Bundle Trust Board Meeting in Public Session 6 June 2023

Agenda attachments

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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 Presentation

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5.1 Minutes of the meeting held on 2 May 2023
Chair

Item 5.1 Public Board Minutes May 2023v1.docx

5.2 Matters arising from the previous meeting/action log
Chair

Item 5.2 Public Action log May 2023.docx

6 Chief Executive Horizon Scan Including ICS
Chief Executive

Item 6 CEO Update, 060623.docx

6.1 CQC Feedback Letter following inspection 31 May 2023

Item 6.1 CQC Feedback letter.docx

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

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

8.1 Assurance and Risk Report from the Quality Governance Committee
Chair of QGC

Item 8.1 QGC Upward report May 2023 v1.doc

Item 8.1 QGC App 1 Ward to Board Quality Acreditation Update position April 23 final.docx

Item 8.1 QGC App 1 Quality Accreditation Dashboard Overview Updated to February 2023.pdf

8.2 PSIRF Update
Director of Nursing (Dep Dir Clin Gov attending)

Item 8.2 PSIRF Report Phase 3 Closedown May 2023 v2.docx

Item 8.2 PSIRF Flow Chart draft v1.docx

Item 8.2 PSIRF Structure.pptx

8.3 Covid 19 Serious Incident Report
Director of Nursing

Item 8.3 Trust Board - Hospital-onset Covid-19 Duty of Candour Update June

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

9.1 Assurance and Risk Report from the People and Organisational Development Committee
Chair of PODC

Item 9.1 POD - Upward Report - May 2023.docx

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

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

Item 10.1 FPEC Upward Report May 2023 v1.docx

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

11.1 Paediatric Consultation
Family Health Division

Item 11.1 Front Cover- Pilgrim paediatrics consultation- 060623 v2.docx
Item 11.1 Pilgrim Paediatrics Consultation Slide Summary Jan 2023 V2i.pptx

12 Integrated Performance Report
Director of Finance & Digital

Item 12 IPR Trust Board - Front page.docx
Item 12 IPR Trust Board May 2023 Final.pdf

12.1 Integrated Improvement Plan 2023/24
Director of Improvement and Integration

Item 12.1 Cover Paper - Trust IIP for Trust Board review June 2023 -FINAL.docx
Item 12.1 IIP 2023 v3.pdf

13 Risk and Assurance

13.1 Risk Management Report
Director of Nursing

Item 13.1 TB - Strategic Risk Report - June 2023.docx
Item 13.1 Appendix A - FPEC Risks rated 15-25 - May 2023.pdf
Item 13.1 Appendix A - People OD High and Very high risks (15-25) - May
Item 13.1 Appendix A - Quality and Safety Risks rated 15-25 - May 2023.pdf

13.2 Board Assurance Framework 2023/24
Trust Secretary

Item 13.2 Item BAF 2023-24 Front Cover June 2023.docx
Item 13.2 Draft BAF 2023-2024 30.05.23.xlsx

13.3 Code of Governance - Update
Trust Secretary

Item 13.3 Code of Governance Update.docx

13.4 Provider Licence Update and Declaration
Trust Secretary

Item 13.4 NHS Provider Licence Modifications.docx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 4 July 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.

Agenda Trust Board Meeting in Public Session

Date 06/06/2023
Time 10:15 - 13:15
Location MS Teams
Chair Elaine Baylis

PLEASE NOTE THAT ALL OF THE AGENDA TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1 **Introduction, Welcome and Chair's Opening Remarks**
Chair

2 **Public Questions**
Chair

3 **Apologies for Absence**
Chair

4 **Declarations of Interest**
Chair

5.1 **Minutes of the meeting held on 2 May 2023**
Chair

5.2 **Matters arising from the previous meeting/action log**
Chair

6 **Chief Executive Horizon Scan Including ICS**
Chief Executive

7 **Patient/Staff Story**
Director of Nursing

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7.1 **Break**

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

8.1 **Assurance and Risk Report from the Quality Governance Committee**

8.2 **CQC Quarterly Report**
Director of Nursing

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

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

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**

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

11.1 **Paediatric Consultation**

12 **Integrated Performance Report**

12.1 **Integrated Improvement Plan 2023/24**

13 **Risk and Assurance**

13.1 **Risk Management Report**

13.2 **Board Assurance Framework 2023/24**

13.3 **Code of Governance - Update**

13.4 **Provider Licence Update**

14 **Any Other Notified Items of Urgent Business**

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United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 2 May 2023

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Professor Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Mr Neil Herbert, Non-Executive Director
Dr Chris Gibson, Non-Executive Director
Ms Michelle Harris, Chief Operating Officer
Ms Dani Cecchini, Non-Executive Director

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mr Jon Young, Deputy Director of Finance
Professor Ciro Rinaldi, Deputy Medical Director
Ms Jennie Negus, Head of Patient Experience
Ms Sarah Addlesee, Associate Director of Nursing
Mr Jason Green, Matron – Lincoln Theatres
Ms Julie Record, Matron – Surgical Unit Grantham

Apologies
Dr Colin Farquharson, Medical Director
Mr Paul Dunning, Medical Director
Mrs Rebecca Brown, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Mrs Vicki Wells, Associate Non-Executive Director

508/23	**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.
509/23	**Item 2 Public Questions**

	Q1 from Vi King **Please can I ask who is going to take on the service of Grantham's 24 UTC. Also, when will this be fully open to provide this service.** **I know this was part of the consultation and ULHT have said before its not down to them, but with the staff who are employed by ULHT and are working in Grantham's A&E surely you have a duty of care to keep them informed as well as the public.** **With the waiting times that people are having to endure at the other hospitals, this would help ease this issue by having Grantham hospital open 24/7.**
510/23	The Chief Executive responded: The Urgent Treatment Centre (UTC) and medical beds at Grantham were 2 key outcomes of the consultation led by the Integrated Care Board (ICB) with colleagues being informed about progress with both of the services. Updates were being offered as necessary with the last formal updated received in February 2023. Since then, the ICB had been working on the service specification for both the UTC and medical beds The Chief Executive noted that the second part of the question referred to the procurement process of the services. The service specifications were now complete and, in the last week, the ICB had confirmed the way forward in terms of procurement. The approach was for the 2 local providers, United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) to work together to agree how the 2 services were managed and provided. This would avoid the need for a lengthy formal procurement and the next steps would be for the 2 providers to work through this process. Assurance was offered that this would be progressed as quickly as possible to conclude the discussions with LCHS and communicate the outcome, including the date of commencement of both the UTC and beds at Grantham. The Chair noted the progress that had been made and looked forward to future updates and establishing the services in the way intended.
511/23 512/23	**Item 2.1 Ward Accreditation** The Chair welcomed the Associate Director of Nursing, and Matrons Green and Record to the meeting.

	The Director of Nursing was delighted to welcome the Associate Director of Nursing, and Matrons Green and Record for the third occasion at the Board where the presentation of accreditation awards were made. This was another proud moment for members of the Board, as professionals but also for patients for the standards each area had gained.
513/23	The Associate Director of Nursing was pleased to attend the Board to introduce further teams who had been successful in achieving diamond awards, including the first silver diamond award.
514/23	There were a number of core requirements departments needed to achieve against a wider range of quality indicators, in addition to presenting a portfolio of evidence to the quality accreditation panel.
515/23	It was noted that Lincoln Theatres had applied and were successful in achieving a bronze award with the Surgical Unit at Grantham applying, and being successful for, the first silver diamond award.
516/23	The Associate Director of Nursing advised the Board that in order to achieve the silver diamond award the Surgical Unit had built on the previous bronze award and achieved additional weeks and months in all quality indicators on a rolling 12-month programme, in addition to presenting a new portfolio of evidence of continuous quality improvement.
517/23	Matron Green was proud of the theatres team in making the quality improvement in the department noting that this reflected all of the hard work the team were doing to make improvements in the area. One of the improvements made had been to introduce a separate area for the preparation of instruments pre-surgery. Feedback had been offered from various members of the team including newly appointed staff, new international nurses and apprenticeship colleagues.
518/23	The creation of the environment had enabled a controlled safe environment to be used which was also educational for all staff. Feedback received was that staff were pleased to have the environment to work in.
519/23	Matron Record noted that the Surgical Unit at Grantham was the first to receive the silver diamond award noting the hard work of the team to achieve this.
520/23	One aspect of improvement had seen a continuation of the call don't fall initiative that had been implemented as a result of unexpected falls from patients who were not high risk. There had been consideration of the medications being used and multi-disciplinary discussions about changes which would be implemented.
521/23	Matron Record noted that since the implementation of call don't fall there had been no falls or slips since November 2022. The changes made to medication used had resulted in improvements for patients and would continue for a further month before wider consideration of other medications was made.
522/23	The Director of Nursing noted that nurses required a range to technical skills and a high level of education to effective but also needed to be critical thinkers and decision

	makers. This was not just about what nurses did but how it was done with the examples demonstrating the core values of the organisation of compassion, dignity and respect, as well as desire to do the best of patients which could not be overestimated.
523/23	The improvements described were a small example of the wider improvement work which had been undertaken and demonstrated what United Lincolnshire Hospitals NHS Trust was capable of undertaking.
524/23	The Director of Nursing was proud of the work done across the ward area and offered thanks to Matron's Green and Record and the respective teams.
525/23	The Chief Executive supported the comments made noting that it was a complete team effort from a range of professions. At the launch of the NHS new strategy around continuous improvement it was noted that this was not a new area of work for the Trust with people focused on continuous improvement, using resources at their disposal to make improvements.
526/23	It was hoped that Matron Green would strive for silver and Matron Record for gold accreditations in the near future.
527/23	The Director of Improvement and Integration echoed the sentiments and asked how, in such a busy environment, improvements were achieved and offered support of the improvement teams should it be needed.
528/23	Matron Green noted that consideration was given to what needed to be achieved in terms of quality for patients, as the Director of Nursing had stated the team was patient focused and with that focus this was how achievements were made.
529/23	Matron Record support the view on achievements and improvements noting support was already in place and now that the Get it Right First-Time accreditation had been achieved for the Grantham Hub this had driven the focus.
530/23	It was noted that the achievements of the accreditation supported the team to remain motivated.
531/23	The Chair was pleased to be able to present the awards noting these were not easily given out and were hard earnt requiring all team members to make a contribution along with great leadership.
532/23	It was noted that staff were encouraged to offer feedback and the example from Matron Green demonstrated that the team felt about to offer this and see a positive response as a result.
533/23	The learning from Matron Record's team demonstrated professional curiosity to understand why something was happening and then went beyond this to explore best practice and was all done in the patients best interest.
534/23	The Chair noted that the certificates and awards would be presented in person but offered congratulations on behalf of the Board.

535/23	**Item 3 Apologies for Absence** Apologies were received from Dr Colin Farquharson, Medical Director, Mr Paul Dunning, Medical Director, Mrs Rebecca Brown, Non-Executive Director, Professor Phil Baker, Non-Executive Director and Mrs Vicki Wells, Associate Non-Executive Director.
536/23	The Chair welcomed Mr Jon Young, Deputy Director of Finance and Professor Ciro Rinaldi, Deputy Medical Director to the meeting.
537/23	**Item 4 Declarations of Interest** There were no new declarations of interest.
538/23	**Item 5.1 Minutes of the meeting held on 4 April 2023 for accuracy** The minutes of the meeting held on 4 April 2023 were agreed as a true and accurate record.
539/23	**Item 5.2 Matters arising from the previous meeting/action log** The Chair took the action log as read noting there were no actions due.
540/23	**Item 6 Chief Executive Horizon Scan including ICS** The Chief Executive presented the report to the Board noting that the system continued to be busy with a number of public holidays and a balance needed to run services as well as having planned for Easter. There were further bank holiday's including the coronation weekend and at the end of the month.
541/23	This planning was alongside coping with industrial action however there had not been industrial action on the 1 May by the Royal College of Nursing (RCN) as there was no mandate to strike in Lincolnshire currently.
542/23	The Chief Executive noted the impact on the Trust of the Junior Doctor industrial actions in March and April advising that, as a result, 165 electives and 1474 outpatient appointments had been lost due to cancellations. Whilst some would have already been rearranged and completed the Chief Executive apologised to those patients who had been cancelled.
543/23	There had been a cost of £250k to the Trust for staffing cover over the duration of the strike action as well as £300k in lost activity however activity should be recovered when the work was caught up.
544/23	The Board noted that the NHS Staff Council was meeting to consider the outcomes of the ballots that the unions had conducted in respect of the government pay offer with the Chief Executive noting that it appeared that the offer would be accepted by the majority of unions.

545/23	Whilst there was a need to await the outcome of the meeting it was noted that any acceptance of the offer would not prevent unions for continuing with further ballots and possible further strike action.
546/23	The Chief Executive advised of the year-end financial position which had seen a system deficit of £16.8m and Trust deficit of £13.6m. There had been detailed discussions with NHS England about the 2023/24 plan with a final operational plan for the system due to be submitted on 4 May.
547/23	A review had taken place with NHS England on 28 April which had been positive, and it was felt that it would be possible to submit a plan for Lincolnshire which would meet expectations on service delivery targets as well as finances. The system plan looked to be a deficit of £15m following the meeting with NHS England.
548/23	The Hewitt review in to Integrated Care Systems (ICSs) had been published and made a number of recommendations, setting out key principles. The report was now with minister for them to decide on the action to be taken.
549/23	NHS England had issued a new report around continuous improvements, as well as NHS Impact, the methodology for improvement in the NHS. The Trust would build on this to continue with the Trust's improvement journey, as well as doing this alongside system colleagues.
550/23	The Chief Executive noted that the 75th anniversary of the NHS would be in July and would be celebrated across the system, nationally coordinated by the NHS Assembly.
551/23	It was also noted that the Chief Executive and ICB Chief Executive were now members of the Court of the University of Lincoln and congratulations had been offered to local MP Gareth Davies who had been appointed as junior minister in treasury.
552/23	The Chief Executive advised Board members of attendance at a national conference on the NHS People Promise, delivering a session based on the Trust being the second most improved Trust in the country for staff survey results. Information was also offered on the culture, leadership and behaviour changes that were being taken.
553/23	It had been pleasing to noted that the Chief Workforce Officer's weekly blog had covered the Trust's work on flexible working.
554/23	The Chief Executive advised that Mr Matthew had now left the Trust and the new Interim Director of Finance and Digital, Mr Barry Jenkins, would join the Trust on 8 May.
555/23	The Chair commented on the Chief Executives appearance at the NHS People Promise event noting that it was positive to have the Trust being represented in the national environment to celebrate the success of improvement in the staff survey.

556/23	This reflect the work being done in the Trust with thanks extended to the Chief Executive for taking the time to commit to presenting at the event with positive feedback having been received.
557/23	The Chair formally thanked Mr Matthew for the work done whilst in the role of Director of Finance and Digital noting that the Trust had been left in a good position. The Chair extended a welcome to Mr Jenkins who would be joining the Trust the following week. The Trust Board: • **Received the report and significant assurance provided**
558/23	**Item 7 Patient Story** The Director of Nursing introduced the patient story advising that this was from the perspective of the schedulers who work in the heart centre. The schedulers visit all patients on the cardiac ward prior to planned procedures taking place to meet patients in person.
559/23	This allows the schedulers to get to know the patients and find out what would help to calm them if anxious but to also understand if there were any additional needs or requirements for the procedure. This ensures that the patient receives the best experience and outcome when going through what is quite an invasive procedure.
560/23	The Trust Board watched the video which detailed the work of the team to support a patient with learning disabilities to be less anxious and to have support in place to ensure a smooth procedure and also a patient who was supported through the procedure by having music, of their choice, played for the duration of the procedure.
561/23	The Chair noted with interest the insight of staff who were day in day out closely engaging with patients and responding to their needs.
562/23	Dr Gibson noted that whilst the video offered the focus on the patient the staff still demonstrated empathy and understanding of the individual patients themselves.
563/23	The Head of Patient Experience noted that, what was important about the level of patient centred care was that this was not new to the scheduling team in the heart centre. There were many services in the Trust which embed personalised care and this example truly demonstrated going above and beyond.
564/23	The team know that it is likely that patients will return to them and in patient experience training it is known, from research in the United States, that it can take 12 good experiences to wipe out 1 wrong one. This was a great example of getting it right first time in terms of patient experience.
565/23	The Director of Nursing thanked the Head of Patient Experience for what was both a staff and patient story noting that, despite the pressured environment being worked in, the team continued to proactively deliver patient centred care and prioritised this part of the patient journey.

566/23	It should be recognised that it was an incredibly important lesson to share across the organisation as this was not the only part of the organisation which provided such an intense and invasive type of care which was anxiety provoking.
567/23	There was a need to consider how this could be adopted and spread across the Trust to work to tailor care.
568/23	The Director of Nursing was proud of the teams and the work being undertaken to keep, not just those in the video but all patients supported to receive the level of care and input to ensure good patient experience.
569/23	As indicated in the MS Teams Chat by Mr Herbert this was a perfect example of outstanding care personally delivered.
570/23	The Chair endorsed all of the comments made and reflected that, from the video, it was clear that the teams were also enjoying what they were doing and having fun whilst working in the constrained clinical setting. It was great to see the level of enthusiasm and commitment demonstrated. 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
571/23	**Item 8.1 Assurance and Risk Report Quality Governance Committee** Dr Gibson, on behalf of the Chair of the Quality Governance Committee, provided the assurances received by the Committee at the 18 April 2023 meeting.
572/23	Dr Gibson noted that a number of groups were unable to meet fully due to industrial action however assurance could be offered to the Board.
573/23	The report from the Patient Safety Group had looked at incident analyses, internal incidents and those alerted through the national Central Alert System (CAS) with actions agreed to improve the response to CAS alerts by the Trust.
574/23	Dr Gibson made specific reference to the excellent national cardiac alert data for which the Trust was a top performer in the country.
575/23	The Committee received the regular report on serious incidents and noted the first never event which had occurred in the current financial year. This had been reported and would be investigated.
576/23	The Committee had noted improvement in reporting in respect of duty of candour with Dr Gibson noting the important of being honest, open and prompt.
577/23	Whilst an update was not received from the Infection Prevention and Control (IPC) Group the Committee received the outcome letter following the NHS England IPC

	visit. The letter was appended to the report and it was noted that this was not as positive as the verbal feedback offered during the visit.
578/23	Trust staff had responded in the way expected to the comments made and actions to address waste management, healthcare associated infections (HCAI) and sharps management were in place and would be monitored.
579/23	Dr Gibson noted the report from the Medicines Quality Group with the Committee monitoring a number of key issues with slow progress being made on some of the issues.
580/23	The successful rollout of the Electronic Prescribing and Medicines Administration (ePMA) across the medicine division was noted and was now progressing to the surgery division. The impact of ePMA on patient safety would be significant.
581/23	7-day working continued to be difficult in pharmacy however there had been some success through recent international recruitment.
582/23	Dr Gibson noted that the Committee had received the regular upward report from the Children and Young People Oversight Group noting the significant progress made in the service since 2019 with many previous issues resolved. The Committee had been pleased to note the appointment of the Lead Nurse to the paediatric epilepsy service.
583/23	A suite of papers had been received from the Maternity and Neonatal Oversight Group which were appended to the report.
584/23	Dr Gibson noted that the group was looking at post-partum haemorrhage and 3rd and 4th degree tears which had flagged in the recent reports as possibly requiring attention.
585/23	It was also noted that the Trust had successfully submitted full compliance for the Clinical Negligence Scheme for Trusts (CNST) maternity with formal feedback awaited. There was confidence that the Trust had achieved the necessary standard.
586/23	Dr Gibson advised that the national 3-year plan, supplementing the Ockenden and Kirk-Up reports, had been considered by the group and had not integrated in the way hoped. The plan included additional targets to meet with the team working on alignment with the Trust plan.
587/23	There had been some IT connectivity issues for community midwives with a trial now in place to ensure access to required information and as detailed in the report from the Non-Executive Director Maternity and Neonatal Safety Champion, some concern had been raised about the capital plans at the Lincoln and Boston sites.
588/23	The Committee received the report form the Patient Experience Group noting the innovation of the patient panel which was going from strength to strength. The panel had assisted in the co-design of the patient visiting policy.

589/23	A patient story had been received which involved the transfer of a patient between site and the Committee reflected on the positive outcome of the multidisciplinary team working together on one incident that had led to improvement in care.
590/23	The Clinical Effectiveness Group upward report demonstrated a continued improvement in the Summary Hospital Mortality Indicator (SHMI) which was the preferred measure of mortality with the Trust being in a good position in relation to this.
591/23	The Committee also noted the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) into perioperative deaths with a number of outstanding actions received by clinical groups. These had now decreased over quarter 4 however a number required addressing.
592/23	The draft Quality Account was received with comments offered by the Committee, the final report would be offered to the Committee in May and onward to Board.
593/23	The Committee noted that all actions in response to the industrial action had been completed.
594/23	The Chair noted the comprehensive report and disappointment of the first never event being reported however reflected on a number of positives within the report.
595/23	An update was requested from the Deputy Medical Director in respect of the NHS England IPC letter.
596/23	The Deputy Medica Director noted that there were both positives and negatives within the report with the final rating being given as enhanced monitoring and support as a result of the visit.
597/23	The main points related to ongoing regulatory breaches on waste management, locations and safety of bins and sharps container management. Some frustration had been expressed due to issues of the bins having been raised at a previous visit with urgent action now being taken.
598/23	Infection trajectories on specific pathogens were also a concern due to the Trust being an outlier in the trajectories. One area was Clostridioides difficile with a reported 70 cases against a trajectory of 54. Root cause analyses had been undertaken for each with no cross contamination between patients.
599/23	The Trust had also report 15 cases, against a trajectory of 13 for pseudomonas aeruginosa bacteraemia however it was noted that other pathogens were in range.
600/23	The letter highlighted a number of improvements including IPC governance, ward cleanliness and hand hygiene along with the appointment of a Contamination Matron.
601/23	The Deputy Medical Director noted that it was understood that NHS England would likely revisit in 6-months to monitor progress on the areas identified. There had been recognition by NHS England of the significant backlog in estates works however they had recognised that some progress had been made.

602/23	The Chair noted the helpful summary reflecting that whilst there was work to doing progress was being made and NHS England had identified good practice in a number of areas that had not previously been able to provide the requite level of evidence.
603/23	It was hoped that progress would be made against the action plan along with improvement prior to the revisit.
604/23	The Chair moved to the Director of Nursing to offer an update on the maternity papers offered to the Board.
605/23	The Director of Nursing noted appendix A of the reports with the Head of Midwifery having presented at a recent regional event, associated with the Ockenden review, showing the Trust's significant improvement journey.
606/23	This had been well received and subsequently a number of NHS maternity services had approached the Trust seeking support and information sharing.
607/23	The transferable learning from the Kirk-Up report and how this could be shared with other areas of the Trust was being considered along with the Ockenden report. Whilst this focused on maternity and neonatal services there were aspects and themes within the reports which could equally apply across the organisation.
608/23	Work had commenced on a gap analysis across the Trust which would be offered to a future Quality Governance Committee meeting.
609/23	The maternity services 3-year plan was published on 30 March, following several national plans including Ockenden and Kirk-Up with the plan bringing together key objectives services were being asked to deliver against over a 3-year time period.
610/23	The report set out 12 priority actions for Trusts and systems across 4 themes of listening to women and families with compassion, supporting the workforce, developing and sustain a culture of safety and meeting and improving standards and structures.
611/23	The Director of Nursing noted that, through the Maternity and Neonatal Oversight Group, that work to consider the 3-year plan had commenced. Early indications demonstrated that the current improvement plan supported the 4 themes with work ongoing in relation to the 12 priority objectives. It was believed that the Trust was on track to meet these.
612/23	A paper would be offered to the group in June and through to the Quality Governance Committee ahead of the Board in July with the Director of Nursing proposing that the Maternity Team attend the Board to present.
613/23	The Chair noted the great work of the team with the need to ensure the work on the themes was completed and further updates offered to the Board. The Chair would welcome the Head of Midwifery to a future Board meeting to present. **Action: Trust Secretary, 4 July 2023**

	The Trust Board: • **Received the assurance report**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
614/23	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair noted that the People and Organisational Development Committee had note met during April due to industrial action however a report was offered from the Director of People and Organisational Development.
615/23	The Director of People and Organisational Development advised that due to the conflict with the Junior Doctor strike the meeting had been stood down however the assurance report summarised highlights.
616/23	It was noted that there had been concerns around the quoracy of the Workforce Strategy and Organisational Development Group (WSODG) however assurance was offered in terms of the review of members and the reinforcement of the importance of attendance.
617/23	The meeting which took place in April was quorate however this would continue to be monitored moving forward to ensure continued attendance.
618/23	The Director of People and Organisational Development advised that the Trust had submitted the Trust Workforce Plan to NHS England noting that the overall headcount position remained static for 2023/24. Dedicated recruitment and retention plans would be in place to bolster the work being undertaken.
619/23	The Board was advised that there was now 21 Freedom to Speak Up Champions in the organisation meaning that staff continued to be supported in terms of feelings that there were able to speak up or speak with a champion to seek support and sign posting.
620/23	The Director of People and Organisational Development noted that full papers due at the April meeting would be considered in May.
621/23	The Chair noted that it had been important to receive the report and understand the position and advised that the Non-Executive Director Chair of the Committee had escalated the issue of non-quoracy of WSODG.
622/23	It was helpful that this had been rectified and thanks were offered to the Director of People and Organisational Development for the personal leadership in moving the position and ensuring the meeting took place in the right way. This was a fundamental group to the assurance work of the Committee.
623/23	The Director of Nursing, in support of the Director of People and Organisational Development noted that, as the Director of Nursing, monthly safer staffing reports

	continued to be seen and whilst this had not reached the Committee oversight and scrutiny had been offered on this occasion. The Trust Board: • **Noted the position reported**
624/23 625/23 626/23 627/23 628/23 629/23 630/23	**Item 9.2 Staff Survey Update** The Chair noted that the report offered a position statement following formal receipt of the staff survey results. The Director of People and Organisational Development advised that the report offered an update on the preparation of the 2023 staff survey whilst also celebrating that the Trust was the second most improved in the country. There was a need to galvanise the position and continue the work with the plan presented in line with the structure of the People and Organisational Development Directorate. There was now a fully resourced Organisational Development team in please and a new Head of Organisational Development who, as part of their objectives, would lead the work, in conjunction with the Divisions and Organisational Development Leads. The Director of People and Organisational Development advised that key themes had been identified from the 2022 survey with 10 strategic actions outlined in the paper. Alongside the strategic actions a 'you said we did' campaign was being run to highlight the great work the Trust was undertaking in terms of culture. The next steps would be to finalise the plans by the end of May to be shared with the Executive Directors and Trust Leadership Team. Progress against the actions would be monitored through WSODG and upwardly reported to the People and Organisational Development Committee. It was recognised that, whilst this would continue to galvanise the work already done there were still some areas that needed to be addressed. The Chair noted the achievements made noting the reliance on the Divisions to work with the People and Organisational Development Directorate staff in order to deliver the improvements being sought. The Trust Board: • **Received the report noting the moderate assurance**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
631/23	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini provided the assurances received by the Committee at the 20 April 2023 meeting.

632/23	Ms Cecchini advised the Board that some assurance had been received around estates with a verbal update offered regarding mortuary services, a Quality Governance Committee referral.
633/23	It was noted that the required improvements had been made but it was also noted that a business case was being progressed through the Capital, Revenue and Investment Group in respect of mortuary services.
634/23	The finance report was received with the Chief Executive report offering the final position. The Committee had been pleased to note that the Trust had fully utilised the capital allocation of £47.7m which had been a significant investment into the Trust estate, equipment and IT.
635/23	The Committee noted the delivery of £18m efficiency however due to a large proportion being non-recurrent this was impacting on the new financial year.
636/23	Ms Cecchini advised the Board that the contract position remained ongoing for 2023/24.
637/23	The Committee had received an update on the financial plan which was believed to be in line with what would be accepted by NHS England, given the update offered by the Chief Executive.
638/23	There was £32m of cost improvement plans (CIP) within this, largely predicated on some significant productivity improvements which would be overseen by the Committee.
639/23	The Committee also noted the capital resource for the year and the significant backlog maintenance to be addressed which was potentially not all affordable in year.
640/23	Ms Cecchini noted that the Committee was looking to received greater oversight of strategic procurement having received a report on this. It was hoped that there would be a clearer view of the pipeline and for significant contracts the Committee wanted to receive clarity on when these would be due for renewal.
641/23	The Digital Hospital Group meeting had been cancelled due to industrial action so a report was not received, and the Committee noted an update in respect of a further Quality Governance Committee referral in relation to clinical records.
642/23	The Committee held significant discussion regarding operational performance and escalation beds which remained open. It was understood that there was system work ongoing around right sixing of the bed base for Lincolnshire as a whole with the Committee looking forward to seeing the outcome of this.
643/23	In planned care the Committee noted achievement of 0.79% of cancelled operations noting that the ward accreditation achieved and presented to the Board at the start of the meeting was part of the improvement.

644/23	Ms Cecchini noted that, unfortunately, the 78-week zero target had not been achieved, largely as a result of the Junior Doctor strike and patient choice was also an issue in this.
645/23	The Committee noted improvement in cancer services, particularly the 104-day backlog and on the basis of the report and monitoring of the position, the red rating in the Board Assurance Framework was moved to amber. This was to recognise the additional assurances being received in respect of the improvements.
646/23	Discussions were also held by the Committee around governance arrangements following the work which had commenced last year. This work had commenced to ensure clarity and lines of reporting from the reporting groups to the Committee and onward to the Board.
647/23	A planning update had been received which required further discussion however it was noted that the Trust had been able to reduce agency spend broadly in line with plan. There had been some positive outcomes of the 2022/23 Integrated Improvement Plan.
648/23	The Chair noted the detailed report which had covered all aspects of the Committee's terms of reference with some encouraging signs of improvement in a number of areas.
649/23	The Board would need to come back to the 2023/24 plan once feedback had been received from NHS England.
650/23	The Deputy Director of Finance noted that the plan continued to move with a submission due on the 4 May however good progress was being made and the Board would be updated at the following meeting once there was an outcome.
651/23	The Chair noted the strategic procurement report and the recent comments of the Board recognising the positive action to be clearer about the oversight.
652/23	The amazing achievement of the capital programme was noted along with the investment into the organisation which could not be underestimated due to the impact on both patients and staff and how the Trust buildings were benefiting from this.
653/23	There was great work seen in the improvements for cancer access and it was helpful to see this reflected in the movement of the Board Assurance Framework.
654/23	The Board received and noted the content of the Committee annual report. The Trust Board: • **Received the assurance report and annual report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
655/23	No items

656/23	**Item 12 Integrated Performance Report** The Chair noted that the Integrated Performance Report had been considered in the course of the Committees inviting Executive Directors to raise any other areas required.
657/23	It was noted that there was nothing further to add with the Chair expressing appreciation for the work undertaken in the Committees. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
658/23	**Item 13.1 Audit Committee Upward Report** The Chair of the Audit and Risk Committee, Mr Herbert presented the report to the Board from the meeting held on 19 April 2023.
659/23	The Committee reviewed the progress on audit and the annual accounts and received a report from the external auditors with the Committee noting that the scope of work was unchanged with work on track for the year end audit,
660/23	The Committee considered and approved the Trust accounting policies with Mr Herbert noting that these remained largely unchanged year on year with the exception of the new IFRS16 leasing standard which was in hand.
661/23	Mr Herbert advised that the Committee had supported the assumption that the accounts would be completed on an ongoing concern basis.
662/23	The Committee had been pleased to note the progress on the Internal Audit plan with 4 of the reaming 6 reports presented to the Committee with the final 2 reports with management for comment.
663/23	The significant progress to clear overdue internal audit actions was noted however there remained 1 report where an update had been requested by the Committee from management due to stalled progress on actions on a prior year audit.
664/23	The draft Head of Internal Audit Opinion have been received with the Committee welcoming the notable improvement in the control environment that had been identified. There had been a positive response to the proactive approach of management in directing Internal Audit to the areas of highest risk and concern.
665/23	The Committee welcomed the new Internal Auditors with an update offered form them on the process for producing and agreeing the internal audit plan.
666/23	The Counter Fraud progress report had been received along with the 2023/24 annual plan. The Committee was pleased to see the continued progress on fraud metrics noting that the overall position would move from amber to green in the end of year report which was a notable achievement.

