2	222.0	206	241	219										666	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	345	326	371	28.8	27.2	30.9	29.8	25.3	23	32	21										76	
	No of First Episode Admissions	283	282	299	23.6	23.5	24.9	23.8	20.3	21	23	17										61	
	% of First Episode Admissions against Live Births			N/A			11%	10%	9.2%	10.2%	9.5%	7.8%										N/A	
	No of Admissions to TC	152	202	220	12.7	16.8	18.3	19.0	12.3	10	17	10										37	
	All Ex-utero transfers	73	62	69	6.1	5.2	5.8	5.3	4.3	4	8	1										13	
	Ex-utero transfers <27 weeks	1	2	1	0.1	0.2	0.1	0.3	0.3	0	1	0										1	
	In-utero transfers	4	13	11	0.4	1.1	0.9	0.8	1.7	1	2	2										5	
	In-utero transfers <27 weeks	0	8	6	0.0	0.7	0.5	0.5	0.7	0	1	1										2	
	NNU Term Admissions	143	168	170	11.9	14.0	14.2	13.8	9.0	11	8	8										27	
	Live Term Births	2654	2725	2584	221	227	215	216	205	191	219	204										614	
	% NNU Term Admissions (Live Term births) - Target <5%	N/A	N/A	N/A	5.4%	6.2%	6.5%	6.4%	4.4%	5.8%	3.7%	3.9%										N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	68%	63%	69%	71%	67.9%	72.7%	74.2%	56.7%										N/A	
		TC	N/A	N/A	N/A	83%	80%	45%	43%	37.0%	37.5%	29.4%	44.2%										N/A	
		Total (NNU & TC)	N/A	N/A	N/A		67%	61%	63%	57.1%	60.4%	58.6%	52.3%										N/A	
	Hypothermia on Admission - Ep.1 (<36.5◦c)	NNU	34	53	28	2.8	4.4	2.3	1.2	0.7	1	1	0										2	
		TC			15			1.3	1.9	0.3	0	1	0										1	
	(% of first episode admissions)	NNU %			N/A			0.1	4.6	2.5%	4.3%	3.1%	0.0%										N/A	
		TC %			N/A			0.1	9.6	2.0%	0.0%	5.9%	0.0%										N/A	
	Transferred for Therapeutic Cooling		5	0	4	0.4	0	0	0	0.7	2	0	0										2	
	HIE (all grades)		8	2	6	0.7	0.2	0.5	0.3	0.3	1	0	0										1	
	Neonatal Deaths (following admission to NNU)		0	1	1	0	0.1	0.1	0.0	0.0	0	0	0										0	
	Neonatal Deaths (delivery room)								0.1	0.3	0	0	1										1	
	Unit Closures (any)		0	2	0	0	0.2	0.0	0.0	0.0	0	0	0										0	
	No. of Exceptions		8	13	22	0.9	1.1	1.8	1.1	1.0		1											1	
	Medication Errors (moderate and above)									1.3	3	1	0										4	
	No of Serious Incidents (SI)		1	1	1	0.1	0.1	0.1	0.0	0.0	0	0	0										0	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthy Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Staffing	Appraisals - % (Target 100%)	Registered and unregistered	N/A	N/A	N/A			86%	89%	71.9%		64.1%	79.6%										N/A	
		ANNPs	N/A	N/A	N/A	75%	75%	71%	79%	50.0%	50.0%	50.0%	50.0%										N/A	
	Sickness - % (Target - Trust avg <4%)	Registered and unregistered	N/A	N/A	N/A	6.3%	5.1%	6.8%	6.8%	3.1%	1.8%	3.3%	4.2%										N/A	
		ANNPs	N/A	N/A	N/A	4.0%	0.6%	4.9%	9.7%	2.5%	0.8%	1.5%	5.3%										N/A	
	Mandatory training % (Core Learning) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	94%	91%	90%	95%	92.4%	91.0%	92.9%	93.3%										N/A	
		ANNPs	N/A	N/A	N/A	96%	97%	90%	94%	97.3%	97.0%	98.0%	97.0%										N/A	
	Mandatory training % (Core Learning Plus) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	92%	86%	86%	90%	84.3%	89.0%	74.0%	90.0%										N/A	
		ANNPs	N/A	N/A	N/A	96%	89%	86%	87%	93.0%	90.0%	94.0%	95.0%										N/A	
	BLS (Target >95%)		N/A	N/A	N/A	95%	63%	77%	82%	66.0%	74.0%	57.0%	67.0%										N/A	
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	N/A	N/A	64%	64%	47.6%	46.7%	49.0%	47.2%										N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	3.9	4.6	2.3	1.6	2.4	2.8	2.2	2.2										N/A	
	% staff with in-date NLS (Target 100%)		N/A	N/A	N/A	100%	95%	90%	100%	100.0%		100%	100%										N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Pilgrim Hospital, Boston

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit	Live Births	1762	1612	1798	146.8	134.3	149.8	142.5	132.3	128	130	139										397	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	209	172	218	17.4	14.3	18.2	17.1	16.0	11	20	17										48	
	No of First Episode Admissions	175	137	191	14.6	11.4	15.9	15.1	14.0	10	19	13										42	
	% of First Episode Admissions against Live Births			N/A			11%	11%	10.6%	7.8%	14.6%	9.4%										N/A	
	No of Admissions to TC	72	65	80	6.0	5.4	6.7	7.1	6.7	7	8	5										20	
	All Ex-utero transfers	30	28	23	2.5	2.3	1.9	2.1	4.3	4	5	4										13	
	Ex-utero transfers (<32 weeks)	12	7	9	1.0	0.6	0.8	0.6	1.0	1	1	1										3	
	All in-utero transfers	20	14	8	2.0	1.2	0.7	0.8	1.3	3	1	0										4	
	In-utero transfers (<32 weeks)	15	13	5	1.5	1.1	0.4	0.8	1.3	3	1	0										4	
	NNU Term Admissions	87	65	113	7.3	5.4	9.4	8.7	8.3	4	12	9										25	
	Live Term Births	1638	1510	1672	136.5	126	139	132	121	119	117	127										363	
	% NNU Term Admissions (Live Term births) Target <5%	N/A	N/A	N/A	5.3%	4.3%	6.7%	6.6%	6.9%	3.4%	10.3%	7.1%										N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Pilgrim Hospital, Boston

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	46%	44%	42%	38%	45.5%	36.3%	39.9%	60.4%										N/A	
		TC	N/A	N/A	N/A	50%	39%	51%	55%	50.3%	40.0%	71.0%	40.0%										N/A	
		Total (NNU & TC)	N/A	N/A			42%	45%	43%	47.1%	37.5%	50.3%	53.6%											
	Hypothermia on Admission - Ep.1 (<36.5ºc) (% of first episode admissions)	NNU	35	39	30	2.9	3.3	2.5	1.5	1.7	0	3	2										5	
		TC			5			0.4	0.2	1.3	0	4	0										4	
		NNU %			N/A			0.2	10.8	8.9%	0.0%	15.0%	11.8%										N/A	
		TC %			N/A			0.1	3.3	16.7%	0.0%	50.0%	0.0%										N/A	
	Transferred for Therapeutic Cooling		2	2	1	0.2	0.2	0.1	0.1	0.0	0	0	0										0	
	HIE (all grades)		2	3	2	0.2	0.3	0.2	0.1	0.0	0	0	0										0	
	Neonatal Deaths (following admission to NNU)		0	0	2	0	0	0	0	0.0	0	0	0										0	
	Neonatal Deaths (delivery room)								0	0.0	0	0	0										0	
	Unit Closures (any)		0	0	0	0	0	0	0	0.0	0	0	0										0	
	No. of Exceptions		24	23	22	2.0	1.9	1.8	1.2	2.0	3	1											4	
	Medication Errors (moderate and above)									1.0	0	2	1										3	
	No of Serious Incidents (SI)		0	0	1	0	0	0	0	0.0	0	0	0										0	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Pilgrim Hospital, Boston

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Staffing	Appraisals - % (Target 100%)	NNU	N/A	N/A	N/A			83%	73%	74.9%	69.2%	68.0%	87.5%										N/A	
		Outreach																						
	Sickness - % (Target - Trust avg <4%)	NNU	N/A	N/A	N/A	5.5%	6.3%	6.3%	10.5%	7.1%	7.8%	6.0%	7.4%										N/A	
		Outreach								13.4%	0.0%	18.1%	22.1%											
	Mandatory training % (Core Learning) (Target >95%)	NNU	N/A	N/A	N/A	95%	96%	98%	98%	97.2%	97.2%	97.0%	97.5%										N/A	
		Outreach								86.3%	89.5%	83.3%	86.1%											
	Mandatory training % (Core Learning Plus) (Target >95%)	NNU	N/A	N/A	N/A	92%	94%	96%	96%	95.9%	97.2%	93.0%	97.6%										N/A	
		Outreach								90.4%	95.0%	87.7%	88.4%											
	BLS (Target >95%)	NNU	N/A	N/A	N/A	97%	99%	96%	93%	93.0%	92.0%	92.0%	95.0%										N/A	
		Outreach								55.7%	67.0%	33.0%	67.0%											
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	62%	67%	70%	74%	72.0%	72.0%	72.0%	72.0%										N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	2.0	0.6	1.5	1.1	0.0	0.0	0.0	0.0										N/A	
	% staff with in-date NLS (Target 100%)	NNU	N/A	N/A	N/A	96%	100%	98%	99%	100.0%	100%	100%	100%										N/A	
		Outreach							83.50%	100.0%	100%	100%	100%										N/A	

United Lincolnshire Hospitals NHS Trust

Quarterly Perinatal Mortality Review Report January – March 2023

Author – Samantha Tinkler – Patient Safety Lead Midwife – ULHT

Highlight Report

Year 4 CNST standards were until 5th December 2022. Compliance according to Year 4 CNST standards:

1 case for surveillance was submitted 1 day late due to awaiting information from the coroner prior to submission. Lesson Learned – to submit with the information available and then reopen and amend if required at a later date.

Year 5 CNST standards were published on 31st May 2023. These new standards came into effect for any babies that were born and died in our Trust from 30th May 2023. These new standards will be reflected in the next quarterly report.

PMRT Action Plans developed from Published reviews January-March 2023

8 Perinatal Mortality Review Reports were published using the National Perinatal Mortality Review Tool (PMRT) between January – March 2023. 5 were ULHT Perinatal Mortality Review Reports and 3 were External Perinatal Mortality Review Reports where ULHT were involved in care and completed a review.

1 External Report (ID 82554) had no ULHT actions.

1 ULHT Report (ID 83518) – had no action plan regarding the Maternity Care provided but continues as an SI and under the SUDIC process as baby was 21 days old at the time of death.

6 Published reports had actions for ULHT.

Themes from reviews

1. There is no evidence in the notes that this mother was asked about domestic abuse at booking in 3/6 cases.
2. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available in 4/6 cases
3. The opportunity to take their baby home was not offered to the parents as there is no local policy for this in 3/6 cases.

United Lincolnshire Hospitals NHS Trust

Quarterly Report for Perinatal Mortality cases January – March 2023

Author - Samantha Tinkler – Patient Safety Lead Midwife – June 2023

Baby Losses for January – March 2023

January 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No. and PMRT required	Date MBRRACE Notified within 7 Working days	CNST Year 4 Standards draft deadline date	DATIX ID Taken to Panel Declared SI
LCH	LFL/NND	02/01/2023	22+3	DCDA Twins, spontaneous labour Twin 1 born showing no signs of life, Twin 2 lived for 1.30min	85298 Yes	Yes - 03/01/2023	02/05/2023 Completed 25/04/2023	303302 No No
PHB External	Neonatal Death	Received 04/01/2023 Born – 11/09/2022 Died – 11/09/2022	27 +0		83477 Yes	Not Applicable – external notification	Not applicable. ULHT review completed and returned 15/02/2023. Published report received 10/03/2023.	None
PHB	MTOP	05/01/2023	17+3	Kidney dysplasia & Oligohydramnios	N/A	N/A	N/A	None
LCH	MTOP	07/01/2023	21/40	Multiple abnormalities	N/A	N/A	N/A	None

LCH	Miscarriage	09/01/2023	18+3	P0+1, 17+1 bulging membranes, 4cm dilated, spontaneous labour	N/A	N/A	N/A	303716 No No
PHB	Miscarriage	12/01/2023	19+4	P1, IVF pregnancy, abdominal pain 19/40 IUD diagnosed, fetal hydrops seen	N/A	N/A	N/A	303994 No No
LCH	MTOP	14/01/2023	25+1	Brain abnormalities	85504 Not required	Yes - 16/01/23	N/A	None
LCH	SB	30/01/2023	38+5	P0, IOL, GDDM-diet, RFM, tailing growth, intrapartum SB	85843 Yes	Yes - 30/01/2023	30/05/2023	305131 Yes Yes/HSIB

February 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No. and PMRT required	Date MBRRACE Notified within 7 Working days	CNST Year 4 Standards draft deadline date	DATIX ID Taken to Panel Declared SI
PHB	SB	09/02/2023	29+2	P1, low risk pregnancy, RFM 2/7, no FH on attendance.	86036 Yes	Yes 10/02/23	04/06/2023	305776 Yes No

PHB	NND	04/02/2023	18 days	Born by ELCS 37/40. Out of area visiting family, found by mum with no signs of life, unsuccessful resuscitation attempts.	86035 Yes	Yes 10/02/23	09/06/2023	A&E
LCH	Miscarriage	12/02/2023	20+5	P0+1, Previous 16/40 miscarriage, GDM diagnosis 15/40, suture 16/40, 20/40 bulging membranes, APH so suture removed, spontaneous birth.	N/A	N/A	N/A	306140 No No

March 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No. and PMRT required	Date MBRRACE Notified within 7 Working days	CNST Year 4 Standards draft deadline date	DATIX ID Taken to Panel Declared SI
LCH	Miscarriage	03/03/2023	16/40	P1, MCMA Twins, no fetal heart beats on USS at QMC 15+5.	N/A	N/A	N/A	None
PHB	SB	03/03/2023	39+6	P2, EFW 100th centile. Shoulder dystocia.	86356 Yes	Yes 06/03/23	03/07/2023	307455 Yes Yes/HSIB
LCH	SB	12/03/2023	26+5	P1, recurrent APH, spontaneous birth at home. Circumvallate placenta found on PM	86590 Yes	Yes 20/03/23	12/07/2023	308034 ? ?
LCH	MTOP	25/03/2023	17+6	P2, T21	N/A	N/A	N/A	None

LCH	Late fetal Loss	23/03/2023	23+4	P1, IVF, HC<3rd centile on anomaly USS. No fetal heart on scan at 23/40	86720 Yes	Yes 29/03/2023	23/07/2023	308829 No No
LCH	MTOP	30/03/2023	19+4	P1 (Previous SB @ 25/40), essential hypertension. SROM.	N/A	N/A	N/A	None

Total Quarterly losses January – March 2023

Hospital	No of TOPs	No of SBs	No of LFL	No of Misc	No of NND	Total losses for ULHT	External cases received where ULHT provided care during pregnancy.	Total
Pilgrim	1	2	0	1	0	4	1	5
Lincoln	4	2	2	3	1	12	0	12
Total	5	4	2	4	1	16	1	17

Total PMR cases received January – March 2023

Hospital	ULHT PMRT cases	External PMRT cases	
Pilgrim	3	1	
Lincoln	5	0	Total PMRT
Total	8	1	9

Update on position of all ULHT Perinatal Mortality Reviews for 2022

Hospital	Loss Category	Gestation	Date	MBRRACE Notified	MBRRACE Case No.	PMRT start date	PMRT draft date	Report Published
LCH	SB	28	08/02/2022	09/02/2022	79878	09/02/2022	31/02/2022	28/04/2022
PHB	SB	27	20/02/2022	20/02/2022	80059	22/02/2022	31/03/2022	31/03/2022
LCH	SB	39	02/03/2022	03/03/2022	80244	03/03/2022	27/05/2022	27/05/2022
LCH	LFL	22	29/03/2022	30/03/2022	80699	31/03/2022	22/04/2022	22/04/2022
PHB	SB	36	11/04/2022	12/04/2022	81071	13/04/2022	09/06/2022	29/09/2022
PHB	LFL	23	21/04/2022	22/04/2022	81212	22/04/2022	10/06/2022	13/06/2022
PHB	SB	32	21/04/200	22/04/2022	81228	22/04/2022	13/06/2000	13/06/2022
LCH	LFL	22	16/06/2022	20/06/2022	82074	20/06/2022	07/09/2022	13/09/2022
PHB	SB	32+3	07/07/2022	11/07/2022	82419	27/07/22	03/11/22	05/01/2023
LCH	LFL	22+1	19/07/2022	21/07/2022	82627	28/07/22	18/11/22	17/01/2023
LCH	SB	34+5	28/07/2022	28/07/2022	82725	03/08/22	23/11/22	26/01/2023
PHB	SB	24+3	01/08/2022	03/08/2022	82820	03/08/22	30/11/22	31/01/2023
LCH	NND	21 days	14/09/2022	14/09/2022	83518	24/10/2022	12/01/2023	08/03/2023 Continued as SI and SUDIC
LCH	SB	38+6	19/10/2022	20/10/2022	84123	07/11/2022	17/02/2023	13/04/2023
LCH	SB	34+4	31/10/2022	02/11/2022	84326	10/11/2022	01/02/2023	06/04/2022 Continued as SI

Update on position of all External Perinatal Mortality Reviews for 2022

Hospital	Loss Category	Gestation	Date Request Received	MBRRACE Case No.	PMRT MDT meeting held	Report Published by Lead Trust
PHB	NND		16/09/2022	82554	17/10/2022 and 21/10/2022	19/01/2022
LCH	NND		28/09/2022	81943	24/10/2022	02/12/2022
LCH	NND		22/10/2022	83759	14/11/2022	20/04/2023
LCH	NND		26/10/2022	84000	28/11/2022	10/03/2023
LCH	NND		10/11/2022	84432	12/12/2022	01/06/2023
LCH	SB	31+3	17/11/2022	83449	28/12/2022	Not yet published
LCH	LFL	22+	25/11/2022	84608	12/12/2022	20/04/2022
PHB	NND		07/12/2022	84845	16/01/2023	Not yet published

Update on position of all ULHT Perinatal Mortality Reviews for 2023

Hospital	Loss Category	Gestation	Date	MBRRACE Notified	MBRRACE Case No.	PMRT start date	PMRT draft date	Report Published
LCH	LFL	22+	02/01/2022	03/01/2023	85298/1	19/01/2023	25/04/2023	Not yet published
LCH	NND	22+	02/01/2022	03/01/2023	85298/2	19/01/2023	25/04/2023	Not yet published
LCH	Intrapartum SB	38+	30/01/2022	30/01/2023	85843	27/01/2023	18/05/2023	SI and HSIB investigation Not yet published
PHB	NND	Born at 37	04/02/2023	10/02/2023	86035	29/03/2023	01/06/2023	Not yet published
PHB	SB	29	09/02/2023	10/02/2023	86036	27/02/2023	19/05/2023	Not yet published
PHB	Intrapartum SB	39	03/03/2023	06/03/2023	86356	02/05/2023		SI and HSIB investigation Not yet published
LCH	SB	26+5	12/03/2023	20/03/2023	86590	04/04/2023		Not yet published
LCH	LFL	23+4	23/03/2023	29/03/2023	86720	11/04/2023		Not yet published
LCH	SB	27	25/04/2023	02/05/2023	87242			Not yet published

Update on position of all External Perinatal Mortality Reviews for 2023

Hospital	Loss Category	Gestation	Date Request Received	MBRRACE Case No.	PMRT MDT meeting held	Report Published by Lead Trust
PHB	NND	Born at 27	04/01/2023	83477	30/01/2023	10/03/2023
PHB	NND	Born at 23+5	06/04/2023	86825	Planned 15/05/2023	Not yet published
LCH	NND	Born at 36+6	11/04/2023	86868	24/04/2023	Not yet published

Year 4 CNST standards were until 5th December 2022. Awaiting new CNST standards. Compliance according to Year 4 CNST standards:

Required standard for babies that were suitable for review:	CNST required %	ULHT %
Percentage of eligible perinatal deaths reported to MBRRACE within 7 working days.	100%	100%
Percentage of surveillance completed for eligible perinatal deaths within 1 month of death.	100%	87.5%
Percentage of eligible perinatal death reviews using the PMRT started within 2 months of each death.	95%	100%
Percentage of eligible baby deaths reviewed using the PMRT.	50%	100%
Percentage of eligible baby deaths that were reviewed by an MDT.	50%	100%
Percentage of eligible baby deaths reviewed that had a draft generated within 4 months of their death.	50%	100%
Percentage of eligible baby deaths reviewed that had a report published within 6 months of their death.	50%	100%
Percentage of babies whose parents' were informed of the review and their perspectives sought.	95%	100%

Case ID	Date of birth	Date of death	Surveillance case status	Date surveillance first closed	Review status	Date review opened	Factual questions currently completed (%)	Date draft report first available	Date review first published	Working days to notify	Months to complete surveillance	Months to start review	Months to draft report	Months to publish report	Parents informed of review	Parents views sought
86720	23/03/2023	23/03/2023	Surveillance complete	11/04/2023	Reviewing	11/04/2023	100%	Not set	Not set	4	< 1	< 1	Draft report not published	Review report not published	Not answered	Not answered
86590	12/03/2023	12/03/2023	Surveillance complete	04/04/2023	Reviewing	04/04/2023	100%	Not set	Not set	5	< 1	< 1	Draft report not published	Review report not published	Yes	Yes
86356	03/03/2023	03/03/2023	Surveillance complete	03/04/2023	Reviewing	13/04/2023	100%	Not set	Not set	1	< 2	< 2	Draft report not published	Review report not published	Not answered	Not answered
86036	09/02/2023	09/02/2023	Surveillance complete	27/02/2023	Reviewing	27/02/2023	100%	Not set	Not set	1	< 1	< 1	Draft report not published	Review report not published	Yes	Yes
86035	17/01/2023	04/02/2023	Surveillance complete	21/02/2023	Reviewing	21/02/2023	100%	Not set	Not set	4	< 1	< 2	Draft report not published	Review report not published	Yes	Not answered

85843	30/01/2023	30/01/2023	Surveillance complete	27/02/2023	Reviewing	27/02/2023	100%	Not set	Not set	0	< 1	< 1	Draft report not published	Review report not published	Yes	Yes
85298/1	02/01/2023	02/01/2023	Surveillance complete	19/01/2023	Writing report	19/01/2023	100%	25/04/2023	Not set	0	< 1	< 1	< 4	Review report not published	Yes	Yes
85298/2	02/01/2023	02/01/2023	Surveillance complete	19/01/2023	Writing report	19/01/2023	100%	25/04/2023	Not set	0	< 1	< 1	< 4	Review report not published	Yes	Yes

1 case for surveillance was submitted 1 day late due to awaiting information from the coroner prior to submission.
Lesson Learned – to submit with the information available and then reopen and amend if required at a later date.

PMRT Issues and Action Plans developed from Published reviews January-March 2023

8 Perinatal Mortality Review Reports were published using the National Perinatal Mortality Review Tool (PMRT) between January – March 2023. 5 were ULHT Perinatal Mortality Review Reports and 3 were External Perinatal Mortality Review Reports where ULHT were involved in care and completed a review.

1 External Report (ID 82554) had no ULHT actions.

1 ULHT Report (ID 83518) – had no action plan regarding the Maternity Care provided but continues as an SI and under the SUDIC process as baby was 21 days old at the time of death.

6 Published reports had actions for ULHT.

ULHT Cases:

Issues ID 82419:

1. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available.
2. The mother felt she was not aware of the reasons or need to take Aspirin in pregnancy. There is no clear information regarding Aspirin available to provide the mothers
3. The Mother and Partner felt that some aspects of care had not been fully explained and felt that their feelings and wishes were not listened to and that the mother did not have a choice in her care
4. Fundal Height measurement should have been taken at 31 weeks to assess fetal growth prior to the commencement of planned serial growth scans. If there had been a concern with the SFH measurement, then referral for a growth scan would have been appropriate.
5. The mother consented to remember my baby photography and consent form signed. Initial caring Midwife ticked checklist as completed and contacted remember my baby and left a message prior to birth. However not followed up later on and organised.
6. Although indicated this mother was not offered infection screening for herself and her baby

Issues ID 82725:

1. There is no evidence in the notes that this mother was asked about domestic abuse at booking
2. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available
3. The opportunity to take their baby home was not offered to the parents as there is no local policy for this
4. A mean BP was not calculated following a BP profile assessment as per local guidance.
5. A CTG was not performed to assess fetal wellbeing during an assessment for hypertensive disorders.

Issues ID 82627:

1. There is no evidence in the notes that this mother was asked about domestic abuse at booking
2. Mother advised to access Doctor or GP to review a "slow water leak" - possible rupture of membranes, at 15 week's gestation. Mother did not access review as working away and had appointment 2 days later.
3. Missed opportunity to review the loss of "water" when attending for a cervical length scan and a "slither of fluid" was documented to be seen in the cervical canal. This mother had a history of PPROM at 28 week's gestation in a previous pregnancy and loss of "water" at 15 week's gestation in this pregnancy.
4. It is not possible to tell from the notes if the parents were told where their baby was being taken to and why when he/she was taken to the mortuary
5. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available
6. The opportunity to take their baby home was not offered to the parents as there is no local policy for this

Issues ID 82820:

1. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available.
2. It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home.
3. Parents were not able to take photos and make memories of their baby twins together on the Neonatal Unit.

External Cases

Issues ID 84000:

1. This mother was not appropriately managed given her carbon monoxide level
2. This baby was resuscitated and delayed cord clamping was not instituted although this was indicated
3. The review group were unable to identify whether the woman received appropriate follow - up care with regards to the loss of her baby and future pregnancies.
4. Delay in Neonatal Consultant attendance in preparation for imminent birth of an extremely premature baby due conflicting priorities on the Neonatal Unit.
5. Appropriately sized face mask was not available in the resuscitation equipment on the Labour Ward. All available masks were too large, and a smaller mask was not easily accessible however, were obtained from the Neonatal Unit once resuscitation had commenced.

Issues ID 83477:

1. This mother booked late. Are there any organisations to consider in relation to her booking late?
2. There is no evidence in the notes that this mother was asked about domestic abuse at booking.
3. There is no information available on Medway Maternity regarding any reviews in gynaecology during pregnancy, although there had been five different admissions/reviews.

4. There is no information to indicate that the woman had been in contact with “out of area” midwives to arrange a first contact or booking, although there had been five different admissions/reviews.

Themes from reviews:

1. **There is no evidence in the notes that this mother was asked about domestic abuse at booking in 3/6 cases.**
    - Regular audits to review the enquiry at each visit and actions taken according to findings. For PMRT the question is only related to booking and does not specify if there was a reason given not to ask – such as partner present. It also doesn’t allow to note if enquiry had occurred at a subsequent visit.

2. **This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available in 4/6 cases**
    - Significant estates improvements required, ongoing work required into the provision of sufficient facilities. New development of Labour Ward at Lincoln is planned. Building work has now been complete at Pilgrim Hospital and the bereavement suite is being utilised. Bereavement fridges are in place to facilitate the babies remaining on the Labour Ward whilst mum is an inpatient. Previous provisions did not enable this and allow for parents to see their baby at any time and to keep the babies at appropriate temperatures to slow deterioration whilst not with parents. However, the bereavement fridges cannot be used at this present time. Pilgrims fridge was anticipated to be in use when the bereavement room had been completed. However, there are issues related to alarm systems which need to be resolved prior to usage. We are currently unsure when Lincoln’s will be in use due to current plans for Labour Ward movement and development. We have delayed commissioning use at present as we do not want to allocate the financial resources required. Installing the fridge now would not be cost effective or a good use of materials and resources as it is intended the fridge will be relocated.

3. **The opportunity to take their baby home was not offered to the parents as there is no local policy for this in 3/6 cases.**
    - Reviewing service provision and creating a Standard Operating Procedure (SOP) to facilitate this. Current provisions enable the parents to take their babies home if they do not wish a Post Mortem and are making private funeral arrangements. However, we are unable to facilitate return of the baby to the hospital unless the parents bring their baby back themselves. This does not show compassion and consideration, we are therefore reviewing the current contract ULHT has with funeral directors to add collection of babies to the contract. The current funeral contract is up for renewal. The head of bereavement services is reviewing the current tender. This work is still pending.

Maternity Safety Improvement Plan
HEADLINE REPORT for Maternity & Neonatal Oversight Group

Jules Bambridge – Consultant Midwife
May 2023

v3.0 Maternity Neonatal Safety Imp

The Maternity Safety Improvement Plan (MatSIP) is a dynamic live document for the collation and monitoring of improvement actions arising from national maternity reports and assurance requirements as well as internally identified improvement actions e.g. actions identified through Serious Incidents.
The maternity team held an ad hoc meeting compromising the Senior Leadership team and specialist midwives to review a large number of actions, over 50 were agreed and archived, with distal measures to be developed to monitor ongoing assurance.

Following this all in progress actions related to the Ockenden report were added for team oversight, actions related to a recent report on our BAME population have also been added.

Section	Total Actions	**Red** Not yet completed / significantly behind agreed timescales or non-compliance expected	**Amber** In progress / on track / completion expected	**Green** Completed & ongoing and / or not yet fully embedded (awaiting evidence of embedding)	**Blue** Completed & embedded with evidence, to be signed off at MNSC prior to closure
Optimise Safety	**27** (-15)	0 (-5)	18 (+17)	9 (-27)	0 (=)
Optimise Experience	**17** (+4)	3 (+2)	9 (+2)	4 (=)	0 (=)
Improve Leadership	**1** (=)	0 (-1)	1 (+1)	0 (=)	0 (=)
Choice & Personalised Care	**18** (+8)	0 (-6)	15 (+15)	3 (=)	0 (=)
Provide Assurance	**6** (-32)	0 (-7)	6 (+2)	0 (-19)	0 (-8)
TOTAL	**69**(-17)	**21 (+2)**	**12 (-12)**	**63 (+14)**	**0 (-15)**
Archived Actions	**192** (+56)	Completed, embedded and signed off by MNSC for closure			

Patient-centred ◆ Respect ◆ Excellence ◆ Safety ◆ Compassion

The following actions are currently rated Red due to expected completion date being passed or there is a concern that compliance will not be achieved by the expected completion date.

	Action No	Action Milestone	Responsible Lead	Due Date	Comments
OE11	1	Mapping of the IOL patient journey including delays	IOL MW	31/05/23	Ongoing project, 296 patient experience surveys returned, being thematically analysed by data analysed Audit of 40 patient journeys, data collected and currently being analysed
OE14	2	Address inequities in information-giving and consent process	IOL MW	31/05/23	Checklist compliance has increased, IOL journals have been now been printed and delivered, about to be rolled out. Will be monitored through patient feedback.
OE17	3	Development of ongoing patient feedback mechanism	IOL MW	31/05/23	13/7/23 - Taking part in Shared Decision Making CQUIN and trialling CollaborATE tool - Working with MVP to develop maternity specific FFT with Patient Experience Group

United Lincolnshire Hospitals NHS Trust

NED Maternity & Neonatal Safety Champion's Report: May / June 2023

Executive summary:

The role of the Maternity & Neonatal Champions is to provide proactive Board level leadership to ensure that:

- High quality clinical care
- Maternity & neonatal service & facilities
- Workforce numbers
- Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback)
- Effective team working

are all in place.

This Maternity & Neonatal Safety NED Champion's report aims to report and provide assurance in support of the above areas. Where required, the report will include risks and concerns requiring escalation as well as good practice, improvement, and innovation.

Activities undertaken:

Since the last report, the MNSC NED attended the following meetings:

2nd May - Public Trust Board
2nd May - Private Trust Board
3rd May - Quality Governance Committee Agenda Setting Meeting
9th May – Maternity and Neonatal Safety Champion Clinic (virtual)
16th May – Board Development session
16th May – Safety Walk around Lincoln site
16th May – Safety Walk around Pilgrim site
17th May – Audit Committee (informal)
18th May - Discussion regarding Maternity and Neonatal Estate and Facilities with Chief Nurse and Director of Estates
19th May - NED/MVP Chair monthly 1:1
22nd May - Maternity Neonatal Oversight Group Meeting
23rd May – Quality Governance Committee

6th June – Public Trust Board
6th June – Private Trust Board
13th June – System QPEC Meeting
13th June – Maternity and Neonatal Safety Champion Clinic (virtual)
13th June – Ockenden Prep Meeting
14th June – LMNS Board Meeting
14th June – Meeting with System Quality Committee Chairs
15th June – 1:1 with LMNS Chair
16th June – 1:1 with MVP Chair
19th June – Pre meet Quality Governance Committee
20th June – Board Development
20th June – Ockenden Insight Visit Interview
20th June – Appraisal
20th June – Quality Governance Committee
21st June - Audit Committee – Final Accounts
22nd June – Midlands Perinatal NED Safety Champions Network Event
23rd June – Aspirant Chairs Program Day 1 – The Chairs Role in Developing an Effective Unitary Board

Since the last report the MNSC NED spent time involved in planning the following items:

- Preparation for Okenden Insight visit

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
• Building on continuity of care teams, targeting towards areas greatest need • Consolidated improvement plan and ensuring evidence objectively reviewed prior to sign off. • Deep dive of current outcomes and service provision for BAME women. • Increased staff communications and dedicated organisational development support being provided	• Continued theme of Communication during labour • Sensitivity when safeguarding referral is required including documentation and communication with families • Environmental issues at both maternity sites.	• Continued concerns about the Medway IT system/ environment including storage space. Challenges especially on the Lincoln site – the need to keep staff informed of progress • Strong Visibility of leadership team • Positive recruitment but recognition that training is putting pressure on staff (staff not complaining as pleased to have new colleagues) • Environmental issues that require progressing as a priority, Pilgrim site – Theatre provision, sanitation pipe leaks and smell. • Office facilities for PMA team, Tobacco Team • Excellent Team ethos • Pride of staff • Student nurses felt supported and part of the team.

Good practice, improvements & innovation to share:

- Recruitment to additional new roles for Skegness Community Team
- Achievement of Bronze Ward Accreditation for Lincoln Neonatal team
- PMA Pulse survey.
- Excellent engagement and timely completion of complaints
- Engagement of staff from all areas in the virtual drop in clinics
- Candour of staff
- Correlation with HOM on staff issues and concerns
- Engagement in Okeden visit
- Completion of Saving Babies Lives and planning for next phase.
- Formal notification of CNST completion.

Areas for discussion (potential risk and concerns to escalate):

Ongoing

- Status and timing of capital plans at Lincoln site, Status, timing, and disruption of capital works at Pilgrim site
- Status and implementation of new maternity IT system – whilst this is closer funding and implementation dates have not been agreed.
- Community IT connectivity
- Moving of staff to cover labour ward.

New this month

- Medical cover over night and limited cover on antenatal ward.
- Outpatient clinics space at Pilgrim

Activities planned:

- Liaising with regional team re Maternity Safety Champion NED regional meeting
- Maternity and Neonatal site visits = Boston Community team.
- Compile a video for social media to share the role of the Maternity and Neonatal Safety Champion role and to publicise the virtual drop in clinics
- Exploring a system-wide strategic planning session for the ICB Quality Committee

Rebecca Brown
Non-Executive Director and Maternity & Neonatal Safety Champion

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5 September 2023*
Item Number	*Item 8.2*

CQC Improvement Action Plan in Response to 2022 Inspection Report

Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Jeremy Daws, Head of Compliance*
Report previously considered at	*Relevant 'cuts' of the CQC plan are shared with: Trust Leadership Team and sub-committees of the Trust Board.*

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	
3b Efficient use of our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c Becoming a university hospitals teaching trust	

Risk Assessment	Not Applicable
Financial Impact Assessment	Not Applicable
Quality Impact Assessment	Not Applicable
Equality Impact Assessment	Not Applicable
Assurance Level Assessment	Moderate

Recommendations/ Decision Required Executive Summary	• *note the progress update on the 5 'Must-Do' actions in section 2;* • *note appendix 1 which demonstrates the CQC action plan.*

- With the inclusion of Surgery & Critical Care division actions in June 2023, there are 59 improvement actions that relate to the 2022 published inspection report.
- 12 of the 59 improvement actions have been completed, with assurance evidence filed.
- Within most of the 59 improvement actions there are a series of underpinning sub-actions. As at 25 August 2023, there are 274 underpinning sub-actions currently detailed within the improvement action plan.
- **NB:** The CQC improvement action plan is a 'live' document, being reviewed and updated throughout the month. As part of this process, the number of underpinning sub-actions may be subject to change, as progress is made resulting in closure or inclusion of additional sub-actions.
- As at the 25 August 2023, the following progress is reported:

2022 Inspection Report: CQC Improvement Action Plan:										
	Jul-22		Oct-22		Jan-23		May-23		Aug-23	
Number of CQC Improvement actions:	54		54		54		54		59	
Number of CQC sub-actions:	166		181		193		225		274	
BRAG Rating Matrix:										
Blue [Completed and embedded]	26	15.66%	29	16.02%	31	16.06%	37	16.44%	59	21.53%
Green [Completed but not yet fully embedded/evidenced]	45	27.11%	74	40.88%	85	44.04%	110	48.89%	138	50.36%
Amber [In progress/on track]	62	37.35%	51	28.18%	22	11.40%	22	9.78%	34	12.41%
Red [Not yet completed/significantly behind agreed timescales]	30	18.07%	19	10.50%	34	17.62%	29	12.89%	13	4.74%

  - 197 or 72% have been completed or are in the process of being embedded;
  - 13 or 5% of sub-actions are currently rated as 'Red' or overdue.

- **Focus on 'Must-Do' Actions:**
- From the 2022 inspection report, there were 5 'must-do' actions that the Trust must take in order to comply with its legal obligations, to demonstrate compliance with Regulation 12 and 13 of the Health and Social Care Act 2008. These all fall under the remit of QGC.
- In summary, as of 25 August 2023, the following progress is reported:

2022 CQC Inspection Report: Focus on the 5 'Must-Do' Actions										
	Jul-22		Oct-22		Jan-23		May-23		Aug-23	
Number of CQC Improvement actions:	5		5		5		5		5	
Number of CQC sub-actions:	30		36		39		40		46	
BRAG Rating Matrix:										
Blue [Completed and embedded]	7	23.33%	8	22.22%	8	20.51%	8	20.00%	8	17.39%
Green [Completed but not yet fully embedded/evidenced]	13	43.33%	21	58.33%	24	61.54%	25	62.50%	32	69.57%
Amber [In progress/on track]	2	6.67%	3	8.33%	1	2.56%	2	5.00%	2	4.35%
Red [Not yet completed/significantly behind agreed timescales]	7	23.33%	1	2.78%	3	7.69%	2	5.00%	2	4.35%

  - 40 or 87% have been completed or are in the process of being embedded;
  - 2 or 4% of sub-actions are currently rated as 'Red' or overdue.

- **Key areas of focus for Trust Board: (Section 2 refers)**
- **Progress with the 5 open 'Must-do' actions:**
- Progress has been made with respect of the 5 'Must-Do' actions – refer to sections 2.1, 2.2 and 2.3.
- **Areas of particular focus: 'Should-do' actions:**
- For a summary of these areas, mapped to the new CQC Quality Standards, refer to section 2.4.

Section One:

1.0 Background & purpose:

- CQC published their findings on the 8 February 2022.
- The CQC improvement action plan has been developed with divisions and corporate owners and is updated with owners at regular intervals.
- This paper is designed to summarise for the Trust Board progress against the CQC improvement action plan.
- Included in the scope of this paper are the actions being taken in response to the 'must-do' or 'should-do' requirements from the 2022 published inspection report.

Section Two:

Summary of the key areas of focus for the Trust Board:

Sections 2.1-2.3: Progress with the 5 open 'Must-Do' Actions:

2.1 The trust must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored (2 'Must-Do' actions).

2.1.1 A comprehensive central training log is in place which records and tracks nursing and medical staff training compliance and performance. This demonstrates very high rates of training compliance and competence. An agreed training SOP and escalation policy underpins this. This includes training on the Child Protection Information System (CP-IS) as part of the induction programme for all new medical and nursing staff joining the department.

2.1.2 An audit of medical staff awareness is in place designed to test awareness and educate, with a run of 3 cycles of audit per doctor since December 2022. Escalation process clarifies the escalation route if, following 3 cycles of the audit, awareness has not improved to result in >90% compliance with audit.

2.1.3 The outcome of these controls are evaluated as part of weekly case reviews, using a 9 question audit tool. Results from these weekly audits are tracked using Statistical Process Control (SPC). The table below demonstrates improving compliance from the weekly audits that demonstrates an increasing number of audit questions are deemed to be embedded.

Question:	LCH	PBH	GDH	Question:	LCH	PBH	GDH
1	Embedded	Ongoing	Embedded	6	Not embedded	Not embedded	Embedded
2	Embedded	Ongoing	Embedded	7	Not embedded	Ongoing	Embedded
3	Ongoing	Embedded	Ongoing	8	Not embedded	Ongoing	Embedded
4	Not embedded	Ongoing	Embedded	9	Ongoing	Ongoing	Embedded
5	Not embedded	Ongoing	Embedded				

2.1.4 A second-check process has been agreed and is in the process of being rolled out where the Nurse in Charge (NIC) and Emergency Physician in Charge (EPIC) receive notifications from the CP-IS system, in addition to the current departmental controls, to enable greater oversight of necessary actions in response whilst the patient is in the department.

2.1.5 Whilst work is still underway around these 2 'Must-Do' actions, significant progress has been made.

2.2 The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented (1 'Must-Do' action).

The service must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Patients waiting on ambulances should be reviewed by medical staff within an hour and within 30 minutes where the national early warning score is five or more or requiring prioritisation (1 'Must-Do' action).

2.2.1 Immediately following the CQC inspection, the Trust revised the Pre-Hospital Practitioner (PHP) standard operating procedure (SOP) to better clarify the role and responsibilities of staff when ambulances are waiting to offload patients. However, from audit data, the processes in place were insufficient to consistently meet the principles laid out by the revised SOP, especially when operational pressures resulted in multiple ambulance queues. In response a new pathway of care was scoped.

2.2.2 The Trust launched the 'Breaking the Cycle' (BTC) Initiative during November 2022 in response to unprecedented levels of pressure within the Emergency Departments and across UEC pathways. This approach focussed on earlier senior decision making, increased focus on earlier discharges from in-patient ward areas and the consistent movement of at least one patient per hour from ED to the medical and surgical assessment unis over a 24-hour period. A key aim of this initiative was to prevent ambulances from queuing for longer than 60 minutes.

2.2.3 Despite the wider System adopting aligned processes, alongside the Trust, called 'Breaking the Cycle Two', the pressures faced by the Trust's Emergency Departments increased during December 2022 and January 2023. Industrial action and the Christmas period added to the challenges being faced. The formal trial period for BTC ended in January 2023 with the learning from the approach and revised processes now being adopted and included within the Trust's Full Capacity Protocol.

2.2.4 Whilst the BTC approach was successful in reducing ambulance handover times and a decrease in the number of patients waiting over 12 hours to be admitted to hospital during the period of the pilot, the PHP audit data still demonstrated inconsistencies in achieving face to face triage and medical assessment of patients on ambulances within the timescales agreed.

2.2.5 In early 2023 a new pathway of care centred on the 'pit stop' process was agreed and commenced. The pit stop pathway seeks to improve the consistency of initial face to face triage of the patient to ensure their condition and risk of deterioration is fully assessed by the PHP within the pit stop area of ED. When there is flow and capacity within the department, the patient is moved through into a cubicle for standard ED management and assessment by medical staff. In instances where there is no flow, patients following face to face assessment, are moved back to the ambulance until there is capacity to bring the patient in.

2.2.6 Weekly audit of the pit stop pathway has continued since the launch of the new pathway with UEC oversight and action in response.

2.2.7 Whilst the audit data provides evidence that patients with higher NEWS scores waiting on ambulances are clinically prioritised for medical review when compared to the average time to first medical assessment, it has demonstrated that patients with high NEWS are not consistently seen within 30 minutes of arrival. In response, UEC have undertaken a review of its demand and capacity and concluded that an increase to the establishment for the medical workforce within the Emergency Departments at both Lincoln and Pilgrim was needed. This has now been agreed and funded by the Trust with recruitment activity now underway, with progress tracked via trajectories, to recruit to these additional tier 1/tier 2 medical posts within the department. As the medical workforce increases, this should support achievement of the 30 minute target.

2.2.8 When under significant pressure, the ability for the PHP to see all patients waiting on ambulances hourly falters. In response, the Care Navigator, an East Midlands Ambulance

Service (EMAS) funded resource has been included within the PHP SOP to support timely assessment and oversight when patients are forced to wait on ambulances.

2.2.9 Recognising the operational flow challenges that results in difficulties in moving people out of ED which risks overcrowding within the department and increased delays for ambulances being able to off-load patients, the work around these 'must-do' actions are linked very closely to the wider Trust improvement work around operational flow. This is a Trust priority, managed as part of the IIP improvement programme.

2.3 The trust must ensure that all medicines are stored safely and securely (1 'Must-Do' action).

2.3.1 Recognising some of the estate related challenges in managing appropriate ambient (room) temperatures in locations where medicines are stored, the Trust used the maternity area as the location for a pilot project aimed at improving the consistency of temperature monitoring. The pilot resulted in the roll out of Stanley remote temperature monitoring digital probes and to trial new temperature recording documents.

2.3.2 The deployment of the Stanley remote temperature monitoring probes enabled the collection of reliable data on temperature ranges and excursions (above 25 degrees for ambient room stored medicines). This has supported the identification of 4 ward areas within the Maternity buildings at both Lincoln and Boston, where temperatures are consistently above 25 degrees.

2.3.3 In one of the 4 locations, the location where medicines are stored has been moved to a different room within the ward layout that is cooler. Temperature monitoring is in place.

2.3.4 In the remaining 3 areas, other mitigations to lower the temperature are not viable. In response to this, following a review of the evidence available and networking with NHS Trusts in Leicester and Leeds, an options appraisal has been undertaken and agreed with Pharmacy and Maternity colleagues to mitigate the risks posed of medicine and fluid efficacy, as a result of storage in hot ambient room temperatures. The mitigation is two-fold:

- (1) review of maternity ward areas stock lists and removal of stock used infrequently and a reduction of the amount of stock held and;
- (2) a halving of the manufacturers expiry date. Both steps aim to reduce the likelihood of medicines being adversely affected due to storage for long durations in sub-optimal conditions, whilst the longer term refurbishment plans are worked up.

2.3.5 To support the implementation of this change, a standardised operating procedure (SOP) has been developed to support the affected ward areas in manually reducing the manufacturer's expiry date. Given the significance of this change, the implementation of the SOP is being piloted and the impact evaluated. 2 of the 3 areas are now piloting the reducing expiry dates procedure, with the remaining area planning timescales for the pilot to commence.

2.3.6 In respect to security of medicines, a review of arrangements has been conducted for completeness during 2023 and to test the controls applied following the CQC inspection. This has identified a gap on one ward which is being addressed through the application of swipe card access.

2.4 Areas of particular focus: 'Should-do' actions:

4.2.1 There are a number of areas within the CQC action plan on which there is a particular focus.

These areas have been mapped against the **new CQC Single Assessment Framework's quality statements** alongside the CQC core service, and the overseeing ULHT sub-committee of the Board where updates are reported. The following table summarises these areas.

		ULHT areas of focus	Priority	ULHT Priority Description	CQC Core Service	ULHT Oversight
Key Question:	**SAFE**					
Quality Statement:	*Learning Culture*	0				
	Safe systems, pathways and transitions	2	MUST DO Should-Do	Safety of patients waiting on ambulances / Ambulance delays Ensure safety checks of new ward environments before moving patients	UEC Medical Care	QGC FPEC
	Safeguarding	1	MUST DO	Embedding process for checking CP-IS	UEC	QGC
	Involving people to manage risks	0				
	Safe environments	1	MUST DO Should-Do	Medicines security and temperature monitoring within maternity *CLOSED/COMPLETE* Undertake a 6-facet survey of the Trust's estate	Maternity All	QGC FPEC
	Safe and effective staffing	3	Should-Do Should-Do Should-Do	Appraisal rates: 90% target Mandatory Training: 95% target Paediatric competent and skilled staff in the Emergency Department	All All UEC	PODC PODC PODC
	Infection prevention and control	2	Should-Do Should-Do	Cubicle space cleaning to prevent the spread of infections Documented use of cleaning schedules	UEC CYP	QGC QGC
	Medicines optimisation	1				
Key Question:	**EFFECTIVE**					
Quality Statement:	*Assessing needs*	1	Should-Do	Mental Health and falls risk assessments	UEC	QGC
	Delivering evidence-based care and treatment	1	Should-Do	Review, update and approve all UEC SOPs and policies	UEC	FPEC
	How staff, teams and services work together	0				
	Supporting people to live healthier lives	0				
	Monitoring and improving outcomes	0				
	Consent to care and treatment	0				
	Learning Culture	0				
Key Question:	**CARING**					
Quality Statement:	*Kindness, compassion and dignity*	0				
	Treating people as individuals	0				
	Independence, choice and control	0				
	Responding to people's immediate needs	0				
	Workforce wellbeing and enablement	0				
Key Question:	**RESPONSIVE**					
Quality Statement:	*Person-centred care*	0				
	Care provision, integration, and continuity	0				
	Providing information	2	Should-Do Should-Do	Communication aids and leaflets available in other languages Availability of patient information within the Emergency Department	All UEC	QGC QGC
	Listening to and involving people	0				
	Equity in access	1	Should-Do	Use of interpreting services	CYP	QGC
	Equity in experiences and outcomes	0				
	Planning for the future	0				
Key Question:	**WELL-LED**					
Quality Statement:	*Shared direction and culture*	0				
	Capable, compassionate and inclusive leaders	0				
	Freedom to speak up	0				
	Workforce equality, diversity and inclusion	0				
	Governance, management and sustainability	0				
	Partnerships and communities	0				
	Learning, improvement and innovation	0				
	Environmental sustainability – sustainable development	0				

2.2.2 The largest grouping relates to the CQC quality statement: 'Safe and effective staffing', with 3 specific areas of focus encompassing appraisals, mandatory training and ongoing assurance work around controls in place to ensure safe paediatric staffing within the paediatric area of the Emergency Department.

2.2.3 In the August report:

- 1 risk is closed as complete: The outstanding 6-facet survey. This is now underway and featured within the assurance report received by FPEC to review wider controls in place for Estate and Facilities actions.

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 25/08/2023

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

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-06	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure that staff complete mandatory training in line with trust targets. Including but not limited to the highest level of life support, safeguarding and mental capacity training.	All	The Trust's established process for overseeing and targeting improvement around mandatory training and appraisal rates will be strengthened as a result of an increased focus through the Performance Review Meetings (PRM) with increased assurance reporting to the People and Organisational Development Sub-Committee of the Board. Improvement trajectories will be set via the PRM process with divisions. Target to achieve is 95% to have completed mandatory training. Key performance indicators to be included to summarise progress along with highlight reporting.	Claire Low (Deputy Director of People)	31-Mar-23	Red		(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.	(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.		Claire Low, Director of People and Organisational Development (OD)	People and Organisational Development Committee (PODC)
CQC2021-07	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.	All	The Trust has already established work streams focussed on ensuring sufficient nursing and medical staff. The Nursing work stream includes the process for twice daily oversight arrangements, annual nurse staffing reviews for all ward areas led by the Director of Nursing and reporting through to Trust Board. This is supported by the Trust's 5-year workforce plan which includes new and emerging roles. Key performance indicators to be included to summarise progress along with highlight reporting.	Helen Clark (Assistant Director of Nursing for Workforce & Education) Claire Low (Deputy Director of People) Lisa Geraghty (HR)	31-Mar-23	Amber		(1) Reporting to PODC committee on progress with workforce plans; (2) Progress with key workforce indicators.	(1) Reporting to PODC committee on progress with workforce plans; (2) Progress with key workforce indicators.		Claire Low, Director of People and Organisational Development (OD)	People and Organisational Development Committee (PODC)
CQC2021-08	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure there are mechanisms for providing all staff at every level with the development they need through the appraisal process.	All	The Trust's established process for overseeing and targeting improvement around mandatory training and appraisal rates will be strengthened as a result of an increased focus through the Performance Review Meetings (PRM) with increased assurance reporting to the People and Organisational Development Sub-Committee of the Board. Improvement trajectories will be set via the PRM process with divisions. Target to achieve is 90% to have an appraisal. Key performance indicators to be included to summarise progress along with highlight reporting.	Claire Low (Deputy Director of People)	31-Mar-23	Red		(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.	(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.		Claire Low, Director of People and Organisational Development (OD)	People and Organisational Development Committee (PODC)
CQC2021-10	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.	All	The Trust have an established improvement programme of work in place to review and manage the work required to improve medicines management. Medicines management related themes and findings from the CQC inspection have been included within this programme of work. The Medical Director chairs the Medicines management T&F group to oversee delivery of this work. Key performance indicators will be scoped and included to summarise progress along with highlight reporting.	IIP Improvement Project focussing on Medicines Management	Various	Amber		(1) Assurance reporting from IIP programme of work; (2) Assurance reporting into QGC sub-committee.	(1) Assurance reporting from IIP programme of work; (2) Assurance reporting into QGC sub-committee.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
CQC2021-11	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they are using timely data to gain assurance at board.	All	Provide a paper to FPEC considering options available in response to CQC Should-do action. Establish additional milestones in response to actions agreed at FPEC.	Shaun Caig (Associate Director of Performance & Information)	30-Apr-2022	Green	04-Jul-22	(1) Paper to FPEC summarising options; (2) Actions agreed in response.	(1) Board reporting of performance.	Paper has been tabled outlining options and taken to FPEC.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	All	Update Trust provision of information to patients policy (ULHT-NUR-PPI-PDWPI) to include process for escalation to PEG should 'information owners' not update existing information resources in line with periodic, 2 yearly review dates.	Sharon Kidd (Patient Experience Manager)	31-Mar-22	Green	08-Jun-22	Revised policy in draft.	Evidence from information resource register showing ongoing work to update information with escalation to PEG for those overdue review; Evidence that overdue information is being risk stratified and escalated	The Trust policy has been updated to reference reporting through to PEG and escalation steps where steps in the Trust policy are in danger of not being followed.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

All	Approve new policy at PEG.	Sharon Kidd (Patient Experience Manager)	10-May-22	Green	08-Jun-22	(1) Minutes of PEG demonstrating approval of policy.	None.	Revised policy has been submitted to PEG and approved.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Refine quarterly PEG update report regarding patient information to include escalation of specific areas/owners of overdue patient information.	Sharon Kidd (Patient Experience Manager)	30-Apr-22	[Abandon & Replace]	31-Jan-23	Revised PEG update; Minutes from PEG when update received.	Evidence from information resource register showing ongoing work to update information with escalation to PEG for those overdue review; Evidence that overdue information is being risk stratified and escalated accordingly to PEG;	The revised approach for patient information has resulted in the need for a new approach to approving patient information resources, once in place, key performance indicators will be agreed for reporting through to PEG. This is captured in a new action.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	Divisional CQC action plan owners (with support from FAB champions).	Set with divisions.	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further strategic actions taken.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Divisions to assign 'information owners' to provide information resources in response to feedback from local patients.	Who: Divisional CQC action plan owners to nominate lead 'information owners'.	To confirm on completion of divisional scoping.	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Divisions to undertake a walk-around/audit of current patient information resource available and being provided to patients within the division and compile a register, to include what languages the information is available in.	Divisional CQC action plan owners to nominate action leads.	Set with divisions.	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Patient Experience team to update the Trust central register with findings from the walk-around/audit and compare and contrast with Trust standards for patient information and determine if further action is required to update the information being provided (i.e. update/refresh the information - Divisional lead required; or update the format - Patient Experience team).	Scope out action needed on completion of audit and scope of work better understood.	Set on completion of audit and scope of work better understood.	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further strategic actions taken.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Refresh Patient Experience strategy and determine KPIs relating to the provision of patient information.	Jennie Negus	30-Apr-22	[Abandon & Replace]	31-Jan-23	Refreshed patient experience strategy with KPIs to support delivery.	Update reporting on progress with strategy to PEG and measurement against agreed KPIs.	Whilst the strategy has been refined, the revised KPIs for reporting through to PEG are affected by the new approach to approving patient information and is captured in a new	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Patient Experience team to work with Maxine Skinner and Denise to ensure communication aids and resource folders are available in the department and agree further actions to ensure these resources are communicated with the wider team and made use of.	Sharon Kidd (Patient Experience Manager)	31-Mar-22	Green	31-Jan-23	(1) Copies of resource available.	None.	New communication tools and resources delivered to all ward areas including the Emergency Department.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Patient Experience team to determine with UEC leads how communication with patients/carers whose first language is not English is currently facilitated and determine what resources would support this to be more effective.	UEC leads with support from Patient Experience Team.	30-Apr-22	Green	31-Jan-23	(1) Evidence of communication.	None.	Equality & Diversity team have raised awareness across the Trust.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Patient Experience team to liaise with specialist teams (i.e. Learning Disability CNS) and review patient/service user feedback to determine if further information in easy read is required, and scope additional milestones/timescales accordingly.	Sharon Kidd (Patient Experience Manager)	30-Mar-22	Green	31-Jan-23	(1) Evidence of communication tools.	None.	Significant work undertaken working with LD CNS and patients & carers including video communication guides & stories.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Scope out plan for translation of internal information resources into different languages.	Jennie Negus (Head of Patient Experience); Sharon Kidd (Patient Experience Manager)	30-Apr-22	Green	30-Apr-22	(1) Plan for translation of patient information resources.	None.	There is a plan to enable current information resources to be made more accessible on a public facing internet site to enable service users to access these resources, using their own devices to translate or make more accessible.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Upload all known patient information resources (approximately 300) to the Trust's public facing website.	Sharon Kidd (Patient Experience Manager)	30-Sep-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Develop communication plan to ensure that clinical areas know where to access information resources and are able to signpost service users to. Include within this messages relating to the use of QR codes to enable easier access.	Sharon Kidd (Patient Experience Manager)	31-Oct-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

All	Review outcomes from the walk-around audit completed in Family Health and agree next steps to support timely information provision.	Sharon Kidd (Patient Experience Manager)	31-Oct-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Following Executive-Led meeting on the 14 October, Patient Information Task & Finish group to formalise improvement plan and quantify projected timescales.	Patient Information Task and Finish Group	30-Nov-22	Green	31-Jan-23	(1) Plan and timescales for patient information improvement actions.	None.	Revised action plan has been agreed following the Patient Information Task and Finish group reviewing and agreeing milestones.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	From current Trust database (n=590), triage and shortlist local information that is likely not needed: * Duplicated by EIDO /national information * Is generic information which should be in a different format (i.e. website) (i.e. contact details, locations) * Is patient specific which should be in a different format (i.e. letter/instruction from the clinical team) Is medicine specific – product information available from manufacturers	Lorraine Parkin (Patient Experience Administrator)	31-Jan-23	Green	31-Jan-23	(1) Evidence of review being undertaken.	None.	Full list of existing information resources triaged. This will inform the meeting of the Information for Patients approval group.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Begin to ratify triage process outcomes from a review of the information via the Information for Patients Approval Group and publish to Information repository.	Information for Patients Approvals Group	28-Feb-23	Green	28-Feb-23	(1) Agreed list of information resources to go through Patient Information Approvals group. (2) Outcome of Patient Information Approvals Group.	None.	Triage process review has begun with a trajectory to clear all information resources from the old database within 6-months.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Develop process charts on which to base the Policy on, from current Trust database and triage findings: * Those information resources duplicated by EIDO / National Information - Notification to local author with signposting to where new resources are to support provision to patients going forwards * Generic information that should be available in a different format - Notification to local author and publishing in different format * Information is valid - but update is needed (information out of date/control) - Notification to author and timescale set for updated information to be made available	Information for Patients Approvals Group	28-Feb-23	Green	28-Feb-23	(1) Agreed process charts outlining the process - potentially there should be 3 process charts.	None.	Process charts developed and approved by group. These have formed the basis of communications to the wider Trust outlining new process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Information approval group set-up and agree TOR.	Jeremy Daws (Head of Compliance)	31-Dec-22	Green	31-Jan-23	(1) Agreed terms of reference.	(1) Evidence from meetings held.	Terms of reference have been agreed for the patient information approvals group.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Develop an information for patients repository via SharePoint to serve as local register and searchable guide for other Trust staff for hosting on the Trust's hub with 'approved' content.	Anna Richards (Head of Communications)	31-Dec-22	Green	31-Jan-23	(1) Evidence of new repository.	(1) Ongoing reporting from repository.	The new repository has been developed and will be populated with the outputs from the information for patients approvals group meetings.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Begin populating new patient information repository with approved patient information.	Anna Richards (Head of Communications)	28-Feb-23	Green	30-Apr-23	(1) Evidence of populated repository. (2) Evidence of comms plan to ensure staff are aware.	(1) Ongoing reporting from repository.	The new repository has had the first approved and finalised documents (n=10) uploaded and made available for staff. A comms plan is being prepared to support when more information is available to signpost to.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Of the 102 information resources agreed, only 10 have been processed through to completion, with the remaining requiring actions post-approval from owners. Review escalation processes following PIAG to include PEG to escalate any instances where owners are delaying and consider PEG upward reporting on a monthly basis of owners who have delayed in taking actions post approval of information at PIAG.	Jennie Negus (Head of Patient Experience)	30-Jun-23	Green	30-Jun-23	(1) Agreed approach to escalation following PIAG.	None.	Escalation process has been drawn up to support issues relating to divisional owners not progressing patient information / delays in process. This will support PIAG make best use of finite resources.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	3. EIDO contract running out in 6-weeks' time. Urgent action for Anna/Jennie to meet with Damian Carter in Surgery to understand surgery divisions plans to do with EIDO contract. If any doubt of this to be continued, Anna/Jennie to escalated via TLT.	Jennie Negus (Head of Patient Experience); Anna Richards (Head of Communications)	31-May-23	Green	31-May-23	(1) Evidence from discussions with Surgery division.	None.	Meetings held and position understood around EIDO.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	**Objective 1: To close Improvement Project and move to BAU: Access to information by patients using QR Code:** Scope actions needed to ensure patient information repository is accessible to patients and service users.	Anna Richards (Head of Communications)	31-Mar-23	Green	30-Apr-23	(1) Evidence of comms plan to ensure patients and service users can access information for patients repository.	None.	The new repository has had the first approved and finalised documents (n=10) uploaded and made available for staff. A comms plan is being prepared to support when more	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	**Objective 1: To close Improvement Project and move to BAU: Access to information by patients using QR Code:** Develop QR code poster template, to include version number/date and a note about this being a work in progress.	Anna Richards (Head of Communications)	31-Jul-23	Blue	31-Jul-23	(1) Copy of QR Code Poster	None.	QR Code poster has been developed and is being printed professionally by the Communications team to enable this to be displayed in public areas of the Trust for patients to access.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

							All	**Objective 1: To close Improvement Project and move to BAU: Access to information by patients using QR Code:** Approve at PIAG the addition of the QR code poster to the PIAG approvals process/administeration function. Once approved, embed within the approvals process following PIAG.	Jennie Negus (Head of Patient Experience)	31-Jul-23	Blue	31-Jul-23	(1) Copy of QR Code Poster	None.	QR Code poster has been developed and is being printed professionally by the Communications team to enable this to be displayed in public areas of the Trust for patients to access.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	**Objective 1: To close Improvement Project and move to BAU: Access to information by patients using QR Code:** Agree a trigger point for when we move from targetted release of QR code posters to individual authors post PIAG to wide spread, Trust wide communication (i.e. link to feedback loop or when 60% of the backlog information resources have been published to repository post PIAG).	Patient Information Task and Finish Group	30-Sep-23	Amber		(1) Agreed approach to wider spread use of QR code communication materials to ensure patients have access to the repository.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	Identify national sources of evidence based information that we would be happy to use. Write to PEG distribution group. Share with team and approve content of message.	Jeremy Daws (Head of Compliance)	31-Dec-22	Green	31-Dec-22	(1) Email to PEG	None.	Communication to the Patient Experience Group seeking out additional sources of information to be considered as 'Trusted sources' has been issued.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	Review Trust website and identify Trusted Sources already on the site and in use and collate these for inclusion within the Patient Information repository.	Anna Richards (Head of Communications)	31-Aug-23	Amber					Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	**Objective 2: To close Improvement Project and move to BAU: Translation Approach:** Draft interim approach to translation and making information more accessible for patient consumption.	Jeremy Daws (Head of Compliance)	28-Feb-23	Blue	28-Feb-23	(1) Written up interim statement/approach to be taken (included within update presentation to Exec Led CQC Assurance Meeting on 28 July	None.	Narrative agreed by the group, to propose approach to the ED&I group on the 8 March 2023 for a steer. Further refined and presented plan to Exec Led CQC Assurance meeting on 28	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	Draft a revised/updated policy outlining the process for creating/sourcing patient information for publishing on the new repository	Sharon Kidd (Patient Experience Manager)	30-Apr-23	Green	30-Jun-23	(1) Draft Policy based on revised process maps.	None.	Patient information policy revised to include refreshed process via PIAG now drafted and approved which accurately captures the revised processes.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	Review Information for Patients Policy 6-months following approval at PEG (in July 2023) to determine if further refinements are needed to reflect the PIAG approvals process as this has developed.	Sharon Kidd (Patient Experience Manager)	30-Apr-24	Amber		(1) Revised policy based on updated PIAG process (if needed)	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	**Objective 2: To close Improvement Project and move to BAU: Translation Approach:** Agree strategy and approach to translation of information into 'ULHT core' languages, including how these are accessible (i.e. QR code links / or printed materials)	Information for Patients Task and Finish Group	31-Mar-23	Green	31-Jul-23	(1) Email to E&D for advice. (2) Outcome of E&D meeting in March 2023. (3) Draft strategy approach for translation.	None.	The presentation to the Executive-Led CQC Assurance meeting in July 2023 demonstrated the draft strategy for translation. This is in the process of being scoped for application, as measured by subsequent milestone.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	**Objective 2: To close Improvement Project and move to BAU: Translation Approach:** Draft translation and accessible access to information strategy for patient information.	Patient Information Task and Finish Group	31-Dec-23	Amber		(1) Written up Trust approach to language translation.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	Undertake Easy Read training course to enable in house development of easy read documentation.	Sharon Kidd (Patient Experience Manager)	31-May-23	Green	30-Jun-23	(1) Evidence of Easy Read communication products.	None.	Easy-Read patient information has been produced in-house before, course supports improve the quality of this information.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	Liaise with specialist teams i.e. LD to plan how information can be more accessible and available.	Information for Patients Task and Finish Group	31-Jul-23	Green	31-Jul-23	(1) Evidence of Easy Read communication products.	None.	Easy-Read patient information has been produced in-house following requests from Safeguarding team (to support patients with LD and Dementia).	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	**Objective 1: To close Improvement Project and move to BAU: Access to information by patients using QR Code:** Identify gaps in information not being available	Jennie Negus (Head of Patient Experience)	31-Oct-23	Amber		(1) Scoped out options for linking patient feedback mechanism to current QR code linked repository.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	Scope out process for escalation of information materials not fit for purpose (i.e. out of date, evidence being photocopied without review controls in place)	Information for Patients Task and Finish Group	31-Mar-24	Amber		(1) Scoped out plan for approaching a review of non-controlled documents.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	**Objective 3: To close Improvement Project and move to BAU: ED Information:** What information is needed in ED?	Jennie Negus (Head of Patient Experience)	28-Feb-23	Blue	28-Feb-23	(1) Evidence of plan with Medicine Division.	None.	Communication between the Patient Experience team and Medicine have been had and a task and finish group within UEC has been agreed as next steps. Milestone added to UEC Improvement Action Plan	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							All	**Objective 3: To close Improvement Project and move to BAU: ED Information:** Agree a slot at PIAG for ED developed information to be reviewed and approved for addition to the repository.	Jennie Negus (Head of Patient Experience)	31-Aug-23	Amber		(1) PIAG review of ED developed information.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

All	**Objective 3: To close Improvement Project and move to BAU: ED Information:** Award contract to external provider to make available ED advice cards.	Sharon Kidd (Patient Experience Manager)	30-Sep-23	Amber		(1) Evidence of agreement with external information provider to support information provision to EDs.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 25/08/2023

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

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating BRAG	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes
CQC2021-01	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	UEC	The flowchart describing the correct process has been reinforced within ED. This will be supported by the Safeguarding team who have commenced education work with key staff as part of team huddles and supervision sessions. This education work will be completed by 30 November 2021. A record of staff trained will be maintained for assurance.	Elaine Todd (Named Nurse for Safeguarding Children and Young People); Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie Peet and Sharon Laverton / Vikki Hoadley (ED Clinical Educators)	31-Mar-2022	Green	20-Jun-2022	(1) Training records for ED staff; (2) Evidence of this being added to UEC risk register.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.	Confirmation received from ED that all relevant staff have now completed CPIS training.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-04	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Must Do	The service must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	UEC	A compliance audit was already planned by the Safeguarding team, this will be undertaken as planned on this process retrospectively and will be completed by 5 November 2021. A re-audit will be undertaken following delivery of educational sessions. This will be completed by 31 January 2022.	Elaine Todd (Named Nurse for Safeguarding Children and Young People)	31-Jan-2022	Blue	31-Jan-22	(1) Audit findings / report; (2) Action plan in response.	(1) Monthly audit to be undertaken to test compliance.	A monthly schedule of audits has been agreed by which the Safeguarding team will support the ED team by undertaking these assurance audits.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	A list of those who cannot access care-portal within ED is needed and then access needs to be requested from IT.	Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie and Sharon (ED Clinical Educators)	31-Mar-2022	Green	09-Jun-2022	(1) Evidence of access arrangements to Care Portal being in place for existing staff.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.	Staff automatically have access to Care Portal via their permissions provided to them once given systems access on commencing their role within the department.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Include within ED nursing competencies Safeguarding and access to the National Child Protection Register spine to ensure this training/education is provided on a routine and regular basis.	Maxine Skinner (Lead Nurse Urgent & Emergency Care) Ellie and Sharon (ED Clinical Educators)	31-Mar-2022	Green	09-Jun-2022	(1) Inclusion of Safeguarding training as part of induction programme for new starters; (2) Inclusion of access to the Care Portal system as part of the induction programme for new starters.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.	Assurance provided by the department that CP-IS training has been included within the departments local induction process to ensure new nursing/medical staff receive this training on commencement of their employment in the Department.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Implement monthly audit process to monitor compliance and to provide assurance that process is fully embedded.	Tracey Wall (Divisional Nurse); Craig Ferris (Head of Safeguarding)	31-Mar-2022	Green	31-Mar-2022	(1) Monthly audit data; (2) Action plan in response; (3) Findings from audit demonstrate compliance.	(1) Monthly audit data demonstrating compliance; (2) Reporting to appropriate UEC governance arrangements; (3) Upward report to CYP Oversight Group.	Monthly audit results are now being provided for assurance purposes to demonstrate performance with checking the Nationally Approved Child Protection Register.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Monthly audit results do not show improvement. Review performance and agree plan of improvement actions.	Denise Dodd, (UEC Matron)	31-May-2022	Blue	20-Jun-2022	(1) Agreed action plan for improvement on monthly audit findings.	None.	Standardised process agreed following pilot project supported by audit evaluation.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Undertake compliance audit of June 2022 following standardising CP-IS process across the Trust and determine action needed as appropriate from the audit findings.	Denise Dodd, (UEC Matron)	31-Jul-2022	Green	31-Aug-2022	(1) Agreed action plan for improvement on monthly audit findings.	None.	Audit findings reviewed and action plan agreed. Results demonstrated improvements annd identified areas where continued education and embedding are required.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Undertake ongoing assurance audits to track progress and agree rolling programme of actions in response to audit data.	UEC Sisters; Safeguarding team	31-Dec-2022	Green	31-Dec-2022	(1) Assurance audit data; (2) Actions in response to audit data.	None.	Audit findings reviewed and action plan agreed. CP-IS Task and Finish Group established who are taking receipt of the audit findings and overseeing actions in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Assurance data does not demonstrate process is embedded on Lincoln site	UEC Leads.	31-Oct-2022	Red		(1) Evidence of improvements being made from the assurance audit data.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Assurance data demonstrates process is on course for being embedded at Boston and Grantham by the end of Q1 (June 2023).	UEC Leads.	30-Jun-2023	Green	31-Jul-2023	(1) Evidence of improvements being made from the assurance audit data.	None.	Audit data collated within SPC charts demonstrate the majority of questions for Boston and Grantham have been embedded.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Embed CP-IS process across all 3 sites as demonstrated by CAS card audit evidence demonstrating compliance when CP-IS is indicated.	UEC Leads.	30-Jun-2023	Green	31-Jul-2023	(1) Evidence of CP-IS process being embedded across all 3 sites.	(1) Evidence of CP-IS process being embedded across all 3 sites.	Audit data collated within SPC charts demonstrate the majority of questions for Boston and Grantham have been embedded. Ongoing work at Lincoln is captured in a separate mileston.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-02	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.	UEC	Assurance data that patients waiting in ambulances are seen by a doctor.	Cheryl Thomson (General Manager)	01-Nov-2021	Green	01-Nov-2021	(1) 30-Sept-21 Information report which shows first location and time seen; (2) Ambulance handover SOP: Section 2.5; (3) S.31 CQC full assurance report; tab 1	(1) Information reports from ED system detailing time seen and location first seen; (2) CQC full assurance documentation – tab 1 focus on triage;	The evidence supplied provides assurance that patients waiting in ambulances, due to capacity bottlenecks with the Emergency Department, are seen and assessed by a	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-05	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Must Do	The service must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Patients waiting on ambulances should be reviewed by medical staff within an hour and within 30 minutes where the national early warning score is five or more or requiring prioritisation. Regulation 12 Safe care and treatment.	UEC	Inclusion of additional field into the Harm template to ensure this is more clearly evidenced from harm reviews.	Cheryl Thomson (General Manager)	01-Nov-2021	Blue	01-Nov-2021	(1) Email request for the UEC harm reviews to include a specific field to capture the time patients receive their first assessment; (2) Copy of amended harm template.	(1) Random, snapshot sample of UEC Clinical Harm reviews	This additional field makes it easier, at the time of undertaking a harm review, for harm to be accurately assessed related to waiting times/locations.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	PHP log not felt to be best solution, amendments to CAS card instead have been made that include location of the patient when handed over.	Blanche Lentz (Clinical Services Manager UEC)	31-Aug-2022	Green	19-Sep-2022	(1) Amended casualty card.	(1) Audit evidence of the new CAS card being used in practice and recording where patient has been seen – including ambulance.	The Casualty Card has been updated to include space to record when a patient is assessed on the ambulance. This has now been approved by UEC and	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Aug-22. This will remain as
						UEC	Develop clinically led standardised admission pathways guidance to support ED teams identify: • The primary specialty to take ownership for the ongoing care from the ED • If necessary, and additional MDT input required, this will be undertaken by the primary speciality. These have been agreed by the group, this was ratified during May and June 2021.	Urgent Emergency Care Clinical Standards Group		Blue	01-Oct-2021	(1) Copy of the standardised admission pathway guidance; (2) Minutes from the Urgent Emergency Care Clinical Standards Group evidencing approval of guidance.	(1) Copy of the standardised admission pathway guidance.	Clinically agreed guidance exists to support the Emergency Department consult and seek assistance from specialties for patients waiting in the department. The guidance includes a commitment for specialties to pull patients out of the Emergency Department.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Review and update the 'Management of Reducing Ambulance Delays in the Emergency Departments' SOP. Ensure this includes links to wider corporate policies and SOPs (i.e. Full Capacity Protocol and the Ambulance Turnaround Protocol) and includes all relevant roles (i.e. Pre-Hospital Practitioners (PHP) and Hospital Liaison Officers (HALO)) and makes it clear that patients are being seen regardless of location (i.e. on ambulances during extreme pressures).	Cheryl Thomson (General Manager)	31-Mar-2022	[Abandon & Replace]	05-May-2022	(1) Revised SOP completed and approved.	(1) Evidence that SOP has been added to the Trust's controlled documents procedures and is available for staff to access easily to guide them; (2) Evidence that SOP has a timely review date to ensure guidance remains updated and fit for purpose.	The Pre-Hospital Practitioner SOP has been re-written and agreed at UEC CBU Governance. This SOP outlines actions for patients waiting on ambulances and outlines when these should be reviewed by medical staff and criteria for prioritisation. This has now been added to the Trust's document control system as a corporate document with a review date of 6-months.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Add the Reducing Ambulance Handover Delays SOP into the Clinical Operational Flow Policy.	Michelle Harris (Chief Operating Officer)	30-Jun-2022	[Abandon & Replace]		(1) Revised SOP included within the Clinical Operational Flow Policy.	None.		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 30-Jun-22. This will remain as
						UEC	Review and Update the PHP SOP following initial implementation.	Cheryl Thomson (General Manager)	31-Aug-2022	Blue	31-Aug-2022	(1) Revised PHP SOP completed and approved.	(1) Evidence that SOP has been added to the Trust's controlled documents procedures and is available for staff to access easily to guide them;	The Pre-Hospital Practitioner SOP has been re-written and agreed at UEC CBU Governance. This SOP outlines actions for patients waiting on ambulances and	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Draft new document to subsume the 'Full Capacity Protocol', 'Clinical Operational Flow Policy' and the 'Reducing Ambulance Handover Delays SOP'.	Michelle Harris (Chief Operating Officer)	30-Sep-2023	Amber		(1) Revised policy document.	N/A		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Revised SOP to include effectiveness measures to track progress with key metrics: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking to provide ongoing assurance against SOP.	Cheryl Thomson (General Manager)	31-Mar-2022	Green	05-Apr-2022	(1) Evidence of effectiveness measures for ongoing monitoring of performance against key metrics.	(1) Evidence that performance with key metrics, as part of revised SOP, are being used for ongoing monitoring of performance against key metrics; (2) Evidence of audit data being used for improvement purposes.	Revised SOP approved which contains key effectiveness measures.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	In the interim, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) ≤ 15 minutes; (b) Doctor assessment ≤ 1 hour; (c) Doctor assessment ≤ 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Jul-2022	Green	04-Aug-2022	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit; (2) Evidence of audit data being used for improvement purposes.	The audit questions have now been amended and added to the Nurse in Charge booklet. This was added from the beginning of July 2022 and the data now needs collating for performance/assurance purposes.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Scope out the inclusion of performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking as part of the Trust's Clinical Audit Programme to provide further external assurance.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	30-Apr-2022	Green	06-May-2022	(1) Development of Clinical Audit Project plan.	None.	Project plan drafted for the audit of compliance with the revised SOP and key measures.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	

						UEC	Undertake first Quarterly audit project of compliance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV.	TBC (Lead Nurse Urgent & Emergency Care)	30-Jun-2022	Green	19-Sep-2022	(1) Audit findings from first audit.	(1) Evidence of ongoing audit for assurance purposes.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting replacing the need for a quarterly clinical audit. Snapshot audit data has now been made available following an audit	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Develop an audit tool to obtain this assurance with key milestones. Feed into monthly CBU governance reporting process (escalations to divisions and PRM).	Jeremy Daws (Head of Compliance)	31-Jul-2022	Green	09-Jun-2022	(1) Completed audit tool; (2) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	The audit tool has been developed and approved at ED Governance. This has been used as part of the NIC booklet during the month of June and first data from the audit will be availble during the w/c 13 June 2022.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Add into Harm Review proforma - Has patient been seen within 1 hour. Review in 3 months to see if this is giving assurance needed.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-Mar-2022	[Abandon & Replace]	20-Jun-2022	(1) Email request for the UEC harm reviews to include a specific field to capture this; (2) Copy of amended harm template.	(1) Random, snapshot sample of UEC Clinical Harm reviews	UEC proposal to CHOG regarding a change in process in undertaking the Clinical Harm Review Process results in this sub-action relating to inclusion of ambulance wait question within the	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Provide a monthly overview of performance against these key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking. In addition to other related metrics (i.e. time to first assessment etc.) to Governance meeting process.	Denise Dodd (UEC Matron)	31-Jul-2022	Green	19-Sep-2022	(1) Ongoing monthly assurance reporting.	(1) Ongoing monthly assurance reporting.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting. Snapshot audit data has now been made available following an audit undertaken.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Build monthly assurance reporting of key milestones into one of the standard ED assurance processes so this becomes a standard feature of the ED assurance process.	Denise Dodd (UEC Matron)	31-May-2022	Green	19-Sep-2022	(1) Ongoing monthly assurance reporting.	(1) Ongoing monthly assurance reporting.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting. Date for go live with the new tool is to be	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	In the absence of assurance data relating to compliance with the PHP SOP, develop an audit plan for Corporate Operational Management Team to undertake.	Jeremy Daws (Head of Compliance)	31-Aug-2022	Green	31-Aug-2022	(1) Copy of the audit project plan. (2) Copy of the audit tool.	N/A	Audit documentation agreed and in place to support the observational audit to be undertaken in LCH and PBH Emergency Departments.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	In the absence of assurance data, undertake the observational audit during September and report compliace data for assurance purposes.	James Hodgkins (Operational Lead Nurse)	30-Sep-2022	Green	19-Sep-2022	(1) Findings from the audit.	N/A	Assurance audit undertaken which has now been completed providing compliance data with the PHP SOP key measures.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Review assurance audit data and agree next steps.	Cheryl Thompson (General Manager)	31-Oct-2022	Green	18-Oct-2022	(1) Findings from the audit.	N/A	Assurance audit undertaken which has now been completed providing compliance data with the PHP SOP key	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Pause actions in response to the PHP audit and evaluate the impact of the 'Breaking the Cycle' initiative that is designed to reduce ambulance handovers and therefore the number/time patients spend on ambulances.	CBU Leads	31-Dec-2022	Green	31-Dec-2022	(1) Findings from the Breaking the Cycle initiative.	N/A	Audit data collected from PHP audit process has not demonstrated the scale of improvements needed to avoid ambulance queues outside of the department.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Take to UEC Clinical Cabinet meeting in December for approval the plans to revise and pilot a different RAT process in case the 'Breaking the Cycle' initiative does not improve the compliance with the PHP SOP.	Blanche Lentz (Clinical Services Manager)	31-Dec-2022	Green	31-Jan-2023	(1) Evidence of discussion at UEC Clinical Cabinet meeting.	N/A	Internal approvals confirmed for a pilot of the revised PHP process designed to bring patients waiting on ambulances into the department for initial face to face assessment and triage, before, if necessary, taking the patient back to	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Evaluate the pilot of the revised PHP Process using PHP audit data. Review for 3 month period. Key metrics to be measured are: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	UEC Leads.	30-May-2023	Red		(1) Evaluation of pilot from ongoing PHP audit data.	(1) Evaluation of pilot from ongoing PHP audit data.		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-35	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure deteriorating patients are identified and escalated in line with trust policy.	UEC	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Denise Dodd (UEC Matron)	31-Jul-2022	Green	19-Sep-2022	(1) Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; (2) Performance against deteriorating patient audits (sepsis); (3) ED Daily Assurance Tool.	(1) Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; (2) Performance against deteriorating patient audits (sepsis); (3) Ongoing monthly assurance reporting as part of S.31 response process; (4) Completed harm reviews.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting. Snapshot audit data has now been made available following an audit undertaken.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Review assurance audit data and agree next steps.	Cheryl Thompson (General Manager)	31-Oct-2022	Green	18-Oct-2022	(1) Findings from the audit.	N/A	Assurance audit undertaken which has now been completed providing compliance data with the PHP SOP key measures. Action plan agreed.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-33	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.	UEC	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Denise Dodd (UEC Matron)	31-Jul-2022	Green	19-Sep-2022	(1) Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; (2) Performance against deteriorating patient audits (sepsis); (3) ED Daily Assurance Tool.	(1) Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; (2) Performance against deteriorating patient audits (sepsis); (3) Ongoing monthly assurance reporting as part of S.31 response process; (4) Completed harm reviews.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting. Snapshot audit data has now been made available following an audit undertaken.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Review assurance audit data and agree next steps.	Cheryl Thompson (General Manager)	31-Oct-2022	Green	18-Oct-2022	(1) Findings from the audit.	N/A	Assurance audit undertaken which has now been completed providing compliance data with the PHP SOP key measures. Action plan agreed.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Assurance data does not demonstrate process is embedded	UEC Leads.	31-Oct-2022	Green	31-Jul-2023	(1) Evidence of improvements being made from the assurance audit data.	N/A	Assurance data received from PHP audit logs demonstrating face to face triage at both sites.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	

CQC2021-16	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure, the paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).	UEC	Provide written clarification with evidence to CQC on the following points: • The Paediatric area within the ED, whilst moved to a distinct part of the department, is retained within the UEC management and governance structure. • There is a 24/7 nominated lead doctor, detailed within the rota. • Close links with the CYP team with cross divisional learning and close working between CYP and UEC matrons.	Denise Dodd, (UEC Matron) Rebecca Thurlow (CYP Matron)	01-Dec-2021	Blue	15-Nov-2021	(1) 24/7 Paediatric named lead clinician rota; (2) Nursing rota demonstrating nurses on duty 24/7 with paediatric competencies.	(1) 24/7 Paediatric named lead clinician rota; (2) Nursing rota demonstrating nurses on duty 24/7 with paediatric competencies.	A written narrative has been provided to CQC that outlines the functionality of the Emergency Department and how it operates, how systems and controls have been established to care for children within the department. The Trust were concerned that CQC inspectors thought that the Trust had a dedicated Paediatric Emergency Department, when it does not.	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
CQC2021-36	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure the, paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).	UEC	Review and confirm RCPCH standards for ED departments in ULHT and staffing requirements from the guidance.	UEC CBU Leads	30-Jun-2022	Green	19-Sep-22	(1) Completed assessment of the impact on ULHT through a review and gap analysis; (2) Highlight reporting to the Children's and Young People Board.	(1) Highlight reporting to the Children's and Young People Board (and inclusion on the UEC risk register if required).	Initial review concluded. Agreed at the Executive-Led CQC Assurance meeting for a full gap analysis to be undertaken and fed back to the CYP Board along with plans for mitigation.	Michelle Harris, Chief Operating Officer	People & Organisational Development Committee (PODC)	
						UEC	Complete workforce review for nursing and medical staff on the back of the gap analysis and draft a business case for additional recruitment to close the gaps (if any).	Cheryl Thomson (General Manager)	30-Jun-2022	[Abandon & Replace]	19-Sep-22	(1) Completed assessment of the impact on ULHT through a review and gap analysis; (2) Highlight reporting to the Children's and Young People Board.	(1) Evidence of a plan to close gaps identified; (2) Clarity on mitigations in place if gaps identified; (3) Highlight reporting to Children's		Michelle Harris, Chief Operating Officer	People & Organisational Development Committee (PODC)	
						UEC	Complete gap analysis against the RCPCH standards and the CQC guidance document.	Fiona Hamer (Divisional Nurse)	31-Dec-2022	Green	31-Jul-23	(1) Draft gap analysis against the RCPCH guidancce.	None.	Draft RCPCH Gap analysis drafted.	Michelle Harris, Chief Operating Officer	People & Organisational Development Committee (PODC)	
						UEC	Present gap analysis against the RCPCH standards and the CQC guidance document to CYP Board with plans for mitigations.	Fiona Hamer (Divisional Nurse)	30-Sep-2023	Amber		(1) Presented gap analysis to CYP Board and action plan in response.	None.		Michelle Harris, Chief Operating Officer	People & Organisational Development Committee (PODC)	
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Matrons audits in place currently that monitor this, but this is a recurrent problem. Senior Sisters and Lead Nurse to meet to refine the contents of the B7 daily assurance process which will support proactive action to address performance issues.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Blue	09-Jun-22	(1) Meeting to approve content of the revised NIC assurance process.	None	Paper reviewed and approved at ED Governance for inclusion of this and other topics of relevance to the 2021 inspection visit to be included in the NIC Assurance Process.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Agreed at ED Governance for this to be added to the NIC Assurance Tool. Task and Finish group established and working with Informatics team to develop draft NIC Assurance Tool for approval and commencement within the department to obtain improved assurance of daily oversight.	Denise Dodd (Matron, Urgent & Emergency Care)	31-Jan-2023	Green	31-May-23	(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in the security of records observed.	This is an additional question which has been added to the NIC assurance tool to close the gap in assurance previously identified. Work will not continue to seek assurance of completion of this action from the newly added NIC assurance tool question.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Review availability of CAS card trolleys availability at Pilgrim.	Holly Carter (Senior Sister, ED)	30-Apr-2022	Green	30-Apr-22	(1) Evidence of a review of note storage controls and identification of any gaps.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in the security of records observed.	Additional medical records storage trolley obtained for use in Fit to Sit area to support the change in process at PBH of greater assessment of patients within the area.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Review evidence from newly added question to the ED Nursing Assurance Tool: **"Are all ED notes stored appropriately to protect the details / confidential information of each patient?"** to test if evidence from the NIC tool demonstrates this is now embedded.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Aug-2023	Amber		(1) Evidence of compliance from newly added NIC Assurance Tool question.	(1) Ongoing monitoring of compliance from NIC Assurance data.		Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	UEC	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards). Include patient information as part of the UEC Governance agenda.	Cheryl Thomson (General Manager)	31-Mar-22	Green	31-Mar-22	(1) Inclusion of patient information within the UEC Governance meeting process/schedule.	(1) Inclusion of patient information within the UEC Governance meeting process/schedule.	Review of patient information to be included with Patient Experience team programme of work.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Undertake a review of the patient information and identify any gaps where additional information is required.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	30-Jun-22	Green	31-Mar-22	(1) Evidence of undertaking review of information resources currently available; (2) Review at Governance of review and any gaps identified where further resources are required.	None.	Review of patient information to be included with Patient Experience team programme of work.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Collate a register of information resources in use within UEC and submit this to the Patient Experience Team to support the strengthening of internal document control processes in relation to patient information.	Cheryl Thomson (General Manager)	30-Jun-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Patient Experience team to work with Maxine Skinner and Denise to ensure communication aids and resource folders are available in the department and agree further actions to ensure these resources are communicated with the wider team and made use of.	Sharon Kidd	31-Mar-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Patient Experience team to determine with UEC leads how communication with patients/carers whose first language is not English is currently facilitated and determine what resources would support this to be more effective.	UEC leads with support from Patient Experience Team.	30-Apr-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Small working group to be established to look at options for patient information to be available bespoke for ED. Consider options available from BOE. Denise / Amy / Pip to lead.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Mar-23	Green	31-Jul-23	(1) Agreed approach with respect of external provider of information.	None.	An approach has been agreed and UEC with support of the Patient Experience Team are reviewing procurement actions to procure external provider of ED advice card information.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Clinically review and approve ED information leaflets and make available for sign off at ED Governance / ED Cabinet meeting, to make available for PIAG meeting on 31 August 2023.	Dr David Flynn (Clinical Lead - A&E)	31-Aug-23	Amber		(1) Agreed ED information submitted for PIAG review and approval.	(1) Availability of ED information within the Patient Information Repository.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Award contract to external provider to make available ED advice cards.	Sharon Kidd (Patient Experience Manager) Blanche Lentz (Clinical Service Manager)	30-Sep-23	Amber		(1) Evidence of agreement with external information provider to support information provision to EDs.	(1) Availability of ED information within the Patient Information Repository.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. (UEC Specific)	UEC	As part of the LCH work to expand resus area, make other improvements in environment; specifically: (1) Secure paediatric area through installation of swipe card access points. This will prevent unauthorised access (i.e. from fit to sit waiting area that is in close proximity; (2) Improved segregation of Paediatric resus from adult resus areas;	CBU Leads	30-Sep-2022	Blue	31-Jan-23	(1) Evidence of improvements made to the environment.	None.	New Resus area of ED to open on Monday 6 February. Additional Mental Health Room now available increasing capacity. Improved childrens area of the Emergency Department now in place.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	Safeguarding review of new Mental Health rooms on the Lincoln site to provide guidance on additional steps needed (if any) i.e. 1:1 supervision.	Denise Dodd (LCH) (Senior Sister, ED) Craig Ferris, Head of Safeguarding.	28-Feb-2023	Green	30-May-23	(1) Evidence following review of Mental Health Rooms at Lincoln.	None.	The areas within ED at LCH designed to accommodate those patients deemed to be at risk to themselves have been reviewed with the Head of Safeguarding and additional risk factors identified (i.e. ligature risks) have been identified and resolved.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	Scope out employment for a play specialist for ED area.	TBC (LCH) (Senior Sister, ED)	30-Sep-2022	[Abandon & Replace]	04-Oct-22	(1) Scoped out plan for recruitment of a play specialist.	None.	This is to be included within the RCPCH scoping of staffing action.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	Review arrangements for 1:1 supervision of patients with mental health needs at Lincoln ED.	TBC (LCH) (Senior Sister, ED)	30-Sep-2022	Green	04-Oct-22	(1) Discussion of plans and mitigations at executive led CQC assurance meeting in September 2022.	None.	Mental health and ligature risk mitigation are included within the CQC Mental Health room action and risk assessment work following the earlier action taken by the Trust to equip Room 15 at PBH	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	Consider addition of the mental health room (location and staffing oversight) to the departmental risk register.	Jemma Bowler (Senior Sister, ED)	30-Apr-2022	Green	30-Apr-22	(1) Evidence of risk scoping and mitigation actions considered.	None.	Consideration of whether this was a risk that required inclusion within the ED risk register.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	New ED at Pilgrim which is valued at £37m and is at the full business planning stage. This is scheduled for Trust Board approval in April, and then for final approval by NHSE/I. Enabling works (included decant of staff) have begun. Build to progress over the next 2 years. Determine if dementia friendly aspects have been included in the plans.	Holly Carter (Senior Sister, ED)	31-Mar-2022	Green	31-Mar-2022	(1) Confirmation that plans for new ED include dementia friendly considerations.	(1) Evidence of dementia friendly considerations included compared with NHS planning guidance for build works.	Confirmation received from ED Manager that Dementia Friendly elements have been built into the new PBH ED plans.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	13-Apr-22: Attended meeting with ED design and building team, chaired by Grant. Designs for ED shared. Agreed to review specific details of relevance to CQC and get formal responses back to specific subjects of interest in line with the following: 1) Dementia friendly - inc. application of standard NHS Planning Guidance in the process; 2) Paediatrics area of ED - security, segregation from the adult area; RCPCH standards; 3) Anti-ligature rooms.	Grant Holley (Senior Capital Projects Manager)	31-Jul-2023	[Abandon & Replace]	31-Jul-23	(1) Confirmation of greater detail of plans in place for new ED at PBH and how they support the Trust in terms of providing care in line with CQC KLOE.	(1) Evidence of dementia friendly considerations included compared with NHS planning guidance for build works.		Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
CQC2021-15	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that falls and mental health risk assessments and transfer documentation are in place for patients when they are required and that completion risk assessments and transfer documentation are audited.	UEC	Process for assessing falls risk has been changed to being assessed on entry to ED by the PHP. Once identified as at risk of falling, yellow socks, yellow wristband and falls risk assessment document completed. Meeting with Senior Sisters, Matron and Lead Nurse to be held to incorporate this into the B7 daily assurance review process.	Denise Dodd (Matron, Urgent & Emergency Care); Holly Carter (Senior Sister, ED)	31-Mar-2022	Blue	09-Jun-2022	(1) Meeting to approve content of the revised NIC assurance process.	None	Paper reviewed and approved at ED Governance for inclusion of this and other topics of relevance to the 2021 inspection visit to be included in the NIC Assurance Process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agreed at ED Governance for falls and mental health risk assessments to be added to the NIC Assurance Tool. Task and Finish group established and working with Informatics team to develop draft NIC Assurance Tool for approval and commencement within the department to obtain improved assurance of daily oversight.	Denise Dodd (Matron) & Holly Carter (Senior Sister, ED)	31-Jan-2023	Green	31-May-2023	(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with falls risk assessments; (3) Improvements in performance with mental health risk assessments.	This is an additional question which has been added to the NIC assurance tool to close the gap in assurance previously identified. Work will not continue to seek assurance of completion of this action from the newly added NIC assurance tool question.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	In the absence of assurance data from the NIC Assurance tool, undertake a snapshot review of MH risk assessments for patients presenting with MH conditions or risks.	Denise Dodd (Matron, Urgent & Emergency Care); Holly Carter (Senior Sister, PBH)	30-Sep-2022	Green	04-Oct-2022	(1) Audit findings from snapshot audit. (2) Action planned in response.	N/A	Snapshot audit undertaken and action agreed in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Action from review of MH risk assessment compliance snapshot audit: Clinical Education team working with Triage teams at both sites to include the completion of the mental health risk assessment at triage rather than being completed by receiving RN's. Impact to be re-audited.	Tracey Wall (Lead Nurse)	31-Oct-2022	Green	30-Nov-2022	(1) Action taken resulting in improved compliance.	(1) Ongoing evidence of compliance.	Mental health risk assessments included within the triage process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	As agreed at the Executive-Led CQC Assurance meeting review assurance evidence available for mitigating mental health risks within the Emergency Department.	Cheryl Thompson (General Manager)	31-Jan-2023	[Abandon & Replace]	31-Jan-2023			Safeguarding team have been commissioned to review MH rooms on the Lincoln site.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	In the absence of assurance data from the NIC Assurance tool, undertake an assurance review from matrons audits data relating to Falls risk assessments.	Denise Dodd (Matron, Urgent & Emergency Care)	30-Sep-2022	Green	31-Jul-2023	(1) Findings from Matrons audit assurance data.	N/A	This has now been incorporated into the NIC Assurance Tool audit data and the revised Matrons assurance tool. Compliance will be reviewed at the end of August 2023 and will remain an area of ongoing oversight.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Review evidence from newly added question to the ED Nursing Assurance Tool: **"Has the falls risk assessment been completed as appropriate?"** to test if evidence from the NIC tool demonstrates this is now embedded.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Aug-2023	Amber		(1) Evidence of compliance from newly added NIC Assurance Tool question.	(1) Ongoing monitoring of compliance from NIC Assurance data.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Monitor and track compliance data for mental health risk assessments in response to actions taken already within UED specificially: * New CAS card with improved prompts (go live early 2023); * Governance meeting and huddle communications to raise awareness; * Linking MH risk assessments into the triage process.	Denise Dodd (Matron, Urgent & Emergency Care)	31-Mar-2023	Green	31-Jul-2023	(1) Findings from snapshot data in the interim of the NIC Assurance Question.	N/A	This has now been incorporated into the NIC Assurance Tool audit data and the revised Matrons assurance tool. Compliance will be reviewed at the end of August 2023 and will remain an area of ongoing oversight.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Review evidence from newly added question to the ED Nursing Assurance Tool: **"Have all patients presenting to the department with mental health problems had a completed mental health risk assessment?"** to test if evidence from the NIC tool demonstrates this is now embedded.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Aug-2023	Amber		(1) Evidence of compliance from newly added NIC Assurance Tool question.	(1) Ongoing monitoring of compliance from NIC Assurance data.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Review evidence from newly added question to the ED Nursing Assurance Tool: **"Has transfer documentation been completed prior to the patient leaving the department?"** to test if evidence from the NIC tool demonstrates this is now embedded.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Aug-2023	Amber		(1) Evidence of compliance from newly added NIC Assurance Tool question.	(1) Ongoing monitoring of compliance from NIC Assurance data.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-32	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	**Part A:** The trust should ensure patients at risk of self harm or suicide are cared for in a safe environment meeting standards recommended by the Psychiatric Liaison Accreditation network (PLAN)... (Completed - see Closed Actions) **Part B:** ... and mental health risk assessments and care plans are completed for all patients at risk. (Open)	UEC	Mental health risk assessments and care plans are completed for all patients at risk. (Open)	As above	As above	Amber					Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
CQC2021-34	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.	UEC	A review of the transfer document has been held with UEC and Quality Matrons. The UEC transfer documentation has been merged with the Trust's transfer documentation and SOP. Transfer documentation has been replaced with a sticker, in SBAR format, to be applied to the CAS card and completed in ED before the patient is transferred. Limited supplies of the sticker are available, to launch pilot when there is a greater stock of stickers.	Jemma Bowler & Holly Carter (Senior Sister ED)	31-Mar-2022	Green	31-Mar-2022	(1) Launch of pilot utilising the newly fashioned transfer stickers; (2) Copy of revised sticker; (3) Evidence of communications to staff regarding pilot.	None.	The transfer sticker has been used in practice and well received by staff within the ED. No formal review or audit has been undertaken, rather the view of those using the documentation is positive. A more formal evaluation is now needed.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Review effectiveness of pilot to determine if supportive of improved documentation.	Jemma Bowler & Holly Carter (Senior Sister ED)	30-Apr-2022	Green	31-Mar-2022	(1) Evidence of performance with completion of transfer sticker documentation; (2) Additional actions if needed to	(1) Ongoing evidence of audit outcomes demonstrating improved recording and documentation of transfer information on the sticker.	The transfer sticker has been well received by staff within the ED. No formal review or audit has been undertaken, rather the view of those	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agreed to include the transfer sticker information within the new CAS card, to scope out measuring of effectiveness.	TBC (LCH) & Holly Carter (Senior Sister ED)	31-Aug-2022	Green	19-Sep-2022	(1) Amended CAS card.	N/A.	The Casualty Card has been updated to include space to record when a patient is assessed on the ambulance. This has now been approved by UEC and Medicine Governance. The Casualty	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agree an audit/evaluation process to review the impact and effectiveness of the transfer sticker/revised section of the CAS card. Agree process (i.e. evaluate on IAC/MEAU on arrival of the patient or undertaken snapshot compliance review within ED).	TBC (LCH) & Holly Carter (Senior Sister ED)	31-Jan-2023	Green	31-May-2023	(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with falls risk assessments; (3) Improvements in performance with mental health risk assessments.	This is an additional question which has been added to the NIC assurance tool to close the gap in assurance previously identified. Work will not continue to seek assurance of completion of this action from the newly added NIC assurance tool question.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Meeting with Senior Sisters, Matron and Lead Nurse to be held to incorporate mental health risk assessment completion into the B7 daily assurance review process.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Blue	09-Jun-2022	(1) Meeting to approve content of the revised NIC assurance process.	None.	Paper reviewed and approved at ED Governance for inclusion of this and other topics of relevance to the 2021 inspection visit to be included in the NIC Assurance Process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agreed at ED Governance for falls and mental health risk assessments to be added to the NIC Assurance Tool. Task and Finish group established and working with Informatics team to develop draft NIC Assurance Tool for approval and commencement within the department to obtain improved assurance of daily oversight.	Denise Dodd (Matron, Urgent & Emergency Care)	31-Jan-2023	Green	31-May-2023	(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with falls risk assessments; (3) Improvements in performance with mental health risk assessments.	This is an additional question which has been added to the NIC assurance tool to close the gap in assurance previously identified. Work will not continue to seek assurance of completion of this action from the newly added NIC assurance tool question.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-17	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.	UEC	Refresh CBU Governance process and arrangements for 2022/23 with renewed TOR for UEC Governance and Cabinet meetings.	Cheryl Thomson (General Manager)	31-Mar-2022	Blue	04-Apr-2022	(1) Approved TOR; (2) Minutes evidencing approval of TOR.	None.	ED Governance arrangements have been reviewed and strengthened. Assurance metrics agreed to test impact of strengthening arrangements throughout the year. This approach includes within it the governance arrangements relating to children.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-39	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.	UEC	Strengthen the UEC Governance processes in line with the revised and approved TOR.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	31-Dec-2022	Green	31-Jan-23	(1) 80% of CBU governance meetings achieved; (2) 75% attendance at meetings; (3) Recognising implications of operational pressures - escalate if more than 2 meetings are cancelled to divisional governance; (4) Addition to CBU risk register if operational pressures lead to cancellation of arrangements.	(1) Evidence that Governance meetings are being held; (2) Regular highlight reporting from UEC to Children's and Young People (CYP) Board.	UEC Governance meetings have been maintained on the whole during 2022.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Make it clearer on the UEC Governance Meeting documentation a demarcation between agenda items focussed on CYP area and those affecting all areas of the Department.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Jun-2023	Green	31-Jul-23	(1) Clearer evidence of specific CYP items of Governance on the UEC Governance agenda.	(1) Ongoing evidence from UEC Governance meetings.	Dedicated paediatric area of ED section included within UEC governance agenda.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-31	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.	UEC	Revised cleaning checklist has been developed. To implement this on a shift by shift basis. To review how this roll-out to be communicated and completion of revised checklist to be completed.	TBC (LCH) & Holly Carter (Senior Sister ED)	31-Mar-2022	{Abandon & Replace}	19-Sep-22	(1) Flo-audit completion data; (2) Mattress audits; (3) Matrons audit contains IPC checks.	(1) Flo-audit completion data; (2) Mattress audits; (3) Matrons audit contains IPC checks.	19-Sept-22: Plan of action presented at the 12-Sept assurance meeting demonstrates this action has been superseeded.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Review completion of domestic cleaning checklist with domestic supervisor and identify any gaps that require further action.	Jemma Bowler & Holly Carter (Senior Sister ED)	30-Apr-2022	{Abandon & Replace}		TBC	TBC	20-Apr-22: On review in greater detail of the context behind this 'Should-do' action and a review of the process within ED, this action has been abandoned and replaced as it is not relevant to the bedspace cleaning process within the department, and therefore unhelpful in addressing the	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	The process for cleaning bedspaces within the department is followed, but is difficult to evidence given the throughput of patients through the ED when under pressure. Scope out and agree appropriate and realistic action in response to be able to better demonstrate and provide assurance that bedspaces are clean.	Denise Dodd (UEC Matron)	31-May-2022	Green	30-Sep-22	(1) Scoped out plan of action.	N/A.	At the Executive-Led assurance meeting the Emergency Department outlined the scoped out plan of action.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Rapid clean criteria for cubicle spaces to be undertaken.	Fiona Hamer (Divisional Nurse)	31-May-2023	Green	31-Aug-23	(1) Facilities developed cleaning chart / record	(1) Assurance evidence from matrons audit demonstrating cleaning record in place.	Facilities led process agreed and in operation at Lincoln and Pilgrim.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Rapid clean criteria for cubicle spaces facilities led cleaning checklist to be evaluated for effectiveness at 3-months.	Fiona Hamer (Divisional Nurse)	30-Nov-2023	Amber		(1) Assurance evidence from matrons audit demonstrating cleaning record in place.	(1) Assurance evidence from matrons audit demonstrating cleaning record in place.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-37	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to investigate incidents in a timely manner and identify and share learning from incidents to prevent further incidents from occurring.	UEC	Backlog of incidents has re-occurred linked to extreme operational pressures. Strengthened governance meetings will include regular ongoing oversight of this area. Theme and trend all backlog of incidents to enable sharing of lessons learnt.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Jun-2022	Green	31-Aug-23	(1) Resolution of the backlog; (2) Sustained compliance with timescales for Serious Incident Reporting and investigation.	(1) Ongoing oversight of incident reporting metrics to measure effectiveness of the process and assurance that a backlog position does not again appear; (2) Ongoing oversight of Serious Incident Reporting and investigation timescales.	Significant improvements made in terms of reducing the backlog.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Review assuance evidence to ensure ongoing progress seen in respect of incident backlog has not re-occurred at 3 months.	Dr David Flynn (Clinical Lead - A&E); Clare Spendlove (Deputy Divisional Nurse)	30-Nov-2023	Amber		(1) Assurance evidence that incident backlog remains reduced.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Review the effectiveness of current learning lessons processes in UEC and strengthen if needed.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Jun-2022	Green	31-Jul-23	(1) Completed review and evidence of action in response.	None.	Learning lessons processes have been improved within ED.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups.	Helen Shelton (Assistant Director of Clinical Governance / Patient Safety Specialist)	31-Dec-2022	Blue	31-Dec-22	(1) Trust level understanding of mechanisms in use to share learning; (2) Evidence of action in response.	None.	Review concluded that reinforced what we thought in that staff use a number of mediums to share lessons. We have therefore continued to use the following: Patient Safety Briefings Learning to Improve Divisional Newsletters quarterly Learning to Improve Trust Newsletter quarterly PSIT monthly newsletter We have discussed setting up a learning lessons forum but PSIRF is moving more towards the terminology of improvement rather than learning so we will see what comes out of the PSIRF implementation team.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-38	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure clinical pathways and policies are updated in line with national guidance.	UEC	Undertake service by service review to identify and catalogue all SOPs and Policies currently being used or referred to within UEC.	Cheryl Thompson (General Manager)	31-Jul-2022	Green	31-Jul-22	(1) List of SOPs and Policies in use.	(1) Addition of all SOPs and Policies in use to central register for tracking and control process.	Service by service review has been undertaken and completed.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						UEC	Review, update and approve all UEC SOPs and Policies and ensure registered as controlled documents, in approved Trust format and stored in the CBU U drive and accessible via the intranet.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	31-Dec-2022	Red		(1) Evidence that all SOPs and Policies have been reviewed and approved; (2) Clear local policy for approval of SOPs and Policies within UEC that includes process to review documents at a scheduled and timetabled point to	(1) Ongoing process to track compliance with the control of SOPs and Policies in use with reference to Trust document control processes.		Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 25/08/2023

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

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes:
CQC2021-03	Maternity	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.	Maternity	Action taken at the time of the inspection. Trolleys with medications were moved to a secure area.	Dr Suganthi Joachim (Division Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Divisional Managing Director)	31-Oct-2021	Green	31-Oct-2021	(1) Evidence submitted as part of core service evidence request; (2) Evidence of communications to team; (3) Evidence of more security for trolleys (locker type trolley).	(1) B7 Assurance process (weekly) includes an assessment of security of medications.	Action was taken at the time of the inspection to remedy the identified issues.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Wall thermometer ordered. Daily check added to the daily check list. Staff aware of escalation process if needed.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Oct-2021	Green	31-Oct-2021	(1) Wall thermometer in place; (2) Daily check added to the daily check list; (3) Audit of the process.	(1) Review of daily checks; (2) Survey of staff regarding action needed if temperature too high; (3) B7 Assurance process (weekly) includes an assessment of this point;	Action was taken at the time of the inspection to remedy the identified issues.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Map out across Maternity at both sites locations where medicines (drugs rooms (inc. fluids), medication fridges, mobile trolleys) are stored	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue	15-Mar-2022	(1) Map of locations within Maternity at both sites outlining where medicines are being stored.	(1) 6-monthly review to determine if any changes in process/location for storing medicines.	A detailed understanding of locations where medicines are stored has been completed as part of the audit process. This will support future actions relating to medicines security and storage.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Undertake gap analysis audit against Trust's Medicines Management Policy that relates to storage and security (i.e. have locations that store medicines got digital thermometers?)	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue	15-Mar-2022	(1) Completed audit, by location, outlining controls in place/gaps.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks; (2) 6-monthly review to determine if any changes in process for storing	A detailed gap analysis has been undertaken to understand the challenges within Maternity.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Develop audit tool for use by Maternity Matrons to undertake gap analysis against medicines storage section of medicines management policy.	Jeremy Daws (Head of Compliance)	03-Mar-2022	Blue	04-Mar-2022	(1) Completed audit proforma.	None.	A detailed gap analysis has been undertaken to understand the challenges within Maternity. This was aided by the development of the audit tool.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Plan out action in response to audit to close any gaps identified (i.e. order digital thermometers).	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Green	29-Apr-2022	(1) Action plan collating all actions in response to gap analysis audit.	(1) Evidence that all gaps have been closed and that actions have been completed; (2) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot	Action plan developed in response to the gap analysis audit undertaken.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Identify any risks from audit undertaken (i.e. rooms where ambient temperature is routinely 25 degrees or above and take advice from pharmacy around mitigations.	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Green	21-Apr-2022	(1) Action plan outlining mitigations to identified risks, in line with policy with Pharmacy advice (inventory of medicines; any with specific sensitivities; stock rotation - how long kept? Insulin length	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.	Risks identified and escalated for support to mitigate the gaps/risks identified relating to ambient room temperatures.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Green	29-Jun-2022	(1) Evidence of PRM escalation; (2) Addition to divisional risk registers of medicines storage matters.	(1) Ongoing escalation reporting to PRM.	Gaps/risks relating to ambient room temperatures have been escalated to PRM and ongoing work is underway to effect mitigations.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Pilot process within Maternity where medicines and fluids to be stored at ambient temperature have their expiry date reduced. Draft SOP to support commencement of pilot.	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-May-2023	Green	30-May-2023	(1) Draft SOP to support commencement of pilot.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.	An SOP to support the manual reduction of expiry dates on receipt within maternity areas has been drafted and shared for comment. This is to be submitted to Obstetrics and Pharmacy Governance for formal approval to enable the pilot to commence, supported by this SOP.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Pilot process within Maternity where medicines and fluids to be stored at ambient temperature have their expiry date reduced. Commence pilot on maternity ward areas.	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	30-Jun-2023	Green	31-Aug-2023	(1) Mitigating actions scoped out in relation to environmental issues (i.e. ventilation and temperature management).	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.	Pilot of the SOP has commenced on 2 of the 3 wards with plans in place to pilot the SOP in the remaining ward area.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Review outcomes from walk-around audit undertaken within Maternity buildings at Lincoln and Pilgrim and agree actions in response.	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-Jun-2023	Green	31-Aug-2023	(1) Action plan in response to the findings from the walk-around audit of the Maternity Buildings examining medicines storage.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.	Review undertaken and actions in place to mitigate the gaps identified.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Resolve security of medicines gaps identified in response to the walk-around audit undertaken within Maternity buildings at Lincoln and Pilgrim sites.	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-Sep-2023	Amber		(1) Evidence that swipecard locks are applied.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Green	29-Jun-2022	(1) Evidence of PRM escalation; (2) Addition to divisional risk registers of medicines storage matters.	(1) Ongoing escalation reporting to PRM.	Gaps/risks relating to ambient room temperatures have been escalated to PRM and ongoing work is underway to effect mitigations.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	

						Maternity	Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Green	29-Jun-2022	(1) Evidence of PRM escalation; (2) Addition to divisional risk registers of medicines storage matters.	(1) Ongoing escalation reporting to PRM.	Gaps/risks relating to ambient room temperatures have been escalated to PRM and ongoing work is underway to effect mitigations.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Matrons audits assess security and storage of records, but main focus will be in relation to nursing documents. The Doctor's office is currently a shared room that doubles as a staff room. The doctor's office is moving to opposite the nurses station. As part of this move incorporate a door closure mechanism to ensure the door is not left open.	Carol Hogg (Ward Manager)	30-Apr-2022	Green	18-May-22	(1) Evidence of door closure device being added to the Doctors Office door.	(1) Ongoing monitoring as part of the Matron's audit process.	The Doctors office relocation to opposite the nurses station improves the ongoing oversight and assurance that medical records are stored securely. The door closure mechanism supports address the human factors elements of staff forgetting to secure the door when moving around the ward	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Scope out with Dr Amol Chingale additional actions in relation to medical staff raised awareness regarding information governance matters and other key messages (i.e. IPC).	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Green	05-Jul-22	(1) Evidence of raising awareness with medical staff.	(1) Programme of work to raise awareness for medical staff.	Dr Chingale has raised for awareness and education purposes with medical staff within CYP.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Obtain assurance via matron audits that IG principles - security of medical records and computer workstations - remain compliant.	Kate Rivett (Divisional Head of Children and Young Peoples Nursing)	31-Dec-2022	Red		(1) Evidence from matrons audits.	N/A.		Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	CYP / Maternity	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	Carol Hogg, Hayley Warner, Emma Young, Kristie Rennison, Karen O'Connor, Kay Probert (Sisters/Clinical Educators/Play	30-Apr-2022	Green	18-May-22	(1) Evidence of divisions identification of currently available information resources and any additional resources that are felt to be needed.	(1) Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).	Findings from the audit undertaken have been collated and shared back to the Patient Experience team to determine next step actions needed in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP / Maternity	Divisions to undertake a walk-around/audit of current patient information resource available and being provided to patients within the division and compile a register, to include what languages the information is available in.	Carol Hogg, Hayley Warner, Emma Young, Kristie Rennison, Karen O'Connor, Kay Probert (Sisters/Clinical Educators/Play	30-Apr-2022	Green	18-May-22	(1) Register of locally held patient information resources being provided to patients.	(1) Maternity: Maternity Voices Partnership (MVP) have done a review of information provision within maternity. Track outcomes from future iterations for assurance.	Findings from the audit undertaken have been collated and shared back to the Patient Experience team to determine next step actions needed in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP / Maternity	Divisions to assign 'information owners' to provide information resources in response to feedback of information for patient needs.	Divisional CQC action plan owners to nominate lead 'information owners'.	31-Oct-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Scope out additional communication aids for use in CYP in British Sign Language and Makaton with Charitable funds.	Rebecca Thurlow (Lead Nurse, CYP)	01-Aug-22	Green	25-Jul-22	(1) Training Needs Analysis.	None.	Additional communication aid developed for use with Children.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust wide	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. [Family Health Specific]	CYP	Understand from Rainforest Ward if the following issues have been reported to Estates: * Entrance flooring; * Some surfaces in poor repair in bathrooms/toilets; * Worn flooring; * Broken equipment (only 1 item - Immediately repaired); * Equipment needing repair	Carol Hogg (Ward Manager)	30-Apr-2022	Green	28-Feb-23	(1) Evidence that environmental issues have been reported to Estates; (2) Evidence of Estates action in response; (3) Escalation if no action yet taken.	(1) Environmental audits evidencing that issues requiring escalation are identified and appropriately reported.	Walkaround by Matron to review completion of flooring works along with additional actions taken to remove Z beds to reduce clutter and improve the environment.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Include within the 15 Steps audit paperwork a question clutter or broken equipment being present on the ward environment.	Kate Rivett (Divisional Head of Children and Young Peoples Nursing)	31-Jan-2023	Green	31-Jan-23	(1) Inclusion within the 15 Steps audit tool questions relating to the presence of clutter or broken equipment within the ward environment.	(1) Ongoing assurance evidence from the 15 Steps audit tool	15-Steps audit tool has been drafted which includes an assessment of clutter and broken equipment for ongoing monitoring.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Charity funds are being secured through a major fundraising for a total refurbishment of the Rainforest Ward. Potential to incorporate Safari into ward footprint.	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2023	Green	30-Apr-23	(1) Refurbishment plans; (2) Evidence of completed works.	None.	Initial bid successful to support commissioning of architects to draw up plans for longer term scheme of works to encompass Safari and Ward 4a.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Charity funds secured for commencement of architectual review. Scope out timescales for subsequent milestones following discussion at CRIG.	Simon Hallion (Divisional General Manager)	30-Nov-2023	Amber		(1) Refurbishment plans; (2) Evidence of completed works.	None.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Replacement of 'Z' beds with new reclining chairs/beds to support decluttering of Rainforest ward with replacement of tables and lockers to support improved environment for patients and parents.	Rebecca Thurlow (Lead Nurse, CYP)	31-Aug-2022	Green	10-Aug-22	(1) Evidence of replacement of old equipment with new; (2) Review of the effectiveness of decluttering of ward environment.	(1) Environmental audits to identify any estates issues; (2) Evidence that environmental issues have been escalated appropriately for remedial action.	Old 'Z' beds have been replaced with new chair beds, these aid the environment by replacing additional clutter.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Scope out the development of an internal Family Health 15-steps process to provide 'fresh eyes' on the environment.	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Green	18-May-22	(1) Evidence of plan being scoped out.	(1) Roll-out of internal 15-steps challenge methodology.	Plan agreed for how to undertake a local programme of 15-steps reviews for CYP clinical areas to better enable gaps in relation to the fabric of the environment, that affect the patient	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Undertake phase 1 of the 15-steps roll-out plan within CYP with Healthcare Support Workers (HCSW) / Reception staff undertake review in their own areas of work and report findings to newly in post CYP Matron.	Rebecca Thurlow (Lead Nurse, CYP); Sandie White (Matron, CYP)	31-Jul-2022	[Abandon & Replace]	31-Jan-23	(1) Findings from phase 1 of the 15-steps rollout plan.	(1) Scheduled activity to ensure regular programmed events for ongoing assurance purposes.	Original plan for the 15-steps review was to undertake using staff evaluating CYP areas. Division feel it would be better use national methodology and involve service users in undertaking review.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

						CYP	Revised approach to undertaking the 15-steps review work. Move away from undertaking review with staff to utilising the national review documentation and initiating with service users undertaking review.	Sandie White (Matron, CYP)	30-Apr-2022	[Abandon & Replace]	28-Feb-23	(1) Findings from 15-steps review.	None.	Original plan for the 15-steps review was to undertake using staff evaluating CYP areas. Division feel it would be better use national methodology and involve service users in undertaking this review. New milestone agreed with	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	03-Feb-23: Executive-led assurance review meeting on 22 February approved closure of this action and resetting timescale to new milestone action.
						CYP	Undertake revised 15-Steps process with service users undertaking the review. Receive findings and demonstrate action in response.	Sandie White (Matron, CYP)	31-May-2023	Red		(1) Findings from 15-steps review & action plan in response.	None.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Understand the ULHT Trust process for undertaking, recording and frequency for undertaking ligature risk assessments.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Blue	04-May-2022	(1) Clarification Trust processes.	None.	Clarity obtained in the process expected for Trust Ward areas in respect of ligature risk assessments.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Scope out assurance available that Ligature Risk Assessments are undertaken annually in line with Trust Policy on CYP ward areas.	Rebecca Thurlow (Lead Nurse, CYP)	31-May-2022	Blue	18-May-2022	(1) Plan to obtain assurance that ligature risk assessments are a programmed activity within CYP.	None.	Agreed plan for frequency of ligature risk assessment reviews with built in reminder process.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Scope out assurance available that Ligature Risk Assessments are undertaken annually in line with Trust Policy on CYP ward areas.	Rebecca Thurlow (Lead Nurse, CYP)	30-Nov-2022	Blue	31-Mar-2023	(1) Plan to obtain assurance that ligature risk assessments are a programmed activity within CYP.	None.	Ligature risk assessments for children's areas and neonatal areas have been completed.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Continue to scope out additional steps for CYP in relation to risk mitigation for children with mental health concerns linking in with LPFT and ULHT Safeguarding team.	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Green	16-May-22	(1) Agree approach with system partners and stakeholders to review care and environment for children requiring Mental Health services.	TBC	Compliance team have developed a gap analysis tool to support CYP and collaborative partners to compare current practice against the GIRFT recommendations. This has been shared with CYP for use going forwards	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	The Trust have identified the latest GIRFT findings and recommendations pertaining to Children and Young People's Mental Health Services, issued in April 22. Scope out how the Trust, alongside key partners, can use this to review current service provision with a view to improving environment and care processes for CYP.	Rebecca Thurlow (Lead Nurse, CYP)	30-Jun-2022	Green	30-Jun-22	(1) Scoped out plan for next steps in reviewing current practice against GIRFT publication.	None.	Collaborative approach agreed with LPFT, ICB and Social Care. This is a proactive focus on improvements with the mental health pathway, not just ligature risks. Progress with this proactive piece of work will be monitored through Divisional oversight	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Review and seek assurance that routine weekly fire checks are being undertaken on Safari ward.	Carol Hogg (Ward Manager)	30-Apr-2022	Green	19-Sep-22	(1) Evidence of weekly fire checks being undertaken.	(1) Assurance of processes in place to maintain this going forward; (2) Evidence of weekly fire checks (spot checks).	Evidence provided that weekly fire checks are being completed on Safari ward.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2021-19	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.	Surgery	Theatre safety bulletin to be devised and disseminated to all theatre staff outlining roles and responsibilities in monitoring of ambient temperatures alongside why this is a requirement.	Lisa Pim (Divisional Nurse, Surgery)	04-Mar-2022	Blue	26-May-22	(1) Completed Safety bulletin; (2) E-mail evidence of dissemination	None.	Guidance shared with Theatre teams on need to record temperatures, roles and responsibilities and action in case of temperature deviation.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Thermometers to be ordered for all Anaesthetic Rooms	Jason Green (Matron, Surgery)	02-Mar-2022	Green	01-Sep-22	(1) Written confirmation by Theatre Matrons that Thermometers are in place; (2) Practice has been commenced.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Daily Temperature Checks Sheets to be installed in all Anaesthetic rooms	Jason Green (Matron, Surgery)	02-Mar-2022	Green	01-Sep-22	(1) Practice has been commenced; (2) Temperature check sheets are used to record temperatures.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Daily Temperature Checks to be instituted by Theatre Teams	Jason Green (Matron, Surgery)	02-Mar-2022	Green	31-Oct-22	(1) Practice has been commenced; (2) Temperature check sheets are used to record temperatures.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Implement remote temperature monitoring probes within Theatres with Clinical Engineering and Pharmacy input.	Jason Green (Matron, Surgery)	30-Jun-2022	Green	31-Jan-23	(1) Remote temperature probes in place.	(1) Matrons audit findings; (2) Band 7 audit findings.	Theatres are having Stanley remote temperature monitoring probes installed across all sites during February 2023.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	SOP to be devised outlining procedure to be undertaken and actions to be undertaken in the case of a temperature breach.	Lead Nurse/Matron for Health Safety	02-Mar-2022	[Abandon & Replace]	11-Apr-22			There is no need for a separate SOP as the Trust's Medicines Management policy covers off the actions required wen temperature identified as being out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Band 7 Weekly Quality and Safety Audit	Matrons/Band 7 Practitioner for Theatre	02-Mar-2022	Blue	01-Sep-22	(1) Audit document with additional checks	(1) Ward accreditation process	This question is now available within the Band 7 weekly spot check audit process to monitor progress and seek ongoing assurance.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Monthly Matrons Audit	Matrons for Theatre	02-Mar-2022	Blue	30-Apr-22	(1) Audit document with additional checks	(1) Ward accreditation process	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	

						Surgery	As this is a new process - compliance will be reported at monthly CBU PRM	Lead Nurse TACC	01-Apr-2022	Green	01-Sep-22	(1) Monthly PRM Slide Deck	(1) CBU PRM Quality Process	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Track for assurance purposes compliance with temperature monitoring following roll-out of Stanley remote temperature monitoring.	Matrons/Band 7 Practitioner for Theatre	31-May-2023	Green	31-May-23	(1) Review of data from Stanley temperature probes; (2) Review of compliance with temperature monitoring policy.	(1) Matrons audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2021-20	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure an interpreter is used as per trust policy to ensure all young people, parents or guardians are able to consent to care and treatment and fully understand clinical conversations.	CYP	Reminders provided to staff around the availability of interpreting services.	Rebecca Thurlow (Lead Nurse, CYP)	01-Nov-2021	Blue	01-Nov-2021	(1) Communication messages shared with the team; (2) Addition (during Nov 21) of this to the monthly matrons audit.	(1) Message of the month schedule; (2) Monthly Matron Audit data.	Work undertaken to proactively remind staff of the availability of translation services for patients/families whose first language is not English.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	To include within the message of the month schedule reminders to act as an aide memoir to support staff continue to make good use of the interpreting services.	Carol Hogg (Ward Manager)	31-Dec-2021	Green	01-Mar-22	(1) Addition to the message of the month schedule.	(1) Message of the month schedule; (2) Monthly Matron Audit data.	Communications aimed at reminding staff about the process to support patients/carers with interpreting needs has been issued to staff.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Nursing admission document being revised, currently in development by Shared Decision Group, with a prompt and space documentation relating to interpreting services booked	Rebecca Thurlow (Lead Nurse, CYP)	31-Dec-2022	Green	31-Jan-2023	(1) Completed nursing admission document.	(1) Message of the month schedule; (2) Monthly Matron Audit data.	Admission document has been finalised and is now awaiting approval by APPG before being rolled out.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Finalise nursing admission document.	Sandie White (Matron, CYP)	30-Apr-2023	Green	31-Aug-2023	(1) Completed nursing admission document.	(1) Monthly Matron Audit data.	Nursing admission document finalised and piloted. To approve now via APPG for final roll-out.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Finalise Nursing Admission Document via APPG.	Sandie White (Matron, CYP)	30-Sep-2023	Amber		(1) Completed nursing admission document approved via APPG.	(1) Monthly Matron Audit data.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Section to be added in Matrons monthly assurance audit. To ensure this practise is embedded and monitored – evidence received	Rebecca Thurlow (Lead Nurse, CYP)	01-Dec-2021	Blue	01-Dec-2021	(1) Addition (during Nov 21) of this to the monthly matrons audit.	(1) Monthly Matron Audit data.	Matrons assurance audit has been updated to include assessment of interpreting service being used. This will support ongoing compliance and	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-21	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure cleaning records are completed as per trust policy.	CYP	Embed use of new cleaning schedules that have been introduced through Nurse In Charge taking a lead role in ensuring this is completed at the end of each day.	Rebecca Thurlow (Lead Nurse, CYP)	31-Aug-2022	Green	31-Jan-23	(1) Evidence from cleaning schedules assurance metrics; (2) Revised cleaning schedule document.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.	Revised cleaning schedules have been launched from December 2022. To track impact and monitor via matrons audit process.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Cleaning schedules have been approved and are in use from December 2022. To evaluate impact at 3-months from matrons audit data.	Kate Rivett (Divisional Head of Children and Young Peoples Nursing)	30-Apr-2023	Red		(1) Evidence from cleaning schedules assurance metrics.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Scope out action needed in relation to Neonatal cleaning records.	Rebecca Thurlow (Lead Nurse, CYP)	31-Aug-2022	Red		(1) Evidence from cleaning schedules assurance metrics.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.	Matrons audit demonstrates that monthly audit data is available. Recent performance is 100%. To track as part of ongoing assurance metrics to evidence process is embedded.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-22	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.	CYP	Scope out further actions in response to inclusion of patients/parents in service provision whose first language is not English. Set up meeting with Lead Nurse CYP; Equality & Diversity Trust Lead and Patient Experience Lead. [Include within this availability of information for	Jeremy Daws (Head of Compliance)	30-Apr-2022	Blue	30-Apr-22	(1) Meeting held and further actions needed scoped and included within CQC Improvement Action Plan.	None.	Meeting held with Equality & Diversity team to inform next steps to support proactive mitigation of mixed sex accomodation within the unit.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	To include this and wider cultural issues to the Shared Decision Making group within CYP to scope out tangible improvement actions to support this action.	Rebecca Thurlow (Lead Nurse, CYP)	30-Sep-22	Green	19-Sep-22	(1) Agreed plan.	N/A.	The action needed has been scoped with the agreement to amend the nursing admission booklet with a prompt to ensure nursing staff are able to proactively explain mixed sex accomodation during the admission process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Include question(s) and prompt into the nursing admission booklet to enable a conversation to be proactively had at the point of admitting the child and their parents regarding mixed sex accomodation.	Sandie White (Matron, CYP)	21-Oct-22	Green	31-Jan-23	(1) Amended draft of the Nursing Admission Booklet.	N/A.	Admission document has been finalised and is now awaiting approval by APPG before being rolled out.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						CYP	Finalise nursing admission document.	Sandie White (Matron, CYP)	30-Apr-23	Green	31-Aug-2023	(1) Completed nursing admission document.	(1) Monthly Matron Audit data.	Nursing admission document finalised and piloted. To approve now via APPG for final roll-out.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Finalise Nursing Admission Document via APPG.	Sandie White (Matron, CYP)	30-Sep-2023	Amber		(1) Completed nursing admission document approved via APPG.	(1) Monthly Matron Audit data.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Review evidence of impact of the new admission booklet through a 3-month assessment of matons audit.	Sandie White (Matron, CYP)	31-Dec-23	Amber		(1) Assurance evidence of the use of interpreters and proactive consideration of mixed sex discussions.	N/A.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-23	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider the use of a communication tool to support staff working with children who have additional needs.	CYP	Work is underway in participating in the Trust trial of 'This is me' document. To be included in the next wave. Aiming to link in with CAMHS and work on this in partnership with LPFT to ensure an integrated approach. To scope out additional details and timescales.	Rebecca Thurlow (Lead Nurse, CYP)	31-Aug-23	[Abandon & Replace]	31-Aug-23			Action superseeded by other work underway to improve communication with children using translation and communication aids.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-24	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that a patient's food and fluid intake is accurately recorded.	CYP	New tool/risk assessment has been drafted specifically for CYP in collaboration with Dietetics and Clinical Education team. Awaiting ratification and approval of the document to then roll-out. Scope out additional detail and timescales and include further milestones to test implementation and	Sandie White (Matron, CYP)	30-Sep-22	Green	30-Nov-22	(1) Revised documentation for capturing food and fluid intake.	N/A.	Revised documentation has been launched to better record nutritional and flud intakes. This will be monitored via the Matrons audit.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Monitor compliance via Matrons audits of the documentation of fluid and nutritional intake over a 3 month period.	Sandie White (Matron, CYP)	28-Feb-23	Green	30-Apr-23	(1) Revised documentation for capturing food and fluid intake.	N/A.	Revised risk assessment document has now been approved at APPG.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Monitor compliance via Matrons audits of the documentation of fluid and nutritional intake over a 3 month period.	Sandie White (Matron, CYP)	30-Sep-23	Amber		(1) Assurance data demonstrating compliance with recording.	(1) Assurance data from matrons audit.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-30	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should improve the completion of safety, quality and performance audits to ensure these are consistently completed effectively, to enable safety and quality concerns to be identified and acted upon.	Maternity	BAU: Ongoing review and assurance that environmental audits do assess the estate and escalate appropriately into MNOG.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	Green	21-Feb-22	(1) MiCad audits focus on cleanliness; (2) Matrons audits pick up estate issues.	(1) MiCad audits focus on cleanliness; (2) Matrons audits pick up estate issues; (3) Evidence of onward escalation reporting into MNOG.	This was a business as usual action. Estate deficiences are identified proactively via the FLO audits and fed upwards into the IPC committee.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-41	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider all key services being available seven days a week.	CYP	Scope out and define key clinical support services needed by CYP over a 7 day period by urgency (i.e. routine management vs. seriously unwell).	Dr Suganthi Joachim (Divisional Clinical Director)	31-Mar-2022	Blue	09-Mar-22	(1) Defined list of key services and when needed in terms of urgency.	None.	A review of the Clinical Support Services not available 24/7 was undertaken to understand and quantify the gaps and risks associated.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Identify availability of key clinical support services over a 7 day period, by urgency and identify any gaps.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	31-May-2022	Green	10-Aug-22	(1) Key services availability and identification of any gaps.	None.	A list of clinical support services and tests, such as ultrasound, not always available at weekends has been identifed. The risks of this have been quantified and added to the risk register.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Apr-22, moving to the 31-May-22. This will remain as 'RED' rated.
						CYP	Outline a plan for mitigating any gaps in available clinical support services and define risks.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	31-May-2022	Green	10-Aug-22	(1) Risk stratification of gaps; (2) Plan in place to mitigate gaps.	None.	A list of clinical support services and tests, such as ultrasound, not always available at weekends has been identifed. The risks of this have been quantified and added to the risk register.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Add any risks to divisional risk register.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	30-Jun-2022	Green	10-Aug-22	(1) Evidence that risk has been considered and added to the risk register as necessary.	(1) Evidence of ongoing risk mitigation as part of risk register process.	A list of clinical support services and tests, such as ultrasound, not always available at weekends has been identifed. The risks of this have been quantified and added to the risk register.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	

						CYP	Draft an assurance report summarising what the services where, what are the risks and what are the mitigations with the aim of discussing with clinical colleagues for internal confirm and challenge.	Kate Rivett (Divisional Head of Children and Young Peoples Nursing)	30-Nov-2022	Green	30-Apr-23	(1) Evidence that risk has been considered and added to the risk register as necessary.	(1) Evidence of ongoing risk mitigation as part of risk register process.	Summary report summarising services available over 7 days has been drafted.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-42	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider routine monitoring or auditing of waiting times for children to have a medical review as per the Royal College of Paediatrics and Child Health (RCPCH).	CYP	Review RCPCH guidance to determine specific requirement as to what waiting times need auditing and then discuss further with Lead Nurse and Clinical Lead for CYP.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Green	24-Feb-22	(1) Evidence of detail for the audit being scoped out.	None.	RCPCH guidance reviewed and metrics identified that require proactive assurance monitoring against to inform the development of an audit to assess.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Plan a prospective audit to log and record the details, a set number of times a year (to scope). Co-ordinators to collect data. Scope of wards included would be 4a/Safari/Rainforest. To be led by Dr Chingale and Becky.	Dr Chingale (Clinical Lead); Rebecca Thurlow (Lead Nurse CYP)	30-May-2022	[Abandon & Replace]	28-Feb-23	(1) Plan for the audit.	(1) Schedule for the audit to be undertaken throughout the year.	Discussed at the Executive Led - CQC Assurance meeting. Agreed that this is not an area of high risk and for the division to move to a programme of audits as opposed to continuous data collection. New action agreed to scope for inclusion within the CYP Audit programme.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	01-Mar-2023: Agreed at the Executive CQC Assurance meeting on the 28 February 2023.
						CYP	Discuss with Dr Chingale the need to include this within the Paediatric Audit Calendar and plan frequency of this audit. To include within consideration for the audit a review of incidents/complaints/PALS etc. to understand experience based feedback and if this is an area being flagged as of concern.	Suganthi Joachim (Divisional Clinical Director)	31-Mar-2023	Green	30-Apr-23	(1) Plan for the audit.	(1) Schedule for the audit to be undertaken throughout the year.	Confirmed that this has been included within the CYP audit programme.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

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CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 25/08/2023

BRAG Rating Matrix	
Blue	Completed and embedded.
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URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating BRAG	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes:
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-	Medicine CBU Leads	31-Dec-2022	Green	31-Mar-23	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	overseen by the Quality Governance Committee (QGC). Divisions are provided with ongoing support from the central Clinical Governance team. Performance data demonstrates high compliance rates with Duty of Candour.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Review assurance evidence available from existing metrics to determine if additional action is required, other than the ongoing education work resulting from ongoing assurance work.	Clare Spendlove (Lead Nurse); Donna Gibbins (Deputy Divisional Nurse)	30-Apr-2022	Green	30-Apr-22	(1) Matrons audit data in relation to security of patient records/information (systems etc.).	(1) Matrons audit data in relation to security of patient records/information (systems etc.).	Audit data reviewed and agreed that further action is required as compliance audits show room for improvements.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Scope and agree improvement plan to support improved compliance and evidence using the matrons audits.	Katy Mooney (Divisional Lead Nurse)	31-May-2022	Green	24-May-22	(1) Agreed action plan	None.	Action plan agreed in relation to monitoring compliance with security of personal information from unsecured	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Order and put into use medical records storage trolleys within the Cath Lab.	Claire Spendlove (Lead Nurse Cardiovascular)	30-Nov-2022	Green	31-Jan-23	(1) Evidence of two notes trolleys available in Cath Lab.	None.	Confirmation received that the outstanding notes trolley has now been received. Assurance metrics from	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Monitor evidence from the following assurance sources to demonstrate compliance with Information Governance Requirements: * IG mandatory training compliance (reported through to Medicine PRM);	Katy Mooney (Divisional Lead Nurse)	31-Dec-2022	Red		(1) IG Training Compliance within Medicine; (2) Compliance with IG questions contained within the Matrons audit.	(1) IG Training Compliance within Medicine; (2) Compliance with IG questions contained within the Matrons audit.		Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	All	Medicine Cabinet to scope out how to determine what information resources are required that do not currently exist (including UEC and advice cards) and catalogue information currently available and in use.	Katy Mooney (Divisional Lead Nurse)	31-Mar-2022	Green	18-May-22	(1) Agreed action plan	None.	Plan agreed within medicine on how best to approach this audit/data collection exercise.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	To first undertake review of information for patients kept and provided at ward level. Discuss with weekly sisters meeting and develop clear plan to undertake this audit of information available.	Katy Mooney (Divisional Lead Nurse)	31-Oct-2022	(Abandon & Replace)	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. [Medicine specific]	Medical	Review evidence that estates issues are being identified as part of the Ward/department environmental audits and FLO audits and determine mitigations in place to safeguard quality of service provision.	Clare Spendlove (Lead Nurse); Donna Gibbins (Deputy Divisional Nurse); Maxine Skinner (UEC).	30-Apr-2022	Green	30-Nov-22	(1) Environmental audits / FLO audits demonstrating that estates issues are being identified; (2) Evidence of escalation / mitigation of estates related issues by risk.	(1) Environmental audits / FLO audits demonstrating that estates issues are being identified; (2) Evidence of escalation / mitigation of estates related issues by risk.	Meeting established between Division and Estates teams to focus on prioritising estate actions required for issues identifed on FLO audits.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Medical	Scope out opportunities to better plan routine replacement programme for equipment with Trust's procurement team.	Clare Spendlove (Lead Nurse).	30-Apr-2022	(Abandon & Replace)	31-Aug-23	(1) Understand options available.	None.	Action replaced as out of scope of the original gap identified by CQC.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2021-26	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that safety checks of new ward environments are fully completed before moving patients.	Medical	Standardise and merge out-of-hours checklist with Divisional checklist and ensure this is accessible and version controlled as part of the Trust's documentation control processes and procedures. Katy to chair a meeting of matrons and lead nurses across divisions	Katy Mooney (Divisional Lead Nurse)	31-May-2022	Green	18-May-22	(1) Draft Revised checklist for opening a ward.	(1) Assurance evidence the checklist is in use when opening a ward.	Draft checklist developed, now being consulted on to develop final draft for approval and implementation.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Medical	Agree final draft of the merged Surgery/Medicine checklist and agree group to approve the revised checklist and agree frequency of review (6-monthly) to ensure the document adapts in line with changing nature of the service/reflects new challenges.	Kathyrn Mayer (Matron, Surgery); Sophie Rudge (Matron, Medicine)	30-Jun-2022	Green	28-Jun-22	(1) Final draft checklist for opening a ward.	None.	Final draft checklist has been agreed and is in the process of being ratified and plans in place to implement.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Medical	Ratify checklist and ensure this is a controlled document with support from SOP on utilisation.	Clare Spendlove, Lead Nurse, Cardiovascular	30-Sep-2022	Green	31-Aug-23	(1) Final checklist and SOP approved as controlled Trust documents.	None.	Evidence of ward checklist and minutes approved at TLT	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Medical	Evidence of new ward checklist being available for staff to use	Clare Spendlove, Lead Nurse,	30-Sep-2023	Amber							

						Medical	Evaluate the new ward checklist	Katy Mooney (Divisional Lead Nurse)	31-Oct-2023	Amber					Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2021-27	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.	Medical	With support from the Trust's audit department, embed the process that all national audits are participated in, presented at the respective audit meetings, discussed at Governance and an action plan agreed.	National Audit leads (with support from Trust Audit Team)	31-Mar-2023	Red		(1) CEG Quarterly Report; (2) CQC Insights data.	(1) CEG Quarterly Report; (2) CQC Insights data.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Divisional action: Improve 'Board to Ward' following governance meeting to support learning and sharing throughout the division	Alison Stutt (Lead Nurse, Cardiovascular); Donna Gibbins (Lead Nurse, Specialty Medicine)	31-Oct-2023	Amber					Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan

Executive Lead: Karen Dunderdale, Director of Nursing

Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance

Progress Review Date As At: 25/08/2023

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URN	Core Service	Trust/ Site	Recommendation	Immediate/ Must Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for	Notes:
CQC2021-19	Children and young people	Lincoln County Hospital	Core services inspection 2021	Should Do	The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.	Surgery	Theatre safety bulletin to be devised and disseminated to all theatre staff outlining roles and responsibilities in monitoring of ambient temperatures alongside why this is a requirement.	Catherine Capon (Divisional Nurse, Surgery)	04-Mar-2022	Blue	26-May-22	(1) Completed Safety bulletin; (2) E-mail evidence of dissemination	None.	Guidance shared with Theatre teams on need to record temperatures, roles and responsibilities and action in case of temperature deviation.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Thermometers to be ordered for all Anaesthetic Rooms	Jason Green (Matron, Surgery)	02-Mar-2022	Green	01-Sep-22	(1) Written confirmation by Theatre Matrons that Thermometers are in place; (2) Practice has been commenced.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Daily Temperature Checks Sheets to be installed in all Anaesthetic rooms	Jason Green (Matron, Surgery)	02-Mar-2022	Green	01-Sep-22	(1) Practice has been commenced; (2) Temperature check sheets are used to record temperatures.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Daily Temperature Checks to be instituted by Theatre Teams	Jason Green (Matron, Surgery)	02-Mar-2022	Green	31-Oct-22	(1) Practice has been commenced; (2) Temperature check sheets are used to record temperatures.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Implement remote temperature monitoring probes within Theatres with Clinical Engineering and Pharmacy input.	Jason Green (Matron, Surgery)	30-Jun-2022	Green	31-Jan-23	(1) Remote temperature probes in place.	(1) Matrons audit findings; (2) Band 7 audit findings.	Theatres are having Stanley remote temperature monitoring probes installed across all sites during February 2023.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	SOP to be devised outlining procedure to be undertaken and actions to be undertaken in the case of a temperature breach.	Lead Nurse/Matron for Health Safety	02-Mar-2022	[Abandon & Replace]	11-Apr-22			There is no need for a separate SOP as the Trust's Medicines Management policy covers off the actions required wen temperature identified as being out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Band 7 Weekly Quality and Safety Audit	Matrons/Band 7 Practitioner for Theatre	02-Mar-2022	Blue	01-Sep-22	(1) Audit document with additional checks	(1) Ward accreditation process	This question is now available within the Band 7 weekly spot check audit process to monitor progress and seek ongoing assurance.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Monthly Matrons Audit	Matrons for Theatre	02-Mar-2022	Blue	30-Apr-22	(1) Audit document with additional checks	(1) Ward accreditation process	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	As this is a new process - compliance will be reported at monthly CBU PRM CQC action: The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.	Lead Nurse TACC	01-Apr-2022	Green	01-Sep-22	(1) Monthly PRM Slide Deck	(1) CBU PRM Quality Process	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2021-12	Trust Wide	Trust	Core Services Inspection 2021	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Determine those outpatient areas that have now come under the Division of Surgery.	Catherine Capon (Divisional Nurse, Surgery)	30-Jun-22	Green	19-Aug-22	(1) List of outpatient areas managed under the Surgery Division	None.	Clarification provided regarding which outpatient areas now feature within Surgery Division.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	The division of surgery continues to promote the importance of Information Governance and the security and protection of personal identifiable data. Assurance data is tracked from Matrons audit data. This is therefore a BAU action and assurance data will be monitored for evidence of compliance.	Catherine Capon (Divisional Nurse, Surgery)	31-Mar-2023	Red		(1) Matrons audit findings; (2) Outpatient areas transferred under surgery - Matrons audit findings	(1) Matrons audit findings; (2) Outpatient areas transferred under surgery - Matrons audit findings; (3) Divisional mandatory training compliance with IG core learning.		Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	

CQC2021-13	Trust Wide	Trust	Core Services Inspection 2021	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	All	Whilst the Division of Surgery make use of an externally provided source of information leaflets (EIDO) there is a need to understand what information is being used and whether there are gaps. Share the audit tool developed with other divisions with Surgery.	Jeremy Daws (Head of Compliance)	30-Jun-22	Green	19-Aug-22	(1) Audit tool developed for use with other divisions shared with Surgery.	None.	Audit tool developed to help capture information resources being used shared with the Team in Surgery.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust Wide	Trust	Core Services Inspection 2021	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.	All	The Division of Surgery proactively review their environment using the monthly FLO audits which identify and detail estates problems. These are reported through to the IPC group. This is therefore a BAU action with assurance evidence from the FLO audit process.	Catherine Capon (Divisional Nurse, Surgery)	31-Mar-2023	Red		(1) Monthly FLO audits; (2) Escalation to IPC group.	(1) Monthly FLO audits; (2) Escalation to IPC group.		Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						All	Shuttleworth Ward is awaiting refurbishment. Delays as a result of flow issues and lack of decant wards to enable works to begin. This is on the risk register as there are estate issues in the interim affecting the patient experience. Scope mitigating actions to improve the facilities.	TBC	30-Sep-23	Amber		(1) Evidence of risk register entry; (2) To be confirmed.	To be confirmed.		Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						All	Ward 5A is in need of refurbishment. This is on the risk register as there are estate issues in the interim affecting the patient experience. Scope mitigating actions to improve the facilities.	TBC	30-Sep-23	Amber		(1) Evidence of risk register entry; (2) To be confirmed.	To be confirmed.		Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						All	Daycase areas (Daycase Ward, PBH; Surgical Admission Lounge (SAL) are in need of refurbishment. These are converted from ward areas which means they do not have ideal facilities given that these are limited for the number of patients in the area on a daily basis. Scope mitigating actions to improve the facilities.	TBC	30-Sep-23	Amber		(1) Evidence of risk register entry; (2) To be confirmed.	To be confirmed.		Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						All	Ventilation systems in Theatres do not meet the latest legislation requirements. This has been added to the risk register. Scope out risk and determine actions to mitigate.	TBC	30-Sep-23	Amber		(1) Evidence of risk register entry; (2) To be confirmed.	To be confirmed.		Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan: Completed and Closed Action Repository
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance

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

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Context - Taken from the report (why was this identified as an issue)	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Status summary and update	Complete ness rating BRAG	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes
CQC2021-32	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	**Part A:** The trust should ensure patients at risk of self harm or suicide are cared for in a safe environment meeting standards recommended by the Psychiatric Liaison Accreditation network (PLAN)... **Part B:** ... and mental health risk assessments and care plans are completed for all patients at risk. [OPEN still]	Patients presenting with acute mental health concerns did not have access to a dedicated room which met national guidance relating to the provision of a safe environment. Staff told us a patient requiring additional supervision would be placed in an observable majors' bay. However, due to the layout of the department patients who were at risk of self harm could have access to rooms and equipment which had the potential to cause harm. For example, the clean procedures room was easily accessible and we saw contained hazardous equipment. Toilets and bathrooms were accessible and contained ligature points. Following our inspection, the trust provided us with a plan to reinstate a mental health room (room 15) which was intended to be modified to meet appropriate standards. As an interim, the trust advised us any patient with mental health conditions requiring use of the room will receive one to one supervision. The trust confirmed they had also removed ligature risks identified in this room. (Page 31) Mental health risk assessments were not routinely completed. However, staff told us they would be completed if a patient attended with a mental health related concern or following self-harm or attempted suicide. During our inspection we reviewed the care of a patient who attended following self-harm. Despite the notes indicating the patient was at 'medium' risk, there was no mental health risk assessment in place. This meant the service did not identify actions to be taken to reduce the risk of harm to the patient whilst in the department. This was escalated and the risk assessment was subsequently completed. (Page 34) Staff did not always complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During our inspection we reviewed one record where a patient was deemed to be medium risk of self-harm. However, there was no mental health risk assessment completed to ensure the patients' needs were being met and mitigations in place to reduce risk of self-harm. This was escalated and the risk assessment was implemented. Managers told us risk assessments were normally in place, however, did not audit compliance. (Page 35) We also identified the mental health risk assessment had not been updated to reflect changes with the footprint of the department and removal of the mental health room. This had a significant impact on the safe management of patients at risk of self harm. Whilst staff appeared to be aware of pathways, they could not always sign post us to where to find local guidelines. (Page 42) Processes were in place to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, we did not see evidence these processes were fully implemented. Documentation was in place which directed staff on managing patients presenting with a mental health condition. We reviewed one set of notes for a patient presenting with mental health concerns and self-harm. However, there was no mental health risk assessment in place to determine the patients background, individual needs, risks and actions to prevent the patient coming to harm. Audits were not completed to assess staff compliance with mental health risks assessments to provide assurance they were consistently implemented. (Page 43)	UEC	Room 15 has been identified as a suitable room that can be used to assess mental health patients with some modifications. The room has 2 doors meaning suitable access / egress and is situated away from the 'plaster room'.	Blanche Lentz (Clinical Services Manager UEC)	31-Jul-2022	29-Sep-22: ED Risk Tool provide context for the department resulting in the dynamic risk assessments; Patient level risk assessment. The two correlating will provide assurance. 01-Sept-22: Assurance document approved. MH Risk assessments have been split out as part B. 04-Aug-22: Assurance document completed and to be presented for internal confirm and challenge through UEC Governance processes prior to presenation to Exec assurance meeting in September 2022. 07-Jul-22: To meet with Blanche and review assuranc evidence and pull together an assurance document. 09-Jun-22: Team considered that this action is now complete, with the exception of undertaking a ligature risk assessment for the room. _____ 21-Dec: Cost code order has been sent to the contractor. Exact timescales for works to be completed to be confirmed. 15-Feb-22: Works commenced. Panic strips should be fitted. 06-Apr-22: Panic strip has been fitted in some of the room. Confirmed with contractor that this will surround the entire room. Need timescale.	Blue	31-Jul-2022	(1) Quote for modifications; (2) Photographic evidence of modifications made to Room 15.	(1) Audit evidence of appropriate access/use by MH patients; (2) Ligature risk assessment completed for refurbished MH room.	MH Room has been modified following CQC identified concerns. UEC Governance where happy to approve this as completed.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
							UEC	In the interim, until the modifications to room 15 are complete, any patient with mental health conditions requiring use of the room will have 1:1 supervision from a sitter. The staffing template for the unit will enable this in most circumstances, and in situations where this is more challenged, escalation will be made to Site Management Team to support backfill arrangements. This arrangement has been communicated to all the team.	Denise Dodd (UEC Matron)	01-Nov-2021	Complete	Blue	01-Nov-2021	(1) Evidence of communication cascade.	(1) Audit to be undertaken in Nov-21.	The need for a 1:1 sitter for patients cared for within room 15 has been communicated to the team and assurance that this is maintained will be included in a regular assurance audit.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
							UEC	The Trust's Estates team have been contacted to fit locks to cupboard doors in the clean procedures room to ensure that there is not easy access to sharps.	Estates	01-Dec-2021	Complete	Blue	01-Dec-2021	(1) Photographic evidence of pin locks fitted and in use.	(1) Audit/walk-around visits.	The Trust's Estates team have fitted locks to cupboard doors in the clean procedures room to ensure that there is not easy access to sharps.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
							UEC	An audit will be undertaken during November 2021 to test this arrangement and the quality of record keeping. Evidence from this audit will made available for sharing with CQC.	Denise Dodd (UEC Matron)	29-Nov-2021	01-Nov: Undertake the audit, deadline: 29-Nov-21 and report back results to CQC by 31-Dec-21. 09-Dec: Project plan for the audit drafted, awaiting confirmation of the plan/progress update. Update meeting 23-Dec cancelled. 06-Jan-22: UEC CBU leads to obtain update on progress with the audit. 10-Jan-22: Audit results received. They demonstrate that room 15 has been used 11 times during December 2021 for patients with Mental Health needs and in each occasion a 1:1 sitter was present to safeguard the patient.	Blue	20-Jan-2022	(1) Audit findings / report	None	An audit has been completed which demonstrates that all patients with mental health needs who have been cared for in Room 15 within Pilgrim ED have had a 1:1 sitter with them to mitigate the fact that the room has not yet had the required alterations to make this ligature free.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
							UEC	Agree a schedule of audits to provide ongoing assurance that enhanced care is provided where needed, including for patients with identified mental health needs.	Holly Carter (Senior Sister, ED)	31-Mar-2022	01-Sep-22: Need latest audit data for the assurance document for PBH. 04-Aug-22: Assurance document for internal confirm and challenge through UEC Governance processes during August before exec assurance meeting in September 22. 07-Jul-22: To meet with Blanche and review assuranc evidence and pull together an assurance document. 09-Jun-22: Need audit data for Apr 22, May 22, Jun 22 _____ 21-Feb-22: Enhanced care is included on the Matrons audits. If gaps in UEC staffing available, escalation needed to OPS matrons to enable extra staff to cover. Lincoln now have improved access to LPFT Mental Health team. 05-Apr-22: Confirmation from Holly that Enhanced care now included on Matron's Audit. Holly also completes a separate audit on a monthly basis (reported to Nick McCauley) - Also on Huddle comms completed by NIC ahead of shift change (room utilisation for previous 12 hours - Was cubicle 15 used Y/N? Was 1:1 used? Holly reports on a monthly basis. Tracey Wall has stipulated that MH patients MUST have 1:1 sitter - There have been no breaches of this since CQC visited (Evidence provided). 25-Apr-22: Audit data available for Dec-21, Jan-22, Feb-22, Mar-22	Blue	31-Mar-2022	(1) Evidence of scheduled audits being undertaken; (2) Appropriate action in response to the audit findings.	(1) Ongoing assurance that audits are continuing.	Audits underway monthly at PBH demonstrate that each time room 15 has been used for a patient with Mental Health conditions, a 1:1 sitter has been assigned and supervised the patient whilst in the room.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
CQC2021-29	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff.	Specialist training for staff specific to their roles was provided. However, effective systems were not in place to ensure staff consistently completed all the required additional training for their roles. We found that an effective system was not in place to ensure midwives responsible for recovering women post anaesthesia were competent to carry out this role. At the time of our inspection, only 24 of the 42 midwives eligible for recovery training had completed this training and a list of competent midwives in recovery was not readily accessible to enable midwives in charge to allocate competent staff to the recovery role. This meant there was a risk that women would be recovered by staff who were not trained to do so. We escalated this during our inspection and the trust told us how they would address this to mitigate this risk. We found no evidence that harm had been caused as a result of this competency gap. (Page 128)	Maternity	Midwives whose training / sign off of competence is outstanding to have obtained competencies. In the interim, where there is a case and a midwife who has not received the training for GA recovery, the theatre recovery nurses will remain in attendance. *NB: Original action planned to have fully completed competence for those midwives outstanding by Dec-*	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-Apr-2022 (PBH); 31-Oct-2022 (LCH).	28-Dec-22: Controls in place and linked into Health Roster. To present as closed at January CQC Assurance Meeting. 28-Oct-22: 13 new midwives will result in a fall in compliance. Action: Libby to raise with Exec-Assurance meeting based on controls in place if this action can be closed as completed. 19-Sept-22: Discussed at the executive assurance meeting. Based on assurance evidence already provided regarding process to recover women in Recovery by	Blue	19-Sep-2022	(1) Assurance provided to CQC directly; (2) Clinical Education team have all the records – reviewed each year during Mandatory training.	(1) Progress against trajectory for outstanding midwives whose training / sign off of competence is outstanding, who work on labour ward; (2) Database of competences is maintained by Education team and consultant midwife; (3) Strengthened reporting to	Assurance evidence available that demonstrates that women recovered following GA are done so in Theatre Recovery, improvement in competency rates and controls around rota planning demonstrate this action has been completed.	Michelle Harris, Chief Operating Officer	People and Organisational Development Committee (PODC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
							Maternity	Look at further strengthening, reduce the likelihood still further, by including this competency as part of roster planning. Scope out during October 2021. *Action amended subsequently to being provided to CQC:*	Libby Grooby (Divisional Head of Nursing and Midwifery)	01-Dec-2021	09-Mar-22: Clarity obtained that B6 midwives will have completed their competencies, whilst B5 will still be going through the process. Therefore Labour Ward would have a higher proportion of midwives competent to recovery women following GA. Evidence to be obtained from Heather's paper going to MNOG. This is on the agenda.	Blue	01-Dec-2021	(1) Rotas that evidence staffing on the unit and higher ratio of B6 nurses to B5.	(1) Rotas that evidence staffing on the unit and higher ratio of B6 nurses to B5.	Evidence obtained that the bulk of midwives are at B6 level ensuring higher level of competencies and therefore able to care for women post theatre.	Michelle Harris, Chief Operating Officer	People and Organisational Development Committee (PODC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
							Maternity	Monitoring of compliance and assurance through the Maternity and Neonatal Assurance Group.	Yvonne McGrath (Consultant Midwife)/ Emma Upjohn (Interim Deputy Head of Midwifery)/Lead Nurse Breast/Gynae	31-Mar-2022		Blue	31-Mar-22	(1) Update provided in the Maternity and Neonatal Assurance Report to the Maternity & Neonatal Oversight Group in November 2021.	(1) Formal reporting on compliance against the agreed trajectories to be included within the Maternity and Neonatal Assurance Report; (2) Include within next MNOG report.	Formal reporting of compliance with Recovery competencies has now been included within the monthly MNOG meeting.	Michelle Harris, Chief Operating Officer	People and Organisational Development Committee (PODC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
CQC2021-28	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	Most staff knew what incidents to report and how to report them and we saw evidence that incidents were being reported however, two of the 14 midwifery staff we spoke with told us they did not always report incidents relating to safe staffing. One staff member told us their manager had told them not to report safe staffing incidents and the other staff member had not recognised that the incident they described to us was potentially a reportable incident. The systems in place to ensure there was shared learning from incidents were not consistently followed. These systems included emailing all staff with this learning and reading out lessons learned and safety information in every handover. This safety update was referred to as a 'newsflash'. Staff did not read the newsflash out during the handovers we observed during our inspection which was not in line with the trust's agreed processes. This meant there was a risk that staff may not access learning from incidents in a timely manner if they were unable to access their emails. Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. Staff told us that managers provided debriefs and support after any serious incident. (Page 128)	Maternity	The incident 'Trigger List' has been provided to all staff and discussed at team meetings. On the back of this link in with the Trust piece of work looking at mapping of the various processes that share learning across both sites.	Paula Izod (Risk Midwife)	31-Mar-2022		Blue	31-Mar-22	(1) Copy of the trigger list.	None.	Trigger list has been shared with staff to raise awareness of incident reporting criteria to support strengthening of current processes.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
							Maternity	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups.	Helen Shelton (Assistant Director of Clinical Governance / Patient Safety Specialist)	31-Dec-2022	31-Dec-22: Review concluded. Survey undertaken that reinforced what we thought in that staff use a number of mediums to share lessons. We have therefore continued to use the following: Patient Safety Briefings Learning to improve Divisional Newsletters quarterly Learning to Improve Trust Newsletter quarterly	Blue	31-Dec-22	(1) Trust level understanding of mechanisms in use to share learning; (2) Evidence of action in response.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
							Maternity	Review the corporate assurance tools to understand what questions are regularly asked of staff and determine if further assurance relating to incidents could be included within these (i.e. ward accreditation review process).	Jeremy Daws (Head of Compliance)	30-Jun-2022	25-Jul-22: B7 and Matrons audit contain questions relating to incidents: o B7 Audit: Are harms or potential harms identified and reported and escalated? If so, has a datix been completed? o Matrons audit: (Quality Governance and Safety): Are Datix/SI's reviewed and being managed within timescale	Blue	25-Jul-22	(1) Review of corporate assurance tools.	None.	Corporate assurance questions reviewed and Matrons audit and B7 audit questions identified as having relevance to incidents and learning from. They do not provide complete assurance going forwards.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
							Maternity	Scope out with Director of Nursing process to review and refresh contents of the corporate ward assurance programme with reference to key themes identified by CQC in their 2021 inspection.	Jeremy Daws (Head of Compliance)	31-Aug-2022	08-Sept-22: Removed from Maternity action plan - not maternity specific but across the board in all areas. Not appropriate to be aligned to this action. 25-Jul-22: To discuss with Angie Davies.	[Abandon & Replace]	TBC	TBC		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
CQC2021-43	Medical care (including older people's care)	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider giving ward managers direct access to training systems for their areas in order to monitor and action mandatory training needs of their teams on a more regular basis.	The trusts target for mandatory training was 90%, the average completion across all the courses for medical wards was 82%. Nursing staff received and kept up to date with their mandatory training. Face to face modules of mandatory training had been reduced during the pandemic. The division had a plan in place to increase this training as the pressure of the pandemic decreased. The trust aimed to be back to 90% by the end of November 2021. During the inspection, bank staff across the trust reported that they did not always feel supported with their mandatory training and having time to complete it. This was raised with the trust and they provided us with assurance that they were looking into mandatory training for bank staff and putting processes in place to	Medical	Scope out with HR/ESR level of access Ward managers have already to ESR which provides oversight in relation to training compliance levels within their teams.	Katy Mooney (Divisional Lead Nurse)	30-Apr-2022	4 May 2023: shared on sharedrive Ward leads access doen from hieracht form. They wil then be able to get the information. ESR report will be pulled from the month before. If new ward lead starts tomorrow would be able to get as soon as start. When have access would log into manager access on ESR and will be able to drill down to what want to look at. Part of the starter checklist - on intranet under recruitment selection policy. Recruitment send to employee?	Blue	04-Oct-22	(1) Understanding of difficulties in obtaining information from ESR; (2) Evidence of access to manager ESR.	None.	Confirmation received demonstrating that all ward leads do have the appropriate access to Manager ESR that enables them to see and access training systems and compliance of staff within their teams to action mandatory training needs of their teams on a more regular basis.	Claire Low, Director of People and Organisational Development (OD)	People and Organisational Development Committee (PODC)	Signed off as complete by Executive-Led assurance process on the 25-May-23.

CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	**Maternity - Pilgrim (Page 64; Safe):** Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. **CYP - Pilgrim (Page 103; Safe):** They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed governance meeting minutes and found that duty of candour had been used for each of the incidents discussed. **Maternity - Lincoln (Page 127; Safe):** Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. **CYP - Lincoln (Page 164; Safe):** Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. The duty of candour is a legal requirement; every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.	Family Health	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Suganthi Joachim (Divisional Clinical Director); Simon Hallion (Divisional Managing Director); Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	01-Mar-23: Assurance document to be written up with evidence for assurance purposes. 28-Oct-22: 100%. _____ 01-Mar-22: Family Health: DoC performance: Women's health and breast services: 2021: 30 incidents; 93% verbal; 73% written 2022: 3 incidents; 100% verbal; 0% written Children and Young Persons: 2021: 4 incidents; 100% verbal; 100% written 2022: 0 incidents Team consider this to be a data quality issue where the relevant field in DATIX is not being updated. Need to check whether written DoC has taken place - Emma to check whether work has been undertaken to ensure outstanding DoC taken place.	Blue	31-Dec-22	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	Performance with Duty of Candour is overseen by the Quality Governance Committee (QGC). Divisions are provided with ongoing support from the central Clinical Governance team. Performance data demonstrates high compliance rates with Duty of Candour. Improvements made by Divisions are reflected in Trust wide compliance data.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Signed off as complete by FH Cabinet on the 17-May-23; Signed off as complete by Executive-Led assurance process on the 25-May-23.
CQC2021-25	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider adding specific action plans to the service risk register.	The service had a corporate risk register for the children and young people service as a whole. This included one risk specific to Pilgrim Hospital; the remainder were more generalised potential risks rather than specific to the current status of the service at Lincoln County Hospital. Mitigating actions were listed to reduce risks however these were not specifically allocated or dated therefore it was not possible to tell from the risk register if these actions were being delivered at the time of inspection. Despite this, we saw managers including the directorate leadership team, matrons and ward manager had a good understanding on active risks to the service at the time of inspection and were able to talk about how these were being specifically mitigated. (Page 182)	CYP	Revised risk register format now being used. Continue to embed the use of this in strengthened governance structures.	Dr Suganthi Joachim (Divisional Clinical Director); Libby Grooby (Divisional Head of Nursing and	31-Mar-2022	01-Feb-23: Assurance data. Review with Jasmine. Governance meeting evidence. 21-Feb-22: At the time of the visit, the Trust was using the previous version of the risk register which contained a list of actions. This has been replaced by a	Blue	20-Apr-22	(1) Maternity risk register in new style format and updated.	(1) Evidence of the risk register being reviewed within Maternity meeting structure and updated as per Trust policy.	The Division's risk register has been revised and strengthened.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Signed off as complete by FH Cabinet on the 17-May-23; Signed off as complete by Executive-Led assurance process on the 25-May-23.
							CYP	Undertake review for assurance purposes that risk registers are being reviewed in line with the Trust policy timescales.	Dr Suganthi Joachim (Divisional Clinical Director); Libby Grooby (Divisional Head of Nursing and	30-Apr-2023	10-May-23: Assurance evidence demonstrates controls in place. Review with Jasmine evidence and consider assurance document. ?Move to green. 01-Mar-23: 01-Mar-23: Assurance data: CYP very high risk overdue (row 152). 6 moderate risks overdue (row 160); 3 low risks overdue (row 164).	Blue	30-Apr-23	(1) Maternity risk register in new style format and updated; (2) Evidence of the risk register being reviewed within Maternity meeting structure and updated as per Trust policy.	(1) Evidence of the risk register being reviewed within Maternity meeting structure and updated as per Trust policy.	Evidence demonstrates ongoing oversight and monitoring of divisional risks on the risk register.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Signed off as complete by FH Cabinet on the 17-May-23; Signed off as complete by Executive-Led assurance process on the 25-May-23.
CQC2021-18	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	Divisional risk register review and oversight processes were not always effective. It was not always clear what the risk was, when the risk was added, and it was unclear who had oversight of the risk registers. Local leaders did not have ownership of the risk register therefore there was the potential for departmental risks to be missed. Whilst most managers could describe risks, they could not always tell us what the risks were on the risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures. (Page 213)	UEC	CBU Risk Register has been refreshed. Embed regular review of risk register at strengthened Governance meeting process.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Apr-2022	21-Feb-22: New style risk register now being used and all UEC risks captured. Continuous work in progress to strengthen the process and oversight. 05-Apr-22: Cheryl and Maxine have met with Helen Hartley to discuss risk register - Request update. 05-May-22: UEC Risk register has been refreshed and reviewed at Governance	Blue	30-Apr-22	(1) Evidence that risks on the register have a named owner; (2) Risks should be clear and concise.	(1) Ongoing evidence of Risk Register review; (2) Evidence from meeting documentation that risk register is being reviewed and is effectively capturing risks.	CBU Risk Register has been refreshed and is regularly reviewed at the strengthened Governance meeting process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
							UEC	Evaluate effectiveness of review of risks in line with Trust Policy over next 3 months: * Very high risk: Monthly review * High risk: Quarterly review * Moderate risk: Quarterly review * Low risk: 6-Monthly review	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Apr-2023	10-May-23: Row 31: None overdue review. Move to green. Assurance document to evidence completion. Liaise with Helen Hartley . 06-Apr-23: None overdue review. 07-Mar-23: * Row 48	Blue	31-May-23	(1) Evidence that risks on the register have a named owner; (2) Risks should be clear and concise; (3) Risks should be reviewed in line with timescales within Trust (new) policy.	(1) Ongoing evidence of Risk Register review; (2) Evidence from meeting documentation that risk register is being reviewed and is effectively capturing risks.	CBU Risk Register has been refreshed and is regularly reviewed at the strengthened Governance meeting process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	**UEC - Pilgrim (Page 41; Safe):** Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, three serious incidents we reviewed showed duty of candour was not applied in line with trust policy. **UEC - Lincoln (Page 196; Safe):** Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, three serious incidents we reviewed showed duty of candour was not always applied in line with trust policy.	UEC	Understand performance with DoC at CBU Level and ensure reliable data is available to feed into monthly Clinical Governance processes.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	23-Feb-22: DoC is currently included in clinical governance process (data from dashboard on Datix). Escalation report given by DoC Leads (Jonathan Thomas-Thompson and Denise Dodd). Understand process of ensuring Datix record completed for both verbal and written DoC is completed. (CHECK VALIDITY OF DATA as UEC team felt compliance was 100%).	Blue	31-Mar-2022	(1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements; (2) inclusion within the	(1) Ongoing regular reporting of DoC into CBU Governance; (2) Ongoing inclusion within the Divisional PRM process.	Division have confirmed that this is a compliance issue and not a data quality issue. UEC performance is being monitored on an ongoing basis.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
							UEC	Review DoC performance data and, through CBU Governance, scope additional improvement actions to be taken.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	31-Mar-22: Update received - DoC report now at UEC CBU Clinical Governance meeting monthly basis - Agenda and minutes supplied as evidence (Rachel Ryalls).	Blue	31-Mar-2022	(1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements.	(1) Use of data to inform improvement action plans.	Duty of candour is now brought through to the strenthened CBU governance meeting for the group's review of latest performance data and	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
							UEC	Achieve 100% compliance within UEC with verbal and written duty of candour.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-Jul-2022	04-Aug-22: Target met, reduced to zero with none overdue by the end of July. Review data for assurance purposes on a monthly basis through Urgent care governance meetings with Helen. Holly and Denise meeting with Helen weekly.	Blue	31-Jul-2022	(1) Performance reporting of DoC compliance within UEC.	(1) Ongoing assurance of DoC performance for UEC.	No overdue duty of candour responses outstanding at the end of July 2022 in line with stated target.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
							UEC	Summarise performance with Duty of Candour and test embedding of improvement actions taken by the CBU.	CBU Leads	31-Mar-2023	10-May-23: Row 23: Medical compliance with DoC training dropped. 06-Apr-23: Assurance data row 26 and training row 29. 02-Feb-23: Assurance data: Row 89 12-Jan-23: Assurance Data: Row 85	Blue	31-Mar-2023	(1) Performance reporting of DoC compliance within UEC.	(1) Ongoing assurance of DoC performance for UEC.	Performance with Duty of Candour is overseen by the Quality Governance Committee (QGC). Divisions are provided with ongoing support from the central Clinical Governance team. Performance data demonstrates high compliance rates with Duty of Candour. Improvements made by Divisions are reflected in Trust wide compliance data.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-09	Trust Wide	Trust	Core Services Inspection 2021	Should Do	The trust should ensure the requirements of duty of candour are met.	The Division of Surgery were not inspected during the October 21 inspection. This 'Should-do' action is based on gaps seen during the inspection where Duty of Candor requirements had not been fully followed.	Surgery	The division of surgery continues to promote duty of candour requirements and monitors compliance on a monthly basis. This is therefore a BAU action and assurance data will be monitored for evidence of compliance.	Catherine Capon (Divisional Nurse, Surgery)	31-Mar-2023	4 April 23: Need to review march data to see whether change 01 March 23: Assurance data: January assurance data showing not responded to duty of candour in January. dip was due to late notifications, we did not know until the end of the month. Its the written follow ups which are the issues. This was discussed at cabinet last week. Verbal being completed. If something goes to rapid review feel need to wait for outcome before write the letter to family. Stressed that this is not the reason why. People waiting for SI being completed. Being stressed with matrons and at cabinet. 01-Nov-22: Assurance data.	Blue	31-Mar-23	(1) IIP Scorecard (2) Monthly PRM	(1) IIP Scorecard (2) Monthly PRM	Performance with Duty of Candour is overseen by the Quality Governance Committee (QGC). Divisions are provided with ongoing support from the central Clinical Governance team. Performance data demonstrates high compliance rates with Duty of Candour. Improvements made by Divisions are reflected in Trust wide compliance data.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-40	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	Divisional risk register review and oversight processes were not always effective. It was not always clear what the risk was, when the risk was added, and it was unclear who had oversight of the risk registers. Local leaders did not have ownership of the risk register therefore there was the potential for departmental risks to be missed. Whilst most managers could describe risks, they could not always tell us what the risks were on the risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures. For example, we reviewed the Pilgrim site ED speciality governance meeting minutes for 11 August 2021. There was reference to the risk register in terms of a discussion about the best way to present to the CQC, however, there was no discussion about risks and actions. Furthermore, there was no	UEC	Include within the UEC risk register the risk around the control of policies and SOPs.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	30-Mar-2022	21-Feb-22: Include within the risk register SOP and Policy control risk. 03-Mar-22: Agreed to include on the UEC risk register. 31-Mar-22: Cheryl has added control of policies and SOPs to UEC Risk Register This will need to go onto DATIX and through Trust confirm and challenge. 27-Sept-22: Seen this is on the UEC risk register.	Blue	30-Mar-22	(1) Addition of risk to risk register.	(1) Addition of risk to risk register.	Assurance received that this has been included within the UEC risk register.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.	The design, maintenance and use of facilities, premises and equipment did not always keep people safe or follow national guidance. (Page 4 and 7) **UEC - Pilgrim (Page 30-31; Safe):** The design of the environment did not always follow national guidance. However, following our focused inspection in 2020 action was taken to improve the department. Reconfiguration works at Pilgrim hospital included a new x-ray room, an additional triage room, a modular waiting room, a fit to sit area and paediatric emergency department (ED). Patients were no longer cared for in the central area of majors. All majors' patients were streamed to a cubicle if they required a trolley. Furthermore, a fit to sit area had been created within majors and in the main waiting room. Patients attending by ambulance were held on ambulances when the department was at capacity. Whilst this was not what senior staff in the department wanted it allowed for patients to be monitored by ambulance staff whilst waiting f the department. In order to improve safety, patients were reviewed on arrival by the pre-hospital practitioner (PHP). Patients presenting with acute mental health concerns did not have access to a dedicated room which met national guidance relating to the provision of a safe environment. Staff told us a patient requiring additional supervision would be placed in an observable majors' bay. However, due to the layout of the department patients who were at risk of self-harm could have access to rooms and equipment which had the potential to cause harm. For example, the clean procedures room was easily accessible and we saw contained hazardous equipment. Toilets and bathrooms were accessible and contained ligature points. Following our inspection, the trust provided us with a plan to reinstate a mental health room (room 15) which was intended to be modified to meet appropriate standards. As an interim, the trust advised us any patient with mental health conditions requiring use of the room will receive one to one supervision. The trust confirmed they had also removed ligature risks identified in this room. **UEC - Pilgrim (Page 51 ; Safe):**	Corporate	Service specific actions relating to the estate (i.e. the £37m development of a new Emergency Department at Pilgrim) are outlined within the service level improvement action plans.	For further detail see the service level improvement action plans.	For further detail see the service level improvement action plans.	04-Mar-22: The Trust Board have approved at 2-year estates strategy at their meeting on the 1 March 2022. Delivery of "A modern, clean and fit for purpose environment" is one of the key objectives of the Trust's Board Assurance Framework (BAF) for 2021/22. ULHT submitted an 'Expression of Interest' for the Health Infrastructure Plan Future New Hospitals scheme 2021. This totals a £560m investment across our three acute sites in Lincoln, Boston and Grantham.	Blue	30-Jun-23	(1) FPEC assurance report received in June 2023.	(1) FPEC ongoing oversight as part of BAU monitoring, as agreed by FPEC in June 2023.	A summary document was produced outlining the various controls and assurances in place to demonstrate that this CQC Should-Do action had been taken. The Trust's Finance, Performance and Estates Committee (FPEC) considered this evidence at their meeting in June 2023 and agreed. Whilst this action is marked as completed, FPEC will continue to oversee Trust compliance against these areas as part of their Business as Usual (BAU) approach.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
							Corporate	Undertake a 6-facet survey to refresh the Trust's understanding of current estate conditions to further support the Trust to take a risk based approach.	Michael Parkhill (Director of Estates & Facilities)	31-Dec-2022	28-Jul-23: Agreed at Exec-Led CQC Assurance meeting that now that 6-facet survey has commenced, this will, on publication, support the ongoing development of estates plans. This will be a part of Business as Usual. Agreed to link to wider FPEC assurance piece and move to blue. 13-Jul-23: The Trust have commissioned a 6-facet survey which will commence during July 2023 with external contractors visiting site to commence this work through July - September. 04-Mar-22: The Trust Board have approved at 2-year estates strategy at their meeting on the 1 March 2022. Delivery of "A modern, clean and fit for purpose environment is one of the key	Blue	30-Jun-23	(1) Evidence that 6-facet survey has commenced.	None.	The 6-facet survey has commenced during July 2023. This will link into the development of future estate plans. This links to the wider assurance document summarising estate controls that FPEC have considered and approved.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

						The department was not designed to meet the needs of patients living with dementia. Most areas of the department were bright, busy and noisy which some groups of patients might find distressing, and there were very few side rooms where quieter care could be provided. **Medical Care - Pilgrim (Page 71; Safe):** The design of the environment did not always follow national guidance. Some of the wards we visited were old and required refurbishment. The trust had plans in place regarding refurbishments and were working through the wards. Time scales were sometimes changeable according to ward risks. However, senior ward staff and matrons were aware of changes and involved in ensuring the wards they were being decanted into were suitable for the patients within their care. For example; the cardiac monitored patients would all be moved into an area that would always be able to provide the same monitoring facilities to ensure safety of the patient. The discharge lounge was an old mental health secure unit. There was identified space in each bay for six patients. However, there were only effective curtained areas for four patients. This meant if the area did reach capacity some patients may not be afforded privacy. (Health Building Note 04-01 – Adult in-patient facilities 4.21 Privacy). **Medical Care - Lincoln (Page 135; Safe):** The design of the environment did not always follow national guidance. Some of the wards we visited were old and required refurbishment. The trust had plans in place regarding refurbishments and were working through the wards. The trust had recently carried out some refurbishment works on Coleby ward, Clayton ward, Lancaster ward and Medical Emergency Assessment Unit (MEAUB). However, staff did report that timescales could change and they weren't fully assured the improvements would be made. The service had enough suitable equipment to help them to safely care for patients. However, there was no telemetry available in the Medical Emergency Assessment Unit (MEAU) and to enable staff to safely monitor patients they would be required to sit in the patients bed area to monitor the screen. Staff working on the ward managed this risk by using the extra member of staff to complete these observations who would usually assist with admissions. **CYP - Lincoln (Page 157-158; Safe):**	Corporate	The Trust is continuing to focus on strengthening its Planned Preventative Maintenance (PPM) regime with ongoing assurance reporting through the Trust's Finance, Performance and Estates Committee. This is supported by the appointed Authorising Engineers (AEs) across the Trust focussed on all aspects. The Premises Assurance Model (PAM) provides a key assurance function as part of this process. This is a business as usual action.	Michael Parkhill (Director of Estates & Facilities)	31-Mar-23	28-Jul-23: Executive-Led CQC Assurance meeting considered this to be closed following FPEC approval. Evidence embedded in FPEC report. Move to blue. 13-Jul-23: Paper submitted to FPEC in June outlining controls and assurances and embedded evidence. FPEC have approved the closure of this Should-Do action. This will continue to be overseen as a BAU action by the committee. Need to ratify for completeness via Exec Led CQC assurance meeting. 09-Mar-22: PPM regime is key. Over the last 18 months the Trust has appointed AE for all aspects of what we do. The AE act as external independent advisors to CEO and BOARD. PAM tells us we have gaps in controls and describes the risks and mitigations. This reports through to FPEC who oversee. FPEC receive regular assurance reports outlining the number of PPMs supposed to complete in the month/broken down to what we have done. Recent focus has been to ensure this is focussed on the statutory PPMs. Maintenance regime is based on national statutory guidance i.e. water. AES will audit the Trust to ensure we are doing what we should be doing. AEs report specifically, guided by the HTM reporting structure. They will sit on key groups (i.e. water safety group) with upward reporting to oversight groups (i.e. IPC, H&S). There has been a backlog of reported maintenance jobs. External support to clear the backlog is underway and the helpdesk has been relaunched with more staff on it.	Blue	30-Jun-23	(1) FPEC assurance reporting of progress with planned preventative maintenance regime; (2) FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; (3) PAM assurance reporting into FPEC; (4) FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; (5) AE reporting from key subgroups (i.e. water, fire, electrical).	(1) FPEC assurance reporting of progress with planned preventative maintenance regime; (2) FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; (3) PAM assurance reporting into FPEC; (4) FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; (5) AE reporting from key subgroups (i.e. water, fire, electrical).	A summary document was produced outlining the various controls and assurances in place to demonstrate that this CQC Should-Do action had been taken. The Trust's Finance, Performance and Estates Committee (FPEC) considered this evidence at their meeting in June 2023 and agreed. Whilst this action is marked as completed, FPEC will continue to oversee Trust compliance against these areas as part of their Business as Usual (BAU) approach.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred. For the reporting period October 2020 to September 2021, compliance with the duty of candour regulation had been variable (verbal compliance 84%, written compliance 68%). The board were sighted on duty of candour performance and had taken a number of actions to address this. Further planned actions included; commissioning a piece of investigative work to review the way in which the trust record duty of candour compliance to try and understand the variability in the data, refresher training for staff covering duty of candour requirements and a review of the trust's duty of candour policy and related documentation to ensure it was fit for purpose. (Page 13) UEC - Pilgrim (Page 41; Safe): Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, three serious incidents we reviewed showed duty of	Corporate	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Divisional/CBU Leads (see Divisional / CBU CQC Improvement Action Plans)	31-Dec-2022	09-Jan-23: To ascertain assurance data.	Blue	31-Mar-23	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met; (3) Oversight through PRM process.	Performance with Duty of Candour is overseen by the Quality Governance Committee (QGC). Divisions are provided with ongoing support from the central Clinical Governance team. Performance data demonstrates high compliance rates with Duty of Candour. Improvements made by Divisions are reflected in Trust wide compliance data.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	11 July 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 inc process and timeframe for mandatory training review** The Committee received the upward report noting that the group had considered the performance dashboard in detail. Significant time had been spent by the group considering mandatory and statutory training with the Committee noting the impact being had by the Education and Learning Team which was now fully in place. Mapping of training requirements to role was in its infancy however timelines were being put in place which would be offered to the Committee. There continued to be small improvements seen in appraisal rates with some system issues identified which, once resolved, were anticipated to have a positive impact on the completion rate. The Committee noted the positive position in respect of Doctor appraisals and sought clarity on the reporting of appraisal rates to ensure this was appropriately sighed at both Committee and Board level. **Committee Performance Dashboard** The Committee received the dashboard noting the information presented which had been considered in detail by the Workforce Strategy and Organisational Development Group and considered through the upward report of the group.

	Safer Staffing inc nursing additional hours The Committee received the report and noted there were no escalations to be made. Care Hours Per Patient Day continued to move in the right direction with staffing fill rates, vacancies and agency use. Triangulation against quality indicators continued to demonstrate the positive position reported. The Committee noted the focus on midwifery in the monthly report and the ratio of 1:23 for midwives to expectant mothers, against a birth rate plus ratio of 1:28. The Committee received a verbal update on the June position noting that the positive position continued and there had been reduced agency use and spend with a period of time reported with no off-framework agency usage. **Update band 2 to band 3 job descriptions for Healthcare Support Workers** The Committee noted the progress being made in respect of the review of job descriptions with sessions being held throughout June and July to understand the current position of clinical and nursing care being provided. The Committee would await the outcome of the sessions for the development of this work. **Trauma and Orthopaedic Deep Dive** The Committee received the deep dive and associated recommendations noting the intention for the action plan to be developed in order to continue to offer support to the service to further improve the culture.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Workforce Race Equality Standards and Workforce Disability Equality Standards Action plans** The Committee received the action plans for WRES and WDES noting that these had been externally evaluated and a good rating issued. Progress was being made in respect of the actions identified with support in place through the staff networks. **Freedom to Speak Up Quarterly Report** The Committee received the report and noted the recent praise from the National Guardians office due to the work being undertaken in the Trust. The Committee noted the positive improvements being seen and the number of staff feeling confident in raising concerns. The Committee considered the Freedom to Speak Up Training that was currently being

	discussed in order to determine if this would be mandatory training for all staff. The Committee also noted the 40 champions in place across the organisation and noted the ongoing work to identify further champions in additional areas. **Responsible Officer revalidation annual report** The Committee received the report noting that there we no escalations and noted that, in line with recent standard changes, the report for the following year would be amended. The Committee recommended the report to the Board for approval.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **University Teaching Hospital Group Upward Report** The Committee received the report noting the progress being made, particularly around the development of the joint strategy with the University. The Committee noted the intention to pursue teaching status only at this time and that this had been confirmed with the Department of Health and Social care with the intention of this being achieved by the end of the year. The Trust continued to develop the relevant portfolios of information in order to support the application process. **Quarterly Research and Innovation Update** The Committee received the report noting the current position of 135 participants in research trials and the intention that, with the opening of further trials additional participants would be recruited. The Committee requested sight of the recruitment to trials trajectory to ensure that the Trust was on target to achieve 2000 participants by the end of the year as anticipated. It was recognised that there had been a recent engagement session with the Trust Leadership Team around research and innovation in order to provide guidance to staff and support to the R&I to further develop activity.
	Assurance in respect of other areas: **Draft Terms of Reference and Work Programme** The Committee received the draft documents noting the proposed changes and the need to offer clear articulation of the education element that the Committee would seek assurance of.

	Integrated Improvement Plan The Committee received the report noting the content and the update provided for Q1 reflecting that the position presented was as expected. **Internal Audit Recommendations** The Committee received the report noting the position of the recommendations and the requirement for actions to be updated. **CQC Action Plan inc CQC Single Assessment Framework update** The Committee received the report noting the progress being made in respect of the action plan and the work ongoing, specifically in relation to mandatory training. The actions underway in respect of the single assessment framework were noted with the divisions being asked to complete a self-assessment against the domains in order to provide a baseline position. **Savile Action Plan** The Committee received the report noting the discussions around the 3-year DBS cycle and the current position. It was recognised that there was a need to seek financial support to cover the costs of the checks being undertaken by the Trust due to the scale of the work with over 4000 checks needing to be performed this financial year. Once the work had been completed in year the figures would reduce moving in to the 3-year cycle aligned with recruitment processes.
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	S	O	N	D	J	F	M	A	M	J	J
Philip Baker (Chair)	No meeting held	X	X	X	X	X	X	X	No meeting held	X	X	X
Gail Shadlock												
Karen Dunderdale		X	X	D	A	D	A	D		D	D	D
Paul Matthew		X	X									
Claire Low				X	X	X	X	X		X	X	X
Colin Farquharson		D	D	D	D	D	D	D		D	D	D
Chris Gibson		X	X	X	X	X	X	X		X	X	A
Vicki Wells		A	A	X	X	X	A	X		X	X	X

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 September 2023*
Item Number	*Item 9.2*

Workforce Disability Equality Standards (WDES) Action Plan

Accountable Director	*Claire Low, Director of People and Organisational Development*
Presented by	*Alison Marriott, Equality, Diversity and Inclusion Project Manager*
Author(s)	*Alison Marriott, Equality, Diversity and Inclusion Project Manager*
Report previously considered at	*Workforce Strategy and OD Group; Equality, Diversity and Inclusion Group* *People and Organisational Development Committee*

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	
3b Efficient use of our resources	*X*
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	*New*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *To receive and note the Report and Action Plan*

Executive Summary

The **Workforce Disability Equality Standard (WDES)** is an annual data collection, analysis and action-planning requirement that highlights the experiences of Disabled colleagues compared to their non-Disabled counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract, to improve the experience and outcomes for Disabled colleagues.

The WDES requires NHS organisations to demonstrate progress against 10 metrics specifically focused on disability equality and suggests actions to address the disparities identified. The data and statistics used in this report reflect Workforce indicators from ESR and Trac as at 31st March 2023, NHS Staff Survey results from the latest (i.e. 2022) staff survey, and a Board representation indicator.

This WDES report and action plan has been developed in line with the national NHS EDI Improvement Plan, launched in June 2023, and following a process of face-to-face and virtual engagement sessions with a wide range of stakeholders, kindly facilitated by Ryan Kelleher, Improvement Manager.

In line with NHS England WDES reporting, the term “Disabled” is used in this report, but it is acknowledged that some colleagues may more readily identify as having a long-term condition or being neuro-diverse, rather than a disability.

Areas where the Trust is performing well and has seen significant improvement are:

- ✓ Confidence of Disabled colleague to report bullying, harassment and abuse remains strong, and above average
- ✓ The extent to which Disabled colleagues feel the Trust values their work has improved significantly, by 8 percentage points in the last year.
- ✓ The level of satisfaction with reasonable adjustments is around national NHS average, and this is before full implementation of improvements
- ✓ Levels of bullying, harassment and abuse are improving (WDES indicator 4a)
- ✓ The Trust is performing well at enabling Disabled colleagues to have a voice
- ✓ Satisfaction with fairness of career progression is improving for Disabled colleagues too

Areas of most concern/focus are:

Indicator	**Major Actions Proposed**
Indicator 1 – Representation at all bands compared to overall percentage of Disabled colleagues working in the Trust	• Launch Mutual Mentoring Programme • Career Conversations for all, but also targeted support for Disabled colleagues • Action for Indicator 2 - a deep and broad inclusive recruitment review. From multiple perspectives, throughout the whole process, end-to-end. • Talent Management plan for diversity in Executive and Senior Leadership roles (national NHS EDI Improvement Plan requirement)
Indicator 9 – Trust Board representation	• Trust Board to agree their EDI objectives in line with national NHS EDI Improvement Plan • A Trust Board-specific inclusive recruitment review

The committee are asked to receive and note the Report and Action Plan and to confirm the Report and Action Plan can be progressed to full Trust Board.

NHS
United Lincolnshire Hospitals
NHS Trust

Workforce Disability Equality Standard (WDES) Report and Action Plan 2023-2024

Alison Marriott

EDI Project Manager

OUTSTANDING CARE
personally DELIVERED

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Introduction

The **Workforce Disability Equality Standard (WDES)** is an annual data collection, analysis and action-planning requirement that highlights the experiences of Disabled colleagues compared to their non-Disabled counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract, to improve the experience and outcomes for Disabled colleagues.

The WDES requires NHS organisations to demonstrate progress against 10 metrics specifically focused on disability equality and suggests actions to address the disparities identified. The data and statistics used in this report reflect Workforce indicators from ESR and Trac as at 31st March 2023, NHS Staff Survey results from the latest (i.e. 2022) staff survey, and a Board representation indicator.

This WDES report and action plan has been developed in line with the national NHS EDI Improvement Plan, launched in June 2023, and following a process of face-to-face and virtual engagement sessions with a wide range of stakeholders, kindly facilitated by Ryan Kelleher, Improvement Manager.

In line with NHS England WDES reporting, the term “Disabled” is used in this report, but it is acknowledged that some colleagues may more readily identify as having a long-term condition or being neuro-diverse, rather than a disability.

Summary

4.22% of the ULHT workforce is Disabled (Source: ESR).

This is up 0.74% compared to last year

7.82% of the workforce is "Unknown"

The number of "unknowns" is down 1.4% on last year

While the WDES uses ESR as the data source for these metrics, it is important to note that in the staff survey (NSS) results for 2022, the percentage of respondents at ULHT identifying as disabled or having a long-term condition was **23.5%.** This suggests that there continue to be more disabled colleagues working at the Trust than are known in ESR.

Areas where the Trust is performing well and has seen significant improvement are:

- ✓ Confidence of Disabled colleagues to report bullying, harassment and abuse remains strong, and above average
- ✓ The extent to which Disabled colleagues feel the Trust values their work has improved significantly, by 8 percentage points in the last year.
- ✓ The level of satisfaction with reasonable adjustments is around national NHS average, and this is before full implementation of improvements
- ✓ Levels of bullying, harassment and abuse are improving (WDES indicator 4a)
- ✓ The Trust is performing well at enabling Disabled colleagues to have a voice
- ✓ Satisfaction with fairness of career progression is improving for Disabled colleagues too

Areas of most concern/focus are:

Indicator	Major Actions Proposed
Indicator 1 – Representation at all bands compared to overall percentage of Disabled colleagues working in the Trust	• Launch Mutual Mentoring Programme • Career Conversations for all, but also targeted support for Disabled colleagues • Action for Indicator 2 - a deep and broad inclusive recruitment review. From multiple perspectives, throughout the whole process, end-to-end. • Talent Management plan for diversity in Executive and Senior Leadership roles (national NHS EDI Improvement Plan requirement)
Indicator 9 – Trust Board representation	• Trust Board to agree their EDI objectives in line with national NHS EDI Improvement Plan • A Trust Board-specific inclusive recruitment review

Workforce Disability Equality Standard (WDES) Action Plan 2023-24

WDES Indicator	Current WDES Performance	Lead	Actions	Timescale
1. Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce. NHS EDI Improvement Plan: High Impact Action 2 *"Embed fair and inclusive recruitment processes and talent management strategies that target under-representation & lack of diversity"*	 Please see Appendix 1	Director of People & OD Supported by: Deputy Director, People & OD (Nico) Deputy Director, People & OD (Lindsay) Leads of Recruitment, EDI & OD (Simon, Alison, Damien) Staff Networks Lincolnshire ICB People Hub	Establish **Mutual Mentoring Programme** – "Mentoring Together" and include Disabled colleagues in the programme, with reasonable adjustments where required. Continue with **Career Conversations** action from Gender Pay Gap Action Plan, extending to all - including Disabled colleagues Establish meaningful career conversations with both Disabled and non-disabled colleagues, to ensure targeted career support, including reasonable adjustments where required, to remove barriers to progression. Establish and enact a **talent management plan for Executive and Senior Leadership Teams**, which includes improvements in the diversity of these teams Implement a plan to **widen recruitment opportunities within local communities**, aligned to the NHS Long Term Workforce Plan and Lincolnshire Integrated Care Board (ICB). To include those with disabilities, including pathways into employment for those with Physical Disabilities, Learning Disabilities or Difficulties, Autism, ADHD, Dyslexia, Dyscalculia, Sensory Processing Disorder and other neuro-diversities.	To establish actions and launch both by January 2024: Mutual Mentoring – Launch at end October 2023 Career Conversations – January 2024 ELT/TLT Talent Management Plan – by June 2024 Wider recruitment opportunities & social mobility – by October 2024

			Ensure that **medical engagement work** recognises and works to actively improve the confidence of medical colleagues to share that they have a disability or long-term condition. **Measurable outcomes:** • Improvement in the relative likelihood of being appointed (please also see Indicator 2 below) • Improvement in the National Staff Survey (NSS) question "Access to career progression, training & development opportunities" • Year-on-year improvement in disability and race representation, including senior leadership (Bands 8c and above) • Improvement in HEE NETS (National Education & Training Survey) metric on quality of training • Declaration of long-term condition or disability in ESR has increased by 2% for all colleagues, including medical colleagues. **All of the measurable outcomes in this plan are linked to the NHS EDI Improvement Plan, published in June 2023** NHS equality, diversity and inclusion (EDI) improvement plan | NHS Employers	Ongoing and embedded into all medical engagement by January 2024
2. Relative likelihood of staff being appointed from shortlisting across all posts. **High Impact Action 2**	 Trust overall: 1.16	**Director of People & OD** Supported by:	The use of a more reliable source of data (Trac) this year, as planned in last WRES and WDES Action Plans, has highlighted that it is more likely that a shortlisted candidate will be appointed to the role if they do not state their disability or long-term condition when they apply, but leave it as "unknown" in Trac. Feedback from colleagues and	Review completed and actions identified & agreed by end October 2023

		Deputy Director, People & OD (Nico) Deputy Director, People & OD (Lindsay) Leads of Recruitment & EDI (Simon, Alison) MAPLE Staff Network	applicants with lived experience confirms that the wording in Trac does not provide an encouraging message to share this information. The Trust will undertake **a deep and broad Inclusive Recruitment review**, including feedback from staff networks, use of the CQ-Leading Inclusively model and "No More Tick Boxes" guidance NHSE-Recruitment-Research-Document-FINAL-2.2.pdf (england.nhs.uk). The aim is to ensure that the process and training is even more inclusive from end-to-end, at all touchpoints, from the perspective of candidates with many different long-term conditions and disabilities, as well as recruiting managers and the recruitment team. The Trust is also aiming to achieve **Disability Confident Leader** status by end March 2024, and continuing actions around education and awareness of reasonable adjustments and different long-term conditions, and making the process of implementing reasonable adjustments clearer and easier. To ensure easy access to **resources** for candidates, colleagues and line managers regarding **Neuro-diversities** and how to support **Measurable outcomes** • Improvement in the relative likelihood of being appointed score, with overall aim of parity (1.0) • Aim to increase the percentage of applicants happy to say that they are disabled or have a long-term condition in Trac by 2%	Identified actions completed and in place by end April 2024 End March 2024 (in line with renewal of Disability Confident Employer award scheme, April 2024) End February 2024

3. Relative likelihood of staff entering the formal capability procedure. **High Impact Action 6:** *"Create an environment that eliminates the conditions in which bullying, harassment, discrimination and physical violence at work can occur"*	 Trust overall ratio: 2.85 National average NHS: 1.94	**Director of People & OD** Deputy Directors of People & OD (Lindsay, Nico) Lead for EDI & MAPLE network	To continue with the Culture & Leadership Programme (CLP), including **launch and embedding of the Mersey Restorative Just and Learning Culture model** at the Trust. Restorative Just and Learning Culture :: Mersey Care NHS Foundation Trust This data is based on a two-year average, and in the second year (i.e. last 12 months from 31st March 2023) there had been no Disabled colleagues entering the formal capability procedure. **Review Capability procedure** with the MAPLE staff network. **Measurable outcomes** • Reduce disparity ratio to national NHS average and then 1.0 (parity) • Reduction in number of formal grievances and dignity at work cases • Continued reduction in Employment Tribunals citing disability discrimination	June 2024 By end April 2024

4a. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months Percentage of staff experiencing bullying, harassment or abuse from managers in the last 12 months Percentage of staff experiencing bullying, harassment or abuse from other colleagues in the last 12 months **High Impact Action 6**	 All 3 areas are improving. But there is still disparity, i.e. Disabled colleagues are more likely to experience these behaviours, than those without a disability or long-term condition	**Deputy Directors of People & OD** Lead for EDI (Alison) plus United against Discrimination working group	**Complete the implementation of United against Discrimination actions:** • Launch QR code reporting system, which includes anonymous option • Develop a workshop (virtual and face-to-face options) for "calling-out" and "calling-in". Topics to include: racism, LGBTQ+ hate, misogyny, ageism, religious discrimination, ableism etc. Develop in conjunction with Staff Networks. • Start regular discrimination case and outcome reporting, through the People & OD Scorecard. To continue with the **Culture & Leadership Programme** with emphasis on respect and civility. **Measurable outcomes from 2023-2024 onwards:** • Continue upward scores and positive trajectory for NSS results for this indicator and achieve 'national average score' for Acute Trusts in all related indicators • Achieve above average scores and position ULHT in upper quartile for NSS results for all related indicators	In progress Target completion date: 30th September 2023 June 2024
4b. Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	 As with the previous year's data, disabled staff or their colleagues are more likely to report it, and this has	**Freedom to Speak Up Guardian** Lead for EDI (Alison) plus United against Discrimination working group	To continue with Freedom to Speak Up and United against Discrimination actions to encourage all to report harassment, bullying or abuse at work so that it can be addressed and resolved at the earliest opportunity **Measurable outcome:** • To maintain the Trust's above-average performance in this indicator. • To learn from the experiences of Disabled people and their colleagues who have spoken up, to encourage	Ongoing By April 2024

	increased. It sits above the national NHS average. For note: confidence to report has decreased for those without a disability or long-term condition and sits below the national NHS average.		those without a disability to report harassment, bullying or abuse at work – as measured by any improvement in this metric for those without a disability.	
5. Percentage believing that trust provides equal opportunities for career progression or promotion **High Impact Action 2**	 48.4% National NHS average: 51.4%	**Deputy Directors People & OD (Nico, Lindsay)** Supported by: Leads of Recruitment, EDI & OD (Simon, Alison, Damien)	**Mutual Mentoring "Mentoring Together" & Career Conversations** – as per Indicator 1. **Inclusive recruitment review** – as per Indicator 2. **Measurable outcomes** • Incremental improvement in NHS Staff Survey results for 2023/24 onwards: • Achieve 'national average score' for Acute Trusts in this indicator • Achieve above average score and position ULHT in upper quartile for this indicator.	Mutual Mentoring – Launch at end October 2023 Career Conversations – By January 2024 Recruitment review completed and actions identified & agreed by end October 2023 Identified actions completed and in place by end April 2024

6. Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	 30.4% National NHS average: 30%	**Associate Director - OD, Wellbeing & Inclusion** Lead for EDI (Alison) MAPLE Staff Network	Whilst the Trust is on track with national benchmarking, Disabled colleagues are still 8% more likely to feel under pressure to attend work despite not feeling well enough, compared to those without a disability or long-term condition. Therefore, it is important to continue the **work on reasonable adjustments and the education/awareness action** under United against Discrimination.	30th September 2023 – United against Discrimination April 2024 – Reasonable Adjustments work
7. Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	 31.9% National NHS Average: 32.5% This score has rapidly-improved by 8% against declining position nationally	**Associate Director - OD, Wellbeing & Inclusion** Lead for EDI (Alison) MAPLE Staff Network	**Mutual Mentoring "Mentoring Together" & Career Conversations** – as per Indicator 1. **Inclusive recruitment review** – as per Indicator 2. **Measurable outcomes** • Incremental improvement in NHS Staff Survey results for 2023/24 onwards: • Achieve 'national average score' for Acute Trusts in this indicator • Achieve above average score and position ULHT in upper quartile for this indicator.	Mutual Mentoring – Launch at end October 2023 Career Conversations – By January 2024 Recruitment review completed and actions identified & agreed by end October 2023 Identified actions completed and in place by end April 2024
8. Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	 71.5%	**Associate Director - OD, Wellbeing & Inclusion** Lead for EDI (Alison) MAPLE Staff Network	To continue the **work on Reasonable Adjustments** to full implementation. To then **consider the feasibility and benefits of a centralised budget** to fund reasonable adjustments.	April 2024 By September 2024

	National NHS Average: 71.8%		**Measurable Outcomes:** • To achieve Disability Confident Leader award • To fully-achieve national NHS average and position ULHT in the upper quartile for this indicator	April 2024 NSS 2023 and 2024 results
9a. The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. 9b. Have you taken action to facilitate the voices of disabled staff to be heard in your Trust?	 Trust Overall: 6.4 Disabled staff: 6.2 National NHS Average for Disabled staff: 6.4 9b – yes 	**Associate Director - OD, Wellbeing & Inclusion** Lead for EDI (Alison) MAPLE Staff Network	To ensure that all disabled staff are well-supported in the Trust, with consistency of positive experience in all Divisions - including those with less-visible disabilities, mental health conditions and wellbeing (including men – with the establishment of a men's network) and those who are neuro-diverse. **Measurable Outcomes for 9a & 9b:** • To reach national NHS average for Disabled staff • To position ULHT in the upper quartile for this indicator • Continued growth (numbers) of MAPLE staff network and meaningful involvement of members in initiatives & actions	April 2024

10. Percentage difference between the organisation's Board voting membership and its overall workforce representation. **High Impact Action 1:** *"Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable"*	 See Appendix 1		There is no representation on ULHT Board**.** Disabled colleagues/those with long-term condition more-accurately represent c.20% of the overall workforce (Source: NSS 2022), compared to 4.22% in ESR. c.11% of the Lincolnshire population has a disability or long-term condition which impacts on daily life (Source: Census, 2021) **Trust Board to agree EDI objectives** which are SMART and have been cascaded & communicated widely in the Trust. One of these objectives should aim to increase the diversity and representation of BME and Disabled people holding voting membership of the Board. **Inclusive Recruitment and Selection review** specifically regarding Board recruitment process, with improvements identified & agreed. **Measurable Outcomes** • In 2026, Trust Board representation is in line with the Lincolnshire population we serve, based on 2021 Census data for the county of Lincolnshire. That it also reflects our workforce, which is more diverse in terms of ethnic background and disability/long-term conditions than the Lincolnshire population, at around 20% Trust-wide for both – based on NSS 2022 data which is generally higher than ESR because it is anonymous. • The Board has reviewed relevant data to understand where EDI areas of concern are, including this WDES action plan, and prioritised actions. Progress will be tracked and monitored via the Board Assurance Framework (BAF).	By end September 2023 By end December 2023 By end 2026 By March 2024

Appendix 1

Indicator 1 – Representation at each Band, compared to Trust overall percentage

1a) Total Workforce: 4.22% AfC Non-Clinical: 5%	Agenda for Change Non-Clinical Workforce			
	Disabled	**Not Disabled**	**Unknown**	**Percentage of Disabled staff in each band**
Under Band 1	0	2	0	0%
Band 1	2	29	17	4.2%
Band 2	66	1204	171	4.6%
Band 3	33	501	31	5.8%
Band 4	14	291	30	4.2%
Band 5	11	170	9	5.8%
Band 6	10	128	7	3.5%
Band 7	3	88	1	3.3%
Band 8a	3	52	2	5.3%
Band 8b	4	32	4	10%
Band 8c	0	16	1	0%
Band 8d	0	8	1	0%
Band 9	1	11	1	7.7%
VSM	0	4	1	0%

1b) AfC Clinical: 4.4%	Agenda for Change Clinical Workforce			
	Disabled	Not Disabled	Unknown	Percentage of Disabled staff in each band
Under Band 1	1	7	0	12.5%
Band 1	0	0	0	N/A
Band 2	40	1013	75	3.8%
Band 3	15	209	14	6.3%
Band 4	13	296	7	4.1%
Band 5	73	1372	119	4.7%
Band 6	49	868	68	5.0%
Band 7	23	489	28	4.2%
Band 8a	7	190	19	3.2%
Band 8b	0	39	4	0%
Band 8c	0	18	1	0%
Band 8d	1	8	2	9.1%
Band 9	0	5	0	0%
VSM	0	0	1	0%

1c) Medical: 1.26%	Medical & Dental Workforce			
	Disabled	Not Disabled	Unknown	Percentage of Disabled staff in each band
Consultants	1	323	41	0.3%
Non-consultant career grade	3	220	22	1.2%
Trainee grades	9	377	32	2.15%
Other	0	0	0	N/A

Indicator 9 – Representation on Trust Board

	Disabled	Not Disabled	Unknown
Total Board members	0	6	9
of which: Voting Board members	0	4	7
: Non-Voting Board members	0	2	2
Total Board members	0		2
of which: Exec Board members	0	5	2
Non Executive Board members	0	1	7
Number of staff in overall workforce	7021	1871	169
Percentage Difference: Total Board – Overall Workforce	-4%	-48%	52%
Percentage Difference: Voting Membership – Overall Workforce	-4%	-52%	56%
Percentage Difference: Executive Membership – Overall Workforce	-4%	-17%	21%
Trend (compared to 2022) – Overall Workforce & Voting Membership	**1% lower**	**10% lower**	**11% higher**

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 September 2023*
Item Number	*Item 9.2*

Workforce Race Equality Standards (WRES) Action Plan

Accountable Director	*Claire Low, Director of People and Organisational Development*
Presented by	*Alison Marriott, Equality, Diversity and Inclusion Project Manager*
Author(s)	*Alison Marriott, Equality, Diversity and Inclusion Project Manager*
Report previously considered at	*Workforce Strategy and OD Group; Equality, Diversity and Inclusion Group* *People and Organisational Development Committee*

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	
3b Efficient use of our resources	*X*
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	*New*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *To receive and note the Report and Action Plan*

Executive Summary

The **Workforce Race Equality Standard (WRES)** is an annual data collection, analysis and action-planning requirement that highlights the experiences of Black, and Minority Ethnic (BME) colleagues compared to their white counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract, to improve the experience and outcomes for BME colleagues.

The WRES requires NHS organisations to demonstrate progress against nine metrics specifically focused on race equality and suggests actions to address the disparities identified. The data and statistics used in this report reflect Workforce indicators from ESR and Trac as at 31st March 2023, NHS Staff Survey results from the latest (i.e. 2022) staff survey, and a Board representation indicator.

This WRES report and action plan has been developed in line with the national NHS EDI Improvement Plan, launched in June 2023, and following a process of face-to-face and virtual engagement sessions with a wide range of stakeholders, kindly facilitated by Ryan Kelleher, Improvement Manager.

In line with NHS England WRES reporting, the acronym BME (Black & Minority Ethnic) is used on this occasion, instead of possible alternatives such as “minoritised”.

Areas where the Trust is performing well and has seen significant improvement are:

- ✓ Indicator 3, which is relative likelihood of entry into formal disciplinary process if you are Black or Minority Ethnic
- ✓ Continuing success in Indicator 4, relative likelihood of accessing non-mandatory training & CPD
- ✓ Indicators 6 and 8, which consider bullying, harassment, abuse and discrimination from other staff towards BME staff, are at their best-ever levels of performance and are now rapidly closing the gap with NHS national average performance

Areas of most concern/focus are:

Indicator	Major Actions Proposed
Indicator 1 – Representation in Agenda for Change non-clinical roles and above Band 5 in clinical roles	• Launch Mutual Mentoring Programme • Career Conversations for all, but also targeted groups such as experienced Internationally-Educated Nurses and other Agenda for Change Clinical BME colleagues • Action for Indicator 2, a deep and broad inclusive recruitment review – from multiple perspectives, throughout the whole process, end-to-end • A Talent Management plan for diversity in Executive and Senior Leadership roles (national NHS EDI Improvement Plan requirement) • Actions for Indicator 8, including training and support for line managers of international recruits
Indicator 9 – Trust Board representation	• Trust Board to agree their EDI objectives in line with national NHS EDI Improvement Plan • A Trust Board-specific inclusive recruitment review

The committee are asked to receive and note the Report and Action Plan and to confirm the Report and Action Plan can be progressed to full Trust Board.

NHS
United Lincolnshire Hospitals
NHS Trust

Workforce Race Equality Standard (WRES) Report and Action Plan 2023-2024

Alison Marriott

EDI Project Manager

OUTSTANDING CARE
personally DELIVERED

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Introduction

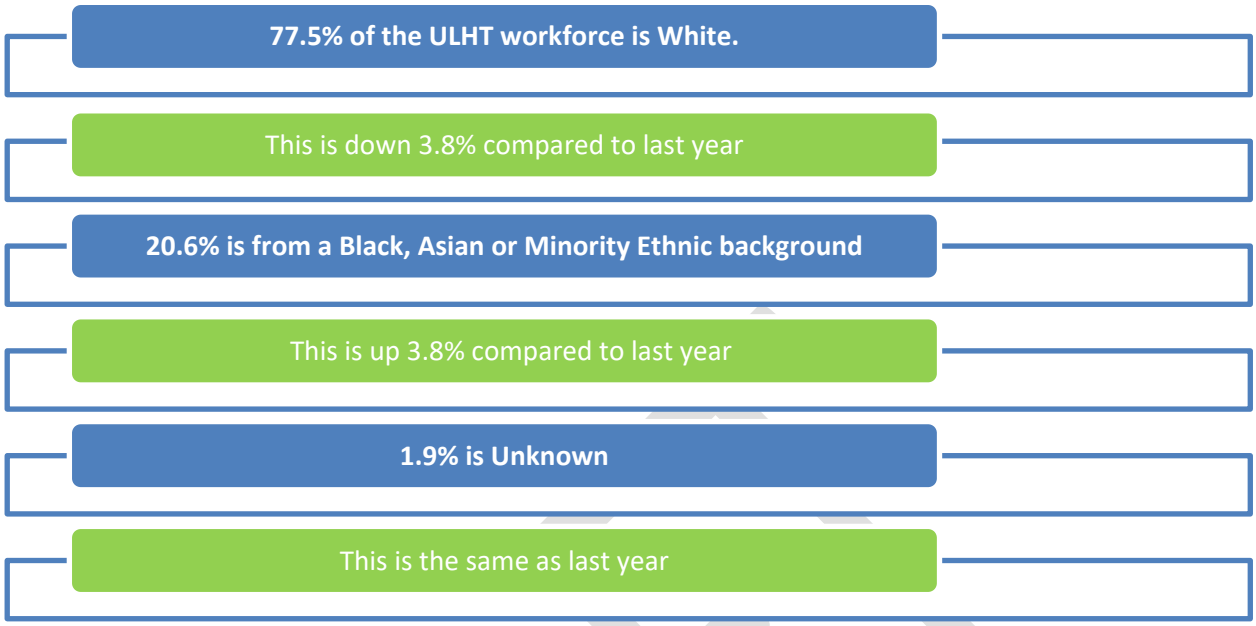
The Workforce Race Equality Standard (WRES) is an annual data collection, analysis and action-planning requirement that highlights the experiences of Black, and Minority Ethnic (BME) colleagues compared to their white counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract, to improve the experience and outcomes for BME colleagues.

The WRES requires NHS organisations to demonstrate progress against nine metrics specifically focused on race equality and suggests actions to address the disparities identified. The data and statistics used in this report reflect Workforce indicators from ESR and Trac as at 31st March 2023, NHS Staff Survey results from the latest (i.e. 2022) staff survey, and a Board representation indicator.

This WRES report and action plan has been developed in line with the national NHS EDI Improvement Plan, launched in June 2023, and following a process of face-to-face and virtual engagement sessions with a wide range of stakeholders, kindly facilitated by Ryan Kelleher, Improvement Manager.

In line with NHS England WRES reporting, the acronym BME (Black & Minority Ethnic) is used on this occasion, instead of possible alternatives such as “minoritised”.

Summary



Areas where the Trust is performing well and has seen significant improvement are:

- ✓ Indicator 3, which is relative likelihood of entry into formal disciplinary process if you are Black or Minority Ethnic
- ✓ Continuing success in Indicator 4, relative likelihood of accessing non-mandatory training & CPD.
- ✓ Indicators 6 and 8, which consider bullying, harassment, abuse and discrimination from other staff towards BME staff, are at their best-ever levels of performance and are now rapidly closing the gap with NHS national average performance

Areas of most concern/focus are:

	Major Actions Proposed
Indicator 1 – Representation in Agenda for Change non-clinical roles and above Band 5 in clinical roles.	• Launch Mutual Mentoring Programme • Career Conversations for all, but also targeted groups such as experienced Internationally-Educated Nurses and other Agenda for Change Clinical BME colleagues. • Action for Indicator 2, a deep and broad inclusive recruitment review – from multiple perspectives, throughout the whole process, end-to-end. • A Talent Management plan for diversity in Executive and Senior Leadership roles (national

	NHS EDI Improvement Plan requirement) • Actions for Indicator 8, including training and support for line managers of international recruits.
Indicator 9 – Trust Board representation	• Trust Board to agree their EDI objectives in line with national NHS EDI Improvement Plan • A Trust Board-specific inclusive recruitment review

Workforce Race Equality Standard (WRES) Action Plan 2023-24

WRES Indicator	Current WRES Performance	Lead	Actions	Timescale
1. Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce. NHS EDI Improvement Plan: High Impact Action 2 *"Embed fair and inclusive recruitment processes and talent management strategies that target under-representation & lack of diversity"*	 Please see Appendix 1	Director of People & OD Supported by: Deputy Director, People & OD (Nico) Deputy Director, People & OD (Lindsay) Leads of Recruitment, EDI & OD (Simon, Alison, Damien) Staff Networks	Establish Mutual Mentoring Programme – "Mentoring Together" Continue with Career Conversations action from Gender Pay Gap Action Plan, extending to all: Establish meaningful early career conversations with internationally-educated colleagues in Agenda for Change Clinical roles, recognising where they have substantial previous experience, to ensure targeted career support. To incorporate good practice examples from Northants "Levelling-Up" programme for Internationally-Educated Nurses, and the Great Western Hospitals "Stay & Thrive" initiative. Ensure Black, Asian and Minority Ethnic colleagues in Agenda for Change non-clinical roles and their line managers are well-supported to engage in Mutual Mentoring and Career Conversations too. Establish and enact a talent management plan for Executive and Senior Leadership Teams, which includes improvements in the diversity of these teams.	To establish actions and launch both by January 2024: Mutual Mentoring – Launch at end October 2023 Career Conversations – January 2024 ELT/TLT Talent Management Plan – by June 2024 Wider recruitment opportunities & social mobility – by October 2024

		Lincolnshire ICB People Hub	Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan and Lincolnshire Integrated Care Board (ICB) Measurable outcomes: • Improvement in the relative likelihood of being appointed (please also see Indicator 2 below) • Improvement in the National Staff Survey (NSS) question "Access to career progression, training & development opportunities" (please also see Indicator 7 below) • Year-on-year improvement in race and disability representation, including senior leadership (Bands 8c and above) • Improvement in HEE NETS (National Education & Training Survey) metric on quality of training All of the measurable outcomes in this plan are linked to the NHS EDI Improvement Plan, published in June 2023 NHS equality, diversity and inclusion (EDI) improvement plan | NHS Employers	
2. Relative likelihood of staff being appointed from shortlisting across all posts. **High Impact Action 2**	 Trust overall: 1.60 Medical 1.16 Non- Medical 1.71	**Director of People & OD** Supported by: Deputy Director, People & OD (Nico)	The use of a more reliable source of data (Trac) this year, as planned in last WRES and WDES Action Plans, has highlighted this area of improvement. It is more likely that a shortlisted candidate will be appointed to the role after the interview/assessment process if they do not state their disability or ethnicity. The Trust will undertake **a deep and broad Inclusive Recruitment review**, including feedback from staff	Review completed and actions identified & agreed by end October 2023 Identified actions completed and in place by end April 2024

		Deputy Director, People & OD (Lindsay) Leads of Recruitment & EDI (Simon, Alison)	networks, use of the CQ-Leading Inclusively model and "No More Tick Boxes" guidance NHSE-Recruitment-Research-Document-FINAL-2.2.pdf (england.nhs.uk). The aim is to ensure that the process and training is even more inclusive from end-to-end, at all touchpoints & stages, from the perspective of candidates as well as recruiting managers and the recruitment team. **Measurable outcomes** Improvement in the relative likelihood of being appointed score, with overall aim of parity (1.0)	
3. Relative likelihood of staff entering the formal disciplinary procedure, as measured by entry into formal investigation. **High Impact Action 6:** *"Create an environment that eliminates the conditions in which bullying, harassment, discrimination and physical violence at work can occur"*	 0.82	**Director of People & OD** Deputy Directors of People & OD (Lindsay, Nico)	To continue with the Culture & Leadership Programme (CLP), including **launch and embedding of the Mersey Restorative Just and Learning Culture model** at the Trust. Restorative Just and Learning Culture :: Mersey Care NHS Foundation Trust **Measurable outcomes** • Maintain our improved WRES Indicator 3 at parity • Reduction in number of formal grievances and dignity at work cases • Continued reduction in Employment Tribunals citing race discrimination	June 2024
4. Relative likelihood of accessing non-mandatory training & CPD **High Impact Action 2**	 0.84	**Deputy Director of People & OD** AD – OD, Wellbeing & Inclusion	Data confirms that Black, Asian and Minority Ethnic staff are more likely to access non-mandatory training. Action: OD review of who is accessing non-mandatory training, by role (acknowledging that a high percentage of	By end April 2024

		Head of OD	medical and clinical staff are from Black, Asian & Minority Ethnic backgrounds) and protected characteristics (race, disability, gender and any other available data in ESR). **Measurable outcome:** the Trust understands any disparities for other groups sharing a protected characteristic by April 2024, and has identified and agreed actions to close the gap(s).	
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. **High Impact Action 6**	 27.4% National NHS Average: 30.8% Gap is closing and better than NHS average, but BME colleagues are 1.8% more likely to experience these behaviours than White colleagues	**Associate Director - OD, Wellbeing & Inclusion (Interim: Lindsay)** Lead for EDI (Alison) plus United against Discrimination working group	**Complete the implementation of United against Discrimination programme.** **Summary of remaining actions:** • Launch QR code reporting system, which includes anonymous option • Develop a workshop (virtual and face-to-face options) for "calling-out" and "calling-in". Topics to include: racism, LGBTQ+ hate, misogyny, ageism, religious discrimination, ableism etc. Develop in conjunction with Staff Networks. • Finalise regular discrimination case and outcome reporting (anonymised), through the People & OD Scorecard. **Measurable outcome:** • Incremental improvement in NSS results • For 2023/24 - achieve upward score and positive trajectory, whilst maintaining current above-national NHS average performance for this particular indicator.	In progress Target completion date: 30th September 2023

6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. **High Impact Action 6**	 31.8% National NHS average: 28.8%	**Associate Director - OD, Wellbeing & Inclusion** Lead for EDI (Alison) plus United against Discrimination working group	This indicator has improved to a "best-ever" position. However BME colleagues are still 5% more likely to experience these behaviours than White colleagues. **Continue implementation of United Against programme** (see actions detailed in indicator 5) To continue with the **Culture & Leadership Programme** with emphasis on respect and civility. **Measurable outcomes** from 2023-2024 onwards: • Continue upward scores and positive trajectory for NSS results for this indicator. • Achieve 'national average score' for Acute Trusts in all related indicators • Achieve above average scores and position ULHT in upper quartile for NSS results for all related indicators	Target completion date: 30th September 2023 June 2024

7. Percentage believing that trust provides equal opportunities for career progression or promotion **High Impact Action 2**	 47.4% National NHS average: 47%	**Deputy Directors People & OD (Nico, Lindsay)** Supported by: Leads of Recruitment, EDI & OD (Simon, Alison, Damien)	Gap is closing and better than NHS average, but BME colleagues are still 9% less likely to believe that career progression or promotion is fair at this Trust. **Mutual Mentoring "Mentoring Together" & Career Conversations** – as per Indicator 1. **Inclusive recruitment review** – as per Indicator 2. **Access to non-mandatory training** – as per Indicator 4. **Measurable outcome:** Incremental improvement in NHS Staff Survey results for 2023/24 onwards • Continue above-average score when benchmarked nationally and the positive trajectory for NSS results for this indicator. • Close the disparity gap by 3% each year, until parity is achieved	Mutual Mentoring – Launch at end October 2023 Career Conversations – By January 2024 OD review of who is accessing non-mandatory training by end April 2024
8. Percentage of staff who personally experienced discrimination at work from a manager, team leader or other colleagues **High Impact Action 5:**	 18.6% National NHS average: 17.3%	**Associate Director - OD, Wellbeing & Inclusion** Lead for EDI (Alison) plus United against Discrimination working group	This has improved significantly and is the best-ever performance at this Trust. However there is still disparity (a gap) between the experiences of BME colleagues and White colleagues, of 11.2% Please see Actions for indicators 5 and 6 above, plus: Ensure that **on-boarding, induction and ongoing support programmes for internationally-educated colleagues** take account of the United against Discrimination messages	Target completion date United against Discrimination: 30th September 2023 On-boarding, training for line managers and ongoing support for

"Implement a comprehensive induction, on-boarding and development programme for internationally-recruited staff" **Also High Impact Actions 2 and 6**		Medical Director's Office, Medical Workforce Team & International On-boarding Team for Nurses & AHP's	and processes available, and also national standards such as Health Education England's Welcoming & Valuing International Medical Graduates and NHS England's International Recruitment Programme. **To include a programme of training and support for those who are receiving and line-managing international recruits** into their teams. **Measurable outcomes** from 2023-2024 onwards: • Continue upward scores and positive trajectory for NSS results for this indicator. • Achieve 'national average score' for Acute Trusts in all related indicators • Achieve above average scores and position ULHT in upper quartile for NSS results for all related indicators	all: by end March 2024

9. Percentage difference between the organisation's Board voting membership and its overall workforce BME representation. **High Impact Action 1:** *"Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable"*	 See Appendix 1	**Trust Board** Supporting colleagues: Trust Board Secretary AD – OD, Wellbeing & Inclusion. Lead for EDI	There is no substantive* BME representation on ULHT Board, compared to the BME workforce of c.11% of the Agenda for Change clinical staff group and 75% in the Medical & Dental group. **Trust Board to agree EDI objectives** which are SMART and have been cascaded & communicated widely in the Trust. One of these objectives should aim to increase the diversity and representation of BME and Disabled people holding voting membership of the Board. Inclusive Recruitment and Selection review specifically regarding Board recruitment process, with improvements identified & agreed. **Measurable Outcomes** • In 2026, Trust Board representation is in line with the Lincolnshire population we serve, based on 2021 Census data for the county of Lincolnshire. That it also reflects our workforce, which is more diverse in terms of ethnic background and disability/long-term conditions than the Lincolnshire population, at around 20% Trust-wide for both. • The Board has reviewed relevant data to understand where EDI areas of concern are, including this WRES action plan, and prioritised actions. Progress will be tracked and monitored via the Board Assurance Framework (BAF).	By end September 2023 By end December 2023 By end 2026 By March 2024

			*The Board has one BME member on secondment from another Trust and therefore not on ULHT's ESR. They are a non-voting member.	

Appendix 1

Indicator 1 – Representation at each Band, compared to Trust overall percentage

1a)	Agenda for Change Non-Clinical Workforce			
	White	BME	Unknown	Percentage compared to overall workforce (20.6% BME)
Under Band 1	1	1	0	50%
Band 1	47	0	1	0%
Band 2	1383	46	12	3.2%
Band 3	540	21	4	3.7%
Band 4	325	8	2	2.4%
Band 5	185	4	1	2.1%
Band 6	137	5	3	3.45%
Band 7	88	2	2	2.2%
Band 8a	57	0	0	0%
Band 8b	39	1	0	2.6%
Band 8c	17	0	0	0%
Band 8d	8	1	0	12.5%
Band 9	13	0	0	0%
VSM	5	0*	0	0%

*There is one BME colleague who is on secondment to the Trust, therefore is not on the Trust's ESR.

1b)	Agenda for Change Clinical Workforce			
	White	BME	Unknown	Percentage compared to overall workforce (20.6% BME)
Under Band 1	8	0	0	0%
Band 1	0	0	0	0%
Band 2	997	120	11	10.6%
Band 3	227	10	1	4.2%
Band 4	167	143	6	45.25%
Band 5	933	589	42	37.6%
Band 6	866	103	16	10.4%
Band 7	508	31	1	5.7%
Band 8a	193	20	3	9.2%
Band 8b	39	4	0	9.3%
Band 8c	15	4	0	21%
Band 8d	11	0	0	0%
Band 9	5	0	0	0%
VSM	1	0	0	0%

1c)	Medical & Dental Workforce			
	White	BME	Unknown	Percentage compared to overall workforce (20.6% BME)
Consultants	121	225	19	61.6%
Non-consultant career grade	19	206	20	84%
Trainee grades	66	327	25	78.2%

Other	0	0	0	0

Indicator 9 – Representation on Trust Board

	White	BME	Unknown
Total Board members	10	0	5
of which: Voting Board members	8	0	3
: Non-Voting Board members	2	0	2
Total Board members	10	0	5
of which: Exec Board members	7	0	0
: Non Executive Board members	3	0	5
Number of staff in overall workforce	7021	1871	169
Total Board members - % by Ethnicity	66.7%	0.0%	33.3%
Voting Board Member - % by Ethnicity	72.7%	0.0%	27.3%
Non-Voting Board Member - % by Ethnicity	50.0%	0.0%	50.0%
Executive Board Member - % by Ethnicity	100.0%	0.0%	0.0%
Non-Executive Board Member - % by Ethnicity	37.5%	0.0%	62.5%
Overall workforce - % by Ethnicity	77.5%	20.6%	1.9%
Difference (Total Board -Overall workforce)	-10.8%	-20.6%	31.5%
Trend (compared to 2022)	**Down 14.1%**	**Down 3.8%**	**Up 18%**

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of the United Lincolnshire Hospitals NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None.
Comments: Mr Paul Dunning has taken over Medical Director and RO duties to cover long term sickness of Mr Colin Farquharson (Medical Director).
Action for next year: None.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/~~No~~ [delete as applicable]
Action from last year: None
Comments: The Trust provides adequate funding and resources to the RO and the Professional standards team to discharge their duties.
Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: None
Comments: An accurate record of all licensed medical practitioners is maintained using the ALLOCATE software. Alongside, a detailed tracker is maintained by the Professional Standards office and the list is regularly validated against internal sources such as list of starters, leavers and the GMC list of practitioners with a prescribed connection to the Trust.
Action for next year: None

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The final version of the policy to be ratified and uploaded on the Trust intranet.
Comments: The existing policy is still fit for purpose and the Trust's approach is consistent with current GMC and other guidance as per the Medical Appraisal Guide 2022. The policy draft has not been approved yet as it requires further amendment to include the new guidance. The draft will include revised Trust operation procedures and format of communication from the Professional

Standards office in the event of a doctor's apparent non-participation in the medical appraisal process.

Action for next year: Policy draft to be completed and ratified by the Medical Director and the Trust Policy Development Group.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: None.

Comments: No requests for a peer review have been received from the NHSE. For quality assurance, audits are carried out within the Trust using the Appraisal Summary and PDP Audit tool (ASPAT). Appraisers with low ASPAT scores receive additional support from experienced Senior appraisers to improve their performance.

Action for next year: Introduce the new QA audit tool.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None

Comments: Continuing Professional Development is available and encouraged. Information is provided to other designated bodies to facilitate appraisal and revalidation as required. All doctors are encouraged to attend clinical governance meetings. It is ensured that all doctors have participated in appraisals and revalidation process as required. Due to recent change in practice, processes have been developed to support doctors in production of governance information to facilitate the appraisal process. This includes information such as theatre logbooks and SI/Complaints data.

Action for next year: None.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: As directed by the NHSE, the Professional standards team to coordinate with the Trust Information support services to provide as much information as possible about a doctor's practice to assist them with the preparation for their appraisal i.e. facilitate 'supported governance'.

Comments: The Trust uses the ALLOCATE software to record appraisals for all doctors, that now supports the new Appraisal 2022 model. The Professional Standards office has informed all doctors and will ensure that they have switched to the new appraisal form in 2023-24 and supplied the relevant guidance from the AoMRC website. This move to the revised model is included on the agenda for all appraisal and revalidation training and appraisers' network meetings.

To assist doctors with the preparation for their appraisal, the Professional Standards team is now facilitating 'supported governance'. Doctors are provided with their theatre logbooks and any SI/complaints data prior to their annual appraisal.

Any information related to a doctor's fitness to practice is recorded on RO notes in the ALLOCATE system and the doctor is advised to discuss this during their next appraisal.

Action for next year: None.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None

Comments: None

Action for next year: None

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: The final version of the policy to be ratified and uploaded on the Trust intranet.

Comments: The existing policy is still fit for purpose and the Trust's approach is consistent with current GMC and other guidance as per the Medical Appraisal Guide 2022. The policy draft has not been approved yet as it requires further amendment to include the new guidance. The draft will include revised Trust operation procedures and format of communication from the Professional Standards office in the event of a doctor's apparent non-participation in the medical appraisal process.

Action for next year: Revised draft to be completed and ratified by the Medical Director and the Trust Policy Development Group.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To regularly review the Trust appraisers' database to ensure there are adequate number of trained appraisers to complete appraisals for all licensed doctors. Further appraiser training events to be organised as required.

Comments: The Trust organised two training events in 2022-23 to meet the shortfall of appraisers. As at the date of completion of this report, there are 114 trained appraisers who carry out appraisals for 799 doctors i.e. an average of 7 to 8 appraisals per appraiser, which is adequate as per the Trust policy.

Action for next year: None

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: None

Comments: Face-to-face appraiser network meetings took place at the 3 Trust sites. Each Trust appraiser is assigned to a Senior Appraiser who oversees and audits the quality of their appraisal summary and PDPs using an electronic ASPAT scoring system and provides feedback and support as required.

All new appraisers are appointed after successful completion of a 2 days' training course as designed by the NHSE. New appraisers are expected to shadow their senior appraiser and conduct a supervised appraisal prior to taking on independent appraisals.

Action for next year: Introduce the new QA audit tool.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None Comments: The ASPAT scoring tool is used for quality assurance. The Professional Standards team sends a monthly report to the Workforce and OD Trust Board Assurance Committee for onward reporting to the Trust Board. A monthly report of compliance is also sent out to individual Divisions within the Trust. Action for next year: Introduce the new QA audit tool.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	**784**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**713**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**71**
Total number of agreed exceptions	**70**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None Comments: The ALLOCATE system is used to record appraisals, information related to doctors' fitness to practice and support RO recommendations in a timely manner. Action for next year: None

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None

Comments: The recommendations for deferrals are disclosed to the doctor at the same time that the recommendation is submitted.

Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None

Comments: There is a close alignment of governance with the Trust Operating Model (TOM). Governance leads have been appointed in each clinical division (Clinical support services, Medicine, Family health and Surgery). The Patient Advice and Liaison Service (PALS) and Complaints service allows to improve services. The Trust has a dedicated Mortality team to identify, report, investigate and learn from deaths within our care. The Clinical Effectiveness team ensures implementation of nationally agreed guidance, standards and clinical performance indicators reflecting 'best practice'. It also incorporates a range of mechanisms required to measure and assess 'effectiveness' (e.g. clinical audit, clinical outcome measurement, service evaluation, benchmarking data, "clinical indicators" data capture). All Trust doctors are encouraged to attend Clinical governance meetings.

Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None

Comments: The Responsible Officer Advisory Group (ROAG) within the Trust includes the Medical Director/RO, Deputy Medical Directors and representatives from HR. The ROAG meets weekly to discuss issues relating to conduct, capability and health for doctors, decide and record a course of action (formal/informal) and provide the relevant information for doctors to include at their appraisal, for e.g. Letter of advice issued by the RO.

Action for next year: None

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> Action from last year: Final version of the policy to be approved and uploaded on Trust intranet.
>
> Comments: The Trust has an established Responsible Officers' Advisory Group (ROAG) that oversees fitness to practice processes. The Staff Investigation Protocol remains in place. The draft policy covering Conduct, Capability, Ill health, Appeals procedures for doctors was reviewed again to allow issues relating to Conduct to be addressed within the Trust wide Disciplinary policy for all staff.
>
> Action for next year: Revised draft to be ratified and uploaded on Trust intranet.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

> Action from last year: Final version of the policy to be approved and uploaded on Trust intranet.
>
> Comments: The Equality, Diversity and Inclusion (EDI) lead analyses the results of the Trust wide Audit of Concerns in relation to the individuals' protected characteristics. The draft of the new Trust policy related to responding to concerns includes a requirement to follow an Equality Analysis assessment procedure while gathering information for a full investigation. Matters related to equality, diversity and protected characteristics may apply to the person raising the concern, the clinician involved, or both.
>
> Action for next year: Revised draft to be ratified and uploaded on Trust intranet.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: None

Comments: The Trust uses NHS England's Medical Practice Information Transfer (MPIT) form. An Additional Medical Roles form is completed and returned by doctors to annually have up to date knowledge of doctors connected to our Designated Body but practising elsewhere. An electronic form has been created and used to capture additional roles undertaken by Trust doctors.

Action for next year: None

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Final version of the policy to be approved and uploaded on Trust intranet.

Comments: At present, the ROAG does not have access to this data. The draft of the new Trust policy related to responding to concerns includes a requirement to follow an Equality Analysis assessment procedure while gathering information for a full investigation. Matters related to equality, diversity and protected characteristics may apply to the person raising the concern, the clinician involved, or both.

Action for next year: Revised draft to be ratified and uploaded on Trust intranet.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None

Comments: Locum and short-term doctors have appropriate background checks completed prior to appointment.

Action for next year: None

Section 6 – Summary of comments, and overall conclusion

General review of actions since last Board report

- New appraisers to be appointed to complete appraisals for all licensed doctors. **Status**: Completed.
- As required by NHSE/I, to put processes in place to support doctors in production of governance information and minimise the preparation work required ahead of appraisal discussions, giving doctors more time to actually engage meaningfully in reflective practice. **Status**: Completed

Actions still outstanding

- Review and update the MHPS Disciplinary Policy for Medical Staff. **Status**: Revised draft to be approved and uploaded on the Trust intranet.
- Combining data for protected characteristics and disciplinary action, include safeguards in MHPS Disciplinary policy. **Status**: Revised draft to be approved and uploaded on the Trust intranet.
- Review and update the Medical Appraisal and Revalidation policy. **Status**: Draft to be revised to include new Medical Appraisal 2022 guidance, approved and uploaded on the Trust intranet.

Current Issues

- None. Appraisal completion rate exceeds the 95% compliance target for the Trust.

New Actions

- Introduce the new QA audit tool.

Overall conclusion:

The professional standards activities have been maintained effectively and in line with NHSE/I recommendations and guidance. Relevant policies and procedures are being reviewed and improved to ensure that they are up to date, consistent and effective. Processes have been put in place to facilitate 'supported governance' for all doctors in preparation for their appraisals.

Section 7 – Statement of Compliance:

The Board of United Lincolnshire Hospitals NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: United Lincolnshire Hospitals NHS Trust

Name: Andrew Morgan Signed: _ _ _ _ _ _ _ _ _ _

Role: CEO

Date: _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication reference: PR1844

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 September 2023*
Item Number	*Item 9.3*

Revalidation Annual Report 2023

Accountable Director	*Mr Paul Dunning, Interim Medical Director*
Presented by	*Mr Paul Dunning*
Author(s)	*Poonam Panjwani*
Report previously considered at	*People and OD Committee*

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	
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	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Significant* • *Moderate* • *Limited* • *None*

Recommendations/ Decision Required	• *To receive the report, note the content and that this will be shared at Trust Board and NHS England*

Executive Summary

This report gives assurance that the statutory functions of the Responsible Officer are being appropriately and adequately discharged and there are the appropriate procedures in place to support Professional Standards.

Purpose

Revalidation and Appraisal are the processes which enable doctors to demonstrate to the Trust and the GMC that they are up to date, fit to practice and compliant with relevant professional standards.

This report which is in a questionnaire format that is aimed to ensure designated bodies understand what is needed for revalidation and identify and prioritise areas for development.

It also gives assurance that there are effective systems in place for monitoring conduct and performance of medical colleagues.

Key messages

Completed Actions since the last Board report:

- The Trust have appointed additional appraisers to ensure timely appraisals to take place
- Training Events are now organised for Appraisers
- Implemented the process to support doctors with the production of governance information.

Actions for the coming year are:

- Medical and Revalidation Policy needs to be ratified and uploaded to the Intranet – including the inclusion of data for protected characteristics and disciplinary action.
- Maintaining High Professional Standards policy to be approved and uploaded to the Intranet

Conclusion/Recommendations

The Trust has an appraisal completion rate that exceeds the 95% target set and the Trust has a robust process in place to ensure that Professional Standards are maintained and in line with NHSE/I recommendations and guidance.

To receive the report, note the content and that this will be shared with NHS England

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	20 July 2023
Chairperson:	Dani Cecchini, Chair
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** Report deferred.
	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 reported £8.8m deficit at the end of quarter 1, in line with the plan of a £20.8m deficit for the year. The Committee noted the income position and the need for this to be delivered to plan and reflected the good progress in respect of the pay position impacting positively on the Financial Recovery Plan, due to the reduction in agency use. Whilst there was confidence in the delivery in the first half of the year, with moderate assurance received, the Committee noted the risk to the second half due to cost pressures and excess inflation. The capital position was reported as behind plan due to the Pilgrim ED build however actions were in place to recover the position. The Committee noted the external funding bid for endoscopy which would present a funding gap with the Committee recommending to the Board that a pre-commitment be made to support this, with the intention to seek additional external funding. This would support the Trust's JAG accreditation.

	The Committee noted that Frontline Digitisation had approved the EPR business case which could now be offered to the Join Investment Committee for approval. The Committee received the Capital Delivery Group reports and the letter for the Lincolnshire System Operational Plan which included controls and stipulations on controls on pay. **Procurement Quarterly Update Q1** The Committee received the quarterly report noting the updates made to the report which responded to a number of questions raised by the Committee, including the expectation of the need to receive contract award reports. The Committee noted the development of the contracts register which would offer further assurance in respect of procurement arrangements and contracts in place. The work involved in the development of the electronic patient record was noted with the Committee seeking to understand if there was sufficient capacity in place for this and other large ongoing procurements. It was noted that there was capacity at the current time due to the way in which work was being managed however there was a need to consider the structure of the team going forwards.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee noted that the report was deferred due to the timing of the meeting however this would be received by the Committee in August. Meeting dates would be amended to ensure timely upward reporting.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting that the Trust had seen an improvement in time to triage in A&E with less patients waiting over 59 minutes to be handed over by ambulance crews. There had also been a reduction in the non-elective length of stay. The Committee noted the planned care position against 78-week waits noting that, at the end of June, the Trust had 141 waiters. Whilst this had been planned to be zero there had been an impact as a result of industrial action. There had been an increase in the utilisation of Grantham for planned care with the further faster initiative also underway for outpatients at Grantham. A positive impact was noted in respect of the outpatient recovery and improvement programme with the Committee noting that this would

	continue to be driven forward to achieve a minimum of 103% productivity. There continued to be improvements seen in DM01 at 67.84% which was the highest compliance since March 2022. The breast cancer faster diagnosis trajectory was being met with the achievement of this noted at a recent regional meeting. The Committed was advised that the revised constitutional standards would be published in August, moving from 10 to 3. Once received these would be presented to the Board. There had been achievement in 104-day and 62-day cancer waits which were decreasing with support in place for patients who disengaged due to the emotional impact of the treatment process.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 3f Urgent Care **As reported at SO 3d**
	Assurance in respect of SO 4a Establish new evidence based models of care No reports
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review **Objective 4c position update** The Committee deferred the report to the August meeting to enable sufficient time to consider the report.
	Assurance in respect of other areas: **Terms of Reference and Work Programme Draft 2023/24** The Committee received and commented on the terms of reference and work programme it was noted that further work was required around the reporting of objectives 4a and 4c before the work programme could be approved. The terms of reference would be updated to remove specific year references with the Committee seeking to approve these at the August meeting. **Reporting Group Governance update** The Committee received a number of work programmes of the reporting groups noting that there was a need for further work to be

	completed to ensure all groups had the appropriate documentation in place. The Committee noted the need to ensure that, where required, legislation was appropriately captured within the reporting group terms of reference and work programmes. Work would be undertaken to support the development of the terms of reference and work programmes of the group to ensure that, through the upward reports, assurances were offered to the Committee. **Committee Performance Dashboard** The Committee took the report as read noting that discussions had taken place through other reports presented. **Integrated Improvement Plan** The Committee received the report noting that there was limited assurance, and the Trust was behind plan to date. It was noted by the Committee that there were cultural and behavioural aspects which required addressing in order to transact the changes required. The Committee reflected on the metrics reported noting that there did not appear to have progressed as expected. It was noted that a number of the plans would see delivery in to the second half of the year. **Improvement Steering Group Upward Report** The Committee received the report noting the positive progress achieved against missing outcomes which had reduce from £1m to £9k. The Committee also noted the achievement against agency spend and the progress being made across the Trust and the development of the Quality Improvement training. The medical extra contractual rate was noted with no plan in place however this was not expected to deliver until month 7. The Committee noted the need for clarity on a plan being in place. The Committee was assured of a number of interventions in place, reflecting disappointment that results were not yet being seen with long lead times for a number of programmes. **Internal Audit Recommendations** The Committee received the report noting that the data quality issues had been discussed by the Audit Committee. It was noted that these were not being tracked and therefore would be restarted. The Committee noted that there remained other actions which were overdue and require review and update. **CQC Action Plan**

	The Committee received the report and noted the expectation that actions were being overseen through the governance routes of the reporting groups with escalations made where required. The Committee requested that future reports indicate where oversight of actions was taking place.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	24 August 2023
Chairperson:	Dani Cecchini, Chair
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 there remained some ongoing issues which required capital investment in order to progress and manage. There had been concern noted around the P1 maintenance requests which required immediate attention and were detracting from statutory Planned Preventative Maintenance (PPM). It was recognised around 50% of P1s raised were appropriate with the remaining ones downgraded. The Committee was pleased to note the achievement against the Cost Improvement Programme in respect of the housekeeping agency use. The Committee noted the current work being undertaken in respect of the 6-facet survey for which the report would be offered to the Committee in November. This would support prioritisation of any issues identified. **Health and Safety Committee Upward Report** The Committee received the report noting that the Committee had received a full suite of upward reports from the relevant groups. The Committee questions the appropriateness of the fire safety group moving to quarterly meetings however noted that the H&S Committee had received assurance that work continued to progress well. Concern was noted regarding clinical representation at the Medical Gases Group and therefore would refer to the Quality Governance Committee the need for representation to be identified.

	It was noted that an external auditor was currently undertaking a piece of work to map legislative requirements of the Trust which would be offered back to the Committee. This would support the governance development and demonstrate clear reporting routes. **Emergency Planning Group Upward Report** The Committee received the report noting the work undertaken on Business Continuity Plans recognising that the continual development and testing required. The Committee reflected on the number of strikes that had taken place which required emergency planning to support the management of these with the recognition that these required significant resource and time to respond to. **Green Plan delivery update** The Committee received the Green Plan update noting the limited progress that had been made to date against the actions within the plan. It was recognised that in order to successfully progress consideration of dedicated resource and support should be had. The Committee supported the recommendation of Green Champions to support delivery and also recognised the wider system work which could be beneficial. There would also be a requirement for investment in order to deliver the Green agenda with the Committee noting the ongoing work to develop a business case, in order to bid for funding in order to support the Trust's progress.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts and CIRG Upward Report** The Committee received the suite of reports noting that the Trust continued to deliver to plan and was ahead by £3.4m in respect of the Financial Recovery Plan. It was noted that the Trust was behind plan against capital however this was expected to be resolved. The Committee noted the Community Diagnostic Centre developments which would come forward to a future Committee once further information was received from the regulator. The Committee noted the medium-term finance plan that had been requested to 2025/26, this had also been shared with the ICB. Current proposals within the plan detailed a similar level of efficiency over the coming 2 years. The Committee recommended the proposal, detailed within the report, to the Board for approval, noting that this did not align to the ICB ambition of achieving a breakeven position at the end of 24/25. The Committee held a detailed discussion about the FRP overperformance of £3.4m noting that there was a system request for

	this to support the overall £55m system efficiency position. Discussions continued with the ICB to understand the impact this would have on the Trust's financial position and to seek formal confirmation of this. The National Oversight Framework (NOF) Level 4 exit criteria was now known with the need to deliver, in full the system efficiency position and to have in place an agency trajectory better than £41m, which was in place. The Committee received and noted the capital, efficiency and Capital, Revenue and Investment Group (CRIG) reports and recognised the limited assurance received in respect of the finance report due to the pressure expected to manifest in the second half of the year. **2023/24 Plan close down letter and financial actions update** The Committee received the plan close down letter and associated actions noting that work was taking place in the system to address the required actions. It was noted that subsequent to the letter a further checklist had been received with additional actions which were also being considered and responded to. The Committee noted the work which was taking place and received the HFMA checklist in addition to the letter, for information.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report and noted the follow up audit by the Information Commissioner's Office (ICO) following the audit at the end of 2022. It was noted that reasonable assurance had been received in the initial audit with actions identified which the Trust had addressed however some actions remained outstanding and required the support of the wider organisation to deliver. A formal outcome of the ICO follow up audit was awaited from the ICO. In order to ensure continued progress with the actions the Committee noted the creation of a Task and Finish Group and engagement with the Trust Leadership Team in order to seek support. The Committee noted that the Trust had submitted the Data Security Protection Toolkit which 5 areas incomplete, an action plan had been submitted to the national team which reflect actions from the ICO audit. Compliance with Subject Access Requests and Freedom of Information requests were noted and whilst it was recognised that these remained challenging progress was being seen. **Digital Hospital Group Upward Report**

	The Committee received and took the report as read. Challenges were noted in respect of the capacity of the Digital Teams to deliver projects due to the competitive nature of the digital workplace. It was recognised with the EPR project coming online in the future that there needed to be a consistent workforce to deliver the project. Work was taking place to ensure that the Trust would have the capacity in place to deliver.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting performance as reported through the performance dashboard and reflecting that productivity was behind plan. There was a continued commitment to achieve zero against 78-week waits with a trajectory to zero to be achieved by the end of September. It was noted that this would be challenging due to the continued strike action. The Committee noted the new elective care priorities and also the recent communication from NHS England regarding winter planning which was underway. Pressures in the EDs was noted with increased attendances, due to seasonal variation, and a decline in performance in respect of 12-hour waits in the departments. The Committee noted the focused work being undertaken with the departments in order to identify actions to resolve some of the difficulties being seen. Whilst the Committee noted a number of areas of performance had deteriorated there had been some improvements in 31 and 62-day cancers. The Committee noted concern regarding activity at the Grantham Hub and the concerns raised by Professor Briggs which could impact on the accreditation which had been awarded to the Trust. The division was focused on recovering the activity in order to retain the accreditation status.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d** **Bed meddling calculations / System Right Sizing** The Committee deferred the item to the September meeting noting further information would be available.
	Assurance in respect of SO 3f Urgent Care

	As reported at SO 3d
	Assurance in respect of SO 4a Establish new evidence based models of care No reports
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review **Objective 4c position update** The Committee deferred the report to the September meeting to enable further detailed updates to be made.
	Assurance in respect of other areas: **Terms of Reference and Work Programme Draft 2023/24** The Committee received and commented on the terms of reference and work programme noting that these were approved. **Reporting Group work programmes and terms of reference** The Committee received the suite of work programmes and terms of reference noting the development of these and supporting these to be utilised by the groups to enable assurance to be provided to the Committee. It was recognised that due to the nature of the Capital, Revenue and Investment Group that a work programme had not been developed however consideration would be given to the ability to provide a work programme offering indicative dates of key pieces of activity coming forward. **Estates and Facilities Governance Arrangements** The Committee received the report detailing the governance arrangements in respect of Estates and Facilities noting that the reporting groups to the Committee were the Estates Group and Health and Safety Committee. It was recognised statutory and legislative areas of reporting would, in the main, be reported through the Health and Safety Committee, via the relevant safety groups. The Committee was assured that for each legislative area there was a reporting route through to the Committee and noted that the schedule for Authorised Engineer reports would be offered to the Committee in September. This would provider further assurance of governance arrangements within the directorate. **Committee Performance Dashboard** The Committee took the report as read noting that discussions had taken place through other reports presented and considered by the Committee.