667/23	The payroll payment and recovery report had been received with the Committee requesting an update to the next meeting on the implementation of the agreed actions form this.
668/23	The Committee was pleased to note the continued progress in respect of risk management, evidenced by the risk management internal audit which had offered significant assurance with some improvement required. It was noted that all actions from this had been cleared.
669/23	The Committee considered and confirmed the assurance rating of objective 2c – Well led services as amber on the Board Assurance Framework.
670/23	Mr Herbert advised the Board that the Committee had undertaken the annual self-assessment effectiveness review and as Chair of the Committee one to one meetings had been held with all Committee members. A follow up session would be held to discuss future areas of development for the Committee.
671/23	The Chair noted that the report provided assurance on key areas within the terms of reference of the Audit Committee and was pleased to note the comments of the auditors in respect of the notable improvements in the control environment.
672/23	The annual self-assessment review was noted with the Board pleased to hear how this would be taken forward. The Trust Board: • **Received the assurance report**
673/23	**Item 13.2 Risk Management Report** The Director of Nursing presented the risk report to the Board noting that, since the previous report, there had been 5 very high risks discussed at the March Risk Register Confirm and Challenge meeting.
674/23	These risks had been added to the report and were regarding medication reconciliation compliance, consultant capacity for haematology outpatient appointments, outpatient appointment process in haematology, non-recurrent funding in cancer services and intensive care unit capacity for elective surgery.
675/23	There were 11 remaining quality and safety risks rated very high, 3 very high risks reported to the People and Organisational Development Committee, which did not meet in April with the risks remaining the same as the previous month.
676/23	5 very high risks were reported to the Finance, Performance and Estates Committee and again remained the same as the previous month.
677/23	There were a number of risks awaiting review at the next meeting where Executives would review these with the divisions and corporate areas.
678/23	The Director of Nursing noted that the report offered the detail of each of the very high risks and associated mitigations and risk reduction plans which again

	demonstrated the live and dynamic nature of the risk register. The appendix to the report offered the detail of the risks which it was hoped would be recognised by the Board.
679/23	The Director of Nursing offered significant assurance, in part, from an audit perspective due to the level of assurance received through the risk management internal audit.
680/23	The Chair noted that the Committees saw the pertinent risks and assumed that the mitigations were considered to be relevant and appropriate. Board members were invited to accept the strategic risk report and be satisfied that the mitigating actions were relevant and appropriate. The Trust Board: • **Accepted the risks as presented noting the significant assurance**
681/23	**Item 13.3 Board Assurance Framework** The Chair noted that the Board Assurance Framework (BAF) presented was the 2022/23 version recognising that this was the last time the report would be received.
682/23	The Trust Secretary confirmed the report offered was the close down report for the 2022/23 year with the BAF having been considered through each of the Committees in month, with the exception of the People and Organisational Development Committee. This had however been subject to executive review and with senior teams.
683/23	As noted in the Finance, Performance and Estates Committee upward report, objective 3d Improving cancer services had moved from red to amber with the Trust Secretary seeking the support of the Board in the movement of the objective.
684/23	The 2023/24 BAF was being drafted and would be presented through the Committees in May alongside executive review prior to being received at the Board in June.
685/23	The Chair stated that this presented as a dynamic governance document and supported the review and achievement of the strategic objectives. The movement of objective 3d was noted, as described in the upward report from the Committee.
686/23	There had been a number of movements of the strategic objective assurance ratings from places where some had not been receiving much assurance to full or partial assurance.
687/23	The Chair was pleased with the progress made in what had again been another challenging year. The BAF represented some of the fantastic work that had taken place across the Trust and provided assurance on delivery.
688/23	Thanks were offered to all involved in the updating of the BAF. The Trust Board:

	• **Received the report noting the moderate assurance** • **Approved the rating of Objective 3d from red to amber**
689/23	**Item 14 Any Other Notified Items of Urgent Business** No items
690/23	The next scheduled meeting will be held on Tuesday 6 June 2023 via MS Teams live stream

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

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
7 March 2023	340/23	Assurance and Risk Report from the Finance, Performance and Estates Committee	Update on medicines management to be offered to the Board in 3 months' time in order to ensure sight was not lost to due this having been an issue for some time	Medical Director	07/06/2023	Agenda item. Complete
2 May 2023	613/23	Assurance and Risk Report from the Quality Governance Committee	Head of Midwifery to be invited to attend the July Board meeting to present the outcome of the review of the maternity 3-year plan	Trust Secretary	04/07/2023	

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*6 June 2023*
Item Number	*Item 6*

Chief Executive's Report

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

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

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

Recommendations/ Decision Required	• *To note*

OUTSTANDING CARE personally DELIVERED

Executive Summary

System Overview

a) All parts of the system continue to be under operational pressure due to service demand. Services coped well over the long weekend of the Coronation celebration and the later May Bank Holiday weekend. Preparations are now being made for the next round of strike action by Junior Doctors, which is due to take place between 07:00 on Wednesday 14th June and 07:00 on Saturday 17th June.

b) The Government has reached agreement with Trades Unions, via the National NHS Staff Council, on the Agenda for Change pay award for 2022/23 and 2023/24. Some Trades Unions are still in dispute with the Government and are balloting their members about industrial action. Irrespective of this industrial action, the pay award will be implemented for staff, with the first payments being made in June salaries. The pay award comprises a pay uplift for 2023/24 and two non-consolidated payments on top of the 2022/23 pay award.

c) The final operational plan for the system was submitted to NHS England on 4th May 2023, in line with the national timetable. This followed a constructive meeting with NHS England on 28th April 2023, during which it was agreed that the system financial plan should consist of a planned deficit of £15.4m in 2023/24.

d) At Month 1 the system has delivered £3.69m of savings against the identified savings plan of £3.15m, a positive variance of £0.54m. The full year savings plan requirement is £55m.

e) The NHS Lincolnshire ICB is working with partner Trusts and other key stakeholders to produce the five year Joint Forward Plan. The national deadline for the plan is 30th June 2023. A number of workshops have been held to identify the priorities for the plan and there will be wider public and stakeholder engagement during June. As the Joint Forward Plan is a system document, it will be important for partner organisations to take the final draft plan through their own governance processes before it is published.

f) The Lincolnshire system has been allocated into Tier 3 in relation to Urgent and Emergency Care. The tier level determines the level of improvement support and oversight from NHS England. Tier 3 systems are those systems that require less intensive support than Tier 1 and 2 systems. Those systems in Tier 3 will benefit from a universal improvement support offer that spans the full urgent and emergency care pathway. This includes national tools and guidance, as well as best practice sharing and peer learning. Approximately two-thirds of systems nationally are in Tier 3.

g) NHS England is currently going through a management of change process regionally following the introduction of ICBs and a new national operating model. As a result of these changes, NHS Midlands is moving to two Directors of Strategic Transformation as a transitional arrangement, pending formal consultation. Julie Grant will cover the East Midlands ICBs. The Director of Intensive Support responsibilities will be taken on by Dominic Raymont the Regional Director of Service Improvement during the transition period. These changes mean that Oliver Newbould, the previous Director of Strategic Transformation (Central Midlands) and Director of Intensive Support, will end his relationship with the Lincolnshire system. We wish Oli well for the future and thank him for his support and guidance.

h) Chris Hopson, the Chief Strategy Officer for NHS England spent the day in Lincolnshire on Friday 26th May visiting services in Boston and Grantham and meeting staff. Chris will be writing a tweet thread with his reflections on his day in the county.

Trust Overview

a) At Month 1, the Trust reported a deficit of £2.1m which is in line with plan. The full-year plan is for a deficit of £20.8m. Savings of £1.691m were delivered against a plan of £1.160m, a positive variance of £0.531m. The full-year savings plan is £28.1m.

b) Phase 1 of the Pilgrim Hospital A&E redevelopment commences in June 2023. This consists of the demolition of 'H block' and the building of the first part of the new A&E, pending future service decants and moves to enable further building work to take place. All the building work is due to be completed by the end of 2025.

c) As part of the NHS@75 celebrations, a discussion took place with a group of staff about their views of the NHS. This was part of a national programme. Three themes were used for this discussion- 'How far has the NHS come in 75 years?' 'Where is it now?' and 'What would you like from it in the future?' Seven questions were used to inform these discussions. The outcome is being shared with the NHS Assembly which includes members from NHS clinical and operational leaders, frontline staff, patients, and representatives from charities and community organisations. The NHS Assembly is seeking to gain a consensus on the future development of the NHS, so it can advise the NHS England Board.

d) Professor Sir Jonathan Van-Tam visited Pilgrim Hospital on Thursday 25th May to mark the second anniversary of the Complex Covid Vaccination service at the hospital. This service has supported over 800 higher-risk patients to receive their Covid vaccinations. This cohort includes those with complex medical histories who were housebound or shielding during the pandemic and who were unable to receive their vaccinations in more traditional settings. It also included those who previously had a bad reaction to their first dose. Sir Jonathan met patients and staff and did a number of media interviews.

e) The Staff Networks in the Trust are continuing their development and held a very positive 'ELT Live special' with staff across the Trust. This involved the leaders of the Networks explaining the work of their specific Network and answering questions from staff. In addition to the five existing Networks, a new Staff Network for Carers is being established.

f) I have announced that I intend giving up full-time work at the end of March 2024 and will therefore leave my role as CEO of the Trust. I have worked in the NHS full-time since 1982, so will be leaving after a career of 42 years. In that time I have had 19 jobs in 14 organisations in eight parts of the country. I will have been a CEO of eight different organisations spread over 21 years and will have been a Board member for 34 years in total.

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Citygate
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NE1 4PA

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Our reference: INS2-15740436541
Andrew Morgan
United Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
Lincolnshire
LN2 5QY

Date: 1 June 2023

CQC Reference Number: INS2-15740436541

Dear Mr Morgan

Re: CQC inspection of (United Lincolnshire Hospitals NHS Trust)

Following your feedback meeting with Jeremy Daws, Kathryn Helley, Paul Dunning, Angela Davis, Kate Rivett, Simon Hallion, Suganthi Joachim, and yourself on Wednesday 31 May 2023. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues Jeremy Daws, Kathryn Helley, Paul Dunning, Angela Davis, Kate Rivett, Simon Hallion, Suganthi Joachim, and yourself at the feedback meeting.

This letter does not replace the draft report we will send to you, but simply confirms what we fed-back on Wednesday 31 May 2023 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report, this correspondence should be used to inform discussions with the board.

An overview of our preliminary findings

The preliminary findings that we fed back to you were:

- We are assured that the actions identified relating to the two serious incidents have been actioned and completed.
- We saw that staff were caring whilst we were on site.
- A doctor told us that they struggled to locate guidelines relating to how to calculate the amount of medication that should be administered.

- The serious incidents had pharmacy input however this had not been identified in your serious incidents.
- 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.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater at NHS England.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Greg Rielly

Deputy Director of operations – Midlands network

c.c.

Dale Bywater - NHS England representative

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	23 May 2023
Chairperson:	Rebecca Brown, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
	Assurance in respect of SO 1a Issue: Deliver high quality care which is safe, responsive and able to meet the needs of the population **Clinical Harm Oversight Group (CHOG) Upward Report – meeting cancelled** Whilst the Committee noted that the meeting had not gone ahead it was recognised that consideration would be given to the future of the meeting as the harm review monitoring process would move to the Patient Safety Group. The Committee would receive a proposal paper in June regarding the future of the group and detail of reporting moving forward. **Patient Safety Group Upward Report** The Committee received the report noting that the group had received, for the first time, clinical harm data alongside the suite of incident management information. The Committee was pleased to note the close down of the ophthalmology actions which were responded to as a result of a National Patient Safety Alert. The Committee also noted that there were no outstanding Never Event actions with the team being congratulated on the achievement. **Serious Incident Summary Report inc Duty of Candour** The Committee received the report noting the position presented and again recognised that there were no outstanding actions form Never Events. The Committee noted the continued improvements being seen in respect

	of duty of candour and noted the ongoing work to validate the data at the end of each month. The Committee considered the ongoing reporting, which would be seen due to the implementation of the Patient Safety Incident Response Framework (PSIRF) acknowledging that reporting would change but data would likely continue to be received on a monthly basis. **Update on Covid SI** The Committee received the report noting the guidance issued from the national team and the investigation that was undertaken. It was noted that the Trust had considered the national guidance in detail and conducted a thorough piece o work to close the actions appropriately. It was noted that appropriate duty of candour had been undertaken in the relevant cases. The Committee noted that the process had now been built into the business-as-usual process going forward to ensure no future backlog would arise should there be a further wave of Covid-19. The report has been offered to the Board to ensure transparency of the process. **High Profile Cases** The Committee received the report noting the content. **Safeguarding Group Upward Report** The Committee received the report noting the ongoing issues with training which required a further push in order to ensure appropriate completion by staff. This would be addressed with the Divisions through the PRMs. The Committed noted that responsibility for CPIS had now been transferred to the Medicine Division however concern continued to be noted in relation to the completion of this by the group. **Medicines Division Upward – Child Protection Information Sharing (CPIS)** The Committee welcomed members of the Medicine Divisions Quadrumvirate to present an update on the progress being made in respect of CPIS. It was noted that weekly audits had commenced at Lincoln which demonstrated improvement as a result however the intention was to put these in place across Pilgrim and Grantham to see consistent improvement across sites. The Committee was pleased to note the 4-stage escalation process in place where the audits identified a lack of engagement by clinicians however requested additional measure at stage 1 with a letter being sent from the division and escalating to the Medical Director by stage 4 with HR support in place.

	Further development of the process would include the validation of the audits and the sharing of the audit results with the Director of Nursing and Chief Operating Officer to ensure oversight. At this stage the committee has received limited assurance that the issue has been addressed. The Committee has requested that the Quadrumvirate representatives attend the Committee in 3 months' time to demonstrate sustained progress. **Infection Prevention and Control (IPC) Group Upward Report** The Committed received the report noting the outturn position of 66 c-difficile cases which was above trajectory. This was however noted to be in keeping with national prevalence. The Committee noted the ongoing actions being taken as a result of the NHSE IPC Visit outcome letter with a degree of assurance that the actions would result in a positive outcome. There was ongoing close engagement with the estates and facilities team to support ventilation, water supply, cleanliness and waste management. The Committee noted how the departments interlinked with progress being made as a result of the Nurse Lead in estates and facilities. **PSIRF General Update including Phase 3 Close Down Report** The Committee received the report noting the phase 3 close down report which is offered to the Board for information. The Committee noted that PSIRF was the biggest change in patient safety for a number of years with fundamental changes as to how patient safety incidents were reviewed going forward. There was clear national guidance in place on investigations of incidents and ensuring appropriate training was in place for staff. The Committee noted the changes to the structure being put in place to ensure the appropriateness of the team to deliver the required changes, which had been informed through consultations with the divisions. Following the close of phase 3 the Committee noted that phase 4 was well underway with an intended implementation date of 1 October 2023, which would link to the commencement of the Datix IQ system and support the process. The Committee recognised the significant change not only for the Trust but also for the NHS in incident management with the team commended for the work being delivered. **UEC Oversight Group Upward Report** The Committee noted that the first Urgent and Emergency Care Oversight

	Group had been held to offer support to the teams. The Committee noted as a result of the meeting a compare and contrast had been undertaken to determine if pre-existing meetings already undertook the work intended to be supported by the oversight group. As a result, the Committee noted that the group would be stepped down as established arrangements were considered sufficient. **Ward Accreditation (Appendix 1)** The Committee received the report noting the significant achievements that had been made across the Trust in respect of Ward Accreditations. The Committee noted that engagement of the Patient Panel in the review of evidence to support the achievement of ward accreditation and provide feedback. To provide a detailed update in respect of the achievements made the Committee has appended the report for Board members information. **Medicines Quality Group Upward Report** The Committee received the report noting the continued progress in a number of areas in respect of medicines management. The Committee noted that since the report had been compiled progress had been made on the matrons benchmarking quality measures and the development of the medicines training programme. The Committee noted the ongoing concerns in respect of pharmacy staffing which was impacting on the ability to provide a 7-day service and medicines reconciliation. It was noted however that there had been a positive outcome following international recruitment with 10 new starters due to join the Trust.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Report and Patient Experience Group Upward Report** The Committee received the quarterly report and group upward report noting the ongoing positive work in respect of patient experience and engagement with patients. The Committee noted that the group had received the Savile action plan for the first time and requested that consideration be given to this to ensure that this was appropriately updated to reflect the position of delivery of actions. **Mixed Sex Accommodation (MAS) Assurance Report** The Committee received the annual report noting that this offered an overview of how breach reporting was managed and the national guidance, which stated that local commissioning groups could determine how this was managed.

	It was noted that it was possible to agree locally that gold commander level decisions could be taken to breach single sex accommodation on a balance of risk. It was noted that the Trust had established a task and finish group to gain grip and control of the systems, processes and decisions with the Committee noting that there had been 0 breaches since July 2022 which had not met internal or national guidance. It was recognised the Trust continued to experience breaches however monthly reporting was in place and any breaches continued to be resolved as soon as possible and root causes considered for each. The Committee commended the work undertaken to address and progress work in respect of mixed sex accommodation breaches. **Complaints Quarterly Report** The Committee received the report noting the content for information.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the ongoing oversight of national audits with an outlie alert for the Early Inflammatory Arthritis audit with an action plan requested for presentation at the group in June. Actions were due to be taken in respect of the Care at End of Life Audit by the Palliative and End of Life Oversight Group, which would address part of the work plan. The Committee noted the outcome of the 22/23 CQUINS and the progress on the NICE baseline assessments. A lack of assurance was noted in respect of mortality due to the reporting group not having met for a number of months, this would be addressed with the Chair of the group. The Committee did however note assurance of the oversight of national audits and the actions being taken in respect of those with ongoing progress on NICE TAs and baseline assessments.
	Assurance in respect of other areas: **Draft Terms of Reference and Work Programme 2023/24** The Committee received the proposed draft terms of reference and work programme for 23/24 noting that further refinement was required to ensure that the appropriate information was included to enable the Committee to provide assurance to the Board. It was noted that the Integrated Improvement Plan was due to be

	approved at the Board in June which would allow full consideration of the documents to be presented back to the June Committee. **Integrated Improvement Plan** The Committee received the 2023/24 IIP noting the need for this to be formally approved by the Board. It was noted that the report offered the metrics for the year, which would require concise reporting to ensure appropriate assurances were offered. The Committee was pleased to note the detail included in the report which detailed the 22/23 achievements. **Report Group Terms of Reference** The Committee received the reporting group terms of reference noting that the purpose was to ensure these had been received in year. It was noted that some had historic dates associated and so confirmation would be sought that these had been considered in year. **Internal Audit Recommendations** The Committee received the report for information noting the position presented. **CAS and FSN Audit Report** The Committee received the internal audit report noting that this had been received by the Audit Committee with actions in place to address the areas highlighted as a result of the limited assurance. The Committee noted that the outcome of the audit was not unexpected and reflected that this had been requested to be undertaken to support progress being made. **Follow up review of Clinical Governance Recommendations Audit Report** The Committee received the internal audit report noting the positive outcome. **CQC Action Plan** The Committee received the report noting the limited change from the previous month. **Quality Account 2022/23** The Committee received a further draft of the Quality Account which would be shared with stakeholders for comment prior to final amendments being made and submitted to Trust Board for approval. **Committee Performance Dashboard** The Committee received the dashboard noting that a number of items had been considered through the reports to the Committee. It was noted that there had been an increase in harm as a result of falls with the Committee noting intensive work was being undertaken on the

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

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

Position update paper April 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 regarding the wards and departments 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 in turn shows the current position regarding the state of readiness of potential award applications from the wards and Departments across the Trust. Appendix 1* shows the overall accreditation dashboard results for all areas in the programme and reflects the continuous assessment approach being taken to achieve 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. The weekly spot-check outcomes are submitted by the area Manager / Deputy weekly. 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 to meet the criteria for each level of accreditation.

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

The previous position at the end of November 2022 was that 61 areas had achieved 24 or more green weeks in the previous 12 rolling months (December 21 – November 22). The updated position at the end of February 2023 is that 68 areas have achieved 24 or more green weeks in the previous 12 rolling months (March 22- February 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.

The position at the end of February 2023 for areas that have achieved 30 or more green weeks in the previous 12 rolling months (March 22-February 23):

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

LCH OPD	42	**ACU**	35	**GDH Theatres**	30
MEAU B	41	**Johnson**	35		
Ingham	41	**Neustadt Welton**	35		

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 to meet the criteria for each level of accreditation.

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

The previous position at the end of November 2022 was that 36 areas had achieved 5 or more green months in the previous 12 rolling months (December 21 – November 22). The updated position at the end of February 2023 is that 44 areas have achieved 5 or more green months in the previous 12 rolling months (March 22 – February 23)

The position as at end of February 2023 for areas that have achieved 5 or more green months in the previous 12 rolling months (March 22 – February 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	**AMSS**	9	**Waddington**	6
Ward 1	12	**PHB ICCU**	9	**Cardiac Short Stay**	6
GDH Theatres	12	**LCH Neonatal Unit**	8	**LCH SDEC**	6
CHL Theatres	12	**Greetwell**	7	**Saxon Suite**	6
Cardiac Catheter Suite		**Ashby**	7	**Branston**	5
LCH Theatres	11	**PHB Dayward**	7	**MEAU B**	5
PHB Theatres	10	**GDH Hospice**	7	**LCH Stroke**	5
Johnson	10	**PHB SDEC**	7	**SAL**	5

GDH Surgical Unit	10	**5A**	7	**Neustadt-Welton**	5
Shuttleworth	10	**LCH ICCU**	7	**5B**	5
CMDU	10	**Bostonian**	6	**LCH UIS**	5
PHB Labour Ward	9	**GDH EAU**	6	**Vulcan Suite**	5
PHB ANC	9	**Harrowby**	6	**LCH ANC**	5
PHB Maternity	9	**SEAU**	6	**LCH Clinic 6**	5
Navenby	9	**PIU**	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 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 Dashboard meetings 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 50 ward/department review visits undertaken as at the end of February.

The previous position at the end of November 2022 was 23 areas had achieved a green visit in the previous 12 rolling months (December 21 – November 22). The updated position at the end of February 23 is 25 areas have achieved a green visit in the previous 12 rolling months (March 22- February 23).

The following position as at end of February 2023 for areas that have achieved green status in the previous 12 rolling months (March 22 – February 23):

Ward	Ward
Johnson	**Burton**
Cardiac Catheter Lab	**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	

The remaining wards/departments (visit undertaken March 22–February 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.

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 will be presented at Best Practice Day in May.

The following position as at end of February 2023 for areas that have achieved harm free certificates.

(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)	6
Ruby (150 days)	13
Gold (100 days)	15
Silver (60 days)	29
Bronze (30 days)	57

Pressure Ulcers Harm Free Award	Number of Wards/Departments
Emerald (1 year)	2
Sapphire (250 days)	9
Ruby (150 days)	15
Gold (100 days)	18
Silver (60 days)	24
Bronze (30 days)	49

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 be able 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 from the DoN.

2.5 Themes for Improvement

The monthly quality dashboard meetings provide oversight and allow early identification of any themes, which require a focus to improve.

Current themes being observed are around:

- Late observations
- Indwelling Devices
- Missed medication doses
- Fluid Balance
- 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 late observations 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 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; x1 PHB.

Areas that are under enhanced monitoring are identified in blue per area on the dashboard in Appendix 1.

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 has led to a Trust wide Oversight Group being 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 as grip is established. This in turn reflects the process is successful in providing assurance or reassurance to the DoN regarding safety and quality metrics within the Dashboard.

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
Family Health x1 LCH
Medicine x2 LCH; x4 PHB.

Areas that are under divisional monitoring are identified in amber per area on the dashboard in Appendix 1.

The current position to the end of February 2023 is that ten 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. Seven 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.

Appendix 1 shows the 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.

4.0 Accreditation Award summary position

The current position (February 2023) is that there is one area which has submitted an application for a SILVER diamond award and have prepared their portfolio of evidence to present to Quality Accreditation Panels in March/April namely: GDH Surgical Unit. They have demonstrated further progress since achievement of their BRONZE award.

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

The current position (February 2023) is that there is one area which has submitted an application for a BRONZE diamond award and have prepared their portfolio of evidence to present to present to Quality Accreditation Panels in March/April namely:

LCH Theatres.

The current position (February 2023) is that there are six areas which are currently in the process of preparing their portfolio of evidence and application for a BRONZE diamond award namely:
Navenby, Johnson ward, PHB Neonatal, Cardiac Short Stay, GDH Theatres, and Ward 1.

The current position (February 2023) shows that 20 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, Bostonian, Branston, Cardiac Catheter Suite, Harrowby, SEAU, 5A, PHB ICCU, LCH ICCU, PHB Chemotherapy Suite, GDH OPA, Ingham, LCH MDU, 6A, LCH ANC, GDH Hospice, AMSS , Neustadt Welton and LCH Stroke.

Three of these areas have previously been under enhanced monitoring and two 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 has commenced 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 will be representing ULHT at a newly formed Nursing and Midwifery Excellence Regional Network which will have Ward Accreditation programmes as a focus and support shared learning.

5.0 Summary

The Quality Accreditation 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.

*Note: Appendix 1 is a large spreadsheet which captures and provides an overview of accreditation evidence and progress by Division. The plan is to seek to develop this into a digital solution.

Accreditation Progress   Medicine - GDH & LCH

🟧 = Divisional Monitoring
🟦 = Enhanced Monitoring

Weekly Spot Check [Monthly]	GDH EAU	GDH Emergency Dept.	GDH Harrowby	LCH Burton	LCH Cardiac Cath Lab	LCH Cardiac Short Stay	LCH Clayton (Lancaster Team)	LCH Dixon	LCH ED MAJORS	LCH ED Chair 4 Treatment	LCH Johnson	LCH Lancaster [FAU Team]	LCH MEAU A	LCH MEAU B	LCH Navenby [L1023] (ex Carlton)	LCH Neustadt Welton	LCH RSU	LCH Scampton	LCH Stroke Unit	LCH Witham
Apr-21	Closed	LCHS	Closed	Amber		Red	Red	Red	Red	Red	Amber	Red	Amber	Amber	Red	Amber		Red	Amber	
May-21	Closed	LCHS	Closed	Green		Amber	Red	Red	Red	Red	Green	Red	Amber	Amber	Red	Red		Red	Amber	
Jun-21	Closed	LCHS	Closed	Amber		Amber	Red	Amber	Red	Red	Green	Red	Green	Green	Amber	Amber		Amber	Amber	
Jul-21	NIL RET	NIL RET	NIL RET	Red	NIL RET	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	Amber	Red	Green	Red	Amber	Red	Red	Amber	Red	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	Green	Amber	Amber	Green	Green	Amber	Red	Red	Amber	Green	Amber	Amber	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	Green	Amber	Amber	Amber	Amber
Apr-22	Green	Red	Red	Amber	Red	Red	Amber	Red	Red	Red	Green	Amber	Amber	Amber	Red	Amber	Amber	Green	Red	Amber
May-22	Amber	Green	Red	Amber	Red	Amber	Amber	Green	Red	Red	Red	Amber	Green	Green	Red	Green	Red	Amber	Red	Red
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	Green	Red	Green	Green	Green	Red	Red	Red	Red	Green	Red	Green	Green	Red	Red	Green	Amber	Red	Green
Aug-22	Red	Green	Red	Red	Green	Green	Green	Red	Red	Red	Green	Green	Red	Red	Amber	Green	Amber	Red	Amber	Amber
Sep-22	Red	Green	Green	Red	Green	Green	Amber	Red	Red	Red	Red	Red	Red	Red	Green	Amber	Amber	Red	Red	Amber
Oct-22	Red	Green	Red	Amber	Green	Green	Green	Red	Amber	Amber	Green	Red	Green	Green	Red	Green	Green	Red	Green	Green
Nov-22	Red	Green	Red	Green	Red	Green	Green	Red	Red	Red	Green	Red	Amber	Green	Green	Green	Green	Red	Amber	Green
Dec-22	Red	Green	Green	Green	Red	Green	Green	Red	Red	Red	Green	Red	Red	Green	Green	Red	Red	Red	Red	Red
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	Red	Green	Red	Green	Green
Mar-23																				

Weekly Spot Check (Weekly)	GDH EAU	GDH Emergency Dep	GDH Harrowby	LCH Burton	LCH Cardiac Cath Lab	LCH Cardiac Short Stay	LCH Clayton (Lancaster Team)	LCH Dixon	LCH Emergency Dept MAJORS	LCH ED Chair 4 Treatment	LCH Johnson	LCH Lancaster [FAU Team]	LCH MEAU A	LCH MEAU B	LCH Navenby [L1023] (ex Carlton)	LCH Neustadt Welton	LCH RSU	LCH Scampton	LCH Stroke Unit	LCH Witham
Apr-21	CLOSED	LCHS	CLOSED	A A A A		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	A A A A	A A A A	R R R R	A A A A		R R R R	A A A A	
May-21	CLOSED	LCHS	CLOSED	G G G G G		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	G G G G G	R R R R R	A A A A A	A A A A A	R R R R R	R R R R R		R R R R R	A A A A A	
Jun-21	CLOSED	LCHS	CLOSED	A A A A		G A A G	R R R R	A A A A	R R R R	R R R R	G G G G	R R R R	G G G G	G G G G	A A A A	G A A A		A A A A	A A A A	
Jul-21	R R A A	A A A A		R R R R		G G R R	A A A A	R R R R	A A A A	A A A A	G G G G	R R R R	A A A A	A A A A	A A A A	A A A A		R R R R	A A A A	
Aug-21	A R R A G	R R R R R	R R R R R	R R R R A	R R R R R	G G G G G	G G G G G	R R R A R	R R R R R	R R R R R	G G G A R	A R R R R	R G R R R	R G R R R	R R R R R	R G R G 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	A A A A	R R R R	G G G G	G A G A	R G A A	R R R R	R R R R	R A G G	R R R R	R G G R	R G G R	R G G G	G R G G	R	R R R R	R R R A	R
Oct-21	G R R A	R R R G	R R R A	A G R A	G R R R	G G G G	A A G R	G A A R	R R R R	R R R R	G G A G	G G R G	G R G R	G R G R	G G G R	G R R G	G G A A	R R A A	R G A R	G G A A
Nov-21	R G R R R	R R G G R	R R R A R	R R G R A	R R G G G	G G G G G	G G G G G	A G R R G	R R R R R	R R R R R	A G G G G	R A G G A	G G G G G	G G G G G	A G A G G	G R G G R	A G G R G	R G G R R	A R G A A	A G G R G
Dec-21	R A R R	R G R R	R G G G	G G G R	G G G R	G G G G	R G G G G	G G R A	R R A R	R R A R	G A G G	R G A G	G R G G	G R G G	R G R G	G G R G	G A A A	A G R R	A R G G	G A A A
Jan-22	R G G G A	G G G G G	G G R R G	A A G A G	R G G R G	G G G R G	G G G R G	R A A G G	A R R R R	A R R R R	G A G G A	G G G A G	R R G G G	R R G G G	G R R G G	G G G G G	G G G A R	R A A A G	G G G A A	G G G A R
Feb-22	A G G G	R A G G	G R G R	G R A G	G G G R	G G G G	G R G G	R G R R	A R R R	A R R R	A A G A	G G A R	G A G G	G A G G	G G G G	G G G G	A A G A	R A R G	A A A R	A A G A
Mar-22	G R R R	R G G G	G G R R	G R A G	G G R R	R R G G	G G G R	R R R R	R R R A	R R R A	G R G A	G G G R	G G G G	G G G G	G G R G	G G R G	G G A R	G G A R	A A R A	G G A R
Apr-22	G G G G	R R G R	R R R R	A A G G	R R R G	R R G R	R G G R	R A R A	A R R A	A R R A	G A G G	G G R A	G R G A	G R G A	R R G R	G R G R	R R G A	G G G G	G R R R	R R G A
May-22	R A G R G	G G G G R	R G G R R	G G G A A	R R R R R	G R G R G	G G R G R	G G G R G	A R G A R	A R G A R	A R R R R	A A A G R	G G G G A	G G G G A	R G G R R	G G G G G	R G A R A	G A A A A	A R G R R	R G A R A
Jun-22	R G R R	G G A G	G G G G	G A G A	R G G R	G G R R	R R G R	R R R A	R A R R	R A R R	G R R G	G R A R	G G G A	G G G A	G G R G	R R R R	A A G R	G G A R	G R A A	A A G R
Jul-22	G R R G	G G G G	R G R R	G G A G	G G G G	G G G G	R G R G	A A R R	R R A A	R R A A	G G A G	R G R G	G R G G	G R G G	R R G R	R R G G	G G A G	A A A G	R A R G	G G A G
Aug-22	G G R R A	G G G G G	R R R R R	G G R A A	G G G G R	G G G A G	G A G G G	A A A R A	A A A R A	A A A R A	G G G G R	G G G A G	A A R G G	A A R G G	A G G G A	G G G G G	G A G G A	R A G R A	G A A G R	G A G G A
Sep-22	A G A R	G G G G	G R G G	A A G R	G G G G	G G A G	R G A A	A A R R	R R A R	R R A R	R R R A	A A A G	G A A G	G A A G	R G G G	G G R G	G R G G	G R G R	R A A R	G R G G
Oct-22	A G R R R	G G G G G	R G G R R	G G G A R	G R G G G	G G R G G	A G G G G	R R A R R	A G A A A	A G A A A	G G G G G	R R R R A	G G G G G	G G G G G	R R R R G	G G R G G	R G G G G	G A R A R	G G A G G	R G G G G
Nov-22	A R G R	G G G G	R G R G	G G G A	G R G R	G G G G	G G G G	G R A G	R A A A	R A A A	G G G G	R G G R	A G A G	G G G G	G G R G	G G G R	G G G G	R G R G	A G A G	G G G G
Dec-22	A R R R	G G G G	G R G G	A G G G	G R R R	G G R G	G G A G	G R A R	R R R R	R R R R	G G G G	G A R G	G A G R	G G G G	G R G G	R R R G	R G A G	R G R G	A R A G	R G A G
Jan-23	A R R R R	R G G G G	R G R G R	R A G G A	R R G R G	R G G G G	G G A G G	R R A R R	R G R A A	R G R A A	G G G G G	G G R R G	G G G G A	G G G G G	R R R A R	G G G G G	G A G G G	G G A G R	A G G G G	G A G G G
Feb-23	R G A R	R G G G	R G R R	G G G G	G R R G	R A G R	R G G G	R R G R	R A A R	R A A R	G G A G	G R R G	G A G G	G A G G	R R G R	G G R R	G A G G	R G G R	G G G A	G A G G
Mar-23																				
Count of GREENS	25	55	30	44	41	69	58	17	3	3	67	36	59	64	42	58	41	28	27	41

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

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

Harm Free Certificate	GDH EAU	GDH Emergency Dept.	GDH Harrowby	LCH Burton	LCH Cardiac Cath Lab	LCH Cardiac Short Stay	LCH Clayton (Lancaster Team)	LCH Dixon	LCH ED MAJORS	LCH ED Chair 4 Treatment	LCH Johnson	LCH Lancaster [FAU Team]	LCH MEAU A	LCH MEAU B	LCH Navenby [L1023] (ex Carlton)	LCH Neustadt Welton	LCH RSU	LCH Scampton	LCH Stroke Unit	LCH Witham
Apr-21						B - Skin B - Falls	G - Skin	B - Skin	IPC	IPC	S - Skin B - Falls	B - Skin	B - Falls	B - Falls		IPC	B - Skin	B - Skin		B - Skin
May-21						S - Skin S - Falls	G - Falls				S - Falls	B - Skin						S - Skin		
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	S - 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 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	R- 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								
Jul-22	B - Falls	B - Falls	B - Falls	B - Falls			B - Skin	B - Falls										B - Skin		
Aug-22	B - Skin	S - Falls	B - Skin			B - Falls B - Skin		B - Skin			B - Falls B - Skin				B - Falls			B - Falls		
Sep-22			B - Falls					S - Skin	S - Skin				B - Falls					B - Skin	B - Skin	
Oct-22			S - Falls		B - Falls B - Skin				B - Skin									S - 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																				
Mar-23																				