	Activity was reported as 89% against 2019/20 activity with the Committee noting that this was not at a sufficient level. There were also continued pressure in the ED's and concern over activity levels at Grantham. **Integrated Improvement Plan** The Committee received and took the report as read and noting the cross over of reporting with the performance and operational reports. **Improvement Steering Group Upward Report** The Committee received and took the report as read noting the content and the updates provided. **Internal Audit Recommendations** The Committee noted that updates were being made by the internal auditors to recommendations with a full report to be offered to the next meeting. **CQC Action Plan** The Committee received the report and noted the update provided.
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 Quality Governance Committee the need for Nursing and Medical representatives/leads to be nominated to lead and attend the Medical Gases Group due to the patient safety risk and non-compliance with HTM.
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	S	O	N	D	J	F	M	A	M	J	J	A
Dani Cecchini, Non-Exec Director	X	X	X	X	X	X	X	X	D	X	X	X
Director of Finance & Digital	D	X	X	X	X	X	X	X	X	X	X	X

Chief Operating Officer	X	X	X	X	X	X	X	X	D	X	X	D
Director of Improvement & Integration	X	X	X	D	X	X	X	X	X	X	X	X
Sarah Buik, Associate Non-Executive Director	X	X	X	X	X	A	X	X	X	X	X	X

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5th September 2023*
Item Number	*Item 12*

Integrated Performance Report for July 2023

Accountable Director	*Barry Jenkins, Director of Finance & Digital*
Presented by	*Barry Jenkins, 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

Medications

For the month of July, the number of incidents reported in relation to omitted or delayed medications has increased to 32%. Medication incidents reported as causing harm has reduced to 16.5% from the previous reporting period. 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.

SHMI

The Trust SHMI has reduced further to 102.85 for July. 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 continuing to roll 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 87.1% with sending eDDs within 24 hours for July, which is a decrease from the previous month. 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 June data

Screening compliance Inpatient Adult – was 86.3% which is a decrease from previous month. The reduced compliance is mainly a reflection of the number of missed screens within medicine across both the Lincoln and Pilgrim sites but compliance across maternal inpatients has also demonstrated a decline in recent months. The majority of the omissions were non-infective in nature. There is an ongoing education programme for the staff.

Screening compliance Inpatient Child –was at 89.1% for paediatrics an increase from the previous month. Four of the children with delayed screens had an underlying cause for the raised PEWS that was either non/infective or viral in nature. Two children had a delayed

screen and had a bacterial infection, Datix and Harm Reviews completed and no harm found. One child was an oncology patient and instruction from tertiary centre were not to immediately start antibiotics

Screening compliance ED Child –was at 89% for paediatrics, an increase from the previous month.

IVAB Inpatient Child - The administration of IVAB for inpatient children decreased to 40%. Only 2 out of 5 children requiring treatment received this in a timely manner. 3 children had delayed antibiotics. Harm reviews undertaken and no harm has been found.

IVAB ED child - The administration of IVAB for children in ED increased to 63.6%, an increase from the previous reporting period. There were 4 patients in ED this month that were delayed in receiving antibiotics. New Sepsis E- learning package is now available and staff have been role mapped to complete this.

Duty of Candour (DoC) – June Data

Verbal compliance for June was at 91% against a 100% target and 88% 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. Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's and performance is included in monthly divisional governance reports.

Operational Performance

This report covers July's performance.
At the time of writing this executive summary (12th August 2023), the Trust has 2 positive COVID inpatients with no patients requiring Intensive Care intervention. The July peak was 9 patients. It should be noted the numbers of COVID positive patients attending ED and inpatients have begun to increase nationally but at present showing a very low impact to our Trust.

The current Influenza inpatients is 0 with the peak in June being recorded at 0 patients versus 630 tests completed. RSV peaked at 4 patients in July versus 209 tests completed, but as of the date of this report there are zero confirmed. There were also zero norovirus cases in July. However CDIFF cases increases from 4 to 11 in July, with 7 currently in occupancy (Lincoln, Pilgrim).

Performance to increase activity levels to 116% of 2019/20 remains significantly under plan. Year to date percentages against 2019/20 for key PODS are: Daycase 89%, Electives 69%, Outpatient Firsts (including Procedures) 91%, Outpatient Follow Ups Procedures 83% (it should be noted that Outpatient Follow Ups (excluding Procedures) is required to reduce to 75% of 2019/20 levels).

Plans to increase activity levels continue to be worked up with the Divisions, including the increased use of advice and guidance and moving patients to a patient initiated follow up pathway. Weekly meetings have been set up with Divisional Leadership Teams, Further Faster Productivity Group, to ensure more timely reviews on activity and changes are monitored. This group includes Executive Leadership attendance. Activity for the previous few weeks will be reviewed, as well as a forward look at theatre session utilisation and outpatient clinic bookings, to ensure capacity is used as effectively as possible. The group will also review workforce and finance elements of the productivity ask to ensure these align with the activity increases.

A & E and Ambulance Performance
The 23/24 4h-hour performance target has been set for yearend achieving 76% with a rolling monthly ambition to track achievement.
June has not met its target of 59.18%, out turning at 57.02% a negative variance of 2.16%. The SPC chart below documents both the 22/23 and 23/24 target to reflect performance ambition.
This trajectory is based on Type 1 and co-located Type 3 activity. Combined type 1 and type 3 activity is demonstrating an achievement of 71.24% against the overall position. The Informatics Team are working through how this is communicated more systematically within this report going forward.

There were 697 12-hr trolley waits, reported via the agreed process in July. This represents a decrease of 5 patients from June 2023, and 55 less than July 2022. Sub-optimal discharges/timely recognition to meet emergency demand remains the root cause of these delays.

Performance against the 15 min triage target demonstrated a decline of 3.66% against June performance compliance. A deeper review is required of patients who leave the department or refuse treatment that compromise this performance target.

There were 391 >59minute handover delays recorded in July, an increase of 2 from June, this is 405 less than seen in July 2022 (50.88%) less. July's turnaround represents 8.84% of arrivals waiting over this timeframe. However to note, ULHT saw 206 more conveyances in July compared to June 2023.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 4.79 days against an agreed target of 4.5 days. This is a decline of 0.02 days compared to June. The average bed occupancy for July against "Core G&A" was an average of 94.86%. July saw an average of 27 escalation beds open to maintain adequate and safe flow within the acute sites. By doing so the occupancy vs escalation brought a safer percentage of 92.29% against the new national standard of 92%.
PHB continues to demonstrate the highest level of occupancy against core (104.3%). July saw an average of 25 escalation beds open to maintain adequate and safe flow within the acute sites.
System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3. Pathway 0,1, and 3 saw an increased length of stay compared to June 2023. Pathway 2 however saw a decrease in length of stay by 0.02 days.

Referral to Treatment

May demonstrated an improvement in performance of 0.42%. June outturn was 50.44% versus 50.02% in May. The Trust is now reporting patients waiting over 65 weeks as opposed to 52 weeks. The Trust reported 2,117 patients waiting over 65 weeks, which is an increase of 14 patients on the May reported position. The position has close monitoring and scrutiny.

At the end of June, the Trust reported 4 patients waiting longer than 104 weeks. These were due to complex pathways involving other Trusts for specialist input. Discussions continue to take place with NHSE weekly in regard to 104 and 78-week waiters with month end figure June

at 140 >78-week waiters including first definitive treatment. This position was due the impact of the Junior Doctors strike action and patient choice.

Waiting Lists

Overall waiting list size increased in June. June reported 73,320 compared to May's position of 72,605 an increase of 715. Work continues between Outpatient department and the Clinical Business Units regarding returning better access to our bookable services for primary care and patients' choice.

As of 13th August 2023, ASI recovery has demonstrated a deterioration (1117 in August verses 859 at the same point in July) and is not in line with the agreed trajectory of 550. Additional resource has been directed to resolving missing outcomes which is having a positive effect on the bookings team being able to move the ASIs to open referrals.

DM01

DM01 for June reported an improvement of 1.74%. 67.84% in June verses 66.10% in May. Compliance against the national target of 99%. Whilst an improvement, there remains a negative variance of 31.16% against the nationally agreed target. Whilst the main area of concern remains Echocardiography, a continued month on month improvement is noted. DEXA breaches are at 137 in July and with the machine now being repaired, significant improvements are expected.

Cancelled Ops

July outturn for cancelled operations on the day demonstrated a deterioration at 1.57% for July versus 1.22% in June.

The target for not treated within 28 days of cancellation is 0.8%. July experienced 22 breaches against the standard which has deteriorated over the last 4 months.

Whilst there has been significant improvement in on the day cancellations, the last 4 months have demonstrated a deterioration in performance The continuous review of the effectiveness of the 6:4:2 theatre scheduling meetings continues along with the pre-op improvement workstream, both of which are expected to drive down on the day cancellations.

Cancer

28-day Faster Diagnosis Standard (FDS) started to show a recovery in June, achieving 59.17% against a national KPI of 70%. This has continued in July, achieving 68.8% (unvalidated), there is a high level of confidence that the 70% trajectory agreed with NHSE will be achieved in September.

62day classic treatment performance in June was 44.84% (against a national KPI of 85%) The number of patients >62 days continues to decrease and was at 267 at the end of July compared to 295 at the end of June.

104+ day waiters reduced to 72 at the end of July compared to 100 at end of June. The highest risk speciality is colorectal with 25 pathways greater than 104 days, this a further reduction of 6 since the last reporting period.

The Deputy Chief Operating Officer for Urgent Care has now assumed responsibility for Cancer Delivery. Meetings with each tumour group take place twice weekly - divisional engagement is high. The meetings are chaired by the Deputy COO with support from ICS colleagues.

Workforce

Mandatory Training – July 2023 saw us move into Q2 of 2023/24 with the mandatory training rate being 91.81% against a target of 93.00% which is again a slight increase compared to June 2023 (90.70%). Work continues to ensure that all areas and individuals are given the time to complete core learning modules. Work continues to be undertaken to support low compliance, particularly those at 50% and less. This has been communicated Divisionally and action is being taken to address locally, with the aid of a new report produced by the Education & Learning Team within our People & OD Directorate. A number of support measures are being implemented in terms of ESR user support, including the provisions of 'pop-up' core learning sessions for departments and individual users requiring additional input. We are set to introduce compliance sessions where managers will be asked to book those that are consistently showing <50% compliance. Work is also underway to develop a mandatory training study day offered bi-weekly following approval from the MTGG. These will be online sessions covering a range of the core CSTF modules, it is anticipated that this will have a larger impact should approval of the delivery format be given. The Mandatory Training Action Plan has been approved and work is underway to improve our mandatory training compliance. The review of all core topics has been completed and changes will be made to the core and core + offer moving forward, with consideration as to whether training needs could be aligned individually to roles. This work is gathering momentum following some changes to the competence data and re-mapping against a number of core+ modules.

Sickness Absence – Sickness absence rates have remained stable over across Q1 of 2023/24, but remains above target. In July 2023 our sickness rate was 5.61% against a Q2 target of 4.90%. The Trust continues work to further reduce its vacancy level and as such, we are hopeful this continued improvement will impact positively on our colleague's health and wellbeing. Further work to support managers and leaders in absence processes and supporting our people to attend the work environment are continuing to be delivered through the mandated 'Basics Brilliantly' workshops which is one of our actions following this year's annual staff survey results. In addition, focussed work is being undertaken with Divisions where sickness absence trends have been identified so as to further our journey towards a "supporting attendance" approach as opposed to managing absence. Staff continuing to be signposted to our health and wellbeing services.

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 a significant increase in July 2023 to 72.30% Trust appraisal rate. As we enter Q2 our target is 80.00%. To support continued improvement, we continue to recommend 90 minute appraisals for each colleague to ensure that staff have had an appraisal. Work continues to educate leaders on the process required to update ESR, including the use of 'how to' guides/sessions and utilising reporting to identify areas of low completion. Additionally, raising through Finance, People and Activity assurance meeting (FPAM) discussions provides a further opportunity for Divisional Teams to seek support from People & OD of required, as well as raise any challenges they are facing with being able to focus attention on Appraisals.

Staff Turnover – Turnover saw us exceed our target for Q1 of 2023/24 (13.00%) by achieving 12.60%. In July 2023 we achieved 12.21% against a Q2 target of 12.50%. As previously reported, we expected increases in our establishment in April 2023 due to the impact of financial year end leavers e.g. fixed term contracts etc. Operational pressures, staffing and culture challenges are continued challenges, and the People & OD Teams continue to work closely with Divisions, the Trust and the ICB to explore retention improvement opportunities, and bringing best practice into the organisation. We are working towards a more robust reporting process via ESR to capture leaver's data and understand trends. There is also a continued focus on retention issues, including flexible working. There is a Lincolnshire System retention project due to conclude soon which will provide additional insight into wider retention trends and provide an opportunity to share best practice as we move towards planning for 2024/25.

Vacancies – July 2023 saw us move into Q2 of 2023/24 with a reported Vacancy Rate of 9.78% against a target of 7.00%. As acknowledged in June 2023, we have seen an increase in our Vacancy Rate in June 2023 and July 2023 as sizeable business cases have been agreed which have increased our funded establishment. However, work is in progress to review our overall establishment with our Divisional Teams to ensure that our establishment levels remain in line during 2023/24 with our Workforce Plan. It is expected once this this review had been completed, that our overall Trust Vacancy Rate for July 2023 would have been approx. 8.00% for July 2023. Despite this, we have seen a continued reduction in our Vacancy Rate over the last 12 months as we have moved from a position of 11.35% in July 2022. There continues to be significant recruitment to substantive positions, with our Medical & Dental Vacancy Rate being as low as 2.1%, and our Nursing Vacancy Rates continuing to reduce – we are on target to have reduced this by September 2023. We will be keeping an ongoing focus on HCSWs over the coming months to backfill those IENs achieving NMC status.

Finance

The Trust's financial plan for 2023/24 is a deficit of £20.8m, the plan is inclusive of a £28.1m cost improvement programme.

The Trust delivered a deficit of £10.2m YTD in line with plan.

CIP savings of £8.8m have been delivered YTD, which is £3.4m favourable to planned savings of £5.5m.

Capital funding levels for 2023/24 have been agreed with NHSE and system partners; the Trust delivered capital expenditure of £2.1m YTD, which is £4.2m lower than planned capital expenditure of £6.3m.

The July cash balance is £49.6m; this is an increase of £8.3m against the March year-end cash balance of £41.3m

Barry Jenkins
Director of Finance & Digital
August 2023

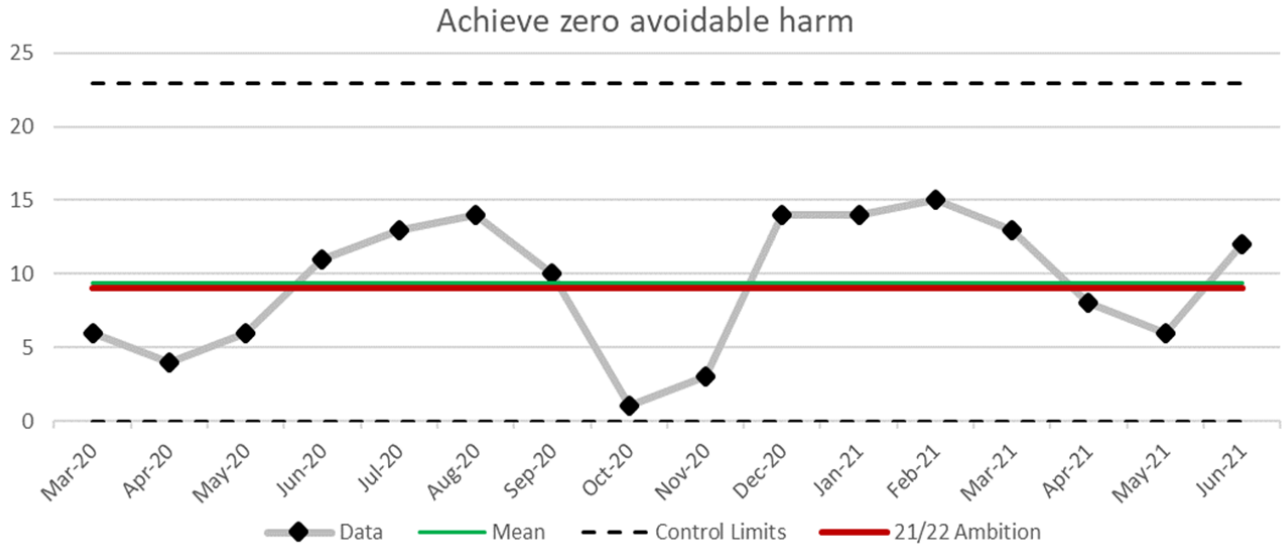
Statistical Process Control Charts

Statistical Process Control (SPC) charts are an analytical tool that plot data over time. They help us understand variation which guides us to make appropriate decisions.

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

An example chart is below:



Statistical Process Control Charts

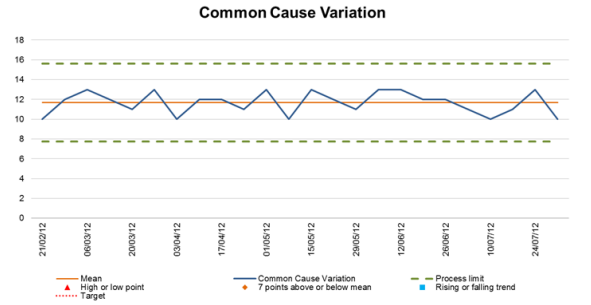
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- A trend – may be identified where there are 7 consecutive points in either a patter that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

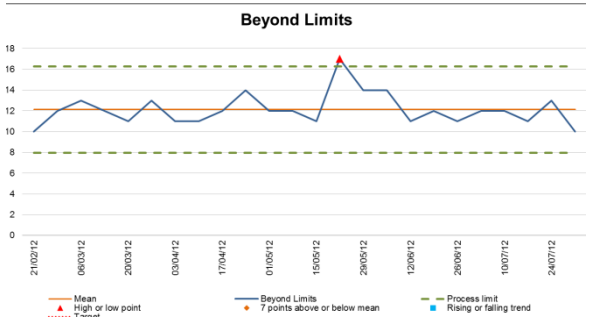
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



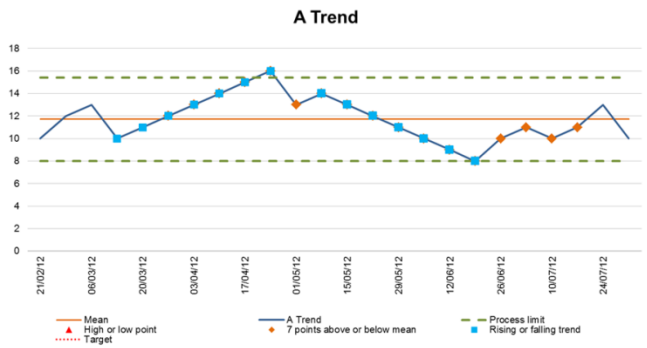
Extreme Values

There is no Icon for this scenario.

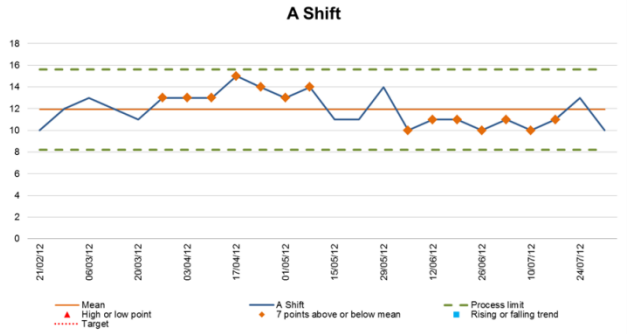


Statistical Process Control Charts

A Trend (upward or downward)



A Trend (a run above or below the mean)



Where a target has been met consistently

Where the target has been met or exceeded for at least 3 of the most recent data points in a row, or sitting is a string of 7 of the most recent data points, at least 5 out of the 7

Where a target has been missed consistently

Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	May-23	Jun-23	Jul-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	9	8	9	28	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.01	0.01		
	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	0.02	0.02	0.02		
	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	0.04	0.15	0.09	0.08	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	1	0	2	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	1	2	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	3	4	4	13	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	94.27%	95.18%	94.66%	94.76%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	1	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	6.06	6.41	5.62	5.97	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	13.4%	20.3%	16.5%	15.75%	F	

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-23	Jun-23	Jul-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			
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	95.07	93.84	94.25	94.60	P	B
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	103.08	104.40	102.85	103.25	F	B
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	100.00%	100.00%	P	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	87.90%	89.60%	87.10%	88.70%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.0%	86.3%		89.10%	F	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	87.8%	89.1%		84.60%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.0%	95.6%		95.53%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	71.4%	40.0%		51.40%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	92.0%	90.8%		91.27%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	87.8%	89.0%		89.77%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	98.0%	95.8%		96.93%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	42.8%	63.6%		64.63%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.45	2.67	2.23	2.40	P	B
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%	91.0%	91.0%	Data not yet available	92.67%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	84.0%	88.0%	Data not yet available	86.67%	F	

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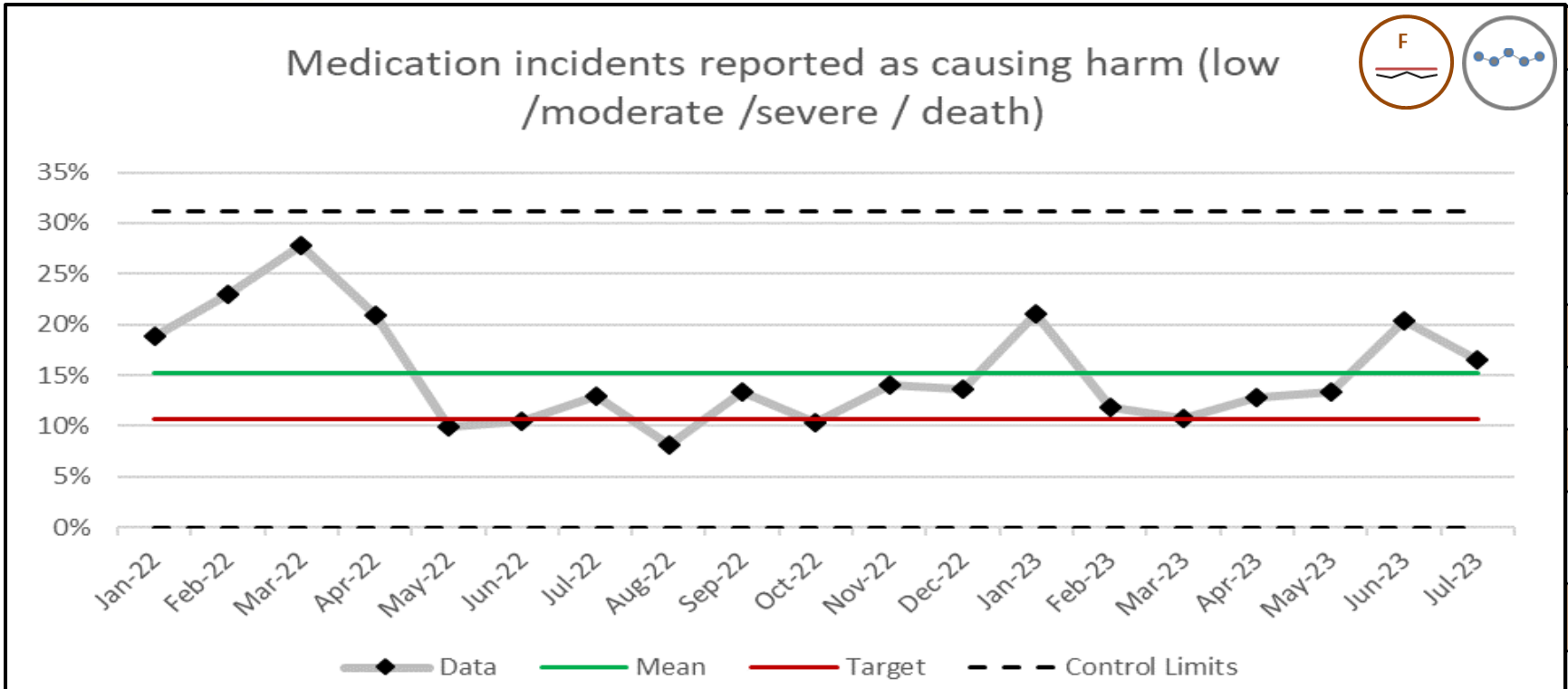

Jul-23
16.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10.7%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of July the number of incidents reported was 194. This equates to 5.62 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 16.5% which is above the national average of 11%.

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

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

Mitigations:

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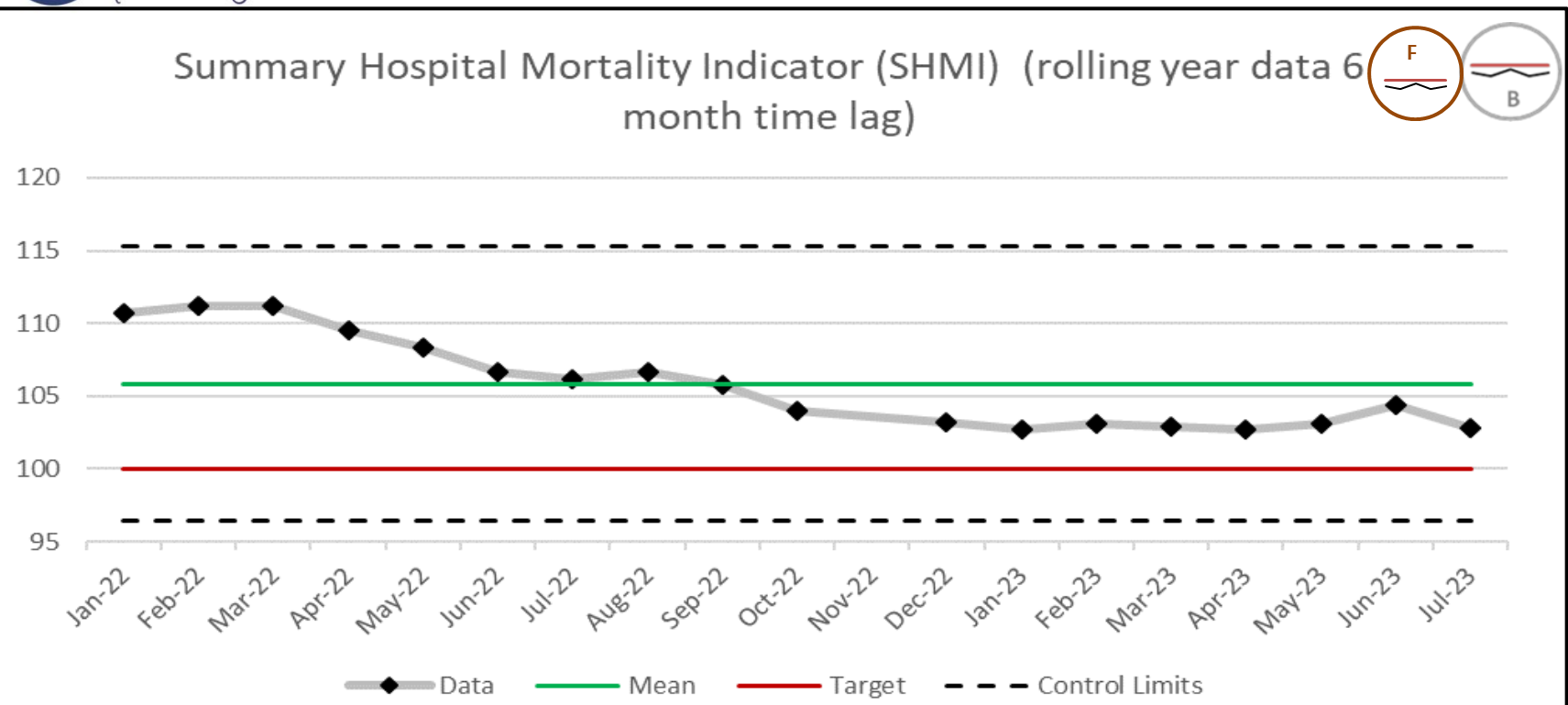

Jul-23
102.85
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
To remain in “as expected” range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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 in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. There are 28 GPs referring their deaths. This will enable greater learning on deaths in 30 days post discharge.

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

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

HSMR is 94.66(rolling 12 months)

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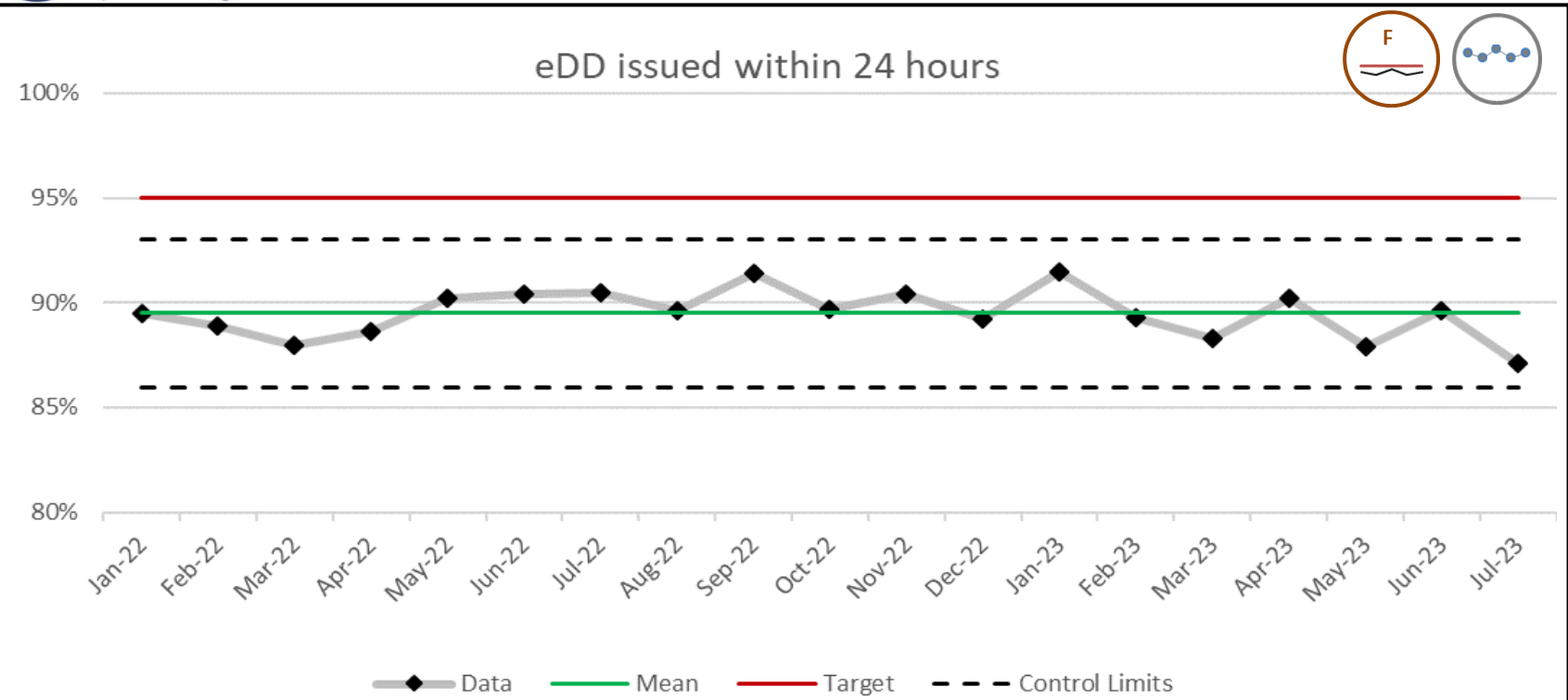

Jul-23
87.10%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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 87.10%.

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

No Narrative owner

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

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

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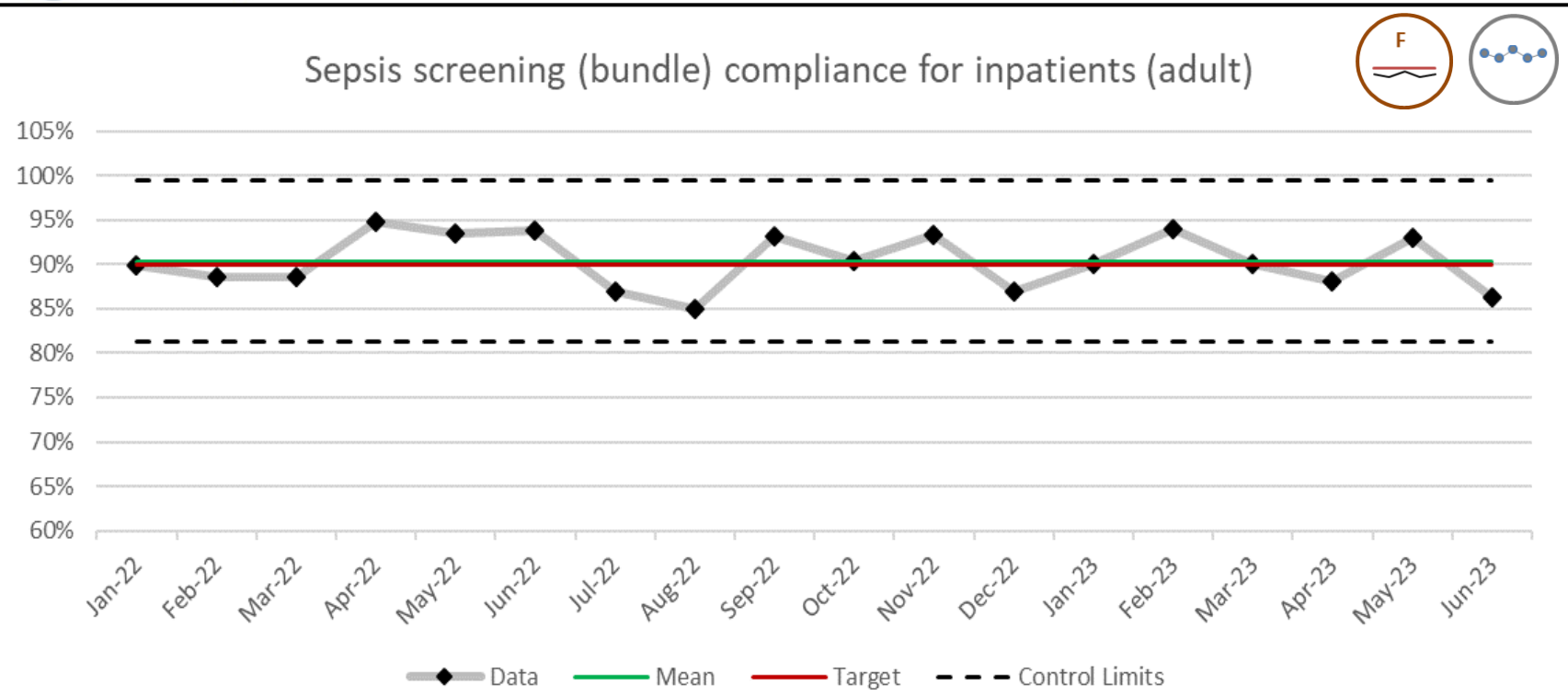

Jun-23
86.3%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for sepsis for adult inpatients has unfortunately fallen in the month of June to 86.3% that represents 284/329 patients.

Issues:
The reduced compliance is mainly a reflection of the number of missed screens within medicine across both the Lincoln and Pilgrim sites but compliance across maternal inpatients has also demonstrated a decline in recent months. The majority of the omissions were non-infective in nature.

Actions:
Ad hoc teaching continues to areas falling short of the 90% target with the focus of the training being in the medical directorate accounting for 32 of the 45 omissions.
Regular teaching provided on AIM courses concerning the deteriorating patient including sepsis.
Sepsis team beginning to work collaboratively with primary care in the hope to provide community sepsis training to release some on the pressure on our hospitals.

Mitigations:
Ward areas carry out harm reviews to acknowledge themes and if any harm from the sepsis omission has been caused to the patient allowing for more focussed training.

New adult Sepsis Trust e- learning package now live on ESR, which includes up to date guidance from NICE.

Sepsis workbook accessible to all staff, available on staff intranet page.

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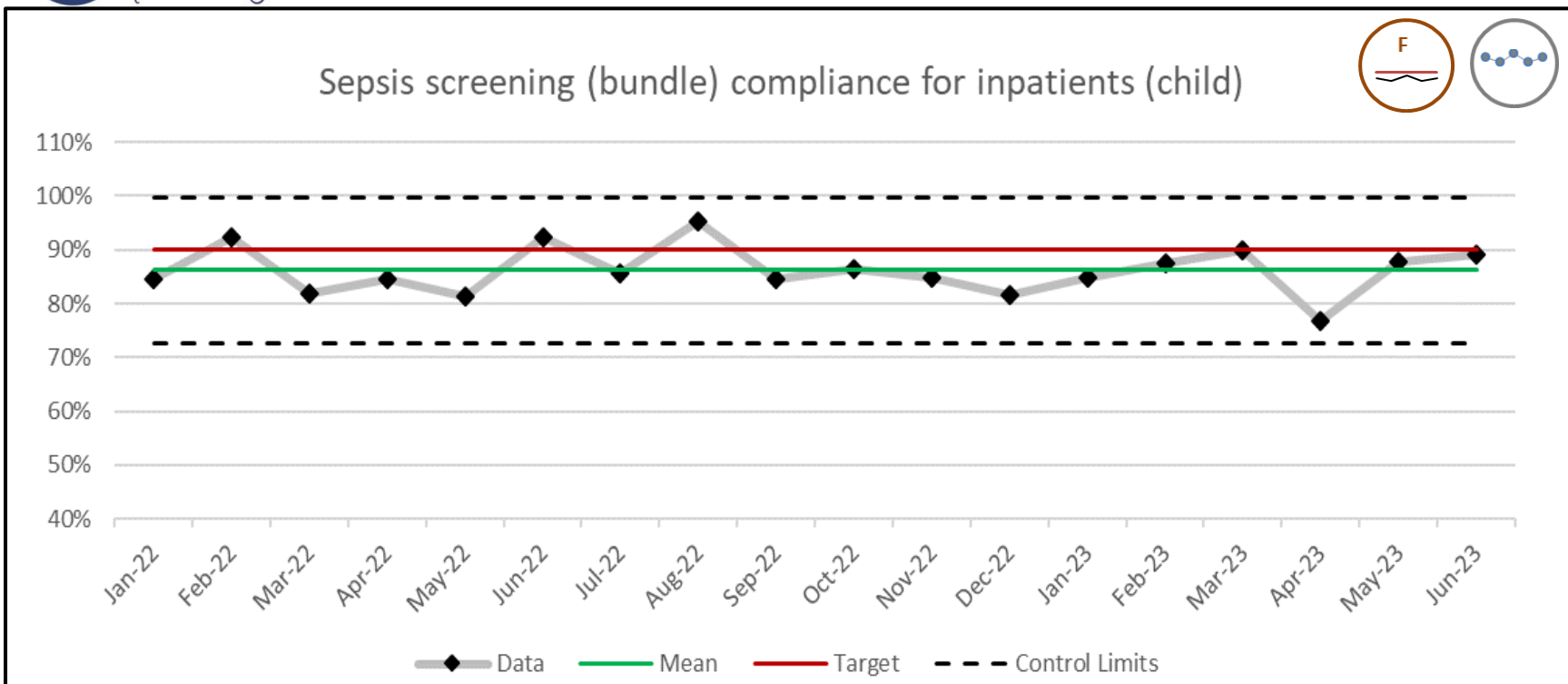

Jun-23
89.1%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Sepsis screening compliance for this month was 89.1%. 49 out of 55 patients received their Sepsis screening within the hour time limit.

Issues:
Four of the children with delayed screens had an underlying cause for the raised PEWS that was either non/infective or viral in nature. Two children had a delayed screen and had a bacterial infection – Datix and Harm Reviews completed – no harm found. One child was oncology patient and instruction from tertiary centre were not to immediately start antibiotics. Later started when child had a pyrexia. Drs wanted to wait for bloods for other child before making decision.

Actions:
Sepsis practitioner has attended wards on both sites and had discussions with all members of staff. Reminder given to escalate a PEWS of 5 or above to nurse in charge. Also advised to add a note to WEBV about who they have escalated to. No harm found from any delayed screens. Training will be offered to the new starters joining the trust in the coming months. Paediatric Sepsis e-learning now available and staff have been role mapped to complete this.

Mitigations:
Datix completed for the screens that were delayed as a bacterial infection was found. Staff involved have been asked to look at this case and offer statements of reflection. Ward staff are completing all harm reviews.

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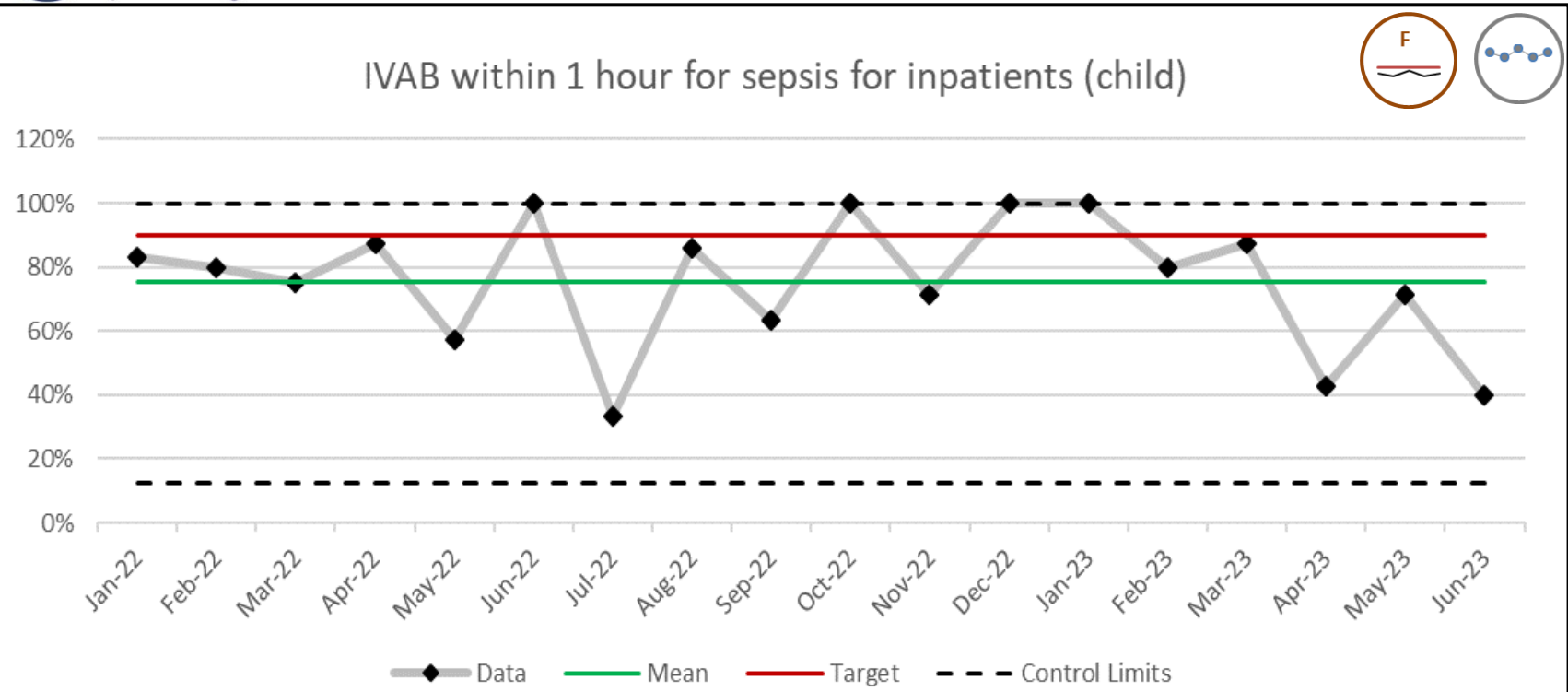

Jun-23
40.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Only 2 out of 5 children requiring treatment received this in a timely manner. 3 children had delayed antibiotics.

Issues:
2 children did not receive antibiotics within the 60 minute timeframe. One child was oncology patient and instructions from tertiary centre were not to immediately start antibiotics. Later started when child had a pyrexia. Drs wanted to wait for bloods for other child before making decision.

Actions:
Sepsis practitioner has met with ward managers on both sites to discuss the delays and wards are putting actions in to place. The wards have completed harm reviews for these patients and no harm has been found. Staff involved have been asked to look at these cases and write a reflection.
Cases discussed at Paediatric Clinical Governance

Mitigations:
Simulation training is taking place monthly involving both nursing and medical staff. This is embedded at Lincoln and now focusing on getting this running at Pilgrim Clinical Educator and Sepsis Practitioner are doing Sepsis training with new starters. New E-learning package for Paediatric Sepsis is now live as of beginning of July.

Quality | Operational Performance | Workforce | Finance

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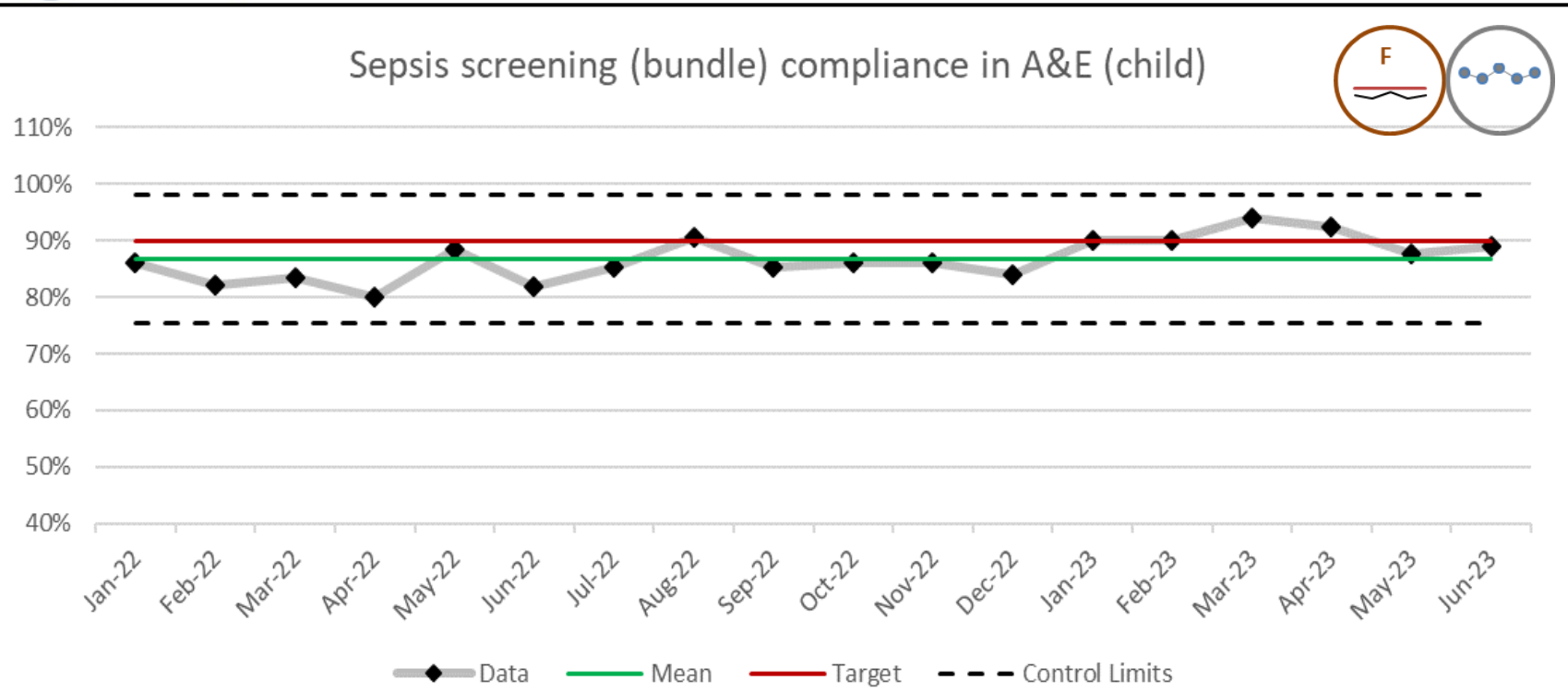

Jun-23
89.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance this month for sepsis screening is 89.0%, which is below the 90% target. 168 of 189 children were screened within a timely manner.

Issues:
There were 21 children who were not screened for sepsis in a timely manner. All of the children, excluding those with delayed treatment, were found to have either a non-bacterial cause or could be treated with oral antibiotics.

Actions:
Delays also discussed at Paediatric governance. Sepsis Practitioner is doing walk rounds of department when available to offer support. New Paediatric Sepsis E-learning is now available and staff have been role mapped to complete this.

Mitigations:
Harm reviews completed for all delayed treatment and no harm found. IM administration discussed at the Focus group meeting. Urgent meeting held with ED link nurse in order to identify the issues. Action plan made based on the findings.

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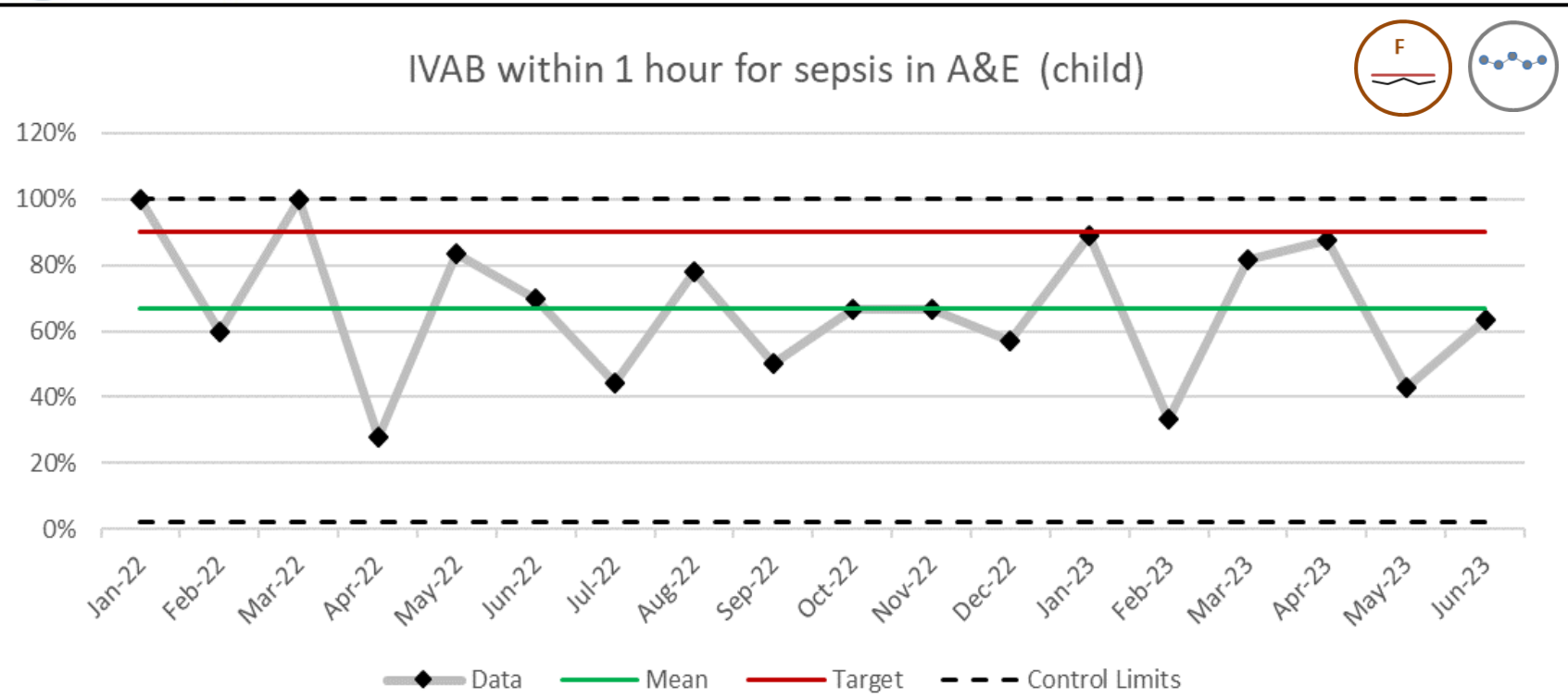

Jun-23
63.6%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The data this month shows that the IVAB compliance was 63.6%, which is 7 of 11 patients, which is well below the 90% target. There has been an improvement on last month's figures but 4 children were still delayed receiving antibiotics.

Issues:
There were 4 patients in ED this month that were delayed in receiving antibiotics. Three children waited over 120 minutes for antibiotics as Drs wanted to wait for blood results first. A further child waited over 120 minutes but cause for delay is not documented.

Actions:
Patients discussed with ED staff at Focus group and with ED Sepsis Link nurse. All harm reviews to be forwarded to ED staff in order that an action plan can be formulated. New Sepsis E- learning package is now available and staff have been role mapped to complete this.

Mitigations:
Harm reviews completed for all delayed treatment and no harm found.
IM administration discussed at the Focus group meeting.
Delays also discussed at Paediatric governance.
Urgent meeting held with ED link nurse in order to identify the issues.
Action plan made based on the findings.

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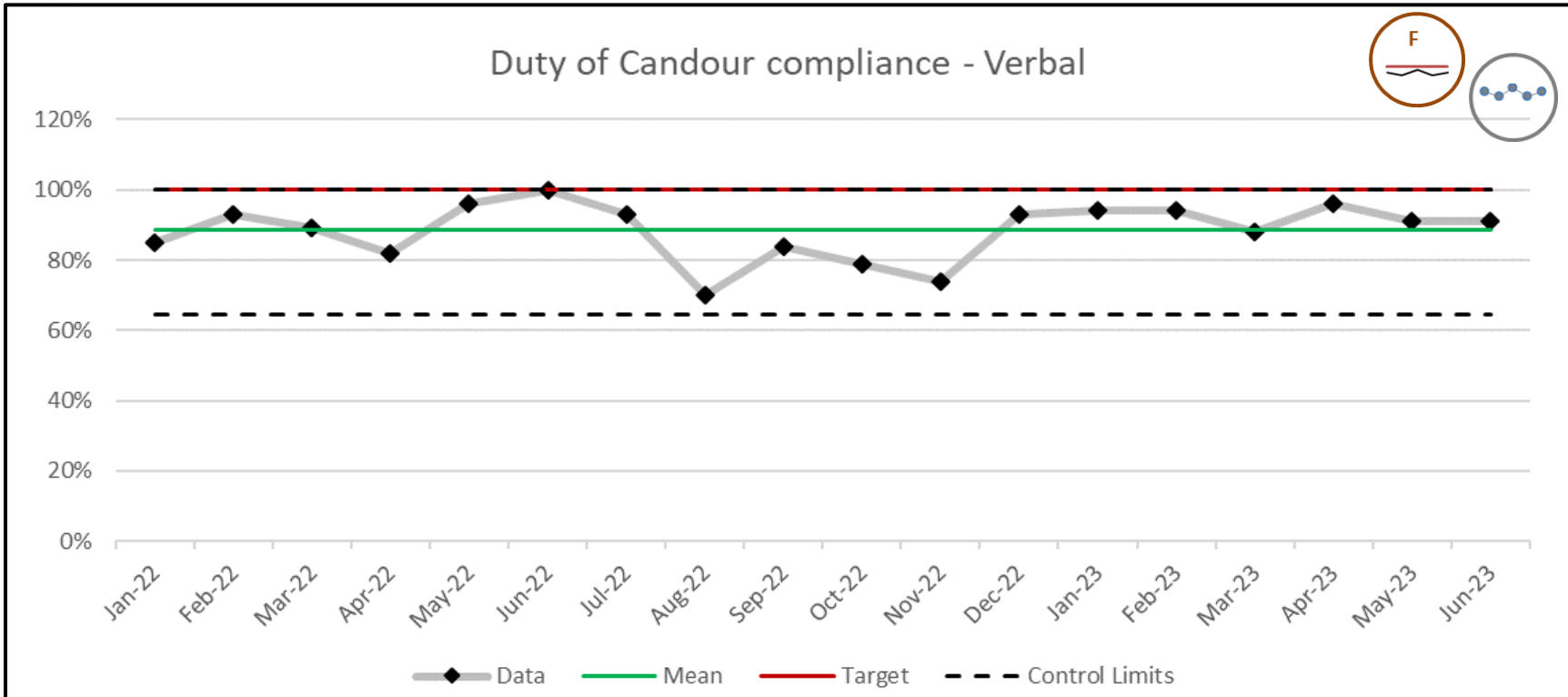

Jun-23
91.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:

Compliance with the 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 over previous months compliance is consistently 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.

Mitigations:

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

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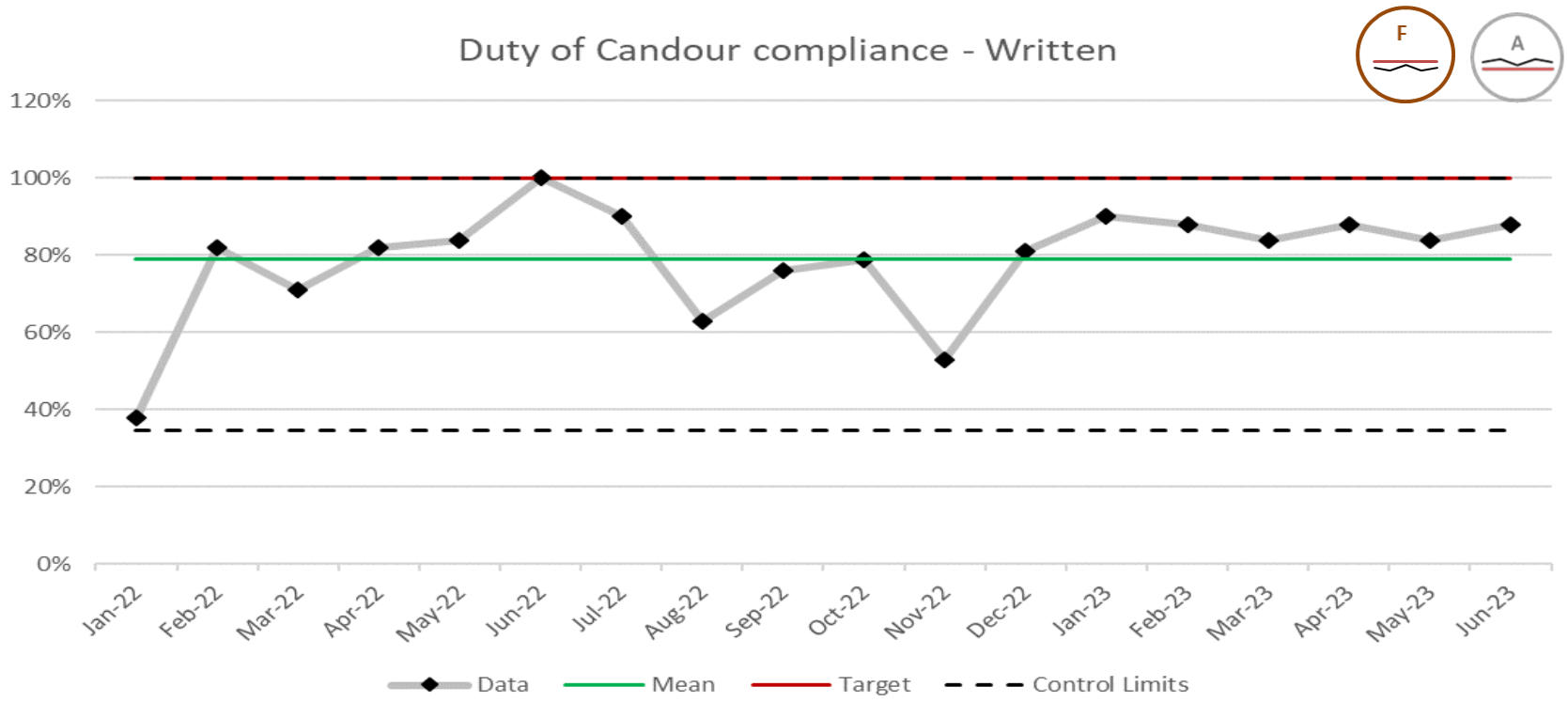

Jun-23
88.00%
Variance Type
Metric is currently experiencing a trend above the mean
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:

Compliance with the written follow-up to 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 over previous months compliance is consistently above 85%.

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.

Mitigations:

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

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PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-23	Jun-23	Jul-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.46%	0.27%	0.49%	0.38%			
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	59.18%	57.01%	56.30%	57.02%	57.46%	55.24%		
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	798	702	697	2862	0		
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	75.65%	75.99%	72.33%	76.39%	88.50%		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	5,231	6838	6823		20,835	5,834		
	65 Week Waiters	Responsive	Services	Chief Operating Officer	1,868	2,103	2,117		6,342	2,083		
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	50.02%	50.44%		49.78%	84.10%		
	Waiting List Size	Responsive	Services	Chief Operating Officer	67,823	72,605	73,320		n/a	n/a		
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.0%	53.92%	59.17%		56.98%	75.00%		
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	52.04%	44.88%		50.88%	85.39%		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	53.98%	53.35%		52.85%	93.00%		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	14.29%	7.87%		10.08%	93.00%		
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	87.50%	94.64%		90.26%	96.00%		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	95.36%	95.76%		96.11%	98.00%		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	66.33%	68.75%		73.60%	94.00%		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	87.83%	84.62%		88.41%	94.00%		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	55.88%	67.69%		66.95%	90.00%		

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PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-23	Jun-23	Jul-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	61.45%	65.48%		65.61%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	66.10%	67.84%	70.10%	66.46%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.21%	1.22%	1.57%	1.26%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	11	10	13	48	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	88.89%	88.24%	78.26%	87.30%	90%	F	
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	63.89%	60.00%	66.67%	60.91%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,380	4,215	4,421	4,269	4,657	P	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	541	389	391	440	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	82	74	70	317	40	F	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.07	2.52	2.89	2.84	2.80	F	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.87	4.77	4.79	4.89	4.5	F	
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%		
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	26,816	27,663	28,481	27,231	4,524	F	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	31.25%	30.20%	32.83%	31.26%	70.00%	F	
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	46.89%	40.90%	41.43%	43.51%	45.00%	F	

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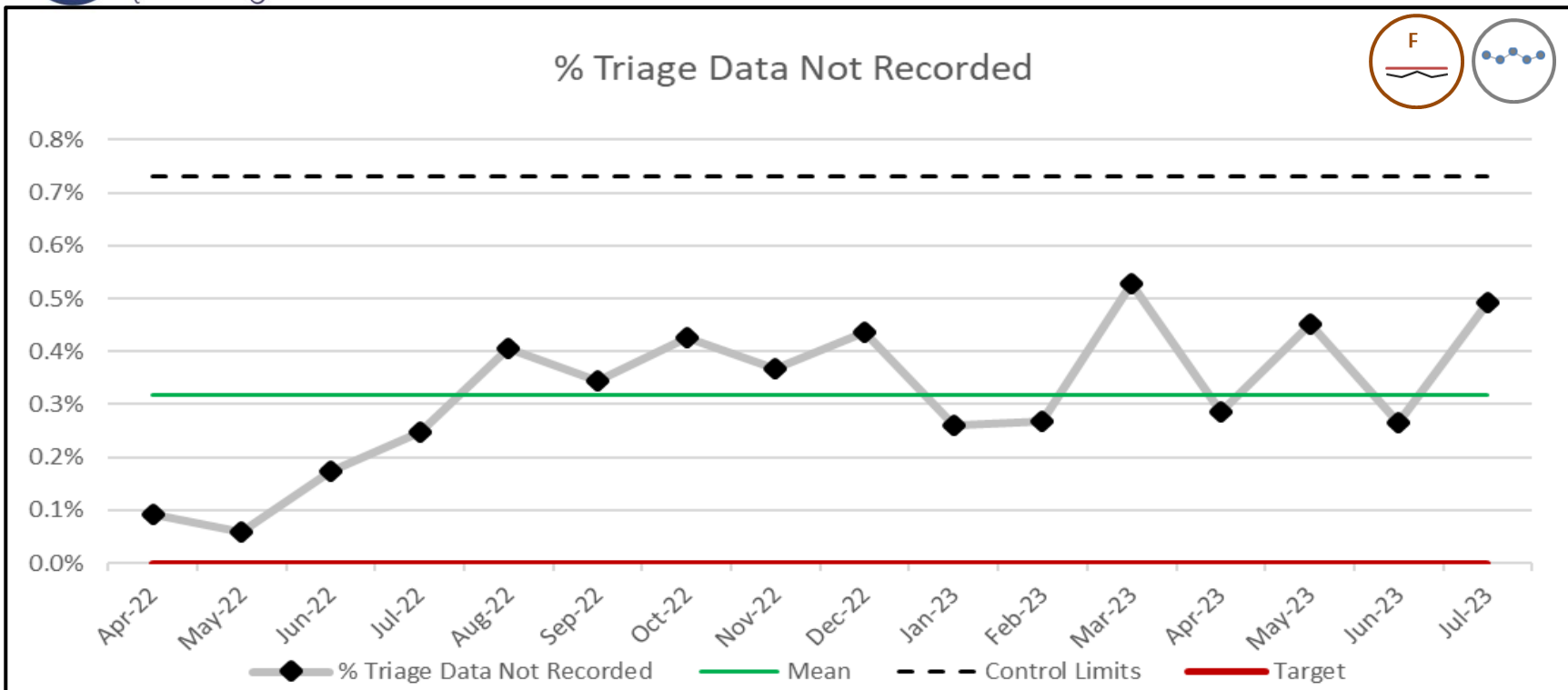

Jul-23
0.49%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of triage data not recorded.

What the chart tells us:

July 23 reported a non-validated position of 0.49% of data not recorded verses target of 0%. What the chart doesn't tell us is that 78% of those without a triage "did not wait" to be seen. And a further 4% sadly were RIP on arrival.

Issues:

- Recognition of patients that "Did Not Wait/Refused Treatment" 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).

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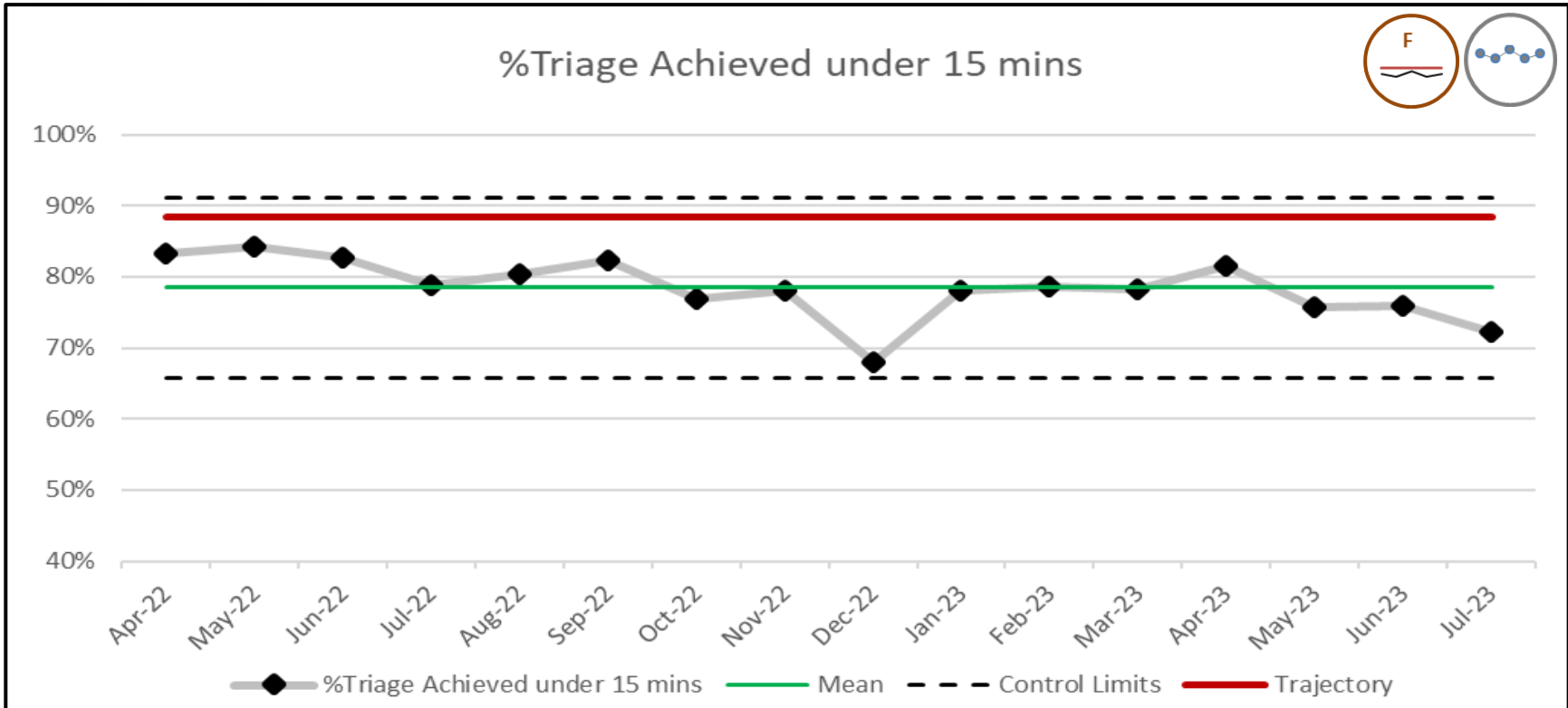

Jul-23
72.33%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of triage achieved under 15 minutes.

What the chart tells us:

The compliance against this target is 88.50%.
July outturn was 72.33% compared to 75.99% in June (validated).
This target has not been met.
What the chart doesn't tell us is the 0.68% increase in daily attendances for July 23.

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.

Mitigations:

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

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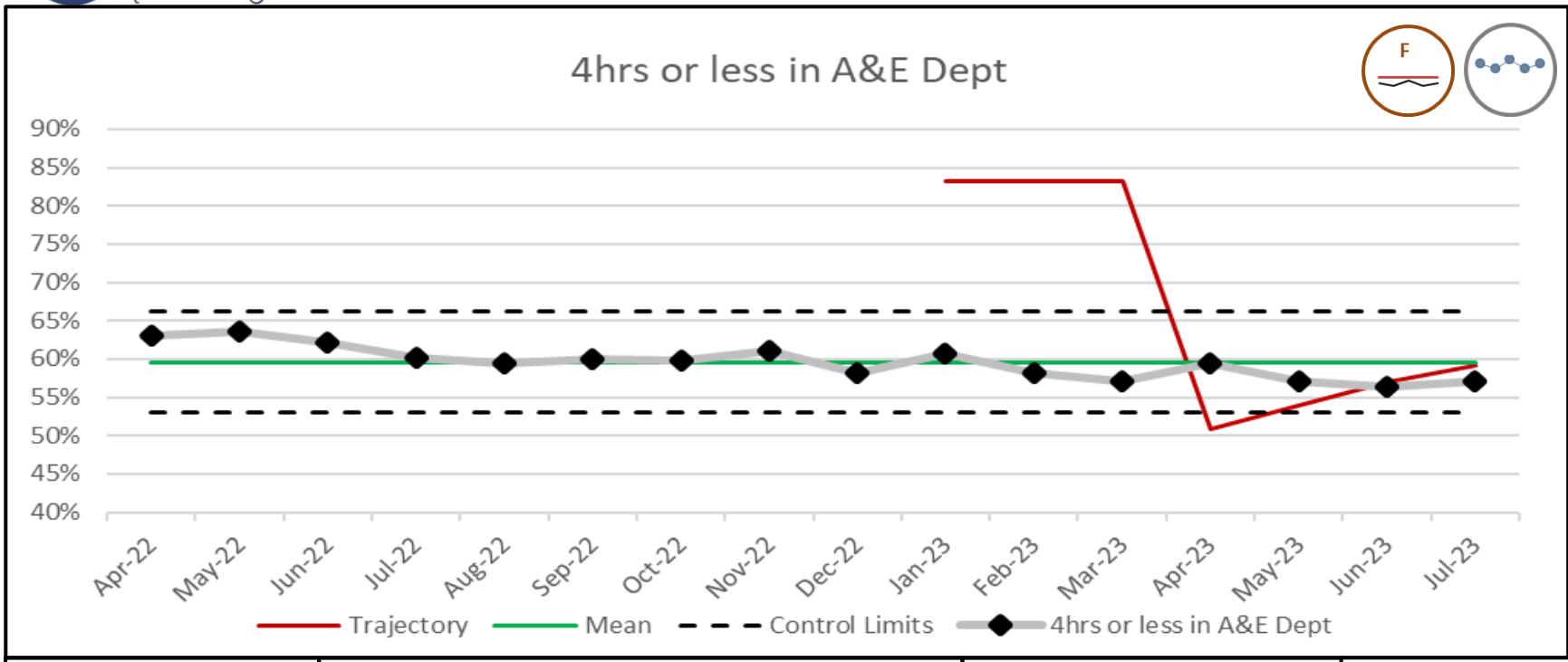

Jul-23
57.02%
Variance Type
Metric is currently experiencing Common Cause Variation
Recovery Trajectory
59.18%
Trajectory Achievement
Metric is failing recovery trajectory
Executive Lead
Chief Operating Officer

Background:

The 23/24 target has been set at 76% with a rolling trajectory by month to achieve by year end. The ULHT improvement trajectory is based on Type 1 and co-located UTC Type 3 attendances.
With July 2023 set at a 59.18% ambition.

What the chart tells us:

The 4-hour transit target performance for Type 1 and co-located UTC Type 3 for July was 57.02% against a target of 59.18%, June was 56.30%.
This improvement target has not been met.
The Type 1 and combined Type 3 position is 71.24%.

Issues:

Main factor in decline of performance due to increased attendances within the Emergency Departments.
July saw 2.75% more patients (368) compared to June. This is also 3.58% (476) more than 2022.

This increase mirrors the yearly Holiday Makers that are seen within ED due to our costal connections. But also a high increase seen throughout all ED's in England for July 2023.

Ward Based Discharges were an average of 23 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. (With 63.25% recognised after 4pm daily)

Ongoing medical and nursing gaps that were not Emergency Department specific.
Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps.
Escalation of some SDEC areas into Inpatient areas was frequent.

Actions:

Reducing the burden placed upon the Emergency Departments further will be though the continued expansion of Same Day Emergency Care (SDEC) Services, maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients, the System flow and discharge improvements to increase access pathway 1 (D2A) capacity and the 'Care Closer to Home' programme.
Breaking the Cycle initiative experienced a reduced benefit during December so has been re-launched and daily discharge target have been set for the organisation and marked through the course of the day.

Mitigations:

EMAS continue to enact a targeted admission avoidance process, including no Cat 4 conveyances should arrive at the Emergency Department.
The Discharge Lounge at LCH and PHB continues operating, where possible, a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and transport home. The closure of the Discharge Lounges due to inadequate staffing sits solely with the Chief Operating Officer and the Director of Nursing but can be delegated to Dep Chief Operating Officer/ Gold Commander "Out of Hours"
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.

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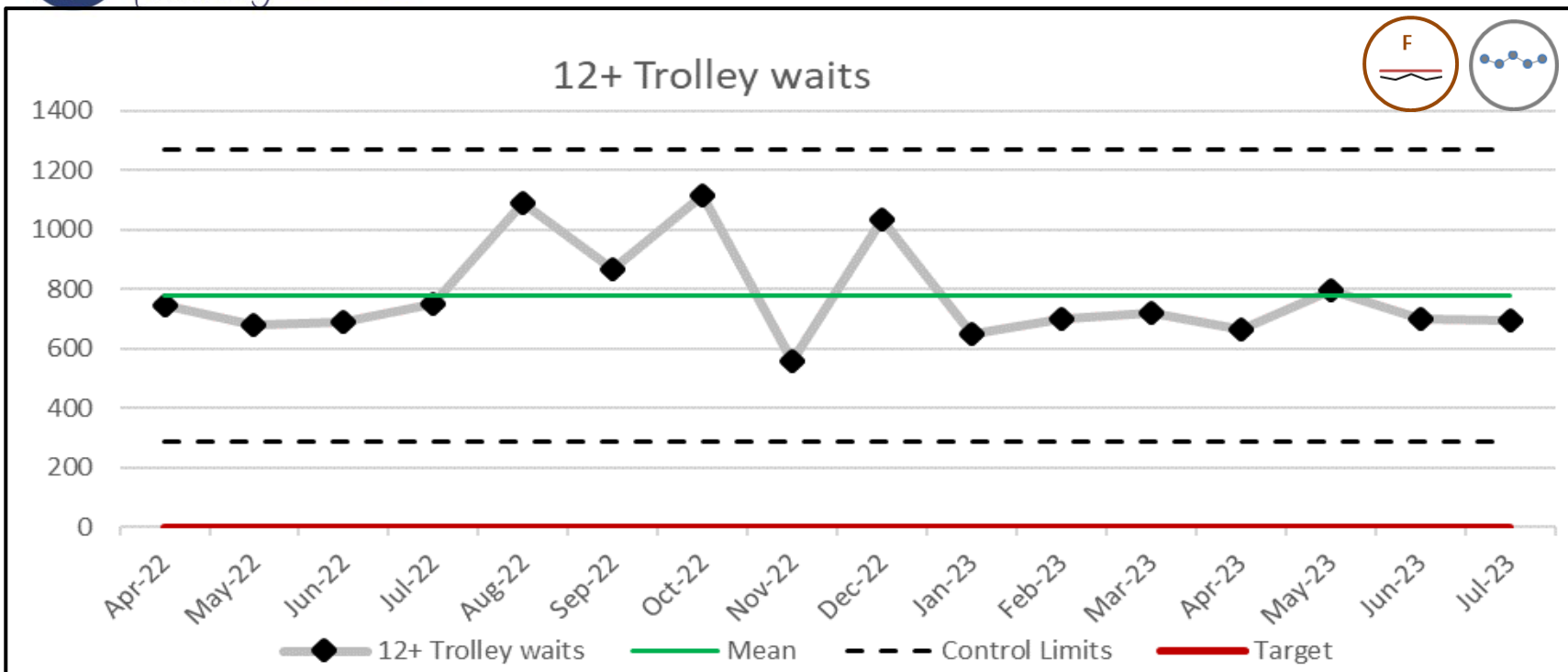

Jul-23
697
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

July experienced 697 12-hr trolley wait breaches compared to June of 702. This is a decrease of 5 patients.
The 697 seen, equates to 5.06% of all type 1 attendances for July
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.

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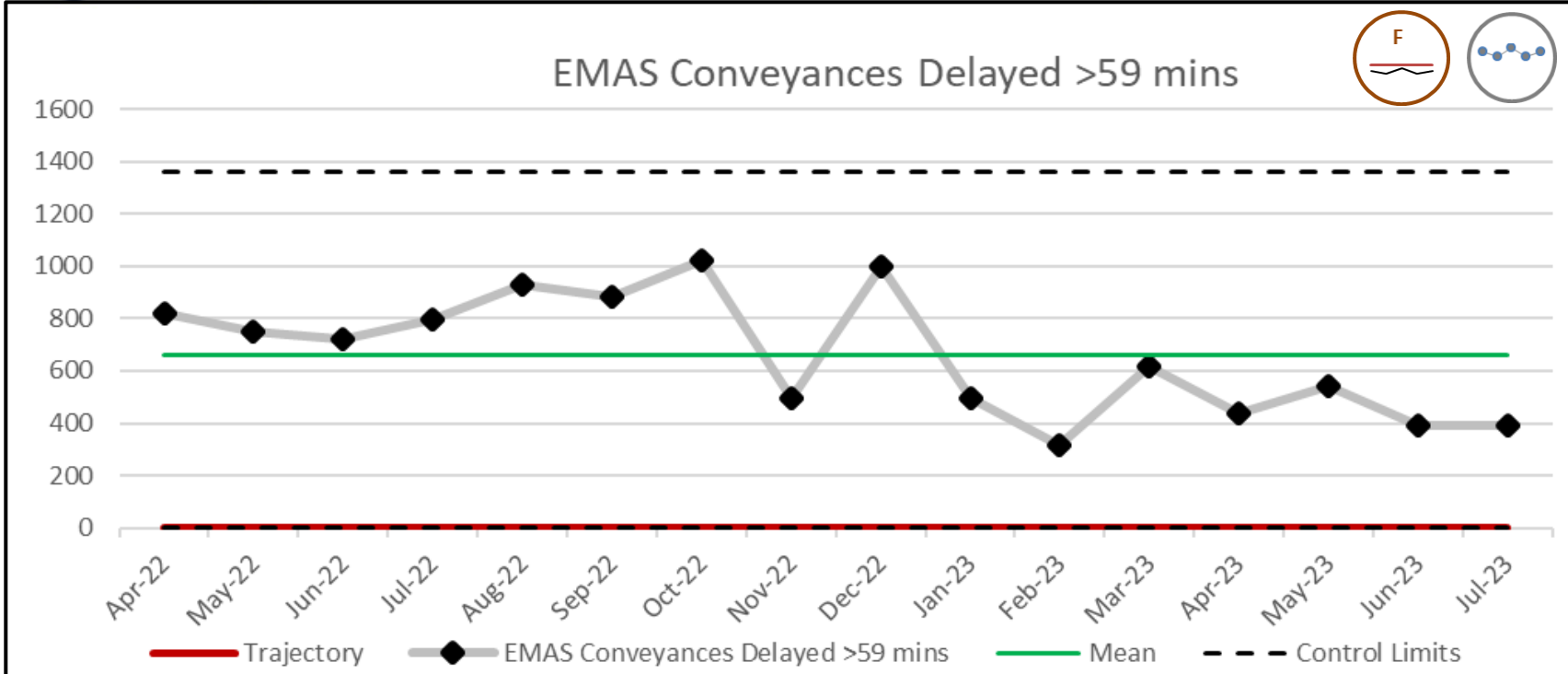


Jul-23
391
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

July demonstrated a static performance in waits greater than 59 minutes' to that seen in June 2023, with an increase of 2.
What the chart doesn't tell us is that the static position remained even with a 4.89% increase of arrivals (206) compared to June 2022.
ULHT also saw 665 more arrivals in July compared to July 2022.

Issues:

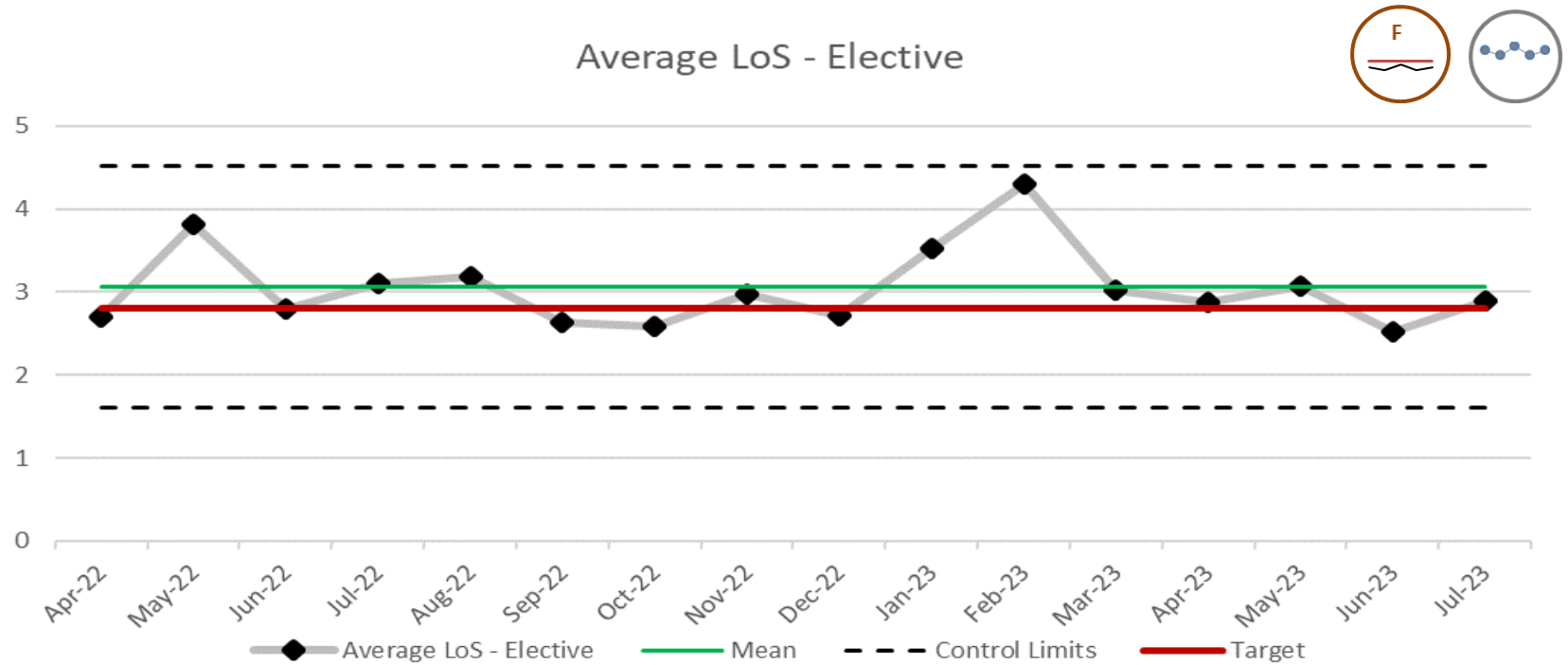
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number of category 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.



Jul-23
2.89
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 to 2.89 days compared to 2.52 days in June. This is a deterioration of 0.37 days and represents a negative variance of days against the agreed target of 0.09 days.

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

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

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

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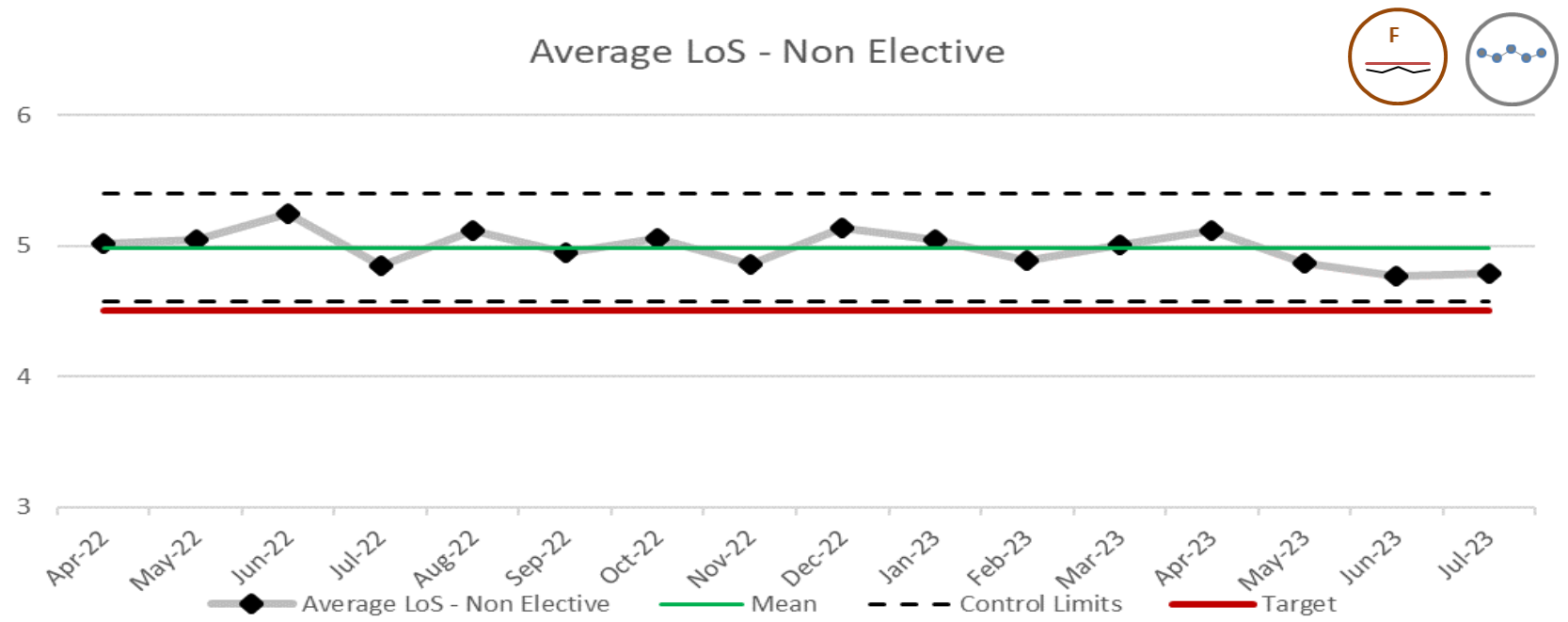

Jul-23
4.79
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 4.79 days in July.
This is a decline of 0.2 days and a 0.29-day negative variance against the agreed target.

What the chart doesn't tell us is the increases were seen only in;
Pathway 1 (0.7) days
Pathway 3 (0.2) days

Issues:

Super stranded patients has seen a slight improvement from June daily average of 143 patients to July 141.

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 Industrial Strike activity 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.

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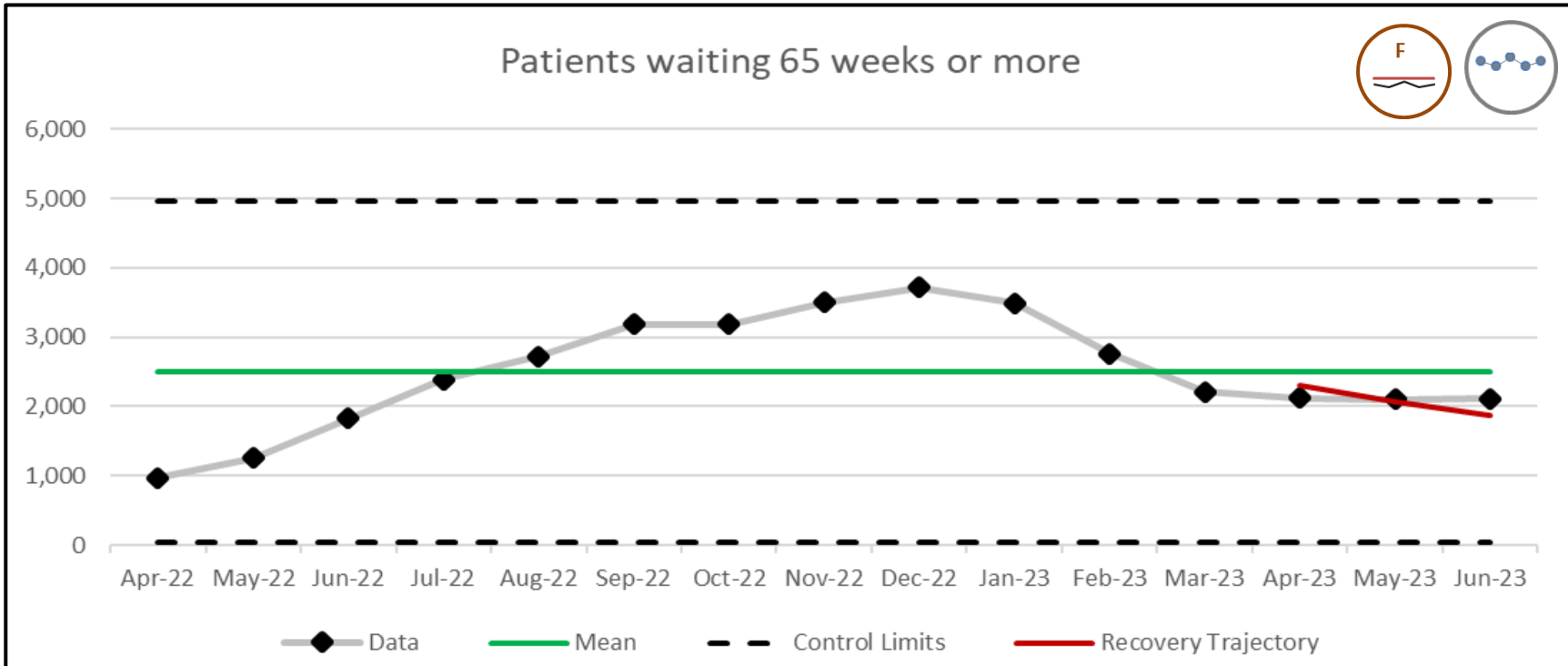


Jun-23
2,117
Variance Type
Metric is currently experiencing Common Cause Variation
Recovery Trajectory
1,868
Achievement
Metric is failing recovery trajectory
Executive Lead
Chief Operating Officer

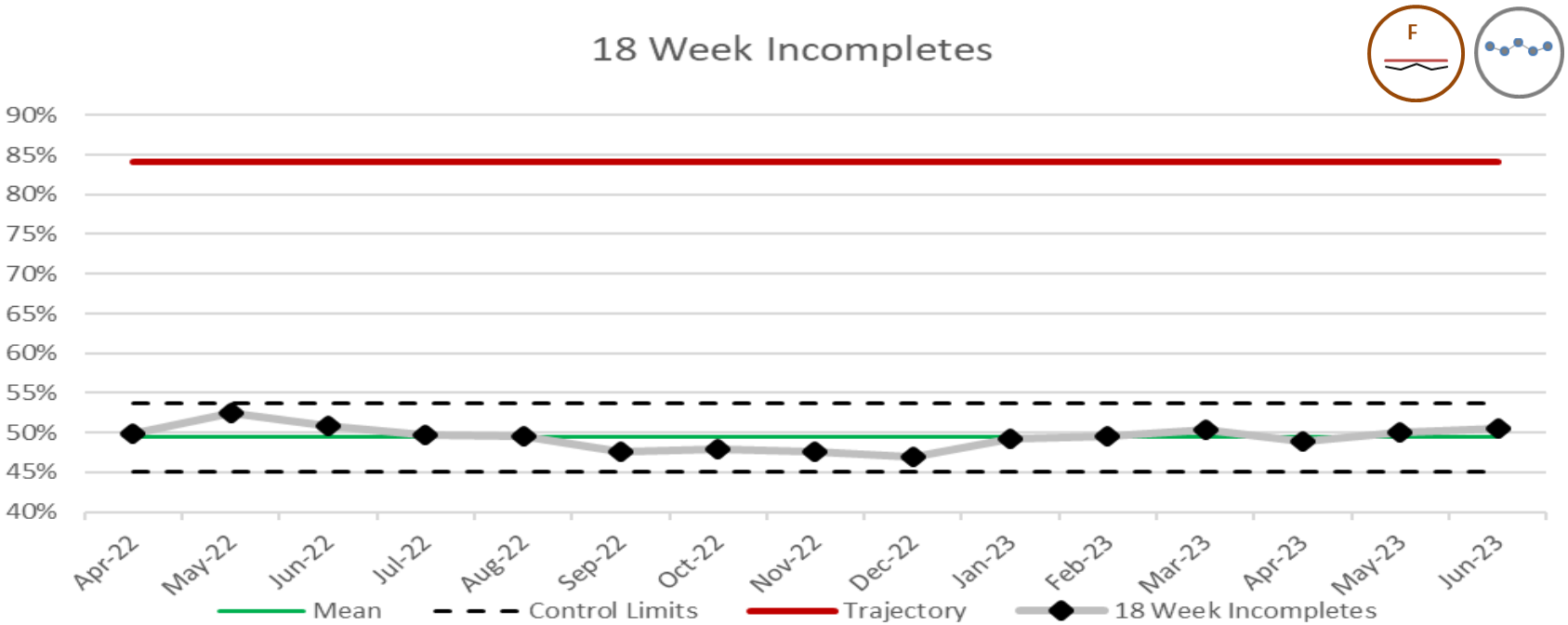
Background:
Number of patients waiting more than 65 weeks for treatment.

What the chart tells us:
The Trust reported 2,117 incomplete 65-week breaches for June 2023, an increase of 14 from May 2023's 2,103.

Issues:
ULHT's position is strong with 104 week wait patients, with 4 patients reported for June. As shown above, 65 week waiters are positively performing against trajectory. Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways. The doctor's ongoing industrial action continues to have a detrimental effect on performance.

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through the PTL meeting. This meeting is currently under review to assess effectiveness and to improve the monitoring of patient pathways.

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



Jun-23
50.44%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background

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

What the chart tells us:

There is significant backlog of patients on incomplete pathways. However, June 2023 saw RTT performance of 50.44% against an 84.1% target, which is 0.42% up from May 2023.

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 – 5991 (increased by 248)
Gastroenterology – 3666 (decreased by 98)
Dermatology – 2699 (increased by 127)
Ophthalmology – 2582 (decreased by 7)
Gynaecology – 2533 (increased by 60).

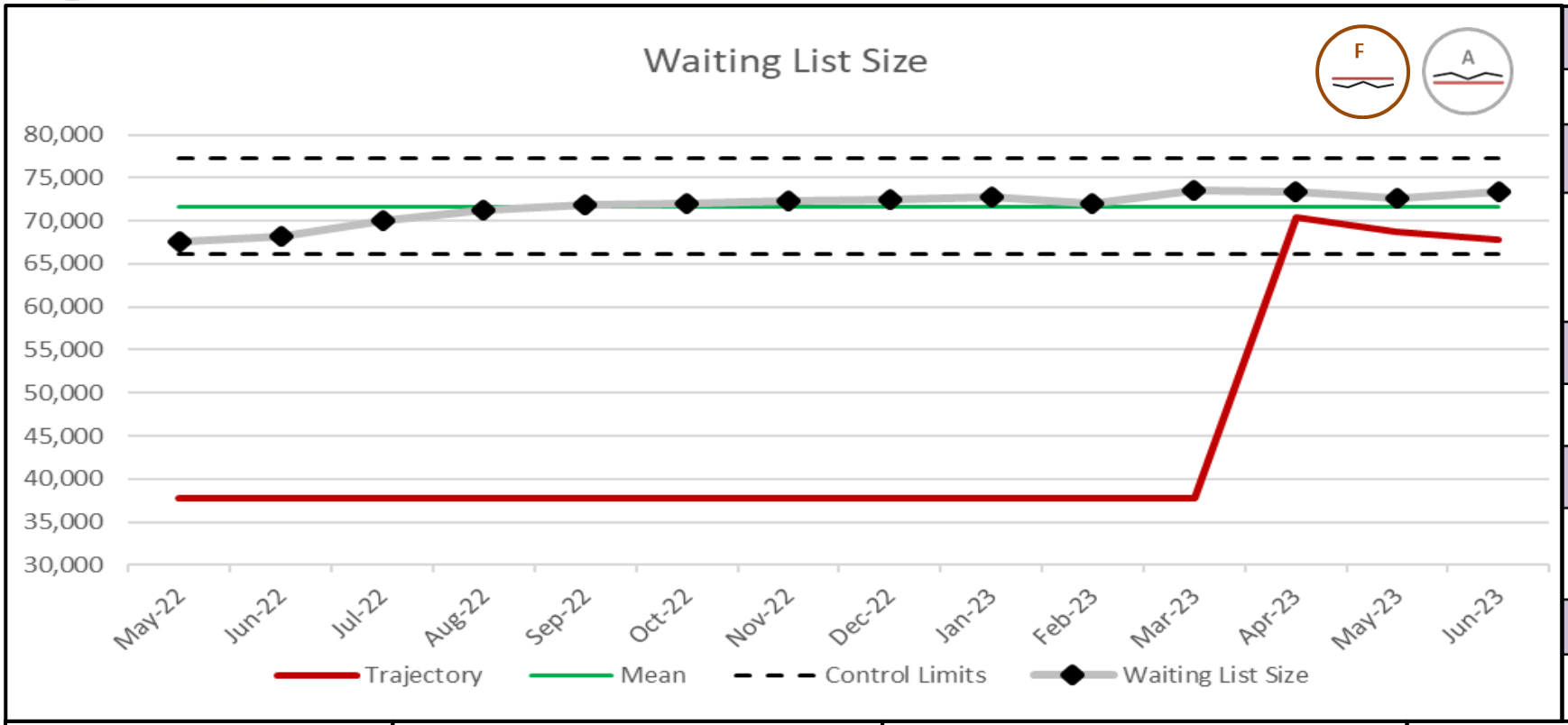
Actions:

Priority remains focussed on clinically urgent and Cancer patients. National focus continues to be on patients that are waiting 78 weeks and over. Resource is targeted at patients who have the potential to be >78 weeks. Schemes to address the 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 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 is also on capturing all activity.
Clinical prioritisation – Focusing on clinical priority of patients using theatres.



Jun-23
73,320
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
Recovery Trajectory
67,823
Target Achievement
Metric is failing recovery trajectory
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 May 2023, with June showing an increase of 715 to 73,320 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; COVID sickness and urgent care pressures
The five specialties with the largest waiting lists are;

ENT – 9642
Ophthalmology – 6314
Gastroenterology – 5816
Gynaecology – 5347
Dermatology – 5280

Actions
Improvement programmes as described above for RTT performance. In addition, all patients >52 weeks are monitored weekly by the Trusts RTT team. Phase 1 of the validation programme continues. This will be followed by phase 2, an administrative review; involving contacting patients to review the need for treatment. The Integrated Elective Care Co-Ordination Programme is now being reviewed for use for the non-admitted waiting list.

Mitigations:
The number of patients waiting over 78 weeks has decreased by 118 from May. There is a 78 week cohort meeting between the ICB and ULHT to monitor progress against target which takes place 3 times a week. 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.

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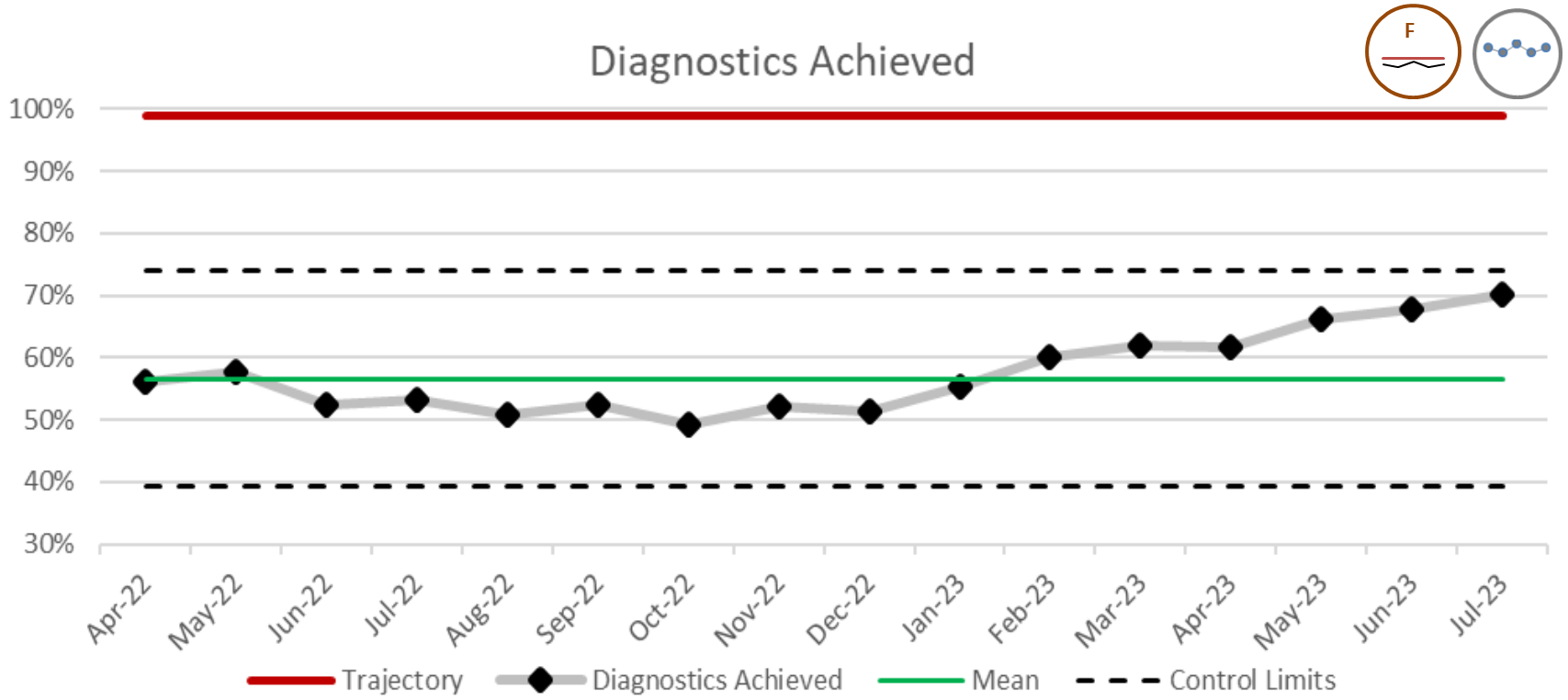


Jul-23
70.10%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Diagnostics achieved in under 6 weeks.

What the chart tells us:

We are currently at 70.10% against the 99.00% target.

Issues:

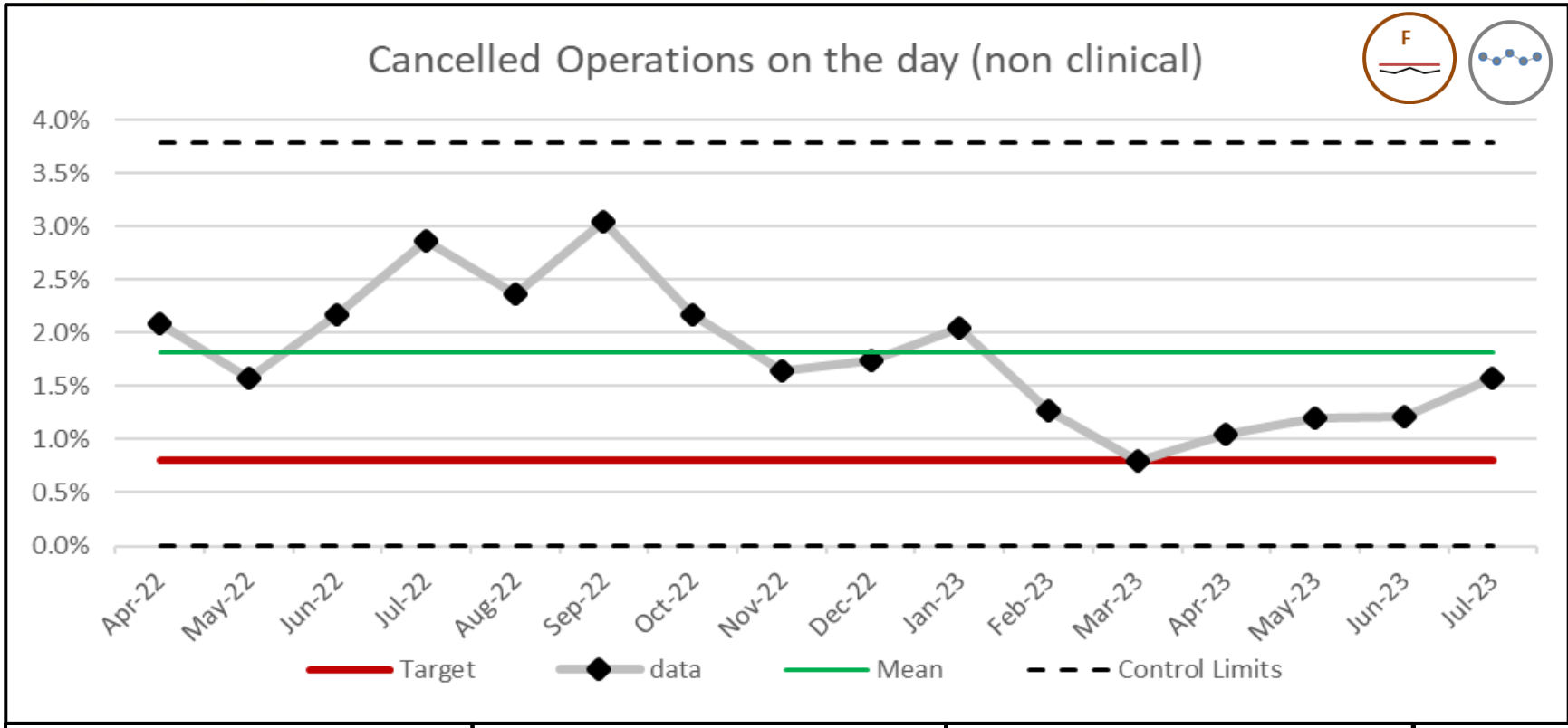
1. The majority of diagnostic breaches sit in Cardiac Echo with 4176 breaches recorded in July.
2. MRI has 371 breaches. Additional outsourcing to help reduce the backlog from January 2023 hopefully reducing breaches to within limits by November
3. There is 137 Dexa Breaches as the scanner is now up and running we should see a reduction of around 150 breaches each month but slowed down due to increase in demand and staff vacancy
4. Additional to the 475 cardiac echoes there are additional 103 Stress/TOES and 174 echo-paediatrics.

Actions:

Where demand out strips capacity additional resource is being sort. All areas have completed a recovery trajectory to NHSE. These will now be affected by the 78 weeks work. 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 steadily reducing as expected each month as now up and running.

Mitigations:

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



Jul-23
1.57%
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 July.

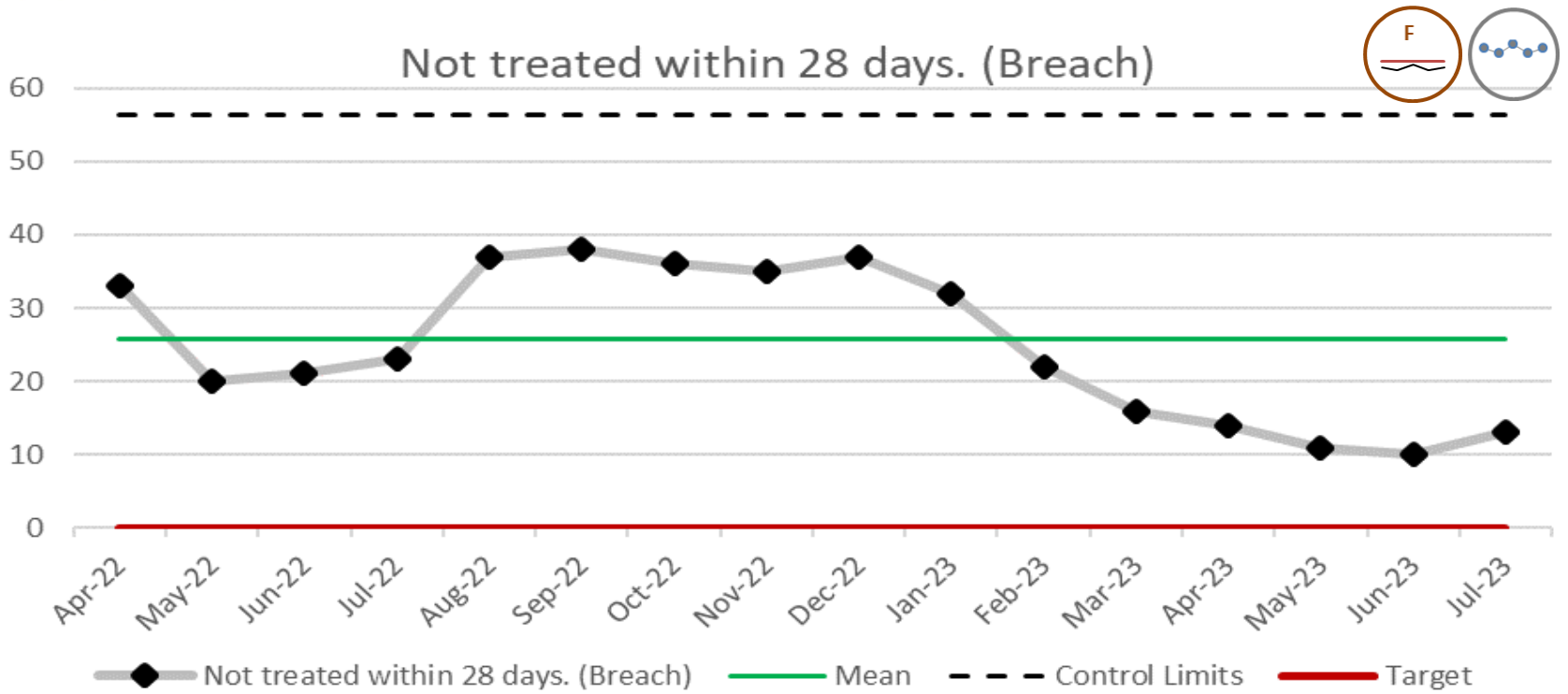
What the chart tells us
There has been an increase in number of patients cancelled on the day from 1.22% in June to 1.57% in July which remains above the agreed trajectory of 0.8%.

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

- Lack of time (8)
- No surgeon (3)/Equipment unavailable (3)/beds (3)

Actions:
Ensuring theatres start on time will reduce the possibility of cancellations for lack of time due to late starts. In July lists cancelled due to lack of time were a result of a mix of late starts and complexity of patients started late.

Mitigations:
Steris aware of equipment issues and have provided information re opportunity to make good issues before cancelling patients – this has been shared across theatres for future information.



Jul-23
13
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 July 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 has been an increase in July, with the total number of breaches now at 13 and therefore the agreed target of zero has still not been achieved.

Issues:
List availability has been reduced during July due to both Consultant and Junior Doctor Industrial Action. This has resulted in fewer patients being able to be re-dated within 28 days.

Actions:
Grantham utilisation continues to be pushed with all CBUs to provide an increase of lists being used as well as in session utilisation.

Dedicated resource is working with waiting list teams and CBU/Clinical Leads to improve uptake of empty lists.

Mitigations:
Improved 642 now means CBUs are holding pre meets and are challenged if lists fall below a planned utilisation of 85%. This has seen an increase in utilisation across many lists.

Annual leave of our clinical workforce has also meant reduced list availability.

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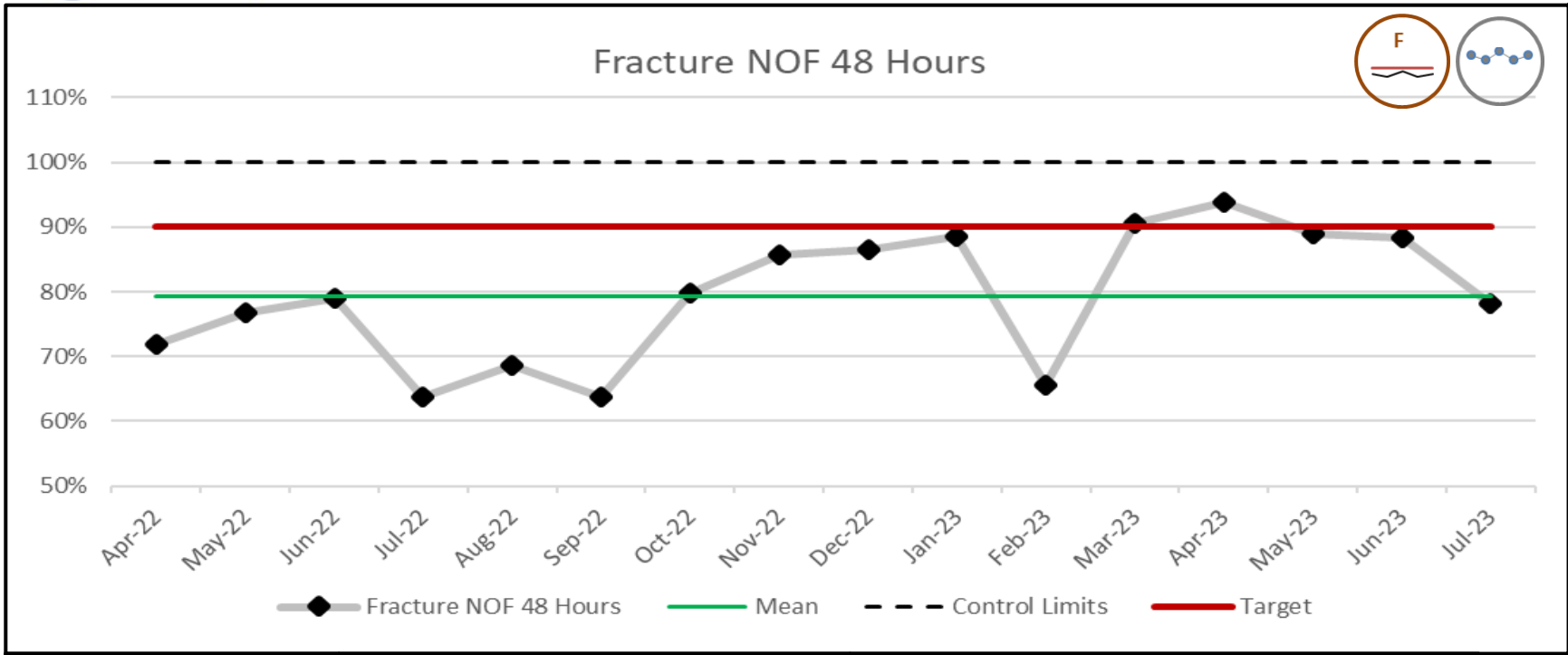


Jul-23
78.26%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

For July
LCH achieved 91.18%
PHB achieved 73.53%

The average percentage across both sites for June was 78.26%

Issues:

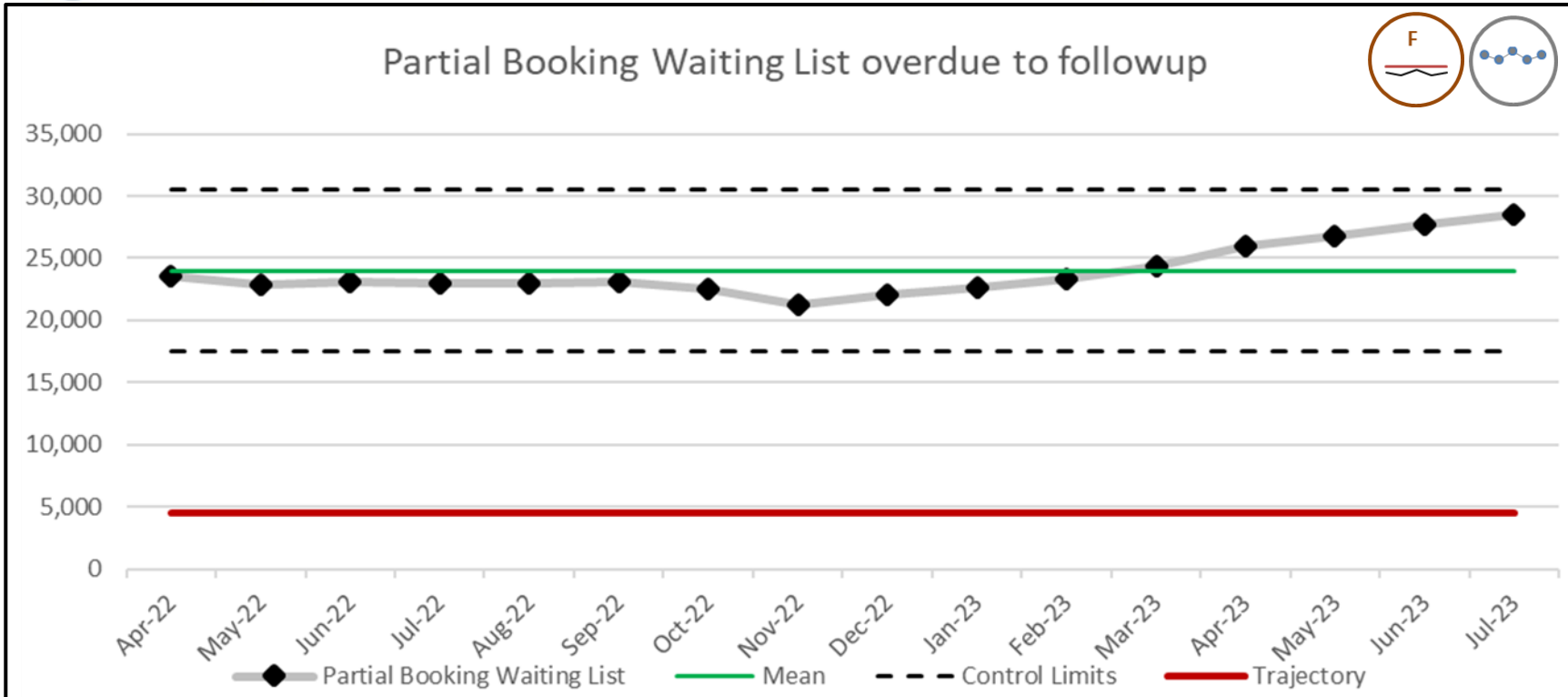
- 15 fractured neck of femur patients did not go to theatre within 48 hours of admission due to not having enough theatre capacity.
- Patients medically unfit for Surgery causing delays.
- ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
- Due to increase in trauma demand and the types of injuries seen, certain procedures have been clinically prioritised ahead of fractured femur patients.
- Specialty trauma lists on Boston and Lincoln sites not having capacity to add trauma patients.
- Lack of anaesthetic or theatre staff to provide additional trauma capacity.

Actions:

- NOF pathway project to commence with the multidisciplinary team complying with the best practice tariff for femur fractures.
- 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.
- Review of additional trauma lists through job planning process to see if additional trauma lists can be available for Femur fractures to avoid breaches.
- To ensure that the band 7 trauma lead continues to the utilisation of lists and escalate high capacity of trauma cases to the CBU to see if extra theatre lists are available.
- Trauma coordinator team to ensure that femur fractures are listed on the trauma list before breaches.
- Band 7 lead trauma coordinator to discus with the CBU to see if extra theatre lists are available for Femur fractures.

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.
- Once daily additional CBU review of trauma and plans to ensure capacity maximised for clinical priority.



Jul-23
28,481
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 28,481 against a target of 4,524.
During Covid the number of patients overdue significantly increased until April 2022, at which point it remained stable. Since November 2022 the PBWL has steadily been increasing.

Issues:
The organisation has a number of competing priorities. The current focus is on the 78 week patients and potential cancer patients. The current PBWL demand outweighs the current capacity which is being impacted by industrial action and available capacity, rooms and resources.

Actions:
The PBWL meeting with the CBU's has been relaunched with a new agenda and template to improve attendance and focus. First meetings have taken place with improved attendance since relaunch. PIFU implementation has been refreshed and continues to be an area of focus to reduce PBWL.

Mitigations:
Clinics and patients have previously been cancelled and added to the PBWL due to industrial action. Booking team priorities are to support the industrial action plans and supporting the booking of the 78 week cohort as a priority.

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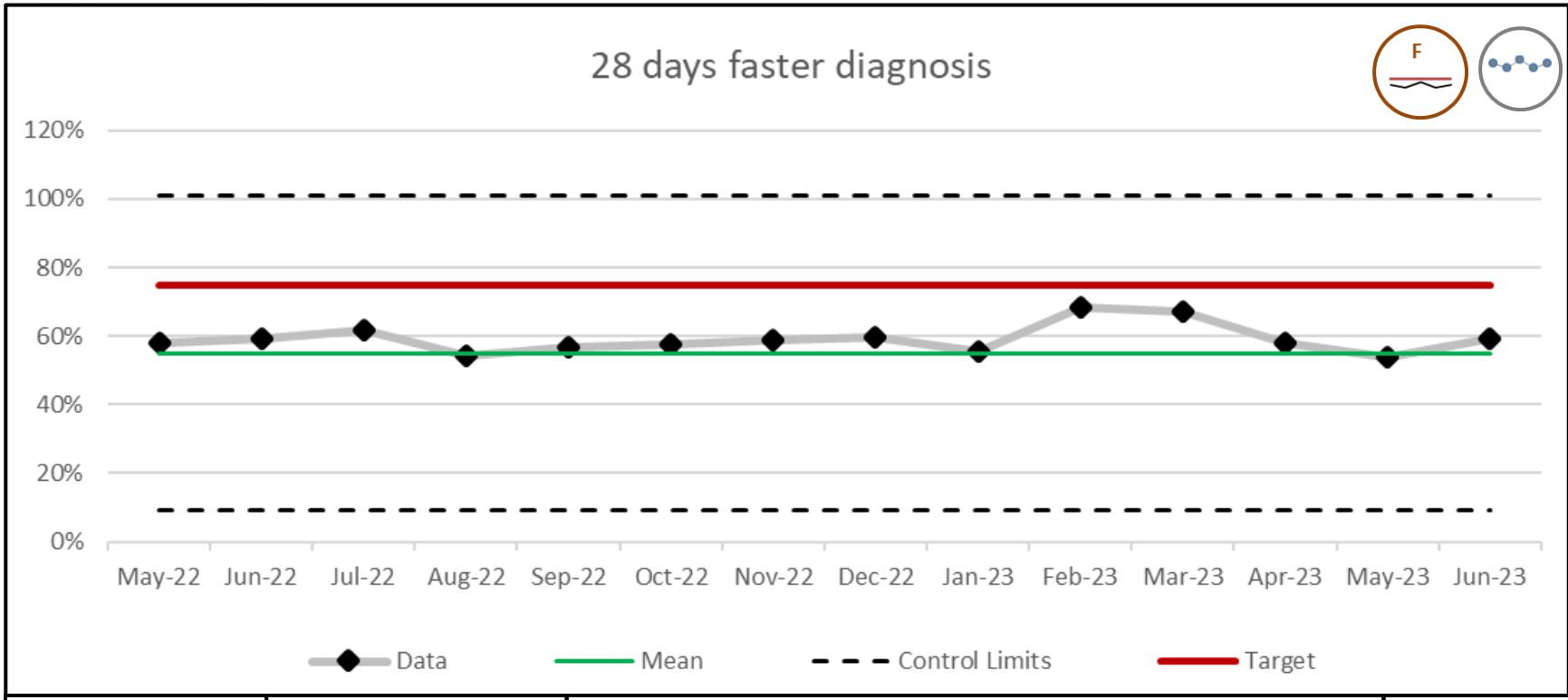

Jun-23
59.17%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
75%
Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 59.17% against a 75% target.

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, gynaecology and lung (see 2ww Suspect).
Diagnostic capacity challenges and clinical review capacity.

Actions: (Please also see Actions on 2ww suspected cancer page)

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 and capacity for diagnostics in Urology – work to increase this capacity and reduce bottlenecks is ongoing. A number of medical vacancies are expected over the summer months that will impact diagnostic capacity – recruitment processes and mitigations are in place. Diagnostic capacity for TPGA at Louth will be in place from August 2023.
Radiology – Bed capacity for Interventional Radiology patients at PHB. Development of OR theatre recovery unit to allow the service to recover its own patients. Constant shortfall of CTC reporting sessions (10 sessions needed, currently running 6-7).
In Upper GI2 x Cancer Navigator posts are being shortlisted and interviewed in August.
Concerns regarding the MDT functions and MDT Lead status for both UGI and HPB – Meetings regarding MDT streamlining support and processes are underway.

Mitigations: (Please also see Mitigations on 2ww suspected cancer page)

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.
Intensive Support Meetings are taking place twice weekly to understand and resolve the themes and issues in 28 day FDS performance in a number of tumour site specialties.
The radiology clinical lead is looking at job plans to support and improve CTC reporting capacity with another radiologist in training to report CTCs.
Navigator SOP developed in conjunction with Colorectal CBU that can and will be introduced and utilised by other Divisional specialties to support escalation processes.

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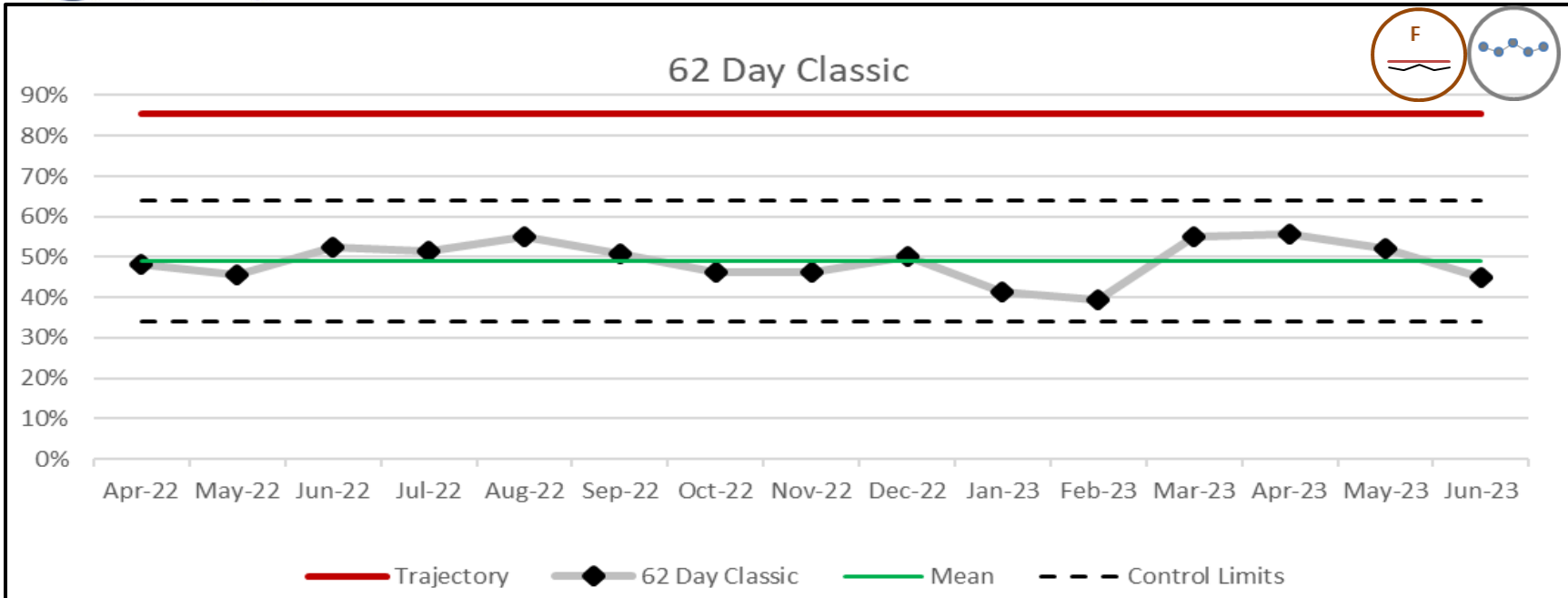


Jun-23
44.88%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 44.88% 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, Head & Neck, Gynaecology and Lung.
Limited theatre capacity continues to impact cancer pathways across the Trust. Anaesthetic assessment and pre-op capacity is also limited and impacts the ability to be able to populate lists at short notice.

Actions:

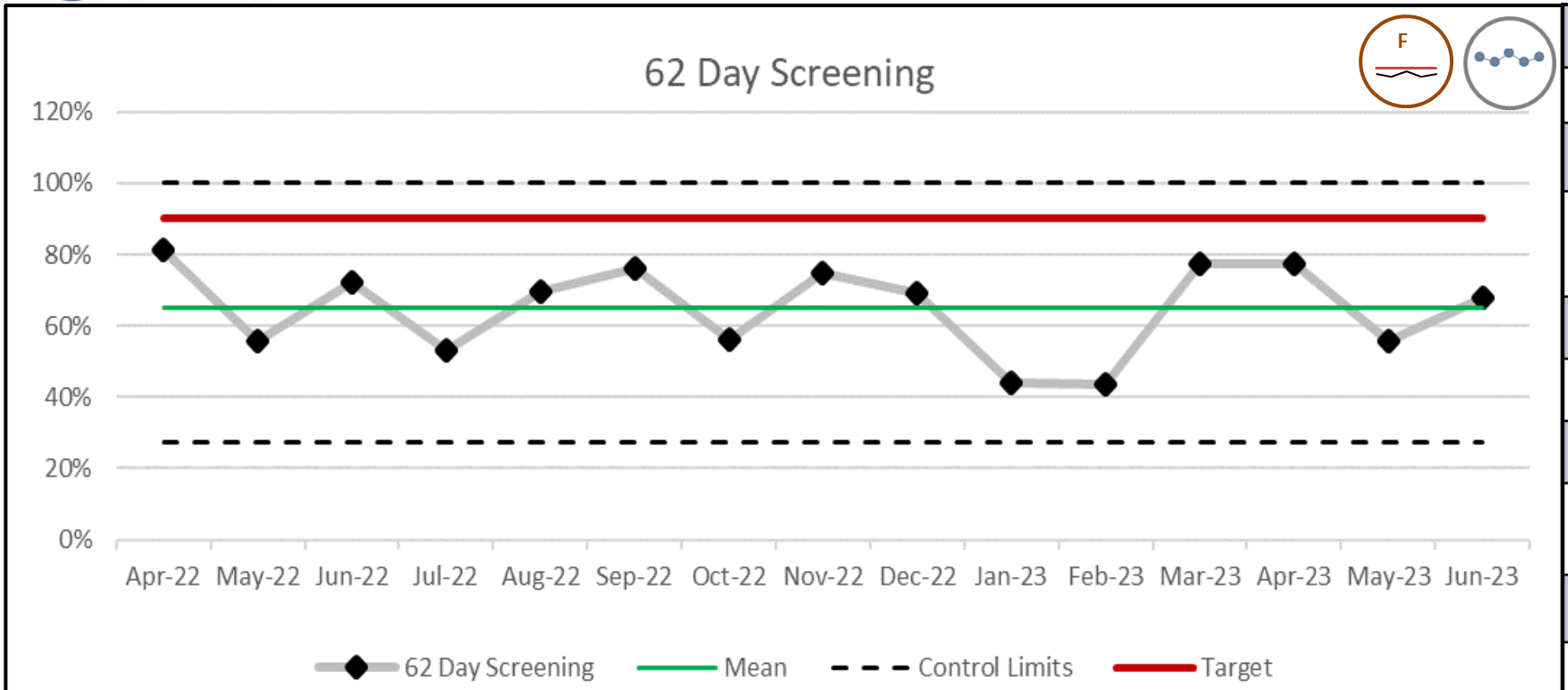
Oncology Fragile Service – Recruitment is ongoing to secure NHS fixed term locums. 2 Medical Oncologist (fixed term) have been offered posts and are awaiting start dates. One further Medical Oncology post has been offered awaiting acceptance of offer. The post offered for Oncology Sp Dr is awaiting the PLAB2 exam (passed PLAB 1).
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.



Jun-23
67.69%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

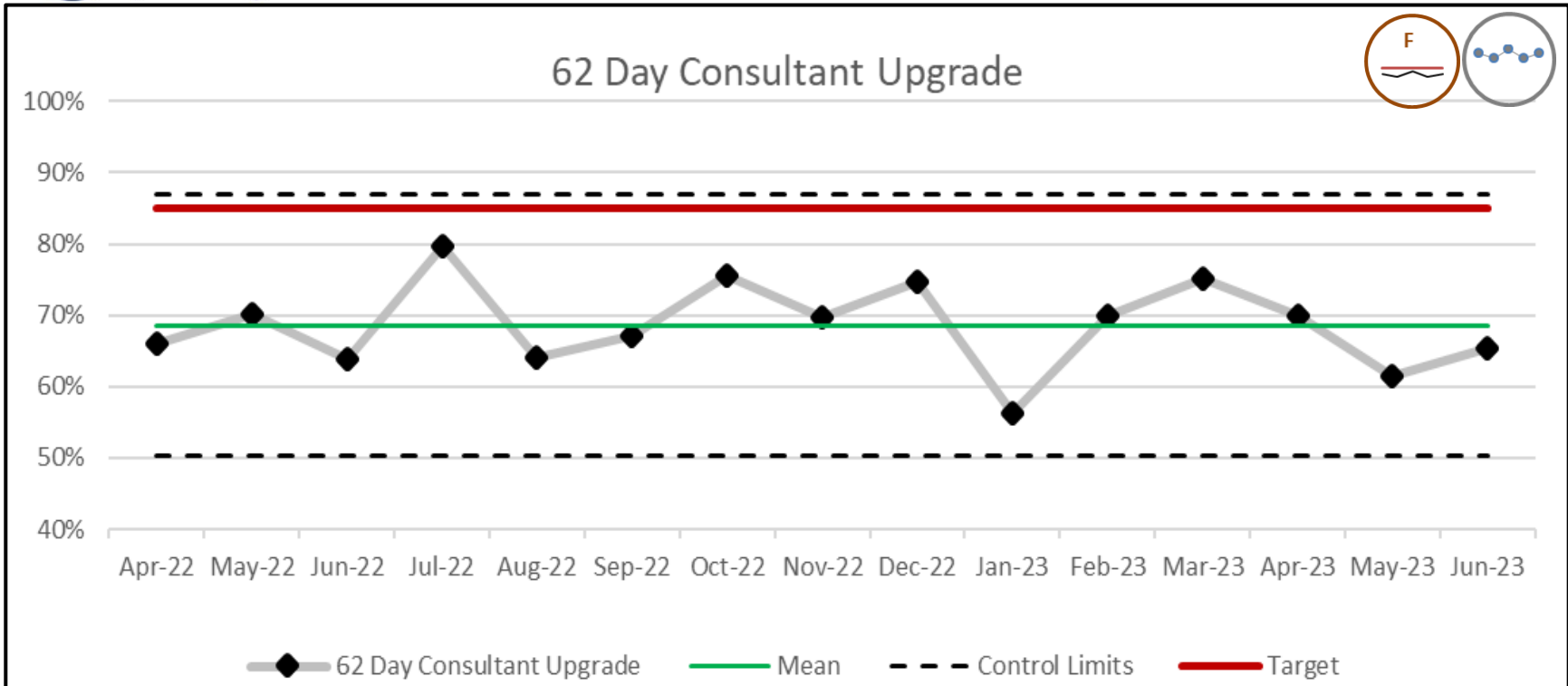
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 67.69% 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.



Jun-23
65.48%
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 65.48% against an 85% target.

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

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

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

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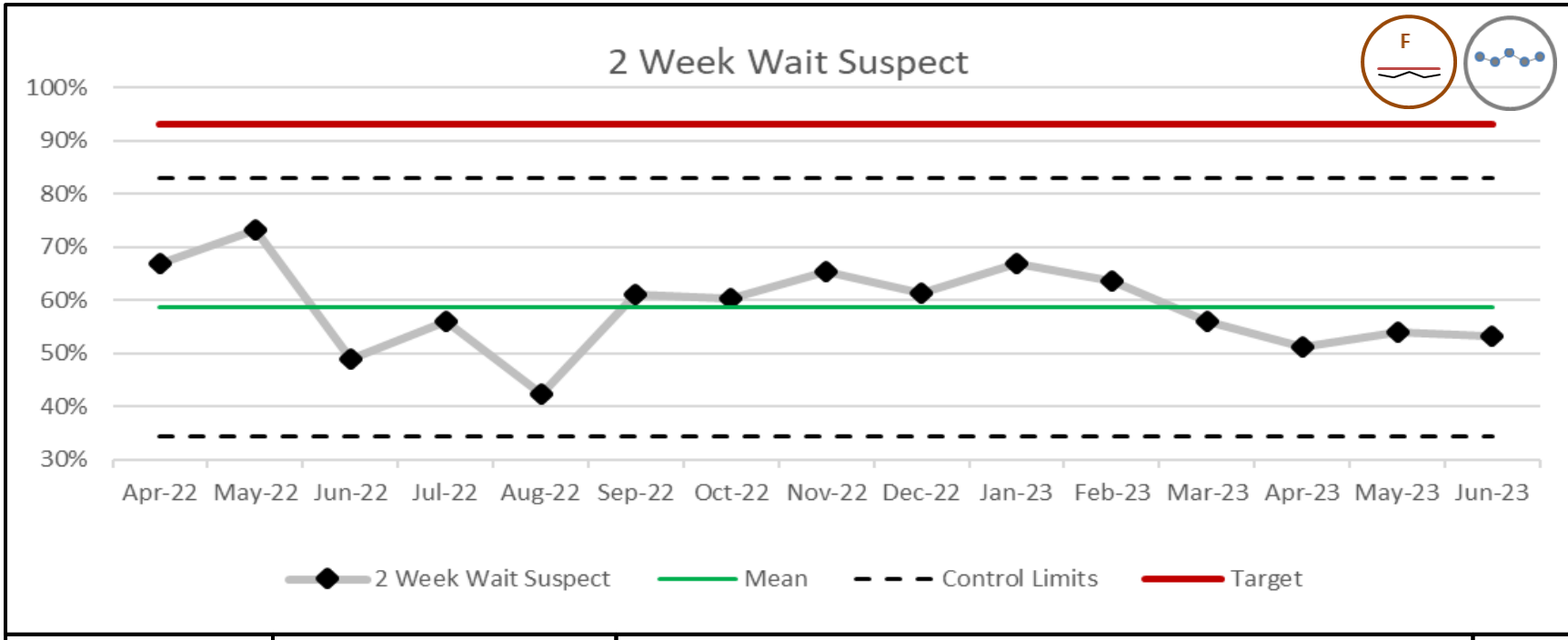

Jun-23
53.35%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 53.35% against a 93% target.

Issues:

Patients not willing to travel to where our service and/or capacity is available.
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with 38% of the Trust's June 14 Day breaches within that tumour site.
Also of concern was skin performance which accounted for 38% of the Trust's 14 day breaches.
The Gynae tumour site accounted for 10% of June breaches.

Actions:

In Gynae, a number of work streams have been identified through the oncology strategy meetings. The urgent PMB pathway is set to be implemented in August.
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues.
Respiratory Consultant capacity is a continuing issue and the consultant recruitment drive is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. The Lung Cancer Clinical Reference Group has commenced to resolve issues surrounding the unsustainable increase in FRED referrals and Direct Access chest x-rays are in place. 2 x Lung Cancer CNS posts (funding until March 25 - risk stratification to reduce unnecessary CT scans and demand on Cons triage are out to advert.
The UGI Triage CNS post to support the start of UGI pathway is undergoing recruitment processes currently. ICB EACH are providing 3 months support with 2ww referrals to reduce the delays from receipt of referral to STT booking.
Lung Cancer CNS x 2 posts funding until March 25 - risk stratification to reduce unnecessary CT scans and demand on Cons triage.
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:

Haematology is in fragile services due to vacancy/capacity. Issues with inappropriate referrals and GP engagement continue to be escalated and supported by the ICB. Delays in the booking and utilisation of appointment slots which continue to be addressed with C&A.
In Dermatology, The seasonal increase in referrals is evident – extra clinics are being arranged to accommodate these referrals and deal with the elevated levels of annual leave at this time of year.
In Urology virtual clinics commenced in July to minimise pathway delays and free up 2ww capacity.

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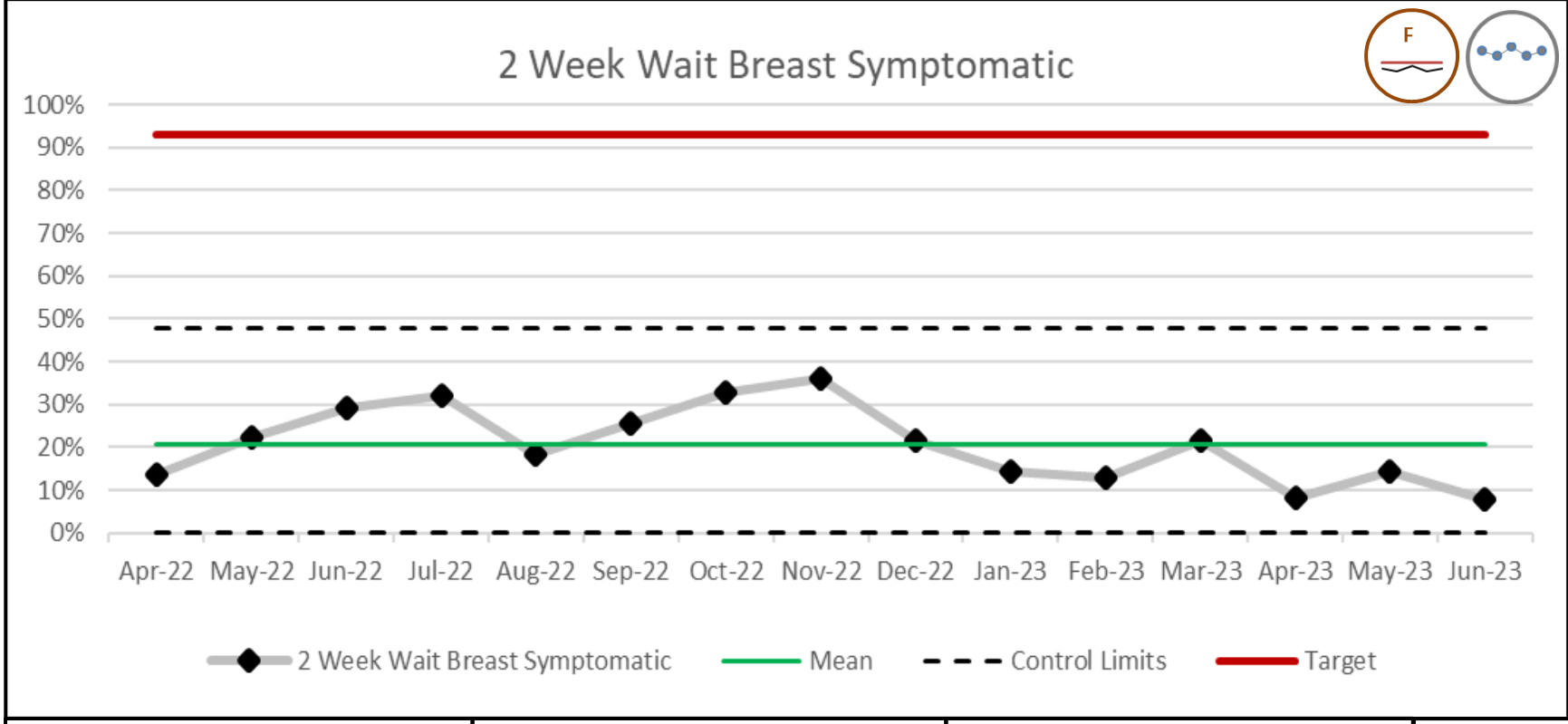


Jun-23
7.87%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 7.87% against a 93% target.

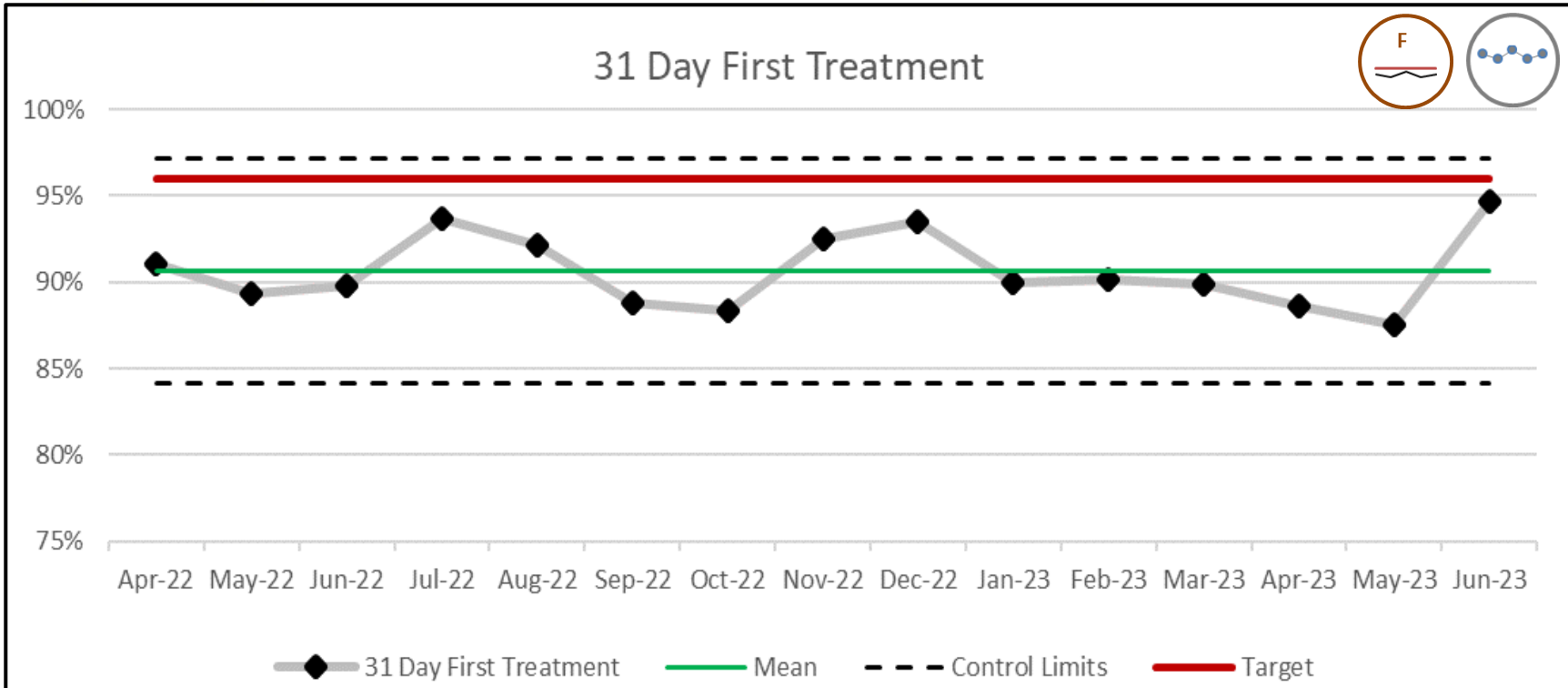
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-23
94.64%
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 94.64% against a 96% target.

Issues:

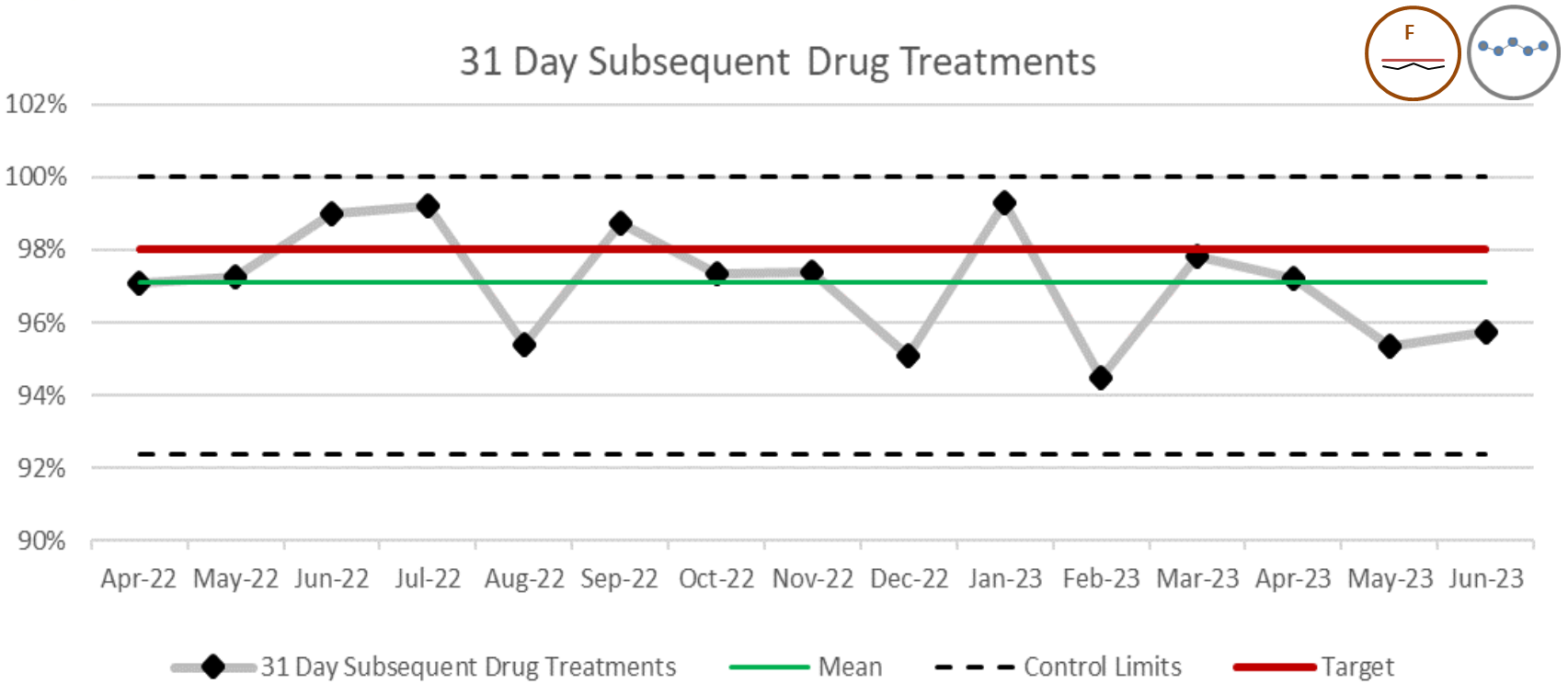
The failure of the 31 Day standards was primarily attributed to lack of AA, pre-op and theatre capacity.
Patient compliance including willingness to travel to where our service and / or capacity is.

Actions:

Oncology Fragile Service – Recruitment is ongoing to secure NHS fixed term locums. 2 Medical Oncologist (fixed term) have been offered posts and are awaiting start dates. One further Medical Oncology post has been offered awaiting acceptance of offer. The post offered for Oncology Sp Dr is awaiting the PLAB2 exam (passed PLAB 1).
OMF Capacity issues are impacting both Head and Neck and particularly Skin pathway performance – escalated as a risk.
Radiotherapy & Brachytherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

Mitigations:

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. A training plan for Skin Surgery nurses to support with head and neck lesions is being developed.
In Head and Neck, an ENT consultant has recently been recruited and a start date is pending. Locum consultant currently taking on non-cancer Thyroid cases to release capacity for cancer.



Jun-23
95.76%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

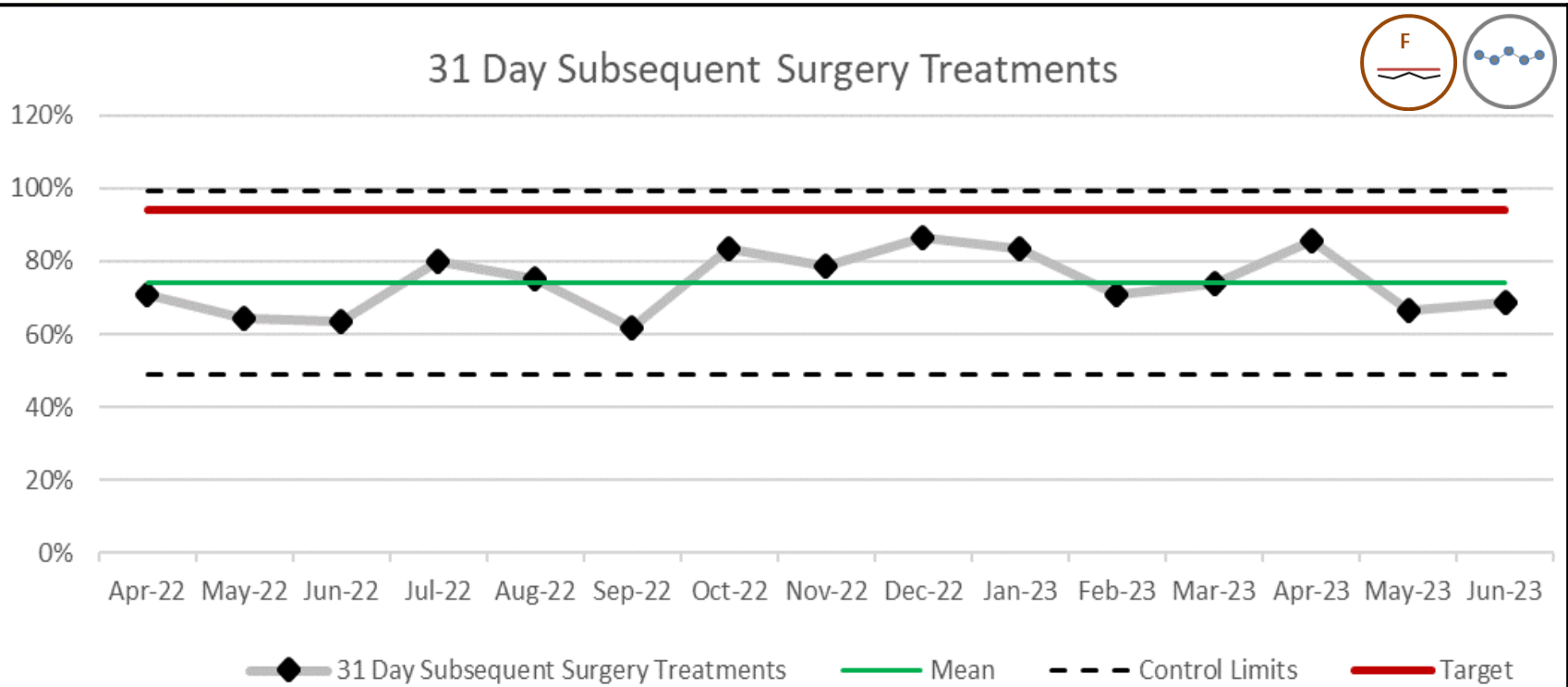
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was drugs.

What the chart tells us:
We are currently at 95.76% against a 98% target.

Issues:
The failure of the 31 Day standards was primarily attributed to lack of AA, Pre-op and theatre capacity. In June, the Trust only narrowly missed achieving the standard for Drug.

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

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



Jun-23
68.75%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

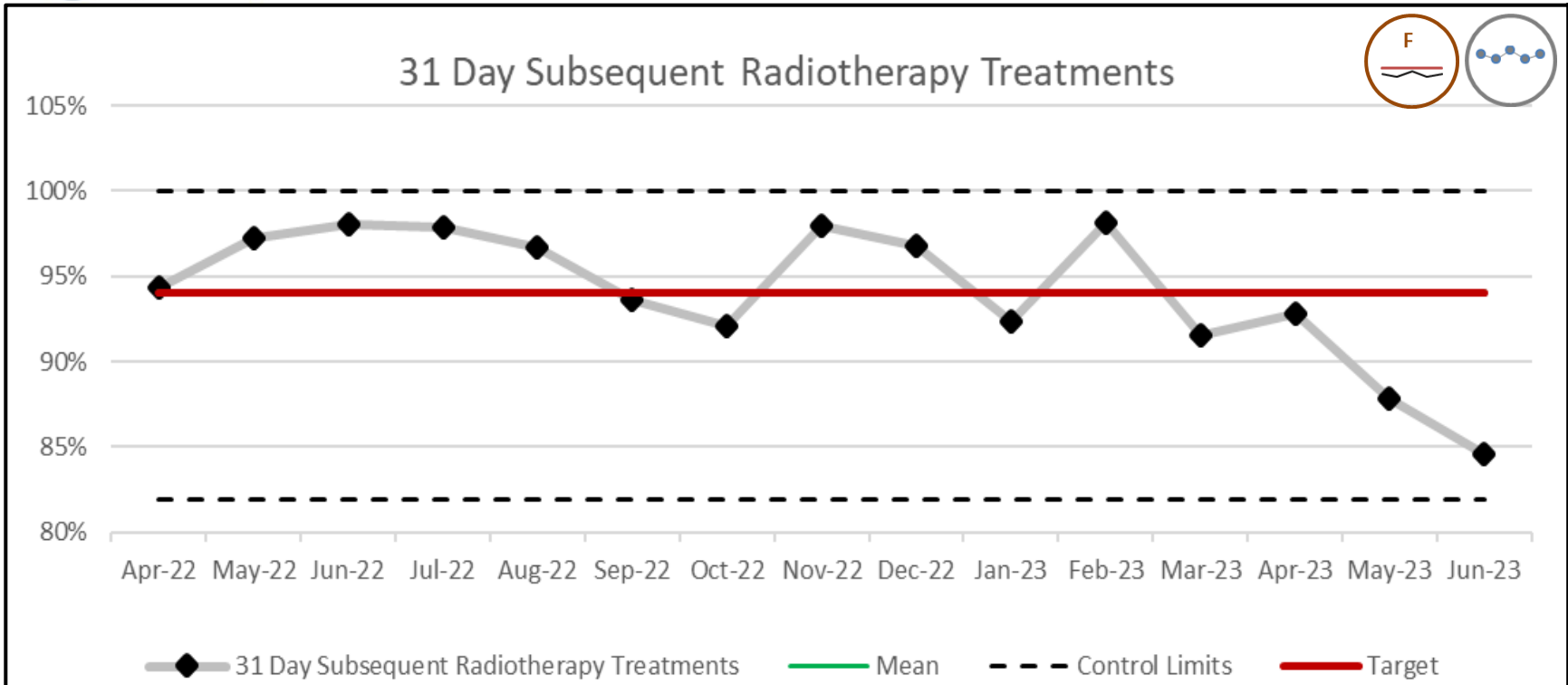
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was surgery.

What the chart tells us:
We are currently at 68.75% against a 94% target.

Issues:
The failure of the 31 Day standards was primarily attributed to lack of AA, Pre-op and theatre capacity.

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

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



Jun-23
84.62%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

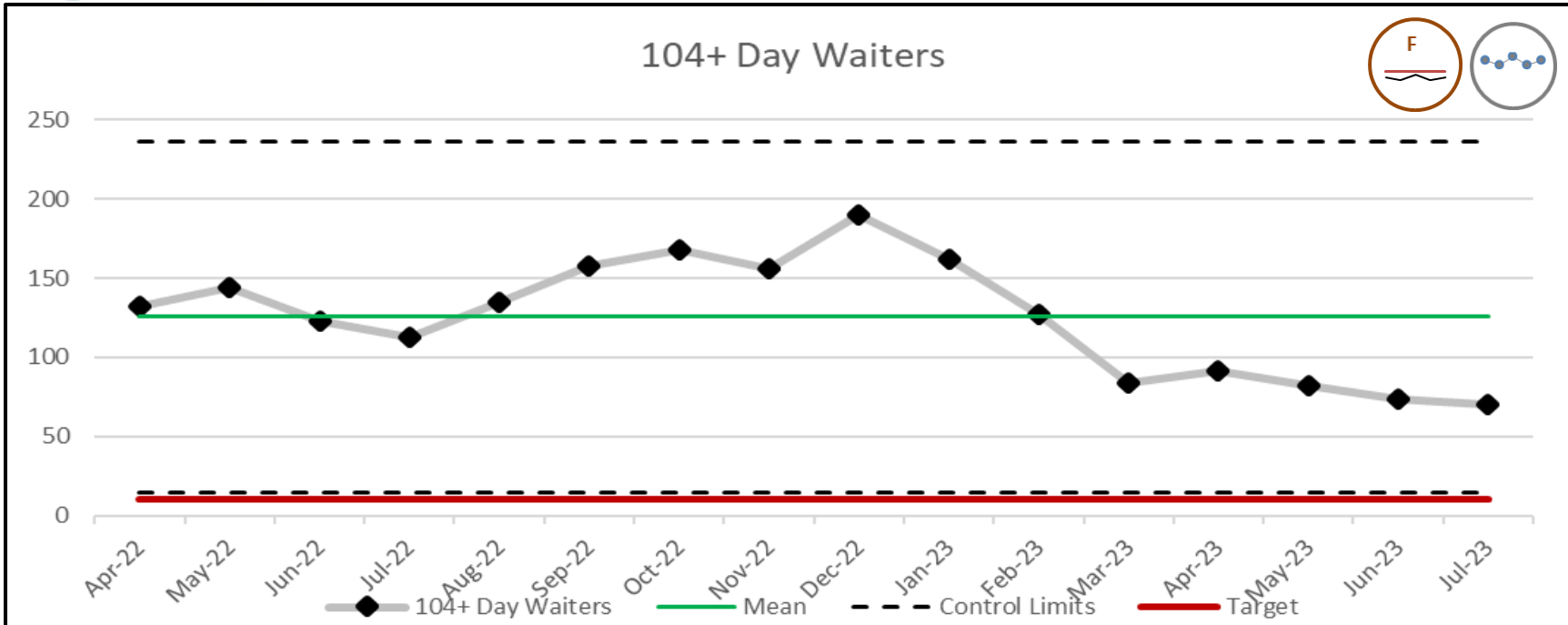
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was radiotherapy.

What the chart tells us:
We are currently at 84.62% against a 94% target.

Issues:
Radiotherapy & Brachytherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

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

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



Jul-23
70
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 10th August the 104 Day backlog was at 70 patients. The agreed target is <10.

There are three tumour sites of concern:-

Colorectal 23
Urology 14
Head and Neck 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, Head & Neck, Gynaecology, and Lung.
Approximately 23% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Actions:
See Actions on previous pages

Mitigations:
See Mitigations on previous pages

Intensive Support Meetings in place to support Colorectal, Urology, Lung, Upper GI, Skin, Gynae and Breast recovery.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-23	Jun-23	Jul-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	93.00%	90.56%	90.91%	91.81%	90.86%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	7.00%	6.73%	8.91%	9.78%	8.28%		F		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.90%	5.56%	5.60%	5.61%	5.58%		F	A	
	Staff Turnover	Well-Led	People	Director of HR & OD	13.00%	13.01%	12.62%	12.21%	12.77%		P		
	Staff Appraisals	Well-Led	People	Director of HR & OD	80.00%	67.93%	68.72%	72.30%	69.03%		F	A	

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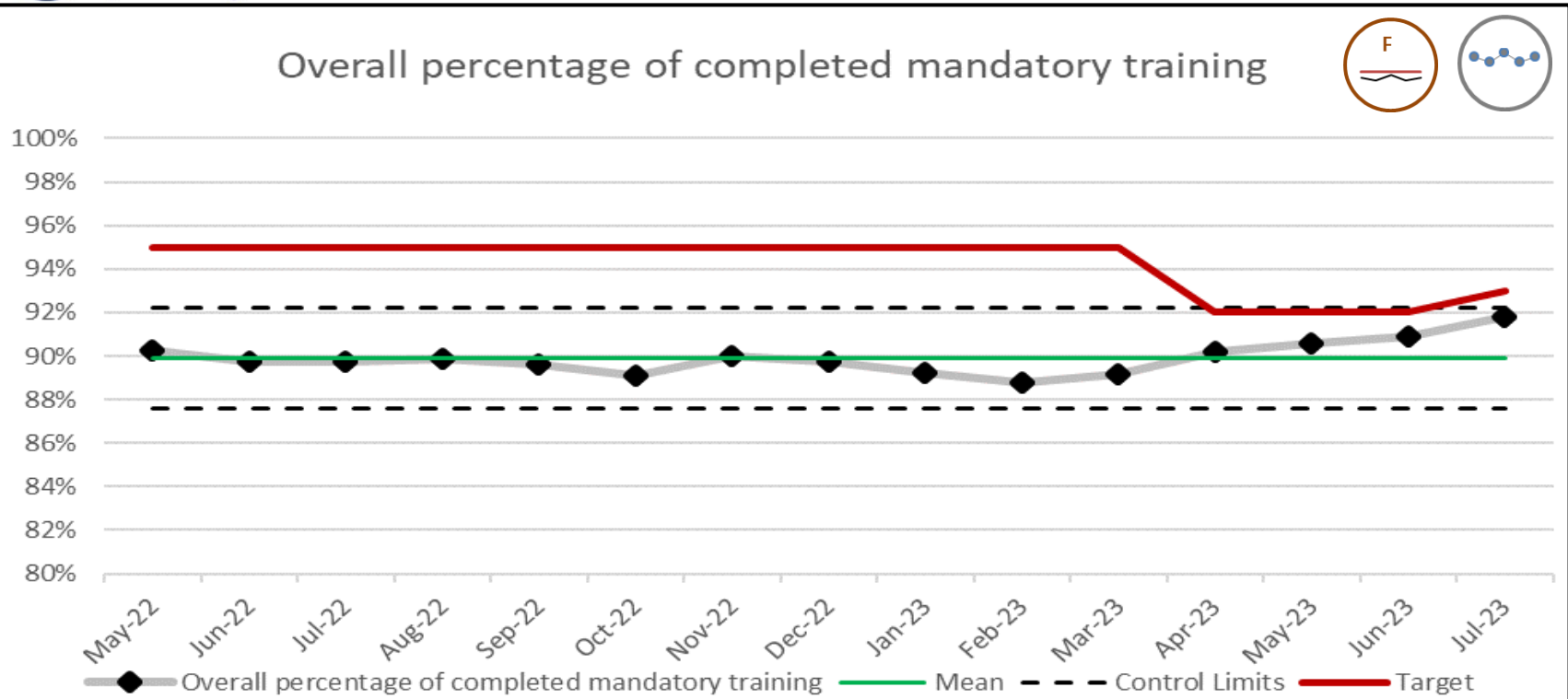

Jul-23
91.81%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
% completion is currently 91.81% against a Q2 target of 93.00%

What the chart tells us:
Mandatory training compliance has seen an improvement to the previous month's position.

Issues:

- Protected time for core learning continues to be an issue, particularly clinical staff.
- Junior Doctor Induction different to that of all other staff affecting overall core compliance.
- Training profiles are not aligned on an individual/role basis meaning some staff groups are undertaking training which is not required to perform their role.
- Number of staff starting role without induction is effecting compliance.