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

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

Accreditation Progress Medicine - PHB

🟧 Divisional Monitoring
🟦 Enhanced Monitoring

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

Weekly Spot Check (Weekly)	PHB ACU					PHB AMSS					PHB ED MAJORS					PHB ED CHAIR 4 TREATMENT				
Apr-21	R	R	R	R		R	R	R	R		R	R	R	R		R	R	R	R	
May-21	R	A	A	R	G	A	G	G	G	G	R	R	R	R	R	R	R	R	R	R
Jun-21	R	G	R	R		G	G	G	G		R	R	R	R		R	R	R	R	
Jul-21	G	R	G	G		G	G	G	G		R	R	R	R		R	R	R	R	
Aug-21	R	R	R	R	G	R	G	G	G	G	R	R	R	R	R	R	R	R	R	R
Sep-21	R	R	R	A		G	G	G	G		R	R	R	R		R	R	R	R	
Oct-21	G	G	R	G		G	G	R	G		R	R	R	R		R	R	R	R	
Nov-21	R	R	R	R	A	G	G	R	G	G	R	R	R	R	A	R	R	R	R	A
Dec-21	R	R	R	A		G	G	R	G		A	A	R	R		A	A	R	R	
Jan-22	R	R	G	R	A	G	G	A	G	G	R	R	A	A	A	R	R	A	A	A
Feb-22	G	R	G	A		R	G	G	G		R	R	R	R		R	R	R	R	
Mar-22	G	A	G	A		G	A	R	R		R	A	R	A		R	A	R	A	
Apr-22	R	G	G	G		G	R	G	A		A	R	R	R		A	R	R	R	
May-22	G	A	G	G	A	A	R	A	G	A	R	R	R	R	R	R	R	R	R	R
Jun-22	G	A	A	R		G	A	G	G		R	A	A	G		R	A	A	G	
Jul-22	A	G	R	R		G	G	G	G		G	R	G	A		G	R	G	A	
Aug-22	G	G	R	R	G	G	G	G	G	G	R	R	R	G	G	R	R	R	G	G
Sep-22	G	G	G	A		G	G	G	G		R	A	G	R		R	A	G	R	
Oct-22	G	G	G	G	G	G	G	G	A	G	A	A	R	A	R	A	A	R	A	R
Nov-22	G	G	G	G		A	G	R	G		A	A	R	R		A	A	R	R	
Dec-22	G	R	G	G		G	G	G	G		G	A	R	A		G	A	R	A	
Jan-23	G	G	A	G	G	G	G	G	G	G	R	A	G	R	A	R	A	G	R	A
Feb-23	R	G	G	G		G	G	A	G		A	A	R	A		A	A	R	A	
Mar-23																				

Weekly Spot Check (Weekly)	PHB IAC					PHB Stroke Unit					PHB Ward 1					PHB 6A				
Apr-21	R	R	R	R		A	A	A	A		A	A	A	A		R	R	R	R	
May-21	R	R	R	R	R	A	A	A	A	A	R	A	A	R	G	R	R	R	R	R
Jun-21	R	R	R	R		R	R	R	R		R	G	R	R		A	A	A	A	
Jul-21	R	R	R	R		R	R	R	R		G	R	G	G		A	A	A	A	
Aug-21	R	R	R	R	R	R	R	R	R	R	G	G	G	G	R	R	R	R	R	R
Sep-21	G	G	R	R		R	R	R	A		A	R	R	A		R	R	G	G	
Oct-21	A	R	R	G		R	R	R	R		R	A	R	G		G	G	G	R	
Nov-21	G	R	G	G	R	R	R	R	A	R	G	R	R	R	R	G	G	R	G	R
Dec-21	R	R	R	R		R	A	R	R		G	G	R	G		G	R	G	G	
Jan-22	R	A	A	R	R	R	A	G	A	A	R	A	G	G	R	G	G	G	G	G
Feb-22	G	R	R	R		A	G	R	A		G	R	G	G		G	G	G	R	
Mar-22	G	G	A	G		A	R	R	A		G	R	R	G		G	G	G	G	
Apr-22	G	R	G	R		R	R	R	R		R	R	R	R		G	G	G	G	
May-22	G	A	A	G	G	A	A	A	R	A	R	R	R	R	G	G	G	G	G	G
Jun-22	A	G	G	G		G	R	A	A		G	G	R	R		G	G	G	G	
Jul-22	R	R	R	R		R	R	R	R		R	A	A	A		G	G	G	G	
Aug-22	A	R	A	A	R	A	G	R	R	G	A	G	G	G	A	G	G	G	G	G
Sep-22	G	R	A	R		R	A	G	A		G	G	A	G		G	G	G	G	
Oct-22	R	A	R	A	A	A	G	A	A	R	G	A	G	A	G	G	G	G	G	G
Nov-22	R	A	A	G		G	R	R	R		G	G	A	A		G	G	G	G	
Dec-22	R	R	A	R		A	A	A	A		A	G	G	G		G	G	G	G	
Jan-23	R	A	A	G	G	A	R	A	R	G	G	A	A	G	G	G	G	G	G	G
Feb-23	A	A	A	G		A	R	G	A		A	A	A	A		G	G	G	G	
Mar-23																				

Weekly Spot Check (Weekly)	PHB 6B					PHB 7A					PHB 7B					PHB 8A				
Apr-21	R	R	R	R							A	A	A	A		R	R	R	R	
May-21	R	R	R	R	R						A	A	A	A	A	A	A	A	A	A
Jun-21	A	A	A	A							R	R	R	R		R	R	R	R	
Jul-21	R	R	R	R							R	R	R	R		A	A	A	A	
Aug-21	R	R	R	A	A						G	R	A	R	R	R	R	R	R	R
Sep-21	G	G	G	G							A	R	R	A		R	R	R	R	
Oct-21	G	G	G	G							R	G	A	G		R	A	G	A	
Nov-21	A	G	G	R	G						G	G	R	G	G	A	R	A	A	G
Dec-21	G	G	G	A							G	G	R	G		A	A	G	R	
Jan-22	G	G	G	G	G						G	R	G	R	G	A	A	A	G	G
Feb-22	G	G	G	G							G	G	G	G		A	G	R	A	
Mar-22	G	G	G	R							G	G	G	G		A	A	G	A	
Apr-22	G	G	G	A							G	G	R	G		G	A	R	G	
May-22	G	G	A	G	G						R	G	R	G	G	G	G	G	G	A
Jun-22	G	R	G	G		R	G	G	G		G	R	R	R		A	G	G	A	
Jul-22	A	G	G	A		G	A	G	G		G	R	R	G		A	G	G	G	
Aug-22	CLOSED					G	G	G	G	G	G	R	R	G	R	G	A	A	A	G
Sep-22	G	G	A	G		G	R	R	R		G	R	G	G		G	G	R	A	
Oct-22	G	G	G	G	A	R	R	R	R	R	R	G	R	G	G	R	A	G	R	A
Nov-22	G	R	A	G		R	R	R	R		R	R	G	G		G	A	G	A	
Dec-22	R	G	G	A							R	G	A	G		G	A	A	A	
Jan-23	G	G	G	G	A	R	A	R	R		G	R	R	G	R	A	G	G	G	G
Feb-23	G	G	G	A		G	R	R	A		G	R	R	R		G	A	G	G	
Mar-23																				

0 0 0 0 0

Count of GREENS	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 7A	PHB 7B	PHB 8A
	47	75	8	8	23	10	41	71	56	13	45	33

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Matron Audit	PHB ACU	PHB AMSS	PHB ED	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7A	PHB 7B	PHB 8A
Apr-21	Red	Red	Red	Red	Red	Amber	Green	Red	Red		Amber	Red
May-21	Red	Amber	Red	Red	Red	Green	Green	Red	Red		Amber	Amber
Jun-21	Amber	Green	Amber	Amber	Amber	Amber	Green	Amber	Amber		Amber	Red
Jul-21	Amber	Amber	Red	Red	Amber	Amber	Green	Amber	Red		Amber	Green
Aug-21	Red	Amber	Amber	Amber	Amber	Amber	Green	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	Amber
May-22	Amber	Amber	Red	Red	Amber	Amber	Green	Green	Amber	Green	Green	Amber
Jun-22	Amber	Green	Red	Red	Red	Green	Green	Amber	Amber	Green	Amber	Amber
Jul-22	Green	Green	Amber	Amber	Amber	Green	Green	Green	Amber	Green	Amber	Amber
Aug-22	Green	Amber	Red	Red	Amber	Amber	Green	Amber	CLOSED	Green	Amber	Amber
Sep-22	Green	Green	Red	Red	Amber	Green	Green	Red	Red	Amber	Amber	Green
Oct-22	Green	Green	Amber	Amber	Amber	Amber	Green	Amber	Amber	None	Amber	Red
Nov-22	Red	Green	Red	Red	Amber	Amber	Green	Green	Green	Amber	Amber	Amber
Dec-22	Amber	Green	Red	Red	Green	Amber	Green	Amber	Amber	Amber	Amber	Green
Jan-23	Amber	Green	Red	Red	Green	Amber	Green	Amber	Green	Amber	Amber	Green
Feb-23	Amber	Green	Red	Red	Green	Amber	Green	Amber	Amber		Green	Green
Mar-23												

Ward/Dept. Review Visit	PHB ACU	PHB AMSS	PHB ED	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7A	PHB 7B	PHB 8A
Apr-21												
May-21											Amber	
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												
Feb-23												
Mar-23												

Harm Free Certificate	PHB ACU	PHB AMSS	PHB ED	PHB ED CHAIR 4 TREATMENT	PHB IAC	PHB Stroke Unit	PHB Ward 1	PHB 6A	PHB 6B	PHB 7A	PHB 7B	PHB 8A
Apr-21	B - Falls IPC						B - Falls	B - Skin	IPC		S - Skin	
May-21	B - Skin					B - Skin						
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		B - Skin			
Apr-22	IPC						IPC		B - Skin		B - Skin	
May-22						B - Skin			S - Skin			
Jun-22												
Jul-22	B - Skin									B - Falls	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												
Mar-23												

FLO	PHB ACU	PHB AMSS	PHB ED	PHB ED CHAIR	PHB IAC	PHB Stroke	PHB Ward 1	PHB 6A	PHB 6B	PHB 7A	PHB 7B	PHB 8A
Apr-21	A	G	A	A	G	G	A	R	G		G	G
May-21	A	G	R	R	R	G	R	G	R		G	G
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	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	A	G
Aug-22	G	G	R	R	A	G	G	G	CLOSED	G	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	N/A	G
Jan-23	G	G	A	A	A	G	A	G	G	G	A	G
Feb-23	G	G	A	A	A	G	A	G	G		R	G
Mar-23												

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

Accreditation Progress Surgery - Wards:

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB 5A	PHB 5B	PHB 9A
Apr-21											
May-21											
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	Red	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	Red
Jul-22	Green	Red	Green	Green	Green	Green	Red	Red	Amber	Green	Red
Aug-22	Green	Red	Green	Amber	Amber	Red	Red	Red	Red	Amber	Amber
Sep-22	Green	Red	Green	Green	Green	Amber	Amber	Red	Amber	Green	Green
Oct-22	Green	Red	Green	Amber	Green	Green	Red	Red	Red	Green	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	Green
Jan-23	Green	Red	Amber	Red	Green	Red	Red	Red	Amber	Green	Amber
Feb-23	Green	Red	Green	Red	Green	Green	Red	Red	Red	Green	Green
Mar-23											

Weekly Spot Check (Weekly)	GDH Surgical Unit					LCH Digby					LCH Greetwell					LCH Hatton				
Apr-21	A	A	A	A		R	R	R	R		R	R	R	R		A	A	A	A	
May-21	R	G	G	G	R	R	R	R	R	R	A	A	A	A	A	R	A	G	G	A
Jun-21	G	G	G	G		R	R	R	R		A	A	A	A		G	G	R	G	
Jul-21	G	G	G	G		R	R	R	R		R	R	R	R		G	G	G	G	
Aug-21	G	G	G	G	G	G	G	G	R	G	G	G	R	A	A	R	R	G	G	G
Sep-21	G	R	G	G		R	R	R	R		A	R	G	G		G	G	G	G	
Oct-21	G	G	G	G		R	G	G	R		G	R	R	G		R	G	G	R	
Nov-21	G	G	R	G	G	R	R	R	R	R	R	R	A	R	A	R	R	R	R	R
Dec-21	G	G	G	G		G	R	R	R		A	A	G	G		G	G	G	R	
Jan-22	G	G	G	G	G	R	A	R	R	R	G	A	G	G	G	G	G	R	G	G
Feb-22	G	G	G	G		G	R	R	A		R	G	G	G		G	G	G	G	
Mar-22	G	G	G	G		A	G	G	R		G	G	G	R		G	G	G	G	
Apr-22	G	G	G	G		R	R	R	G		A	G	G	G		G	G	G	G	
May-22	G	G	R	G	G	R	G	G	G	R	G	G	G	R	G	G	G	G	G	G
Jun-22	G	G	G	G		A	A	G	A		G	G	G	R		G	G	G	G	
Jul-22	G	G	G	G		R	G	R	R		G	G	G	R		G	G	G	G	
Aug-22	G	G	G	G	G	G	R	R	A	R	G	G	G	G	G	G	G	G	A	A
Sep-22	G	G	G	G		R	R	G	R		G	G	R	G		G	G	R	G	
Oct-22	G	G	G	G	G	R	R	R	G	R	R	G	G	G	G	A	R	G	A	A
Nov-22	G	G	G	R		G	A	G	R		G	A	G	G		G	G	A	A	
Dec-22	G	G	G	G		G	G	G	G		G	G	G	G		G	G	G	G	
Jan-23	A	R	G	G	G	A	R	G	G	G	A	R	G	G	G	A	R	G	G	G
Feb-23	G	G	G	G		G	G	G	G		G	G	G	G		G	G	G	G	
Mar-23																				

Weekly Spot Check (Weekly)	LCH SEAU					LCH Shuttleworth					LCH SAL					PHB Day Ward				
Apr-21	A	A	A	A		R	R	R	R		R	R	R	R		R	R	R	R	
May-21	A	A	A	A	A	R	R	R	R	R	R	R	R	R	R	G	G	G	G	G
Jun-21	R	R	R	R		R	R	R	R		A	A	A	A		G	G	G	G	
Jul-21	R	A	R	R		A	A	A	A		R	R	R	R		G	G	G	G	
Aug-21	R	R	R	A	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Sep-21	R	A	R	G		A	G	G	R		R	R	R	R		R	R	R	R	
Oct-21	G	R	A	R		G	R	G	R		R	R	R	R		R	R	R	R	
Nov-21	A	R	R	R	G	G	G	G	G	A	R	R	R	R	R	G	R	R	G	R
Dec-21	R	R	R	R		G	G	G	R		R	R	R	R		G	R	G	G	
Jan-22	G	R	R	R	G	A	R	G	G	G	R	R	R	R	R	R	G	G	G	R
Feb-22	G	A	R	A		G	R	A	G		R	R	R	R		G	G	G	R	
Mar-22	A	R	A	R		G	G	G	R		R	R	R	R		G	G	G	G	
Apr-22	A	A	A	G		G	R	G	G		R	R	R	R		G	R	G	G	
May-22	R	G	G	G	R	G	G	G	R	G	R	R	R	R	R	G	G	R	R	G
Jun-22	G	G	G	G		G	R	A	G		R	R	R	R		G	G	R	G	
Jul-22	G	G	G	G		R	G	G	G		R	R	R	R		R	G	G	R	
Aug-22	R	G	A	G	G	R	A	A	A	R	G	R	R	R	R	G	G	G	R	R
Sep-22	G	G	G	R		A	G	G	A		G	G	R	R		R	R	R	G	
Oct-22	G	G	G	G	G	G	G	R	G	G	R	R	R	R	R	R	R	R	R	G
Nov-22	G	G	G	R		R	R	A	G		R	R	R	R		R	R	G	G	
Dec-22	G	G	G	G		G	G	G	G		G	G	G	G		G	G	G	G	
Jan-23	A	R	G	G	G	A	R	G	G	G	A	R	G	G	G	A	R	G	G	G
Feb-23	G	G	G	G		G	G	G	G		G	G	G	G		G	G	G	G	
Mar-23																				

Weekly Spot Check (Weekly)	PHB 5A					PHB 5B					PHB 9A				
Apr-21	A	A	A	A		A	A	A	A		R	R	R	R	
May-21	R	R	R	R	R	R	G	R	G	A	R	R	R	R	R
Jun-21	R	R	R	R		G	G	G	G		R	A	R	R	
Jul-21	R	R	R	R		G	G	G	G		R	R	R	R	
Aug-21	R	R	R	R	R	R	R	R	R	G	R	A	R	A	R
Sep-21	R	R	R	R		G	G	G	G		A	A	G	R	
Oct-21	R	R	R	R		G	R	R	R		A	G	G	R	
Nov-21	R	R	R	R	R	G	G	G	G	R	G	R	A	G	R
Dec-21	R	R	R	R		R	R	G	G		A	G	R	R	
Jan-22	R	R	R	A	G	R	G	R	G	G	G	G	G	R	R
Feb-22	R	R	R	A		R	G	G	G		R	R	R	A	
Mar-22	R	A	A	A		G	G	G	G		R	R	R	R	
Apr-22	R	R	G	R		G	G	G	R		A	R	R	R	
May-22	A	G	G	A	A	G	G	G	G	G	G	R	R	R	R
Jun-22	A	G	A	A		G	G	R	A		G	R	R	R	
Jul-22	A	A	A	A		G	A	G	G		R	R	A	G	
Aug-22	A	R	R	R	R	A	A	G	G	G	G	G	G	R	A
Sep-22	A	A	R	A		G	G	G	A		G	G	R	G	
Oct-22	R	A	R	A	A	G	G	G	G	G	G	A	G	G	G
Nov-22	R	R	R	A		G	G	G	A		G	R	G	G	
Dec-22	G	G	G	G		G	G	G	G						
Jan-23	A	R	G	G	G	A	R	G	G	G					
Feb-23	G	G	G	G		G	G	G	G						
Mar-23															

Count of GREENS	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB 5A	PHB 5B	PHB 9A
Count of GREENS	88	32	57	70	43	49	14	57	16	70	25

Matron Audit	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB 5A	PHB 5B	PHB 9A
Apr-21	Green	Red	Red	Green	Amber	Red	Amber	Green	Amber	Amber	Red
May-21	Green	Red	Green	Amber	Amber	Red	Green	Green	Amber	Amber	Red
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	Green	Amber	Amber	Red	Green	Green	Amber	Amber	Red
Oct-21	Green	Red	Amber	Amber	Amber	Amber	Green	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	Green
May-22	Green	Amber	Green	Green	Green	Amber	Green	Amber	Green	Green	Amber
Jun-22	Green	Green	Green	Amber	Green	Green	Amber	Amber	Green	Green	Amber
Jul-22	Amber	Amber	Green	Green	Green	Green	Green	Green	Green	Green	Green
Aug-22	Green	Amber	Green	Red	Amber	Green	Green	Green	Green	Amber	Amber
Sep-22	Green	Red	Green	Amber	Amber	Green	Green	Green	Green	Amber	Amber
Oct-22	Green	Amber	Amber	Red	Red	Green	Amber	Amber	Amber	Amber	Green
Nov-22	Green	Amber	Amber	Red	Amber	Green	Amber	Amber	Green	Amber	Amber
Dec-22	Green	Red	Red	Red	Amber	Green	Amber	Green	Red	Amber	Amber
Jan-23	Green	Red	Amber	Red	Green	Green	Green	Amber	Amber	Amber	Green
Feb-23	Green	Amber	Green	Amber	Amber	Green	Amber	Green	Amber	Green	Amber
Mar-23											

Ward/Dept. Review Visit	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB 5A	PHB 5B	PHB 9A
Apr-21											
May-21											
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		Green		
Dec-22											
Jan-23											
Feb-23											
Mar-23											

Harm Free Certificate	GDH Surgical Unit	LCH Digby	LCH Greetwell	LCH Hatton	LCH SEAU	LCH Shuttleworth	LCH SAL	PHB Day Ward	PHB 5A	PHB 5B	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			
Jun-22			B - Skin	B - Skin	G - Skin				B - Skin		
Jul-22	B - Skin		S - Skin	B - Skin			G - Skin	B - Falls			
Aug-22	S - Falls		B - Falls		R - Skin	B - Skin	G - Falls				
Sep-22		S - 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											
Mar-23											

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

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

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						

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	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	R			R	G	R	R		G	G	G	R		G	A	G	A		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	G	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																														

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						

Count of GREENS	39	62	32	58	31	36

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						

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						
Mar-23						

FLO	CHL Theatres	GDH Theatres	LCH Theatres	PHB Theatres	LCH ICU	PHB ICU
Apr-21	R	G	G	G	R	G
May-21	R	G	R	G	R	G
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						

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						

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	R	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		R	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	G	R		G	R	G	G		G	G	G	R	
Mar-23																														

Count of GREENS	31	33	37	39	41	67

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						

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						

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			Sapphire - Skin		B - Skin	
Feb-23						
Mar-23						

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						

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						

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]
Apr-21			Red	Amber	Red	Amber	Green
May-21			Amber	Amber	Red	Red	Green
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							

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]				
Apr-21											R	R	R	R		A	A	A	A		R	R	R	R		A	A	A	A		G	G	G	G	
May-21											A	A	A	A	A	A	A	A	A	A	R	R	R	R	R	R	R	R	R	R	G	G	G	G	G
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	R	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	R	A	A	G	G	A	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																																			

Matron Audit	GDH Kingfisher [UG4737]	LCH Clinic 5 [UL4720]	LCH Rainforest [UL4735]	LCH Safari [UL4734]	PHB 4A [UP4736]	LCH NNU [UL4736]	PHB NNU [UP4735]
Apr-21	Amber		Red	Amber	Amber	Amber	Green
May-21	Red		Amber	Amber	Red	Red	Green
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							

Count of GREENS	0	0	13	16	1	54	86

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]
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							
Nov-22							
Dec-22							
Jan-23							
Feb-23							
Mar-23							

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]
Apr-21			G - Falls	G - FallsIPC	IPC	IPC	
May-21							
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			R - Skin	
Feb-23							
Mar-23							

FLO	GDH Kingfisher [UG4737]	LCH Clinic 5 [UL4720]	LCH Rainforest [UL4735]	LCH Safari [UL4734]	PHB 4A [UP4736]	LCH NNU [UL4736]	PHB NNU [UP4735]
Apr-21	R	R	A	G	R	G	G
May-21	R	R	G	G	R	G	G
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							

SEPSIS	GDH Kingfisher [UG4737]	LCH Clinic 5 [UL4720]	LCH Rainforest [UL4735]	LCH Safari [UL4734]	PHB 4A [UP4736]	LCH NNU [UL4736]	PHB NNU [UP4735]
Apr-21			A	A	A		
May-21			A	A	A		
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							

Accreditation Progress:

= Divisional Monitoring

= Enhanced Monitoring

Weekly Spot Check (Monthly)	LCH ANC	PHB ANC
Apr-21	X	X
May-21	X	X
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		

Weekly Spot Check (Weekly)	LCH ANC					PHB ANC				
Apr-21										
May-21										
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										

Matron Audit	LCH ANC	PHB ANC
Apr-21	Amber	Green
May-21	Green	Amber
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		

Count of GREENS	27	49

Ward/Dept Review Visit	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	Green	
Sep-22		
Oct-22		
Nov-22		
Dec-22		
Jan-23		
Feb-23		
Mar-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		

FLO	LCH ANC	PHB ANC
Apr-21	G	R
May-21	R	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	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		

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		

Accreditation Progress:

Weekly Spot Check [Monthly]	GDH Comm Mid	SLE CofC	LCH Comm Mid	PHB Comm Mid	Skeg Cof C	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							
Apr-23							
May-23							
Jun-23							
Jul-23							
Aug-23							
Sep-23							
Oct-23							
Nov-23							
Dec-23							
Jan-24							
Feb-24							
Mar-24							

Weekly Spot Check (Weekly)	GDH Comm Mid					LCH Comm Mid					PHB 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																																		
Apr-23																																		
May-23																																		
Jun-23																																		
Jul-23																																		
Aug-23																																		
Sep-23																																		
Oct-23																																		
Nov-23																																		
Dec-23																																		
Jan-24																																		
Feb-24																																		
Mar-24																																		

Matron Audit	GDH Comm Mid	SLE CofC	LCH Comm Mid	PHB Comm Mid	Skeg Cof C	JCH CofC	Wolds CoCo
Sep-21	Amber	Amber	Amber	Amber	Amber	Amber	Amber
Oct-21	Amber	Amber	Amber	Amber	Amber	Amber	Amber
Nov-21	Red	Red	Red	Red	Red	Red	Red
Dec-21	Red	Red	Red	Red	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							
Mar-23							
Apr-23							
May-23							
Jun-23							
Jul-23							
Aug-23							
Sep-23							
Oct-23							
Nov-23							
Dec-23							
Jan-24							
Feb-24							
Mar-24							

Count of GREENS Rolling 12 Months	0	0	0	0	0	0	0

Ward/Dept Review Visit	GDH Comm Mid	SLE CofC	LCH Comm Mid	PHB Comm Mid	Skeg Cof C	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							
Apr-23							
May-23							
Jun-23							
Jul-23							
Aug-23							
Sep-23							
Oct-23							
Nov-23							
Dec-23							
Jan-24							
Feb-24							
Mar-24							

Harm Free Certificate	GDH Comm Mid	SLE CofC	LCH Comm Mid	PHB Comm Mid	Skeg Cof C	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							
Apr-23							
May-23							
Jun-23							
Jul-23							
Aug-23							
Sep-23							
Oct-23							
Nov-23							
Dec-23							
Jan-24							
Feb-24							
Mar-24							

Accreditation Progress: CSS Wards

(amber)	=	Divisional Monitoring
(blue)	=	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							

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																														
Count of GREENS	51					34					51					42					49					45				

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							

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							

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							

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							

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							

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

Weekly Spot Check (Weekly)	CHL Endoscopy					GDH Endoscopy					GDH Radiology [X-Ray]					GDH MRI					GDH Nuclear Medicine				
Apr-21																									
May-21																									
Jun-21																									
Jul-21																									
Aug-21																									
Sep-21																									
Oct-21																									
Nov-21		🟥				R	R	G	R	A															
Dec-21		🟥				R	A	G	R																
Jan-22	R	R	R	R	G	R	R	R	R	R															
Feb-22	R	R	R	R		R	G	G	G																
Mar-22	R	G	G	R		G	G	G	G																
Apr-22	G	R	R	R		G	R	G	R																
May-22	R	R	G	R	R	G	G	G	G	G															
Jun-22	R	R	R	R		G	G	R	G																
Jul-22	R	G	R	R		G	G	G	R																
Aug-22	R	R	G	G	R	R	G	G	G	R															
Sep-22	R	G	R	R		G	G	G	R																
Oct-22	R	G	R	G	R	G	G	G	A	G											R	R	R	R	R
Nov-22	R	R	G	G		G	G	R	G												R	R	R	R	
Dec-22	G	R	G	G		R	G	G	G		R	R	R	R							R	R	R	R	
Jan-23	G	G	G	R	R	G	G	G	G	G	R	R	R	R	R						R	R	R	R	R
Feb-23	G	G	R	G		G	R	R	R		R	R	R	R							R	R	R	R	
Mar-23																									
Count of GREENS	22					44					0					0					0				

Weekly Spot Check (Weekly)	LCH Audiology					LCH Radiology CT & Xray					LCH Endoscopy					LCH MRI					LCH Nero Physics				
Apr-21																									
May-21																									
Jun-21																									
Jul-21																									
Aug-21																									
Sep-21																									
Oct-21																									
Nov-21																									
Dec-21																									
Jan-22											R	R	R	R	G										
Feb-22											G	G	R	G											
Mar-22	R	R	R	G							R	R	G	G							R	R	R	R	
Apr-22	R	R	R	R							R	G	G	G							R	R	R	G	
May-22	R	G	G	G	R						G	G	G	R	G						R	G	G	R	R
Jun-22	G	G	R	G							G	R	G	G							G	R	G	G	
Jul-22	G	G	R	G							G	G	G	R							G	G	G	R	
Aug-22	G	G	G	G	R						R	G	R	G	R						G	G	G	G	R
Sep-22	G	G	G	R							R	R	G	R							G	G	G	G	
Oct-22	G	G	G	G	R	R	R	R	R	R	R	R	R	R	R						G	R	R	R	R
Nov-22	G	G	G	G		R	R	R	R		G	G	G	R							R	R	G	R	
Dec-22	G	G	R	R		R	R	R	R		G	G	R	R							G	R	R	R	
Jan-23	R	G	G	G	G	R	R	R	R	R	G	R	R	R	G						R	R	R	R	R
Feb-23	G	R	G	G		R	R	G	R		G	R	R	R							R	R	R	R	
Mar-23																									
Count of GREENS	34					1					30					0					20				

Weekly Spot Check (Weekly)	LCH Nuclear Medicine					LCH Resp Physics					LCH Ultrasound					PHB CT					PHB Endoscopy				
Apr-21																									
May-21																									
Jun-21																									
Jul-21																									
Aug-21																									
Sep-21																									
Oct-21																									
Nov-21																									
Dec-21																									
Jan-22																									
Feb-22																									
Mar-22	R	R	R	R																	R	R	R	G	
Apr-22	R	R	R	R																	R	R	G	G	
May-22	R	R	R	R	R																G	G	G	R	G
Jun-22	G	G	G	G																	G	G	R	G	
Jul-22	G	G	G	R																	G	G	G	R	
Aug-22	R	R	G	G	G																G	G	R	G	R
Sep-22	R	G	R	R																	R	R	R	R	
Oct-22	G	G	R	R	R																G	R	G	R	R
Nov-22	G	R	R	G																	R	R	R	R	
Dec-22	G	G	R	R												R	R	R	R		R	R	G	R	
Jan-23	R	R	R	G	R											R	R	R	R	R	G	G	G	G	R
Feb-23	G	R	R	R												R	R	R	R		R	G	R	R	
Mar-23																									
Count of GREENS	19					0					0					0					24				

Weekly Spot Check (Weekly)	PHB Nuclear Medicine					PHB Radiology CT					PHB Interventional Radiology					PHB Ultrasound					PHB X-Ray				
Apr-21																									
May-21																									
Jun-21																									
Jul-21																									
Aug-21																									
Sep-21																									
Oct-21																									
Nov-21																									
Dec-21																									
Jan-22																									
Feb-22																									
Mar-22						R	R	R	R																
Apr-22						R	R	R	G							R	R	R	R						
May-22						G	G	A	G	G						R	R	R	R	R					
Jun-22						G	R	R	R							R	R	R	R						
Jul-22						R	G	R	R							R	R	R	R						
Aug-22						G	R	R	R	A						R	R	R	R	R					
Sep-22						R	G	R	R							R	R	R	R						
Oct-22	R	R	R	R	R	R	R	R	G	R						R	R	R	R	R					
Nov-22	R	R	R	R		R	R	G	R							R	R	R	R						
Dec-22	R	R	R	R		R	R	R	R							R	R	R	R						
Jan-23	R	R	R	R	R	R	R	R	R	R						R	R	R	R	R					
Feb-23	R	R	R	R		R	R	R	R							R	R	R	R						
Mar-23																									
Count of GREENS	0					11					0					0					0				

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
Apr-21						Red		Amber		Red										
May-21							Green						Red			Amber				
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																				

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
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																	Amber			
Jul-22																				
Aug-22																				
Sep-22																				
Oct-22																				
Nov-22																				
Dec-22																				
Jan-23																				
Feb-23																				
Mar-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
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																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																				

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
Apr-21	G	G	G	R	R	G	R	G	G	G	G	G	R	R	R	G	R		G	G
May-21	R	G	G	R	R	G	R	G	G	G	R	A	R	R	G	A	R		R	R
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	R	G	G	R	R	G	R	G	G	G	G	G	R	R	A	G	R		R	R
Sep-21	R	G	G	R	R	G	G	G	G	G	G	R	A	R	G	G	G		G	G
Oct-21	G	G	G	R	G	G	G	R	R	G	G	A	R	R	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	G
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	G	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	G	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	G	G	G	R	G	G	G	G	R	G	G
Oct-22	G	G	G	G	G	G	G	G	G	R	G	G		G	G	G	G		R	G
Nov-22	G	G	G	R	G	G	G	G	G	G	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	G	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																				

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
Apr-21		N/A						N/A											N/A	
May-21		N/A						N/A											R	
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						N/A											G	
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																				

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

Weekly Spot Check (Weekly)	CHL OPD					GDH Eye Clinic					GDH OPD				
Apr-21															
May-21															
Jun-21															
Jul-21															
Aug-21	R	R	R	R	R	A	R	A	A	R	A	R	A	A	R
Sep-21	R	R	R	R		R	A	A	R		R	A	A	R	
Oct-21	R	R	R	R		R	A	A	A		R	A	A	A	
Nov-21	R	R	R	R	R	A	R	R	R	R	A	R	R	R	R
Dec-21	R	R	R	R		R	G	A	R		R	G	A	R	
Jan-22	R	R	R	R	A	R	A	G	R	G	R	A	G	R	G
Feb-22	G	R	R	R		G	G	G	G		G	G	G	G	
Mar-22	R	A	R	R		A	G	A	R		A	G	A	G	
Apr-22	R	R	G	G		G	G	G	G		G	G	G	G	
May-22	G	G	R	R	G	R	A	G	R	G	R	R	R	G	G
Jun-22	G	R	G	G		G	G	G	G		G	G	R	G	
Jul-22	G	R	R	G		G	G	G	G		G	G	G	G	
Aug-22	G	G	G	G	G	G	G	G	G	A	G	G	G	G	G
Sep-22	R	G	G	G		G	A	G	G		G	G	G	G	
Oct-22	G	G	G	G	G	A	R	A	A	G	A	G	A	G	G
Nov-22	G	G	G	G		G	G	G	G		G	G	G	R	
Dec-22	G	G	G	G		R	G	G	G		G	G	G	G	
Jan-23	G	G	G	G	G	G	G	G	G	G	G	R	G	G	G
Feb-23	G	G	G	G		G	R	R	G		G	G	G	G	
Mar-23															
Count of GREENS	41					44					49				

Weekly Spot Check (Weekly)	LCH Clinic 6					LCH Clinic 7					LCH Clinic 8				
Apr-21															
May-21															
Jun-21															
Jul-21															
Aug-21	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	
Oct-21	R	R	R	R		R	R	R	R		R	R	R	R	
Nov-21	R	R	A	R	R	R	R	A	R	R	R	R	R	R	R
Dec-21	R	G	G	R		R	R	G	R		R	R	R	G	
Jan-22	A	R	A	R	A	R	R	R	R	R	R	R	R	R	A
Feb-22	A	R	A	A		A	G	R	A		R	G	A	R	
Mar-22	G	G	G	G		G	R	G	G		G	G	G	A	
Apr-22	G	G	G	G		G	A	G	A		G	G	G	G	
May-22	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G
Jun-22	G	G	G	G		G	G	G	G		G	G	G	G	
Jul-22	G	G	G	G		G	G	G	G		G	G	G	G	
Aug-22	G	G	G	G	G	G	G	G	G	G	A	G	G	G	G
Sep-22	R	G	G	G		G	G	G	G		G	R	G	G	
Oct-22	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G
Nov-22	G	G	G	G		G	G	G	G		G	G	G	G	
Dec-22	G	R	G	G		G	G	G	G		G	G	G	G	
Jan-23	G	G	G	G	G	G	G	G	G	G	G	R	G	G	R
Feb-23	G	G	G	G		G	G	G	G		G	G	G	G	
Mar-23															
Count of GREENS	52					51					49				