Actions:

- Core learning offer now aligned to the national Core Skills Training Framework (CSTF).
- Core+ offer has been reviewed. Move from position number to role level will create a more appropriate learning burden, this is underway.
  Work is underway to develop a mandatory training study day offered bi-weekly following approval from the MTGG. These will be online sessions covering a range of the core CSTF.

Mitigations:
Improvement Action Plan and targeted work with Divisions.

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

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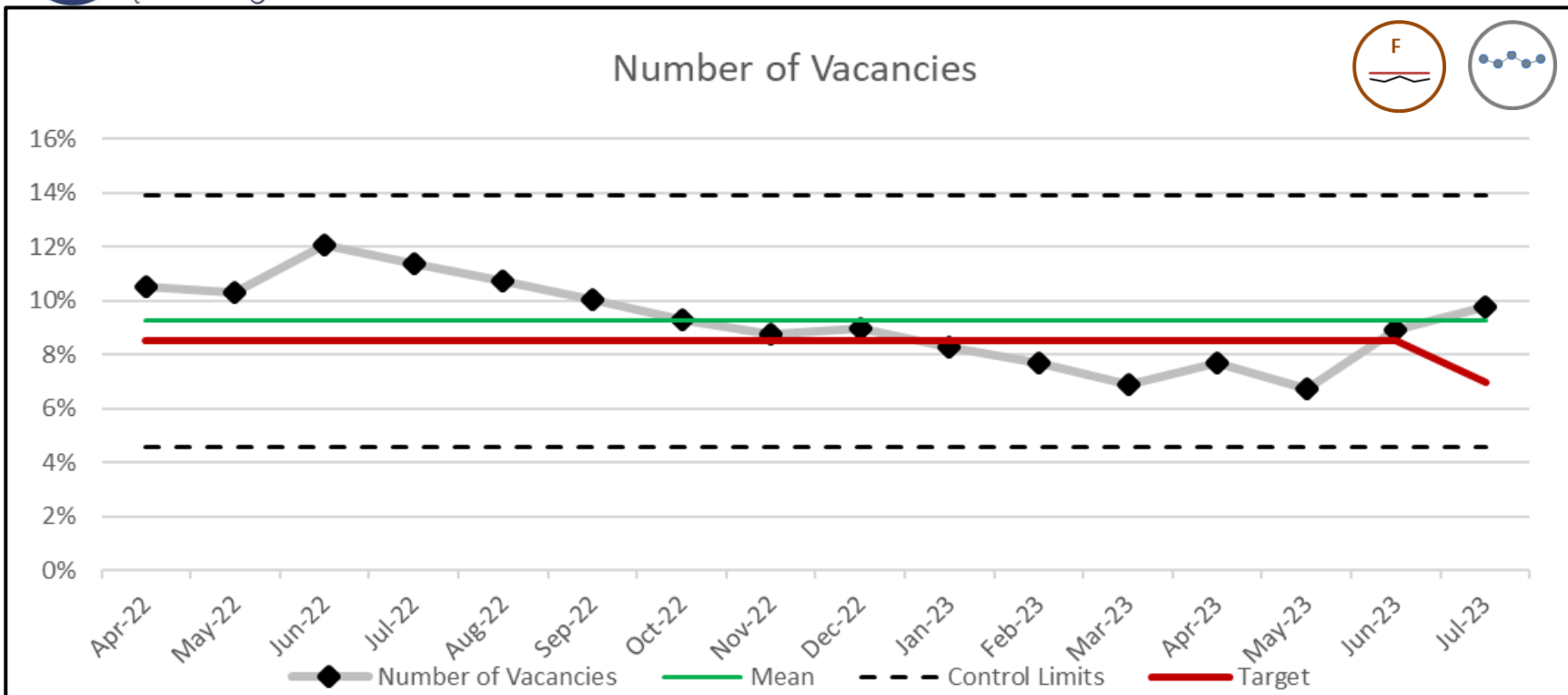


Jul-23
9.78%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
7%
Achievement
Metric is failing the target
Executive Lead
Director of People and OD

Background:
July 2023 reported Vacancy Rate is 9.78% against a Q2 target of 7.00%%.

Our adjusted Vacancy Rate is 8.00%

What the chart tells us:
That we are not within the Q2 target for July 2023.

Issues:

- Sizeable business cases have been agreed which have increased our funded establishment.

Actions:

- Work is in progress to review our overall establishment with our Divisional Teams

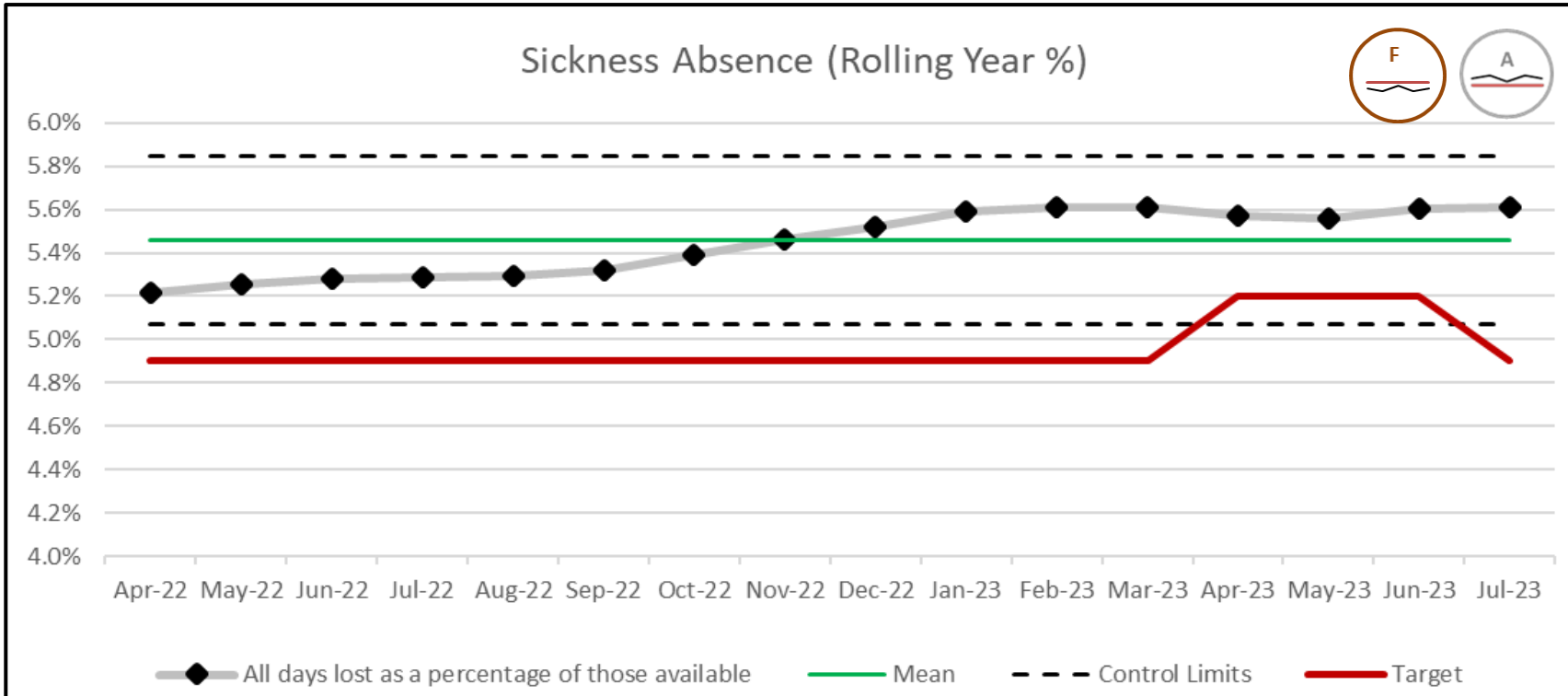
NB:
It is expected when this review had been fully completed prior our overall Trust Vacancy Rate would have been approx. 8.00% (the adjusted rate) at the end of July 2023.

Mitigations:

- Targeted work and monitoring is ongoing to ensure compliance with Vacancy Rate targets, and to ensure that our establishment levels remain in line with our overall Workforce Plan.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-23
5.61%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
4.9%
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:
5.60% is above the Q2 target of 4.90%.

Issues:

- Sickness accounts for >75% of all unplanned absence.
- Consideration to be given to the other reasons that make up the remaining % of unplanned absence.
- AMS compliance remains a challenge

Actions:

- People Management Essentials (PME) training to be mandated, which will provide further foundations as regards the importance/ expectations around absence management/recording within AMS.
- Consideration to be given in respect of our approach to moving away from a culture of managing attendance to one where we support attendance in the workplace, including a focus on RTW compliance.
- Occupational Health work closely with HR colleagues on the review of absence cases making recommendations to support staff to return to work in a timely manner. Continued signposting to the Wellbeing Services/Health & Well Being Champions who help to support staff to remain in the workplace.
- HR colleagues will work with Divisional Teams to identify and understand data trends.

Mitigations:
Robust monthly monitoring of sickness with Divisional Teams, including understanding of any trends and sharing of best practice.

OUTSTANDING CARE personally DELIVERED

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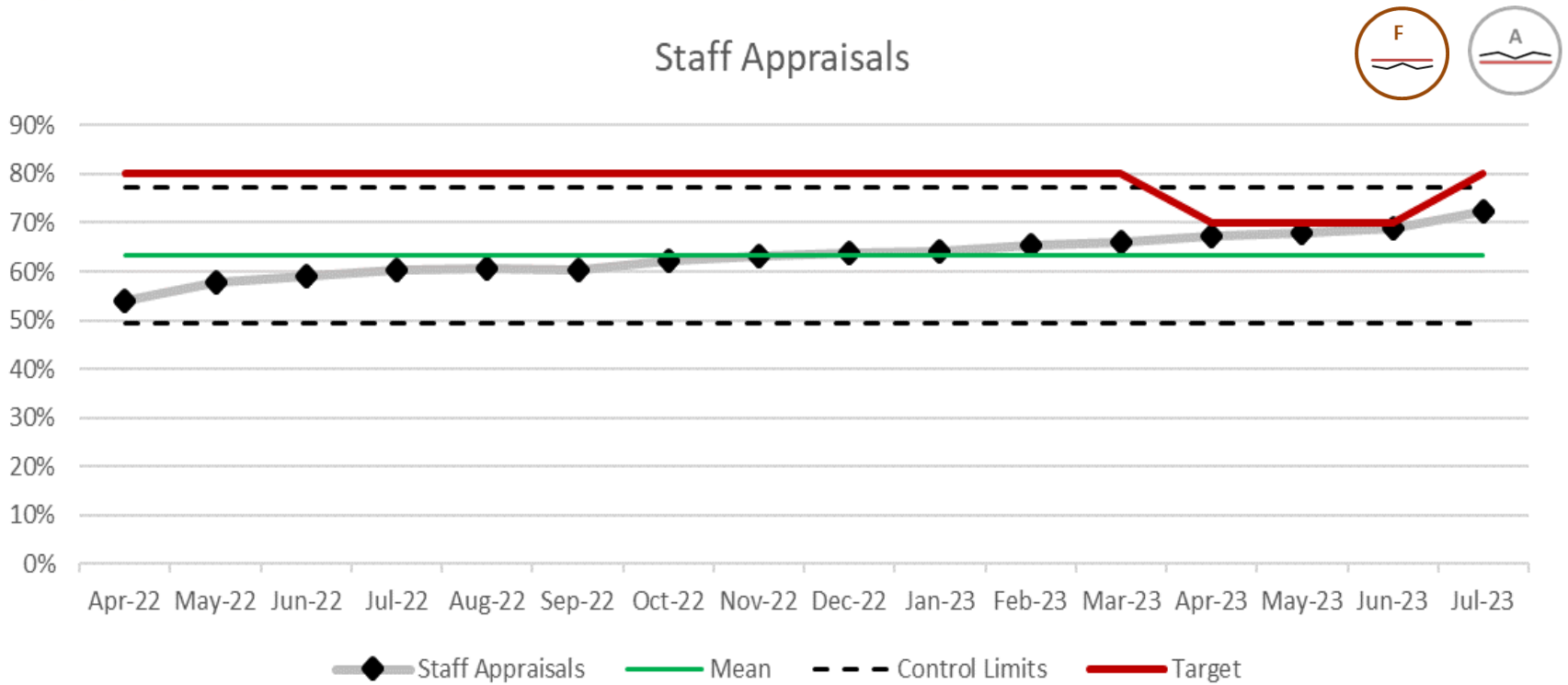

Jul-23
72.30%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
80%
Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
% completion is currently 72.30% (Trustwide)

What the chart tells us:
Despite being off track for this measure when compared to the Q2 target (80%) we have seen a significant improvement when compared to June 2023.

Issues:
- Increased accountability with Managers is needed for appraisal compliance across the Trust's leaders.
- A lack of protected time for the completion of appraisals.
- Service pressures and staffing challenges continue to have an impact on compliance.

Actions:
- Launching 90 minute appraisal 'how to' sessions to improve overall compliance.
- Ensuring that all completed appraisals have been captured in ESR.
- Raising awareness of the importance of an appraisal with a focus on areas of low compliance.

Mitigations:
See actions, and continued focus with Divisions through robust monthly monitoring.

Financial Position Month 4 (2023/24)
Finance Report
5 Year Priority – Efficient Use of Resources

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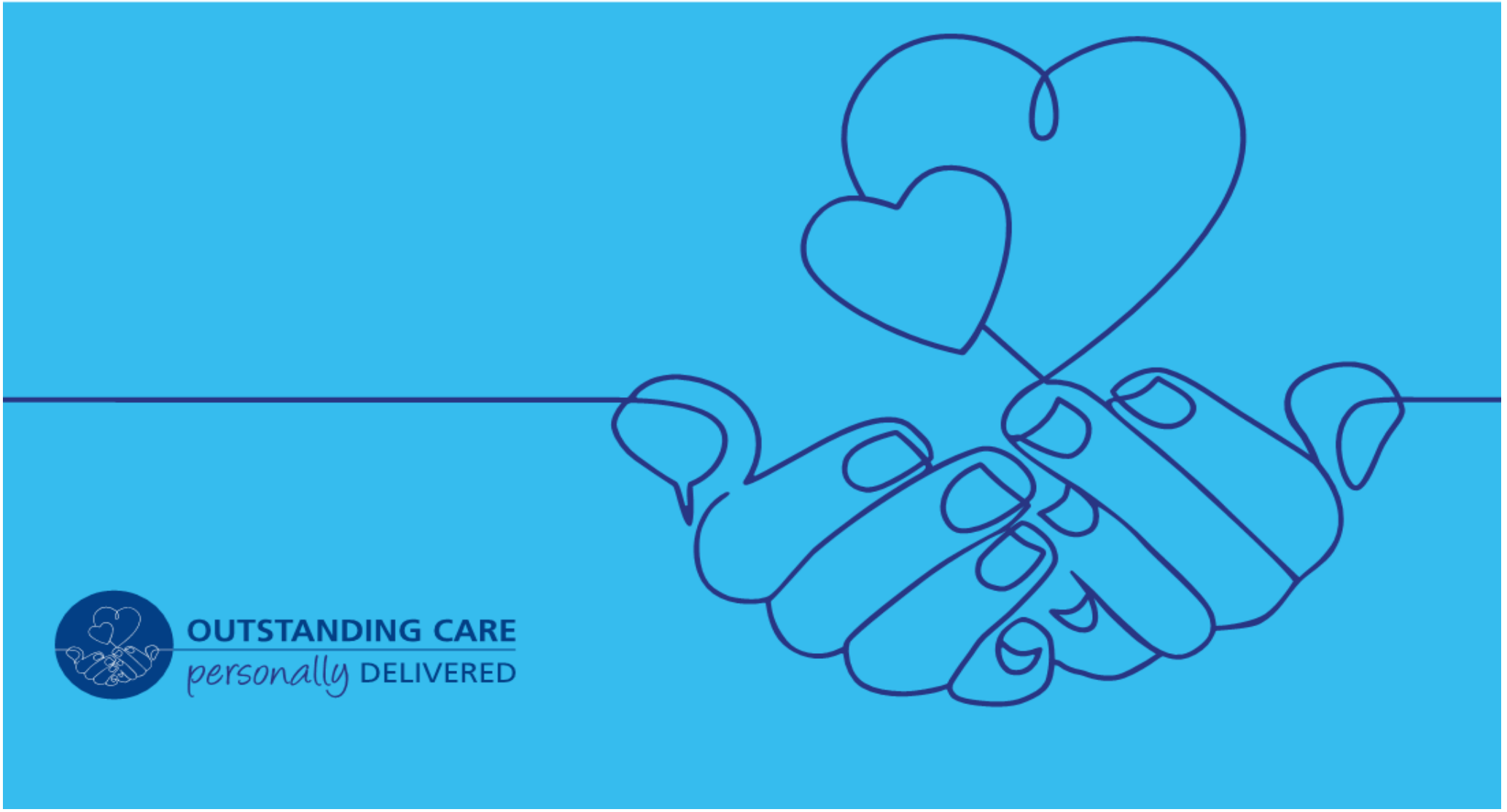
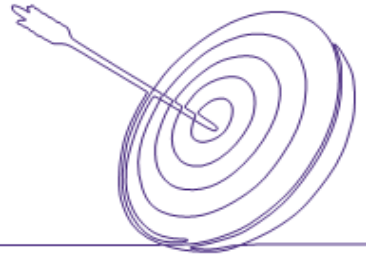


Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)



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Adjusted financial performance	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Operating Income from patient care activities	57,980	57,651	(329)	231,905	231,891	(14)
Other operating Income	3,449	3,905	456	13,794	14,110	316
Employee Expenses	(42,259)	(41,967)	292	(169,536)	(167,814)	1,722
Operating expenses excl employee expenses	(20,121)	(20,550)	(429)	(84,709)	(86,694)	(1,985)
OPERATING SURPLUS/(DEFICIT)	**(951)**	**(961)**	**(10)**	**(8,546)**	**(8,507)**	**39**
Net finance costs	(471)	(459)	12	(1,857)	(1,900)	(43)
Other Gains / Losses	0	2	2	0	50	50
Surplus / (Deficit) for the period	**(1,422)**	**(1,418)**	**4**	**(10,403)**	**(10,357)**	**46**
Below Line Adjustments	52	52	0	209	182	(27)
Adjusted financial performance surplus / (deficit)	**(1,370)**	**(1,366)**	**4**	**(10,194)**	**(10,175)**	**19**

Revenue position

- The Trust's financial plan for 2023/24 is a deficit of £20.8m; the table shows that YTD the Trust delivered an adjusted deficit of £10.2m in line with the financial plan.
- While the risk, mitigations and assumptions relating to the position are detailed in the report, the following specific risk is noted:
  - ❖ As per national guidance, the YTD position revenue position makes no adjustment in relation to the Elective Recovery Fund for non-delivery of activity.

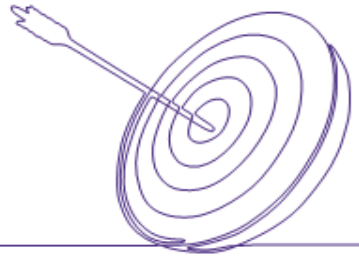
CIP position

- The Trust's CIP plan for 2023/24 is to deliver savings of £28.1m; the Trust planned £9.1m (32%) of savings delivery planned to be in H1 and £19.0m (68%) to be delivered in H2; the Trust has YTD delivered savings of £8.8m, or £3.4m favourable to planned savings of £5.5m.

Capital position

- The Trust's capital plan for 2023/24 amounts to £39.6m; YTD the Trust delivered capital expenditure of £2.1m, or £4.2m lower than planned capital expenditure of £6.3m.

Finance Spotlight Report
(Key areas of focus - Income)



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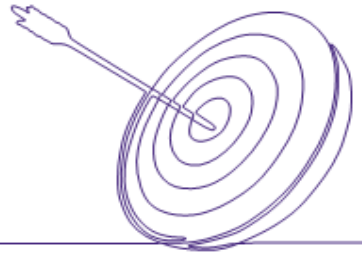
The YTD income position is £0.3m favourable to plan; this includes:

- **NHS patient care income contract – £0.3m adverse to plan**; including
  - Pass through is £0.1m favourable to plan.
  - Provision has been made for £0.4m for income risk in relation to contract activity.
- **Operating income from patient care activities - Other – £0.3m favourable to plan**
- **Other operating income - £0.3m favourable to plan; this includes:**
  - Education and training – under performance of £0.6m
  - Non-patient care services - over performance of £0.4m
  - Research & Development - over performance of £0.1m
  - Car Parking - over performance of £0.1m
  - Catering - over performance of £0.1m
  - Retail sales – over performance of £0.1m (more than offset by additional expenditure)

Finance Spotlight Report
(Key areas of focus - Pay)



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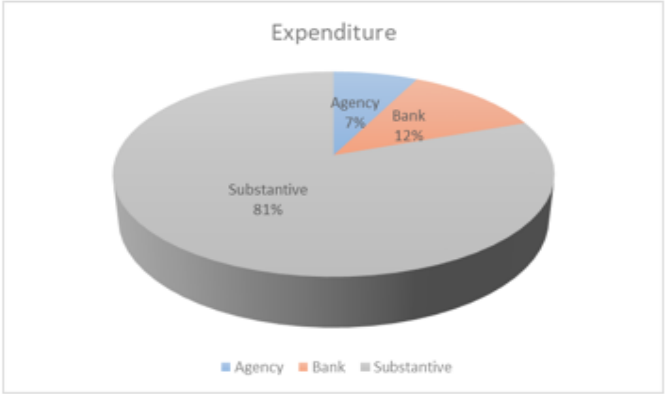
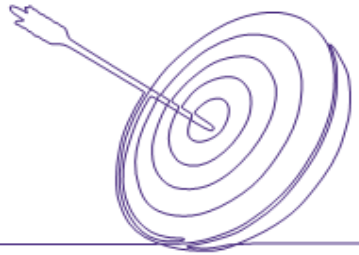
- Pay expenditure of £42.0m in July is £0.3m favourable to planned expenditure of £42.3m; the **YTD pay position is £1.7m favourable to plan**.
- YTD expenditure on Pay comprises of £136.1m (81%) on substantive staffing and £31.7m (19%) on temporary staffing.
- Compared to the same period in 2022/23:
  - ❖ Agency Pay of £12.0m is £5.6m lower than expenditure of £17.6m in 2022/23.
  - ❖ Bank Pay of £19.8m is £4.1m higher than expenditure of £15.7m in 2022/23.



- The YTD pay position includes:
  - ❖ **Pay award** – While the 23/24 A4C pay award was paid (including arrears) in June, the pay award for medical staff has been accrued (as per national guidance) in line with the financial plan.
  - ❖ **Local CEA** - The 23/24 local clinical excellence award has been accrued in line with the financial plan.
  - ❖ **Flowers** - The costs of Flowers have been accrued in line with the financial plan.
- The favourable pay position is driven by £3.0m over delivery of the FRP, although this benefit has been partly mitigated by improved recruitment and retention and other pressures (most notably £0.8m of additional pay costs re the strikes).

Finance Spotlight Report
(Key areas of focus - Other)

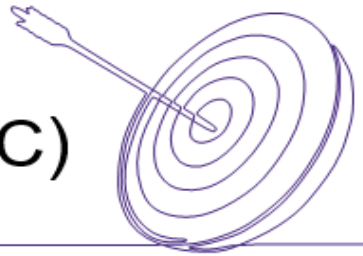


United Lincolnshire Hospitals NHS Trust

Non-Pay

- Non-pay expenditure of £20.6m in July is £0.4m adverse to planned expenditure of £20.1m; the **YTD non pay position is £2.0m adverse to plan**.
- The YTD non-pay position includes:
  - **Activity volumes** - Activity volumes are lower than planned; YTD the benefit of lower than planned volumes is estimated to be £1.8m, but this is in part mitigated by £0.5m of outsourcing; clinical non-pay expenditure is expected to increase as activity volumes increase.
  - **CIP** – £0.3m over delivery of the FRP.
  - **Excess inflation** – While the 2023/24 financial plan includes non-pay inflation as per national planning guidance, the actual level of inflation suffered was expected to be higher than planned; we currently estimate the level of excess non-pay inflation suffered YTD to be £1.6m, but this estimate is still subject to validation and the true figure may be higher.
  - **Other** – The balance of the adverse movement in the YTD non-pay position is driven by a number of pressures; this includes £0.1m re increased depreciation costs, £0.1m re system digital expenditure, £0.2m in relation to retail sales expenditure, £0.3m re bad debt provisions, £0.4m re increased recruitment activity and an increased run-rate in clinical supplies, services and drugs (for some of which there is an offset in pass through income).

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



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Cash

- The July 2023 cash balance is £49.6m (plan: £35.8m); this is an increase of £8.3m against the March year-end cash balance of £41.3m.

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

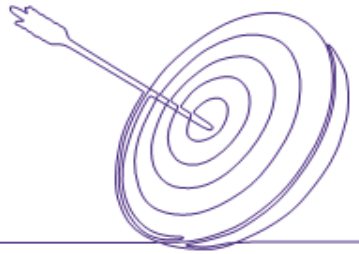
BPPC

- The BPPC performance for July was 93% / 78% by value / volume of invoices paid (appendix 5d).
- Year to date performance is 89% / 78% by value / volume, this compares to the full year performance in 2022/23 of 79% / 70%.

- At the end of July there were circa 1,500 unpaid invoices (£6.3m) over term. These will impact future BPPC performance levels as they are paid.

- The Trust received a letter from Julian Kelly re-iterating the 95% target and directing the Trust to improve performance from April. A multi-faceted improvement plan has since been implemented.

Finance Dashboard



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

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

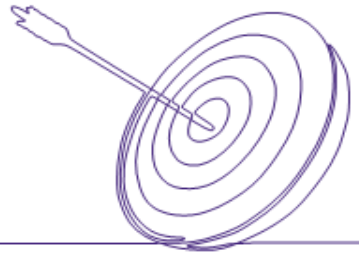
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last four full financial years and the current 2023/24 position are as follows

Finance and use of resources rating	Full Year ending:					Actual	Forecast
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	31/03/2023	JUL 2023	31/03/2024
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	0.15	1.02
Capital service cover rating	4	4	4	1	3	4	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.91)	(11.71)	(20.91)
Liquidity rating	4	4	1	1	3	3	4
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(4.14%)	(2.82%)
I&E margin rating	4	4	2	2	4	4	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]	[illegible]	0.00%
Agency rating	4	4	4	4	[illegible]	[illegible]	1
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	0.07%	0.04%
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	1	1

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

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-23	31-Jul-23			31-Mar-24	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Intangible assets	11,383	5,445	9,938	(4,493)	4,357	7,018
Property, plant and equipment	298,860	288,124	294,950	(6,826)	306,970	320,367
Right of use assets	11,807	11,103	11,004	99	9,656	9,459
Receivables	2,157	1,848	2,118	(270)	1,848	1,848
Total non-current assets	324,207	306,520	318,010	(11,490)	322,831	338,692
Inventories	6,133	7,000	6,501	499	7,000	7,000
Receivables	52,873	29,080	25,857	3,223	30,740	26,375
Cash and cash equivalents	41,269	35,803	49,616	(13,813)	16,201	16,201
Total current assets	100,275	71,883	81,973	(10,090)	53,941	49,576
Trade and other payables	(89,905)	(74,961)	(67,461)	(7,500)	(76,995)	(77,805)
Borrowings	(3,129)	(3,059)	(3,105)	46	(2,879)	(3,161)
Provisions	(17,670)	(6,425)	(19,081)	12,656	(4,825)	(2,792)
Other liabilities	(1,260)	(4,130)	(9,448)	5,318	(1,130)	(1,130)
Total current liabilities	(111,964)	(88,575)	(99,095)	10,520	(85,829)	(84,888)
Total assets less current liabilities	312,518	289,828	300,888	(11,060)	290,943	303,380
Borrowings	(12,189)	(11,191)	(11,014)	(177)	(9,481)	(9,085)
Provisions	(5,108)	(3,074)	(5,179)	2,105	(2,992)	(5,179)
Other liabilities	(11,069)	(10,901)	(10,901)	-	(10,566)	(10,566)
Total non-current liabilities	(28,366)	(25,166)	(27,094)	1,928	(23,039)	(24,830)
Total assets employed	284,152	264,662	273,794	(9,132)	267,904	278,550
Financed by						
Public dividend capital	724,041	723,888	724,042	(154)	738,081	739,789
Revaluation reserve	42,584	28,355	42,203	(13,848)	27,891	41,443
Other reserves	190	190	190	(0)	190	190
Income and expenditure reserve	(482,663)	(487,771)	(492,640)	4,869	(498,258)	(502,871)
Total taxpayers' equity	284,151	264,662	273,794	(9,132)	267,904	278,550

Note 1: The financial plan for 2023/24 was submitted prior to the completion of the year end valuation and accounts. The net upward revaluation of circa £14m is not therefore reflected within the property plant and equipment and revaluation reserve figures quoted within the plan.

Note 2: Cash at £49.6m has increased £8.3m from March but is expected to reduce during the year in line with the planned deficit and a reductions in provisions.

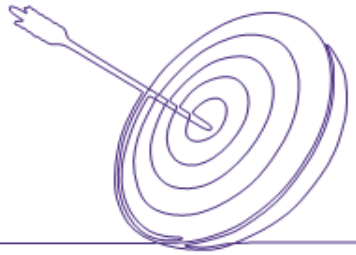
Note 3: Receivables is predominantly a mix of invoiced debt £3.8m, accrued income £8.7m and prepayments £11.8m.

Note 4: The overall level of Trade and other payables at £67.4m has reduced significantly from year end, driven in part by the reduction in capital creditors from the March peak of £21.2m to £3.3m. With the 2023/24 capital programme likely to be weighted towards Q4, a substantial rise is again anticipated later in the year.
BPPC and aged creditor performance is reported at.

Note 6: The planned capital programme for 2023/24 will result in asset additions of £39.5m. This is to be funded through internal cash resources but with an injection of £15.7m PDC capital.

Note 7: The level of provisions remains high but is anticipated to reduce as 'Flowers' and Annual Leave issues are resolved.

Cashflow reconciliation – April 2022– March 2023



United Lincolnshire Hospitals NHS Trust

	31-Mar-23	31-Jul-23			31-Mar-24	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Operating surplus / (deficit)	(13,371)	(8,546)	(8,507)	(39)	(15,300)	(15,752)
Depreciation and amortisation	22,001	8,165	8,298	(133)	24,127	24,803
Impairments and reversals	5,079	-	-	-	-	-
Income recognised in respect of capital donations	(82)	-	(26)	26	(50)	(50)
Amortisation of PFI deferred credit	(503)	(168)	(168)	-	(503)	(503)
(Increase) / decrease in receivables and other assets	(38,148)	(580)	27,144	(27,724)	(2,240)	26,669
(Increase) / decrease in inventories	(127)	-	(367)	367	-	(867)
Increase/(decrease) in trade and other payables	1,593	(9,143)	(7,328)	(1,815)	(11,967)	(8,819)
Increase/(decrease) in other liabilities	130	3,000	8,188	(5,188)	-	(130)
Increase / (decrease) in provisions	10,861	(528)	1,445	(1,973)	(2,210)	(14,844)
Net cash flows from / (used in) operating activities	**(12,567)**	**(7,800)**	**28,679**	**(36,479)**	**(8,143)**	**10,507**
Interest received	1,175	880	854	26	2,100	2,938
Purchase of intangible assets	(4,142)	-	-	-	-	-
Purchase of property, plant and equipment	(42,693)	(21,274)	(19,977)	(1,297)	(45,930)	(42,037)
Proceeds from sales of property, plant and equipment	156	-	31	(31)	-	31
Net cash flows from / (used in) investing activities	(45,504)	(20,394)	(19,092)	(1,302)	(43,830)	(39,068)
Public dividend capital received	19,863	-	-	-	14,193	15,746
Other loans repaid	(402)	(403)	(403)	-	(805)	(805)
Capital element of finance lease rental payments	(2,416)	(775)	(798)	23	(2,319)	(2,315)
Interest element of finance lease	(121)	(37)	(36)	(1)	(104)	(104)
PDC dividend (paid)/refunded	(5,873)	-	-	-	(8,000)	(9,027)
Cash flows from (used in) other financing activities	(8)	(1)	(3)	2	(4)	(4)
Net cash flows from / (used in) financing activities	11,043	(1,216)	(1,240)	24	2,961	3,491
Increase / (decrease) in cash and cash equivalents	**(47,028)**	**(29,410)**	**8,347**	**(37,757)**	**(49,012)**	**(25,070)**
Cash and cash equivalents at 1 April - b'f	88,297	65,213	41,269	23,944	65,213	41,269
Cash and cash equivalents at period end	**41,269**	**35,803**	**49,616**	**(13,813)**	**16,201**	**16,199**

Note 1: Cash held at 31 July was £49.6m against a plan of £35.8m. This represents an increase of £8.3m against the March year-end cash balance of £41.3m.

Note 2: Cash movements have been driven significantly by reductions in receivables as 2022/23 contract variations have been cleared, offset in part by the clearance of year end capital creditors.

Note 3: Cash balances are expected to reduce as we move through 2023/24. Principle drivers being:

- The planned deficit of £20.7
- Release / utilisation of provisions associated with current litigation and contractual obligations – circa £15m.
- A further general reduction in payables as the Trust seeks improved compliance with the Better Payments Performance Target.
- A potential increase in the underlying level of receivables as ICBs move away from the block contract arrangements that have been in place for the last two years,

Note 4: Provided the Trust delivers the financial plan, no requirement to borrow is anticipated for 2023/24. Should the position deteriorate however, the option to move cash between Provider Organisations within the ICB should be explored.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 September 2023*
Item Number	*Item 13.1*

Strategic Risk Report

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

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

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

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

Executive Summary

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

- Due to changes in reporting timeframes this report contains data that covers July and August 2023 at the point of writing.

- There were 17 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;
    - Delivery of paediatric diabetes pathways-community
    - Delivery of paediatric epilepsy pathways-community
    - Quality and safety risk from inability to deliver diabetes pathways that meet National standards-Acute
    - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
    - Medicines reconciliation compliance;
    - Consultant capacity for Haematology outpatient appointments;
    - Non-recurrent funding in Cancer services;
    - ICU capacity for elective surgery.
    - Safety risk from Nationwide shortage of suction catheters as identified by NHS supply chain

- There were 8 People and Organisational Development risks rated Very high (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)
    - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
    - Pharmacy service not able to withstand prolonged staff absence.
    - Pharmacy workload demands
    - Service configuration (Haematology)
    - Consultant workforce capacity (Haematology)

- There were 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month:
    - Potential for a major fire;
    - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
    - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff

- Reliance on agency / locum medical staff in Urgent & Emergency Care
- SAR's Compliance and access to Health records in accordance with statuary requirements.
- Med Air Plant LCH (Medical Gas)-**This risk was validated at RRC&C in June.**

- **The fabric to mortuary services was reduced in score from Very High to now be a High Risk.**

At the time of producing this report, we are yet to have had the August RRC&C meeting. As a part of this meeting, there will be a Deep Dive of the newly updated risk registers for both People and Digital. These updates include a number of high risks that will be reviewed to be validated at this meeting. These updates will be included in the next reporting period.

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 437 active and approved risks reported to lead committees this month.

2.2 There were 31 risks with a current rating of Very high risk (20-25) and 36 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)
31 (7%)	**95** (21%)	**244** (55%)	**36** (8%)	**31** (7%)

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

2.3 There were 15 Very high risks and 13 High risks recorded in relation to this objective. This remains stable from 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
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (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	02/08/2023
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.	15/08/2023
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.	23/07/2023
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.	01/08/2023

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 work plan. • 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.	12/07/2023
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.	02/08/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4932	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. Services which will be stopped: transitional breast, urology and colorectal. PSA ACP monitoring service. Bone marrow nurse led clinic. Chemotherapy suite cancer care coordinator, late side effects pathway, deputy lead cancer nurse, and no Haematology ACP based at PHB. Services which will be affected due to reduction in staffing: haematology CNS team, pre diagnosis team affecting the NSS pathway. Waiting list support, cancer centre team, Radiology admin and PACS services.	Very high risk (20)	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.	03/08/2023
5103	Quality and safety risk from inability to deliver Community diabetes pathways that meet National standards due to resourcing and capacity factors	Very high risk (20)	Due to inadequate service, the service has been forced to be reduced and prioritising the children most in need, in doing so, not meeting BPT or audit requirements. Reduction plan: 1. Business case is being developed to address shortfall, agreed in principal at CRIG. This is for a dietician, psychologist, admin and additional nurses. 2. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance 3. An increase in clinic capacity	15/08/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5101	Quality and safety risk from inability to deliver Community epilepsy pathways that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. In process of appointing 2 x epilepsy nurses, B6 has started, B7 was unable to start so back out to advert. 4. Epilepsy workshop with ICB	15/08/2023
4740	Demand for Haematology outpatient appointments exceeds consultant staffing capacity. High Consultant vacancy levels affecting clinic capacity, performance and review of inpatients. The areas of concern are Lymphoma, and haemostasis (there is only one consultant trust wide). PHB cover and unfilled leadership roles (in practice head of service and clinical governance lead). Due to haematology patients having long term conditions, they are required to have regular review and those on cancer treatment are time critical. If we are not able to meet the demands of the service this potentially could cause severe harm to the patients. At the end of March 2023 there are 322 overdue haem pt at phb and 597 at LCH. From 1 Oct 22 till now the haematologists have held 95 extra clinics which equates to 71 news and 813 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 657 pt on this consultant PBWL with 295 being overdue. The longest waiter was due an appointment around July 2022. This consultant is holding on average 3 extra clinics per month.	Very high risk (20)	Need for workforce review identified. Right sizing work force paper being written. 2 x agency consultants out to support service	01/08/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4947	There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	Very high risk (20)	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	03/08/2023
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	14/08/2023
5102	Quality and safety risk from inability to deliver diabetes pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance; 2. Business case being developed to address resources shortfall (e.g. dietitian, psychologist, admin support, additional nurses) - agreed in principle at CRIG meeting.	14/08/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5175	Safety risk from Nationwide shortage of respiratory supplies as identified by NHS supply chain	Very high risk (20)	1) Continue weekly meetings with Procurement leads, looking at alternative codes when stock becomes available. 2) All families to be contacted at least weekly by CCN's to identify stock levels in the home and to estimate upcoming requirement. 3) Liaise with tertiary centre clinical leads, consultants, rapid response community physio teams, long term ventilation service. 4) Identify those high risk and high demand, prioritise allocated allowance. Reassess education with families surrounding suction to ensure appropriate usage of suction catheters. 5) Devised a letter awaiting sign off to issue to families to inform families of shortage and that they will be contacted weekly. 6) Alternative equipment to be used on clinical decision if oral suction only is required.	15/08/2023
5075	Disease progress for patient's alternative treatments, change of treatment plan, poor clinical outcomes, causing patient's anxiety and worry for the patient. As a consequence of lack of ICU capacity for elective surgery patients this leads to cancellations on the day, this includes cancer patients that require level 2 post-operative care.	Very high risk (20)	The triumvirate to include surgery and TACC are planning to meet to review potential options.	02/08/2023 **This risk has been reviewed and aligned to the appropriate strategic objective**

Strategic objective 1b: Improve patient experience

2.4 There was no Very high risk and 2 High risks recorded in relation to this objective. This remains stable from last month.

Strategic objective 1c: Improve clinical outcomes

2.5 There were 2 Very high risks, a reduction of one due to Risk 5075 being aligned to the correct objective and 3 High risks remaining stable 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
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.	03/08/2023
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.	01/08/2023

Strategic objective 2a. A modern and progressive workforce

2.6 There was 5 Very high risk and 5 High risks recorded in relation to this objective, both remaining stable from last month. 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.	01/08/2023
4844	The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Very high risk (20)	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU.	03/08/2023
4996	Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. HoS/clinical lead	Very high risk (20)	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	03/08/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5093	Baseline pharmacy procurement staffing is at a level where only the basic functions can routinely be delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. The workforce has remained relatively stable over time; however, workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature. A growing number of drugs are now being offered on an allocation basis, which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the Trust and its patients of stock outs. This gives an associated risk to patient care, due to either a lack of personnel to raise orders, manage shortages, chase orders which are not being received, or to process invoices and manage supplier queries."	Very high risk (20)	Gap analysis highlights several areas of ongoing concern (to-follows, shortage management, invoice query management, medical gas invoicing). Occasional additional support is currently being provided to the invoicing team by a Bank Pharmacy Support Worker; we are scoping training this individual to offer procurement support in addition. This post is being paid from vacancy money elsewhere in the department and so cannot be considered a long-term fix for the procurement gaps. A case of need will be prepared to identify workforce requirements to reduce the workload stress the staff are persistently facing, and to provide a robust service which can withstand annual leave and short term sickness absence, based on the more challenging pharmaceutical market we are operating in where shortages are now a daily occurrence."	03/08/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4997	Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Very high risk (20)	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	03/08/2023

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

2.7 There were 3 Very high risks and 2 High risks recorded in relation to this objective, both remaining stable from 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
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	01/08/2023
4439	If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Very high risk (20)	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	01/08/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4948	Workload demands within Pharmacy persistently exceed current staffing capacity which leads to work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Very high risk (20)	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options.	03/08/2023

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

2.8 There were 3 approved Very high risks (20-25), remaining stable from last month and 4 High risk (15-16) recorded in relation to this objective, an increase of 1 from 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	01/08/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - 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	01/08/2023
5189	The Medical Air Plant in Maternity Block and Plantroom 12 at Lincoln County Hospital are of an age and high risk of failure. The systems are none compliant and do not comply with current triplex and quadplex installations. The installed systems or only duplex. Maternity Med Air plant has failed and currently operating with a temporary skid mount compressor plant. On 11th June the Plantroom 12 Med Air Plant failed and created significant patient Harm Risk. Both of these Med Air Plants require replacement to prevent harm to patients and staff.	Very high risk (20)	Our specialist contractors are working with the trust in order to supply temporary medical gas plant in the event of catastrophic failure to enable the impact to be as minimal as possible. The long term and only feasible strategy is to replace the medical gas air plant, upgrade to a quadplex modern and fit for purpose system, but this will require significant capital investment.	03/08/2023 **New Risk validated June RRC&C.**

Strategic objective 3b: Efficient use of our resources

2.9 There were 2 approved Very high risks (20-25), and 3 High risks (15-16), both remaining stable from the last report, 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	01/08/2023
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.	15/08/2023

Strategic objective 3c: Enhanced data and digital capability

2.10 There was 1 approved Very high risk (20-25) recorded in relation to this objective, There were also 3 High risks (15-16), both remaining stable from 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. Lack of technical tools to carry out a search of emails / systems to identify personal information held.	Very high risk (20)	"Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints."	03/08/2023

	Potential financial implications."			

Strategic objective 3d: Improving cancer services access

2.11 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

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

Strategic objective 3f: Urgent Care

2.13 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

2.14 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

2.15 There are currently no Very high 1 High risks recorded in relation to this objective. The risk relating to University Hospital Reputational risk which was validated at Risk Register Confirm and Challenge in June.

2.16 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 review is now complete and will be presented at the Risk Register Confirm and Challenge meeting 30th August 2023.

2.17 **Strategic objective 4c: Successful delivery of the Acute Services Review**. There were no approved Very high risks (20-25) or High risks (15-16) to this objective.

3. Conclusions & recommendations

- There were 17 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;
  - Delivery of paediatric diabetes pathways-community
  - Delivery of paediatric epilepsy pathways-community

- Quality and safety risk from inability to deliver diabetes pathways that meet National standards-Acute
- Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance;
- Consultant capacity for Haematology outpatient appointments;
- Non-recurrent funding in Cancer services;
- ICU capacity for elective surgery.
- Safety risk from Nationwide shortage of suction catheters as identified by NHS supply chain

3.1

- There were 8 People and Organisational Development risks rated Very high (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)
  - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
  - Pharmacy service not able to withstand prolonged staff absence.
  - Pharmacy workload demands
  - Service configuration (Haematology)
  - Consultant workforce capacity (Haematology)

3.2

- There were 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month:
  - Potential for a major fire;
  - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
  - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
  - Reliance on agency / locum medical staff in Urgent & Emergency Care
  - SAR's Compliance and access to Health records in accordance with statuary requirements.
  - Med Air Plant LCH (Medical Gas)

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

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**																			
4932	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Workforce Strategy Group		24/05/2022	16	Workforce Metrics	Clinical Support Services	Cancer Services CBU		Trust-wide	Services will be stopped and/or disrupted due to non-recurrent funding (Macmillan/RDC/SDF funding streams). These include CNS, CCC, Waiting List Clerk, Trainee ACP's/ACP's, Advanced Practitioner Radiographer, PTL administrator, PTL Tracker, Deputy nurses-leadership roles. Services which will be stopped: transitional breast, urology and colorectal. PSA ACP monitoring service. Bone marrow nurse led clinic. Chemotherapy suite cancer care coordinator, late side affects pathway, deputy lead cancer nurse, and no Haematology ACP based at PHB. Services which will be affected due to reduction in staffing: haematology CNS team, pre diagnosis team affecting the NSS pathway. Waiting list support, cancer centre team, Radiology admin and PACS services.	List of job roles provided to Finance. CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology.	Via jo roles list	03/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	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.	[03/08/2023 09:59:07 Rachael Turner] Following a finance quarterly review with the ICB in July there is an action to prepare for the final stage of the CRIG bids to take to Finance committee in December. There will be a follow up meeting with the ICB early September to prepare an update for the quarterly review meeting in October for the CRIG bids. The aim is to review and then prepare an overarching paper that will go to finance committee in December to get sign off for recurrent funding. At this meeting we will discuss what is required to prepare, this will include, activity/ income generated, costs for post including support costs and the gap in the plan. [02/06/2023 12:43:46 Maddy Ward] EMCA have agreed to fund all posts until March 2024. Paper being presented to ICB investment board in June/ July for recurrent funding for these posts. Awaiting outcome of board. Effected staff informed verbally and have received a letter from their line manager and EF2's have been completed. [24/04/2023 10:40:50 Maddy Ward] Business case is submitted for all posts within CSS for review by EMCA and funding from this review would be for 23/24 [03/04/2023 09:40:42 Rose Roberts] We are awaiting EMCA review to see if need the posts. McMillan posts have been funded. Reviewed at confirm and challenge confirmed as v high risk. [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	31/10/2022		03/09/2023
4879	Physical or psychological harm	Harris, Michelle	Lynch, Diane	Patient Safety Group		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU		Trust-wide	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	01/08/2023	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	[01/08/2023 15:29:44 Rachael Turner] Action plan in place July 2023, monitored by the COO weekly for Haematology. Agreements in place to start recruitment for clinical and admin staff. CEO and COO met with Haematologists and CBU Senior Team 31st July. Work will start on oncology in August. [02/06/2023 12:41:34 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. [24/04/2023 10:39:20 Maddy Ward] Oncology and Haematology service review carried out in March/April in association with strategy, planning, improvement and integration directorate [07/03/2023 10:21:35 Rose Roberts] The cancer recovery plan is a high priority for the division. More work to do but good progress in Endoscopy and Radiotherapy. [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	01/09/2023
5103	Physical or psychological harm	Rivett, Kate	Naydeva-Grigorova, Tanya	Children & Young Persons Oversight Group	Clinical Effectiveness Group	15/03/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver diabetes pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors	1. Two Consultant Paediatricians (TN-G and AB) are currently managing all children with diabetes; 2. Team leader currently supporting provision of clinical duties across all 3 sites. 3. Prioritisation of workload to help match against available service capacity; 4. Business case in development to support expansion of diabetes services.	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; 2. Results of National Paediatric Diabetes Audit	15/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Due to inadequate service, the service has been forced to be reduced and prioritising the children most in need, in doing so, not meeting BPT or audit requirements. Reduction plan: 1. Business case being developed to address shortfall, agreed in principal at CRIG. This is for a dietician, psychologist, admin and additional nurses. 2. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance 3. An increase in clinic capacity	[15/08/2023 13:28:25 Jasmine Kent] Awaiting full recruitment (admin, nursing and HCSW). Progressing well. [18/07/2023 13:21:02 Jasmine Kent] Diabetes team recruitment ongoing, nursing post closed, shortlisting ongoing. To chase psychologist support. [22/06/2023 14:16:29 Jasmine Kent] Task and finish group has been established. Job descriptions have been reviewed, due to go to advert imminently. [16/05/2023 14:15:22 Jasmine Kent] Business case has been approved. Plan to increase workforce. [18/04/2023 16:32:20 Jasmine Kent] No change, nursing situation is not improving, escalated for additional support. Seeking continuity with a RN, HCSW or Admin. [15/03/2023 13:17:45 Kate Rivett] 15/03/2022 - KR 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of diabetes services (ID4974 and ID 5051)	4	15/03/2024	15/03/2024	15/09/2023
5101	Physical or psychological harm	Rivett, Kate	Heath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 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; 4. Liaison with ICB and regional network to support development and improvement of local services	1. 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;	15/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. In process of appointing 2 x epilepsy nurses, B6 has started, B7 was unable to start so back out to advert. 4. Epilepsy workshop with ICB	[15/08/2023 13:26:59 Jasmine Kent] 2nd nurse has now started but issues ongoing with tertiary support with Nottingham. Difficulties completing epilepsy 12 audit. Risk remains same for now. [18/07/2023 13:22:27 Jasmine Kent] New nurse starts 07/08, looking to pull together business case to increase nursing team size further. Clarifications on pathway with tertiary centre required. [22/06/2023 14:21:05 Jasmine Kent] Nursing service criteria completed for year 1 - patient cohort restricted in line with team establishment. Team only seeing newly diagnosed children, those on ketogenic diet and CBD oil until uplift in nursing staff. [16/05/2023 14:12:57 Jasmine Kent] Business case has been completed. 2 new people now in post. Risk remains the same for now, to be reviewed next month. [18/04/2023 16:07:35 Jasmine Kent] Successful recruitment 18/04. Recruited and offered post to another band 6, 2 x epilepsy nurses will be in post shortly. No current change to risk rating. [14/03/2023 11:46:07 Kate Rivett] 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of epilepsy services (ID4972 and ID 5073)	8	14/03/2024	14/03/2024	15/09/2023

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
5016	Physical or psychological harm	Hamer, Fiona	Smith, Charles	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 Introduction of "Pit stop" model.	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	15/08/2023	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	[15/08/2023 11:11:54 Helen Hartley] Continuing to look at criteria led discharge 10x10 discharges from wards Staffing model being looked into regarding Extra patients in ED to keep patients safe. Virtual wards has been discussed, has not yet started. [19/07/2023 15:52:30 Helen Hartley] There is a lot of work ongoing regarding flow, can we use virtual wards? Frailty pathways in SDEC being examined to try to move patients out of ED and into the correct places for their needs. Ongoing. [28/06/2023 11:22:34 Rachael Turner] Risk discussed as apart of RRC&C Deep Dive 28/06/2023. Huge demand currently, a lot of work around MEAU handover. There is not enough staff to move patients, conversation around costing at what a transfer team would look like. There is a cost implication about this but discussions are in place. CQC must do Trust initiative, there is work linking with communities looking at support that can be offered at home-use of virtual wards. Risk remains high. [26/04/2023 11:58:09 Carl Ratcliff] No change but will review at next months UC improvement group [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	15/09/2023
4740	Physical or psychological harm	Cooper, Mrs Anita	Rigby, Lauren	Patient Safety Group	Outpatient Improvement Group	13/01/2022	15	Risk assessments	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	Demand for Haematology outpatient appointments exceeds consultant staffing capacity. High Consultant vacancy levels affecting clinic capacity, performance and review of inpatients. The areas of concern are Lymphoma, and haemostasis (there is only one consultant trust wide). PHB cover and unfilled leadership roles (in practice head of service and clinical governance lead). Due to haematology patients having long term conditions, they are required to have regular review and those on cancer treatment are time critical. If we are not able to meet the demands of the service this potentially could cause severe harm to the patients. At the end of March 2023 there are 322 overdue haem pt at phb and 597 at LCH. From 1 Oct 22 till now the haematologists have held 95 extra clinics which equates to 71 news and 813 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 657 pt on this consultant PBWL with 295 being overdue. The longest waiter was due an appointment around July 2022. This consultant is holding on average 3 extra clinics per month.	Overbooking of consultant clinics (unsustainable); introduction of nurse-led clinics to manage demand. Long and short term Locum Consultant used to cover vacancies. Ad-hoc additional clinics outside of consultant job plan	Monitoring of outpatient appointments Clinical harm reviews & reported incidents	01/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Need for workforce review identified. Right sizing work force paper being written. 2 x agency consultants out to support service	[01/08/2023 15:20:30 Rachael Turner] Update provided from Lauren Rigby-we are now having weekly meetings with the COO and at risk recruitment is happening. [02/06/2023 12:40:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. We are exploring what care could take place in primary/community setting. [24/04/2023 10:36:33 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:34:49 Rose Roberts] Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:31:29 Alex Measures] currently out to advert for second haemostasis consultant, the rest of the posts ongoing Workforce information provided to triumvirate, awaiting feedback. ACP still in training, additional vacancy for middle grades difficult to recruit to. 220622 Been identified as IIP priority for 2022/23. This includes workforce review, GIRFT review being considered.	3	01/04/2023	01/04/2023	01/09/2023
5075	Physical or psychological harm	Capon, Mrs Catherine	Dolling, Matthew	Patient Safety Group		13/01/2023	20		Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Disease progress for patients alternative treatments,change of treatment plan, poor clinical outcomes,causing patients anxiety and worry for the patient. As a consequence of lack of ICU capacity for elective surgery patients this leads to cancellations on the day,this includes cancer patients that require level 2 post operative care.	Daily escalations to TACC team who endeavour to establish potential capacity through step down beds following ward rounds on ITU. Request for Anaesthetic review of the elective patients for the potential to identify patients for level 1 care rather than level 2. Patients that are cancelled are re dated as soon as possible following cancellation.	Monitoring the cancellation of elective patients - recording the reason for cancellation this includes bed capacity, due to staffing and patient need and activity at the time. Harm reviews to identify disease progression and changes in treatment plans for patients.	02/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	The triumvirate to include surgery and TACC are planning to meet to review potential options.	[02/08/2023 09:15:57 Rachael Turner] Update provided by Matt Dolling: This risk relates to the beds at LCH being capped at 8. The degree of risk has now decreased as plans to cap beds going forward have been suspended. Nevertheless a degree of risk Persists as whilst the consultant rota is staffed the number of appropriately competent nurses on the unit seems small. That having been said as we are in summer the unit is not being staffed to capacity from a nurse perspective but elective throughput is not being affected as it is reduced. Another way of looking at it is that we are currently staffed to need. Separately our ICUs have flagged on ICNARC as outliers nationally for non clinical transfers and this stems from the period when beds were being capped. It feels as if that has resolved now. In conclusion I do not feel as is there is no risk now but it is significantly reduced and as we plod through the rest of the year I would hope it can be removed as a risk. This risk will be presented at the RRC&C meeting in August for a reduction in score. [15/06/2023 09:01:19 Wendy Rojas] Risk continues as level 3 beds remain capped. Incidents monitored.Work in progress for recruitment. Strategy days planned. [06/04/2023 12:51:22 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration to clarify the risk description.	4	13/04/2023		02/09/2023

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4947	Physical or psychological harm	Simpson, Mr Andrew	Saddick, Ahtisham	Medicines Quality Group	Clinical Effectiveness Group	17/06/2022	20	Policy/Protocol Issues	Clinical Support Services	Pharmacy CBU			There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	NICE guidance NG5 states that in an acute setting, that we should accurately list all of the patient's medicines (including prescribed, over-the-counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another – for example, if they are admitted to hospital.	We conduct monthly medicines reconciliation audits, which consistently have shown us failing to meet NICE targets and we are operating significantly below the national average. This audit is presented at the MQG.	03/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	[03/08/2023 14:48:59 Lisa-Marie Moore] No further updates [27/06/2023 09:47:37 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:45 Lisa-Marie Moore] No change/updates since previous entry [04/05/2023 14:12:22 Lisa Hansford] As advised at confirm and challenge meeting. Lack of compliance with national standards. [06/04/2023 13:07:13 Paul White] Discussed at Risk Register Confirm & Challenge 29 March. Risk agreed and feedback provided for consideration. [21/02/2023 08:47:37 Paul White] Note from Risk Register Confirm & Challenge Group - risk rating to be reviewed and agreed at division level prior to presentation at RRC&CG for validation. [05/01/2023 14:13:48 Lisa-Marie Moore] No change/progress since last update [08/12/2022 12:40:46 Lisa-Marie Moore] Meeting with Divisional Leads and Deputy Medical Director 25/11 to discuss business case and actions needed to be taken to support progression of it. No change to risk - currently performing under 50% on average (this is boosted by the ward based technicians who also complete med recs on patients) Many ward areas have not seen pharmacist for several weeks at LCH. [01/11/2022 15:27:25 Ahtisham Saddick] Business case has been discussed; updated and responded to comments. Trust is still performing below 50% of med recs within 24 hours. [14/10/2022 16:16:26 Rachel Thackray] Business case for additional staff in progress.	8	30/06/2023	29/12/2023	07/09/2023
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. Patient falls reported April 2021-March 2022 Total -1916 Moderate harm -22 Severe -12 Death -4 Patient falls reported April 2022-Mar 2023 Total -1958 Moderate harm -17 Severe-25 Death-1	12/07/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	[12/07/2023 15:04:05 Sarah Addlesee] •Update July 2023 -Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG). Increase in overall numbers of falls observed during June, continued to have incidents resulting in moderate and severe harm reported. •July Focus on Fundamentals is Falls Prevention, key information and guidance will be shared. Additionally a quarterly Falls Prevention newsletter will be launched in July to share learning and improvement work. •Themes from falls incident reports are discussed at monthly Divisional falls prevention forums supporting shared learning. •Quality Matron Team have commenced a review of the Safety Huddle documentation and a pilot is due to be implemented for updated Accountability Handover documentation. Both of these are tools which will support effective handover to ensure that all staff are aware of patients who are vulnerable to falling and the actions to be taken. •A multidisciplinary review of falls incidents relating to bathroom/ toilets, which will include on site environmental assessments will be undertaken in July, outcomes and recommendations will be shared at Falls Prevention Steering Group (FPSG). •The Falls Prevention Quality Council includes representatives from all divisions, corporate nursing and improvement teams will continue to work collaboratively on identified quality improvements and to join up the work being undertaken within divisional falls prevention forums. [07/06/2023 12:28:16 Rachael Turner] Risk reviewed at RRC&C as part of the Deep Dive 07/06/2023. Analysis on tends and themes has taken place. Risk assessments are being updated and monitored. Risk score to remain at 5 x 4 at a score of 20. [05/06/2023 17:43:08 Sarah Addlesee] Update May 2023 Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG). Decrease in overall numbers of falls observed during May, continued to have incidents resulting in moderate and above harm reported.	4	31/12/2021	31/03/2023	13/08/2023
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	02/08/2023	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	[02/08/2023 14:31:41 Rachael Turner] Good progress continues to be made on reducing the time patients are waiting for Outpatient. However, Industrial action for Junior Doctors and now Consultants has significantly impacted recovery and the aim to clear all patients waiting over 78 weeks for treatment has not been met. Additional capacity and focus has been put into place to reduce numbers despite the impact of Industrial action. Numbers of patients waiting over 65 weeks for treatment continues at a rate better than expected [25/04/2023 10:38:37 Rachael Turner] Work continues, no current change to risk grading. [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	8	31/03/2023	31/03/2023	02/09/2023

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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	02/08/2023	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	[02/08/2023 14:32:55 Rachael Turner] The Grantham site has now successfully achieved the status of a GIRFT accredited Elective hub, one of only 8 in the country. This allows the trust to use Grantham as a ringfenced elective site and gives the ability to increase elective activity without an impact from emergency demand. The 6 theatres are now established and a significant amount of elective work as moved from Pilgrim and Lincoln. Whilst patients are dated for surgery in a relatively swift manner, the delays remain in Outpatients. Mitigation is set out in risk 4878 and means the overall risk to the waiting times is significant [25/04/2023 10:41:05 Rachael Turner] Work continues, no current change to risk grading. [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 to drive efficiency and productivity. This piece of work has now concluded and yielded improvement in utilisation and internal processes. This now needs to be embedded as business as usual 3. Clinical prioritisation – Looking at the prioritisation of patients for surgery based on their clinical need to ensure limited theatre resource is used for the patients that most need it. The output of this work has seen good list usage for our most urgent patients and an appropriate mix of lower priority	8	31/03/2023	31/03/2023	02/09/2023
4789	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl	Patient Safety Group		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	23/07/2023	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	[23/07/2023 13:00:46 Carl Ratcliff] Progress continues - WL recovery on track with 400o pts now on list against 8700 at highest point [19/06/2023 15:35:26 Charles Smith] Charles Smith - DGM CDC work continues - Numbers improving as SET recruitment drive moves forward. Trajectories continue to be downward, slightly behind target for 6ww and 13ww cohorts due to staffing of private provider but only 1 month lost in end-point to date. Main TWL trajectory is ahead of NHSE expectations at May 2023 data point. R&R successfull, fully recruited, await new starters. [24/04/2023 12:16:25 Carl Ratcliff] CDC work now started and also smaller service with In HEALTH Recruitment of additional staff underway with 3 joining in next month R/R now in place to prevent more staff loss Now only 44 pts behind the recovery plan extra cap for IP now also in place but does require more work [24/04/2023 12:16:07 Carl Ratcliff] CDC work now started and also smaller service with In HEALTH Recruitment of additional staff underway with 3 joining in next month R/R now in place to prevent more staff loss Now only 44 pts behind the recovery plan extra cap for IP now also in place but does require more work [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.	4	31/03/2022	01/02/2024	23/08/2023
5102	Physical or psychological harm	Rivett, kate	Naydeva-Grigorova, Tanya	Children & Young Persons Oversight Group	Clinical Effectiveness Group	15/03/2023	20		Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver diabetes pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors	1. Two Consultant Paediatricians (TN-G and AB) are currently managing all children with diabetes; 2. Team leader currently supporting provision of clinical duties across all 3 sites. 3. Prioritisation of workload to help match against available service capacity; 4. Business case in development to support expansion of diabetes services.	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; 2. Results of National Paediatric Diabetes Audit	14/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance; 2. Business case being developed to address resources shortfall (e.g. dietitian, psychologist, admin support, additional nurses) - agreed in principle at CRIG meeting.	[14/08/2023 14:36:18 Jasmine Kent] For possible reduction next month due to shortlisting and interviews taking place for nursing, HCSW and admin recruitment. Risk remains same for now, review September 2023. [10/07/2023 13:49:10 Jasmine Kent] Requires discussion at governance and with Diabetes service lead, no change that the team are aware of but will update following governance later this week if any further developments have been made. [12/06/2023 15:51:05 Jasmine Kent] Gap analysis to be conducted to identify risk rating and specifically where improvements need to be made. [16/05/2023 15:40:38 Jasmine Kent] Business case has been approved for further recruitment. [04/05/2023 09:11:59 Rachael Turner] Risk re-opened as not a duplicate, this risk reflects risk for acute where as risk 5103 is for community. [03/05/2023 15:55:20 Rachael Turner] Risk closed as duplicate of risk ID: 5103. [18/04/2023 08:41:20 Jasmine Kent] Un-rejected. Has been approved, rejected by mistake, not a duplicate entry. [03/04/2023 15:13:44 Paul White] Duplicate entry [15/03/2023 12:50:59 Kate Rivett] 15/03/2022 - KR 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of diabetes services (ID4974 and ID 5051)	4	15/03/2024	15/03/2024	14/09/2023

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
5100	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 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; 4. Liaison with ICB and regional network to support development and improvement of local services	1. 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;	14/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[14/08/2023 14:30:44 Jasmine Kent] 2 nurses now in post, risk remains very high due to difficulty engaging with tertiary neurology. [10/07/2023 13:47:04 Jasmine Kent] Requires discussion at governance and with Epilepsy service lead, no change that the team are aware of but will update following governance later this week if any further developments have been made. [12/06/2023 15:55:12 Jasmine Kent] Discussion ongoing regarding reduction of risk level now epilepsy nurses are in post. Unsure of level of involvement with Acute Paeds at this stage, For review next month. Gap analysis to be conducted to identify risk rating and specifically where improvements need to be made. [16/05/2023 15:39:25 Jasmine Kent] Epilepsy nurses are now in place, for review next month to determine if there has been a change in risk level. [04/05/2023 09:09:17 Rachael Turner] Risk re-opened as risk is to cover acute, risk 5101 reflects community risk. [03/05/2023 15:28:19 Rachael Turner] Risk closed as duplicate of Risk ID: 5101. [18/04/2023 08:44:50 Jasmine Kent] Un-rejected, rejected by mistake, not a duplicate entry. Has already been approved. [03/04/2023 15:12:56 Paul White] Duplicate entry [14/03/2023 11:41:00 Kate Rivett] 14/03/2022 - KR 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of epilepsy services (ID4972 and ID 5073)	8	14/03/2024		14/09/2023
5175	Physical or psychological harm	Rivett, Kate	Flatman, Deborah			16/05/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services		Safety risk from Nationwide shortage of respiratory supplies as identified by NHS supply chain.	1) Supplies are being rationed by protect demand management within procurement department, with CCN's prioritising allocation to families based on clinical need. 19,000 a month countywide are required, allocation 9200 currently weekly meetings with procurement leads. Raised at Clinical Governance.	Datix incidents. Feedback from patients and staff. Stock check.	15/08/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	1) Continue weekly meetings with Procurement leads, looking at alternative codes when stock becomes available. 2) All families to be contacted at least weekly by CCN's to identify stock levels in the home and to estimate upcoming requirement. 3) Liaise with tertiary centre clinical leads, consultants, rapid response community physio teams, long term ventilation service. 4) Identify those high risk and high demand, prioritise allocated allowance. Reassess education with families surrounding suction to ensure appropriate usage of suction catheters. 5) Devised a letter awaiting sign off to issue to families to inform families of shortage and that they will be contacted weekly. 6) Alternative equipment to be used on clinical decision if oral suction only is required.	[15/08/2023 13:36:39 Jasmine Kent] No resolution yet, ongoing concern and issue. [18/07/2023 13:19:13 Jasmine Kent] Risk persists, unable to downgrade. Concerns about going into winter due to suction catheter requirement increase. [22/06/2023 14:14:05 Jasmine Kent] Matron d/w patient supplies coordinator - Team Leaders are liaising with families and are managing suction catheters well, daily stock, adequate supply at present, 2-3 months worth of stock. [07/06/2023 12:55:43 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023. Risk score 4 x 5 20-high risk. [06/06/2023 16:06:25 Kate Rivett] 06/06/23 - KR - explanation of risk. Safety risk due to nationwide shortage of essential respiratory supplies (including suction catheters, heat moisture exchangers and naso-pharyngeal airways) as identified by NHS supply chain. Potential 6 month issue, 50 children in the community with these requirements. The unavailability of these rolling order consumables will have a direct impact on patient safety for children within the children's community team countywide. Stocks are beginning to run dangerously low, soon to be at critical levels. Without sufficient supplies in the home, there is also potential for service level disruption as patients will require 1:1 care, with unnecessary patient admission for airway management. Increased risk of chest infection, aspiration, pneumonia, and preventable child/young persons death.	5	30/11/2023		15/09/2023
4843	Physical or psychological harm	Dunning, Mr Paul	Costello, Mr Colin	Medicines Quality Group	Patient Safety Group, WORK	19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Screening, management and review mechanisms of patients requiring or in receipt of Intravenous Immunoglobulin (IVIg) is inadequate.	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)	Reported incidents involving use of Intravenous Immunoglobulin (IVIg)	27/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Single staff reliance for local panels, 1x haematology consultant, 1x neurology consultant and 1x chief pharmacist only. Antimicrobial and High Cost Drugs Management Pharmacist undertaking administrative functions to ensure all referrals are screened and are done so in a timely manner. Shared care arrangements and prescribing accountabilities are unclear and need review.	[27/06/2023 09:45:04 Alex Measures] Discussed in risk register review meeting- no further updates [26/06/2023 13:55:27 Lisa Hansford] Risk discussed with Paul Dunning. Sue Leo to give PD list of patients that this effects. PD to review information and discussed with NHSE again. [01/06/2023 14:32:36 Lisa-Marie Moore] Meeting arranged to happen with Paul Dunning [04/05/2023 14:21:25 Lisa Hansford] meeting to be arranged to review the process for reviewing patients [29/03/2023 10:06:27 Maddy Ward] We have raised the risk today to quite likely and the medical director needs to review the process for review of these patients by an immunologist. [20/12/2022 14:25:21 Alex Measures] No further progress 19/07/21 - Shared care document was sent to NUH for review. However, NUH business unit manager expressed difficulties to advance on the SCA due to staff shortages in immunology division. Dr Neill Hepburn will discuss with NHS England regarding next step. 150622 ongoing until get an immunologist in the trust.	4	01/10/2021	31/07/2023	27/09/2023
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		Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale).	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Rotas (gaps). Agency spend - financial risk. Number of Datix incidents recorded.	15/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[15/06/2023 09:32:33 Wendy Rojas] No change to risk status.beds capped at x8 L3 [18/04/2023 13:52:46 Caroline Donaldson] No change in risk status. Bed base number remains at x8 Level 3 beds. [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		18/08/2023

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5095	Physical or psychological harm	Capon, Mrs Catherine	Sewell, Chris		Patient Safety Group	24/02/2023	16	Risk assessments	Surgery	Surgery CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6 venous access nurse to take on the clinics as the work load for the ACPs was also increasing. The Royal College of Radiologists state that a PICC line should be inserted with 72 hours. However, due to the varied nature of why a line is required particulary for urgent cases this has been	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	03/05/2023	Quite likely (4)	Severe (4)	High risk (15-16)	16	Business case established with final finance input outstanding to then go to CRIG 6 month secondment for a PICC nurse has been advertised and will require training Give consideration to training of a wider network of clinicians associated with their individual service needs	[03/05/2023 10:26:45 Rachael Turner] Following further quantitative data provided this risk has now been validated as an active risk for the trust register. [26/04/2023 11:26:50 Rachael Turner] Risk needs to return to RRC&C once we have the quantitative data confirmed. Needs to look at where this risk sits as possibly more appropriate with CSS. This will be re-presented in the May RRC&C meeting. [25/04/2023 10:06:15 Chris Sewell] Due to unforeseen circumstances and long term absence the service has had to rely on the ACP and Interventional Radiology options as outlined in the risk controls. It is anticipated that they will return at the beginning of May. This has led to an increase in IR1s.	1	01/06/2023		03/06/2023
4779	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl			16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	23/07/2023	Quite likely (4)	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[23/07/2023 12:57:33 Carl Ratcliff] Proposal been constructed to allow better use of LCH beds - await feedback from Execs on next steps [24/04/2023 12:28:58 Carl Ratcliff] Improvement work started with team and perfect week in May will look at all opportunities for service. [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	29/12/2023	30/06/2023
5161	Physical or psychological harm	Rivett, Kate	Flatman, Deborah			23/04/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Community	Quality and safety risk from non-integrated paper records.	Community matron, Team Leaders and service leads aware of the risks. Risk escalated to senior management team Meeting held with Digital Transformation Leads	To complete IR1 reports	18/07/2023	Quite likely (4)	Severe (4)	High risk (15-16)	16	1) CCNS to have access to SystemOne	[18/07/2023 13:25:46 Jasmine Kent] As we move to increase CCN team and deliver an on call service, the absence of an integrated electronic record system is going to post a larger risk, staff will be asked to provide opinion on children they do not know. [07/06/2023 13:07:24 Kate Rivett] 07/06/23 - KR - 1. Discussed at Risk Register Confirm and Challenge - panel advised score of 16 (severity of 4 x likelihood of 4) rather than the proposed 20 (severity of 4 x likelihood of 5). This was to align this risk with levels of risk across other divisions and in recognition that lack of incidents due to mitigation does not support the likelihood being= 5. [07/06/2023 13:00:51 Rachael Turner] Risk discussed at RRC&C meeting 07/06/23 Risk score agreed as 4x4 16 high risk. [06/06/2023 16:12:48 Kate Rivett] 06/06/23 - KR - explanation of risk: The children's community nursing services(CCNS) are working with a paper-based patient records system when providing direct nursing care to CYP with highly complex needs & their families within the home. There are increasing challenges for the 12 teams / specialisms when sharing information / communicating care with each other and with other professionals involved in the child's care, both within ULHT and externally with partner organisations across the ICS. 1) An individual child & family may receive care from >1 team / service within the CCS, resulting in multiple sets of records held in locked cabinets / locked offices in different locations. 2) Practicalities of sharing information when CYP may require frequent home visiting eg, daily, in various community settings / locations eg. home & school, across Lincolnshire (geography & time constraints). 3) Inability to provide contemporaneous patient healthcare information to GPs & MDT i.e.) every face-to-face & telephone contact. Including personalised care plans, complex medical & medicine management plans, PRPs / emergency healthcare plans at the end of life. Patient safety risk & poor patient experience. Risk of inappropriate treatment being delivered - actions & omissions. 4) Lack of essential information in a timely manner - GP Consultations, episodes of hospitalisations & associated CCN follow-ups, safeguarding concerns which may result in significant harm.	6	30/04/2024		18/10/2023

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4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	Maternity & Neonatal Oversight Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors. Breach of Medicines Act: Regulation 3 of the Human Medicines Regulations 2021 permits doctors to prepare medicines for administration. The expectation would be that preparation would be in compliance with current best practice and governance expectations. Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner. This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief Pharmacists March 2017 NHS Pharmaceutical Quality Assurance Committee which defines acceptable practice as: administration immediately after (within 30 minutes) preparation and completed within 24 hours. It is noted the Trust Injectable Medicines	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.	27/06/2023	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.	[20/07/2023 10:43:27 Lisa-Marie Moore] narrative updated to reflect conversation between Fran Martinez and Regional QA about breaching medicines act regulation 3 [27/06/2023 09:45:38 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:26:57 Lisa-Marie Moore] Risk assessment resent to anaesthetists - to discuss at next MQG. If no further progress to discuss with CQC [04/05/2023 14:26:40 Lisa Hansford] needs to go back to MQG [29/03/2023 10:16:01 Maddy Ward] This risk needs to go to MOpS for escalation to medicines quality group. [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 150622 Ongoing awaiting confirmation on drugs that can be bought in. Risk is in the medical quality drugs agenda to agree and finalise.	4	30/09/2022	31/03/2023	27/09/2023
5142	Physical or psychological harm	Ratcliff, Carl	Smith, Charles			12/04/2023	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Lincoln County Hospital	Within Lincoln and Pilgrim Emergency Departments there is a risk that, given increases in demand/footfall, the current staffing template for middle grade doctors overnight may not provide assurance to maintain patient safety.	Utilisation of on-call Consultant to support dependant on holistic risk. Specialty support and signposting to other directorates and providers. Full capacity protocol and boarding.	4 hour target/12 hour breaches. Time to first assessment. Decision to admit.	15/08/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	[15/08/2023 11:15:38 Helen Hartley] This will align into the medical workforce tier 2 recruitment process as per risk 5020 Also links into overcrowding piece. [19/07/2023 15:54:10 Helen Hartley] This has been looked at and updated, remains and will review next month [13/06/2023 11:09:55 Helen Hartley] Risk reviewed, level remains the same. Agreement for workforce plan has been given, adverts going out imminently. [07/06/2023 12:52:03 Rachael Turner] Risk discussed at RRC&C meeting 07/06/23 Risk added following three escalations. Night cover increased from 5 to 6 after funding secured. As recruitment comes on board risk will reduce. Risk score 4 x 4 at a score of 16. [24/04/2023 12:18:07 Carl Ratcliff] Review underway of short term ability to support more staffing at night by changing some shifts from day team	9	31/08/2023	01/11/2023	15/09/2023
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	07/08/2023	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.	[07/08/2023 17:06:10 Donna Gibbins] Funding agreed- recruited workforce continues due to agreement to ensure safe staffing Annual audit for NIV compliance complete- report to be generated and shared with Cabinet Ongoing discussions regarding provision of NIV in ED continues No SI since project commenced for NIV Full outcome of provision for Trustwide achievement not yet equal due to lack of RSU at PHB- mitigations in place to deliver a safe service Domiciliary NIV provision ongoing [23/07/2023 12:53:54 Carl Ratcliff] Funding approved for complete RSU unit in budget setting - will ask CBU for full update on project [27/04/2023 09:20:46 Silvia Tavares] update from Donna Gibbins: The risk currently remains the same. However, the following actions are being considered for June to reduce risk following the last confirm and challenge meeting: A full year review of NIV audit data will be captured and shared through clinical cabinet, once this is available a decision can be made of reducing further. Provision of National standards at PHB to be reviewed and formalised within the SOP. Funding for the LCH site is currently paused awaiting budget setting and an update will be available if any concerns for escalation. Rationale for currently remaining at level of risk in addition to the above is due to recent incidents reported of NIV commenced in ED which is outside of the trusts agreed process. [26/04/2023 12:00:12 Carl Ratcliff] Await possible funding approval via BC or budget setting [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	4	30/09/2022	01/12/2023	29/09/2023
5067	Reputation	Shelton, Helen	White, Paul	Patient Safety Group		23/12/2022	8		Corporate	Nursing Directorate	Clinical Governance	Trust-wide	There is a risk that the timeframe within which Serious Incidents are investigated may not meet Trust, ICB and CQC expectations in line with the 12 weeks specified in the national SI Framework, resulting in damage to reputation. This is caused by an increased number of SIs being reported and a lack of capacity in both clinical and support functions to expedite the investigation of Serious Incidents. There may also be an adverse impact on staff morale and wellbeing as a result of workload pressures.	National Serious Incident Framework ULHT Incident Management Policy & Procedures Serious Incident Panel Serparate approval process for patient falls and pressure ulcer SIs Datix system dashboard reports (live data) Divisional Clinical Governance Reports (monthly)	Currently the risk is being measured by the amount of SIs that are open and the amount that are 'overdue' the 12 week timeframe. As of 2 Dec 2022 there were: - 72 open SIs - 38 were overdue	07/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Weekly SI Update and Planning meetings taking place within Clinical Governance. Planning underway for transition to the new national incident framework (PSIRF) in 2023. Consideration to be given to not declaring falls and pressure ulcers as automatic serious incidents as a step towards the implementation of PSIRF. ICB / CQC not currently enforcing the 12 week timeframe (post-Covid pandemic). There is no specified timeframe in PSIRF.	[07/06/2023 12:32:58 Rachael Turner] Risk reviewed at RRC&C meeting 07/06/23 as part of the deep dive. Despite controls in place incidents continue to be raised and we have a new framework coming into place in September. Need to highlight risks that could come to other patients. Risk score to remain at a 16. [26/04/2023 15:29:22 Rachael Turner] Reviewed at clinical governance senior management team 24/04/23 current position 49 overdue SI investigations. Risk governance continue to support divisional teams with completion. Weekly update provided with oversight, SI panel panels continue but these have been recently effected by industrial action. Significant process has been made for PSERF implementation, which will eventually result in SI's being stood down and therefore risk will be closed at that stage. [27/03/2023 10:51:48 Rachael Turner] Risk reviewed-no change.	4	30/09/2023	30/09/2023	07/09/2023

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
4722	Physical or psychological harm	Cooper, Mrs Anita	Ogunyemi, Olubuymi		Patient Safety Group, WORK	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If there is insufficient enhanced care support available at the level required for the number of patients on Ashby Ward who require it (the ward has a high level of complex rehabilitation patients and regularly has 3 or more patients requiring enhanced care due to high risk of falls; cognitive impairment; wandering - security of self and other patients) then it may lead to safety and security incidents resulting in serious harm to patients	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Quality Governance Committee (QGC) assurance through lead Patient Safety Group (PSG) - CSS Division, CBU / speciality governance arrangements - Capital & Revenue Investment Group (CRIG) management of business case process	Patients requiring enhanced care on Ashby Ward Patient falls incidents on Ashby Ward Patient security incidents on Ashby Ward	23/06/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Business case written and submitted for additional Band 2 HCSW staff for the ward to ensure enhanced care requirements can be met and within the ward budget rather than regularly overspending on Bank and Agency staff. Review by Specialised Commissioners.	[23/06/2023 14:04:21 Rose Roberts] Discussed at cabinet yesterday. Looking at other areas of staffing that may be able to support. Ongoing with enhanced level of pt on Ashby. [10/03/2023 13:25:31 Rose Roberts] Meant to only have 4 enhanced pt, last 2 weeks they have had 7. Pt safety compromised. Have asked for increased agency staff. Considered raising risk level, left as is but monitor. [15/12/2022 09:42:18 Alex Measures] They have not been recruited, still some vacancies, have got the funding so should improve Business case written and submitted for additional Band 2 HCSW staff. Funding in place and posts being recruited to Support from Specialised commissioners for staffing review. Some recruitment complete but further vacancies have arisen therefore process still in progress. 130622 ongoing not up to establishment yet.	3	31/10/2021	21/09/2022	22/09/2023
5169	Physical or psychological harm	Ratcliff, Carl	East, Mr Sean			09/05/2023	15	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	Approx 15-20 Stroke outliers at any time on the LCH site. Therefore not on the stroke unit and not receiving specialist stroke therapy at the frequency and duration required by SSNAP. Outlier patients are not cohorted on site and can be on any ward therefore Stroke staff cannot go and review and advise. Stroke patient on other non stroke ward will not be assessed as a priority as they are not medically optimised and ready for discharge. Current staffing levels are for the 28 bedded Stroke unit only. If a stroke patient is seen o a non stroke ward this is to the detriment of another patient on that ward. Increased staff stress. General wards do not have the treatment facilities that Stroke patients need.	Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment.	Datixes M&H injury to staff and patient	23/06/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed	[23/06/2023 14:13:54 Rose Roberts] No change, went to C&C recently and level agreed. [07/06/2023 12:45:33 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023. Hyper acute patients outlied to LCH site.Specialist staff not currently available to support these patients. Patients are at risk due not being put into priorities causing delays.This causes a risk of patient harm due not progressing or adding to disability due to not being seen in appropriate pathway. This is also impacting is discharging delays to patients. More work is also required with the community. Score agreed at 15	8	13/05/2024		22/09/2023
5143	Service disruption	Lynch, Diane	Parkin, Mr Lee	Trust Leadership Team	Safety Group, Information Governance Group, Outpatient Improvement Group, Patient	13/04/2023	25	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Pilgrim Hospital, Boston	The demolition of H Block will remove facilities and amenities that the health records teams utilise. The impact of removing the lift will restrict the movement of patient notes and potentially the number of patients being seen in outpatients. The health records team will need to move notes in the dumbwaiters which is previously resulted in injury and legal action. With using the dumbwaiters, this will impact information governance and security of notes due to the storage and location. Staff morale will be impacted due to extra manual handling and loss of amenities required to support with mitigating this risk. This risk also has an impact on staff workload due to extra time the tasks will now take, this will also have a knock on effect to other services such as porters, secretaries. With no lift to support the department if any large items fail i.e printer or racking, replacement items will be unable to be delivered.	There is addition of dumb waiter(x2). Health & Safety risk assessment on the dumbwaiters limits the capacity to two boxes. Process in place to ensure notes are either with a member of staff or in lockable storage areas.	Patient cancellation, waiting times and waiting list increase for patients due to patient notes being unavailable or delayed. Staff survey results. Staff sickness/injury through Occupational Health and ESR.	06/06/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	To reduce the impact the team will use dumb waiters, one of which is in another area with limited access. Change of processes to mitigate risk and transfer notes over a longer period. Walk around with senior individuals and project team to look at different ways of working and potential solutions. Risks to be highlighted in QIA. Risk to presented at PRM. Health and Safety guidance to be delivered to Team. Further discussions to be had regarding whether all clinicians requiring paper based notes in clinic.	[06/06/2023 11:08:10 Maddy Ward] Since meeting on 26/04/2023, we have met with the CSS DMD, Head of Capital Projects and Estates team are going away to cost up the various works needed. To discuss with the exec team. Highlighted risk is contributing to risks across the PHB site and a number of datix have been registered highlighting health and safety risks. [26/04/2023 11:42:09 Rachael Turner] Risk presented at Risk Confirm & Challenge 26/04/2023 for validation. This was agreed as scoring as a 15-High risk. Escalation is required to look into alternative measures to support with this risk, possibly looking into Electronic records.	1	01/05/2023		06/09/2023
4688	Regulatory compliance	Hallion, Simon	Chantry, Chris	Palliative / End of Life Care Oversight Group	Clinical Effectiveness Group	13/01/2022	15	Risk assessments	Family Health	Children and Young Persons CBU	Children's Community Services	Community	Quality and safety risk from non-compliance with NICE guideline NG61: End of Life Care for Infants Children and Young People with Life Limiting Conditions.	- ULHT processes for managing response to National Institute for Health and Care Excellence (NICE) pathways and guidance	Self assessment against NICE guideline NG61	18/07/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Complete self assessment and implement actions required to achieve compliance Self assessment completed and details following actions: - Ensure that all parents or carers are given the information and opportunities for discussion that they need - Need more trained professionals Doctor and nurses (monitor compliance with EOL care elearning via Speciality Governance) - Manage transition from children's to adult's services in line with the NICE guideline on transition from children's to adult's services - Some groups have clear transition pathways- diabetes, oncology but there is no clear pathway for children with life threatening neuro disability or respiratory issues (D Flatman)(more specific action required) - Think about using a rapid transfer process (see recommendation 1.5.8) to allow the child or young person to be in their preferred place of death when withdrawing life-sustaining treatments, such as ventilation - Rapid Discharge pathway required (J Wooley) - The specialist paediatric palliative care team should include at a minimum: • a paediatric palliative care consultant • a nurse with expertise in paediatric palliative care • a pharmacist with expertise in specialist paediatric palliative care • experts in child and family support who have experience in end of life care (for example in providing social	[18/07/2023 13:13:40 Jasmine Kent] No change in risk, for review next quarter [18/04/2023 15:44:07 Jasmine Kent] For increase of risk. Specialist nurse is leaving, reducing capacity further. Issues with every case of end of life patients due to care not being commissioned, no 24/7 rota. Having to obtain support on a case by case basis depending who is available. [20/01/2023 11:18:34 Alison Barnes] No Paediatric palliative care consultant. Nurse with expertise, no pharmacy with expertise. [31/10/2022 15:02:43 Kate Rivett] 31/10/2022 - KR 1. 'What is the risk' updated to be more succinct to ensure that the risk is clearly articulated Self assessment completed. Actions identified have been detailed and communicated, as transcribed into this Risk Register entry	6	31/03/2022	30/11/2023	18/10/2023
Strategic Objective		**1b. Improve patient experience**																								