Weekly Spot Check (Weekly)	LCH Clinic 9					LCH Clinic 11					LCH Dermatology				
Apr-21															
May-21															
Jun-21															
Jul-21															
Aug-21	R	R	R	A	R	R	R	R	R	R	R	R	R	R	R
Sep-21	R	R	R	R		R	R	R	R		R	A	R	R	
Oct-21	R	R	R	R		R	R	R	R		R	R	R	R	
Nov-21	R	R	R	A	A	R	R	R	A	G	R	R	R	R	R
Dec-21	R	R	A	R		R	R	A	R		R	A	R	R	
Jan-22	R	R	R	A	R	A	R	R	A	R	R	A	R	R	G
Feb-22	A	A	A	A		A	G	A	A		R	G	A	G	
Mar-22	R	G	R	A		R	A	A	G		G	G	A	G	
Apr-22	G	G	R	G		G	R	R	R		G	G	G	G	
May-22	G	G	G	G	A	G	A	G	G	G	G	G	G	G	G
Jun-22	G	G	G	G		G	G	G	A		G	G	G	G	
Jul-22	G	G	G	G		R	A	G	G		G	G	G	G	
Aug-22	G	G	G	G	G	R	G	G	G	G	G	G	G	G	G
Sep-22	G	G	R	G		G	G	G	G		G	G	G	G	
Oct-22	G	G	R	G	G	G	G	R	G	G	G	G	G	G	G
Nov-22	G	G	G	A		G	G	G	G		G	G	G	G	
Dec-22	G	R	R	G		G	G	G	G		G	G	G	G	
Jan-23	G	G	R	G	G	G	G	G	G	G	G	G	G	G	G
Feb-23	G	G	G	G		G	G	G	G		R	G	G	G	
Mar-23															
Count of GREENS	41					42					53				

Weekly Spot Check (Weekly)	LCH OPD					LCH Rheumatology					LCH UIS				
Apr-21															
May-21															
Jun-21															
Jul-21															
Aug-21						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	
Oct-21	R	G	R	R		R	R	R	R		R	R	R	R	
Nov-21	R	R	R	R	A	R	R	A	G	R	R	R	R	G	R
Dec-21	A	R	R	R		R	R	R	R		R	G	R	A	
Jan-22	R	A	R	G	R	G	R	G	R	R	R	G	R	A	G
Feb-22	G	A	G	R		G	G	G	G		G	G	G	G	
Mar-22	A	A	G	G		G	G	G	G		G	R	G	G	
Apr-22	A	G	G	G		G	G	G	G		G	R	G	G	
May-22	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G
Jun-22	G	G	R	G		G	G	G	G		G	G	G	G	
Jul-22	G	G	G	R		G	A	G	G		G	G	G	G	
Aug-22	G	G	G	A	G	G	G	A	G	G	G	G	G	G	G
Sep-22	G	G	G	G		G	G	G	G		G	G	G	G	
Oct-22	G	A	R	G	G	G	G	G	G	G	G	G	G	G	G
Nov-22	G	G	G	G		G	G	G	G		G	G	G	G	
Dec-22	G	G	G	G		G	G	G	G		R	G	G	G	
Jan-23	G	G	R	G	G	G	R	G	G	G	G	G	G	G	G
Feb-23	R	G	G	G		G	G	G	G		G	G	G	G	
Mar-23															
Count of GREENS	46					56					57				

Weekly Spot Check (Weekly)	PHB Breast Clinic					PHB Dermatology					PHB ENT				
Apr-21															
May-21															
Jun-21															
Jul-21															
Aug-21						R	R	R	R	R	R	R	R	R	R
Sep-21						R	R	R	R		R	R	A	R	
Oct-21						R	R	R	R		R	R	R	A	
Nov-21						R	A	R	R	R	R	R	R	R	R
Dec-21						R	R	R	R		A	A	R	R	
Jan-22						R	A	G	G	G	R	A	A	A	A
Feb-22						G	G	R	R		A	A	R	A	
Mar-22						A	R	R	A		R	R	A	A	
Apr-22						R	R	R	G		G	R	R	G	
May-22						R	G	G	R	R	R	G	G	G	R
Jun-22						G	G	G	G		G	R	G	R	
Jul-22						G	G	G	G		G	G	G	R	
Aug-22						G	G	G	G	G	G	G	G	G	G
Sep-22						G	G	G	R		R	G	G	R	
Oct-22						G	G	R	G	G	G	G	G	G	G
Nov-22	R	G	G	G		G	G	G	G		R	G	G	G	
Dec-22	G	R	R	G		G	G	G	G		G	G	G	G	
Jan-23	R	G	G	G	R	G	G	G	G	G	G	G	G	G	G
Feb-23	G	G	G	G		G	G	G	G		G	G	G	G	
Mar-23															
Count of GREENS	12					45					38				

Weekly Spot Check (Weekly)	PHB Fracture					PHB OPD					PHB Royle Eye Clinic				
Apr-21															
May-21															
Jun-21															
Jul-21															
Aug-21	R	R	R	R	R	R	R	A	R	R	R	R	R	R	R
Sep-21	R	R	R	R		R	A	R	R		R	R	R	R	
Oct-21	R	R	R	R		R	R	A	R		R	R	R	R	
Nov-21	R	A	R	R	R	R	R	R	R	G	A	R	R	G	R
Dec-21	R	R	R	R		G	R	R	G		G	R	G	R	
Jan-22	R	A	A	G	G	G	G	G	G	R	R	G	G	R	R
Feb-22	G	G	R	G		G	G	R	G		A	A	R	R	
Mar-22	A	R	R	R		G	R	G	G		G	G	R	R	
Apr-22	G	R	R	G		G	R	R	G		R	R	R	G	
May-22	R	G	G	R	R	R	G	R	G	R	R	R	R	G	R
Jun-22	G	R	R	R		G	R	G	G		R	R	R	R	
Jul-22	G	G	G	G		G	G	G	R		R	R	R	R	
Aug-22	G	G	G	G	G	R	R	G	G	G	R	R	G	G	G
Sep-22	G	G	R	R		G	G	G	R		G	R	R	R	
Oct-22	R	R	R	G	G	G	G	G	R	G	R	R	R	R	R
Nov-22	G	G	G	G		G	G	G	G		G	R	G	G	
Dec-22	G	G	G	G		G	G	G	G		G	R	G	G	
Jan-23	G	G	G	R	G	G	G	G	R	G	G	G	R	G	G
Feb-23	G	G	G	G		G	G	G	G		G	G	G	G	
Mar-23															
Count of GREENS	39					49					27				

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

Ward/Dept. Review Visit	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 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													Amber						
Apr-22																			
May-22																			
Jun-22																			
Jul-22																			
Aug-22																			
Sep-22																			
Oct-22																			
Nov-22																			
Dec-22																			
Jan-23																			
Feb-23																			
Mar-23																			

Harm Free Certificate	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 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																			

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

SEPSIS	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 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																			

Accreditation Progress: OPD Medicine

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check [Monthly]	GDH AAU [SDEC]	GDH Cardiac Physiology	LCH Cardiac Physiology	LCH CMDU	LCH MDU	LCH SDEC	LCH Saxon	LCH Vulcan	PHB Cardiac Physiology	PHB PIU	PHB SDEC
Apr-21											
May-21											
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	G	R	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											

Weekly Spot Check (Weekly)	GDH AAU(SDEC)					LCH CMDU					LCH MDU					LCH Saxon					LCH VULCAN					LCH SDEC					PHB PIU					PHB SDEC				
Apr-21																																							
May-21																																							
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	C							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		R	G	G	R	G	G	G	G	G						G	G	R	G	G
Nov-22	G	G	G	G		G	G	G	G		G	G	G	G		R	G	G	G		R	G	G	A		G	G	G	G		G	G	R	G		G	G	G	
Dec-22	A	R	G	R		R	R	R	R		G	G	G	G		A	R	R	R		G	G	G	G		R	G	R	R		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	G	G	G	G	R	G	G	G	R	R	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		G	G	G	R		R	G	R	G		G	R	G	G		R	R	G	G	
Mar-23																																							

Count of GREENS	32	7	63	7	16	33	6	31

Matron Audit	GDH AAU [SDEC]	GDH Cardiac Physiology	LCH Cardiac Physiology	LCH CMDU	LCH MDU	LCH SDEC	LCH Saxon	LCH Vulcan	PHB Cardiac Physiology	PHB PIU	PHB SDEC
Apr-21											
May-21											
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	Green	Amber	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		Amber	Green	Green		Green	Green
Feb-23				Green		Green	Green	Green		Green	Green
Mar-23											

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

Harm Free Certificate	GDH AAU [SDEC]	GDH Cardiac Physiology	LCH Cardiac Physiology	LCH CMDU	LCH MDU	LCH SDEC	LCH Saxon	LCH Vulcan	PHB Cardiac Physiology	PHB PIU	PHB SDEC
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											

FLO	GDH AAU [SDEC]	GDH Cardiac Physiology	LCH Cardiac Physiology	LCH CMDU	LCH MDU	LCH SDEC	LCH Saxon	LCH Vulcan [Use Burton]	PHB Cardiac Physiology	PHB PIU	PHB SDEC
Apr-21					G	A		G			G
May-21					G	A		G			G
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	G	R	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											

SEPSIS	GDH AAU [SDEC]	GDH Cardiac Physiology	LCH Cardiac Physiology	LCH CMDU	LCH MDU	LCH SDEC	LCH Saxon	LCH Vulcan	PHB Cardiac Physiology	PHB PIU	PHB SDEC
Apr-21						N/A		A			N/A
May-21						N/A		G			G
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											

Accreditation Progress: Surgery OPD

= Divisional Monitoring
= Enhanced Monitoring

Weekly Spot Check [Monthly]	GDH Max Fax Clinic	GDH Max Fax	GDH Pre-Op Assessment	LCH Clinic 8 Opthalmology	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
Apr-21														
May-21														
Jun-21														
Jul-21														
Aug-21				R										
Sep-21				R										
Oct-21				R										
Nov-21				R										
Dec-21				R										
Jan-22				R										
Feb-22				A										
Mar-22				G										
Apr-22				G										
May-22				G										
Jun-22				G										
Jul-22				G										
Aug-22				G										
Sep-22				G										
Oct-22				G										
Nov-22				G										
Dec-22				G										
Jan-23				R										
Feb-23				G										
Mar-23														

Matron Audit	GDH Max Fax Clinic	GDH Max Fax	GDH Pre-Op Assessment	LCH Clinic 8 Opthalmology	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
Apr-21														
May-21														
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							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				
Jan-23							Amber							
Feb-23		Green			Amber			Green	Green		Green	Green		
Mar-23														

Ward/Dept. Review Visit	GDH Max Fax Clinic	GDH Max Fax	GDH Pre-Op Assessment	LCH Clinic 8 Opthalmology	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
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														

Harm Free Certificate	GDH Max Fax Clinic	GDH Max Fax	GDH Pre-Op Assessment	LCH Clinic 8 Opthalmology	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
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														

FLO	GDH Max Fax Clinic	GDH Max Fax	GDH Pre-Op Assessment	LCH Clinic 8 Opthalmology	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
Apr-21				R										
May-21				G										
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		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	N/A		G	G	N/A	G	G	G	G	G
Mar-23														

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 Colorectal					LCH Pre-Op Assessment					PHB Colorectal					PHB Max Fax					PHB Orthoptists					PHB Rpre-Op Assessment					PHB Urology Clinic					PHB Vascular Clinic				
Apr-21																																																																												
May-21																																																																												
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																																								
Feb-22																															R	G	A	R																																								
Mar-22																															G	G	G	A																																								
Apr-22																															G	G	G	G																																								
May-22																															G	G	G	G	G																																								
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Sep-22																															G	R	G	G	G																																								
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Feb-23																															G	G	G	G																																								
Mar-23																																																																												

	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 Colorectal	LCH Pre-Op Assessment	PHB Colorectal	PHB Max Fax	PHB Orthoptists	PHB Rpre-Op Assessment	PHB Urology Clinic	PHB Vascular Clinic
Count of GREENS	0	0	0	0	0	0	49	0	0	0	0	0	0	0	0

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*6th June 2023*
Item Number	*Item 8.2*

Patient Safety Incident Response Framework (PSIRF) Update inc Phase 3 – Governance and Quality Monitoring Phase 4 – Patient Safety Incident Response Planning

Accountable Director	*Professor Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Kathryn Helley, Deputy Director of Clinical Governance*
Author(s)	*Kathryn Helley, Deputy Director of Clinical Governance*
Report previously considered at	*PSIRF Implementation Team – 5 April 2023* *Trust Leadership Team – 21 April 2023* *Patient Safety Group – 9 May 2023* *Quality Governance Committee – 23 May 2023*

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

Risk Assessment	*Moderate*
Financial Impact Assessment	*No financial implications have been identified to date*
Quality Impact Assessment	*Not applicable*
Equality Impact Assessment	*Not applicable*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *Note the work undertaken to comply with requirements of Patient Safety Incident Response Framework (PSIRF) including the outcome of the restructure within the Risk and Governance Team.*

Background

In August 2022, NHS England published the Patient Safety Incident Response Framework (PSIRF) which fundamentally changes the way in which incidents are managed and investigated within the NHS. The framework outlined a 7 stage implementation plan leading to a transition from the current serious incident framework to PSIRF by the Autumn of 2023.

The oversight of the implementation of PSIRF takes place via the monthly PSIRF Implementation Team, chaired by the Deputy Director of Clinical Governance and reports into the Patient Safety Group and Quality Governance Committee.

ULHT have successfully completed Phase 1 (PSIRF orientation) and Phase 2 (Diagnostic and Discovery) and are on track to deliver the remaining phases of the framework by the implementation date of 1 October 2023.

Current Position

General Update

Implementation of PSIRF will fundamentally change the way in which the organisation reviews and responds to patient safety events and will require a robust structure to be in place to support the Divisions and Directorates in the delivery of the framework.

The main themes arising from the framework state that:-

- Learning response leads should have an appropriate level of seniority and influence within the organisation and it is recommended that learning responses are led by staff at Band 8a or above.
- Learning response leads should have dedicated paid time to undertake the role.
- There is dedicated staff resource to support engagement and involvement of those affected by patient safety incidents with at least six hours of formal training and evidence of continuous professional development in engagement and communication skills.
- Formal training and skills development is required for those leading the learning responses including Level 1 and Level 2 training from the patient safety syllabus.
- Learning response leads contribute to a minimum of two learning responses per year.

- Learning response leads are required to apply a human factors and systems thinking principles alongside being able to present complex information and manage potentially conflicting information.
- There are shared insights between the patient safety and quality improvement teams.
- Thorough analysis of organisational data is paramount for creating a patient safety incident response plan and proactive forward planning.

Given the publication of the national guidance, the current structure and model of working within the Risk and Governance team did not support the effective delivery of the framework. This was felt to be the case taking into account both the recommendations arising from the Patient Safety Incident Response Framework and learning from the Early Adopter Sites.

As a result of this, a consultation has recently been undertaken within the Risk and Governance Team. The consultation proposed three alternative structures. The first proposed centralising a new investigation team under the current role of Head of Risk and Governance, the second proposed a new standalone investigation team and the third proposed centralising the new investigation team under the role of the Patient Safety Improvement Lead. The option of divisions undertaking investigations alongside their clinical / operational role was discounted as it did not support the principles within the framework and did not have support from divisions. Helpful and constructive comments were received during the consultation period, which led to the development of option 4, the final option. This is attached as Appendix 1 and is currently in the implementation phase.

The removal of incident management from the current post of Head of Risk and Governance has resulted in the disestablishment of this role. However, the final the structure includes a Risk and Datix Manager supported by 3.0 wte Risk and Datix Facilitators, an increase of 1.0 wte as a direct result of the consultation feedback. The removal of incident management from the portfolio of this team will enable improved focus on risk and the continued business partner approach for divisions and corporate functions.

The Deputy Director of Clinical Governance, supported by the Assistant Director of Clinical Governance is the strategic lead for risk in the Trust. Since the Deputy Director commenced in post 2.5 years ago, a full review of the risk management process has been undertaken and significant changes made to systems and processes which had been identified as not being fit for purpose. This has led to an internal audit opinion of significant assurance in the most recent audit. Risk Management will continue to be included in the annual internal audit programme as is the requirement.

Finally, the Assistant Director of Clinical Governance is part way through completing the Institute of Risk Management (IRM) Risk for Risk Practitioners Course in conjunction with NHS Providers. This is the first course of its kind, with IRM covering the most up to date thinking in regards to Risk Management. Being involved in such an early stage provides the Trust with an excellent platform to continue to strengthen the work already undertaken by the Deputy Director of Clinical Governance. The plan is that the Risk and Datix Facilitators will undertake the course in the future so that, for the first time, the Trust will have a fully accredited team of risk experts.

<u>Phase 3 – Governance and Quality Monitoring (up to 31 May 2023)</u>

The aim of phase 3 is to start to define the oversight structures and new ways of working that will come into place once the Trust transitions to PSIRF on 1 October 2023.

In considering the proposed arrangements, advice was taken from the National leads for PSIRF along with the early adopter sites. The guidance specifically asks that the arrangements are developed with relevant partners and the ICB lead has been instrumental in providing advice and support to the process.

Attached as Appendix 2 is a flowchart outlining the proposed incident management arrangements including meeting and reporting structure. This will be supported by the Patient Safety Incident Response Policy that sits behind the processes and details how it will work in practice.

Of note, all early adopters have stressed that it will be important to take a PDSA approach once we begin implementation as it may be necessary to adapt as we start to work with the revised arrangements.

Phase 4 – Patient Safety Incident Response Planning (up to 30 June 2023)

The Patient Safety Incident Response Plan will determine how we respond to patient safety incidents in future. In order to do that we need to review and agree the Trust's safety profile. There is a requirement that the safety profile is agreed in conjunction with key stakeholders, including the Trust Board and ICB lead.

Work is currently underway to gather data from a variety of sources including incidents, complaints, claims, patient experience, Freedom to Speak up, to name a few. This information was shared and discussed at the PSIRF Implementation Team meeting on 3 May 2023 with a similar event taking place at TLT on 19 May 2023 where the Trust Patient Safety Profile was considered.

Conclusion/Recommendations

The implementation of PSIRF is a key priority for the Trust over the coming months which will impact on all staff members and fundamentally change the way in which we investigate incidents in the future.

The Quality Governance Committee is asked to:-

- Note the work undertaken to comply with requirements of Patient Safety Incident Response Framework (PSIRF) including the outcome of the restructure within the Risk and Governance Team.

INCIDENT MANAGEMENT PROCESS

Patient Safety Event Recorded

Compassionate Engagement
Duty of Candour
Just Culture

Incident triaged against response plan

Consideration of other actions taking place, e.g. current PSII/improvement work

Staff engagement throughout

Patient engagement throughout

Feedback of experience of being involved in the process

Level 1
Other body undertakes investigation e.g. HSIB

Level 2
Meets regulatory requirement to undertake PSII e.g. Never Event

Level 3
Meets local priority to undertake PSII

Central Family Liaison Officer

Develop Safety Actions

Central Improvement Team Support

Level 4
Proportionate response agreed, Supported by Incident Response Team eg AAR, SJR etc

Consider other improvement/safety work taking place
Incidents where contributory factors are not known or understood

Level 5
Log to feed into next year's Patient Safety Incident response plan

No/low harm not identified as priority
Moderate/severe where factors already known & linked to safety/improvement work

Divisional Family Liaison Officer

Develop Safety Actions

Patient Safety Team Support

Issues for further consideration

Involvement of Health Watch, MVP, etc
Leeds University research project on methods for measuring effectiveness
Training - Central Team and Wider organisation
Improvement team & Safety team feedback on improvement
What are our proportionate response methods
Ensure the link with non-clinical incidents
Need to add in the learning loop

REPORTING

Patient Safety Improvement Plan & Patient Safety Improvement Policy to be produced

Stand Down
SI Report & Incident Management Report in current format.

New Report to include:-

- Incident Numbers
- Harm Levels
- Themes and Trends
- Duty of Candour
- Incident numbers from triage – 1,2,3,4,5
- Output from Investigation Approval Panel

Report To

- PSG
- QGC
- ICB

Report on PSIIs to Private Board using recommended template

Usual reporting into
Divisional Governance Groups

MEETING STRUCTURE

Stand Down
Serious Incident Panel and
Rapid Review Panel

Stand Down, ICB, Serious Incident Review Group
New learning group to be developed

Set up Weekly Complex Case Meeting

- Incidents
- Legal
- Complaints
- Divisions
- Safeguarding
- Mortality
- Clinical Effectiveness

- Freedom to Speak Up
- Patient Experience
- Improvement

Revisit

- Triangulation
- Immediate Risks & Actions
- Monitoring ongoing risks

- Record of decision making
- Onside/log for future local priority
- PSIIs agreed
- Investigator & FLO appointed

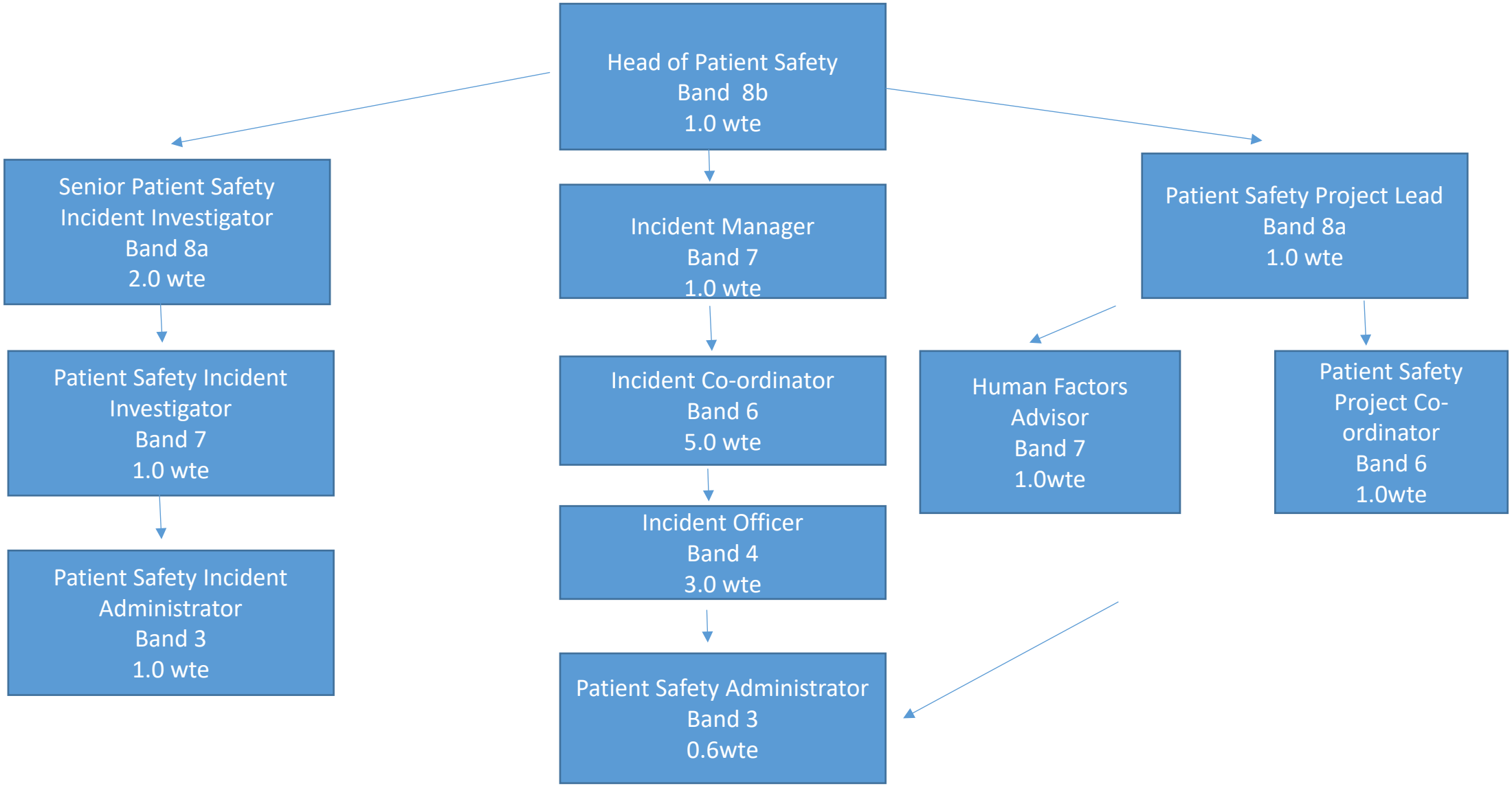
Internal quality assurance monitoring of responses with dedicated tool

Monthly Investigation Approval Panel

- Executives
- ICB
- PSP
- Central Team
- Improvement

Usual reporting into Divisional Governance Groups

Patient Safety Team



United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*6 June 2023*
Item Number	*Item 8.3*

Hospital-onset Covid-19 Duty of Candour Update

Accountable Director	*Professor Karen Dunderdale, Director of Nursing and Deputy Chief Executive*
Presented by	*Professor Karen Dunderdale, Director of Nursing and Deputy Chief Executive*
Author(s)	*Helen Shelton, Assistant Director of Clinical Governance*
Report previously considered at	*Quality Governance Committee – 23 May 2023*

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

Risk Assessment	*NA*
Financial Impact Assessment	*NA*
Quality Impact Assessment	*NA*
Equality Impact Assessment	*NA*
Assurance Level Assessment	• *Significant*

Recommendations/ Decision Required	• *Trust Board is asked to approve the proposed closure of the Duty of Candour process*

1 Introduction

At the meeting on 23 May 2023, the Quality Governance Committee took receipt of the following paper which outlined the process and current position in relation to the Hospital onset Covid-19 Serious Incident investigation and resultant Duty of Candour.

2 Background

The Trust submitted the Hospital onset Covid deaths Serious Incident report to the ICB in November 2022 having been presented at the Serious Incident panel and ELT alongside the proposal for delivering written Duty of Candour to the relatives of the 59 affected patients. At that time the decision was made to postpone the delivery of the duty of candour due to the time of year and potential distress this may cause to those affected.

3 Current Position

A review of all 59 cases of Hospital onset Covid-19 has been undertaken, cross referencing each case with any Complaints / Serious Incidents / Legal and Coroner's cases. It can be confirmed that documented verbal Duty of Candour was delivered to 56 patients or relatives by either the ward staff during the patient's admission or the Medical Examiner following the patient's death. For the 3 cases outstanding there was no formal recorded evidence within the notes or by the Medical Examiner that Duty of candour had been delivered. However on further review it was established that:

Patient 1 – Documented on the ReSPECT form that the patient wanted full treatment for his Covid diagnosis.

Patient 2 – Documented within the notes that both the patient's partner and daughter were aware of the patient's poor prognosis as a result of the Covid diagnosis.

Patient 3 – On review of the notes it has been established that the patient had acquired Covid on their first admission and had undergone a full isolation period and discharged however they were readmitted five days later and were not Covid positive or treated for Covid on this admission and passed away with an unrelated co-morbidity.

In addition to the above, 15 of the cases also received written Duty of Candour in the form of a letter, Complaint response or Serious Incident Report. There was no evidence within the notes of written Duty of Candour for the remaining 44 cases.

The NHSE/I Regional Office issued guidance in March 2021 "Reporting and responding to hospital onset Covid-19 cases" with further updated guidance in July 2021 which states:

'Moderate harm' includes harm that requires a moderate increase in treatment. There is no easy rule for defining what is considered a 'moderate' increase in treatment but applying previous guidance in the context of COVID-19 suggest moderate could include; a move to specialty care (such as ICU), a prolonged hospital stay arising from the treatment needs of the

nosocomial infection, or need for higher levels of oxygen therapy for more than a short period. Transfer to another area for the purpose of infection control alone (that is, transfer to a COVID-19 ward when no other harm is identified) would be considered low harm. Note that prolonged hospital stays for infection control reasons alone (e.g. need to be clear of infection before return to a care home) would not automatically count as a moderate increase in treatment.

CQC have advised that it is reasonable for providers to adapt the form and method of communication. For example, where additional face-to-face meetings are not possible on safety grounds, it is appropriate for providers to find alternative ways to inform, apologise to and support the relevant person rather than delay. **Where providers are able to make clear at the time to the patient or their family/carer that an infection was probably or definitely acquired in the hospital – for example, through conversations with relevant clinicians while an inpatient – this should minimise or remove the need for additional follow-up communications.**

This exercise above was undertaken to ensure that all patients included in the Serious Incident investigation had received Duty of Candour. A business as usual process was instigated for relevant patients identified after the date pertaining to the serious incident investigation.

4 Next Steps

The date range for the delivery of Duty of Candour spans from March 2021 – June 2022. Taking all of the above into consideration, in particular the highlighted section above, alongside the time elapsed since the relatives were contacted, it would be reasonable to assume that any further concerns from the families would have been raised by now and that by proceeding with writing to all 59 affected families at this point could have a detrimental effect potentially causing more unnecessary harm.

5 Action Required

The Quality Governance Committee were asked to approve the proposal to stand down any further Duty of Candour notifications on the basis of the report. This was agreed.

The Trust Board is asked to:

- Note the content of the report
- Note the approval of the Quality Governance Committee to stand down any further Duty of Candour notifications on the basis of the above.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	9 May 2023
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2022/23 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Lack of Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Workforce Strategy and Organisational Development Group (WSODG) Upward Report** The Committee received the report noting the content and focus by the group on the scorecard to ensure appropriate metrics were being considered. It had been determined by the group that this was not the right forum to be considering international recruitment and therefore the recommendation was for this to be solely considered by the International Nursing Group. The Committee supported the recommendation. **Committee Performance Dashboard** The Committee received the dashboard noting the improved vacancy rate that was presented, being the lowest level in 2 years, and noted that there had been national recognition of the improvements being made by the Trust. It was noted that progress against appraisals and mandatory training would be addressed and were being developed into the objectives of the People and OD Directorate objectives. **NHSE/I Workforce Plan and numbers** The Committee received the report noting the submission that had been made and the intention to maintain a resource level of 8700 with a reduction in the reliance on agency and bank staff and increase substantive staff. There would be a focus on a reduction of 25% in dental and medical vacancies and the intention to end the year with a 60/40 split of bank/agency use.

	Through the restructure of the talent academy there would be a local focus on development including apprenticeship pathways and growing our own **Safer Staffing** The Committee noted the safer staffing position presented which had been a stable position enabling Care Hours Per Patient Day to be maintained in month despite a small reduction in fill rate. The Committee noted work which was being undertaken to consider band 2 and 3 staff where changes were being made nationally and requested that, when available, further information be presented to the Committee.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Freedom to Speak Up Quarterly Report** The Committee received the quarterly report noting the position presented and was encouraged by the continued engagement of staff to raise concerns with the Guardian. **Guardian of Safe Working Quarterly Report** The Committee welcomed the new Guardian of Safe Working, Dr Sant, to the Committee to present the quarterly report. The Committee noted the positive progress in respect of the medicine rota but also recognised that a number of immediate safety concerns had been raised which primarily related to staffing issues which had been addressed. The Committee was pleased to note the availability of mess facilities at Pilgrim and Lincoln noting the new opt out approach and charge to access the facilities to address previous concerns which had been seen. **GMC Junior Doctor Survey** The Committee received the update noting that the current survey was still active and had been extended with the output from this expected June/July. Any actions related to this would be presented back to the Committee however it was noted that there had been 2 alerts issues as a result of the survey. These had related to staffing with both alerts being addressed in a timely manner. The Committee noted that the response to the alert demonstrated that the process of the survey was functioning correctly however noted that the alerts would be advised to the Quality Governance Committee for information only due to the possible impact on quality.

	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Research and Innovation Update** The Committee noted the update offered in respect of Research and Innovation noted that a number of clinical trials had been opened with positive recruitment however there remained a requirement to ensure support was in place to recruit greater numbers. The Committee noted the collaborative work with the ICB and University of Lincoln to complete an application for NIHR Integrated Academic Training, 2024/25 Competition for Academic Clinical Fellowships and Clinical Lectureships. This was a positive position which would support the Trust to progress University Teaching Hospital status. **University Teaching Hospital Group Upward Report** The Committee received the report noting that a previous discussion had taken place at the private Board meeting regarding the progress and improved relationship and engagement with the University of Lincoln. The Committee noted the ongoing work in respect of the funding for posts and the need to attract clinical academics however recognised that this was not just about medical academics but the need for integration across all professions.
	Assurance in respect of other areas: **QGC Referral – Healthcare Safety Investigation Branch – Staff Wellbeing** The Committee gratefully received the referral from the Quality Governance Committee as this had enabled a considered response of the occupational health and wellbeing support in place for staff across the Trust. Whilst it was recognised that support was in place consideration would be given as to whether this was sufficient for staff to be appropriately supported. The Committee welcomed the commitment to consider and strengthen the support in place for staff. **QGC Referral – Impact of flu vaccination rates and sickness levels** The Committee noted the response to the referral which did not indicate that there had been an impact on sickness levels as a result of the lower uptake of flu vaccinations however it was noted that there had been a reduced efficacy of the vaccination this year. The Committee considered and noted the positive impact of peer vaccinators across the Trust noting that the approach should be continued to encourage staff to be vaccinated. **Reporting Group Terms of Reference**

	The Committee received and approved the reporting group terms of reference noting the need to further develop the work programme of the Workforce, Strategy and Organisational Development Group. The Committee noted the need to seek clarity of the University Teaching Hospital Group and Research and Innovation Governance Group remits as these ran as parallel streams before approval of the terms of reference could be given. **Integrated Improvement Plan** The Committee noted the ongoing work being undertaken to finalise the 2023/24 metrics within the IIP which would be received to the next meeting. **Internal Audit Recommendations** The Committee received the report noting that 4 actions were overdue however reflected on the progress that had been made in respect of actions being closed. **CQC Action Plan** The Committee noted the action plan and the 7 areas requiring attention noting that 2 of these related to previously discussed appraisal and training compliance. It was noted that there was now a fully established education training and development team within the directorate which would support progression and delivery of mandatory training. Whilst the levels of mandatory and statutory training were being determined the Committee noted that it was not only important to ensure staff complete the appropriate training but were also able to access this. Work was underway to address all aspects of this.
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	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**
Philip Baker (Chair)	No meeting held	X	No meeting held	X	X	X	X	X	X	X	No meeting held	X
Gail Shadlock		A										
Karen Dunderdale		X		X	X	D	A	D	A	D		D
Paul Matthew		X		X	X							
Claire Low						X	X	X	X	X		X
Colin Farquharson		X		D	D	D	D	D	D	D		D
Chris Gibson				X	X	X	X	X	X	X		X
Vicki Wells				A	A	X	X	X	A	X		X

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

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	25 May 2023
Chairperson:	Elaine Baylis, 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 inc Health and Safety Committee Upward Report** The Committee received a series of reports from the estates and facilities directorate and noted that there continued to be learning required in respect of assurance reporting to the Committee and Board. The Committee noted ongoing issues with planned preventative maintenance on the Lincoln site due to staffing and recognised that whilst there were Authorised Engineers in post there was a need to appropriately schedule annual reporting. The Health and Safety Committee had met however challenges with the meeting were noted and would be addressed to ensure this delivered the expected assurances. Fire training was highlighted to the Committee as a concern due to the downward trend with work ongoing to carry out weekly ward level and department checks. Additional fire wardens were required, and fire drills were now in place across the sites. The Committee noted the update in respect of ventilation and Entonox use with work taking place alongside infection prevention and control. A review of clinical space would be required to ensure environments being utilised were done so effectively to ensure productivity. **PLACE Report** The Committee received the PLACE report noting the significant progress since the previous inspection in 2019. The Committee noted the focus of the team to undertake actions which would impact on the outcome of the inspections which had seen a positive outcome.

	Whilst improvements had been seen the Committee noted the lower scores received at Louth however reflected the limited ability of the Trust to affect this as this was not a Trust owned property. **Emergency Planning Group Upward Report** The Committee received the report noting that plans were in place across the Trust to meet statutory requirements with a number of exercises in place to test the Trust's emergency response. It was noted that work was required in respect of business continuity plans with the divisions as these were not felt to be adequate however work was ongoing with each division to ensure these are updated.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts and CIRG Upward Report** The Committee received the informative set of reports noting the detail contained within and the update provided including the positive position reported for month 1. It was however recognised that month 1 reporting was reduced due to the financial plan having only been submitted on 4 May. CIP delivery was £500k favourable to plan with delivery of £1.7m against target for month 1 which was a positive starting position due to the CIP programme being backend loaded. The Committee were keen to receive assurance that the Trust were putting in place any enabling actions that will be required to enable the delivery of the CIP's later in the year. The Committee noted the risk related to income as a result of activity and reflected the need to drive productivity to improve the position with focus being given by the Executive Team. Concern was noted in respect of pending admissions which not only presented a reporting issue but also a quality issue with the Committee referring this to the Quality Governance Committee. The cash position was noted with the intention of producing a cash forward forecast as the year progressed. If the Trust remained on plan this should not pose a risk into 23/24 however could become a potential risk into the following year if a deficit was delivered. The Committee noted the Better Payment Practice Code which was on target in month however as work progressed to clear down old invoices the position was likely to deteriorate before resolving. Work continued to progress and sign relevant contracts which should be resolved in the coming month however it was noted further work was required on specialised commissioning contracts.

	The Committee noted the CRIG upward report and the national cost collection indices report which demonstrated the potential for improvement and offered triangulation in respect of productivity and agency reduction. **2023/24 Capital Plan Final** The Committee received the final plan which had been considered in draft form at a Board Development session with the plan now being recommended with schemes to a total of £37m. The Committee noted the work that had been undertaken across the finance and estates teams in order to mitigate known estates issues. The Committee recommended the plan to the Board for approval. **2023/24 Planning Update** The Committee received the planning update for information noting the significant effort to build the plan. There had been good confirm and challenge of the plan not only between directorates but also organisations with confidence that the plan was challenging but built through a proper assessment process. The Committee noted the need for an agreed mechanism in the system for oversight and assurance on the execution of the plan.. **Strategic Procurements** The Committee received the report including the expiry dates of contracts and noted the forward look offered by the report. The Committee offered thanks to the procurement team for the work to produce the report which offered assurance to the Committee regarding the position of strategic procurements for the Trust as well as continued work, including an amnesty, to improve procurement across the Trust. Ongoing work was noted in respect of the procurement team continuing to ensure best prices were received when purchases were made with the Committee noting that there were some challenges with price when purchasing through the national supply chain, this was being challenged by the team.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting the updates offered and the focus given to the ICO revisit due to take place in June and the achievement against the action plan in place. It was noted that whilst actions would not be fully complete plans were in place to address outstanding actions, it was recognised that a number of actions would require additional resource to address.

	The Committee reflected on the Data Security Protection Toolkit submission due to be made in June noting that 5 of the 113 assertions would not be met. The Committee was advised of the potential risk that this presented in respect of e-mail accreditation and noted that this was being formally placed on the risk register. The improved position in respect of Subject Access Requests was noted however there was recognition of the continued need for improvement to be seen.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting for urgent care that performance was stable overall month on month however the Trust continued to be challenged. The Committee noted the new constitutional standards in place from April including the focus on ambulance handovers under 15 minutes and the revised 4-hour target which had been set at 76% to be achieved and sustained by March 2024. It was recognised that there continued to be patients waiting extensive times along with a number of medically optimised patients requiring pathway 1-3 care. Bed occupancy remained high and whilst some additional capacity had been removed the Trust continued to have a significant number of beds open against a core bed base of 968. System work continued to consider the alignment of beds. The Committee noted the planned care update with the Trust continuing to progress the 78-week target of zero patients by the end of June. It was noted that there were a cohort of patients breaching the 78-week target due to industrial action and patient choice. A further cohort of patients had been identified who required treatment and would be included in the actions being taken to achieve the target. The Committee noted the performance of cancer services noting that the Trust was in the bottom quartile of national performance at 67%. It was noted that whilst there had been progress seen within breast services a change to the rota was anticipated to impact the ability to achieve the faster diagnosis at the end of June. Further work was required to determine the level of risk being presented. The Committee noted the 62-day backlog, noting the need for this to be reduced to by April 2024. Work had commenced with 6 tumour groups in order to provide focused attention on the individual groups to achieve the faster diagnosis standard and reductio in 62-day wait backlogs.

	The Committee noted the significant competing priorities described noting the need to achieve the 78-week waits due to the national expectations and faster diagnosis.
	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 No reports
	Assurance in respect of other areas: **Terms of Reference and Work Programme Draft 2023/24** The Committee received the draft terms of reference and work programme noting the additional work required to ensure clear alignment to the objectives and enable assurance to be delivered to the Board. **Committee Performance Dashboard** The Committee received the dashboard noting this replicated the information seen through the reports received by the Committee. **Integrated Improvement Plan** The Committee received and noting the report and information set out within this which would be considered by the Board. **Improvement Steering Group Upward Report** The Committee received the report noting the position presented in respect of the medical workforce programme which required clear performance trajectories identifying however there was now senior dedicated resource in place. The Committee noted the progress on other programmes including beds, outpatients and productive theatres. A review of quality impact assessments would be undertaken of those CIP programmes already delivered to ensure appropriate close down.

	The urgent and emergency care deep dive report was received which, whist this was not having the intended impact, the principle and theory were correct and therefore consideration of the execution was required. **Internal Audit Recommendations** The Committee received the outstanding internal audit recommendations noting the position and recognising the need for these to be receive to ensure these were current and relevant. **Internal Audit Reports** • **Data Security and Protection Toolkit Internal Audit** • **Core Financial Controls Internal Audit** • **Data Quality Internal Audit** The Committee received the relevant internal audit reports noting these had been received by the Audit Committee and reflecting that relevant actions were in place. Consideration would be given to the role of the Committees in receiving the assurance reports. **CQC Action Plan** The Committee received the CQC action plan noting a number of red items however received verbal reassurance that action had been taken and therefore an update to the report was required to reflect this.
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 data set relating to pending admissions for information due to the impact on quality. The Committee wished to refer fire safety training to the People and Organisational Development Committee to ensure oversight of the position and to enable appropriate action to be taken.
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. The Committee agreed that Objective 3b Efficient use of resources should be uprated to Amber as a result of the level of confidence indicated by the month 1 position.

	The Committee agreed that Objective 3d Improving cancer services access should be downrated to Red due to the declining performance position.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

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Meeting	*Public Trust Board*
Date of Meeting	*Tuesday 6 June 2023*
Item Number	*Item number allocated by admin*
Pilgrim paediatrics consultation plans	
Accountable Director	*Andrew Morgan, CEO*
Presented by	*Simon Hallion, Managing Director for Family Health*
Author(s)	*Anna Richards, Associate Director of Communications and Engagement*
Report previously considered at	*ELT*

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

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 note progress that has been made in developing the model for paediatric care at Pilgrim hospital in the past five years*
	• *To review, feed back on and agree the consultation plan for a 12 week public consultation on the future of the Pilgrim paediatric service, to launch on 07/06/23*

	• *To review, feed back on and agree the draft consultation documentation for Pilgrim paediatrics public consultation*

Executive Summary

This paper provides an update to the Board on the planned 12 week public consultation on the future of the paediatric service at Pilgrim Hospital, Boston.

In August 2018, staffing challenges culminated in the service model being adapted from a children's inpatient ward to a 12-hour Paediatric Assessment Unit, with children requiring a longer length of stay generally being transferred to Lincoln hospital for part of their care. At the same time, the Pilgrim SCBU was limited to only take babies of 36 week gestation or above.

Over the past four years, in response to patient and clinician feedback, the model has been developed into one that enables almost every child or young person to receive all of their care at Pilgrim hospital, without the need to transfer to other hospitals. As a stable model developed at Pilgrim the SCBU was returned to national normalised arrangements and moved back to full SCBU (32 week gestation) status.

Having stabilised the service at Pilgrim we are now hoping to make the current model a permanent arrangement, which will give certainty around the long term future of the service, help with staff recruitment and also ensure ongoing support for Boston-area children and their families.

The unit now:

• Retains a rapid assessment and discharge profile

• Allows for a number of patients to remain longer on the ward, when clinically necessary

• The reduced length of stay has been maintained even with very few children needing to transfer from the hospital, with the exception of those children following specific specialist pathways (which was always the case)

Subject to Trust Board approval, we are proposing to launch the public consultation to make this model a permanent arrangement on Wednesday 7 June 2023, running until Wednesday 30 August 2023.

Appendix A is the draft consultation document to be used as part of the consultation
Appendix B is the EIA and QIIA completed on this change

Further consultation resources, including surveys, meetings and communications activity, will be launched upon launch of the consultation period.

Pilgrim Hospital Paediatric Service- Have your say

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Introduction

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- Children's (paediatric) services at Pilgrim Hospital in Boston have faced a number of challenges in recent years, with significant medical and nursing staffing vacancies.

- In August 2018 this meant the children's inpatient ward was changed to a 12-hour Paediatric Assessment Unit, and any children requiring a longer length of stay were transferred to Lincoln hospital for part of their care.

- Over the past four years we have been continuously listening to feedback from our patients, staff and clinicians, and used this to develop the service further. Our children's (paediatric) services now enables almost every child or young person to receive all of their care at Pilgrim hospital, without the need to transfer to other hospitals.

- Now that the services at Pilgrim have been stabilised, we are proposing to make these current services permanent. This will ensure ongoing support for Boston-area children and their families, give certainty around the long term future of the service and therefore help with staff recruitment.

We now want to hear from you about your views around this proposal

Background – early 2018

United Lincolnshire Hospitals NHS Trust

In early 2018, significant safety concerns were raised about the paediatric service at Pilgrim Hospital, Boston, relating to a shortage of medical staff within the service and subsequent withdrawal of Tier 1 and 2 medical trainees.

This resulted in an extensive public engagement exercise and the ULHT Trust Board agreeing an interim model for the delivery of paediatric inpatient services at the hospital, which was introduced in August 2018. This created a 24/7 Paediatric Assessment Unit (PAU) supported by:

- An agreement to assess and discharge (or transfer) all children presenting at Boston hospital within a 12-hour time frame.
- Children requiring longer inpatient periods being transferred to Rainforest Ward at Lincoln County Hospital or other hospitals.
- At the same time, the Pilgrim SCBU was limited to only take babies of 36 week gestation or above.
- A private ambulance being commissioned to provide this transfer service, although the ambulance was unable to transfer sicker/unstable children when East Midlands Ambulance Service (EMAS) services were then required.

Background – Spring 2019

By the Spring of 2019, it was clear that operationally the unit did/could not strictly adhere to the described 12-hour PAU model with:

- An inability to safely transfer some of the sickest children between hospital sites, with a longer than 12 hour period of treatment therefore being required;
- The rapid discharge of some children at Lincoln following transfer, resulting in an increasing number of families refusing transfer to Lincoln.

In June 2019, the service was inspected by the CQC, and it was apparent to inspectors that the service was not observing the planned12-hour PAU model. At that point we acknowledged that the 12-hour length of stay could not be delivered for all patients.

A more sustainable longer-term model of care has now been actively developed alongside successful recruitment into the medical team and development of a more sustainable nurse staffing model. This development has notably involved service user families, and engagement with representatives of the local population, to ensure their needs are met.

Background – Autumn 2019

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In Autumn 2019, the ULHT Family Health Division worked with clinicians and patient feedback to agree changes to the way the service would be delivered, taking account of clinical need and the safest form of service delivery.

This change meant that for many children, a length of stay of 24 hours allowed for assessment and treatment without transfer, and for children with more complex presentations it would be safest for them to remain at Boston, often to be discharged within a further 24 hours.

The private ambulance service was no longer needed, due to the very low level of transfers and limitations around the ambulance service itself.

This model was tested and resulted in positive medical recruitment, and gave confidence to Health Education East Midlands, who agreed the return of Tier One medical placements in August 2021.

Background – Where we are now

The model of care has further evolved since then. The unit now:

- Retains a rapid assessment and discharge profile
- Allows for patients to complete their full stay at Pilgrim hospital unless transfer is clinically necessary
- Delivers a reduced length of stay, which has resulted in very few children needing to transfer from the hospital, with the exception of those children following specific specialist pathways (which was always the case)

It now offers good performance around limiting patient transfers, quick access to paediatric care for children accessing the Emergency Department, high levels of family satisfaction and a low level of complaints. The service has most recently been rated by the CQC as 'Good'.

In addition, as a stable model has been developed the SCBU has returned to national normalised arrangements to become a full SCBU (32 week gestation).

This has been made possible due to significant improvements in the recruitment of clinical staff, which means we have a full complement of medical staff for the first time in a number of years.

Pre 2018 Inpatient model vs Current Children's Unit model

United Lincolnshire Hospitals NHS Trust

Measure	2018	Present
Number of beds	19	16 (with ability to flex to 21 at times of pressure)
Average length of stay	25 hours	22 hours
Nurse staffing	44.09 WTE	36.9 WTE (WTE reflecting bed numbers)
Medical staffing	1:8 Consultant rota (4.5 substantive plus agency) 4.5 WTE middle tier doctors (high agency usage)	8 consultants on call 8 middle tier doctors 5 HEE trainees and non-training posts making up 1:8 rota

Issues

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- The change of model into a PAU created a high level of uncertainty for the local community, and the development of a community campaign group.

- Whilst the new model of care is not dissimilar to the offer of an inpatient ward, in terms of access for patients, it is still a change.

- Outside of this work, alongside a small number of adult pathway developments, the pathway for some children for ENT and urology has changed with emergency access now delivered at Lincoln rather than Boston.

- The unit continues to work actively with the hospital's Emergency Department (ED) to support prompt identification and transfer of children and young people who need support from the children's unit. Within the next few years, a new ED will open at Pilgrim Hospital, with significantly improved facilities for children and young people and families, following national best practice.

Successes

The new Children's Unit model has built on the successes of the initial move to a Paediatric Assessment Unit (PAU):

- Providing increased access to senior decision makers (including a consultant on site until 10pm weekdays) which has led to more rapid discharges for many patients.
- Improved staff recruitment.
- Removed almost all nurse and medical agency from unit
- The certainty of staffing allows the option of flex to higher bed numbers if necessary.
- We have maintained elective surgery and MRI work, and have set up a new process for children's medical day cases.
- The integration of Assessment / Observation / inpatient care has produced a more responsive model of care for the south of the county.

Engagement to date

Over the last five years, the Family Health Division has participated in a number of discussions with representatives of the community served by Pilgrim hospital, to discuss the developing models of care. Their honest feedback on experiences in hospital was extremely helpful in allowing us to develop an appropriate service model.

They have engaged with the below groups:

- SOS Pilgrim
- Lincolnshire Health Overview and Scrutiny Committee (HSC)
- Lincolnshire Healthy Conversation
- Lincolnshire Children and Young People's Transformation Board

The development of the model has included engagement with affected health professionals and a staff survey.

The team are also now securing real time patient/parent service feedback at point of discharge. The specific detail of this feedback will feature on the 'You said, we did' information boards in our paediatric environments as well as informing future social media activity.

What is being proposed?

The Trust Board of ULHT are confident that the challenges of 2018 have now been addressed, and are seeking views of patients and the public of Lincolnshire around the continuation of paediatric care at Boston Pilgrim Hospital

Therefore, we are proposing to make the current model the permanent arrangement for paediatric care at Pilgrim hospital.

This is the only option being proposed, as alternatives have been explored and worked through and this is the best way to deliver the service for population of Boston and surrounding areas.

This is a unit that offers a service ethos of rapid senior assessment and discharge, but with patients able remain longer on the ward, when clinically necessary.

We believe that the model delivers a service that reflects national best practice, using early decision-making processes to actively assess, treat and discharge patients to avoid the need for a traditional in-patient ward approach.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*6th June 2023*
Item Number	*Item 12*

Integrated Performance Report for May 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

Venous Thromboembolism Risk Assessment

Compliance against this metric has slightly decreased for the month of April and is currently at 94.94%.

Never Event

There has been a Never Event declared in April pertaining to the unintended retention of a guidewire following a central line insertion. This is the first Never Event for this financial year. The Division have undertook a preliminary review of the incident and all immediate actions have been taken.

Medications

For the month of April, the number of incidents reported in relation to omitted or delayed medications has decreased again from the previous two reporting periods and is at 24%. Medication incidents reported as causing harm is currently at 12.8%. A number of work programmes through the IIP continue and are currently being monitored through the Medicines Quality Group. There is a business case that has been submitted to allow 7 day working for the Pharmacy department and to provide a service to all ULHT wards. Increasing the presence of Pharmacy staff on the wards will reduce risks, improve the safety of care that the Trust provide to patients.

SHMI

The Trust SHMI has remained static this month and is currently at 102.67. SHMI is at the lowest level for the Trust and is 'As expected'. The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.

eDD

The Trust achieved 90.2% with sending eDDs within 24 hours for April 2023 against a target of 95%. A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric at their monthly Performance Review Meeting.

Sepsis compliance – based on March data

IVAB Inpatient Child - The administration of IVAB for inpatient children increased to 87.5%. 7 out of 8 children that required treatment received this in a timely manner. 1 child had delayed antibiotics however no harm occurred.

IVAB ED child - The administration of IVAB for children in ED was at 81.8% an increase from the last reporting period. There were 2 patients in ED this month that were delayed in receiving antibiotics however no harm occurred.

Duty of Candour (DoC) – March Data

Verbal compliance for March was at 88% against a 100% target and 84% 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

At the time of writing this executive summary (14th May 2023), the Trust has 18 positive COVID inpatients with no patients requiring Intensive Care intervention. The April peak was 46 patients. The current Influenza inpatients are 0 with the peak in April being recorded at 10 patients versus 1562 tests completed. RSV peaked at 1 patient in April versus 257 tests completed, but as of the date of this report there are zero confirmed. There are also currently 0 patients confirmed Norovirus following 2 outbreaks within April.

This report covers April's performance, and it should be noted the demands of Wave 7 have now decreased with the number of positive COVID cases remaining relatively static. The teams across the organisation continue to transition to 2023/24 and the recovery of waiting times and continues to return pre-Covid access.

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. April has met its target by a positive 8.73%, also showing an improvement in performance of 2.47% compared to March to result in 59.50% compliance overall against the target of 50.77%. The SPC chart below documents both the 22/23 and 23/24 target to reflect performance ambition.

There were 665 12-hr trolley waits, reported via the agreed process in April. This represents a decrease of 56 patients from March 2023 (721). Sub-optimal discharges/timely recognition to meet emergency demand remains the root cause of these delays.

Performance against the 15 min triage target demonstrated an improvement of 3.37% against March performance of 78.23% to Aprils 81.60% compliance. A deeper review is required of patients who leave the department or refuse treatment that compromise this performance target.

There were 440 >59minute handover delays recorded in April, a decrease of 176 from March. This represents 10.84% of arrivals waiting over this timeframe, a 4.89% improvement to the previous month. Following new standards, the <15Min handover performance for April showed an 11.12% compliance which equated to 3,603 crews waiting over the desired timeframe.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 5.12 days against an agreed target of 4.5 days a further deterioration of 0.11 days compared to March and 0.23 days compared to February. The average bed occupancy for April against "Core G&A" was in excess of 96%, with PHB demonstrating the highest level of occupancy against core. April saw an average of 53 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 91.84%.
System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3. Pathway 1 saw an increased length of stay by 0.5 days compared to March 2023. Pathway 2 saw the biggest decrease in length of stay for April by 1.6 days.

Elective Length of Stay decreased further to 2.87 days compared to 3.02 days in March.

Referral to Treatment

March demonstrated an improvement in performance of 0.73%. March outturn was 50.29% versus 49.56% in February. This is highest improvement since August 2022. The Trust is now reporting patients waiting over 65 weeks as opposed to 52 weeks. The Trust reported 2,206 patients waiting over 65 weeks, which is a decrease of 560 patients on the reported February position. The position requires close monitoring and scrutiny.

At the end of April, the Trust reported 2 patients waiting longer than 104 weeks. Both of these were due to patient cancellations. Discussions are taking place with NHSE weekly in regard to 104- and 78-week waiters with month end figure April at 257 including first definitive treatment due the impact of the Junior Doctors strike action.

Waiting Lists

Overall waiting list size has increased since February. March reported 73,514 compared to February's position of 72,055 an increase of 1,459. Work continues between Outpatient department and the Clinical Business Units regarding returning better access to our bookable services for primary care and patients' choice.

The recovery plan for ASIs has been developed, including a recovery trajectory. As of 15th May, ASI recovery has demonstrated a deterioration (1,656 verses 1,499 in March) and is more in line with the agreed trajectory of 550. Additional resource has been directed to resolving missing outcomes which is having an adverse effect on the bookings team being able to move the ASIs to open referrals.

DM01

DM01 for April reported a slight deterioration 61.82% versus 61.83%. Compliance against the national target of 99%. A negative variation of 0.01% on the March outturn and a negative variance of 37.18% against the nationally agreed target. Whilst the main area of concern remains Echocardiography, but a continued month on month improvement is noted. DEXA backlog has reduced to 617 in April compared to 866 in March.

Cancelled Ops

April outturn for cancelled operations on the day demonstrated a slight deterioration at 1.05% versus 0.79% in March.

The target for not treated within 28 days of cancellation is zero. April experienced 14 breaches against the standard verses 16 in March

Again, this is the lowest position reported since December 2021. The continuous review of the effectiveness of the 6:4:2 theatre scheduling meetings continues and ICU capacity as a response to internal and external pressures is improving so it is likely that performance will continue to improve.

Cancer

Trust compliance against the 62day classic treatment standard is 55.08% (against 85.4% target.) This demonstrates an improvement of 15.81% in performance since the last reporting period and is 30.32% below the nationally agreed compliance target. This is the highest compliance against the target since August 2022.However, the position against the Trust recovery trajectory is just in line.

Residual impacts of COVID-19 on the delivery of the cancer pathways remains evident for 31 day and 62-day standards although as per previous statements Cancer pathways remain the highest priority in the recovery of services and the ring-fencing of capacity.

104+ day waiters have reduced and are achieving the agreed trajectory. There are currently 918 patients waiting >104 days against a target of <10. The current figure is an increase of 7 patients since the last reporting period. The highest risk speciality is colorectal with 36 pathways greater than 104 days, this a further reduction of 16 since the last reporting period. 3 times weekly meetings are in place to offer challenge and confirm.

Workforce

Mandatory Training – The mandatory training rate for May has seen a slight increase (by 1.02%) to 90.2% against 95% target. Work is ongoing to ensure that all areas and individuals are given the time to complete core learning modules. Work is being undertaken to support low compliance, particularly those at 50% and less. This has been communicated divisionally and action is being taken to address. A number of support measures are now being implemented in terms of ESR user support and the provision of at elbow support for core learning for those departments and individual users requiring additional input. The Mandatory Training Action Plan has been approved and work is underway to improve our mandatory training compliance. The review of all core and topics has been completed and changes will be made to the core and core + offer moving forward.

Sickness Absence – The April sickness absence rate of 5.57%, has decreased slightly but remains above the target of 4.5%. The trust is approaching its lowest vacancy level over the past two years. As such, we are hopeful this will impact positively on our colleagues health and wellbeing. Nonetheless, our sickness average remains above target, consideration in respect of this target being achievable needs discussion and consideration. Further work to support managers and leaders in absence processes and supporting our people to attend the work environment will be delivered through the mandated basics brilliantly workshop which is one of our actions following this year's annual staff survey results. These recommendations are to the board in May 2023 we are hopeful to commence our journey towards a "supporting attendance" approach as opposed to managing absence.

Staff Appraisals – Ongoing service pressures and staffing challenges in the Trust continue to impact appraisal completion rates but month on month there is a slight improvement with an increase this month to 67.19% non-medical but a decrease to 97.51% for medical. We are recommending that a 90 minute appraisal for each colleague is planned for as we enter 2022/23. Further, we have completed an audit in Urgent Emergency Care whereby we can see that appraisal activity is higher than that reported. A number of colleague's appraisals were completed in the past 12mths on WorkPAL and were not recorded on ESR. Work is underway to educate leaders on the process required to update ESR, even for ones done on WorkPAL already.

Staff Turnover – Turnover has seen an increase in April to 13.23% from 12.82% in March against a Target of 12%. This was expected due to the impact of financial year end leavers e.g. fixed term contracts etc. Operational pressures, staffing and culture challenges mean that a regular proportion of staff are looking for other avenues outside the Trust. People Promise Manager continues to work with the Trust and ICB to explore retention and bring best practice into the organisation to address the challenges, planning currently underway for next year's system plan. Working towards a more robust process via ESR to capture leavers data.

Vacancies – We saw a 0.7% increase in vacancy factor in April to 7.6%, this was due to us having a limited number of starters joining the Trust, and a significant amount of year end leavers. We need to keep an ongoing focus on HCSWs over the coming months to backfill those IENs achieving NMC status. We may see an increase in our vacancy factor next month due to sizeable business cases for Community Diagnostics and Housekeeping being signed off which will increase our funded establishment, however despite this due to significant recruitment our net staffing position will continue to grow.

Finance

The Trust'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 £2.1m in April, which is on plan.

CIP savings of £1.7m have been delivered in April, which is £0.5m favourable to the planned savings in month of £1.2m.

Capital funding levels for 2023/24 have been agreed with NHSE and system partners. The Trust delivered capital expenditure of £0.2m in April which is £0.4m lower than planned capital expenditure of £0.6m.

The April cash balance is £45.6m; this is an increase of £4.3m against the March year-end cash balance of £41.3m

Barry Jenkins
Director of Finance & Digital
May 2023

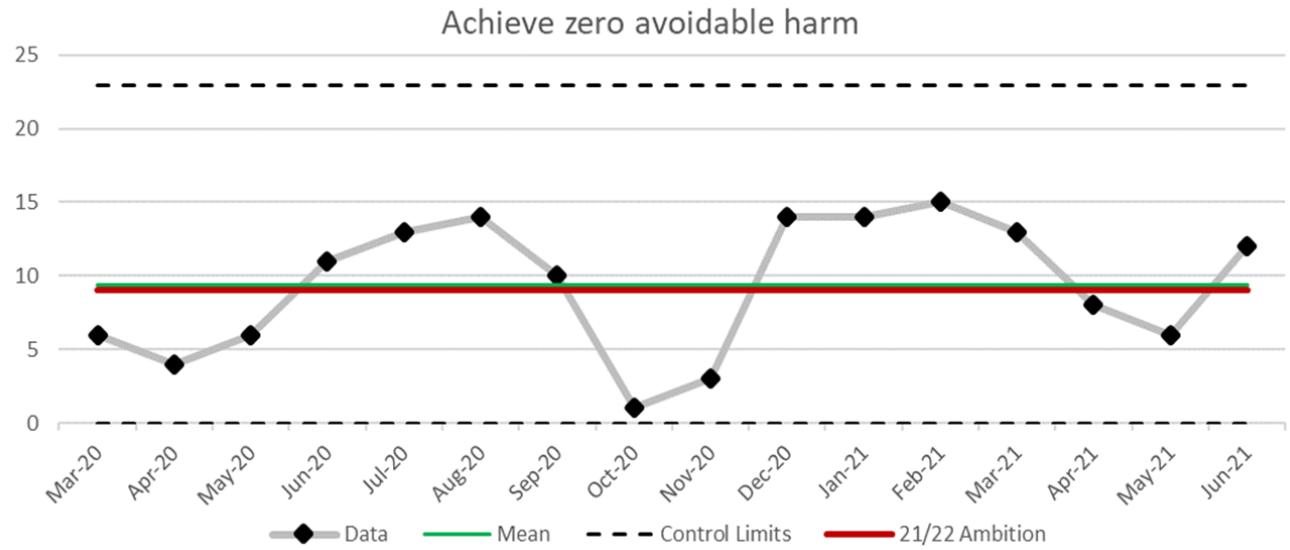
Statistical Process Control Charts

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

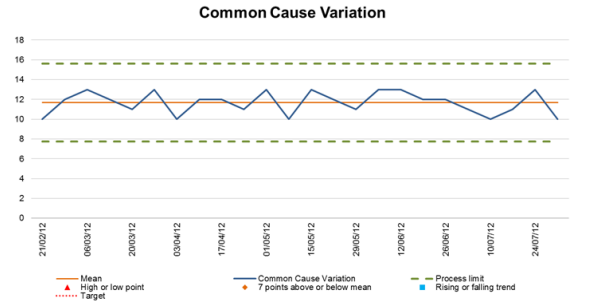
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

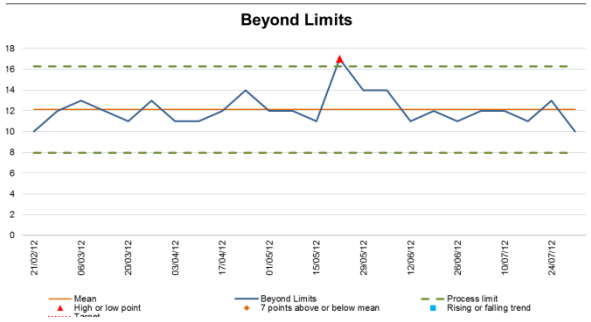
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



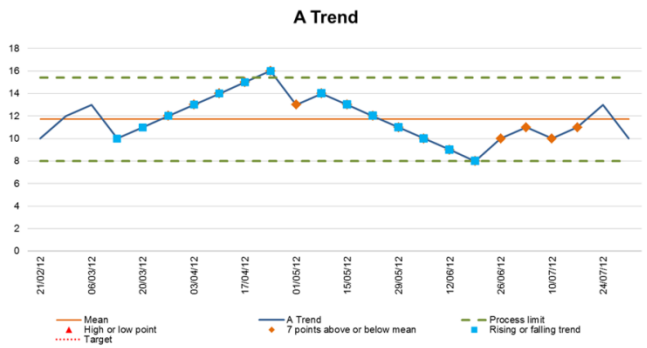
Extreme Values

There is no Icon for this scenario.