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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.	03/07/2023	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.	[04/07/2023 09:11:47 Alex Measures] Risk reviewed 03/07/2023- Nettleham has decanted to 1st Floor to allow for works to commence as per plan. [04/04/2023 12:45:23 Jasmine Kent] Predicted date for decanting Nettleham to Langton 02/05/2023. While awaiting funding for refurbishment of Nettleham. Drain work at Pilgrim site is scheduled. [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	03/10/2023
4724	Physical or psychological harm	LR (Deleted User)	Taylor, Ruth	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.	23/06/2023	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.	[23/06/2023 14:07:53 Rose Roberts] Recruited into the Neuro psychology post. Increase risk in consultant cover - sickness and resignation. potential to have to stop admissions. [10/03/2023 13:43:06 Rose Roberts] Awaiting nhse results. Neuro psychology bid waiting to go to CRIG [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	22/09/2023
Strategic Objective		**1c. Improve clinical outcomes**																								
4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	Digital Hospital 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.	03/08/2023	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	[03/08/2023 14:50:05 Lisa-Marie Moore] No further updates - still behind schedule [27/06/2023 09:46:58 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:19:05 Lisa-Marie Moore] Roll out continues but behind planned schedule [04/05/2023 14:22:48 Lisa Hansford] No for update roll out continues [29/03/2023 10:18:35 Maddy Ward] Due for completion in Lincoln at the end of April/ beginning of May and plan to be fully rolled out across Pilgrim by the end of September and all sites by the end of December. This excludes Paediatrics and Maternity. [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	01/04/2024	07/09/2023
4731	Physical or psychological harm	Harris, Michelle	Parkin, Mr Lee	Medical Records 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.	01/08/2023	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.	[01/08/2023 15:35:42 Lee Parkin] No change since last review 06/06/2023 [06/06/2023 11:46:11 Maddy Ward] Still a very high risk with ongoing concerns. Will be a risk until electronic records are implemented across the trust. To mitigate the risk until that time the records management policy has been updated and communications will be sent by the Medical Director clarifying the protocols on current use of notes. [11/04/2023 11:47:33 Rachael Turner] Risk re-opened until electronic records are implemented. [05/04/2023 10:47:54 Rose Roberts] Email from KB - this can now be closed, updated records management policy now published. [29/03/2023 09:53:02 Anita Cooper] New ToR agreed at IG Group for CRG to become a Trust-wide group, chaired by Deputy Medical Director. Relaunch planned following approval at TLT which will require greater Divisional representation and a broader agenda. [06/03/2023 11:17:40 Maddy Ward] This risk is still ongoing, EPR not yet signed off. [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	31/03/2025	01/09/2023

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
4866	Service disruption	Costello, Mr Colin	Saddick, Ahtisham		Medicines Quality Group	01/03/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Recruitment of ULHT pharmacy technicians to ward-based clinical pharmacy roles affects the balance of the pharmacy workforce and impacts on the core pharmacy service provided	Pharmacy should be fully involved in the development and implementation of these roles. The Chief Pharmacist is accountable for the professional management of these roles, however there is not a clear understanding of the supervision and development framework for the new roles.	Monitoring of Pharmacy Technician performance	27/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To develop a robust supervision, training and development framework for the new pharmacy technicians roles. 1. To undertake a quality impact assessment to evaluate the potential impact on pharmacy services. 2. To develop a robust NVQ apprenticeship training scheme to train band 2/3 staff to band 4/5 roles both on the wards and in pharmacy services to achieve a sustainable pharmacy technician workforce in order to support all pharmacy technician roles.	[27/06/2023 09:45:21 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:31:32 Lisa-Marie Moore] Discussion with CSS Division on how techs could be used to support pharmacy [28/03/2023 15:04:33 Rachael Turner] Risk proposed to be increased to a 16, this will be presented at RRC&C meeting 29th March. [20/12/2022 14:39:34 Alex Measures] no further updates Scheduled project due to commence March 2021, monthly reports will be provided. Monthly ward based technician meetings are addressing the training issue. 150622 ongoing, losing another technician to wards.	16	30/11/2021	28/04/2023	27/09/2023
5154	Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa			17/04/2023	16		Corporate			Trust-wide	The Trust currently does not have a Medicines Management or Intravenous Drug Training package on ESR. Previous Medicines management training was removed when the ESR software was changed. Usually all new nurses will be required to complete the medicines management training as part of the mandatory training. This is to support them to be able to administer medicines to patients. Without a robust Medicines management training package staff will not have access to the r Medicines Management training that has previously been available, which is not in line with Trust standards. This could potentially lead to harm to our patients from medication incidents, we will not be adhering to CG174, NG29, SG1 and QAPPS minimising injectables risk. Risk of breaching CQC regulation 12: Safe care and treatment also	All staff will have had undertaken some level of medicines management as part of their professional qualification, however standards are inconsistent and not aligned to trust standards. National (CG174, NG29,SG1) and Local policies and guidance indicate that training should be available to staff to support in administration and safe medicines management. Additionally won't be compliant with QAPPS in relation to minimising injectable medicines risks. CQC regulation 12: Safe care and treatment all indicated training should be available. None currently in place in the Trust. There are new staff that have comenced employment with the organisation that cannot access the trust medicines management training and ward and department leads require a decision to be made as to whether or not these staff can administer medication.	Reported incidents, Staff feedback on training and support available in staff surveys. Inspection feedback	13/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The Medication Safety Team have written the Medicines Management, Controlled drugs training and the Drug Administration Programme. These training documents are also to be supported by the nationally recognised eLearning for health IV therapy passport. These training packages are under review by MOpS group before they can go through the governance process. The governance process is likely to take a number of months. There is then the added task of getting the training packages put onto ESR and mapped to the correct staff. ESR team is severly understaffed which may delay the process further. As an interim measure to reduce this risk level, once the training packages have been through the relevant governance processess, there could be the option to add the training power points to the Trust intranet. This would not be mapped to staff members, however we could signpost staff to this and local training completion records could be kept by the ward/department leads.	[13/06/2023 12:46:40 Lisa Hansford] Training packages to be signed of by MOpS by 20th June. Then will continue through the governance process before they can go on ESR [04/05/2023 14:24:40 Lisa Hansford] No update as waiting to go through MOpS process [26/04/2023 11:14:07 Rachael Turner] Risk validated at RRC&C Meeting 26/04/2023 as a score of 16 High Risk. Risk to go to Medicines Quality Group to expedite risk.	8	17/04/2024		13/09/2023
4928	Service disruption	Ratcliff, Carl	Marsh, David	Patient Safety 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	11/08/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[11/08/2023 12:57:38 Charles Smith] 1x Cons now in place, another to start September. Backlogs remain and impact of IA has led to reduced performance/clearance. [24/04/2023 12:57:21 Carl Ratcliff] Reduced number of covid pts in system - recruitment of locum consultant in place to cover small service gap [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	8	30/06/2022	01/03/2024	11/10/2023
Strategic Objective						**2a. A modern and progressive workforce**																				
4844	Service disruption	Lynch, Diane	Costello, Mr Colin	Workforce Strategy Group	Medicines Quality Group	19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Service planning & annual budget setting processes: Pharmacy / CSS Division	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours.	03/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU.	[03/08/2023 14:49:28 Lisa-Marie Moore] No further updates [27/06/2023 09:47:18 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:18:15 Lisa-Marie Moore] No change/update since previous entry [06/04/2023 12:53:22 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [09/02/2023 10:43:37 Paul White] Status changed to awaiting approval pending review by division and validation by Risk Register Confirm & Challenge Group. [22/12/2022 14:55:29 Rose Roberts] Confirmed with Paul White that the risk level can be raised here and confirm and challenge will invite the risk lead to discuss it. [20/12/2022 14:35:39 Alex Measures] Business case was not approved, currently stalled, raised to high risk today but the meeting feels it should be very high risk because it would be very likely to happen, to be taken to confirm and challenge to be upgraded 150622 ongoing business case in process of being written	4	29/10/2021	28/04/2023	07/09/2023
4996	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. Head of Service for haematology 6. Transfusion Lead from 17th July 23 (w/o this unable to run transfusion lead) 7. Audit Lead	* Completed a fragile services paper * Additional/extra clinics being undertaken where possible 1. Only 1f/t consultant and 1 p/t consultant who is covering nearly f/t hours. 2. Only 1 f/t consultant covering Trust wide. Unable to mitigate risk during a/l or unexpected absnece. Requirement to discuss with neighbouring Trust eg Notts. 3. Mitigated by high cost agency consultant cover. 4. CG lead duties shared between consultants but no one wishes to take on role. 5. HoS duties divolved to clinical lead for onc and haem and/or CD for CSS	* New referrals and PBWL show ongoing capacity issues. * RTT and cancer performance below target. * Increased PA's for substantive consultants. * Increased Datix, Complaints and PALS * Outcome from Staff Survey results	03/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	[03/08/2023 10:00:17 Rachael Turner] Following the briefing paper being received by ELT, weekly meetings have been set up with DL,EM,LR and MH. An action plan has been put in place. A meeting was held with the Haematology Consultants, Andrew Morgan and Michelle Harris on 31.07.2023 and it was agreed to go out to advert for 4 Haematology Consultants, 1 Haematology Secretary and 2 Secretary Assistants. [02/06/2023 12:38:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 Making enquires if transfusion lead needs to be a consultant of if another profession can pick this up. [24/04/2023 10:35:11 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:42:15 Rose Roberts] Workforce paper with the triumvirate. Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:34:35 Alex Measures] all lead roles currently out to advert further recruitment ongoing	8	30/09/2023	01/04/2023	03/09/2023

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5093	Service disruption	Simpson, Mr Andrew	Baines, Andrew	Medicines Quality Group	Workforce Strategy Group	16/02/2023	20		Clinical Support Services	Pharmacy CBU	Pharmacy		Baseline pharmacy procurement staffing is at a level where only the basic functions can routinely be delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. The workforce has remained relatively stable over time, however workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature. A growing number of drugs are now being offered on an allocation basis which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the Trust and its patients of stock outs, with an associated risk to patient care, due to either a lack of personnel to raise	The team comprises four part time procurement clerks and two part time invoice clerks working from a centralised office in Lincoln but responsible for trustwide ordering and invoicing, and 5 storekeepers who work across the sites, and is lead by a full time pharmacist and technician. All areas of the service are continuously working at or over capacity and any absence results in other staff working additional hours, or attempting to absorb additional duties over and above their own in order to maintain the basic service. There is theoretical potential to cross cover with members of the Homecare team who have a similar skill set, however that service is also under extreme pressure and so there is limited capacity to provide this cross cover – it is most often used to support the invoicing team at times of annual leave. Where staff have recently expressed concern about work related stress the associated risk assessment has been provided. From a procurement perspective the baseline staff level on a day is 2 purchasing clerks, so purely taking annual leave into account there are multiple weeks in the year where only 1 purchasing clerk is available to manage the ordering workload. This impacts adversely on the job role of the procurement technician who often has to backfill these gaps. This makes the team very susceptible to the effects of sickness absence, particularly if this occurs whilst another team member is on leave. On such days it is frequently not possible to meet the full basic demands for all pharmacy sites with the potential to see a reduction in order frequency from twice a day to once a day, and less capacity for chasing of outstanding orders, depending on staff availability – giving further rise to a risk of treatment delays if stock orders are not placed or chased in a timely manner.	Staff morale is low across the pharmacy department as per the last communicated NHS staff survey feedback, and direct feedback from staff within the procurement team highlights that morale within the team is challenged and wellbeing is impacted. An increase in workload due to product shortages can be evidenced with reference to the growing number of Medicines Shortage Notifications (MSNs) and Supply Disruption Alerts (SDAs) issued by the Department of Health and Social Care, which totalled 25 over the last 4 months of 2020 (following the launch of this scheme), 80 in 2021, and 89 in 2022. Whilst not measured, departmental feedback highlights a growing frequency out of stock scenarios which require investigation and follow-up (this may include taxi transfers of stock between sites, where stock is available in one of the other hospitals); these are often caused by a lack of time to follow-up orders which have not been received in a timely manner, and can be associated with delayed or missed doses, or impact on timely discharges.	03/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Gap analysis highlights several areas of ongoing concern (to-follows, shortage management, invoice query management, medical gas invoicing). Occasional additional support is currently being provided to the invoicing team by a Bank Pharmacy Support Worker; we are scoping training this individual to offer procurement support in addition. This post is being paid from vacancy money elsewhere in the department and so cannot be considered a long-term fix for the procurement gaps. A case of need will be prepared to identify workforce requirements to reduce the workload stress the staff are persistently facing, and to provide a robust service which can withstand annual leave and short term sickness absence, based on the more challenging pharmaceutical market we are operating in where shortages are now a daily occurrence.	[03/08/2023 14:47:51 Lisa-Marie Moore] No further updates [27/06/2023 09:33:47 Alex Measures] proposal has been presented to Diane Lynch, questions have come back which need answering, locum member of staff supporting the team, managing with agency and bank staff at the moment [01/06/2023 14:14:06 Lisa-Marie Moore] No change/further update since April [19/04/2023 15:48:11 Andrew Baines] Colin Costello & Andrew Baines met with Diane Lynch on 18/4/23 - outcome was for a proposal to be presented to Diane for which she would find funding for necessary supporting roles. [06/04/2023 12:49:53 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration.	4	16/02/2024	16/02/2024	07/09/2023
4991	Service disruption	Low, Claire	Shankland, Lindsay	Workforce Strategy Group	Patient Safety 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?	01/08/2023	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.	[01/08/2023 09:46:03 Rachael Turner] People and OD Restructure complete. Recruitment team restructured and vacancies all filled. Dedicated medical recruitment team created. Internal agency aspect to recruitment being developed with a Talent Acquisition team of Resourcing Advisors. Workforce Plan for 2023/24 complete and submitted to the system. Recruitment Plan clearly articulated in Workforce Plan with trajectories to a 4% vacancy rate by year end 2023/24. Trust vacancy rate has consistently been under the target of 12%. New to care recruitment being extensively used for HCSW role. Nursing Associate recruitment embedded. Medical Support Worker role now looking to be embedded as business as usual. Agency providers increased to a minimum of three for key roles, rather than one previously. Relationship with LRDP now embedded, GMC registered Drs and MSWs recruited. Agreement reached with third party supplier to support international recruitment for difficult to recruit AHP roles. " [24/04/2023 11:41:33 Rachael Turner] Work still ongoing, following PODC meeting booked in April, risk will be presented at RRC&C meeting in May. [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.	4	31/03/2023	31/03/2023	01/09/2023
4997	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Middle Grade cover in place from Oncology but not sustainable as Haematology is not their area of experise and therefore cannot replace consultant presents with acutely unwell patients.	* Increased Datix, Complaints and PALS * Outcome from Staff Survey results	03/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	[03/08/2023 10:01:13 Rachael Turner] Following the briefing paper being received by ELT, weekly meetings have been set up with DL,EM,LR and MH. An action plan has been put in place. A meeting was held with the Haematology Consultants, Andrew Morgan and Michelle Harris on 31.07.2023 and it was agreed to go out to advert for 4 Haematology Consultants, 1 Haematology Secretary and 2 Secretary Assistants. [02/06/2023 12:39:17 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 [24/04/2023 10:36:05 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:43:59 Rose Roberts] Workforce paper for haem with triumvirate, then will start oncology workforce paper. Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:35:25 Alex Measures] ongoing recruitment ongoing	8	01/04/2023	01/04/2023	03/09/2023

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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. Demand vastly exceeds the capacity, requiring an increase in establishment. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung, urology, HPB Clinical oncology - head and neck, skin, upper GI (RT only). Due to only consultant covering Sarcoma retiring we will no longer have consultant cover for sarcoma from July 23. Lack of cover for leadership roles: Chemotherapy Lead, and succession planning for clinical lead. Lack of continuity of care at PHB, LCH have 'hot week' for consultants, PHB have a different consultant covering for a ward round each day. If there is absence or consultant is on 'hot week' for LCH there is no cover for PHB that day and may be for several consecutive days.	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements email sent to consultants to see if anyone would cover sarcoma - no capacity/specialisation	Monitoring tumour site performance data	28/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	[28/06/2023 14:43:05 Rachael Turner] Following this risk being discussed at RRC&C meeting, the question was raised around the number of patients currently waiting to be seen (including overdue) These are as follows: Oncology PBWL numbers as at 29/5/23: Lincoln County Hospital: Overdue: Clinical - 171 Medical – 55 Total number of patients on PBWL (including overdue): Clinical – 2169 Medical – 226 Pilgrim Hospital Overdue: Clinical - 30 Medical – 9 Total number of patients on PBWL (including overdue): Clinical - 531 Medical - 31 [02/06/2023 13:10:49 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 [24/04/2023 10:37:32 Maddy Ward] Oncology service review carried out in March in association with	4	31/03/2023	31/03/2023	28/09/2023
5173	Service disruption	Morgan, Mr Andrew	Warner, Jayne	Trust Leadership Team		15/05/2023	20		Corporate	Medical Director's Office		Trust-wide	The Trust Board has a number of executive director vacancies which are currently filled by interim or acting up arrangements which may lead to instability. In some instances these appointments are for first time Director posts meaning that the Board could be seen as still developing. In addition to this the Chief Executive has recently announced his intention to stand-down on 31 March 2024, after 42 years service in the NHS.	Fit and Proper Persons Regulations. Voting rights are not impacted as interims / secondees all carry the voting rights of the role as per the Standing Orders/SFIs. Coaching and mentoring in place for those in their first appointment from the Chief Executive and the Director of Nursing/Deputy CEO. There is external coaching provision. with a plan to ensure each director has an external coach and mentor. Each executive director has a substantive deputy director. The ELT also has access to an external OD partner who works with the team on a regular basis.	Out of 6 directors only 2, the Director of Nursing and the Medcial Director are currently substantive. The Director of Nursing post is currently a shared post with LCHS. The Medical Director is currently off on long-term sick. The Chief Executive post is filled substantively but will become vacant at the end of March 2024.	07/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continue with mentoring / coaching arrangements in place where appropriate. Review the succession plans for each post and ensure substantive appointments are made. Joint posts with other system providers to be considered where appropriate as part of the Lincolnshire Provider Review.	[07/06/2023 12:15:17 Rachael Turner] Risk discussed at RRC&C 07/06/2023 Risk score agreed as 4x4 giving a score of 16 making it a High Risk. [15/05/2023 13:41:10 Rachael Turner] Risk to be raised for validation at RRC&C Meeting in May.	10	31/03/2024		07/09/2023
4862		Ratcliff, Carl Marsh, David	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 on top of high volume OP workload, delayed	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)	24/04/2023	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.	[24/04/2023 12:25:14 Carl Ratcliff] Have recruited to Consultant ACP post in nodules to support team - will start in 1/12 Using additional external support to deliver extra capacity for OPD to allow delivery of 78ww and reduce risk for delivery of 2ww urgent work [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..... Option Take down: Benefits Risks: 1 Do Nothing None Cancer patients continue to wait prolonged periods for care. • Inpatient services at LCH and PHB continue to become extremely depleted • Welfare of current consultant workforce continues to suffer, potentially leaving to sickness / prolonged absence • Boston have only x2 Consultants, currently utilising support from already depleted LCH Team. (If annual leave / sickness, we have only 1 consultant on the Pilgrim site) 2 Grantham inpatient respiratory services (Preferred) Releases x1 Agency Locum Consultant who can ?potentially? go over to Lincoln (as per previous agreement) • Releases a consultant to cover the rota to a 'safe' level Non-compliance with ASR due to taking out inpatient respiratory services at GDH	4	30/12/2022	30/06/2023	27/07/2023

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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	28/06/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[28/06/2023 11:17:28 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023, 8 level 3 beds has been abandoned, we will be aiming for 11 level 3 beds. We are in a better position staffing rates has gone up, still a risk in regards with skills. Risk will still remain high as a potential risk for nursing and medical staffing around beds. This will be reviewed along with two other risks relating to ICU and will be re-presented in July. Risk score to remain the same. [19/06/2023 11:30:56 Rachael Turner] Risk to be presented at RRC&C meeting in June 2023 for validating reduction in score. [15/06/2023 09:38:00 Wendy Rojas] Risk rating reviewed and now moderate. [15/06/2023 09:37:17 Wendy Rojas] Positive recruitment in both units. Both units nearly at full establishment. Level 3 capped at 8 which has supported training/staffing needs. Additional clinical educator both sites extended. [18/04/2023 13:54:11 Caroline Donaldson] Staffing situation remains the same. Level 3 beds are still capped at x8. [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	6	30/06/2021	30/09/2022	28/07/2023
4905	Physical or psychological harm	Cooper, Mrs Anita	Taylor, Ruth	Workforce Strategy 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 Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning, PU's, constipation, delirium. 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. Increase in bed stock and boarding beds without recognition of additional therapy staffing needs. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	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. Referral guidelines and 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). Access to Staff wellbeing services. Front door therapy assessments passed to inpatient teams on admission.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service. Staff absence. Staff survey and feedback.	23/06/2023	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.	[23/06/2023 14:12:17 Rose Roberts] Been asked to put in a case of need for RSU on both sites. Will be reviewed by RT to see if the risk needs to be separated out. [09/05/2023 15:14:15 Sara Blackbourn] Addition of escalation beds. Front door pilot. Referral criteria review. [10/03/2023 13:46:14 Rose Roberts] One member of staff has returned but another member is on maternity leave and there is no cover for her. Across all the services continue to be flexible and look at the skill mix to allow to deliver the best service we can. [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	30/09/2023	18/12/2023	22/09/2023
Strategic Objective		**2b. Making ULHT the best place to work**																								
4990	Reputation	Low, Claire	Shankland, Lindsay	Workforce Strategy Group		08/08/2022	20		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally.	1. National and local lessons learnt for engaging staff effectively with surveys 2. Dedicated 'staff experience/engagement' role proposed to lead programme of work (including corporate and local action planning)	1. Pulse Staff Survey response rate (quarterly) 2. NHS Staff Survey response rate (annual)	01/08/2023	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	[01/08/2023 09:53:40 Rachael Turner] Head of Organisational Development appointed and fully commenced in role to develop leadership strategy and pull together current strands of work. Culture and Leadership Programme continues to be delivered and Cultural Ambassadors appointed and commenced their training. Leading Together Forum continues to receive good feedback and each speaker is building on the work of the last creating consistent messaging. People Promise Manager delivering against action plan with national recognition of curent work. Funding for People Promise Manager available for Y2. Flexible working project (Timewise) and system work including Career Coaching continues. National Staff Survey results available and action planning has commenced. Second most improved Acute Trust for positive scores." [24/04/2023 11:39:46 Rachael Turner] No change, currently awaiting response rates from next reviews. [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 [10/03/2023 11:44:40 Rachael Turner] No change. Work currently underway to provide an update in April. [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.	4	31/03/2023	31/03/2023	01/09/2023

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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.	01/08/2023	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.	[01/08/2023 09:55:01 Rachael Turner] Risk has now presented as an issue with staff undertaking periods of industrial action - in November 2022 it was necessary to increase the likelihood of this risk from low to extremely likely. People and Workforce Team working with the Emergency Planning Team to ensure appropriate planning is in place. Industrial Dispute Action Plan and Risk Assessment complete and has been tested through industrial action. Industrial Action Planning Meetings. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review)." [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.	4		31/03/2023	01/09/2023
4948	Physical or psychological harm	Cooper, Mrs Anita	Moore, Lisa-Marie	Health and Safety Group, Medicines Quality Group, Patient Safety Group	17/06/2022	20		Workforce Metrics	Clinical Support Services	Pharmacy CBU			Workload demands within Pharmacy persistently exceed current staffing capacity which leads to work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Business Continuity Plans on ward coverage when staffing low	Sickness rates/vacancy rates and staff turnover - highlight that retention is problematic at current. Staff survey highlights issues low staff morale within the department. Medicines reconciliation, datix incidents and omitted doses highlight that the trust is underperforming and not meeting targets at current	03/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options. Wellbeing team supporting staff - regular visits organised	[03/08/2023 14:48:27 Lisa-Marie Moore] No further updates [27/06/2023 09:47:53 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:03 Lisa-Marie Moore] No change since previous entry [04/05/2023 14:07:20 Lisa Hansford] no update awaiting review on basis of reputational risk as advised at confirm and challenge meeting 29/03/23 [06/04/2023 12:52:25 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [07/02/2023 13:29:22 Rachael Turner] Risk updated to be lead by PODC committee. Requires validation at Confirm and Challenge due to current score. Division to review risk score and attend Confirm and Challenge meeting. [05/01/2023 14:05:09 Lisa-Marie Moore] No change from previous update [08/12/2022 12:33:43 Lisa-Marie Moore] Meeting with Divisional Leads and Deputy Medical Director 25/11 to discuss short and long term actions to support staff, current vacancies and support business case. BCP to be enacted when required. [06/10/2022 14:12:57 Lisa-Marie Moore] Business case still in progress No change	8	30/06/2023	02/10/2023	07/09/2023
4993	Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group	08/08/2022	16		Corporate	People and Organisational Development	Organisation Development		Trust-wide	Workforce management practices that are not inclusive and equitable for people who consider themselves to have a disability may have a negative impact on the recruitment of new employees and the retention of existing ones.	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	20/07/2023	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	[02/08/2023 10:32:59 Rachael Turner] WDES continues to be delivered and progress monitored through EDIG. Current WDES action plan assessed as good by NHSE. EDS published on Trust Website - signed off through EDIG, People and OD Committee and Trust Board. Maple Staff Network continues to be active and ran a series of events through Disability History Month. Culture and Leadership Programme continues to be delivered and Cultural Ambassadors appointed and commenced their training. Leading Together Forum continues to receive good feedback and each speaker is building on the work of the last creating consistent messaging. People Promise Manager delivering against action plan with national recognition of curent work. Funding for People Promise Manager available for Y2. National Staff Survey results available and action planning commenced. Reasonable Adjustment Policy agreed." [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	20/08/2023

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4992	Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Workforce management practices that are not inclusive and equitable for people from all racial and cultural backgrounds may have a negative impact on the recruitment of new employees and the retention of existing ones.	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	20/07/2023	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)	[02/08/2023 10:35:14 Rachael Turner] WRES continues to be delivered and progress monitored through EDIG. Current WRES action plan assessed as good by NHSE. EDS published on Trust Website - signed off through EDIG, People and OD Committee and Trust Board. Anti Racism (United Against Discrimination) Working Group commenced 7 February 2023 and is delivering outputs against the plan. REACH Staff Network continues to be active and a relaunch of the Network as REACH (formerly BAME) and the See Me campaign complete. Culture and Leadership Programme continues to be delivered and Cultural Ambassadors appointed and commenced their training. Leading Together Forum continues to receive good feedback and each speaker is building on the work of the last creating consistent messaging. People Promise Manager delivering against action plan with national recognition of curent work. Funding for People Promise Manager available for Y2. National Staff Survey results available and action planning commenced. [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	31/03/2023	31/03/2023	20/08/2023
Strategic Objective							**3a. A modern, clean and fit for purpose environment**																			
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)	01/08/2023	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	[18/07/2023 14:56:34 Rachael Turner] Risk areas-medium risk areas 50% completed at 3 sites. combustible material noted on ceiling within M1 at pilgrim. Action being taken by estates teams to provide remedial works by 28 July. [23/06/2023 14:25:36 Corporate Dashboards] Risk reviewed no change to report [15/05/2023 13:32:10 Rachael Turner] Progress towards the Fire Deficiency notices, Fire are currently completing inspection of the passive fire protection for ALL Higher Risk areas across the three sites, (typically patient sleeping areas). A report will be issued to the Fire safety team identifying breaches in compartmentation with associated costs. The next phase of surveys will commence June for ALL Medium-Risk areas Chubb have been appointed as a competent person to undertake extinguisher inspections. These have commenced at pilgrim and will be prioritised on the basis of compliance dates. Troup Bywaters + Anders were commissioned to undertake a site survey. A capital bid will be presented to the Capital board, to seek approval for funds to address in a phased approach in a timely manner [25/04/2023 10:09:43 Rachael Turner] Unannounced Fire Drills have now commenced in area across the trust being supervised by the fire safety team. Compartmentation surveys across 3 sites on basis of risk priority by competent contractor in accordance with Notice of deficiency received from Lincolnshire Fire and rescue. Extinguisher servicing has commenced by competent contractor. [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	4	30/06/2022	31/03/2024	01/09/2023
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.	01/08/2023	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	[18/07/2023 14:59:14 Rachael Turner] Risk areas-combustible material highlighted on ceiling M1. Estates implementing Remedial actions by 28 July 2023 [23/06/2023 14:24:47 Corporate Dashboards] Risk reviewed no change to report. [15/05/2023 13:33:34 Rachael Turner] Competent persons are currently completing inspection of the passive fire protection for ALL Higher Risk areas across the three sites, (typically patient sleeping areas). A report will be issued to the Fire safety team identifying breaches in compartmentation with associated costs. The next phase of surveys will commence June for ALL Medium-Risk areas Troup Bywaters + Anders were commissioned to undertake a site survey. A capital bid will be presented to the Capital board, to seek approval for funds to address in a phased approach in a timely manner [25/04/2023 10:10:43 Rachael Turner] Fire door Tender for maintenance, supply and install has gone to framework by procurement teams. Fire Door inspection by competent contractor selected with anticipation of late may start up. [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	10	31/03/2022	31/03/2025	01/09/2023

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
5189	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Medical Gasses Working Group	Health and Safety Group	13/06/2023	25		Corporate	Estates and Facilities	Estates	Lincoln County Hospital	The Medical Air Plant in Maternity Block and Plantroom 12 at Lincoln County Hospital are of an age and high risk of failure. The systems are none compliant and do not comply with current triplex and quadplex installations. The installed systems or only duplex. Maternity Med Air plant has failed and currently operating with a temporary skid mount compressor plant. On 11th June the Plantroom 12 Med Air Plant failed and created significant patient Harm Risk. Both of these Med Air Plants require replacement to prevent harm to patients and staff.	A temporary hired medical air plant is in use at Matternity Block to maintain Medical Air provision. Plantroom 12 is operational and is under investigation and support from specialist contractors to maintain its operation.	Frequent daily inspections of plant is to be implemented immediately, this is to support the service and maintenance from the contractors as an additional monitoring activity.	03/08/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Our specialist contractors are working with the trust in order to supply temporary medical gas plant in the event of catastrophic failure to enable the impact to be as minimal as possible. The long term and only feasible strategy is to replace the medical gas air plant, upgrade to a quadplex modern and fit for purpose system, but this will require significant capital investment.	[03/08/2023 10:12:04 Rachael Turner] Risk reviewed, work currently ongoing, no current update. [28/06/2023 11:48:48 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023. Risk remains at a 20 following an incident. This was declared as a Serious Incident. On 11th they lost one side of medical air vent, the ventilators stopped working. Currently running on higher sets at Lincoln. Now secured capital, looking at a Triplex. Risk score agreed as 4 x 5 at a score of 20.	5	01/03/2024		03/09/2023
5104	Regulatory compliance	Rinaldi, Dr Ciro	Dunning, Mr Paul	Mortality and Learning Strategy (MoralS) Group	Estates Infrastructure and Environment Group	16/03/2023	10		Clinical Support Services			Trust-wide	As a result of the HTA's concerns relating to the fabric and capacity of the Trusts mortuary service and the delay in timescales by which the Trust is able to refurbish these following the HTA inspection in May 2022. There is a risk that The HTA as the regulator could impose conditions on our licence to store the body of a deceased person within the Trusts mortuary facilities.	-HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case is being developed. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity).	ULHT Improvement action plan HTA Governance Group Weekly meetings to oversee mortuary refurbishment plans	21/07/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Risk reduction plan to assure HTA during March that risk controlled above mitigate their concerns over the Trusts mortuary estate. HTA have confirmed their acceptance of the Trust's plans to mitigate and have closed down their inspection process as complete.	[05/07/2023 11:06:25 Rachael Turner] Risk discussed in June RRC&C meeting, agreed to reduce risk score from 20 to a 16 High Risk [08/06/2023 13:22:36 Rachael Turner] Risk to be presented at RRC&C in June for reduction in score from 20 to 16. [31/05/2023 04:53:29 Jeremy Daws] HTA have responded to the Trust during May confirming their acceptance of the Trust's mitigation plans. HTA have confirmed they are assured enough to close down the inspection process as complete. Risk rating likelihood has been reduced from Quite likely (4) to Reasonably unlikely (3). The rationale for this is there is still a risk to the Trust if the current plans around refurbishment are not completed, even if HTA confirm that this current round of inspection/regulation is concluded. [26/04/2023 12:12:07 Rachael Turner] Risk presented at RRC&C meeting 26/04/2023 validated at a score of 20 Very High Risk. [16/03/2023 13:45:21 Rachael Turner] Risk to be presented at the RRC&C Meeting in March for validation.	20	31/03/2024		21/08/2023
5136	Physical or psychological harm	Parkhill, Michael	Pattinson, Paul	Estates Investment and Environment G	Health and Safety Group	28/03/2023	20		Corporate	Estates and Facilities	Estates	Trust-wide	Following monitoring for Nitrous Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)).	Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems. N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced.	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	28/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. Occupational Health have been directly involved with the implementation of sampling and post sampling. Following sample results, Occupational Health were contacted to advise that staff may require support. To date no Datix reports have been raised and no concerns re: ill-health have been escalated in relation to Entonox use/levels to the Health and Safety Team.	[28/06/2023 11:49:31 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023. Pilgrim from a Estates point of view, all mitigation has been put into place. At Lincoln we are still in the same position. This now sits under two separate risks with two separate scoring. 20 score for Lincoln, 12 for Pilgrim. These risks will go to division to agree to be split. [19/06/2023 11:14:32 Rachael Turner] Since the last review, sampling has been carried out for Pilgrim. WEL exposure limits were not exceeded in the last Pilgrim sampling reports with a few caveats: •Sampling was undertaken but use of Entonox was recorded as low •Due to works undertaken by Estates Supply Air was increased to exceed 10ac/hr, although it should be noted extract is via corridor extract so not in full compliance with HTM03. Occupational Health have reviewed this risk with the following findings: Following recent monitoring, we have established there is a tentative but almost certainly very low level of risk to midwives caring for labouring women using Entonox (nitrous oxide, otherwise known as "gas and air"). The theoretical risk is mainly to pregnant staff. There are significant gaps in the knowledge base about adverse health effects of Entonox, but adverse health effects are likely confined to when it is used as a recreational drug. Nevertheless,it is important that there is adherence to protocols associated with Entonox use. Guidance has been reviewed and is in alignment with NHS England current guidance. Pending further advice and investigations NHS England guidance must be followed: •Provide clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece. •Be aware of your positioning relative to exhaust nitrous oxide and the direction of ventilation flow •Turn nitrous oxide off when not in use. •Unplug regulators from outlets when not in use. •Monitor the condition of equipment for leakages. •Ventilate rooms by opening doors and windows when able and when rooms are not in use.	10	28/03/2024		28/07/2023
4830	Service disruption	Cooper, Mrs Anita	Myers,, Joseph	Estates Infrastructure and Environment Group, Medicines Quality Group		17/01/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Pilgrim Hospital, Boston	The area above Pharmacy at Pilgrim Hospital contains estates plant and pipes that are prone to blockage and overflow, which could cause extensive damage to medicines; computer equipment and aseptic facilities that disrupts service continuity.	ULHT policy: - Estates maintenance / repair arrangements - Business continuity plans ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) / Pharmacy CBU / CSS Division	Reported incidents of service disruption	01/08/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Discussions with Estates to identify potential solutions to the blockage / overflow issues. Contingency plan - medicines and equipment are moved to a temporary location in the event of overflow into Pharmacy.	[01/08/2023 14:22:43 Rachael Turner] Risk discussed as RRC&C in July, risk approved to an increase in score to 5x3: 15 High Risk [27/06/2023 09:21:08 Alex Measures] meeting raised risk level to 15 Colin Costello to meet with Paul Dunning on Monday to get exec approval [01/06/2023 14:33:41 Lisa-Marie Moore] Risk ongoing no further update [29/03/2023 11:22:00 Maddy Ward] Discussed at Pharmacy Risk Register Review meeting today and risk is ongoing, no further update. [20/12/2022 14:16:17 Alex Measures] no updates - risk likely to increase in future reviewed 01/07/21 - ongoing, increase likelihood to likely 150622 ongoing. Shut down aseptic facility at PHB and put in a modular unit at PHB as consequence. Colin considers the risk level should be increased, to be discussed at confirm and challenge meeting next week.	6	30/09/2021	31/03/2022	27/09/2023

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4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	21/10/2022	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	[21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	21/01/2023
Strategic Objective							**3b. Make efficient use of our resources**																			
4664	Finances	Matthew, Mr Paul	Young, Jonathan	Workforce Strategy Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£17m. 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 Finance, People & Activity Meeting (FPAM)	01/08/2023	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	[14/07/2023 09:07:10 Rachael Turner] Risk reviewed, score to remain at 20. Work ongoing. [28/06/2023 16:13:10 Rachael Turner] The Trust has hit its own agency plan. This is our internal plan. Score to remain the same at this time. [24/05/2023 13:24:21 Rachel Thackray] Updated to reflect the risk for 2023/24. Cap reduced from £21m to £17m. The Trust's CIP plan for 23/24 is heavily focussed on agency reduction, risks to delivery include; excess beds, winter pressures and not delivering recruitment trajectories. [24/04/2023 13:17:23 Rachael Turner] No change currently, update to be provided next month when financial plan is complete. [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	31/03/2024	01/09/2023
5020	Finances	Hamer, Fiona	Smith, Charles	Workforce Strategy Group	WORK	02/09/2022	20	Risk assessments	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	15/08/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[15/08/2023 11:14:12 Helen Hartley] Remains the same, plans for recruitment and money signed off. Stays the same until recruitment piece has happened. There is a trajectory for this, beginning 2024. Tier 1 in place Tier 2 consultation discussed in case of next steps/formal outcome. Medical workforce additional consultants signed off for RAT, positive steps happening but this will take time. [19/07/2023 15:50:48 Helen Hartley] This remains a risk, should be reduced with medical workforce management project that CS is leading. Some delays with recruitment and HR, a few resignations due to deanery positions. Mitigations in place. [28/06/2023 11:24:27 Rachael Turner] Risk discussed at RRC&C as part of the Deep Dive 28th June 2023. Putting money into medical workforce to increase medical staffing by 2 on each shift. Also looking at people on the agency how we can recruit into substantive posts.Work remains ongoing. This risk remains the same. [13/06/2023 11:13:13 Helen Hartley] Robust recruitment plan and international recruitment plan in place and ongoing. The uplift to meet demand and capacity has been approved and agreed, adverts are going out next week. [26/04/2023 11:58:59 Carl Ratcliff] No update [14/03/2023 13:58:09 Rachael Turner] Robust recruitment plan and international recruitment plan in place. Ongoing work with medical workforce plan. Well ahead of schedule. Agency cost. Proposal for the score to be reduced to a 16 (High) this risk to be presented at RRC&C Meeting. [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	10	02/09/2023		15/09/2023

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5215	Finances	Matthew, Mr Paul	Young, Jonathan			14/07/2023	16		Corporate	Finance and Digital	Finance	Trust-wide	23/24 introduces a new mechanism to record, calculate and apply the API contract and a System incentive / penalty linked to the Elective Recovery Fund. Actual performance/activity is taken from SUS and EROC. At present, there are some SUS/SLAM reconciliation issues and some recording issues including Missing Outcomes. The risk is twofold: 1. that without accurate ERF monitoring through SUS on actual activity delivered, the activity will look artificially low and there will be financial deductions 2. the activity plan has been built on delivery of c116% of 1920 elective, day case, outpatient first and outpatient procedure activity. Under the new regime underperformance will result in lost income	The link between activity and income has been communicated to the Trust. Monitoring is being set up to monitor activity delivery and estimate the financial impact due to the variable adjustment. Lost income through recording issues (e.g. missing outcomes) will be monitored to include a financial estimate in 23/24. An ERF baseline appeal was submitted and 95% accepted nationally. This will reduce the baseline by £5.8m, final confirmation of the revised baseline is awaited.	Monitoring of the variable adjustment and lost income is being set up	14/07/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	"Information have been requested to reinstate SUS/SLAM reconciliation. Oversight of delivery is required through FPEC/FPAMs and any technical reporting issues reported to CFIG in the first instance. Required Trust activity delivery plan and then delivery against it."	[01/08/2023 14:49:23 Rachael Turner] Risk presented at RRC&C meeting in July, approved as 4 x 4 16 High Risk.	9	31/03/2024		14/11/2023
4665	Finances	Matthew, Mr Paul	Young, Jonathan	Financial Turnaround Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	Updated in May 2023 to reflect 23/24. The Trust has a £28m CIP target for 23/24. 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 FPAMs 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 FPAM. Trust focus against Targeted and Transformational schemes is reviewed at the Improvement Steering Group	14/07/2023	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.	[14/07/2023 09:09:38 Rachael Turner] Risk reviewed, risk score to remain as current work is ongoing. The Trust has over delivered against the month 1 trajectory for the FRP by £0.5m. The trust is also forecasting to deliver a full £28.1m CIP programme for 23/24. [28/06/2023 16:16:06 Rachael Turner] Risk reviewed, targets have been reviewed to reflect where we currently stand. we have hit financial improvement target for month 1 and 2. Risk score to remain the same at 16 High Risk. [24/05/2023 13:11:53 Rachel Thackray] Updated to reflect the risk for 2023/24. The Trust has plans to deliver £28m CIP (FRP) target. In month 1 delivery exceeded plan. [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	31/03/2024	14/10/2023
4965	Finances	Hallion, Simon	Chantry, Chris	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	14/08/2023	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.	[14/08/2023 14:41:07 Jasmine Kent] Nursing risk reducing, less reliance on temp staff. Spend reducing, closing vacancies. ?Possible reduction, for discussion at governance. [12/06/2023 15:59:14 Jasmine Kent] Overseas nursing recruitment ongoing, jobs are out to advert. Looking at role development. [13/03/2023 16:09:39 Jasmine Kent] No improvements, despite efforts, lack of traction with filling vacancies. [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		14/11/2023
Strategic Objective						**3c. Have enhanced data and digital capability**																				

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
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. Implementation of digital systems which don't include a disclosure process. 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.	03/08/2023	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.	[03/08/2023 10:14:11 Rachael Turner] Still awaiting response from ICO, this is being chased as no outcome as of yet. [03/07/2023 11:47:54 Fiona Hobday] *Still awaiting response from ICO following Feb 22 meeting. AS follow up question was asked- but no outcome as yet. *Escalated re Procurement of new solution for SARs- rough idea of cost identified. *Focus on clearing backlog emails and identifying gaps to resolve prior to escalating to complaint or ICO. [05/06/2023 17:17:35 Fiona Hobday] *Still awaiting response from ICO to Feb meeting *Escalated re Procurement of new solution for SARs *Focus on complaints, and clearing requests from Feb. March currently. *More requests being disclose digitally which is positive. [25/04/2023 12:45:53 Fiona Hobday] *Resource remains prioritised to requests post Jan 23 to minimise the risk of a complaint to the ICO. *Considerable movement was made of backlog (Pre Dec 22) and the majority of the oldest requests were completed. Oldest currently dates to August 22. *Work is re-starting on the procurement of a dedicated solution as it has been identified again that DATIX cannot meet our needs (4 month delay in work as a result). *New process documents have been developed and released to service; these will aid consistency, assurance and training of new staff- currently being tested. *Still awaiting response from ICO following Feb 22 meeting. Expected completion date has been changed in light of system work and staff departures- this impacts delivery. [29/03/2023 13:01:02 Fiona Hobday] *A work plan has been developed by the Head of IG and Disclosure Supervisor to provide greater oversight. *The spec for the new case mgmt system has been started and the next step is to meet with the project Mgr. *Current reduction in resource due to staff leaving- plans in place to replace.	6	30/06/2023	30/09/2023	03/09/2023
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 non compliance 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 -Privacy by Design Procedure (NEW 2023) 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. Number of escalated issues in relation to project work.	08/03/2023	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.	[05/06/2023 17:25:59 Fiona Hobday] *Privacy by Design Procedure approved and live. *Contracts and IG Guidance document approved and live. *Ongoing comms to staff on a monthly basis. *Head of IG delivered awareness training session to Procurement Managers in 03/23. *Regular monthly meetings now in place with IG/ Digital and IG/ Programme & Project Team. [08/03/2023 13:50:25 Fiona Hobday] 08/03/23- New DPIA template live and published on intranet. Supporting procedure written and due to be ratified at IGG in March 23. Awareness session planned with Procurement Dept 16/3/23 by Head of IG. New 3rd Party Due Diligence in use and due to be published on intranet shortly. Annual comms plan for IG commenced in Jan 23. [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.	6	31/03/2024	30/06/2023	07/08/2023
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/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work. 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. Reports of unmanaged records found in Trust locations.	08/03/2023	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. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	[05/06/2023 17:22:19 Fiona Hobday] *Head of IG has spoken to Trust Sec re current concerns on lack of a strategic approach- linking to 365, EPR and EDMS. Need to look at whole picture and not pieces of work in isolation. *Head of IG has raised with Digital Programme Team to ensure RM is looked at strategically and in a joined up manner and they link in with Trust Secretary as the functional owner for Corporate Records. *365 Project- Records Mgmt identified now as a key deliverable and driver for the project. [08/03/2023 13:53:45 Fiona Hobday] Head of IG and DPO discussed in relation to retention of Health Records and removal of long time ban on disposing of records for Saville enquiry- this has now been lifted and Clinical Records Group to be tasked with taking discussion re record disposal forward. [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	03/07/2023
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
Strategic Objective							**4b. Becoming a University Teaching Hospital Trust**																			

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
5160	Reputation	Morgan, Mr Andrew	Rich-Mahadkar, Sameedha			21/04/2023	16		Corporate				If we don't deliver against our ambition of becoming a University Hospital Trust, this could negatively impact our organisational reputation.	Following UHA guidance Regular discussions between Executive leads from ULHT and UoL regarding financial arrangements Working closely with University of Lincoln to define and agree future collaborations Working with Research and Innovation teams and reporting into R&I groups to maintain oversight	Executive scorecard - number of clinical academics in post and number of collaborations that are developed to support research grants	07/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continued discussions between ULHT and UoL Executive leads to finalise research and financial agreements Contact with UHA to confirm requirements for application	[07/06/2023 12:20:47 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023.Risk needs to reflect more than getting status, such as recruitment, quality of people you attract, development and investment. Risk score 4 x 4 making it a score of 16 High Risk.	8	31/03/2025		07/07/2023

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5 September 2023*
Item Number	*Item 13.2*

Board Assurance Framework (BAF) 2023/24

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

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

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

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

Executive Summary

The relevant objectives of the 2023/24 BAF were presented to all Committees during July and August, with the Audit Committee meeting and receiving the report in July only.

The Board are asked to note the updates provided within the BAF identified by green text.

It should be noted that there have been no proposals to amend assurance ratings from the Committees during either the July or August meetings.

The following assurance ratings have been identified:

Objective		Rating at start of 2023/24	Assurance Rating (Previous Board reported position) June	Assurance Rating (Previous Committee reported position) July	Assurance Rating (Current position) August
1a	Deliver harm free care	**Green**	**Green**	**Green**	**Green**
1b	Improve patient experience	**Green**	**Green**	**Green**	**Green**
1c	Improve clinical outcomes	**Green**	**Green**	**Green**	**Green**
2a	A modern and progressive workforce	**Amber**	**Amber**	**Amber**	**Amber**
2b	Making ULHT the best place to work	**Amber**	**Amber**	**Amber**	**Amber**
2c	Well led services	**Amber**	**Amber**	**Amber**	**Amber**
3a	A modern, clean and fit for purpose environment	**Amber**	**Amber**	**Amber**	**Amber**
3b	Efficient use of resources	**Red**	**Amber**	**Amber**	**Amber**
3c	Enhanced data and digital capability	**Amber**	**Amber**	**Amber**	**Amber**
3d	Improving cancer services access	**Amber**	**Red**	**Red**	**Red**
3e	Reduce waits for patients who require planned care and diagnostics to	**Amber**	**Amber**	**Amber**	**Amber**

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

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2023/24 - August 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. Safety culture surveys are 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. Work to agree Trust culture tools to take place.	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
						Policies are developed and updated in line with national and local guidance and in line with the National IPC Manual for England IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	Some Estates and Facilities IPC-related. Some Estates and Facilities IPC-related policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Estates and Facilities Policy Schedule has been presented to the IPCG containing dates for completion. Each policy is approved by the IPCG. Water, Ventilation and Decontamination IPCG sub groups have oversight of policy development	The IPCG is the primary source of assurance with each policy being an agenda item 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.	None Identified	Not applicable		
						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 quarterly (IPCG)	Non-compliance with some aspects of the Hygiene Code in respect of criterion 2, (provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections) with specific concern relating to decrease in standards of environmental cleanliness (PHB), poor environmental infrastructure (water and ventilation), impact on planned preventative maintenance programme, breach of waste regulations for the safe storage of clinical waste and some aspects of in house decontamination processes	Good monitoring of standards of environmental cleanliness with auditing and process for remedial action. Recruitment of additional housekeeping staff at PHB. Water and ventilation safety groups are established. Planned preventative maintenance subject to assessment of risk and prioritisation processes. Increased waste audits and inspections. Storage capital programme work is progressing. Decontamination remedial work has progresses and Trust-wide audit of compliance is planned. Monthly reporting to the IPCG with upward reporting to the QGC	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	None applicable	Not applicable		
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) NatSIPs 2 in the process of being launched to include 8 steps to safer surgery rather than 5. (PSG)	Improvement seen across all divisions in terms of development of NatSIPs/LocSIPs, however audit is required in order to provide assurance of implementation. Lack of reporting whilst transitioning to the new way of working	Individual Divisional meetings now in place; quarterly reporting to PSG Additional support provided to medicine from the Patient Safety Improvement Team NatSIPS' T&F group currently being established to address the necessary changes	Audit of compliance Upward reporting of the T&F group into PSG.	Reporting into PSG needs to become more robust.	Review occurring through the Divisional meetings with quarterly reporting to PSG. Reporting into PSG will be picked up as part of the T&F group.		

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
1a	Deliver high quality care which is safe, responsive	Director of Nursing/Medical	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	5016 4624 4877 4878 4879 4789 4932 5103	CQC Safe	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 meeting monthly 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 Upward reporting from DTC and the Chemotherapy Group has commenced.	Lack of upward reporting from the Medical Gases, Sedation Group 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	Quality Governance	Green
						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. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. External independent input in to SI process. 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.	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. Training compliance data.	None Identified	Not applicable.		

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1a	and able to meet the needs of the population	Nursing/Medical Director	Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	5103 5101 4740 4947 5100 5102 5175 5075	CQC Safe	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 AKI; sepsis (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 AKI; sepsis; CCOT	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 Robust upward reports recieved monthly into PSG	Fluid Management group has not been meeting and therefore concerns through PSG have been raised.	The chair of DPG is undertaking a relaunch of the Fluid Management group with revised attendance and reporting into DPG	Committee	Green
						A robust safeguarding framework is in place to protect vulnerable patients and staff Safeguarding and Vulnerabilties Oversight Group (SVOG) strategically leads on the overall safeguarding goverance, reporting up to QGC Bi Monthly. Mental Health, Neuro-diversityand Dementia Group (MHNDD) have a topic focus and feed into SVOG (Bi-Monthly). Safeguarding and Vulnerabilty Operational groups within the 4 divisions lead on operational issues and action plans - feeding up to SVOG Safeguarding and Domestic Homicide reviews are monitored and quality assured Via SVOG Safeguarding related policies are Monitored and commissioned by SVOG in line with national and local requirements Safeguarding audits (internal and system) are monitored and commissioned by SVOG Safeguarding training topics /compliance are monitored and commissioned by SVOG	Further system work required in relation to delivering against Oliver McGowan Training risk (ID 5141). Business case and funding required in relation to IDVA service gap to ensure efective DV service provision for patients and staff. Rollout of DMI training needs to be embedded across operational teams	Risk 5114 being monitored via SVOG / MHNDD group with ongoing work via System meetings. LD training tier one and two (internal) rolled out to ensure staff have upto date knowledge accepting this is not Oliver McGowan training. Transition from ULHT training to O.Mc as system Domestic abuse workload being monitored via safeguarding team and SVOG Staff groups for DMI identified and PET group in place - full rollout from August 2023 being monitored via SVOG and Health and Security group	Upward reporting from SG operational groups and MHNDD group to SVOG Learning disabilty training figures monitored monthly by Deputy Director of Safeguarding feeding into system meetings and via SVOG. Clinical Holding / restraint Datix being monitored by safeguarding team to ensure review of any restraint incidents with update paper to SVOG Domestic abuse workload monitored via safeguarding team and adjustments to workload made as necessary with paper to SVOG	None Identified	Not applicable		

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						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. One central monitoring process now in place. (PSG)	Review of compliance metrics required. Internal audit of CAS/FSN process found limited assurance with current processes.	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate. Action plan in place to adress issues identified in internal audit report.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.	Furtther work required on the reporting process for CAS / FSNs.	To be incorporated into the action plan following the internal audit.		
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group Monthly SIG meeting, with highlight report to NMAAF. Patient information booklet shared with patients Annual Stop the Pressure conference and other learning events in week. Quality Improvements overseen by SIG and outputs through the overarching action plan (NMAAF)	None identified.	Not applicable.	Monthly skin integrity performance report to SIG.	None identified.	Not applicable.		
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads (CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices). Includes regular meetings with divisions, CQC action plan which goes to relevant committees, TLT, etc. Regular executive challenge meetings on delivery. Escalation routes into PRM and TLT. (CG)	No gaps identified.	Not applicable.	Monthly reporting to sub-committees with the relevant extract of the action plan. CYC and TLT receive monthly reports. QGC receive quarterly update on the entire plan. Quarterly updates Trust Board. Feedback to CQC on achievements at monthly engagement meeting. CQC assurance data.	CQC assurance data not yet complete. CQC assurance data not yet shared with committees. Output from PRM is not clear. Escalations not always acted upon promptly.	Use of exec led meeting to pick up escalations which may not occur via other routes. Additional resource identified for compliance team to support with sourcing levels of assurance.		

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						Embrace both internal and external assessments of patient experience and safety and triangulate information in order to drive a culture of safety - Ensure you do not come to harm under our care (PSG) remove - included in row 33)							
						Embedded processes to address risk of hidden child and support transition across all services (CYP)							
						Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm and reviewing external reports and assessments of our services (PSG)							
						Well established Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place The Group meets monthly and has a work plan and schedule. (PEG)	There are no identified control gaps.	Not applicable.	Upward reports to QGC monthly and responds to feedback Review of ToR annually as part of the work schedule. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report Divisional Reports have developed in reporting maturity and include a patient story / risks and issues / actions. This is a well embedded part of the PEG meeting.	Themes from the Divisional assurance reports and the Complaints reports and others sources of information are being triangulated, so oversight across the themes is clear, this is work in progress.	Overall report being developed and monitored through PEG.		
						Patient and Carer Experience (PACE) plan 2022 - 2025 The PACE Delivery Plan is actioned and embedded over the life of the delivery plan. (PEG)	There are no identified control gaps.	Not applicable	Patient Experience & Carer Plan progress report to Patient Experience Group as per schedule. Ongoing assurances provided to PEG re: actions.	There are no assurance gaps identified.	Not applicable		

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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		CQC Caring	Quality Accreditation and assurance programme which includes weekly and monthly audits which include feedback on patient experience from patients in the clinical areas. (PEG)	Further development of alignment of findings in audit data to patient experience surveys overarching plan and other sources of patient experience information.	Head of pt experience can access the audit date. Deep dives into areas of concern as identified in quality metrics dashboard meetings Update reports to PEG and QGC as required. Weekly and monthly audits continue to take place including during times of extremis.	Reports to PEG and upwardly to QGC	There are no assurance gaps identified.	Not applicable.	Quality Governance Committee	**Green**
						Communication and engagement approaches to broaden and maximise involvement with patients and carers Expert by Experience Groups are well embedded (one of which relates to discharge) Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging. Sensory Loss group upwardly reports to Patient Panel. (PEG)	Reaching out project (Hard to Reach groups) still in development. Diversity of current patient representatives and panel members is narrow;.C Contact still to be made with some community groups.	Recruitment for new panel members continues. 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. Communication working group set up to look at a range of communication issues affecting patient experience.	Upward reports and minutes to the Patient Experience Group	Diversity of the patients engaging and involving themselves limited meaning that is is not represenative of the local population.	Partnership working established with Healthwatch to reach out to Eastern European community. Staff BAME network approached for community links and contacts. Breast mastalgia group has completed its co-design but will meet again in the future as part of service evaluation. Dementia Carers group has had first meeting and will meet alternate months. Cardiology and QI groups being developed		
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting.	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work.	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. Complaint data now improved in terms of visiting issues.	Patient information currently subject to review and work is ongoing.	Audit of visiting experience planned which will provide an understanding across all aspects of visiting now that all COVID precautions have been stepped down. This will also tie in with national work on Care Partners and visiting guidance under the Health & Care Advisory Board which the Head of Patient Experience is a member of.		

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						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports will need to develop in maturity regarding patient experience	Head of Pt Experience to discuss with EDI lead to ensure data is relevant and triangulated.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic; national programme recommenced September 22	PLACE Lite continues & reports to PEG plus the annual report will be received at PEG, due Jan 23		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. (PEG)	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements.	Discharge experience reports to PEG quarterly.	Work required with the lead nurse for discharge to ensure experience data is collected, analysed and acted upon.	Support to be provided to the lead nurse for discharge.		
						Ensure we provide clinically safe services, through an increased number of Diamond Award Accredited Wards / Departments (PEG)	there are no identified Control gaps	Not applicable	monthly Quality metrics dashboard meeting with all clinical areas. Diamond award applications received and supported by corporate nursing team. Diamond Award Panel chaired by DoN/DepDoN. Award presented by Trust Chair. Metric included with the IIP, and measured Quarterly.	None Identified	Not applicable		
						Clinical Effectiveness Group in place as a sub group of QGC and meets monthly 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. Role of CEG is to Improve clinical effectiveness through increased compliance with national and local standards. Quality of reporting into CEG has improved and is increasingly robust. (CEG)	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics.	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	No gaps identified.	Not applicable.		

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						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (CAG) with quarterly reports to QGC Refocus of CAG to focus on the learning from audit. (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue although this is beginning to improve.	Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed. Quarterly updates with Clinical Audit Leads take place with the Deputy Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions. Reports also include learning and changes in practice as a result of audit.	No gaps identfied.	Not applicable.		
						National and Local Audit programme in place and agreed which is signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit. Quarterly reports and process in place for any areas where the Trust is identified as an outlier. (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable		
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	Not applicable		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project. (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down although this is due to recommence.	National reports to be presented at Governance Meetings once produced		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4731 4828	CQC Responsive CQC Effective	Specialised services quality dashboards (SSQD) Process in place for identifying outliers through Model Hospital. Clinical leads for outlying areas present updates to CEG quarterly. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	No gaps identified.	Not applicable.	Quality Governance Committee	**Green**
						Process in place for implementing requirements of the CQUIN scheme. Monthly meetings take place with CQUIN leads. Quarterly reporting takes place. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC	No gaps identfied.	Not applicable.		
						Process in place for ensuring high quality of record keeping including Medical Records Group. (CEG)	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. Limited evidence that specialties are reviewing record keeping findings and developing actions to address.	Divisional governance leads to pick up within each area.		
						Process in place for monitoring of and implementation of NCEPOD requirements. (CEG)	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.	No gaps identified.	Not applicable.		
						Improve clinical effectiveness and best practice principles by prioritising Cardiovascular pathways							

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						Monthly MorALS meeting chaired by the Deputy Medical Director and attended by a representative of the Triumvirate for each division. Member of systemwide Mortality Collaborative Group. Divisional M&M meetings in place. Business Partner Model approach in place. 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. (CEG)	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. Not all specialties have recommenced M&M meetings since Covid - work is taking place to support them with this.	Following the success in UTOO for ACP's contributing to the SJR reviews, further training is going to be rolled out to the MDT. Standardised process being developed for M&M meetings.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Dr Foster data on depth of coding. Divisional updates at MorALs by the Triumvirate.	Gap identified in the ability to draw learning from SJR's due to ongoing delays with completion	Local data sources are used where possible. Gaps in learning mitigated by ME process and escalation of concerns via incident management processes.		
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)				None identified			

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						Workforce planning and workforce plans Recruitment to agreed roles - plan for every post, for Agenda for Change, Medical and Dental Workforce			Workforce plans submitted for 2023/24 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.				
						Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established and in place for 2023/24. People Promise Y1 work complete with funding for Y2 agreed. Education and Learning Team in place and actively working to improve compliance with Statutory and Mandatory Training. Organisational Development Team in place and actively working to improve completion rates for Appraisals.	System People Promise Manager to be recruited for Yr2	OD picking up retention/flexible working whilst People Promise Manager not yet recruited to	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	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan.		
						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)		

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2a	A modern and progressive workforce	Director of People and Organisational Development	Possible disruption caused by system wide strike action and capacity of Pillar leads	4362 & new high risk on POD register	CQC Safe CQC Responsive CQC Effective	Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Support and training from HRBPs	Sickness/absence data	Various reports through Heads of HR to Divisions	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan. A deep dive is being undertaken of the full utilisation of the AMS management system as early indications show improvement is needed.	People and Organisational Development Committee	**Amber**
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service (pending P&OD restructure) Promote benefits and opportunities of Apprenticeships			WSODG, FPAM and PODC data	None identified			
						Improve the consistency and quality of leadership through:- Reset leadership development offer and support (Leadership SkillsLab and PME) •Improved mandatory training compliance •Improved appraisals rates using the WorkPal system •Developing clear communication mechanisms within teams and departments			WSODG, FPAM and PODC data	None identified			

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						Proactively support staff to remain well and at work, however should the need arise, supporting them through illness and their return to work	Improvement in sickness rate in 23/34 full year affect of 4.5% required.	Continue to fill vacancies within the HR department to support Divisions with sickness management	Health and wellbeing Manager and Health and Wellbeing Group/Wellbeing Champions Upward reporting to WSODG from H&WB Group Board level HWB Guardian change enacted		Nearly at a fully recruited position within the newly restructured HR department.		
						Employee Assistance Programme implemented May 2022 - embedded as business as usual							
						Vacancy levels below 4% across all staff groups	Aligned to the plan for every post, recruitment plans for each division and aligned to the workforce submission plan for 23/24.	Not applicable	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group.	None identified			
						Reduce our staff turnover rate to 6% across all staff groups	Aligned to the continued work under the People Promise Manager role and plans for 23/24 to continue to improve work life balance, flexible working requests, flexible retirement/retire and return options.	Not applicable	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group.	None identified			
						Compliance with National agency utilisation target of 3.7% agency and locum workforce			FRP and ISG				

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2b	Making ULHT the best place to work	Director of People and Organisational	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training	4083	CQC Well Led	Reset ULH Culture and Leadership through delivery and implementation of Culture and Leadership Programme and Restorative and Just Culture Programme.	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 and System People Board Culture and Leadership Programme Group upward report NSS results (Feb 2023)	Delivery of agreed output	Paper being presented to ELT in August to offer a plan in terms of 23/24 National Staff Survey plans and individual priorities being taken forward in preparation for the next NSS. Restorative Just and Learning Culture project team has been created to scope out the plans to roll out in the Trust.		Amber
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.			Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care Director BLOG's	None Identified			
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) Leadership SkillsLab - Re-launched July 2023			National Quarterly Pulse surveys (mandated from July'22) Number of staff attending leadership courses	Limited uptake of quarterly staff survey	Work on-going in terms of uptake and analysis		
						Lincs Belonging Strategy EDI Delivery Plan 2022-25		Not applicable	Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified	None Identified		
						Staff networks	Men's Health Network Group due to be launched November 23	Executive sponsor for Men's Health Network to be identified Launch Network in November	Council of Staff Networks	None identified	None Identified		

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	to work	Organisational Development	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			Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian	Additional resources are now in place within the OD Department to help support culture and engagement within the Medical Workforce.	Task and finish group to review experience of rotation	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	None Identified		
						Embed compassionate and inclusive leadership (aligned to People Promise)	System People Promise Manager to be recruited for Yr2	OD picking up retention/flexible working whilst People Promise Manager not yet recruited to	Culture and Leadership Group	None identified			
						Support Divisions to achieve 95% of our people having completed all relevant statutory and mandatory training by March 2024	Newly created dedicated Education Department now in place as part of the restructure. Aligned to the People Promise continued work for 23/24	Support and training from new Education Department	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting	Delivery of agreed output	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan. Additional monthly assurance offered to CQC through governance team regular meetings		
						Support our Divisions to provide all staff with an appraisal and clear objectives		Support and training from new Education Department	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting				
						55% of our staff recommending ULHT as a place to work and an improved position with regards to our people feeling that they are treated with kindness, compassion and respect.		Further work required aligned to the Quarterly Pulse survey and promotion of this.	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting				
						53% of our staff recommending ULHT as a place to receive care		Further work required aligned to the Quarterly Pulse survey and promotion of this.	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting				

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

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						Complaince with National agency utilisation target of 3.7% agency and locum workforce							
						Reduce our staff turnover rate to 6% acorss all staff groups							
						An external audit agaisnt CQC Well Led measures, to be completed by September 2023 and an action plan to be developed for futher improvements							
						53% of our staff recommending ULHT as a place to receive care							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.		
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments PLACE Full assessments starting in September 22	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response. With PLACE Full assessments starting in September gaps will be closed further.		

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4648 - Fire Safety 4647 - Fire Safety 4858 - Water	CQC Safe	Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID	Improvement teams have started in 2022/23 working through value for money and financial efficiency schemes included development of Housekeeping, Security and Portering Business Cases for future models	MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Groups will report through to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not with Annual Reporting providing assurance and gap analysis on all AE domains.	Finance, Performance and Estates Committee	**Amber**
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report Letter from British Safety Council on External Review				
						Implement Year 1 of our Estates Strategy	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	Estates Group Upward Report				
						Refurbishment of 8 theatres, across our sites							
						Support capacity maximisation ensuring modernisation and utilisation of space, including that leased off the main acute sites							
						Reduce our net carbon footprint							
						Develop Health Master Plans to better algin wards							

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3b	Efficient use of our resources	Director of Finance and Digital	Not identifying and then delivering the required £28m FRP of schemes The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 23/24 financial settlements The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. Failure to deliver the activity targets of 116% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire.	4665 - FRP delivery 4666 - Inflation pressures 4664 -Agency costs 4384 - ERF Clawback (116% activity delivery risk) NEW Risk to be added to the risk register - Availability of Capital	CQC Well Led CQC Use of Resources	Introduction of Aspyre for reporting all FRP schemes Refresh of the CIP framework and training to all stakeholders. Increased FRP governance & monitoring arrangements introduced. Alignment with the Trust IIP and System objectives FRP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream. Internal meeting structure and reporting aligned to the ICS reporting requirements	Operational ownership and delivery of efficiency schemes Detailed delivery plans supported by clear timelines and metrics for all plans	Divisional FPAM to provide oversight of FRP reporting upward into PRMs. Trust wide oversight for FRP schemes in the Improvement Steering Group ICS oversight through the ICB Financial Recovery Board.	Delivery of the Trust FRP target Reporting through Aspyre to - FPAM PRM FPEC Financial Recovery Board	Ability of clinical and operational colleagues to engage due to service pressures. Evidence of system and Trust schemes to reduce the operational pressures and beds numbers in the Trust. Traction in year to produce cost out from cross cutting targeted and transformational schemes	Divisional - Progress is being reviewed monthly with Divisions through FPAMs. Trust wide improvement schemes - Progress is being reviewed monthly with Exec, Divisional and Corporate teams through the Improvement Steering Group. System wide - Progress is being reviewed monthly with system partners including Exec, Operational and Corporate teams through various forums.	Finance, Performance and Estates Committee	Amber
						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 £8.1m in its 2023/24 financial plan submission - over and above national inflation funding allocations. The £8.1m (as per national instruction) sits outside of the Trust financial plan for 2023/24. Inflation pressures primarily relate to Utility costs but also impacts in other non-pay contracts. As prices continue to rise the Trust and / or ICS 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 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 Excess inflation pressures will be reported internally into FPEC and externally into FLG and ICS and Finance Committee	Forward view of market conditions.	Internally through FPAMs and upwards into FPEC. Externally through greater dialogue with suppliers and proactive contract management Flagging with ICS partners and NHSE to understand if any further funding allocations will be available to offset.		
						Financial Recovery Plan schemes Recruitment improvement Medical job planning Agency price reduction Workforce alignment Service Reviews process and transformational programmes of work Budget compliance	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	The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The Trust FRP workstreams are reported to the Improvement Steering Group The Divisional cut of the workstreams are reported to the relevant FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups		

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						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 116%.	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. A production / activity delivery plan.	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. Reporting by POD and Specialty against the delivery plan	Delivery of the 116% 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 116% 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		
						Utilisation of Capital allocation based on risk to enhance our services and support efficiency improvements	Difficult to compare Estate, Digital and Equipment risks. Capacity to produce business cases to access external funds	Revised CRIG process, supported by experts. Green book training roll out. Risk rating pre & post investment required in all investment requests.	Capital, CDC and Benefits realisation upward reports into FPEC. Development of a 5 year capital programme cross referenced to risk register.	6 facet survey not completed.	Investment identified for 6 facet survey.		
						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	OBC approved by Frontline Digitalisation ePR Investment Board (EPRIB) on 19th July 2023. OBC approved by JIC on 28th July 2023. Final approval awiting by Cabinet Office Commercial Spend Controls Process - could take up to 28 days.		

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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.		
						Upgrade of our technological infrastructure to support technology advancements	Insufficient cap/rev to replace aging technology Insufficient capacity to deliver purchased equipment	Technical Design Auhority Digital Hospital Group Information Governance Group (for cyber / info security)	Digital Marurity Assessment		Looking to procure a Technical / Implemenation Parner to provide capacity as and when required		
						Provide our people with real-time data to support high quality care delivery to all clinical staff							
						Enhance our organisational digital capability and skills through training	Insufficient capacity to create and deliver training materials	Digital Hospital Group			Looking to procure a Technical / Implemenation Parner to provide capacity as and when required		

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						Implementation of an Electronic Prescribing system	2023/24 funding not approved yet Insufficient capacity to deliver at pace of current plan	ePMA Steering Group Digia Hospital Group	Number of wards live with ePMA		Paper written to clarify costs. Currently being worked through with Finance colleagues Looking to procure a Technical / Implemenation Parner to provide capacity as and when required		
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 Trust in tier 1 due to delivery of FDs		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**
						Achievment of 104 and 62 week perofmrnace trajectory	Capacity to deliver Faster Diagnosis (FDs) for all services	Additional support secured through mutual aid to provide focus on cancer recovery	Weekly system elective and cancer recovery meetings 3x weekly cancer meeitngs led by Deputy COO, Urgent Care and Cancer and ICB Cancer lead				
						Maximisation of capacity and efficiencies to reduce waiting times and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT				
						Development of plans for seven day working, across all of our services							

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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 Trust in tier 1 due to delivery of FDs		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 is now established and a delivery group is also in train.	Requirement for specialty strategies now part of strategy deployment and for complation in Q1 23/24 Recovery plans at specialty level. To date have delivered required reductions in 104 week waits Outpatient Improvement Group in place and is now supported by a delvery group lead by the Deputy COO for Planned Care and Diagnostics 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. The ULHT COO is now System	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. This now supported with a delivery group that focuses on 'Further Faster'.	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 and now has a Senior Leader attendance rota. 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				
						Meet all National asks for performance, set out in the planning guidance, for elective care							
						Maximisation of capacity and efficiencies to reduce and eliminate 78 week, 65 week waits across all specialties and moves to ambition of reducing 52 week to 700 by end of Q4 2023/2024			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT Weekly planned care update meeting				
						Development of plans for seven day working, across all of our services							

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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)	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.	Finance, Performance and Estates Committee	**Red**
						Urgent Care Recovery Improvement Steering Group which oversees a programme of work linked to increase capacity, flow and discharge through the Trust Wide Emergency Departments, Urgent Treatment Centres and Same Day Emergency Care Breaking the cycle pilot has now ended and lesson learnt document shared and agreed recommendations for embedded changes agreed at UCRIG	Large complex programme which required system working to reduce pathway 0 waits and deliver right care right time principals	Large programme of work so additional resource had been provided through a consultancy Impower & ECIST to assist in identification of areas to improve and on the ground support. This has now ceased. ED 'risk' summit underatlen on 8 August 2023 to support ongoing recovery.	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		
						Recovery Support Plans	Risk of further waves, increased emergency demand and covid related sickness	Urgent and Emergency Care Board.	Daily review via Capacity and performance meetings Weekly reporting to ELT Fortnightly reporting to TLT				
						Meet all National asks for performance, set out in the planning guidance, for non-elective care							

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
						Maximisation of capacity and efficiencies to reduce waiting times in ED and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT				
						Development of plans for seven day working, across all of our services							
SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
						Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority specialities for service reviews by July 2022. 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.		
			Failure of specialty teams to design and adopt new			Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements in 22/23- (1) continued improvements in patient safety and experience (2) reduce long waiting times for treatment (3)make our people feel valued and supported by improving our culture and leadership	Embedding and sustaining cultural change when we remain operationally challenged with staffing issues etc. Ability to demonstrate quick impact on the cultural change due to various interventions as part of our Outstanding Care Together programme will be limited (as these are multi year/multi factorial projects)	ELT/TLT oversight Board / system reporting	Updated IIP reported at relevant Board Committees	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh - completed. Year 4 IIP under development and due to be completed within Mar 2023 following a robust Business Planning Session in Q4 of 2022/23 (including Divisional IIP completions).		

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4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and other planning priorities puts an added constraint on time, capacity and headspace to engage with the ICS agenda. Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor institutions		CQC Caring CQC Responsive CQC Well Led	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 Lincolnshire ICS 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 Lincolnshire System Anchor Workshops underway to align areas of focus and develope system Anchor Plan - next workshop 15th September 2023 EMAP Governance structure and propsal in development, recruitment of EMAP Managing Director, to be hosted by ULHT. 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 Green 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.	Finance, Performance and Estates Committee	**Amber**
						Gain a greater understanding of the Lincolnshire population and support a reduction in health inequalities	Core20PLUS dashboard not yet developed	Development of Core20PLUS dashboard by June 2023	Core20PLUS dashboard	Core20PLUS dashboard not yet developed	Dashboard due to be in place by June 2023		
						Establishment of the Tobacco Cessation service to proactively support better health for the Lincolnshire population	Staff not yet in place to deliver and lead service	Job descriptions being job matched to support mobilisation by August 2023	Service mobilisation of Tobacco Cessation serivce	Service not yet mobilised	Job descriptions being job matched to support mobilisation by August 2023		
						A Joint Forward Plan by June 2023 and continued utilisation of Joint Strategic Needs Assessment (JSNA), population health data from Optum and the health and wellbeing strategy, to influence our collective approach	Final plan not yet in place	Plan being considered by relevant Boards priro to sign to off, expected July 2023	Plan to be considered in Chief Executives Group and formally to the Board	Final plan not yet in place	Plan being considered by relevant Boards priro to sign to off, expected July 2023		
						Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme	Investment Business Cases not yet in place (SDEC frailty assessment, ED Paed Hub, Community Child Nurse, Rapid Assessment and Triage (RAT), Hospital at Night, SAFER)	Business Cases being presented to CRIG in July	Business Cases Shared Performance Dashboard - frequent attenders	Business Cases in development Dashboard in development	Business Cases being presented to CRIG in July Joint work with Optum to create dashboard		

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						Developing a business case to support achievement of University Hospital Teaching Trust Status through development of fit for purpose R&I estate	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 - options appraisal in development	R&I team reworking business case with a phased approach		

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						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	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 Meetings with ULHT and UOL finance/contracting teams have taken place to develop the full financial model including risk share approach. Next meeting planned 23rd August 2023 after which the financial model will be reviewed internally to agree final contractual approach.	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 - discussions with UOL to explore prioritising clinical specialities where there are workforce gaps/high agency spend. RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust in relation to the clinical academic roles until the financial model is completed.	Monthly meetings with ULHT and Uni of Lincoln		
						Improve the training and support environment for students and clinical academics ULHT Library and training facilities improvements are now complete.	Lack of a model for research training and support for new clinical academics as they start to be employed No current agreement between ULHT/UoL in relation to clinical academic accommodation and resources model	Clinical Academic Model financial model and contract will include facilities and resource provision. Exploratory work underway to understand package of support e.g. via clinical rails unit, UoL	Clinical academic financial model once complete GMC training survey Stock check against checklist Internal Audit - Education Funding	Clinical Academic financial model not yet agreed	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		

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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 meet the current UHA requirements to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Develop a joint research strategy with the UoL by September 2023, which identified shared research focus areas which is needed to meet UHA requirements	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 A draft ULHT/UOL MOU has been prepared but this has not been signed off as ideally it will need be combined with the final clinical academic model into a shared contract. 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. There is an existing ULHT R&I Strategy in place and a new version will be developed for 24/25 as the current one is it its final year. The Lincolnshire ICS have commenced work on a system wide R&I strategy - UHLT Director of R&I is engaged with this process. As ULHT are not currently in a position to apply for UHA status due to the lack of clinical academics employed, the shared Strategy is not required currently. However it will need to be in place ahead of a UHA application.	RD&I Strategy and implementation plan agreed by Trust Board	Clinical Academic Model is required to support shared Strategy development 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 Shared Strategy is a requirement for UHA application and not Teaching Hospital Status	People and Organisational Development Committee	Red
						Clear understanding of UHA requirement for University Status which requires 6% of medical workforce WTE to be clinical academics which is being used to build the ULHT/UOL model Develop a portfolio of evidence to apply for Teaching Hospital status as an interim approach towards full University Teaching Hospital status at a later stage	Financial model and clinical academic roles are not yet in place	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status Portfolio of evidence is being captured for Teaching Hospital status application 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)	Financial meetings underway to develop and agree clinical academic models. Working Group meetings have been reestablished and include medical, nursing, AHP and OD representation. Template for teaching Hospital submission and clear timeline in place to achieve status by end 23/24	Lack of finalised, agreed financial and contracting model for clinical academics roles currently	Meeting held 12th July between ULHT and UOL finance/ contracting teams. Next meeting 23rd August 2023 to agree revised model.		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Two potential candidates have been identified for the Clinical Academic recruitment.		

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						Successfully recruit 6 Clinical Academics within the first year of agreement of the UoL/ULHT model	Agreed clinical academic financial model	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status	Working group Meetings, ULHT/UOL Exec meetings and R&I meetings	The financial model is not yet agreed which is delaying appointment of clinical academic roles	Meeting held 12th July between ULHT and UOL finance/ contracting teams. Next meeting 23rd August 2023 to agree revised model.		
						Improve research and innovation activities and culture through new ULHT Growth of Research Culture Steering group	First meeting end June 2023 so has not yet established	R&I held a session with TLT 6th July and further meetings of the Steering Group are being scheduled		No confirmed dates in diaries yet for ongoing meetings	Head of R&I and Director of R&I to confirm forward meeting schedule		
4c	Successful delivery of the Acute Services Review	Director of Improvement and Integration	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**
						Establishment of a rolling programme of service reviews, with 12 completed in year	Sign off of speciaty review strategies and governance route not yet known	To be agreed with ELT, July 2023	Signed off specialty reviews	Governance route not yet established	Agreement of governance through ELT		
						Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships							

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						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire	Partnership Startegy not yet in place	Associate Director of Partnerships started in post May 2023 and has started to draft Partnership Plan with intention to have signed off by December 2023	Signed off Partnership Strategy	Strategy not yet completed or sgned off	Work is underway to develop the strategy, which needs to align with the current IIP and new ULHT clincial services strategy.		

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*10 July 2023*
Item Number	*Item 13.3*

Audit Committee Upward Report

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

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

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report*

Executive Summary

The Audit Committee met via MS Teams on the 10th July 2023. The Committee considered the following items:

Internal Audit

The Committee received the report from the Internal Audit provider noting that there had been little progress against the audit plan for 2023/24. It was noted that the award of the contract to the new provider had come close to the year end and that the pace would now pick up following the agreement of the plan for Q1 and Q2.

The Committee noted that the planned payroll audit was yet to take place following the significant overpayment event. Following the initial meeting it had been agreed that this work would begin in September. The Audit Planning Memorandum would be shared with the lead Executive ahead of commencement.

It was noted by Committee that during the discussion with the payroll provider the issue of the service level agreement had been raised. This matter had been escalated to the Director of Finance and Digital who was working with the provider to resolve the issues. This would be escalated to the system Chief Executive meeting if the issue could not be resolved. It was agreed this matter would be highlighted through the upward report to Board.

The Committee received an update of outstanding audit actions. However it was noted by the internal audit provider that this was not a live position as access for the Trust had not been provided for the portal through which updates and evidence of progress would be captured. The Committee agreed that this should be resolved immediately to allow the true position to be obtained and reported. It was noted that this had also impacted on reporting into the Trust Assurance Committees.

The Chief Operating Officer joined the meeting to provide updates on long standing actions relating to Safeguarding and Data Quality reviews. These would continue to be reviewed until the Committee had received assurances that actions had been closed it was anticipated this would be by 31 July 2023.

External Audit

There was no external update following the completion of the year end annual accounts work.

Counter Fraud

The Committee received the quarterly progress report. It was noted that the Trust was rated GREEN for all elements of the requirements of the Counter Fraud Functional Standard bar component 3 which scored AMBER. The Trust overall rating was GREEN. Component 3 relates to Fraud Risk Assessment. Fraud risks are now included within the Trust Risk Register and during 2023/24 the management of fraud risks will be further embedded.

The Committee received the Local Counter Fraud Specialist Annual Report for 2022/23 which summarised the information reported to the Committee during the year. The Committee noted that this was an excellent reflection of the work done in year and the

assurances received by the Committee relating to Counter Fraud. It was recommended that the report be shared with the Trust Board to highlight the importance of the work.

Minor updates had been made to the Local Counter Fraud Bribery and Corruption Policy which was approved by the Committee.

The Committee were alerted to a new Failure to Prevent Fraud Offence which would hold organisations to account if they profited from fraud committed by employees and could not demonstrate reasonable fraud prevention measures being in place. The Committee would receive further guidance as it was available.