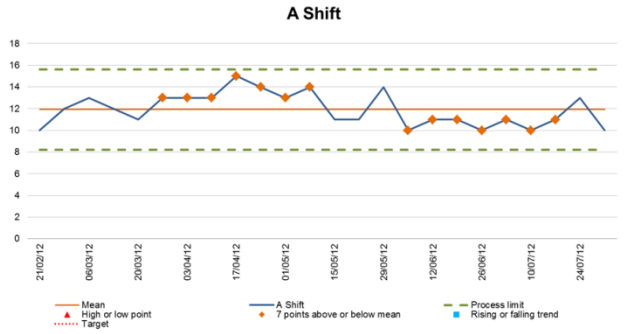


Statistical Process Control Charts

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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NHS United Lincolnshire Hospitals NHS Trust

EXECUTIVE SCORECARD

Measure ID	Domain	Measure	Measure Definition	SRO	2022/23 Ambition	Tolerance	£'000	Feb-23	Mar-23	Apr-23	Latest month pass/fail to ambition/ tolerance	Trend variation
1	Patients	Implementation of SAFER Bundle – LOS > 7 Days pathway 0	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients.	COO	10.00%	1.00%		11.68%	12.50%	12.30%	F	
2	Patients	SHMI performance	Summary Hospital-level Mortality Indicator. National data published by NHS Digital is for rolling 36 month period ending 5 months prior to current month	MD	100	5 points		3rd Quartile (103.12 (71st of 121)	3rd Quartile (102.92 (69th of 121)	3rd Quartile (102.67 (67th of 121)	P	
3	Patients	Reduction in moderate and severe harm and death incidents	Serious incidents (including Never Events) of harm - Moderate, severe and death - per 1000 OBD	DoN	0	0.17		0.06	0.34	0.33	F	
5	Patients	Reduction in medication incidents leading to moderate & severe harm or death	Total number of Medication incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	DoN	0	0.07		0.09	0.03	0.03	P	
6	Patients	Reduction in DKA incidents resulting in moderate & severe harm or death	Total number of DKA incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	MD	TBD	TBD		0.03	0.00	0.00		
7	Patients	Achievement of the IPC BAF	% of green/compliant items from the IPC COVID BAF C1501 v1.8 (quarterly)	DoN	95.00%	1.00%					P	
8	Services	Financial Plan	Variance aganst plan (£'000)	DoF	£0	£0	£'000	(276)	(258)	10	P	
9	Services	Percentage of patients spending more than 12 hours in department	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	COO	1.00%	5.00%		15.01%	15.45%	12.43%	F	
10a	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	COO	503	100		6,935	6,870		F	
10b	Services	Patients waiting 65 weeks or more	Number of patients waiting 65 weeks or more (RTT pathways)	COO	TBD	TBD		2,766	2,206			
11	Services	28 days faster diagnosis	Number of patients diagnosed within 28 days or less of referral as a percentage of total Cancer pathways.	COO	75.00%	5.00%		68.25%	66.98%		F	
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	DoPOD	9.00%	1.00%		7.72%	6.91%	7.69%	P	
13a	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	DoPOD	90.00%	2.00%		65.39%	65.95%	67.19%	F	
13b	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	DoPOD	95.00%	2.00%		88.81%	89.18%	90.17%	F	
14	People	Improved Pulse Survey results (Quarterly staff survey)	Improvement in the % of people rating their likelihood of referring the Trust to Friends and Family (Agree & Strongly Agree)	DoPOD	55.00%	5.00%						
16	Partners	Increased recruitment/academic posts (across the ICS)	Number of posts appointed	DII	10	2						
18	Partners	Early Warning Discharge Indicators	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, for pathway 1-3 patients.	COO	50%	10.00%		75.83%	74.90%	74.85%	F	

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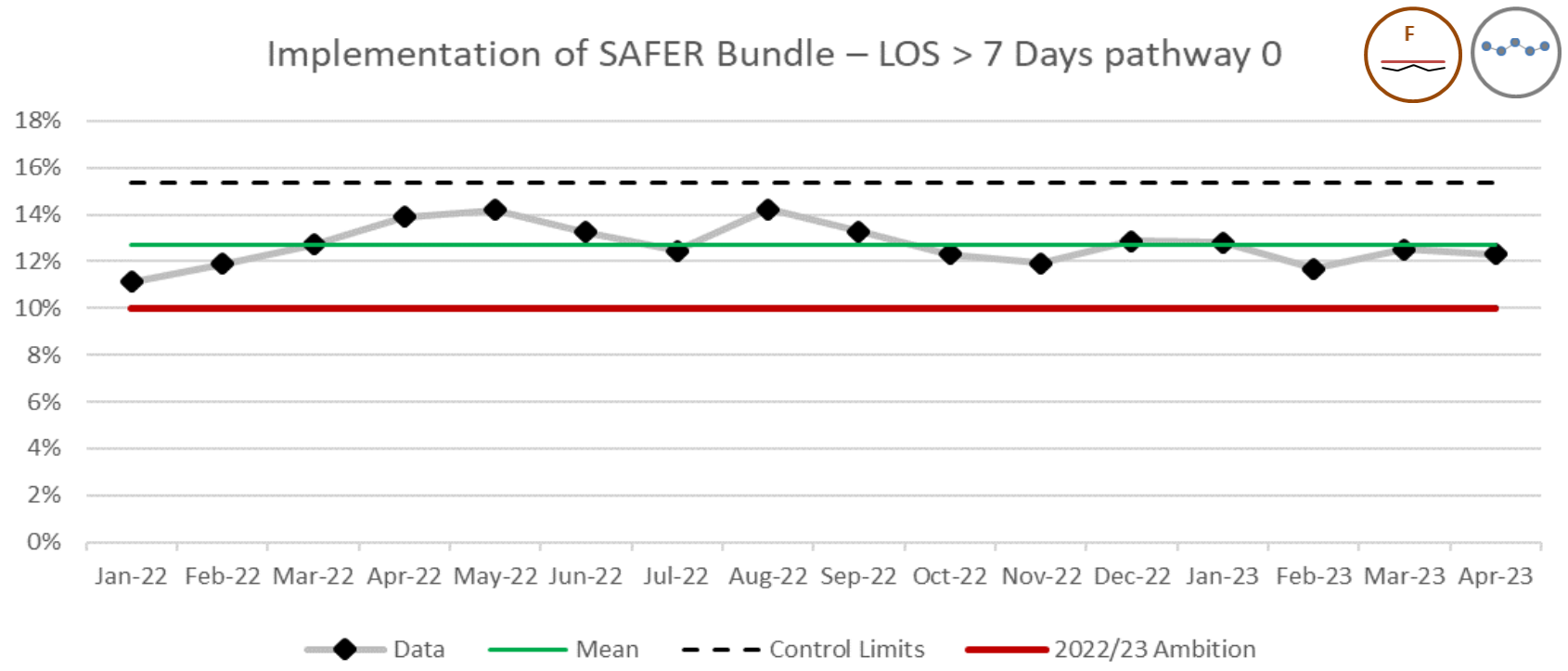

Apr-23
12.30%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
10% with 1% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

Whilst not achieving the ambition of 10%, improvements are being realised.
What the chart isn't telling is that the average time from medically Optimised to discharge for Pathway 0 in April was 1.3 days a consistency from March .Also an improved performance compared to April 2022 of 1.5 days.

Issues:

Numbers of stranded and super stranded patients has increased across all 3 Acute Sites.
Higher acuity of patients requiring a longer period of recovery post Winter Impact, and complexity of post hospital care.
Medical outliers have reduced overall but reduced medical staffing has led to delays in senior reviews.
During April ULHT saw a number of areas impacted due to IPC intervention against Norovirus – delaying review/discharge.

Weekend discharges are still 50% less then weekdays.
Pathway 0 patient discharging remains slow to show improvement but with the continued support of IMPOWER, this is now picking up pace.

Actions:

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

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

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

Mitigations:

Divisional Bronze Lead continues to support the escalation of exit delays to the relevant Divisions and Clinical Business Units for the time being.
A revised Capacity meeting structure and escalation process will be in place week commenced on 12th December
A daily site update message is sent at 6am alerting Key Leaders to ED position, flow and site OPEL position by Site.
The move to working 5 days over the 7 a Day period is in train.

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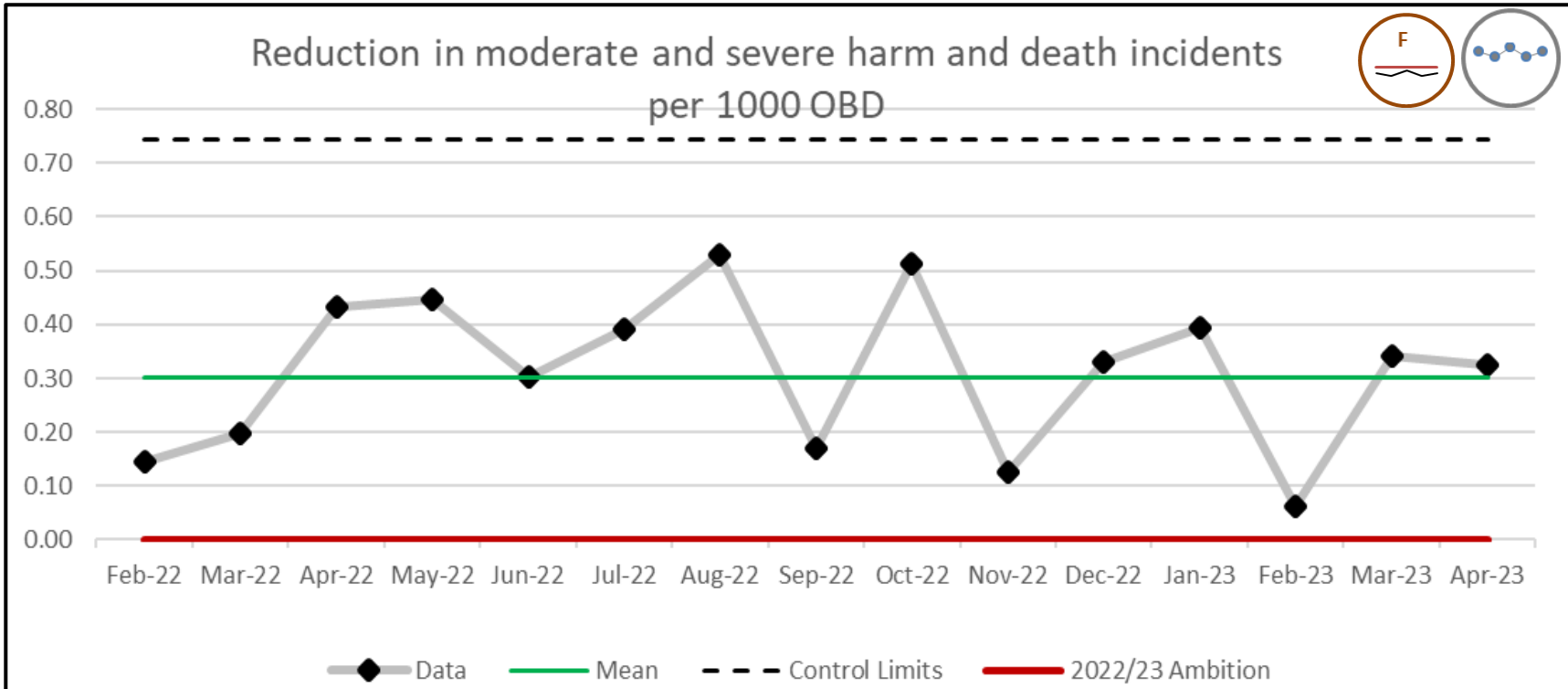

Apr-23
0.33
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
0 with a 0.17 tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

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

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

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

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

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

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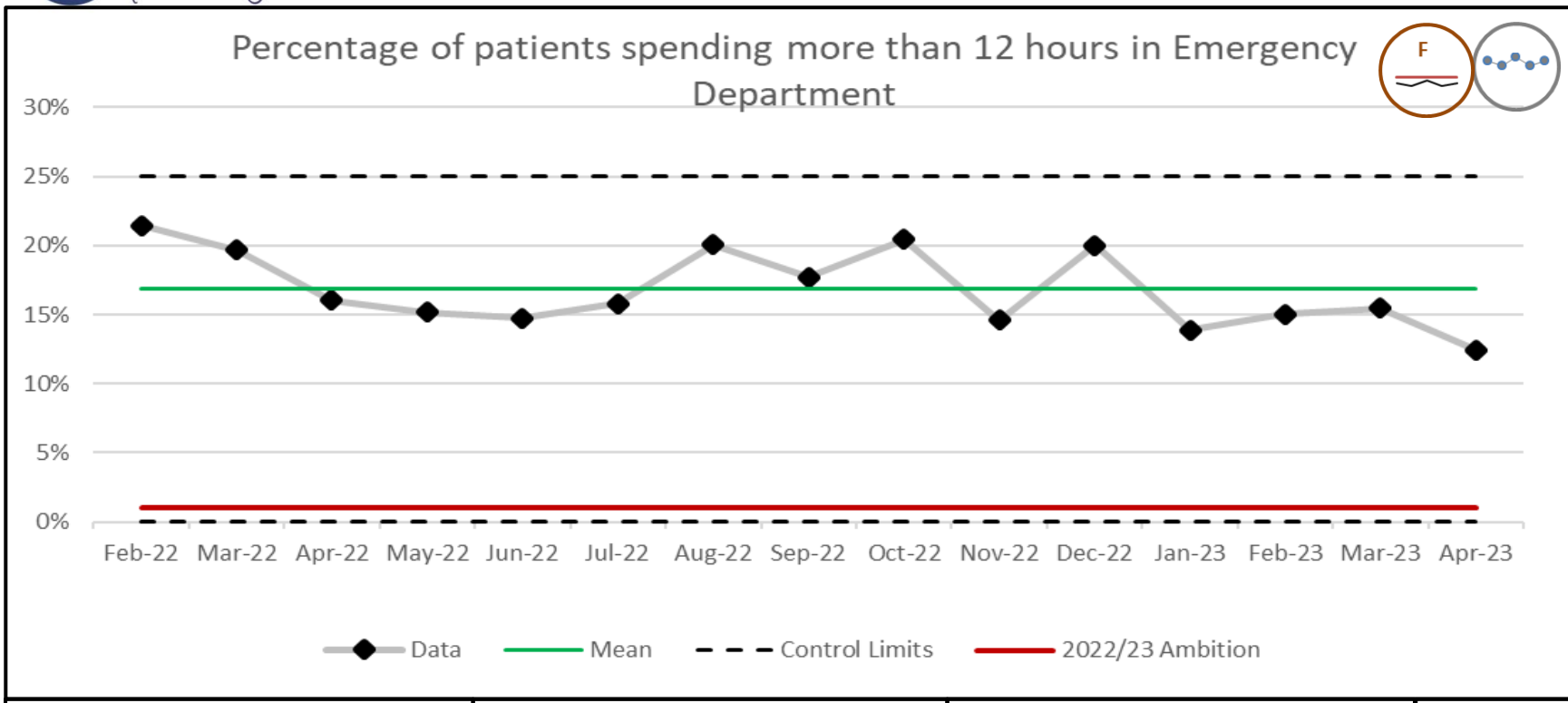

Apr-23
12.43%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
1% with 5% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

April experienced a decrease in the numbers of patients with an aggregated time of arrival greater than 12 hours against total attendance. 1486 compared to 1956 in March.
What the chart doesn't tell us is that 463 went over 24hrs, with the longest at 43 hours. Compared to 546 over 24hrs in March 23 and longest at 56hours.

Issues:

April experienced a 9.71% decrease in Type 1 attendances to ED compared to March 23. This decrease in Emergency Department attendances resulted in 7.12% (274) less non-elective admissions. However the main factor contributing to the delays still seen, is due to inadequate discharges from exit block/ timely recognition of discharges to meet the demand and flow.
Increased number of patients experiencing an elongated LOS due to requiring non acute admission but requiring access to an alternative health care setting such as domiciliary care, transitional care, community hospital and Adult Social Care. The establishment of a joint health and social care off for domiciliary care is in place and capacity to access this is increasing.
Delays in time to first assessment contribute to the clear formulation of a treatment plan, especially out of hours.

Actions:

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

Mitigations:

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

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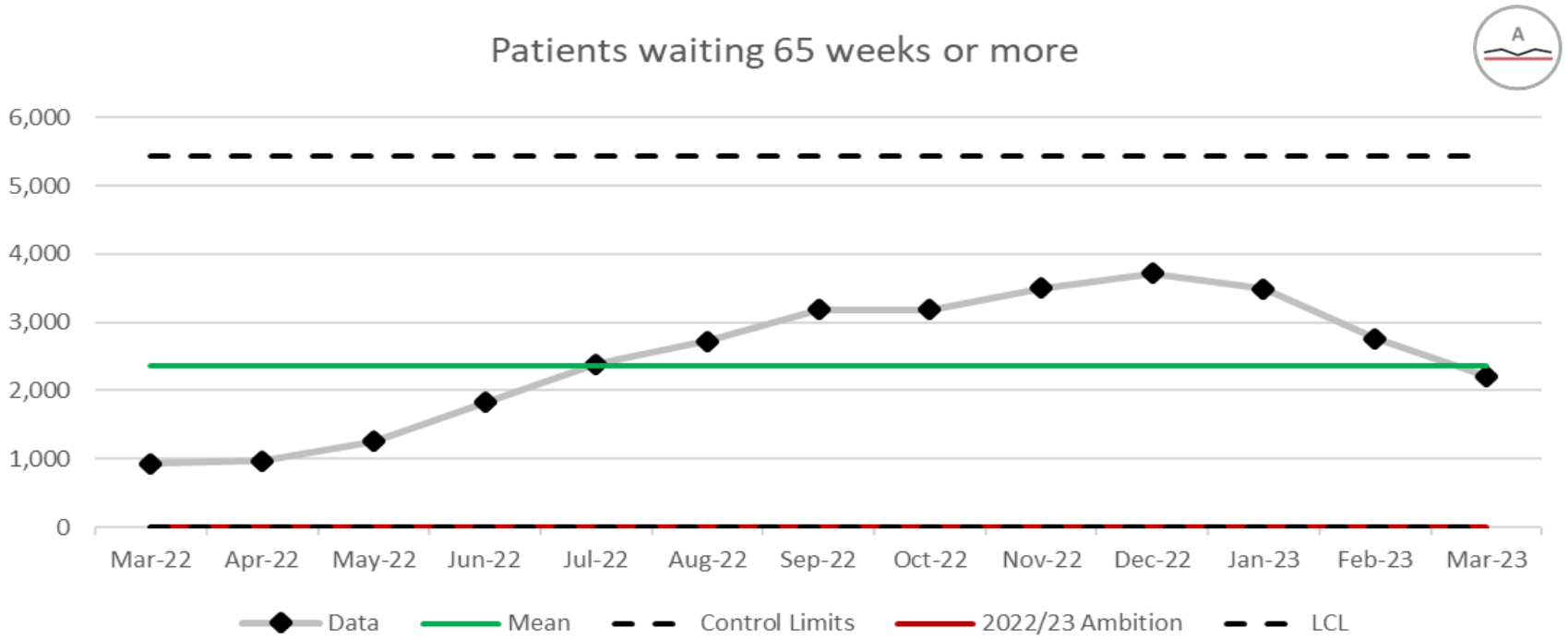

Mar-23
2,206
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
2022/23 Ambition/Tolerance
TBD
Achievement
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 2,206 incomplete 65-week breaches for March 2023, a decrease of 560 from February 2023's 2,766.

Issues:
Whilst ULHT's position is strong with 104 week wait patients, with 4 patients reported for March. Performance is less assured with 65 week waiters, however there continues to be a decrease each month. Both admitted and non-admitted patients sit within this backlog, however, the most significant pressure remains in the non-admitted pathways. The recent doctors industrial action had a detrimental effect on performance.

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

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

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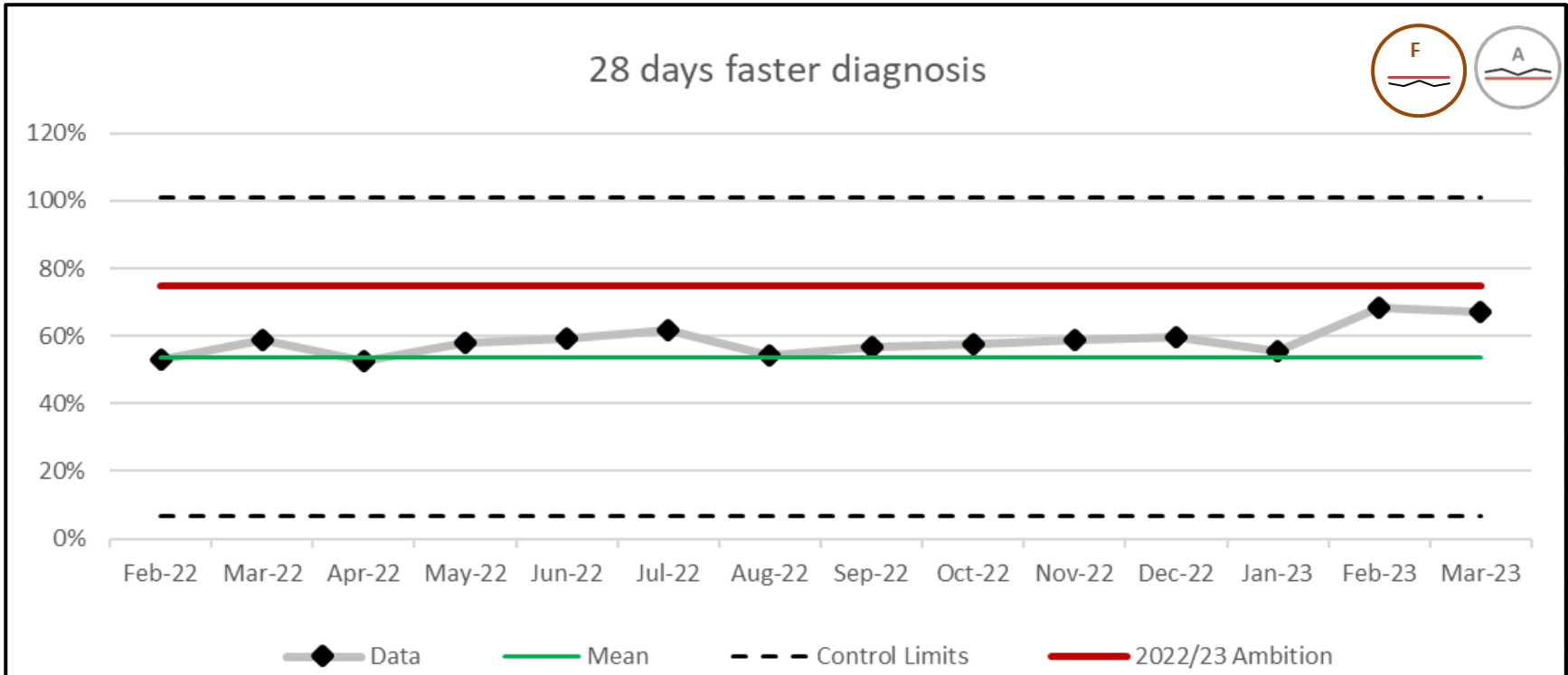

Mar-23
66.98%
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
2022/23 Ambition/Tolerance
75% with 5% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 66.98% against a 75% 2022/23 ambition with a 5% tolerance.

Issues:

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

Actions:

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

Mitigations:

Haematuria Pathway – One-Stop has not improved but GK STT slots have been offered and are pending a start date.
A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention / support. However, the Pre-Diagnosis Team workload continues to be impacted by an increasing backlog.
All tumour site CBUs have engaged with the introduction of the Cancer Centre FDS Dashboard to understand their performance and explore areas to focus on improvement.

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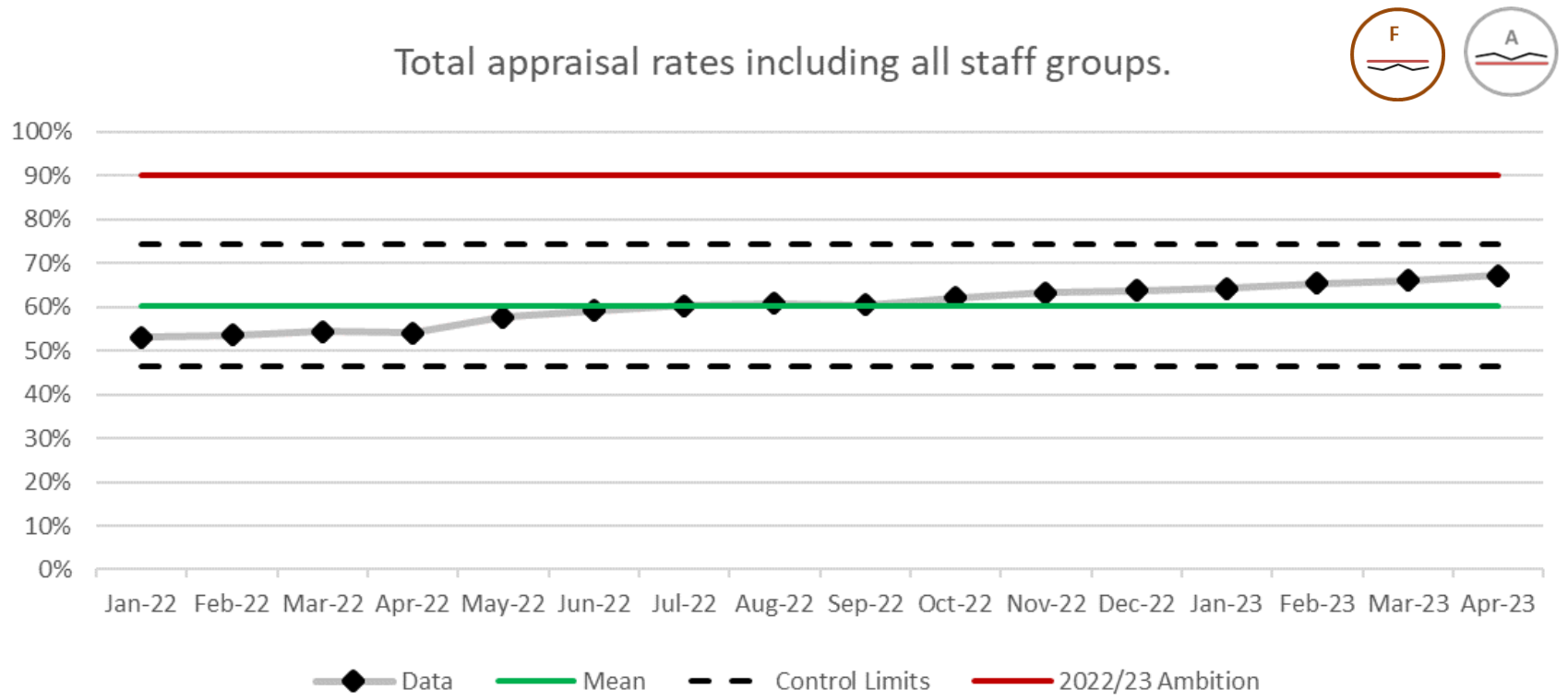

Apr-23
67.19%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
2022/23 Ambition/Tolerance
90% with 2% tolerance
Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
% completion is currently 67.19% **(non-medical)**

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

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:

- Recommending 90 minute appraisals planned for colleagues during 202/24
- Work underway to educate managers on the process required for updating appraisals on ESR.
- A protected learning time policy is being created to support the completion of appraisals and core learning, in turn also increasing the associated compliance rates.

Mitigations:
See actions

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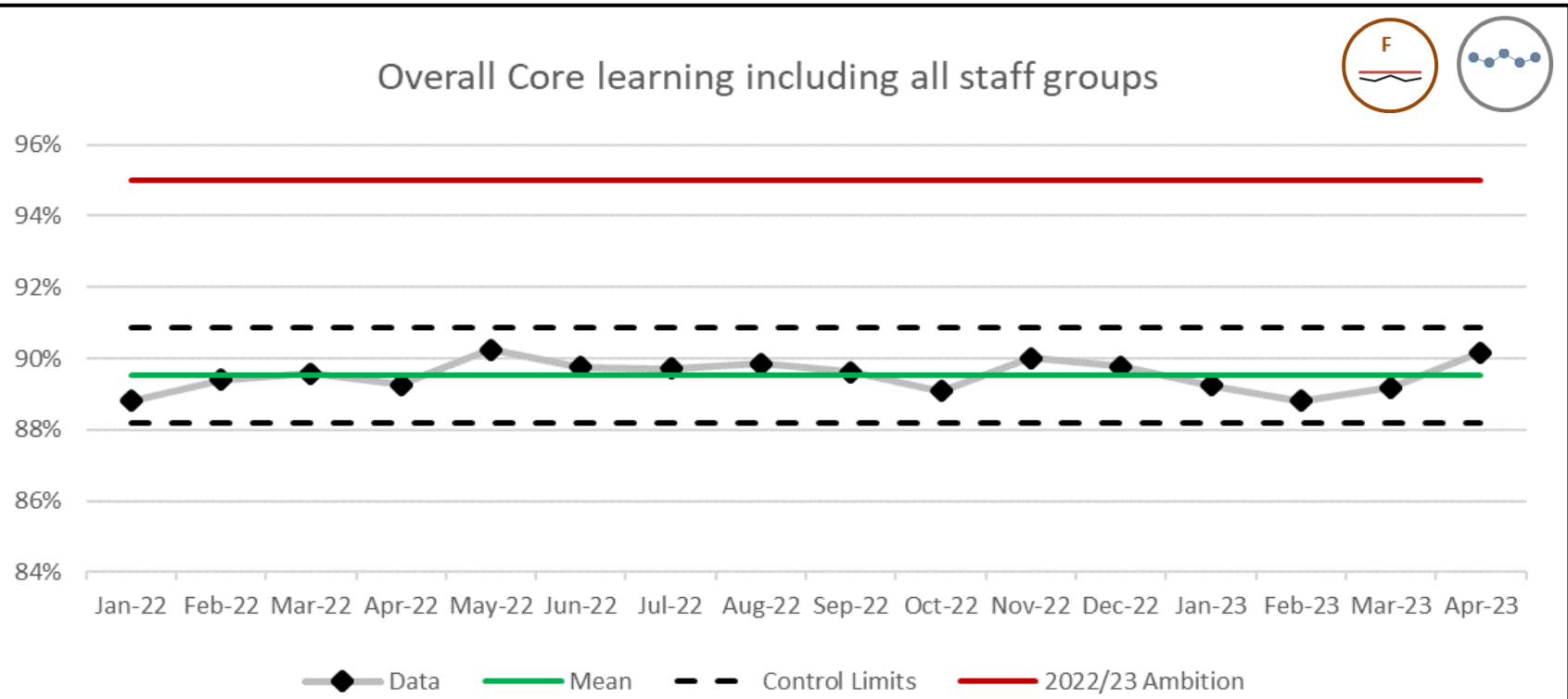

Apr-23
90.17%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
95% with 2% tolerance
Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
% completion is currently 90.2%

What the chart tells us:
Mandatory training compliance has seen a small improvement to the previous months position.

Issues:

- Protected time for core learning continues to be an issues, particularly clinical staff.
- Jr Drs induction sees 200 staff inducted into the Trust on a different programme to that of all other staff affecting core compliance.

Actions:

- A protected learning time policy is being created to support the completion of appraisals and core learning, in turn also increasing the associated compliance rates.
- Core learning offer now aligned to the national Core Skills Training Framework (CSTF).
- Core + offer has been reviewed.
- Each core + module is now being remapped as appropriate to role as opposed to position level.

Mitigations:
Improvement Action Plan

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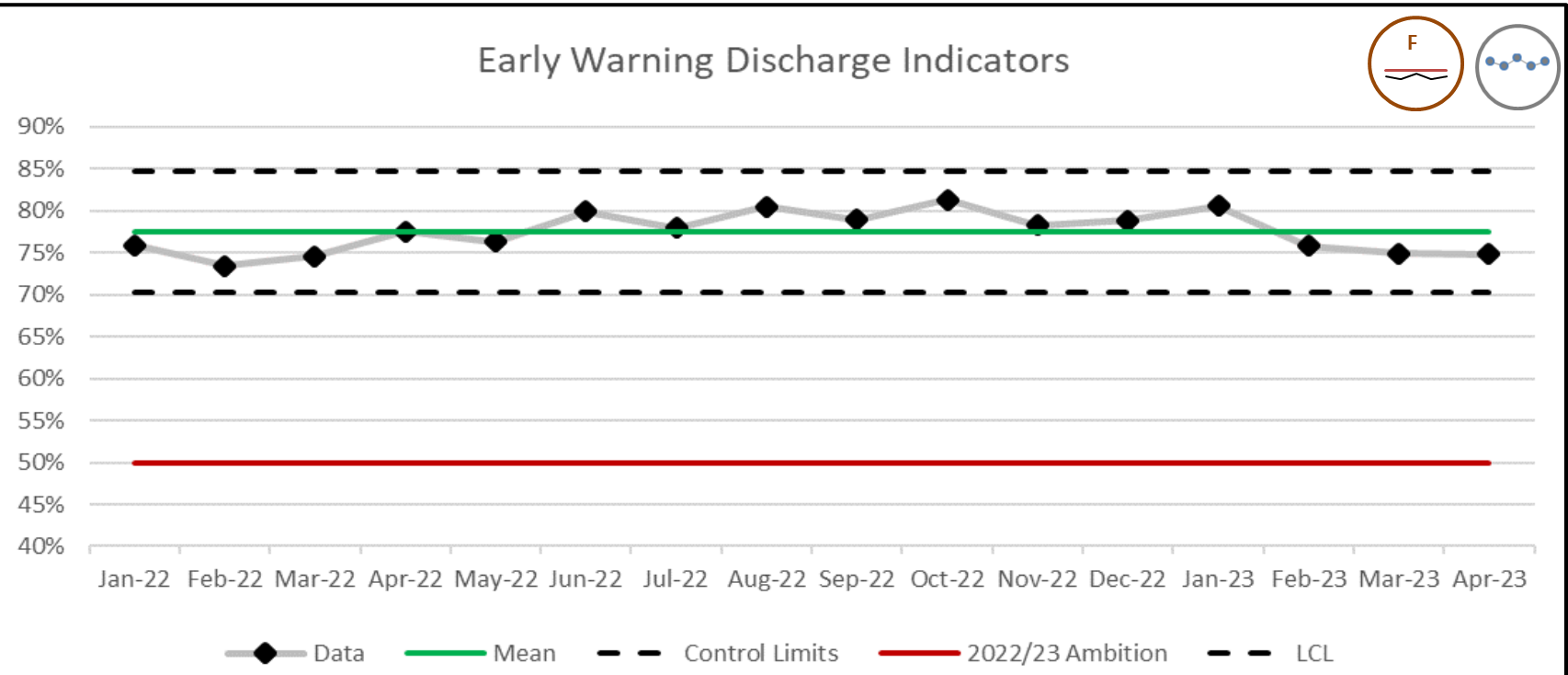
NHS United Lincolnshire Hospitals NHS Trust



Apr-23
74.85%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
50% with 10% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

The Trust is currently at 74.85% against a 50% 2022/23 ambition. This is a decrease in performance of 0.05% compared to March 23, but a 2.68% improvement against, April 2022.

What the chart doesn't tell us is that the most improvement seen is within Pathway 2 – with a decrease of 1.6 days in length of stay compared to March 23.

Issues:

Numbers of stranded and super stranded patients have decreased. Super by 3.15% and stranded by 1.71%

The most significant increase in volume of bed days is Pathway 1 In April Domiciliary care but since the advent of the joint D2A process and additional funding benefits are being realised slowly but there remains insufficient capacity to meet the increasing demand. The Transfer of Care Hub continue to gain more traction on moving discharges forward at an improved pace.

Actions:

Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
The move to Lateral Flow Testing as opposed to PCR testing for access to onward non acute care is proving beneficial once Community and social care is secured.
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.
Transfer of Care Hub escalation of barriers to discharge are monitored though the Capacity Meetings and Hub meetings.