Compliance Report

The Committee noted the escalation of the follow up review conducted by the Information Commissioners Office. It was noted that the output from the audit had been passed to their investigation unit which would determine whether any enforcement action would be taken. It was noted that this had been reported through the Information Governance Group, Executive Leadership Team and Finance, Performance and Estates Committee which has oversight of progress and assurance.

Assurance Committee Chairs Reports

The Committee received areas for triangulation relating to controls and assurance from each of the Assurance Committee Chairs. The Chair of Quality Governance Committee specifically highlighted the Safeguarding Audit report and Medicines Management updating on the actions being taken by the Committee to get traction to ensure the required improvements were seen. The Chair of the People and OD Committee highlighted the lack of traction with mandatory training and appraisals. The Committee continued to seek assurances.

Policies and Guidelines

The Committee recognised that progress continued to be patchy in relation to engagement in respect of clinical policies and guidelines. The Committee were advised that this was being presented to the Clinical Effectiveness Group where divisions would be held to account for getting traction to review the documents and remove those which were no longer required. A trajectory would be expected from each Division for addressing all documents overdue for review. The Committee would continue to receive updates.

Audit Committee Annual Report 2022/23

The Committee approved the Committee Annual Report which would be received by the Trust Board.

Code of Governance

The Committee received an initial gap analysis for the Trust against the code of governance. This analysis would then be developed with supporting evidence and would become a standing item for the Committee around the actions required.

NHS
United Lincolnshire Hospitals
NHS Trust

Draft Annual Report to the Trust Board from the Audit and Risk Committee 2022/23

ROLE OF THE COMMITTEE

Under the agreed terms of reference the Audit and Risk Committee was tasked as follows:

The Audit and Risk Committee's main purpose is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes. In order to discharge this function it is best practise for the Trust Board to receive a formal annual report from the Trust's Audit and Risk Committee (the Committee). This report summaries the work of the Committee for the financial year 2022/23. This report includes information provided by internal and External Audit.

TERMS OF REFERENCE

During 2022/23, in line with all other Committees of the Board, the Committee's Terms of Reference were reviewed. The terms of reference and membership of the Committee reflect the governance arrangements and the guidance requirements set out in the NHS Audit Committee Handbook. Under the agreed terms of reference the Committee was tasked as follows.

To support the Board by scrutinising the robustness of and providing assurance that there is an effective system of governance and control for

- risk
- the accounting policies and the accounts of the organisation
- the planned activity and results of both internal and external audit
- and assurances relating to the corporate governance requirements for the organisation.

MEETINGS

During 2022/23 the Committee reinstated it's full schedule of meetings as the Trust continued it's recovery from responding to the Covid-19 pandemic during which in line with the national steer and to reduce the burden on Trusts the Committee met and operated working where possible to a reduced agenda and length of meeting.

The Committee considered all items necessary to fulfil its role of supporting the Trust Board by critically reviewing and reporting on the relevance and robustness of governance structures and assurance processes on which the Trust board places reliance. Following each meeting, an assurance report was provided 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 Mrs Sarah Dunnett until July 2022, after which Mr Neil Herbert was appointed Chair.

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

Non-Executive Director (Chair)
Non-Executive Director - Finance, Performance and Estates Committee Chair
Non-Executive Director – People and OD Committee Chair
Non-Executive Director – Quality Governance Committee Chair

In attendance
Director of Finance and Digital (Executive Lead)
Trust Secretary and Counter Fraud Champion
Internal Audit
External Audit
LCFS
Deputy Director of Clinical Governance

Members	**Apr 2022**	**May 2022**	**Jun 2022**	**Jul 2022**	**Oct 2022**	**Jan 2023**
Non-Executive Director (Mrs Dunnett, Chair)	X	X	X	X		
Non-Executive Director (Mr Herbert, Chair)					X	X
Non-Executive Director (Ms Cecchini)	X	X	X	X	X	X
Non-Executive Director (Prof Baker)	X	X	A	X	X	X
Non-Executive Director (Dr Gibson / Mrs Brown)	X	X	X	X	X	X

A denotes Apologies given

REVIEW OF BUSINESS

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

The Audit and Risk Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2022/23:

- Objective 2c Well Led Services

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. At the end of the year the strategic objective was rated as follows:

Objective 2c – **AMBER**

This rating has not changed in year, however the Committee have noted the positive trajectory in terms of the evidence to support the level of assurance.

OVERVIEW

The Audit and Risk Committee has continued over the last twelve months, to improve the assurance it can give to the Board on

- the adequacy and effectiveness of the Trust's systems of internal control
- it's arrangements for risk management, control and governance processes.

The work programme for the Committee in 2022/23 has focused on

- meeting the organisations requirements to produce and publish a set of audited accounts and annual report
- Internal Audit Annual Plan and Work Programme
- Counter Fraud Annual Plan and Work Programme
- External Audit Programme

The Committee has reported its progress to the Board through upward reports, reporting progress against the delivery of the work plan, as defined by the terms of reference and through this annual report.

The Committee has been well attended by members. The Chair has been actively involved in the agenda setting alongside the Director of Finance and Digital.

The Committee received regular reports on:

- Board Assurance Framework
- Risk Management
- Compliance with Governance Arrangements

INTERNAL CONTROLS AND RISK MANAGEMENT

Assurance Framework

The Board Assurance Framework (BAF) is the key assurance document for the Trust. The Audit Committee has scrutinised the BAF at each of its meetings in 2022/23 and has considered the adequacy of the mechanisms and processes surrounding the BAF in place to support the Trust Board in seeking assurance in respect of the strategic objectives. The

Committee received the Head of Internal Audit Opinion and acknowledged the opinion given in relation to the BAF.

Care Quality Commission Regulation

The CQC completed a well led inspection during 2021/22. Outcomes from CQC visits were captured in the Compliance Reports presented to the Committee. The Trust achieved Good for the Well Led Domain.

During 2022/23 the Trust was successful in achieving the removal if the final CQC conditions in place in respect of its licence.

Governance Arrangements

The Committee received quarterly reports on compliance with the Trust's governance arrangements. The Committee has continued to monitor closely the level of waivers performed and through the Director of Finance and Digital worked to see these reduce, this has been a particular challenge due to the pandemic.

Annual Review of Governance Arrangements

The Committee reviewed as part of the annual update and in light of best practice, changes to the key corporate governance documents of the Trust:

- Standing Financial Instructions
- Scheme of Delegation
- Standing Orders

Quality Account

There was no requirement for the Trust Quality Report for 2022/23 to be subject to audit. This report was produced and considered by the Quality Governance Committee and published in line with the required timeframe.

Counter Fraud Service

The Trust is required to monitor and ensure compliance with NHS Provider Standards for Fraud, Bribery and Corruption regarding its arrangements for counter fraud and corruption work. A key role for the Committee is to provide assurance to the Trust Board that these arrangements are robust.

During the year, the Committee:

- received and recommended to the Trust Board the LCFS Annual report
- approved the Annual Counter Fraud Plan
- reviewed and approved the Trust's annual LCFS submission to NHSCFA
- monitored progress against the plan

- monitored reactive and proactive fraud work provided by the LCFS, and received reports on the volume of cases under investigation and subsequent actions taken by management to strengthen control, an area of additional reporting requested but the Committee
- received strategic updates

Internal Audit

Grant Thornton have been the Internal Audit service provider. During the year the Committee:

- Approved the Internal Audit Plan for 2022/23 to address areas of internal control where assurance was sought, to cover mandatory areas as required by NHS Internal Audit Standards and to meet the statutory responsibility to provide a Head of Internal Audit Opinion.
- monitored progress against plan, including consideration of issues arising and high priority recommendations through receipt of regular progress reports
- received and considered the Head of Internal Audit's opinion for 2022/23
- focussed on overdue audit recommendations

The overall Head of Internal Audit opinion was Partial Assurance with Improvements Required which is consistent with committee expectations based on reports received throughout the year. The Internal Audit providers noted the positive trajectory of the opinion towards significant assurance and that there had been improvement in three of the four assurance areas.

EXTERNAL AUDIT AND FINANCIAL REPORTING

The Trust's external auditor for 2022/23 was Mazars.

The Audit Plan set out the work to be undertaken in relation to the 2022/23 accounts and was developed on the basis of a risk-based approach to audit planning. This was received and considered by the Committee.

The external auditors presented their Annual Opinion to the Committee prior to the Trust Board's review of the Annual Accounts in June 2023. The Committee considered and recommended the 2022/23 Annual Accounts and report to the Board.

RISKS

The BAF and Corporate risk register have been reviewed at the committee at each meeting identifying where updates have been required based on assurances received at the Committee. The Committee have reviewed the format of the assurance framework and confirmed that it is fit for purpose.

The Audit Committee is an essential element of the Trust's corporate governance structure. It works closely with the Assurance Committees and the Chair of each of these committees is also a member of the Audit Committee, which helps provide additional assurance on the adequacy of the Trust's systems and controls.

The Committee has fulfilled its terms of reference and contributed to strengthening internal control within the Trust.

The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of controls in place and as necessary applied additional control measures in order to maintain, strengthen and develop systems of control that enable the Trust to be compliant with its legislative and statutory duties.

The focus for the new financial year 2023/24 will be on continuing to support and assure the Trust Board on reviewing and strengthening financial reporting, internal control, risk assurance and governance.

The Committee will focus on the following proposed priorities

- Embedding improvements made to risk management arrangements
- strengthening and reviewing new arrangements as they develop within the Lincolnshire ICS
- Improving assurances on the well led services objective including improved controls relating to policies and guidelines
- Meeting the Counterfraud standards
- Improve the control environment as evidenced by Internal Audit opinion
- Ensuring the Trust meets the requirements of the code of governance and best practice

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

LOCAL COUNTER FRAUD SPECIALIST ANNUAL REPORT 2022/23

July 2023
Audit Committee
Peter Riches, Local Counter Fraud Specialist

Counter Fraud Plus is a collaborative fraud and compliance service for Northern Lincolnshire and Goole NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust, Lincolnshire Partnership NHS Foundation Trust, Lincolnshire Community Health Services NHS Trust, and Hull University Teaching Hospitals NHS Trust.

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1. EXECUTIVE SUMMARY

This report is a consolidated summary of all previous reports provided by the Local Counter Fraud Specialist (LCFS) to the Audit Committee from 1 April 2022 to 31 March 2023.

CFP is the operating name of the collaborative counter fraud and compliance service for United Lincolnshire Hospitals NHS Trust (ULHT), Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH), Lincolnshire Partnership NHS Foundation Trust (LPFT), Lincolnshire Community Health Services NHS Trust (LCHS) and Hull University Teaching Hospitals NHS Trust (HUTH). CFP provides a dedicated and resilient counter fraud service, meaning that ULHT enjoys a full time LCFS to deliver all aspects of counter fraud activity. The original collaborative arrangement commenced on 1 July 2013 and is hosted by NLaG, with LCHS and LPFT both joining on 1 September 2020. From 1 April 2023, the CFP collaborative was expanded further to include Hull University Teaching Hospitals NHS Trust (HUTH).

During the reporting period the Trust continued to strategically support the counter fraud work performed by the LCFS. The Director of Finance and Digital (DoF) and the LCFS worked together on all aspects of counter fraud activity, which is turn was supported through direct oversight by the Audit Committee.

The 2022/23 counter fraud operational plan was underpinned by the local fraud risk assessment and was agreed by the DoF on 28 March 2022 and ratified by the Audit Committee on 11 April 2022. Monitoring of counter fraud activity has been undertaken during formal meetings with the DoF and the Chair of the Audit Committee. Detailed quarterly reports have also been provided along with verbal updates to the Audit Committee.

During 2022/23 the Trust has been adhering to the NHS Counter Fraud Functional Standard set by the NHS Counter Fraud Authority (NHSCFA) which is aligned to the Government Counter Fraud Functional Standard. The standard came into effect on 1 April 2021 and has twelve distinct areas of which all NHS organisations must comply (each being mapped to the former areas of strategic governance, inform and involve, prevent and deter and hold to account).

The Trust has continued to support the LCFS in developing an anti-fraud culture amongst staff, which is seen as a key component in preventing, deterring, and detecting fraud. All activities required by the NHSCFA have been undertaken and the details included in regular reports to the Audit Committee. Referrals received by the Trust's LCFS have been appropriately recorded on the NHSCFA's case management system, CLUE, as required by the NHS Counter Fraud Functional Standard. The Trust has recorded the following key facts during 2022/23:

- Eighteen fraud referrals received and progressed by the LCFS.
- 27 referrals closed on the NHSCFA Case Management system.
- 25 investigations remaining open at the year end.
- Fraud losses identified - £8,525.76.
- Fraud losses recovered - £6,336.84.
- Fraud losses prevented - £112,240.69.
- 959 respondents to the annual all-staff fraud awareness survey with generally positive results.
- Three disciplinary sanctions administered to employees who had committed fraud against the Trust.
- 11 Local Proactive Exercises (LPEs) commenced in the reporting year.
- 5 Fraud Prevention Notices (FPNs) actioned.
- 6 Intelligence Bulletins (IBURNS) reviewed and actioned.
- The CFFSR risk ratings in respect of Metrics and the Standard of Business Conduct Policy, which were previously rated as amber, are now green.
- Ongoing assessment of fraud risk in line with the Trust's Risk Management Policy and Government Counter Fraud Profession's methodology.
- Submission of a 'Green' Counter Fraud Functional Standard (CFFSR) to the NHSCFA.

- Submission of a green rated CFFS Return to the NHSCFA.

Overall, 2022/23 has been a productive year for the LCFS in all areas of counter fraud activity.

This report is presented to the Audit Committee for information and will be utilised to support any submission to the NHSCFA as evidence of activities carried out as part of their Quality Assessment process.

2. INTRODUCTION

2.1 The NHS Counter Fraud Authority (NHSCFA) and the NHSCFA Strategy.

Whilst the majority of people who work in and use the NHS are honest, a minority will seek to defraud it of its valuable resources. In 1998, the Government recognised the issue of fraud in the NHS and set up the NHS Counter Fraud Service (CFS). Over the succeeding years various transformations and name changes have occurred and on 1 November 2017 the organisation at that time was replaced by an independent Special Health Authority known as the NHS Counter Fraud Authority (NHSCFA). The NHSCFA is tasked to lead the fight against fraud, bribery, and corruption in the NHS.

The NHSCFA Strategy for 2020 to 2023 released in early 2021, highlighted how the NHSCFA intend to collaborate with stakeholders in the NHS family and beyond to tackle NHS fraud. The strategy outlines how counter fraud activity should operate in line with the five internationally recognised principles of fraud and corruption work:

- There is always going to be fraud.
- Finding fraud is a good thing.
- There is no one solution.
- Fraud and corruption are ever changing.
- Prevention is the most effective way to address fraud and corruption.

The NHSCFA estimate that fraud costs the NHS £1.198 billion each year, which has a detrimental impact on NHS services by taking away vital funds from patient care.

Fraud continues to be a growing problem in the UK as a whole and has recently been reclassified as a threat to national security. As a result, the NHS faces a wide range of fraud risks. The NHSCFA aims to use intelligence to build a better picture of those risks, and encourage fraud reporting, which plays a vital role in improving and understanding of fraud across the NHS. They have indicated the need to develop creative, innovative, and proportionate solutions to identified risks, and will continue to investigate organisation and / or complex fraud.

In summary, the NHSCFA's task is to lead the fight against NHS fraud, working closely with Local Counter Fraud Specialists, Directors of Finance, Audit Committee Chairs and Counter Fraud Champions across the NHS as this is vital to the success of their strategy, and ultimately to protecting NHS resources intended for patient care. The ULHT LCFS and the wider CFP team supports the Trust fully in achieving compliance with the NHS Counter Fraud Functional Standard and will continue to provide the full range of anti-fraud activities in the coming year.

2.2 Counter Fraud Functional Standard Return.

To achieve the aims in 2.1 above, all NHS provider Trusts are required to comply with Service Condition 24 of the NHS Standard Contract. As part of the oversight arrangements, each Trust must assure its commissioners that it is compliant with the NHS Counter Fraud Functional Standard. Details of this Functional Standard appear below, however the four key principles (strategic governance, inform and involve, prevent and deter, and hold to account) remain and this report is structured around these principles.

The NHS Counter Fraud Functional Standard consists of twelve requirements with which all NHS bodies should be compliant:

1. Accountable Individual.
2. Counter Fraud, Bribery and Corruption Strategy.
3. Fraud, Bribery and Corruption Risk Assessment.


Taelor Martin

4. Policy and Response Plan.
5. Annual Action Plan.
6. Outcome-Based Metrics.
7. Reporting Routes for Staff, Contractors, and Members of the Public.
8. Report Identified Loss.
9. Access to Trained Investigators.
10. Undertake Detection Activity.
11. Access to and Completion of Training.
12. Policies and Registers for Gifts and Hospitality and COI.

All NHS bodies will once again perform the annual self-review exercise using the NHS Counter Fraud Functional Standard by completing the corresponding Counter Fraud Functional Standard Return (CFFSR). The CFFSR is required to be completed by the LCFS and agreed and signed off by the DoF and the Chair of the Audit Committee before submission to the NHSCFA as part of their national Quality Assessment programme. The 2022/23 CFFSR submission was completed, signed off and duly submitted to the NHSCFA on 27 April 2023, well ahead of the 31 May 2023 deadline.

2.3 LCFS Provision and the CFP Team.

Pete Riches is the Trust's nominated LCFS at ULHT and has led on counter fraud work since July 2013. Pete came to the NHS at that time with a long record of benefit fraud investigations and internal audit within local government. He also successfully completed a BSc. in Counter Fraud and Criminal Justice Studies through the University of Portsmouth. He is based on site at Lincoln County Hospital which ensures that he can conduct counter fraud work efficiently, effectively and promptly and thus provides visibility and easy access for all staff in relation to counter fraud activities.


Peter Riches

Each organisation within the collaborative arrangement has their own nominated LCFS. The CFP team is fully contracted under a Service Level Agreement (SLA) whereby the Trust enjoys an effective and resilient counter fraud service, with flexibility to buy in extra resources should circumstances require. There is no additional burden of cost to ULHT for investigations (e.g., for support from other CFP team LCFS's for Interviews under Caution).


Sally Stevenson

The CFP team is headed by Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud (and a Graduate Counter Fraud Specialist) for Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Sally became an accredited LCFS in 2000 and investigated many cases during her LCFS career, securing a range of sanctions. In June 2013 she graduated with First Class Honours from Portsmouth University after successfully completing a BSc. in Counter Fraud and Criminal Justice Studies. Sally is responsible for the management of the CFP team and consequently less involved in direct investigation work, but instead performs a supervisory role in the submission of prosecution files to the CPS, etc.

The ULHT LCFS is supported by their CFP colleagues, Taelor Martin (LPFT and LCHS), Nicki Foley (NLaG and HUTH), Mark Bishop (DBTH).

Taelor Martin, who is an Accredited NHS Local Counter Fraud Specialist, has continued to lead counter fraud work for both LPFT and LCHS throughout 2022/23. Taelor graduated from Nottingham Trent University with a first-class honours degree in Criminology and she is currently studying for a Master's degree in Economic Crime through the distance learning programme with the University of Portsmouth. Taelor is also the nominated Support LCFS for ULHT.

Nicki Foley is the nominated LCFS at NLaG and has been in post since June 2011. In her twelve years as an LCFS Nicki has experienced a wide range of LCFS work, particularly in the investigation sphere including working alongside both the NHSCFA National Investigation Service (NIS) and the Police on a former NLaG investigation involving agency timesheet / invoice fraud which saw seven defendants convicted of fraud, of which three received immediate custodial sentences. Nicki has been successful in securing a range of criminal, disciplinary and professional sanctions of NLaG's behalf, and is now the nominated LCFS for HUTH as well as NLAG.


Nicki Foley

Mark Bishop is the nominated LCFS for DBTH and has been a LCFS in the NHS since 2004. He has an outstanding record for his counter fraud work and brings with him a wealth of law enforcement experience. Prior to becoming an LCFS, Mark spent 23 years in the Royal Military Police and for the latter 16 years of that career he served in the Special Investigation Branch investigating serious criminal offences.


Mark Bishop

Jacky Gibbons is the CFP team's Support Officer, joining in 2014, providing support to any member of the CFP team when necessary. Jacky's background is as a Payments Manager at NLaG, and her knowledge of payments systems proves valuable in supporting the rest of the team, particularly with bank mandate compliance checks.

The team continue to support each other daily, despite often being in various locations, by seeking each other's advice and sharing good practice and intelligence, as necessary. In addition, the team provides cross cover absence arrangements and assist each other with Interviews Under Caution (IUC's), etc. Formal team meetings have been held in person on a monthly basis throughout the financial year, with ad-hoc meetings convened as necessary in between scheduled meetings, which provides a platform for intelligence and best practices to be shared.


Jacky Gibbons

3. BACKGROUND INFORMATION

The NHSCFA and LCFS staff are responsible for tackling all types of fraud and corruption in the NHS and protecting resources so that they can be used to provide the best possible patient care.

All counter fraud work undertaken by the LCFS for 2022/23 followed the requirements of the NHS Counter Fraud Functional Standard and complied with guidance contained in the NHS Counter Fraud Manual. The LCFS has the responsibility to support the Trust through the DoF in carrying out the functions required by the

NHSCFA.

The Trust has tailored counter fraud work across the four key areas set out in the relevant standards:

All work carried out in these four areas is described in detail in Sections 5 to 8 of this report. The reactive elements specifically detail the work conducted by the LCFS in the investigation of allegations of fraud and, where necessary, require the LCFS to pursue criminal, civil, and

disciplinary sanctions against anyone who commits fraud against the NHS. This area of work requires the LCFS to operate in accordance with current legislation, including but not exclusively limited to:

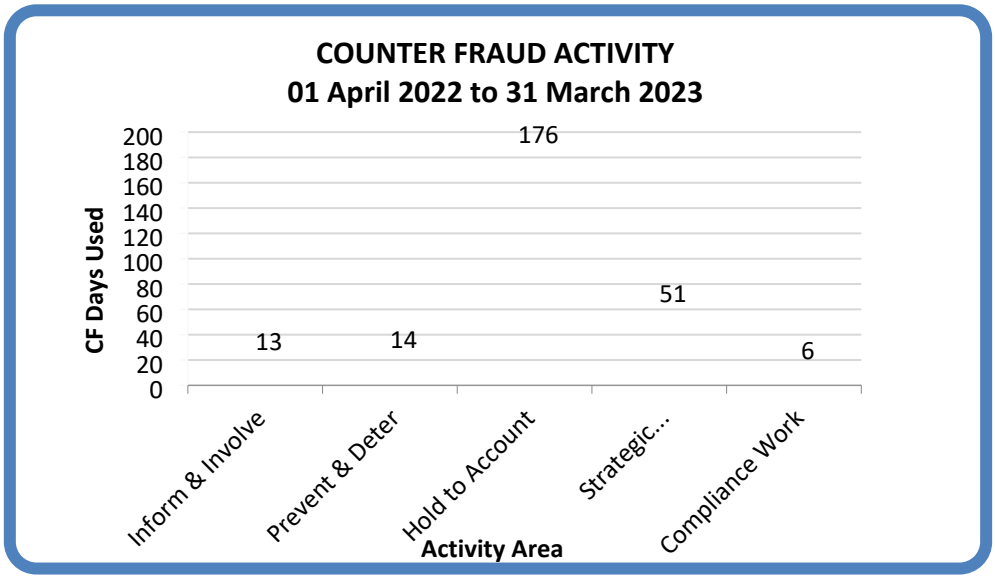
- The Police and Criminal Evidence Act 1984 (PACE)
- The Criminal Procedures and Investigations Act 1996 (CPIA)
- The Data Protection Act 2018 (DPA)
- The Regulation of Investigatory Powers Act 2000 (RIPA)
- The Investigatory Powers Act 2016
- The Fraud Act 2006 (FA)
- The Bribery Act 2010 (BA)
- The Human Rights Act 1998 (HRA)
- The Police, Crime, Sentencing and Courts Act 2022 (PCSC)

4. DELIVERY OF THE OPERATIONAL FRAUD PLAN 2022/23

On behalf of the Trust, the LCFS and DoF are required to prepare a Counter Fraud Operational Plan (CFOP) identifying specific objectives and methods of achievement that accords with the NHS Counter Fraud Functional Standard. The plan is a key document used within the NHSCFA Quality Assurance (QA) process designed to assess the organisations counter fraud arrangements. The 2022/23 CFOP was agreed by the DoF on 28 March 2022 and ratified by the Audit Committee on 11 April 2022.

One of the key elements of the QA process is ensuring NHS bodies allocate sufficient resources to counter fraud work based on risk analysis. The NHSCFA requires a risk based Operational Plan is in place within the Trust that satisfies the requirements of the NHS Counter Fraud Functional Standard. On 1 July 2013, the Trust entered into separate counter fraud arrangements as part of the collaborative agreement that led to the appointment of one full-time LCFS nominated for the Trust. This removed the need to identify the number of days allocated to counter fraud work (including associated daily charge rate) meaning the LCFS is not limited in the extent of work, particularly investigation work, which can be performed and essentially ring fenced a dedicated counter fraud provision with the resilience of CFP support. This model of service was verbally commended by a NHSCFA Quality Inspector as part of its quality inspection of counter fraud work at the Trust in 2015.

Although there is no time constraint on the counter fraud provision, key areas are monitored and recorded to provide the Audit Committee with an overview of where activity has taken place, and for 2022/23 activity by the LCFS is represented in the following graph:



The graph considers the time spent by the CFP team Support Officer performing compliance checks at the Trust, particularly in relation to mandate fraud checks and also the assistance of other CFP team LCFSs for investigation work. The graph does not include any support given by the CFP Team Manager in any area of counter fraud work. It can be seen that due to the high number of fraud referrals and number of ongoing investigations, 'Hold to 'Account' has accounted for the most activity of the LCFS.

5. STRATEGIC GOVERNANCE

Any activity detailed in this section contributes to Components 1A, 1B, 2, 3 and 9 (and referenced in Components 5 and 7) of the NHS Counter Fraud Functional Standard.

5.1 Director of Finance and Digital (DoF) - Liaison.

Component 1A of the NHS Counter Fraud Functional Standard requires a member of the executive board to be accountable for the provision of strategic management of all counter fraud, bribery, and corruption work within the organisation. As such, the Trust's Director of Finance and Digital (DoF) is the executive lead for all counter fraud activity.

The LCFS provides regular updates to the DoF on all matters concerning fraud, bribery and corruption, including the status of investigations. An agenda was compiled for each meeting during the year and actions were documented and completed in a timely manner.

Closure reports or summaries were submitted to the DoF at the conclusion of LCFS work on each referral, providing assurance that the actions of the LCFS were overviewed at an Executive level and that each referral was scrutinised to ensure that all appropriate sanctions were considered, that any control weaknesses were addressed, lessons were learnt and NHS money recovered, where appropriate.

5.2 Meetings with the Chair of the Audit Committee.

The Trust appointed a new Chair of the Audit Committee during 2022/23 and the appropriate nomination form was completed in September 2022 and submitted to the NHSCFA in a timely manner in order for the new Chair's details to be recorded on the NHSCFA's system.

As good working practice and in support of an executive led overview of counter fraud activity, formal meetings have taken place between both Chairs of the Audit Committee in post during 2022/23 and the LCFS. These meetings are required as part of the Counter Fraud Operational Plan and will continue to occur formally on, at least, an annual basis. Routinely, the Chair of the Audit Committee and the LCFS have unrestricted lines of communication between each other as necessary.

5.3 Counter Fraud Liaison Protocols.

The LCFS continues to maintain formal liaison protocols with a number of key individuals/teams to ensure effective communication and working arrangements between the LCFS and the individual/team concerned, namely:

- Internal Audit.
- Local Security Management Specialist.
- Freedom to Speak Up Guardian.
- Communications Team.
- Payroll Team.
- Human Resources.

The LCFS also devised, agreed, and signed off two new liaison protocols during 2022/23, as follows:

- Counter Fraud Champion.
- Head of Digital Health (Cyber).

These new protocols will also be kept under review and any necessary changes will be made where appropriate.

5.4 Liaison with the Counter Fraud Champion

Component 1B of the NHS Counter Fraud Functional Standard stipulates that all NHS health bodies must nominate a Counter Fraud Champion (CFC). The Trust's CFC is the Trust Secretary, Jayne Warner.

The roles and responsibilities of the CFC include promoting and embedding awareness of fraud, bribery and corruption across the organisation and providing additional fraud fighting capability at a senior/strategic level which can support the LCFS in delivering their counter fraud work. Although the NHSCFA has not provided a national strategy regarding the specific activities required by CFCs within the NHS, the CFC continues to support the work of the LCFS at a local level.

The LCFS met regularly with the CFC throughout 2022/23 and assistance has been afforded where appropriate to promote the counter fraud message. During the year CFC activity included:

- Promotion of the Trust's Standards of Business Conduct Policy.
- Assistance with promotion of the Trust's fraud awareness survey.
- Attendance at two CFC National Network meetings.
- Assistance with the Trust's Fraud Risk Assessment (FRA) process.
- Raising awareness of the correct reporting routes for staff who have concerns of fraud.

A new liaison protocol was signed and agreed between the LCFS and CFC, to ensure that effective joint working is maintained.

5.5 External Audit Liaison.

The LCFS continued to liaise with the Trust's External Auditors where appropriate and provided responses to their requests for information when necessary.

5.6 Internal Audit Liaison.

An Internal Audit/LCFS Liaison protocol is in place within the Trust which supports the continued communication between the LCFS and the Trust's Internal Auditors. This protocol was reviewed in 2022/23 to ensure it remained fit for purpose.

The LCFS meets with the Trust's Internal Audit Manager on an at least quarterly basis. During 2022/23 the Trust's Internal Audit Manager changed from Lisa Mackenzie to Susan Brook before returning to Lisa Mackenzie in the latter part of the year. Taelor Martin, the LCFS for LPFT and LCHS, also attends these meetings to ensure there is a joined-up approach to countering NHS fraud across the Lincolnshire patch. These meetings allow for potential areas of joint working to be identified and for intelligence building and sharing of information as appropriate.

5.7 Cyber Liaison.

During 2022/23 the LCFS met with the Trust's Digital Security and Compliance Manger, Paul Ryan. In many instances, cybercrime and fraud go hand in hand and as such these meetings are invaluable and allow for the sharing of information and intelligence between the two parties as well as strengthening fraud and cybercrime awareness materials published throughout the Trust.

During 2022/23 the LCFS devised a formal liaison protocol between both parties which stipulates the expectations and responsibilities of both. This liaison protocol exists as a Lincolnshire-wide document and therefore has been signed by the respective cyber-leads from ULHT, LCHS and LPFT.

Looking ahead to 2023/24, the LCFS, alongside the Taelor Martin, the LCFS for LPFT and LCHS, will have quarterly joint meetings with the Lincolnshire cyber leads to share intelligence and discuss joint matters of interest as appropriate, with the LCFS having unrestricted access to the Digital Security and Compliance Manager between these meetings as required.

5.8 NHSCFA – Counter Fraud Functional Standard Return (CFFSR).

The NHSCFA assesses every NHS body on its counter fraud provision which is carried out as part of the Quality Assessment (QA) process. Counter fraud activity conducted during 2022/23 was assessed against the NHS Counter Fraud Functional Standards by way of the Counter Fraud Functional Standard Return (CFFSR).

The assessment was completed by the LCFS, peer reviewed within the CFP team and then reviewed and approved by the DoF and the Chair of the Audit Committee prior to submission by the required deadline of 31 May 2023. The return was duly submitted on 27 April 2023 and the Trust assessed itself as having an overall rating of '**Green**'. The RAG rating against each individual requirement was assessed as follows:

COMPONENT	1A	1B	2	3	4	5	6	7	8	9	10	11	12
RAG RATING	G	G	G	A*	G	G	G	G	G	G	G	G	G

All CFFSR submissions will be subject to ratification by the NHSCFA, and any Trust can be subjected to further assessment if deemed necessary. An overview of the Trust's assessment against the NHS Counter Fraud Functional Standard is included at **Appendix 1** of this report.

** Component 3 requires the Trust to carry out fraud risk assessments in line with the Government Counter Fraud Profession's methodology and the Trust's Risk Management Policy. The Fraud Risk Assessment (FRA) was completely overhauled by the LCFS, and it now identifies 29 risk areas. The new fraud risks were assessed in line with the Government Counter Fraud Profession (GCFP) methodology and scored by risk owners in line with the Trust's Risk Management policy/scoring matrix. The LCFS continues to liaise with appropriate Trust officers to ensure that fraud risks are managed accordingly. Once the management of fraud risks has been embedded in the Trust, it is expected that Component 3 will be rated as green.*

5.9 Counter Fraud Operational Plan (CFOP).

Component 5 of the NHS Counter Fraud Functional Standard requires the Trust to have a Counter Fraud Operational Plan (CFOP) detailing the counter fraud activities that are to be conducted within the Trust over the course of the year. The LCFS devised a CFOP for 2022/23 which was agreed by the DoF on 28 March 2022 and ratified by the Audit Committee on 11 April 2022. This is a flexible document, meaning it can be altered throughout the year as necessary to include activities in response to emerging fraud risks.

5.10 Fraud Risk Assessment.

Component 3 of the NHS Counter Fraud Functional Standard requires the Trust to carry out comprehensive local Fraud Risk Assessments (FRA) to identify fraud, bribery, and corruption risks. This assessment must be undertaken in line with the Government Counter Fraud Profession's (GCFP) methodology and risks must be recorded and managed in line with the Trust's Risk Management Strategy.

The Trust has 29 fraud risks which have been assessed through the FRA process, i.e., they have each been assigned to a nominated risk owner, assessed in line with the GCFP methodology and the Trust's risk scoring matrix, and are suitably recorded on the Trust's Risk Register. Of the 29 assessed risks, the number of risks at each risk level was determined as follows:

- **Very High (20-25)** **0**
- **High (15-16)** **0**
- **Moderate (8-12)** **4**
- **Low (4-6)** **5**
- **Very Low (1-3)** **20**

Total **29**

As of 31 March 2023, all risks were awaiting their initial risk review by the nominated risk

owners and will be progressed during 2023/24, in accordance with the Trust's Risk Management Policy. The LCFS will continue to maintain regular liaison with each of the identified risk owners to ensure that, where appropriate, mitigation is put in place to reduce fraud risks and that relevant intelligence and incidents are reflected in risk scores.

5.11 NHSCFA Fraud Risk Knowledge Hub (FRKH).

In February 2022, the NHSCFA introduced a new Fraud Risk Knowledge Hub (FRKH) which is accessible to the LCFS, DoF, Audit Committee Chair, and the Counter Fraud Champion. The FRKH is a platform for the NHSCFA to share content relating to fraud risk assessments.

During 2022/23, the CFP team continued accessing resources on the FRKH, primarily the NHS national fraud risk assessments (which are designed to offer detailed fraud risk assessments at a national level), to inform the risk assessment work conducted within the Trust (as detailed in Section 5.10 of this report).

5.12 Freedom of Information Requests.

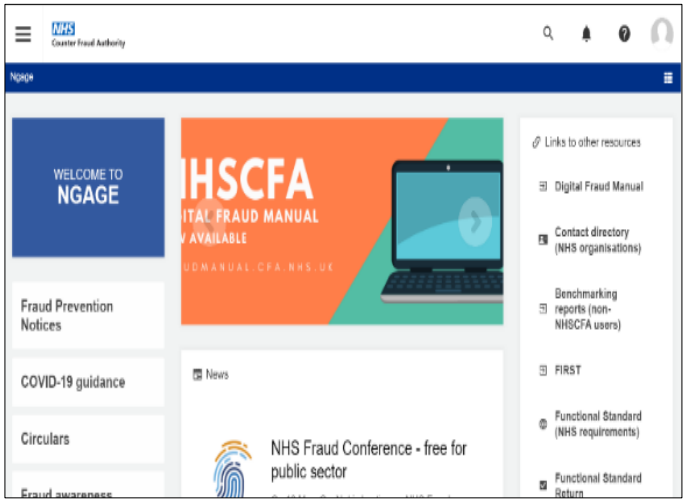
One new FOI request was received by the LCFS on behalf of the Trust in relation to counter fraud work during the reporting year. The relevant information was provided to satisfy the request within the required deadline.

5.13 Single Point of Contact (SPOC) NHSCFA Quality and Compliance Unit.

During the year, the LCFS maintained contact with the assigned single point of contact (SPOC) from the NHSCFA Quality and Compliance Unit through the CFP team, as necessary. The NHSCFA created the SPOC role so that LCFSs can direct any queries they may have related to work the Quality and Compliance Unit undertake in regard to counter fraud activity within NHS bodies.

5.14 NHSCFA Extranet (NGAGE).

The NHSCFA Extranet site, known as NGAGE, acts as a central hub of information regarding NHS fraud for members of the NHS counter fraud community. It is accessible to the LCFS, DoF, Audit Committee Chair and CFC and provides news articles, links to useful resources and access to other NHSCFA webpages. The LCFS accesses NGAGE on a regular basis to ensure that all updates are noted and where necessary, any actions outlined on the site are implemented without delay.



5.15 Public Sector Fraud Authority.

During 2022/23, the Government clarified the future of the counter fraud body that now coordinates all counter fraud activity across the public sector, including the NHS. The newly formed Public Sector Fraud Authority (PSFA) is now a core function of the government, replacing the Counter Fraud Function. The PSFA aims to modernise the public sector counter fraud response, build expert led services to fight fraud, develop capabilities to find, prevent and respond to fraud, and define good practices in the counter fraud arena.

5.16 Counter Fraud Managers' Group.

The CFP team manager attends meetings of the Counter Fraud Managers' Group (CFMG), a useful national networking forum of counter fraud managers employed by NHS organisations (not private firms). The meetings are also attended, at the invitation of the group, by representatives from the NHSCFA to discuss national issues, etc. The group is a useful forum

for sharing of comparative information in respect of LCFS work being undertaken, problems encountered, and other counter fraud work. Feedback was provided by the CFP team manager to the CFP team following each CFMG meeting throughout 2022/23.

5.17 Continuing Professional Development (CPD).

Component 9 of the NHS Counter Fraud Functional Standard requires all NHS bodies to have an accredited Local Counter Fraud Specialist. In order to maintain professional competencies and to further expand their knowledge, the LCFS continued with professional development throughout the year with attendance at a number of fraud-related events, as follows:

- **NHSCFA Webinars.** The LCFS attended four webinars hosted by the NHSCFA throughout the year on topics including, procurement fraud, mandate fraud, functional standard returns and recording financial outcomes from counter fraud activity. Unfortunately, due to other commitments, the ULHT LCFS was unable to attend the following webinars. However, a colleague from the CFP team attended and feedback was provided to the ULHT LCFS as necessary: the NHSCFA plans for 2022/23 and the NHSCFA strategy for 2023-2026.
- **Conducting Effective Social Media Investigations.** In June 2022, the LCFS attended a two-day remote CPD workshop on conducting effective social media investigations. The training, hosted by The Investigator, was both interesting and useful and the knowledge gained assists the LCFS in using social media whilst conducting criminal fraud investigations.
- **Yorkshire and Humber Fraud Forum – Annual Conference.** The LCFS maintains membership of the Yorkshire and Humber Fraud Forum (YHFF), which brings together counter fraud professionals in public and private sectors to share best practice, promote fraud awareness, and protect the region from fraud and financial crime. The LCFS attended the YHFF's annual conference on 16 November 2022 with various speakers.
- **Managing Disclosure Under the Criminal Procedure and Investigations Act.** Hosted by The Investigator on 3 November 2022. Topics covered included disclosure in context, material issues of disclosure, and managing sensitive material.
- **Case Preparation and Court Room Skills.** Hosted by The Investigator, on 9 November 2022. The session covered topics such as how to prepare a case file and provided practical advice on how to present the strongest evidence in court.
- **NHSCFA and LCFS Engagement Meeting.** On 3 February 2023, various members of the NHSCFA attended the CFP team meeting for an engagement meeting. The meeting covered a number of relevant areas including the new NHSCFA Fraud Hub, intelligence reporting and recording, CLUE updates, feedback from the Crown Prosecution Service, and local proactive exercises.
- **Disclosure, Attorney Generals Guidelines 2022 (Criminal Procedure and Investigations Act).** This session took place on 1 March 2023 and was hosted by the NHSCFA. The session covered key topics of disclosure in the management and preparation of a case for prosecution and provide updates from the new Attorney Generals Guidelines on Disclosure which were introduced in 2022.
- **CLUE User Update.** The CLUE user update was provided by the NHSCFA on 2 March 2023. This was a refresher for users and reinforced changes in process that have been introduced since the CLUE case management system was introduced.
- **Getting Started with the Power BI Service.** This session was delivered via MS Teams by Microsoft on 8 February 2023 and provided a basic overview of the Power BI function, which is a collection of software services, apps, and connectors that work together to help create, share, and consume business insights.

5.18 NHSCFA Strategy – 2020 to 2023.

In April 2021, the NHSCFA published their 2020 – 2023 strategy document, which outlines

how the NHSCFA will operate in line with the five internationally recognised principles of fraud and corruption work:

1. There is always going to be fraud.
2. Finding fraud is a good thing.
3. There is no one solution.
4. Fraud and corruption are ever changing.
5. Prevention is the most effective way to address fraud and corruption.

The NHSCFA's vision is to lead and proactively support the NHS to understand, fight and respond to fraud and have set four strategic objectives to this end:

- To lead and influence the NHS to find, prevent and reduce fraud, recovering losses and putting money back into patient care.
- To work with partners to reduce fraud loss in the NHS.
- To support and empower their people to be the best in their roles and feel valued.
- To effectively use their resources, identify and pursue opportunities for growth and innovation and reduce their operating costs.

The Trust's Countering Fraud, Bribery and Corruption Policy and response plan is aligned and includes reference to this strategy.

5.19 NHSCFA Business Plan – 2022/23.

On 22 March 2022 the NHSCFA issued its business plan for 2022/23. The overarching theme of the plan is one of togetherness, with a vision to lead and proactively support the NHS to understand, find, prevent and response to fraud. In order to fulfil this, the plan sets out a path of closer engagement within the wider NHS counter fraud community, so that there is a closer model of thinking, feeling and acting as one fraud-fighting team.

5.20 Counter Fraud Operational Plan – 2023/24.

Looking forward, the Counter Fraud Operational Fraud Plan for 2023/24 was agreed between the DoF and LCFS on 28 March 2023 and submitted to the April 2023 Audit Committee. This plan came into effect on 1 April 2023 and progress against this plan will form the basis of all planned formal meetings with the DoF and future progress reports to the Audit Committee.

6. INFORM AND INVOLVE

Any activity detailed in this section contributes to Components 4, 11 and 12 of the NHS Counter Fraud Functional Standard.

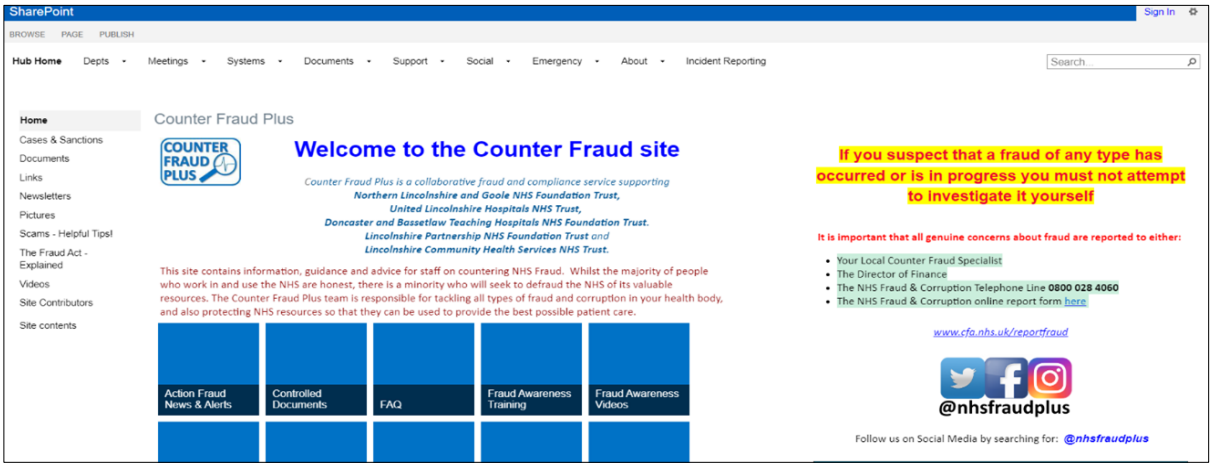
6.1 Counter Fraud, Bribery and Corruption Policy and Response Plan.

The Trust's Counter Fraud, Bribery and Corruption Policy and Response Plan remained in place during 2022/23 since it was last approved by the Audit Committee on 12 July 2021. The LCFS continues to raise awareness of the policy through regular communications articles, bulletins published throughout the year and the Trust's eLearning fraud awareness training.

6.2 Communications Team Liaison.

The LCFS maintains a LCFS/Communications Team liaison protocol document which was reviewed and signed in 2022/23 by the Trust's Associate Director of Communications and Engagement, Anna Richards on 29 March 2023. The document provides a framework for effective liaison between the two parties and outlines the responsibilities each have in relation to fraud, bribery, and corruption.

The LCFS remains in continuous contact with the Communications Team and enlists their valuable support in promoting awareness of fraud, bribery, and corruption throughout the organisation, as necessary.



6.3 Intranet Presence.

The LCFS maintains a presence on the Trust's intranet site. The Trust's counter fraud intranet pages are reviewed regularly by the LCFS to ensure that they remain up to date and fit for purpose. The CFP team also maintains its own informative intranet site. This provides staff with topical fraud related information and the local contact details for counter fraud specialists working across the collaborative group of NHS Trusts. The site is hosted by NLaG and can be visited by any NHS computer here.

6.4 Fraud Awareness Month (FAM) and International Fraud Awareness Week (IFAW).

As in previous years, the CFP team in conjunction with all our collaborative Trust's designated November as Fraud Awareness Month (FAM), which coincided with International Fraud Awareness Week (IFAW). The Trust is a registered supported of IFAW along with other global and UK public sector bodies. FAM and IFAW are dedicated periods of the year where fraud awareness activity is increased through all available communications methods. Activities conducted throughout the Trust during FAM are as follows:

- Article issued by the DoF via his 'Weekly Message' to all staff in which he gave examples of NHS fraud, highlighted the role of the LCFS and the Support LCFS, referred to the Counter Fraud, Bribery and Corruption Policy, the NHS Fraud Reference Guide and the range of sanctions available against anyone found to be committing fraud against the Trust. Staff were also informed of sanctions applied at a local level. The DoF also requested that staff raise their fraud concerns to the LCFS.
- The LCFS posted several awareness items on the Trust's 'ULHT Together' Facebook page which promoted FAM.
- The CFP team issued a FAM related newsletter which was promoted by the Trust's Communications' team via the Weekly Round-Up issued to all staff.
- There was an increase in social media activity on the CFP social media accounts (@NHSFraudPlus).
- To coincide with FAM, the Trust's Standards of Business Conduct Policy was promoted to all staff via a further 'Weekly Message' by the DoF.
- A system-wide media release highlighting FAM was published during November 2022, with a view to reaching the general public as well as staff. The media release included quotes from both the ULHT LCFS and the nominated counter fraud specialist for LCHS and LPFT. The media release also included quotes from the three Trust's DOF's.

6.5 'Fraud Through the Looking Glass' Newsletter.

The CFP team newsletter is intended to be an informative and interesting read for staff

covering current fraud related topics, with dedicated sections on successful NHS prosecutions and scams. It is also intended to serve as a vehicle for deterring staff from committing NHS fraud by the publicising of successful sanctions, both at a local and national level. Staff can subscribe to the newsletter, ensuring that it is received directly into their NHS email inbox as soon as it is published. In 2022/23 four editions of the newsletter were issued (April 2022, August 2022, November 2022, and February 2023). All editions of the newsletter can be found on the Trust's intranet site.

6.6 Social Media.

The CFP team operates dedicated Twitter, Facebook and Instagram accounts and uses them as another medium to regularly promote counter fraud news, advice, and guidance, primarily to those staff within the collaborative CFP Trusts who choose to follow the counter fraud team. In addition to Trust staff, there are a number of external followers to the CFP Twitter account, notably law enforcement fraud and cybercrime units that help ensure the NHS anti-fraud message is reaching a wider audience.

The CFP Twitter account currently has 844 followers. Throughout 2022/23, analytical data was captured from Twitter regarding the number of impressions recorded for the account. An impression is the number of times a post has been delivered to another Twitter account's timeline. The CFP team began recording metrics relating to Facebook activity during 2022/23. Statistics relating to both Twitter and Facebook activity can be found at **Appendix 2** of this report.

6.7 Fraud Awareness Workshops

In May 2022, the LCFS provided a fraud awareness session to the HR Employee Relations team, which included a discussion on the process of working on parallel investigations, so that effective joint working can be maintained.

The LCFS also jointly delivered a fraud risk workshop for the Trust's Procurement department in November 2022. It was designed as an interactive session, and break-out groups were used to explore fraud risks within Procurement. The session was delivered jointly alongside Taelor Martin, the LCFS for LPFT and LCHS, due to Procurement being a shared function hosted by ULHT. Fraud risks discussed included, but was not limited to, splitting of orders, purchasing card fraud, and bribery.

6.8 Fraud Awareness Training.

Fraud awareness training remains a core training requirement in the Trust and all new starters are required to undertake fraud awareness via an eLearning route. All staff have to refresh their fraud awareness training every three years. The following table shows the percentage of staff who, over time, completed counter fraud awareness training, either via eLearning or through a LCFS presentation (up to March 2023). Each quarterly report to the Audit Committee includes an update in respect of the Trust's compliance level for fraud awareness training.

	LCH	PHB	GDH	Trust Total
May 2015	31.0%	27.0%	33.0%	**30.0%**
March 2016	80.0%	77.0%	84.0%	**79.0%**
March 2017	94.0%	93.0%	97.0%	**94.0%**
March 2018	96.6%	96.6%	97.8%	**96.8%**
March 2019	93.1%	93.9%	94.9%	**93.6%**
March 2020	94.2%	94.5%	96.4%	**94.6%**
March 2021	92.6%	93.3%	95.5%	**93.2%**

March 2022	92.3%	92.6%	93.2%	**92.5%**
March 2023	92.7%	93.4%	96.2%	**94.2%**

6.9 Fraud Awareness Staff Survey.

In line with Components 7 and 11 of the NHS Counter Fraud Functional Standard, the LCFS conducted the Fraud Awareness Staff Survey in May 2022 to test general awareness levels of fraud, bribery and corruption issues within the Trust and to compare this with the survey results from previous years. The survey was promoted throughout the Trust in a number of ways including all staff emails, articles in Weekly Round-Ups, social media, and support from the Counter Fraud Champion. The survey attracted a respectable 959 respondents (961 in the 2021/22 survey). It has been agreed within the collaborative that going forward, the Fraud Awareness Staff Survey will occur bi-annually, rather than annually as before, to prevent survey fatigue.

The 959 respondents provided the LCFS with data which enabled a meaningful analysis of the responses to be conducted. The results were fully presented to the Audit Committee in October 2022. However, in July 2022, the Audit Committee was notified of the following headline results:

- 94% of staff had completed fraud awareness training in the last three years.
- 58% would report their fraud concerns to an NHSCFA approved channel, i.e., by contacting the LCFS or the DoF, via the NHS Fraud and Corruption Reporting Line on 0800 028 4060, online at https://cfa.nhs.uk/reportfraud or via the Counter Fraud Champion or Freedom to Speak up Guardian.
- 27% of the respondents would report their concern directly to the LCFS.
- 40% of staff would report their concern to their manager; which although still positive, there is a risk that the manager does not act on the allegation for a variety of possible reasons.
- Only 2% of the respondents would not report a suspicion of fraud.
- 80% had an awareness of the Fraud, Bribery and Corruption Policy.
- 72% of the respondents believe that the Trust takes allegations of fraud seriously compared to only 3% who didn't; 25% of staff did not know either way.

The LCFS also provided benchmarking information to the Trust showing how the results of the survey compared to other Trusts within the counter fraud collaborative.

6.10 Human Resources Liaison.

To ensure that for all allegations received within the Trust, appropriate sanctions were considered and achieved where possible, regular meetings took place between the LCFS and a representative from the Human Resources Directorate. At the start of the year, the LCFS met with a Trust Employee Relations' Manager alongside the Trust's Support LCFS. However, since January 2023, the LCFS met regularly with the Trust's Deputy Director of HR. This arrangement is invaluable and helps to maintain a strong working relationship between the LCFS and the HR Directorate. The LCFS has also continued to work closely and effectively with other Human Resources staff during 2022/23.

6.11 External Body Liaison.

The LCFS continues to maintain strong links with external investigative agencies and other stakeholders. Where applicable, all contacts follow relevant legislative protocols and appropriate guidance issued by the NHSCFA. Agencies communicated with during 2022/23 were as follows:

- NHS Counter Fraud Authority (NHSCFA)

- Internal Audit (Grant Thornton)
- External Audit (Mazars)
- Crown Prosecution Service
- Nursing and Midwifery Council (NMC) regarding Fitness to Practice referrals
- General Medical Council (GMC) concerning ongoing investigations
- Private Employers / companies
- Other LCFS's from other NHS Trusts

7. PREVENT AND DETER

Any activity detailed in this section contributes to Component 10 of the NHS Counter Fraud Functional Standard.

7.1 NHSCFA Intelligence Bulletins.

The LCFS received six intelligence bulletins (IBURNS) from the NHSCFA in 2022/23 in relation to mandate fraud, payment fraud and individuals who may pose a fraud risk to the NHS. All were circulated to appropriate staff and actioned accordingly.

7.2 NHSCFA Fraud Prevention Notices.

The NHSCFA continues to issue Fraud Prevention Notices (FPNs) as new information is made available to them. The purpose of these FPNs is to capture and analyse system weakness referrals and to create fraud prevention solutions and provide guidance to reduce system weakness vulnerabilities. All FPNs are actioned upon receipt and outline details are reported to the Audit Committee in routine progress reports from the LCFS.

During the reporting period, five FPNs were received and actioned, ensuring the Trust addressed potential system weaknesses.

7.3 NHSCFA Post-Event Assurance Exercise.

During 2022/23 the LCFS received organisation specific feedback detailing the Trust's findings from the COVID-19 Post Event Assurance Exercise conducted by the NHSCFA. The Trust was ranked 96 of 210 organisations for non-purchase order spend percentage of total spend. The Audit Committee were appraised of further details in regard to this exercise.

7.4 Supplier Bank Mandate Fraud.

The threat of this type of fraud has continued to remain real and significant, no longer just within the public sector but also across private companies. A robust local procedure is in place and is reviewed by the Trust's Purchase to Payments Manager following receipt of intelligence by the NHSCFA and CFP team. All new intelligence regarding bank mandate fraud attempts is directed to key staff within the Payments' Team to ensure that a heightened awareness is maintained, and this continued to be the case during the reporting year.

The CFP team's Counter Fraud Support Officer (CFSO) performed sample compliance checks on the Trust's adherence to the procedure during 2022/23 and no issues of non-compliance were identified. Continued compliance with the procedure should provide the Trust with maximum prevention from this type of fraud and forms part of the compliance checks within the counter fraud collaborative.

7.5 Cabinet Office - National Fraud Initiative.

The National Fraud Initiative (NFI) is an exercise, conducted by the Cabinet Office every two years. It matches electronic data within and between public and private sector bodies to prevent and detect fraud. The participating bodies include police authorities, local probation boards, fire and rescue authorities as well as local councils, a number of private sector bodies, and the NHS. The Trust participates in the NFI exercise and

throughout the year the LCFS and the LCFS and Trust finance officers actioned the data matches for the 2021 exercise, ensuring they reached a satisfactory outcome.

For the 2023 exercise, the necessary data uploads were completed on schedule in early October 2022 and in January 2023 the resultant data matches were released by the NFI team and ULHT received data relating to 830 matches. A review of the matches and application of filtering shows that these matches are broken down into 314 Payroll matches (including Payroll to Procurement matches) and 516 Creditors matches. Work will continue during 2023 by both the LCFS and Trust Finance officers to review the most recent data matches.

7.6 Local Proactive Exercises (LPEs).

The NHS Counter Fraud Functional Standard requires all Local Proactive Exercises (LPEs) to be solely risk based and recorded on the NHSCFA's case management system, CLUE. The system requires the appropriate risk rational to be recorded alongside the LPE and requires the LCFS to upload LPE outcome reports.

During 2022/23, eleven LPE's were conducted within the Trust in areas of heightened risk, covering Trust procurement cards, mandate fraud, payment terminal fraud and salary diversion fraud; the Audit Committee received details of the LPE's and their outcomes.

7.7 NHSCFA – Strategic Intelligence Assessment

During 2022/23 the NHSCFA's Strategic Intelligence Team (SIT) continued to publish quarterly threat assessments via the NGAGE platform. The aim is within each quarter to alert the NHS counter fraud community to the geographical spread of fraud and allegations across NHS regions. The assessments also include the most prevalent threats and enables within a specific region which could allow fraud to occur. The LCFS continues to review the information provided within these reports but is unable to share this directly with the Audit Committee due to the sensitivity of the information included.

7.8 NHSCFA Reporting Figures.

The NHSCFA continued to issue monthly briefings throughout 2022/23 to highlight areas of fraud concerns. All information and intelligence received from the NHSCFA is considered for impact on the Trust and actions are taken as appropriate, including being fed into the Trust's Fraud Risk Assessment.

7.9 Miscellaneous Prevention Activity

The LCFS dealt with numerous warnings and alerts throughout 2022/23 and many of these required liaison with the Trust's Payments', Digital Security and Compliance Teams:

- On fifteen occasions, the LCFS was informed by the ULHT Payments' Team of information received regarding concerns from suppliers about potential bank fraud attempts against them. On each occasion, the Trust's Payments' Team undertook appropriate checks to ensure the information held by ULHT was correct. The LCFS duly informed the other CFP LCFS's.
- The LCFS was notified of three bank mandate warnings from the CFP team, and these were forwarded to the Trust's Payments' team for action as necessary.
- The LCFS was notified of four bogus telephone calls received within the Trust during 2022/23. It is acknowledged that the primary channel for the reporting of bogus calls in the Trust is now to the Digital Security and Compliance team, therefore this is not necessarily an indication of the true volume of bogus calls received into the Trust. Details of each call was reviewed and where appropriate, referred to the Trust's Digital and Security Compliance team for consideration.
- The LCFS was forwarded an alleged Phishing email and the information was shared with the Trust's Cyber Security team for action.
- In December 2022, the LCFS issued a notice to all appropriate Finance staff, via the Deputy Director of Finance, reminding them that the Christmas season usually sees an increase in mandate fraud attempts against the NHS. Staff were asked to remain vigilant and to always follow existing robust Trust processes.

- The NHSCFA issued an alert which referred to a fraud attempt following the hacking of an external NHS employee's Microsoft Teams account. The LCFS shared this alert with appropriate Trust staff to raise awareness of this threat and to ensure that the adequate controls were in place to prevent this type of fraud.

8. HOLD TO ACCOUNT

Any activity detailed in this section contributes to Components 6 and 8 (and referenced in Component 9) of the NHS Counter Fraud Functional Standard.

8.1 System Weakness Reports (SWRs).

The NHSCFA case management system, CLUE, allows for the recording of system weakness reports (SWRs) that are required as part of Component 8 of the NHS Counter Fraud Functional Standard. System weakness reports can fall into several categories including lack of fraud awareness, lack of segregation of duties, poor record keeping, and poor form design, etc.

There were two SWRs reported by the LCFS during 2022/23 which were identified during ongoing investigations.

8.2 Miscellaneous Advice.

During the year, the LCFS was contacted on 24 occasions by a range of staff in the organisation, including management, regarding potential fraud concerns held by them. Appropriate guidance and advice were provided to enable their concerns to be progressed in a proportionate manner. It should be noted that these contacts were in addition to referrals uploaded to CLUE. This underpins the effectiveness of having a dedicated LCFS, embedded within the organisation.

8.3 Investigation Referrals.

Fraud referrals are received from many sources and are appropriately advanced by the LCFS through the gathering of evidence to ascertain whether a case to answer exists.

The LCFS provided details of all fraud referrals received in routine progress reports to the Audit Committee, supported by verbal updates by the LCFS when required. Information included in this annual report is therefore in summary form only.

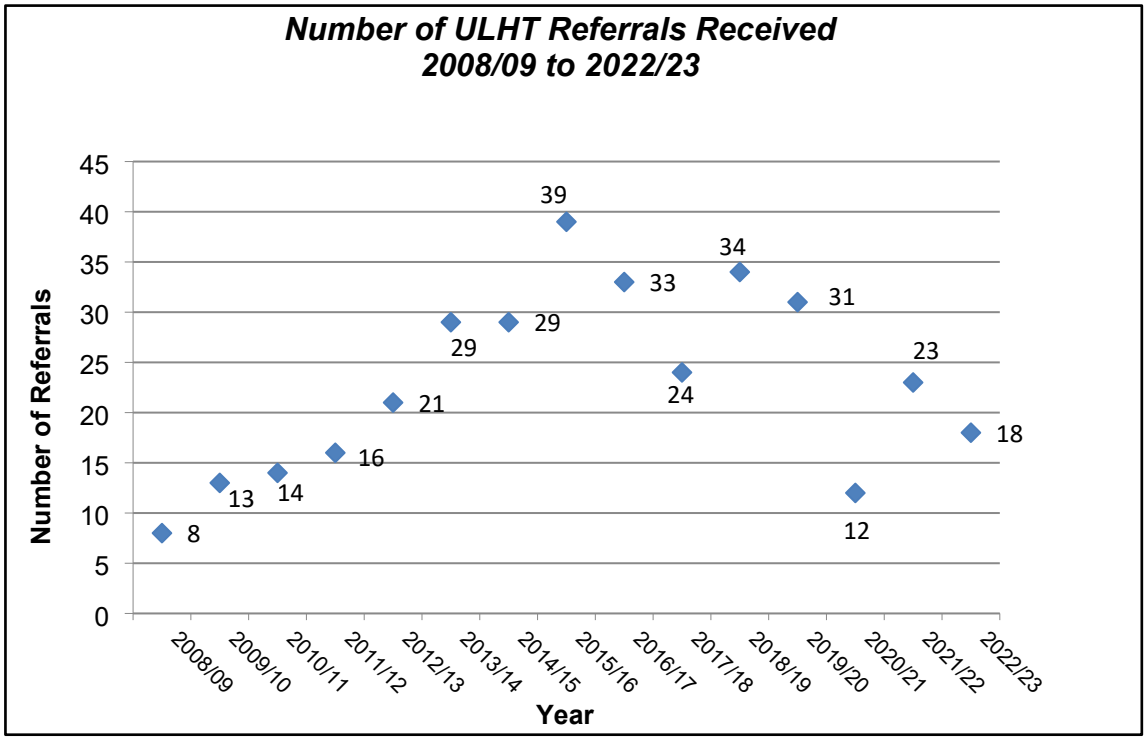
Where evidence does not support a criminal case, it is referred to HR and / or a professional body where appropriate, for consideration of other disciplinary action. Where sanctions are imposed then the outcome is recorded on the on the case management system.

During the reporting period, 1 April 2022 to 31 March 2023, the LCFS dealt with eighteen referrals of fraud. The number of fraud referrals received since 2008/9 is shown in the graph below to provide a year-on-year comparison. Of the eighteen new referrals received during 2022/23, twelve related to current or former employees, three related to patients and three to unknown subjects. All new referrals are notified to the DoF upon receipt and to the Audit Committee via the quarterly progress reports. The status of each referral is updated on each progress report until the matter is concluded.

8.4 Closure of Cases / Information Reports.

It should be noted that information submitted on the Trust's Counter Fraud Functional Standard Return (CFFSR) does not always correlate with the information provided in this section of the Annual Report. To clarify:

- Information related to financial losses identified, monies recovered, and fraud prevented are only included on the CFFSR for cases which were closed during 2022/23, rather than when the money was recovered; non-fraud recovery information is not included on the CFFSR.
- Criminal or disciplinary sanctions are included on the CFFSR for cases which had sanctions applied during 2022/23, rather than when the Case was closed.
- Financial or sanction information is included on the CFFSR for Cases / Investigations only.



Within the four progress reports submitted to the Audit Committee during 2022/23, 27 referrals were reported to the Audit Committee as being closed on the national case management system.

8.5 Responsible Officer's Advisory Group (ROAG).

The LCFS has an effective working relationship with the Chair of the ROAG, who is the Trust's interim Medical Director. The LCFS maintains contact with ROAG, through the Chair and ongoing investigations are discussed where it is necessary and appropriate to do so.

8.6 Sanctions – Evaluation of Criminal, Disciplinary and Professional.

During 2022/23, the LCFS worked in line with the NHS Counter Fraud Functional Standard. Component 6 of the Standard states that the Trust should identify and report on annual outcome-based metrics with objectives to evidence improvement in performance. Metrics should include criminal and disciplinary sanctions.

The Trust's commitment to ensuring that appropriate sanctions are applied when necessary is contained with the Countering Fraud, Bribery and Corruption Policy and Response Plan and sanctions are pursued if an employee is suspected of being involved in a potential fraud. Applying a consistent and thorough approach for all referrals received will ensure that effective investigations are undertaken, where appropriate, including the gathering and assessment of all relevant material which may indicate fraud, bribery, corruption, misconduct and/or unfitness to practise. Each referral received by the LCFS is considered on its own merit for the full range of sanctions at the earliest opportunity. The LCFS maintains a HR/LCFS Liaison Protocol document which outlines how the two parties can work together to achieve parallel sanctions (i.e., criminal and disciplinary).

Criminal investigations are conducted separately to other investigations and the two processes have different purposes, rules of evidence, standards of proof and outcomes. The LCFS's close working relationship with the Trust's HR Department ensures that where appropriate, disciplinary sanctions are considered and progressed where necessary. Such actions are duly reported to the Trust's Audit Committee within the LCFS progress reports for oversight, scrutiny, and the consideration of any further actions.

The LCFS also discusses possible Professional Body referrals with the DoF, HR, ROAG and the Deputy Director of Nursing, with a view to ensuring that such sanctions are also considered and actioned by the Trust where appropriate. In conjunction with the DoF and, only if

necessary, the LCFS can refer individuals to external bodies if the situation supports this action, but ordinarily the Trust should make referrals in line with its own policies.

All instances of potential fraud are discussed with the DoF at regular intervals and upon conclusion and are only closed on CLUE once the DoF is satisfied that all sanctions have been considered and pursued where necessary. For each referral raised on NHSCFA's case management system, the DoF approves a case closure summary which details the allegation and the outcome of Trust investigations. Each summary details whether any sanction was administered, either formal or informal and also reports on whether the subject was referred to a Professional Body and the outcome. To that end, the DoF has to be satisfied with the outcome of all referrals and that all sanctions have been considered and pursued where necessary.

In summary therefore, the Trust regularly and robustly evaluates its sanctions arrangements through the mechanisms described above.

8.7 Sanctions Administered 2022/23 – Criminal, Disciplinary and Professional.

Although there were no criminal sanctions applied during 2022/23, as a result of close working between the LCFS and the Trust's HR department, three disciplinary sanctions were administered during the financial year, in relation to qualification fraud, misuse of access to a Trust system and submission of a false job application form.

The LCFS had several ongoing investigations at the end of the financial year for which both criminal prosecution and/or disciplinary action is either being progressed or expected to be considered.

8.8 Sanctions – Evaluation of Trust's Financial Recovery.

Component 8 of the NHS Counter Fraud Functional Standard states that the Trust should record all financial recoveries on the approved case management system. Component 1B of the standard also states that the Trust should identify and report on annual outcome-based metrics including the value of fraud recoveries.

The Trust's commitment to the recovery of such monies is contained within the Countering Fraud, Bribery and Corruption Policy and Response Plan. In all potential fraud cases, consideration is given by the LCFS to the recovery of monies defrauded from the organisation or paid in error.

All instances of potential fraud are discussed with the DoF at regular intervals and upon conclusion are only closed on CLUE once the DoF is satisfied that all financial recoveries have been considered and pursued where necessary. Additionally, all matters are duly reported to the Trust's Audit Committee within the LCFS progress reports routinely submitted to each meeting throughout the year, for oversight, scrutiny, and the consideration of any further actions.

The LCFS continued to work closely with Finance staff during the year to ensure that an effective process is in place to recover any such monies. Should recovery not be required or not possible to implement, the LCFS discusses these at the time. The LCFS also provides an appropriate explanation on the closure report or summary. Only when the closure report or summary have been approved by the DoF is the referral closed on FIRST/CLUE.

In summary, the Trust regularly and robustly evaluates its financial recovery arrangements through the mechanisms described above.

8.9 Sanctions – Successful Financial Recoveries 2022/23

With regards to referrals closed during 2021/22, the Trust recovered £6,336.84.

The recovered money was returned to the Trust for their intended purpose of providing valuable patient care. There were several other ongoing local cases on 31 March 2023 which also have the potential to make financial recoveries and the LCFS, in conjunction with the DoF, will always seek to recover funds when appropriate to do so.

It is worth amplifying that whilst the sums referred to for 2022/23 are inconsequential in comparison to the Trust's financial stature, there is always a substantial and immeasurable deterrent effect achieved as a result of making any recovery from those committing fraud or attempting to divert monies away from their intended purpose. Consideration must also be given to the immeasurable financial effect achieved as a result of deterring people from committing fraud against the Trust through the various fraud awareness measures deployed at the Trust since July 2013, including the presence of the LCFS.

8.10 Fraudulent Activity - Payments Prevented

Five referrals received during 2022/23 related to unsuccessful attempts to fraudulently obtain monies from the Trust by various means, including mandate fraud, false claim for costs, false job application and a false patient travel claim.

In total, **£112,240.69** of fraudulent payments were prevented.

8.11 Outcome-Based Metrics

In order to comply with Component 6 of the NHS Counter Fraud Functional Standard, the LCFS also reports on outcome-based metrics on an ongoing and frequent basis. These metrics must include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, and both criminal and disciplinary sanctions.

The LCFS, alongside the CFP team, devised a list of outcome-based metrics upon which each of the collaborative Trust's will be measured, therefore allowing for benchmarking where appropriate. Originally, these metrics were presented in a way to accord with the four strategic areas of Strategic Governance, Inform and Involve, Prevent and Deter, and Hold to Account. However, evaluation of these metrics by the CFS team highlighted that this format did not showcase the good work being done by the LCFS. As such, the outcome-based metrics were developed to provide a comprehensive overview of all counter fraud activity. The outcome-based metrics for 2022/23 can be found at **Appendix 2** of this report.

8.12 Referral Types

In addition to other ongoing referrals, the types of fraud allegations received and progressed by the Trust's LCFS during 2022/23 included:

- Payroll frauds – various MOs.
- Abuse of procurement process.
- False ULHT job applications forms – various MOs.
- False costs application form.
- Invoice fraud.
- Patient ID fraud.
- False patient travel claims.

9. FURTHER INFORMATION – REPORTING LINES

The Chief Executive is ultimately liable to be called to account for non-compliance with the NHS Standards for Providers (Fraud, Bribery and Corruption). However, the Director of Finance and Digital is the Executive Director with responsibility for overseeing and providing strategic management and support for all anti-fraud, bribery and corruption work within the Trust.

In addition to the foregoing, and to fulfil the requirements of the Functional Standard, the LCFS maintains close liaison with the Chair of the Audit Committee and the Counter Fraud Champion, who both strongly and positively supports counter fraud, bribery and corruption work within the Trust. Contact details for key personalities are as follows:

Chief Executive	**Andrew Morgan** United Lincolnshire Hospitals NHS Trust

	Lincoln County Hospital Greetwell Road Lincoln LN2 5QY ✉ andrew.morgan@ulh.nhs.uk
Director of Finance and Digital (2022/23)	**Barry Jenkins** (Address as above) Tel: 01522 307109 Mobile: 07866 262864 ✉ barry.jenkins@ulh.nhs.uk
Chair of Audit Committee	**Neil Herbert** (Address as above) ✉ neil.herbert@ulh.nhs.uk
Local Counter Fraud Specialist	**Peter Riches** (Address as above) Mobile: 07890 253234 ✉ peter.riches@ulh.nhs.uk
Counter Fraud Champion	**Jayne Warner** (Address as above) Tel: 01522 573988 ✉ jayne.warner@ulh.nhs.uk
Freedom to Speak Up Guardian	**Deborah Elliot** (Address as above) Tel: 01522 458647 Mobile: 07471 110490 ✉ Deborah.Elliott@ULH.nhs.uk

10. ACKNOWLEDGEMENT

This report summarises the wealth and breadth of counter fraud activity undertaken during 2022/23. The LCFS would like to acknowledge the support and assistance afforded by all those within ULHT in achieving the outcomes outlined in this report.

Pete Riches - Local Counter Fraud Specialist

Appendix 1 - Summary of the Risk Ratings for the 2022/23 CFFSR Submission.

Area of Activity	Red/Amber/Green (RAG)
Component 1A – Accountable Individual	Green
Component 1B – Accountable Individual	Green
Component 2 – Counter Fraud, Bribery and Corruption Strategy	Green
Component 3 – Fraud, Bribery and Corruption Risk Assessment	Amber
Component 4 – Policy and Response Plan	Green
Component 5 – Annual Action Plan	Green
Component 6 – Outcome-based Metrics	Green
Component 7 – Reporting Routes for Staff, Contractors and Members of the Public	Green
Component 8 – Report Identified Loss	Green
Component 9 – Access to trained Investigators	Green
Component 10 – Undertake Detection Activity	Green
Component 11 – Access to and Completion of Training	Green
Component 12 – Policies and Registers for Gifts, and Hospitality and Conflicts of Interest	Green
Overall Rating indicated by the CFFSR automatic assessment	**Green**

The information in the above table reflects the results of the Functional Standard assessment conducted by the Trust for work conducted during 2022/23.

I declare that the counter fraud, bribery and corruption work carried out during 2022/23 has been self-reviewed against the NHS Counter Fraud Functional Standard, and that the above rating has been achieved.

Organisation	United Lincolnshire Hospitals NHS Trust
Director of Finance and Digital	Barry Jenkins
Signature	*Signature removed for Public Meeting.*
Date	11th July 2023

Appendix 2 - ULHT Counter Fraud Metrics Dashboard 2022/23

#	METRIC	ACTIVITY / OUTCOME	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2022/23 TOTAL
	STRATEGIC GOVERNANCE						
1.1	Gov013 Overall Compliance - RAG rated	OUTCOME	GREEN	N/A	N/A	N/A	GREEN
1.2	No. of new Fraud Risks identified	OUTCOME	0	0	0	0	**0**
1.3	No. of Fraud Risks Reducing in risk score	OUTCOME	0	0	0	0	**0**
1.4	No. of Fraud Risks Increasing in risk score	OUTCOME	0	0	0	0	**0**
1.5	Analysis of LCFS Days - Strategic Governance	ACTIVITY	20.79	5.86	7.74	16.06	**50.45**
1.6	Analysis of LCFS Days - Inform and Involve	ACTIVITY	3.46	1.49	6.54	1.85	**13.34**
1.7	Analysis of LCFS Days - Prevent and Deter	ACTIVITY	2.47	2.42	3.84	5.39	**14.12**
1.8	Analysis of LCFS Days - Hold to Account	ACTIVITY	42.89	45.84	42.22	45.37	**176.32**
1.9	Analysis of LCFS Days - Compliance	ACTIVITY	1.14	1.66	0.63	2.86	**6.29**
1.10	Analysis of LCFS Days - Total	ACTIVITY	70.75	57.27	60.97	71.53	**260.52**
#	METRIC	ACTIVITY / OUTCOME	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2022/23 TOTAL
	INFORM AND INVOLVE						
2.1	No. of awareness/training sessions delivered	ACTIVITY	1	0	1	0	**2**
2.2	Mandatory eLearning requirement	ACTIVITY	Yes	Yes	Yes	Yes	**Yes**
2.3	LCH eLearning compliance rates (%) at Quarter End	OUTCOME	93.82%	93.30%	93.50%	92.74%	**92.74%**
2.4	PHB eLearning compliance rates (%) at Quarter End	OUTCOME	94.28%	93.64%	93.67%	93.43%	**93.43%**
2.5	GDH eLearning compliance rates (%) at Quarter End	OUTCOME	94.98%	95.14%	95.85%	96.24%	**96.24%**
2.6	Trust eLearning compliance rates (%) at Quarter End	OUTCOME	94.09%	93.60%	93.79%	93.31%	**93.31%**
2.7	No. of changes to awareness presentations as a result of audience feedback	OUTCOME	0	0	0	0	**0**
2.8	Twitter Activity - No. of Twitter posts	ACTIVITY	30	22	68	23	**143**
2.9	Twitter Activity - No. of Followers at Quarter End	OUTCOME	813	821	841	844	**844**
2.10	Twitter Activity - Tweet Impressions	OUTCOME	3,885	2,501	8,388	3,097	**17,871**
2.11	No. of Comms awareness items issued	ACTIVITY	3	3	6	1	**13**
2.12	No. of LCFS Alerts issued	ACTIVITY	1	1	1	2	**5**
2.13	No. of Comms items launching annual fraud awareness survey	ACTIVITY	7	0	0	0	**7**
2.14	No. of Respondents to Annual Fraud Awareness Survey	OUTCOME	959	N/A	N/A	N/A	**959**
2.15	% Response rate	OUTCOME	11.4%	N/A	N/A	N/A	**11.4%**
2.16	Survey results - % Trust takes allegations seriously	OUTCOME	71.7%	N/A	N/A	N/A	**71.7%**
2.17	Survey results - % would report fraud	OUTCOME	98.3%	N/A	N/A	N/A	**98.3%**
2.18	Survey results - % aware of Fraud, Bribery and Corruption Policy	OUTCOME	80.1%	N/A	N/A	N/A	**80.1%**
2.19	Survey results - % aware of Standards of Business Conduct Policy	OUTCOME	82.1%	N/A	N/A	N/A	**82.1%**
2.20	Survey results - % aware of existence of Counter Fraud Champion - new*	OUTCOME	43.8%	N/A	N/A	N/A	**43.8%**
2.21	No. of Counter Fraud Champion engagements with LCFS	ACTIVITY	3	2	0	2	**7**
2.22	No. of Counter Fraud Champion engagements with wider Trust	ACTIVITY	0	0	0	0	**0**

#	METRIC	ACTIVITY / OUTCOME	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2022/23 TOTAL
	PREVENT AND DETER						
3.1	No. of FPN's received and issued by LCFS	ACTIVITY	1	2	2	0	**5**
3.2	No. of changes to systems / processes as a direct result of an FPN	OUTCOME	0	1	0	0	**1**
3.3	No. of LPE's commenced	ACTIVITY	1	0	7	0	**8**
3.4	No. of CF recommendations made	ACTIVITY	0	0	2	0	**2**
3.5	No. of CF recommendations accepted	OUTCOME	1	0	0	0	**1**
3.6	No. of Trust policies reviewed by LCFS	ACTIVITY	0	0	0	0	**0**
3.7	No. of recommended changes made to Trust policies	ACTIVITY	0	0	0	0	**0**
3.8	No. of recommended changes accepted	OUTCOME	0	0	0	0	**0**
3.9	No. of system weaknesses reported on CLUE	ACTIVITY	2	0	0	0	**2**
3.10	No. of Intelligence Bulletins (IBURNS) Received and Actioned	ACTIVITY	1	1	2	2	**6**

#	METRIC	ACTIVITY / OUTCOME	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2022/23 TOTAL
	HOLD TO ACCOUNT						
4.1	No. of Referrals Received	OUTCOME	4	4	5	5	**18**
4.2	No. of Anonymous Referrals included above	OUTCOME	0	1	0	0	**1**
4.3	No. of Referrals closed on Clue	ACTIVITY	11	3	1	12	**27**
4.4	No. of Disciplinary Sanctions Applied	OUTCOME	5	0	1	0	**6**
4.5	No. of Resignations Associated with Investigation	OUTCOME	2	0	0	0	**2**
4.6	No. of Criminal Sanctions Secured	OUTCOME	0	0	0	0	**0**
4.7	No. of Professional Body Sanctions Applied	OUTCOME	0	1	0	0	**1**
4.8	Value of Financial Recoveries	OUTCOME	£6,555.80	£0.00	£178.20	£0.00	**£6,734.00**
4.9	Number of Financial Recoveries	OUTCOME	3	0	2	0	**5**
4.10	Value of Prevented Financial Losses	OUTCOME	£8,053.66	£196.80	£14,892.31	£97,151.58	**£120,294.35**
4.11	Number of Prevented Financial Losses	OUTCOME	2	1	1	3	**7**
4.12	Advice / Referrals Not Progressed	OUTCOME	7	6	8	3	**24**
4.13	Cases formally referred by the LCFS / Trust a Professional Body	OUTCOME	2	1	0	2	**5**

#	METRIC	ACTIVITY / OUTCOME	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2022/23 TOTAL
	NATIONAL FRAUD INITIATIVE (NFI)						
5.1	No. of Creditor Payments matches received	ACTIVITY	0	0	0	516	**516**
5.2	No. of Creditor Payments matches checked	ACTIVITY	0	0	0	0	**0**
5.3	No. of Creditor Payment financial recoveries	OUTCOME	0	0	0	0	**0**
5.4	Value of Creditor Payment financial recoveries	OUTCOME	£0.00	£0.00	£0.00	£0.00	**£0.00**
5.5	No. of Payroll matches received (including Procurement to Payroll)	ACTIVITY	0	0	0	314	**314**
5.6	No. of Payroll matches checked	ACTIVITY	0	0	0	225	**225**
5.7	No. of Payroll matches financial recoveries	OUTCOME	2	0	0	0	**2**
5.8	Value of Payroll matches financial recoveries	OUTCOME	£2,483.40	£0.00	£0.00	£0.00	**£2,483.40**

Appendix 3 - Summary of the key data required for compliance with NHS Counter Fraud Requirements as reported on the Trust's 2022/23 CFFSR [1].

AREA OF ACTIVITY	DAYS USED
Proactive Work	84
Reactive Work	176
Total Days Used	260

NOMINATIONS OVERVIEW	NAME OF NOMINATED PERSON	DATE OF CHANGE
Accountable Board Member	Barry Jenkins	May 2023
Audit Committee Chair	Neil Herbert	September 2022
Counter Fraud Champion	Jayne Warner	March 2021
Lead LCFS	Peter Riches	July 2013
Supporting LCFS	Sally Stevenson	July 2013
Supporting LCFS	Nicki Foley	July 2013
Supporting LCFS	Mark Bishop	July 2013
Supporting LCFS	Taelor Martin	January 2021

FIRST INFORMATION	NUMBER
Information Reports carried forward from previous years	1
Cases carried over from previous years	14
Information Reports opened during the period	0
Information Reports closed during period	1
Information Reports ongoing	0
Cases opened during the period	0
Cases closed during period	8 (6*)
Cases ongoing	6

* Two cases closed by NHSCFA prior to end of all actions by the LCFS

CLUE INFORMATION	NUMBER
Incidents carried forward from 2021/22	3
Investigations carried forward from 2021/22	16
Incidents opened during the period	12*
Incidents closed during period	15*
Incidents ongoing	0
Investigations Opened during the period	17
Investigations Closed during period	14
Investigations Ongoing	19

* Includes 11 LPE's as referred to in Section 7.6

[1] Figures recorded here relate to activity achieved within the period of 2022/23, as per the requirements of the CFFSR and the NHSCFA Quality Assessment process. Therefore, therefore sanctions achieved outside of the requirements are not included and the figures may not match Trust's metrics data (Appendix 3, below).

SANCTION IMPOSED	NUMBER
Disciplinary	3
Civil	0
Criminal	0
Fraud Identified	£8,525.76
Fraud Recovered	£6,336.84
Fraud Prevented	£112,240.69

FRAUD RISK ASSESSMENTS	NUMBER
Number of FRAs reviewed in line with the organisations risk management policy	29
Number of new FRAs recorded in line with the organisations risk management policy	0

LOCAL PROACTIVE EXERCISES	NUMBER
Number of LPEs conducted during the year	8
Number of LPEs recorded on the NHSCFA Case management system as per Component 8	8
Number of LPEs concluded during the year	8

SYSTEM WEAKNESS REPORTS	NUMBER
Number of SWRs identified during the year	2
Number of SWRs concluded during the year on the NHS CFA Case management system as per Component 8	2
Number of new processes adapted or introduced as a result of SWRs	0