Mitigations:

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

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

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

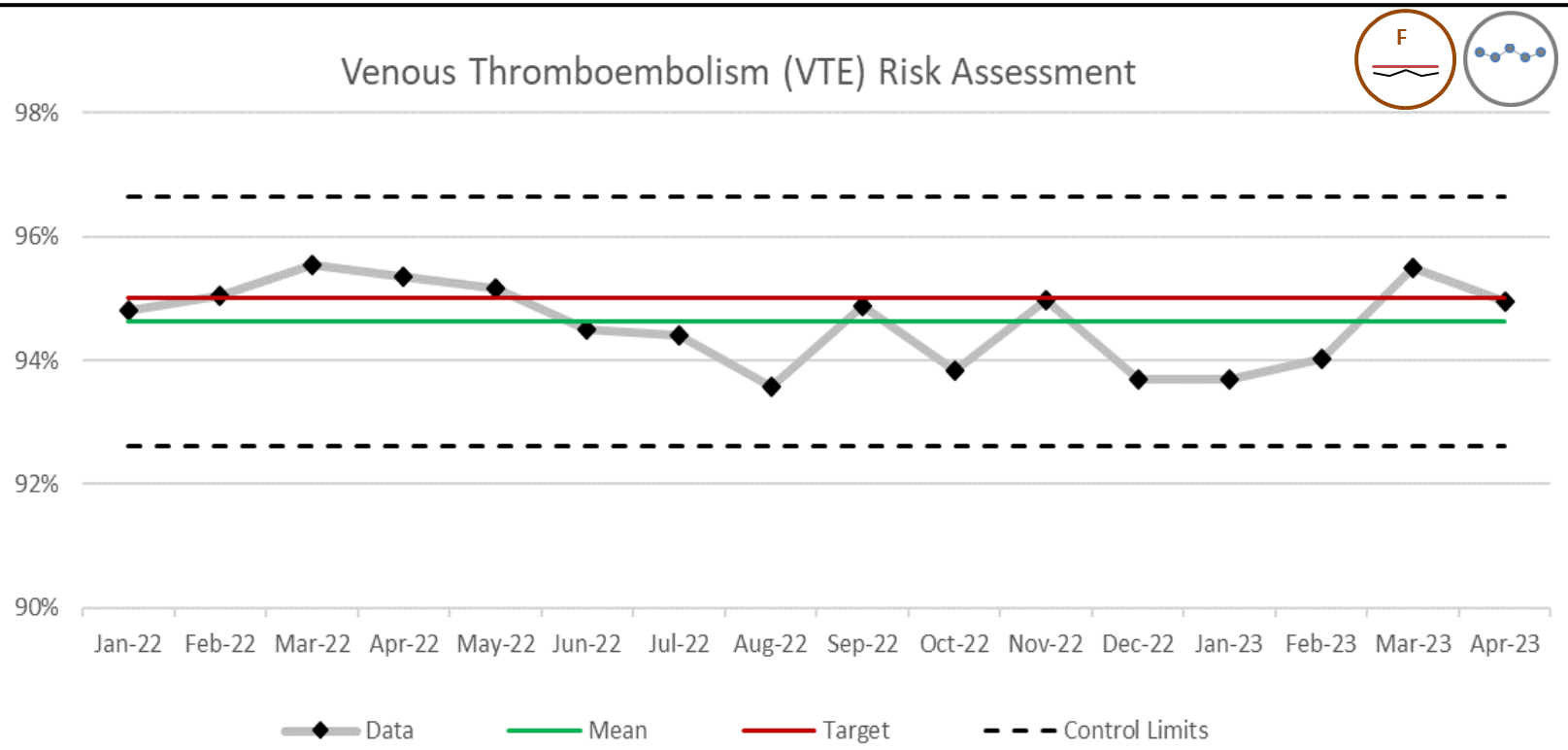
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Feb-23	Mar-23	Apr-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	5	5	2	2	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	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	0.02	0.02		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.02	0.01	0.04	0.04		
	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	0.13	0.04	0.04	0.04	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	0	0	0	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	2	0	1	1	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	4	4	2	2	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	94.03%	95.49%	94.94%	94.94%	F	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	1	1	F	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.32	5.85	5.77	5.77	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	11.80%	10.70%	12.80%	12.80%	F	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Feb-23	Mar-23	Apr-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	0%	None due	None due			
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	93.79	94.03	95.22	95.22	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	103.12	102.92	102.67	102.67	F	L
	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%	89.30%	88.30%	90.20%	90.20%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	94.00%	90.00%		90.98%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	87.53%	90.00%		86.61%	P	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	92.00%	95.00%		93.72%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	80.00%	87.50%		80.51%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	93.00%	92.00%		90.86%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	90.00%	93.90%		86.83%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	96.00%	97.00%		94.32%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	33.30%	81.80%		62.33%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.22	2.43	2.23	2.23	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%	94.00%	88.00%		87.25%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	88.00%	84.00%		80.83%	F	



Apr-23
94.94%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is failing the target
Executive Lead
Medical Director

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

What the chart tells us:
VTE risk assessment continues under perform.

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

No narrative owner

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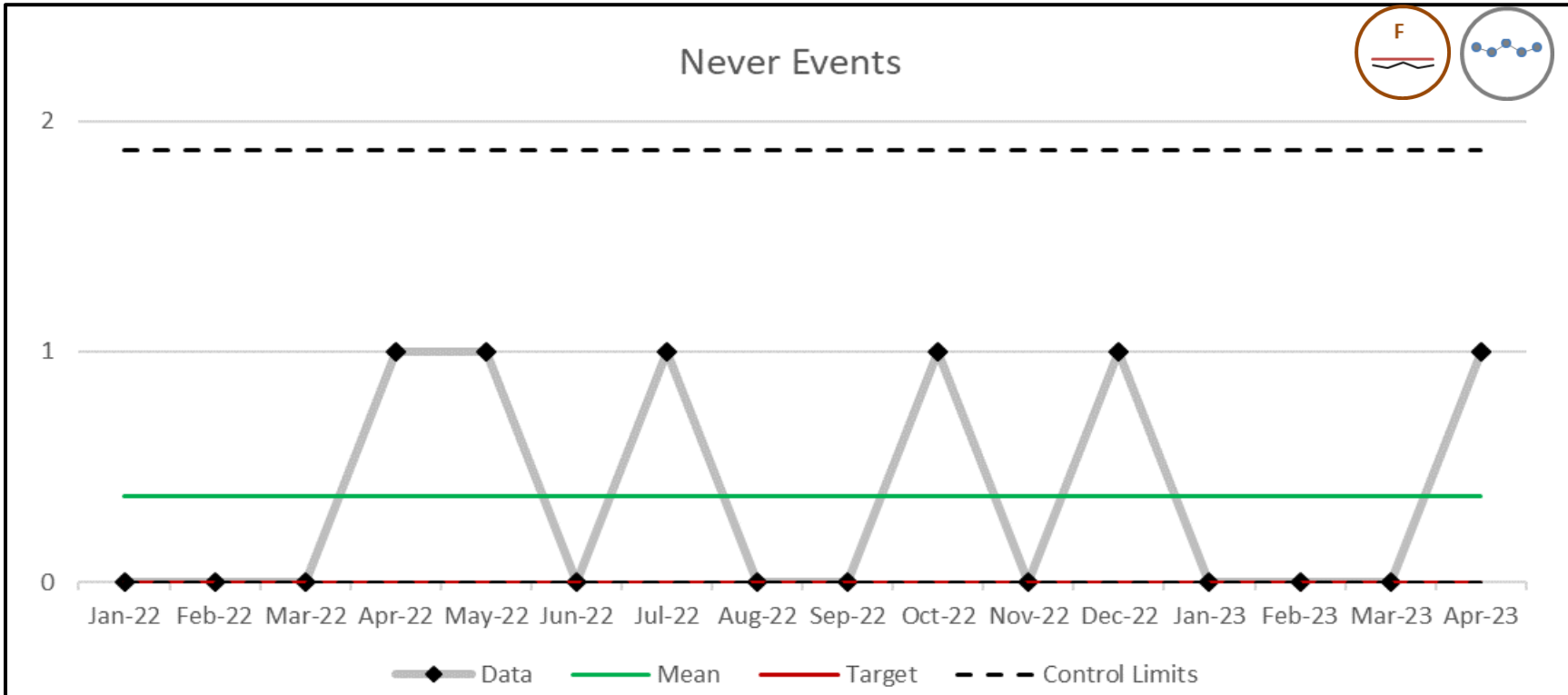
NHS United Lincolnshire Hospitals NHS Trust



Apr-23
1
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
There has been one reported Never Event in April.

Issues:
There have now been 5 Never Events declared by the Trust in 2022/23 and 1 reported for the new financial year 2023/24.
The Never Event declared in April 2023 involved an unintended retention of a guide wire from a central line insertion.

Actions:
Surgery Division held a Never Events Summit in December 2022 to review learning and planned actions from completed investigations. Current Never Event is currently under investigation with any immediate actions already taken.

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

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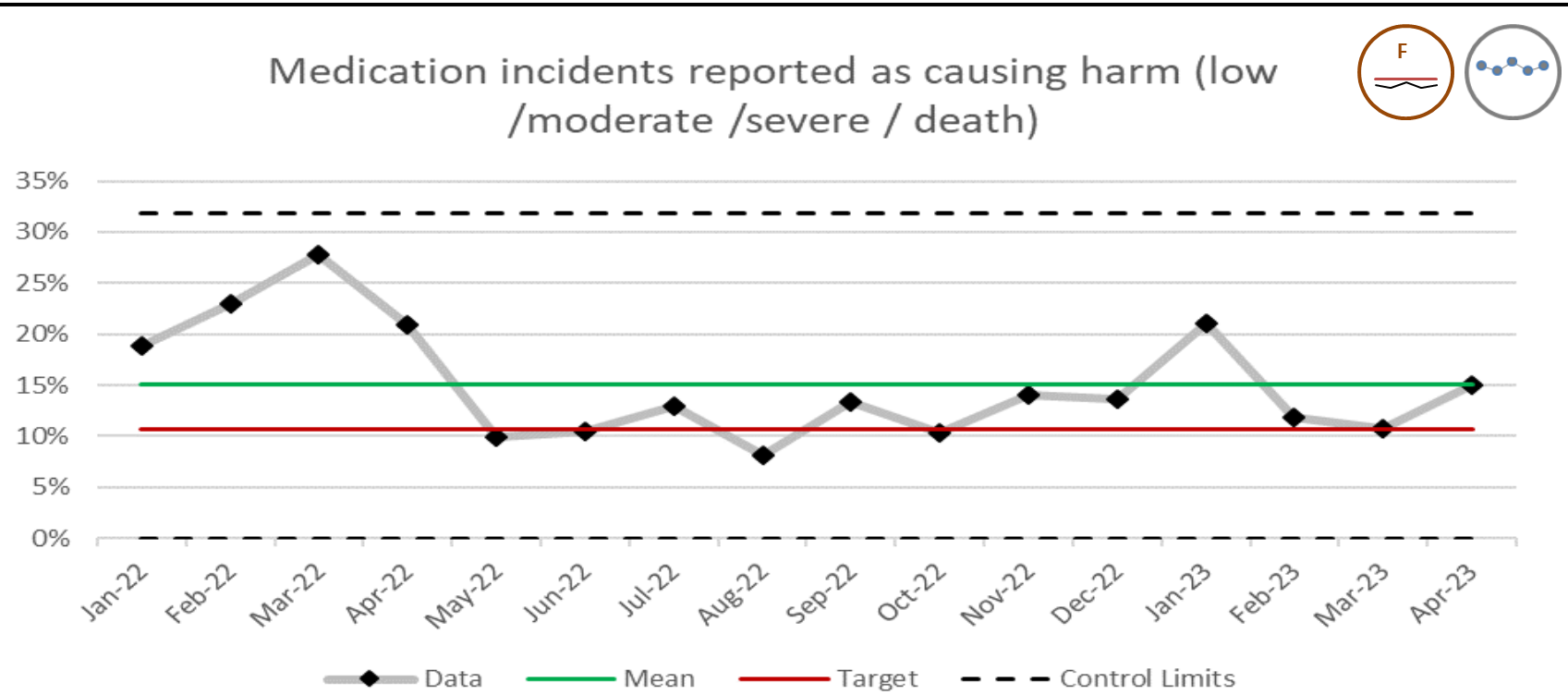

Apr-23
12.8%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10.7%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of April the number of incidents reported was 195. This equates to 5.77 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 12.8% which is above the national average of 11%.

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

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

Mitigations:

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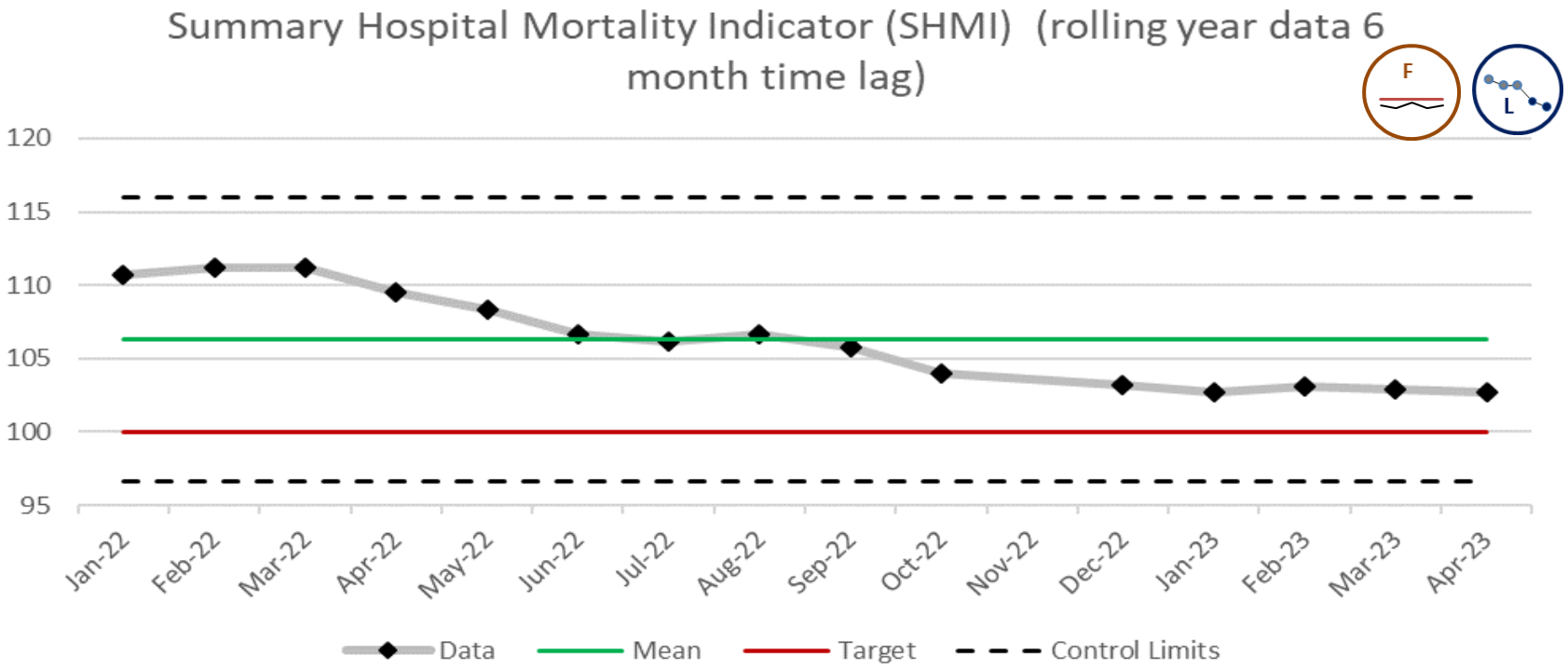

Apr-23
102.67
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
To remain in "as expected" range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

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

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

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

The Trust are 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 95.22 (rolling 12 months)

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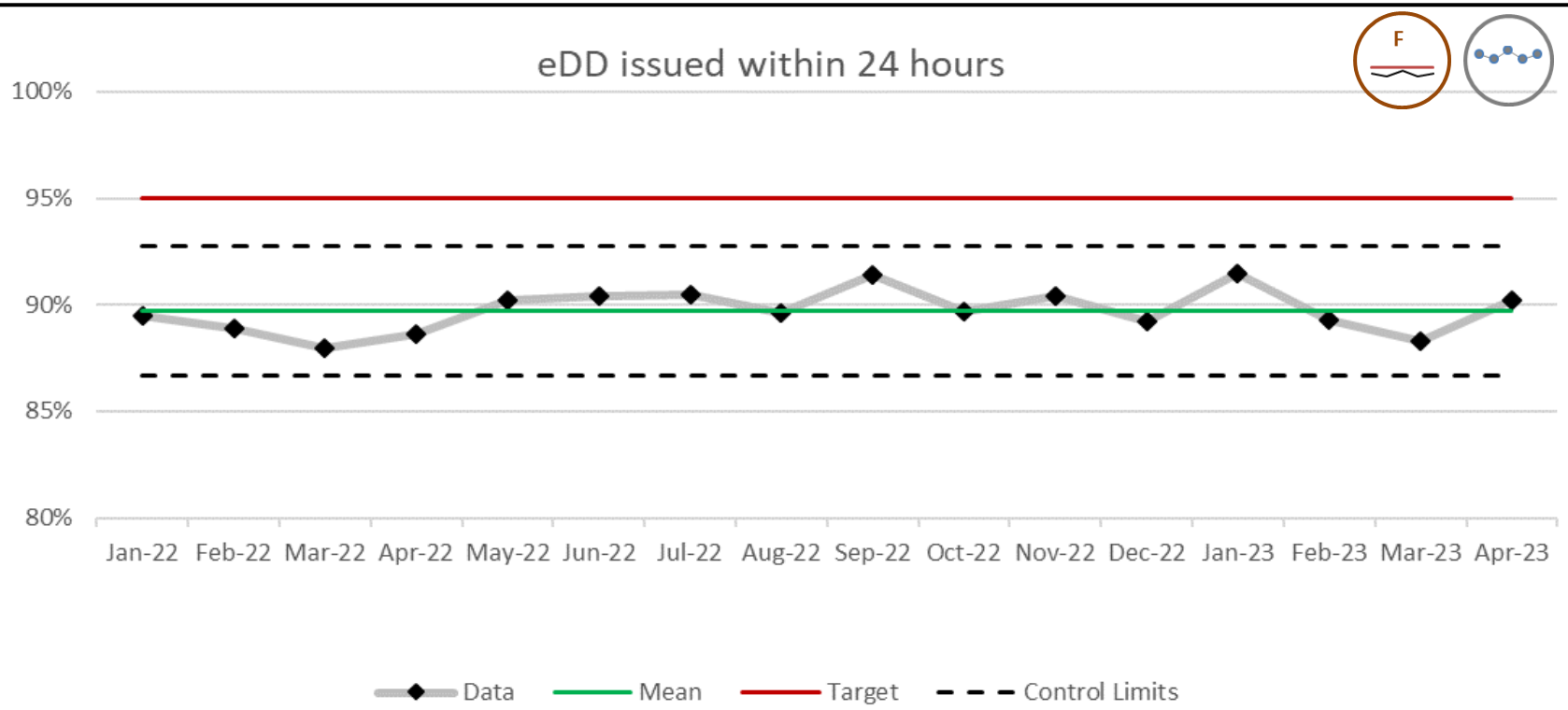

Apr-23
90.20%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 90.20%.

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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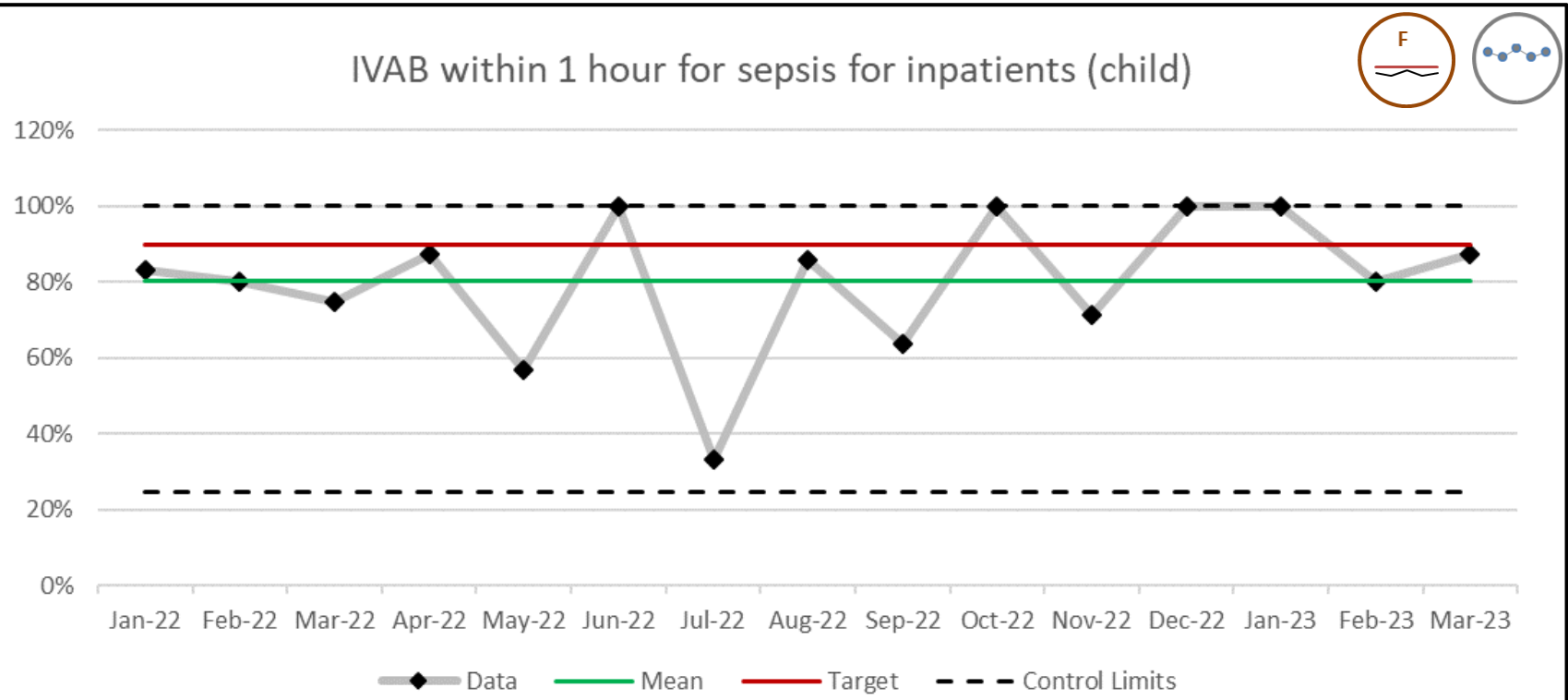

Mar-23
87.50%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
7 out of 8 children that required treatment received this in a timely manner. 1 child had delayed antibiotics.

Issues:
One child had a delay of 48 minutes with their antibiotics. This was due to a difficulty in cannulation of the child.

Actions:
Clinical Educator for ward has completed Harm review and no harm was found from delay.
The child was escalated appropriately and blood gas was taken within the hour. Bloods and cultures were taken at 63 minutes. IVAB were then delayed awaiting cannulation, prescription to be written and preparation time.

Mitigations:
Simulation training is taking place monthly involving both nursing and medical staff.
Clinical Educator and Sepsis Practitioner are doing Sepsis training with new starters. New E-learning package for Paediatric Sepsis to be rolled out within the next few weeks.

Quality | Operational Performance | Workforce | Finance

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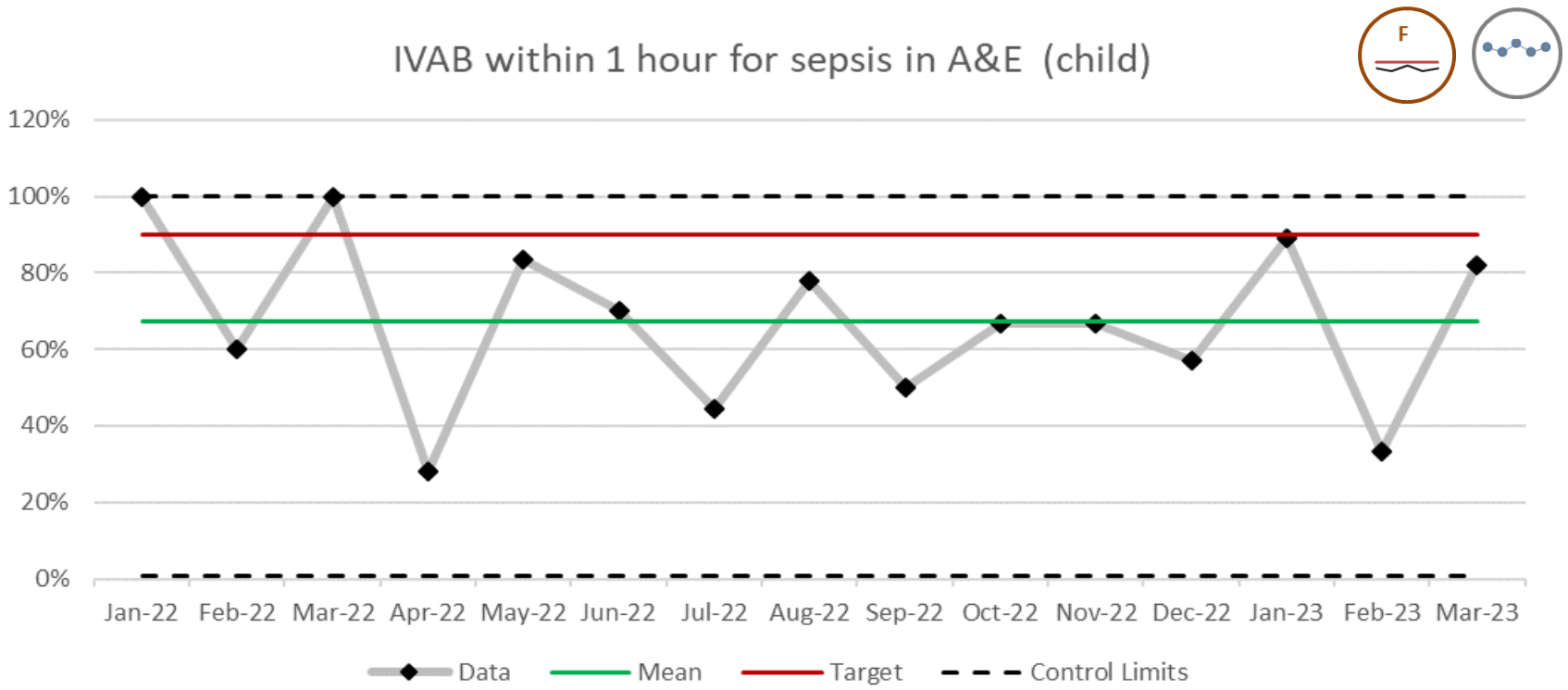

Mar-23
81.80%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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 81.8%, which is 9 of 11 patients, which is below the 90% target. There is a good improvement on last month's figures but 2 children were delayed receiving antibiotics

Issues:
There were 2 patients in ED this month that were delayed in receiving antibiotics. . Both of the delays were on one site. For one child the bloods, blood gas and cultures were all taken prior to the high score. Child was initially thought to be viral bronchiolitis and treated appropriately. Antibiotics given as condition failed to improve. The second delay was waiting to be seen by paediatric team and for them to cannulate child.

Actions:
Harm reviews have been completed for all delayed treatment and no harm found.
IM administration is to be discussed at the next Focus group meeting.
Delays also discussed at Paediatric governance.
Issues around cannulation of children also to be explored further by Sepsis practitioner as this is a common theme.

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

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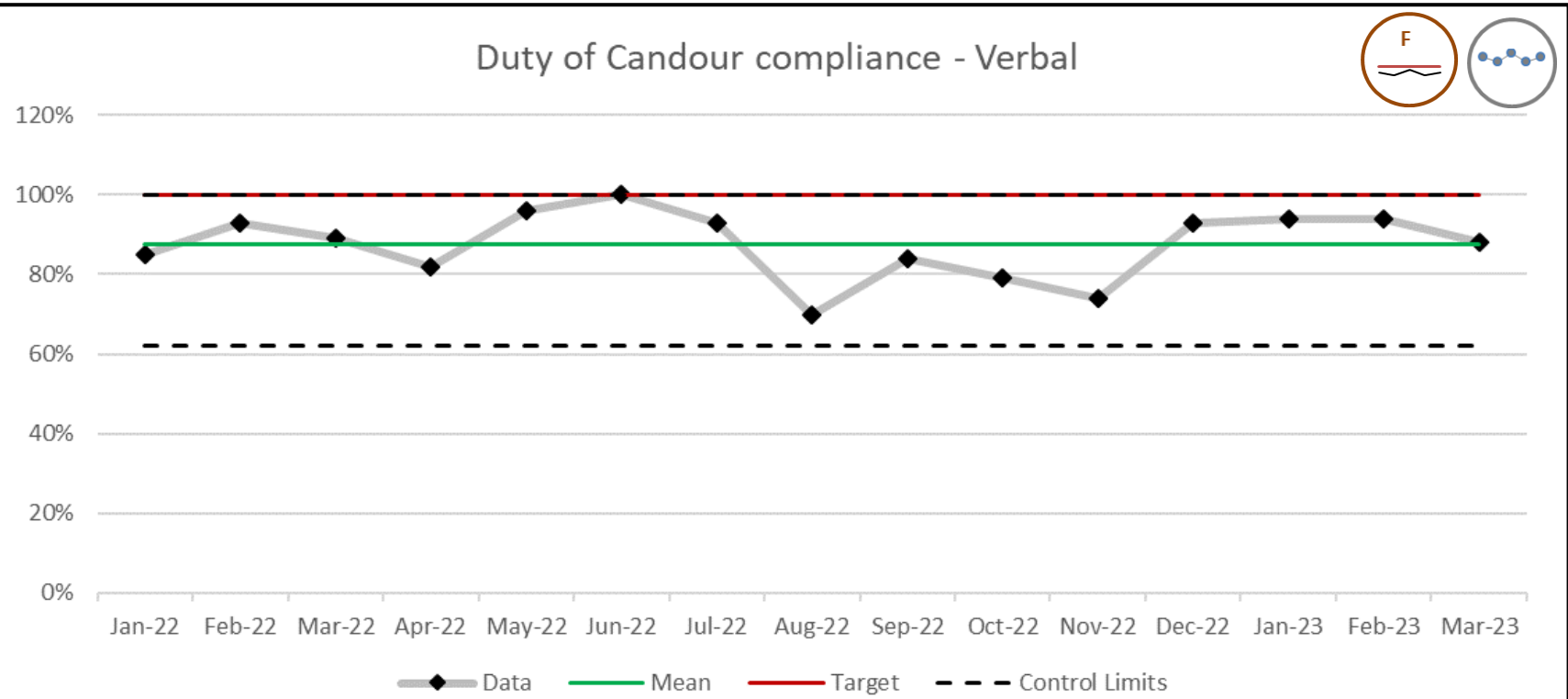

Mar-23
88.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

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, in December 2022, January 2023 and February 2023 it was above 90%.

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

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

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

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

Quality | Operational Performance | Workforce | Finance

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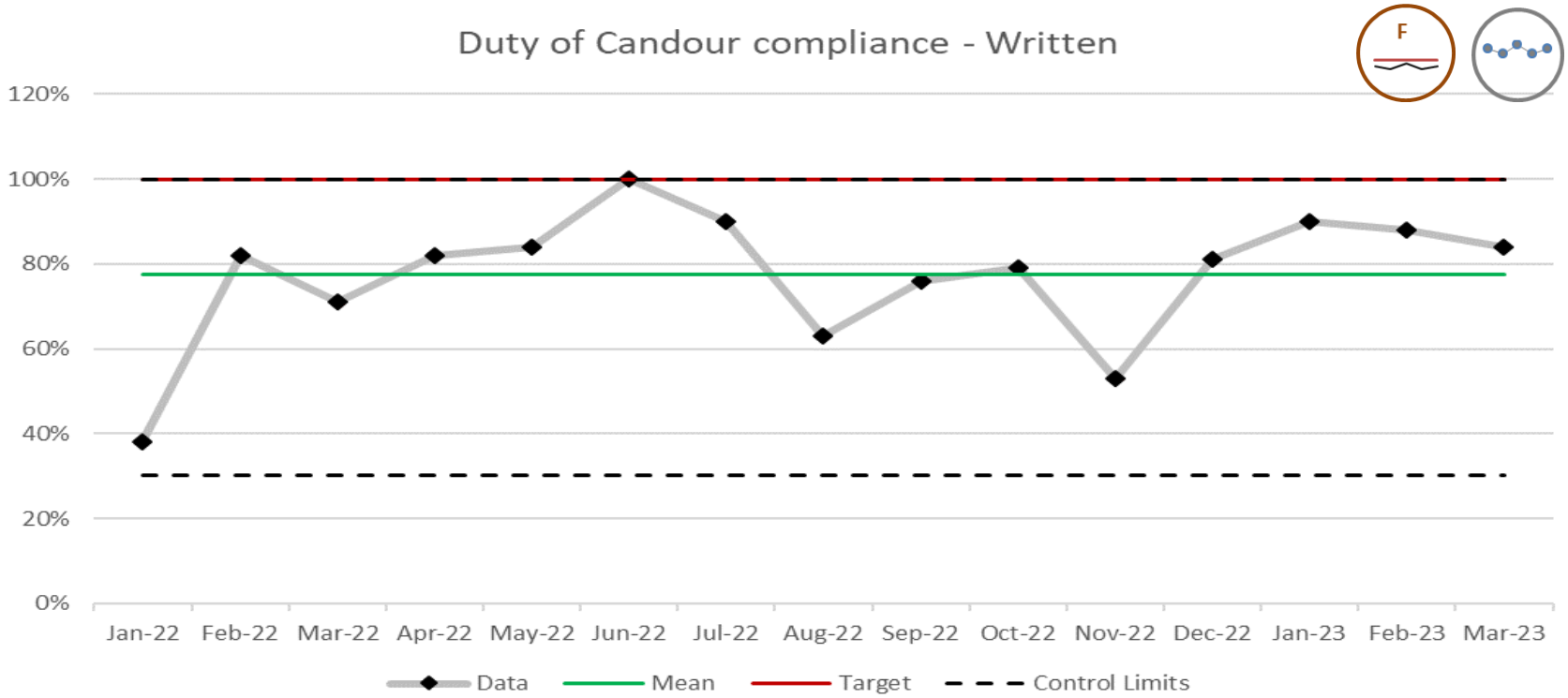

Mar-23
84.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
Compliance with the 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, in January 2023 it was above 90%.and in February it was 88%.

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.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Feb-23	Mar-23	Apr-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.27%	0.53%	0.28%	0.28%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	50.77%	58.21%	57.03%	59.50%	59.50%	50.77%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	702	721	665	665	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	78.62%	78.23%	81.60%	81.60%	88.50%			
	65 Week Waiters	Responsive	Services	Chief Operating Officer	TBC	2766	2206		31,204				
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	49.56%	50.29%		49.28%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	72,055	73,514		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	39.27%	55.08%		48.48%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	63.51%	56.01%		60.16%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	13.08%	21.67%		23.41%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	90.17%	89.89%		90.76%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	94.48%	97.84%		97.35%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	70.83%	73.68%		74.32%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	98.13%	91.54%		95.56%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	43.75%	77.61%		64.49%	90.00%			

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Feb-23	Mar-23	Apr-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	69.92%	75.23%		69.37%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	60.12%	61.83%	61.76%	61.76%	99.00%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.28%	0.79%	1.05%	1.05%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	22	16	14	14	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	65.56%	90.67%	93.83%	93.83%	90%	P		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	37.78%	80.00%	53.09%	53.09%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,475	3,917	4,059	4,059	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	316	616	440	440	0	F		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	127	84	91	91	10	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	4.30	3.02	2.87	2.87	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.89	5.01	5.12	5.12	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	23,309	24,397	25,962	25,962	4,524	F		
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	31.35%	32.33%	30.78%	30.78%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	43.87%	43.05%	44.82%	44.82%	45.00%	F		

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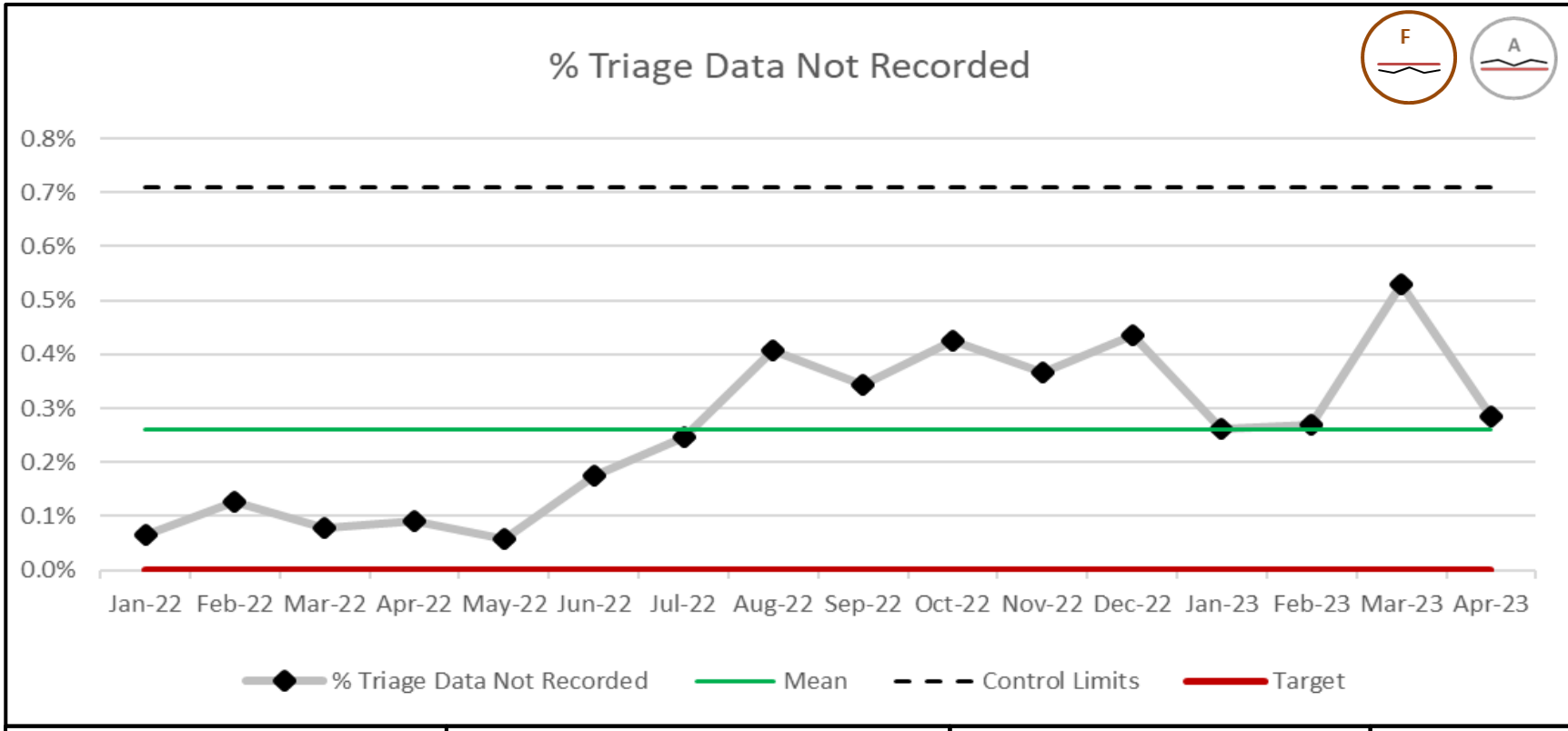


Apr-23
0.28%
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
April 23 reported a non-validated position of 0.28% of data not recorded verses target of 0%.
What the chart doesn't tell us is that 72.2% of those without a triage recorded "did not wait" to be seen.

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:

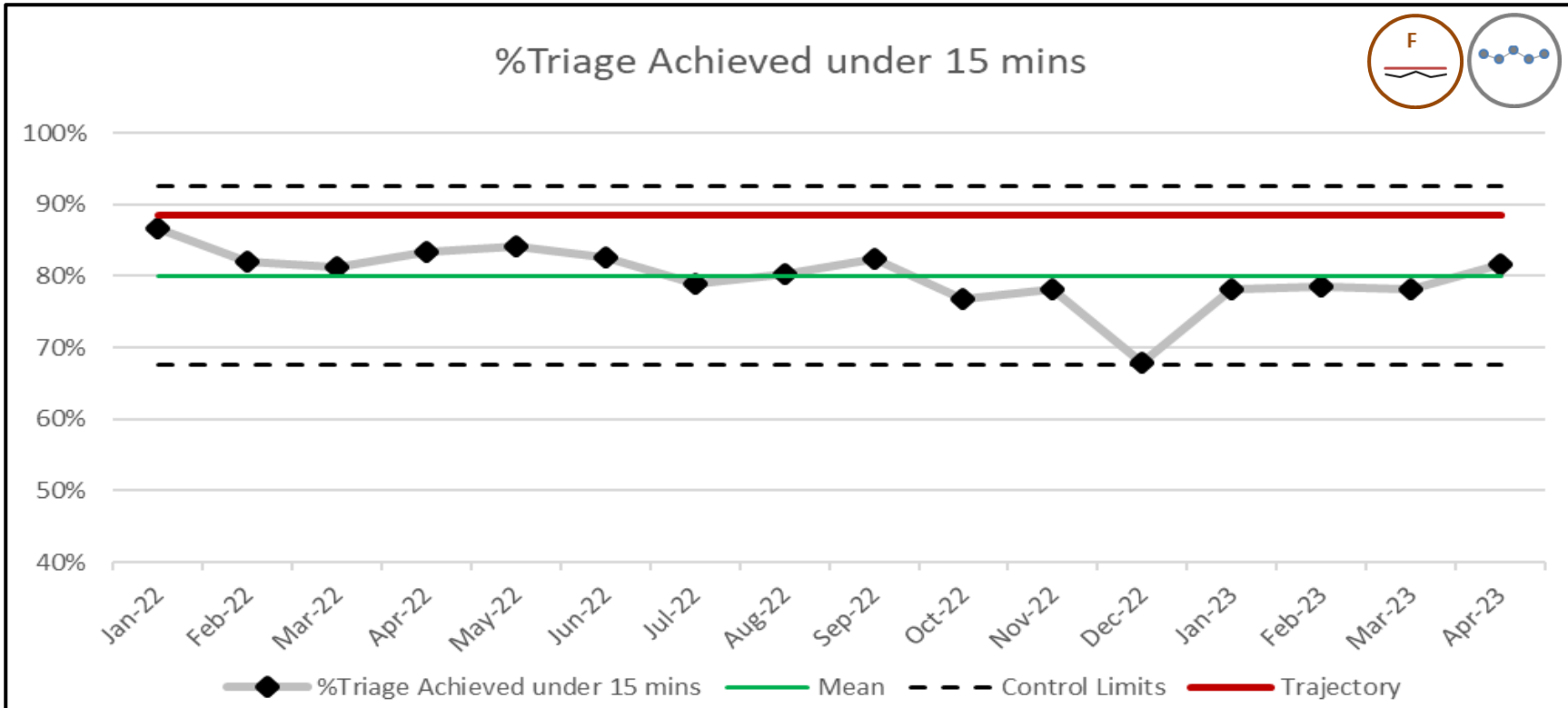
- Increased access to MTS training and time to input data is in place through a rolling teaching programme.
- Increased registrant workforce to support 2 triage streams in place.
- The move to a workforce model with Triage dedicated registrants and remove the dual role component has been more successful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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-23
81.60%
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%.
April outturn was 81.60% compared to 78.23% in March (validated).
This target has not been met.
What the chart doesn't tell us, is that the ED attendances decreased by 1344 less patients in April compared to March 23. However, in February 23 when a similar number of Type 1 patients were seen the performance was 78.63% therefore April is showing a significant improvement by the ED Teams.

Issues:

- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 has deteriorated.
- There is a recording issue for UTC transfers of care to ED that skews that data on occasion.
- Dual department roles. For example, the second triage nurse is also the allocated paediatric trained nurse, whilst reduced is still on occasion, problematic.
- Inability to maintain agreed staffing template, particularly registrants, due high to sickness and agency cancellations at short notice.
- The ability to effectively maintain two triage streams continues to be mainly out of hours but improvement is noted.
- Increased demand in the Emergency Depts. and overcrowding.

Actions:

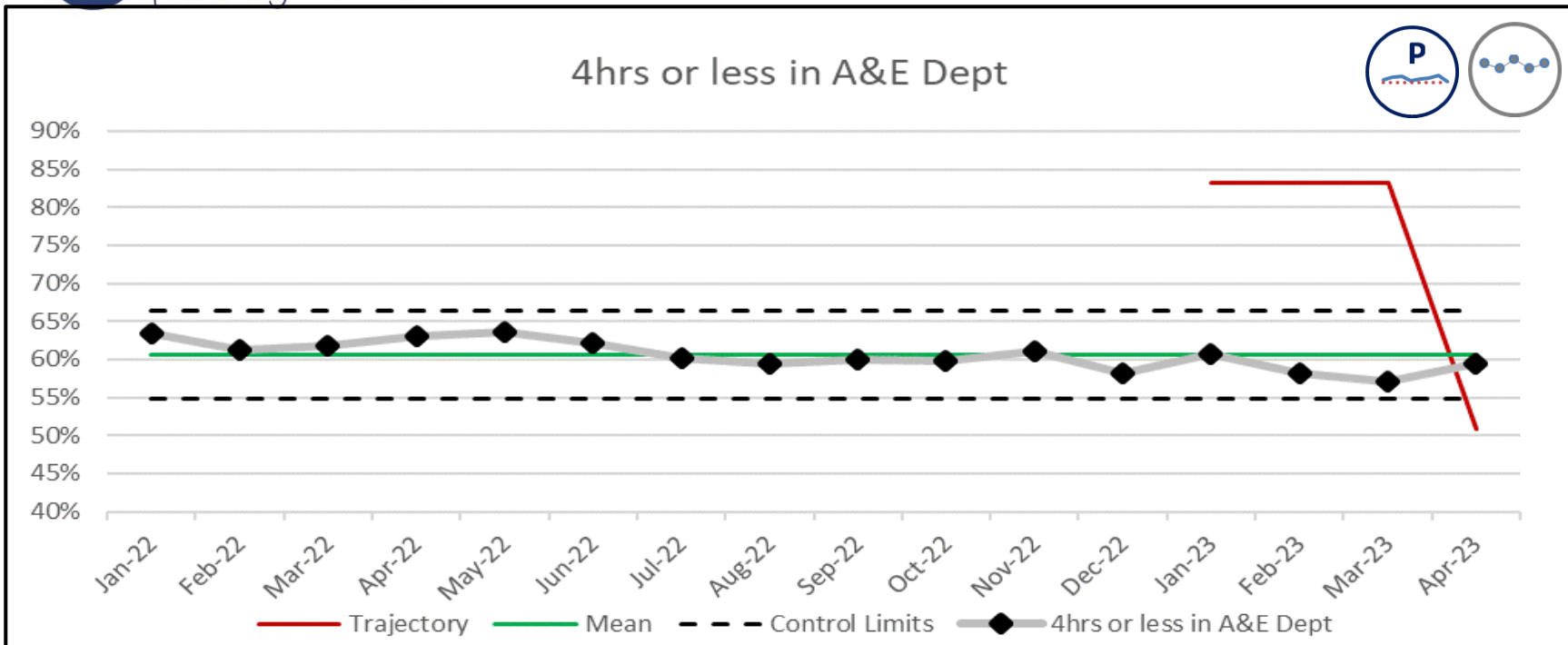
Most actions are repetitive but remain relevant.
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings.
The 60-day trail of the revised Full Capacity Protocol will either see improvement of or expose of departmental planning issues.

Mitigations:

The Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
The confirmation of 2 triage streams is ascertained at the 4 x daily Capacity meetings.
Early escalation and rectification are also managed through the Emergency Department Teams Chat and Staffing Cell.
A twice daily staffing meeting staffing meeting in in operations 7 days a week and a daily staffing forecast is also in place.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-23
59.50%
Variance Type
Metric is currently experiencing Common Cause Variation
Recovery Trajectory
50.77%
Trajectory Achievement
Metric is passing 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. With April 2023 set at 50.77% ambition

What the chart tells us:

The 4-hour transit target performance for March was 57.03%, with an improvement of 2.47% in Aprils 59.50% outturn April shows a positive 8.73% performance against the month ambition.

What the chart doesn't tell us is the conversion rate for admission from ED also

Issues:

Main factor in improvement due to reduction of attendances within the Emergency Departments experienced in April of 935 patients compared to March. 27,453 combined attendances (in ED and UTC) compared to 26,518 combined attendances (ED and UTC) in March 23.

Ward Based Discharges were an average of 35 short to meet ED demand each day – this resulted in prolonged bed waits overnight. Early recognition of discharges also lead to the extended LOS within ED. (With >65% 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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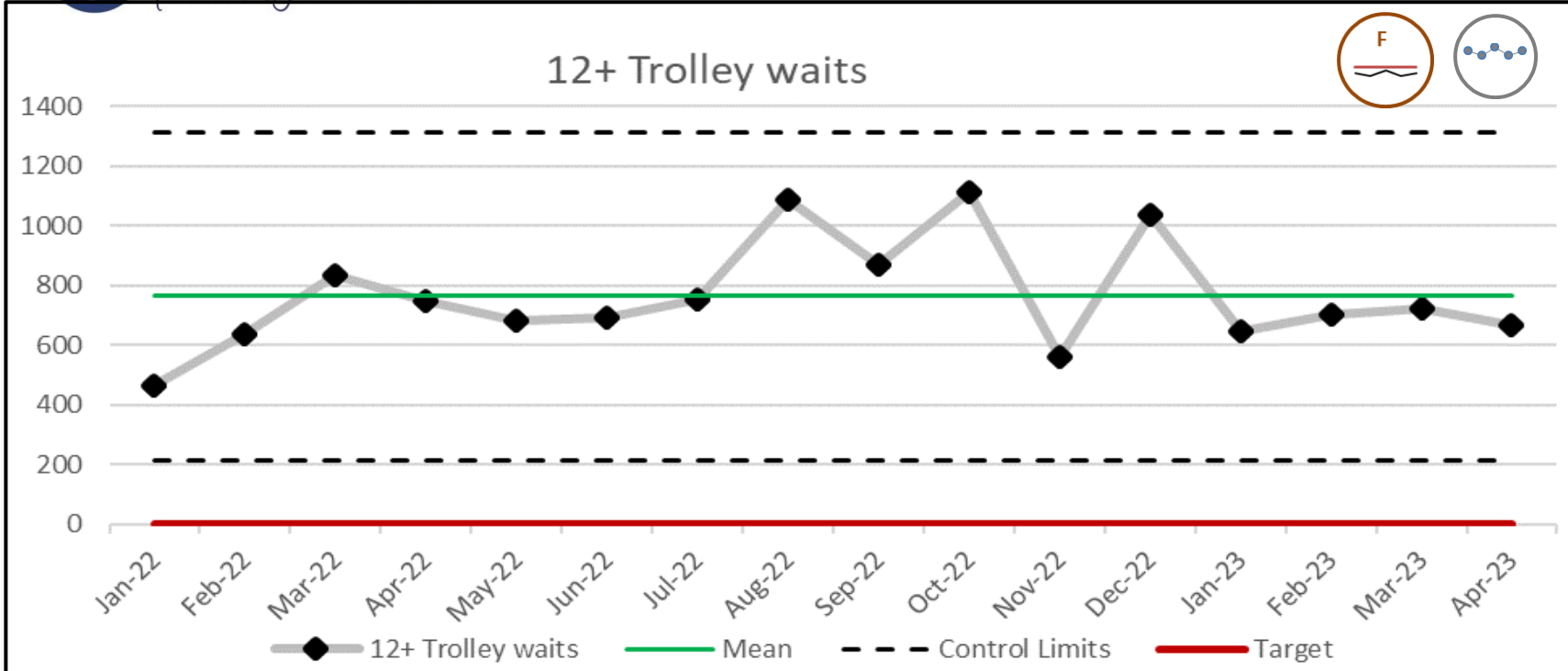

Apr-23
665
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

March experienced (721), 12-hr trolley wait breaches compared to April of (665). This is a decrease of (56), and improvement of 7.76% compared to March.
The 665 seen, equates to 5.32% of all type 1 attendances for April.
What the chart does not explain is the internal decision to move from 12hr DTA to total time in ED to minimise exposure risk.

In April 463 patients remained in ED >24hours, with the longest at 43hours, aged 77 awaiting an inpatient bed.

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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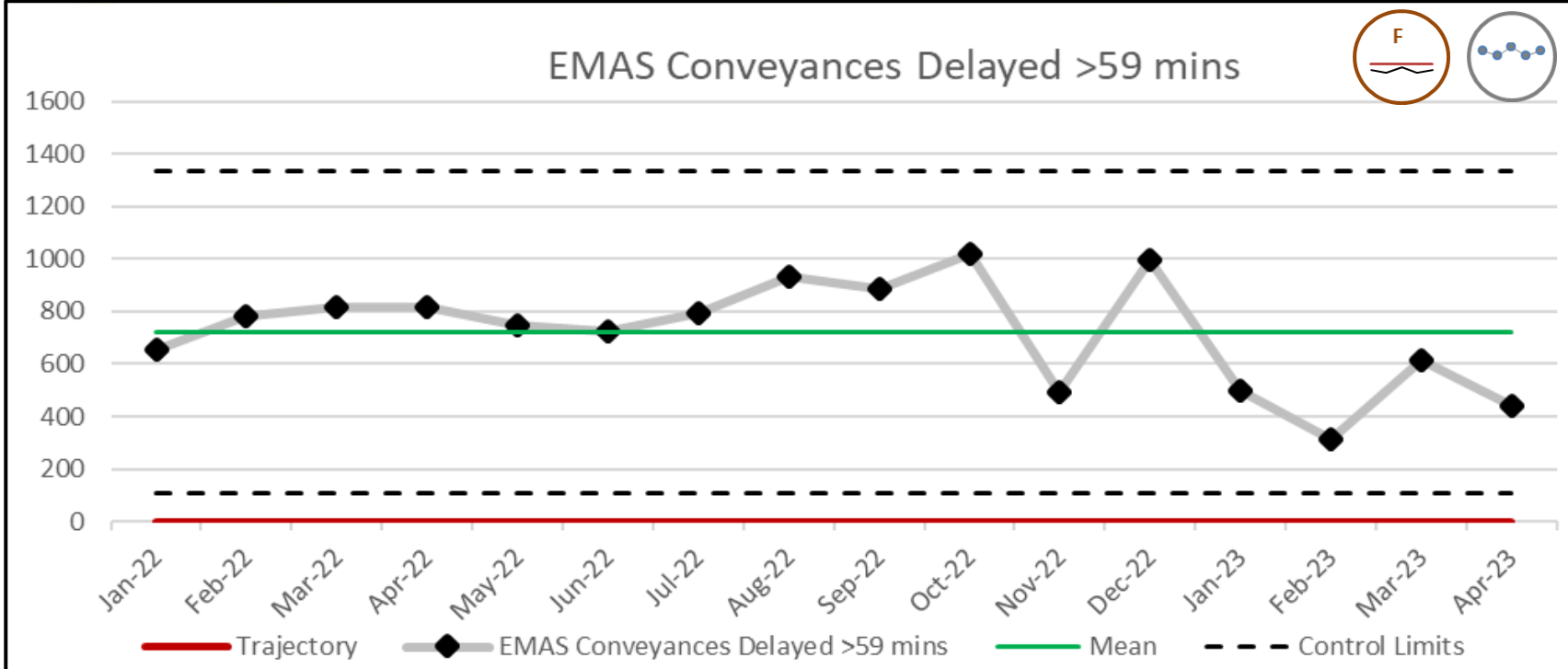


Apr-23
440
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

April demonstrated an improved performance waits greater than 59 minutes' to that seen in March 23. 440 compared to 616. This represents a 28.57% improvement.
What the chart does not tell us is that ULHT actually saw 3.6% more ambulance arrivals to ED in April than that of March when performance declined.

Out of those brought via EMAS – 51.51% were admitted into a hospital bed, this is a reduction in performance of March which saw 53.37% admitted.

Issues:

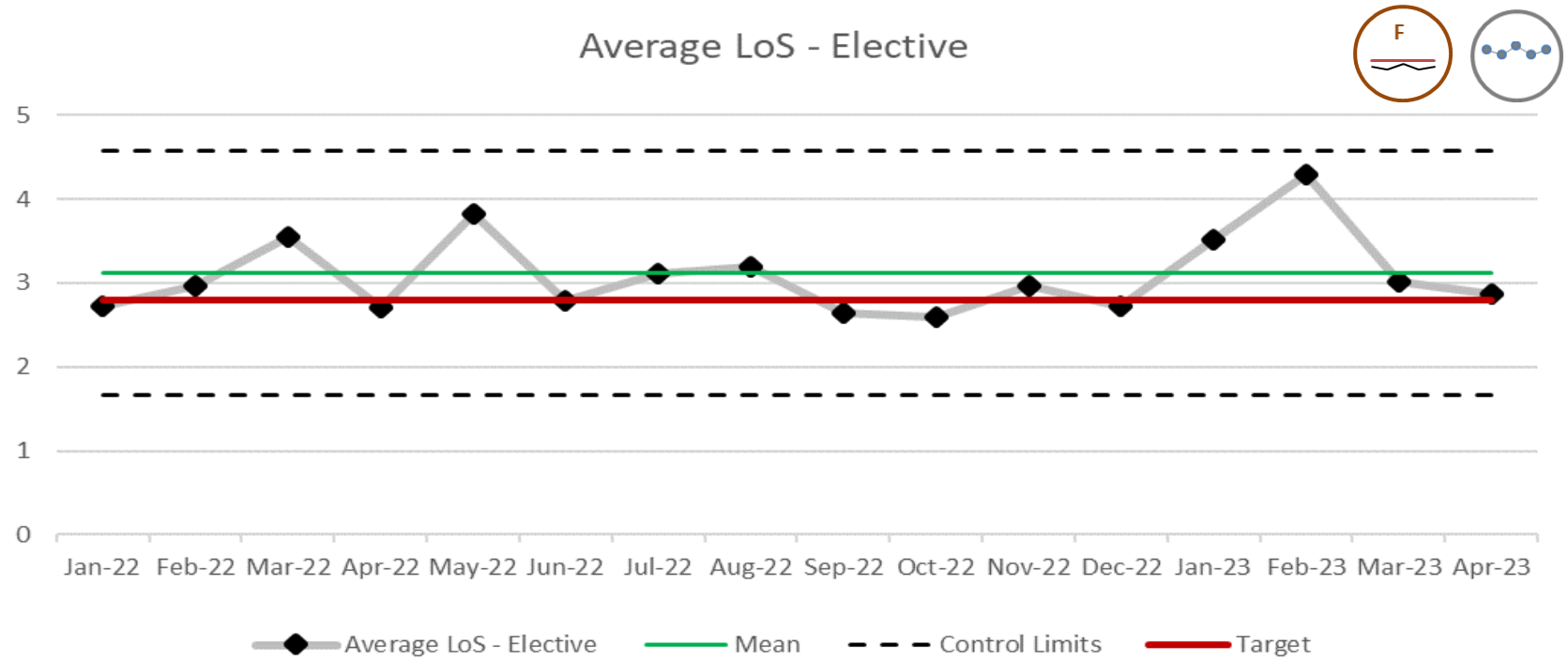
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number of category 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.



Apr-23
2.87
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 decreased to 2.87 days compared to 3.02 days in March. This is an improvement of 0.15 days and represents a negative variance of 0.07 days against the agreed target.

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

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

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

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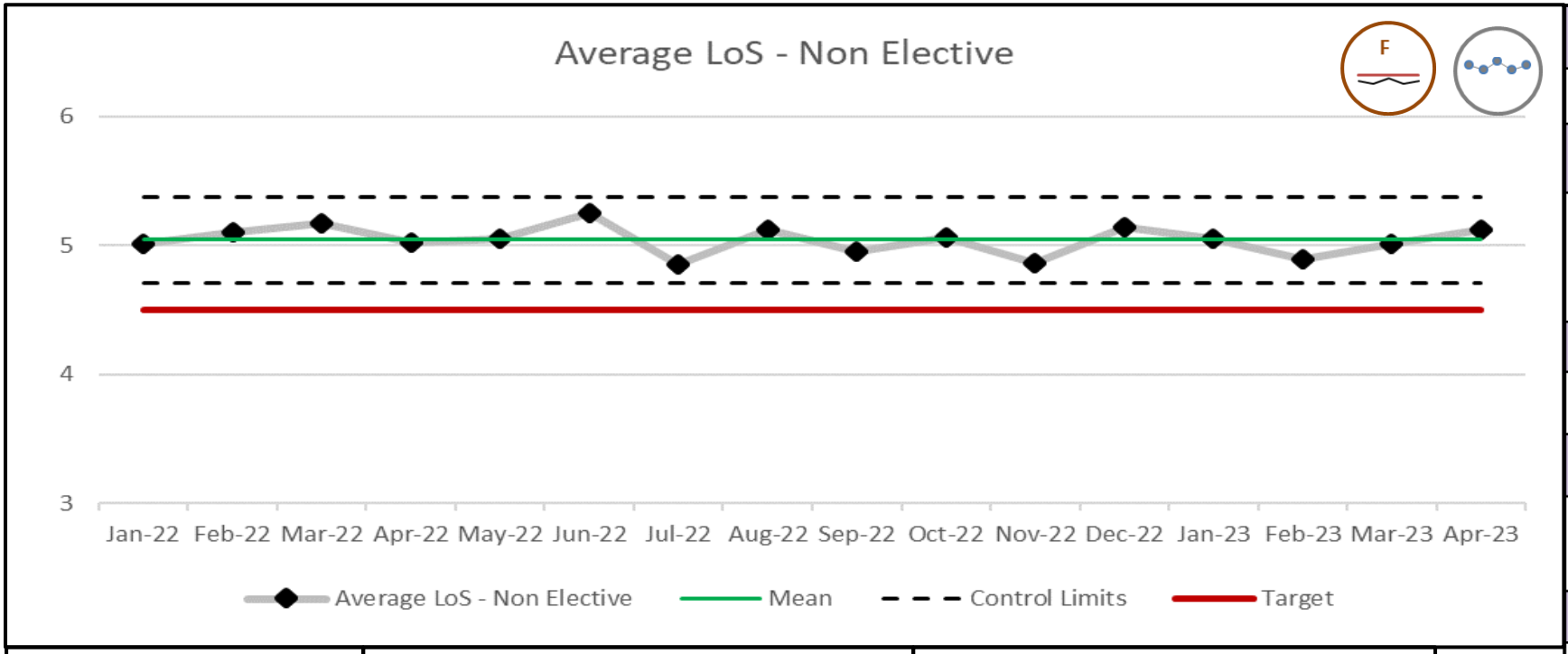

Apr-23
5.12
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for non-Elective inpatients.

What the chart tells us:

The agreed target is 4.5 days verses the actual of 5.12 days in April.
This is a decline of 0.11 days and a 0.62 days negative variance against the agreed target.
What the chart doesn't tell us is that the decline is against Pathway 1 only, whereas the other groups were improvements (days)
P0 – 0.3
P1 +0.5
P2 – 1.6
P3 – 1.0
A number of wards however in April were impacted against IPC precautions – adding to LOS and discharge capability.

Issues:

Numbers of stranded and super stranded patients have decreased.
Super by 3.15% and stranded by 1.71%. With an average of 154 super daily and 381 standard stranded daily.

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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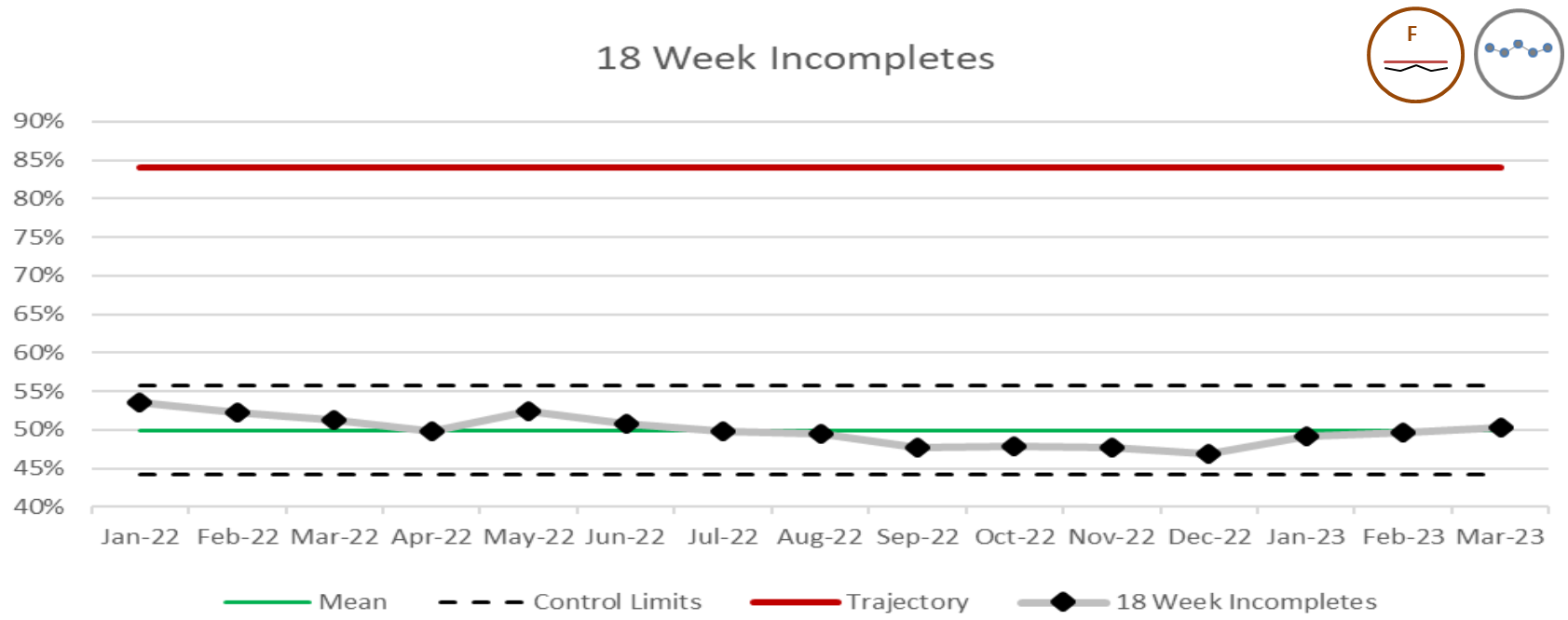


Mar-23
50.29%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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. March 2023 saw RTT performance of 50.29% against a 92% target, which is 0.73% up from February 2023.

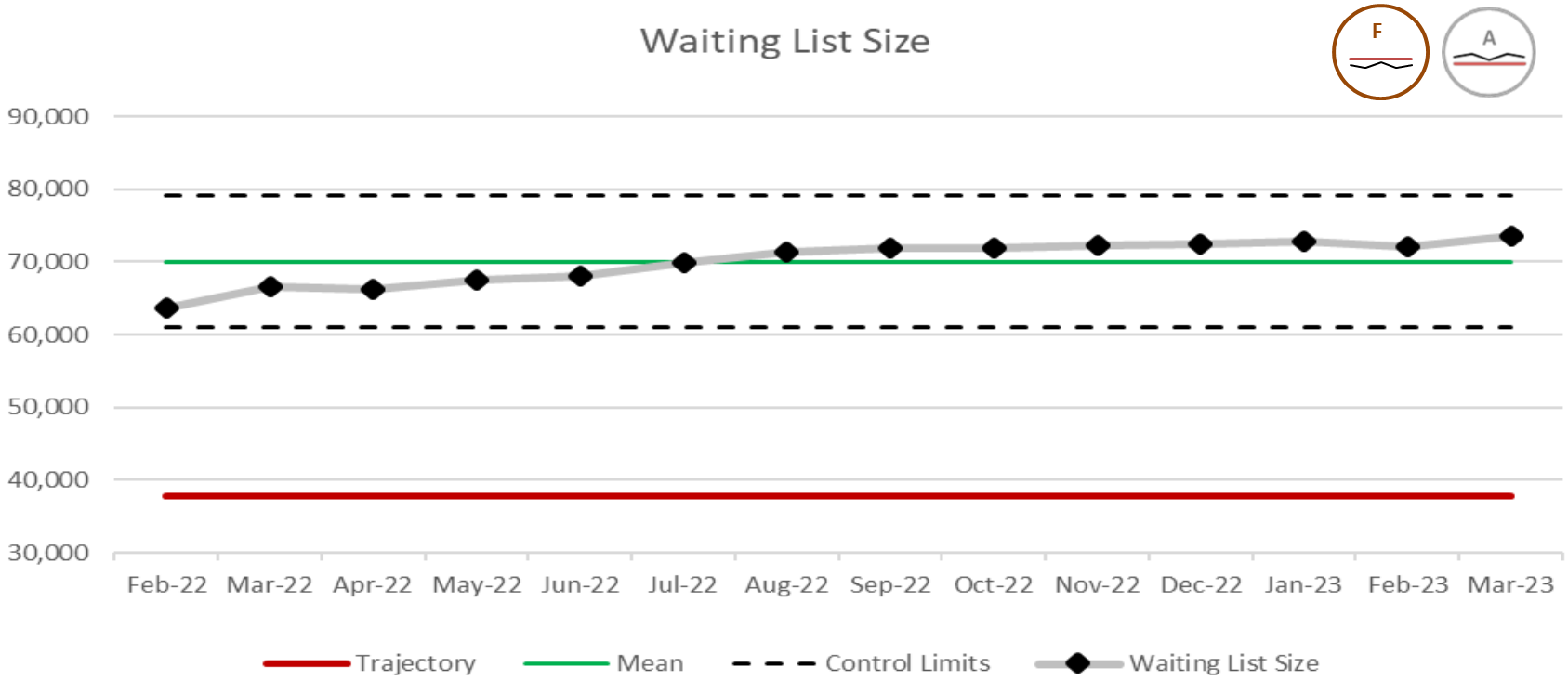
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:

- ENT – 5658 (increased by 16)
- Gastroenterology – 3838 (increased by 29)
- Dermatology – 2921 (increased by 19)
- Gynaecology – 2594 (increased by 102)
- Ophthalmology – 2530 (increased by 69).

Actions:
Priority remains focussed on clinically urgent and Cancer patients. National focus remains on patients that are over 78 weeks with the target to be at zero by May 2023. Resource is now targeted at patients who have the potential to be >78 weeks in May 2023. Schemes to address backlog include;

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

Mitigations:
Improvement programmes established to support delivery of actions and maintain focus on recovery.
SuperSprint progressing at Grantham and Louth is yielding significant benefits, resulting in improved in session and session utilisation together with significant reduction in on the day cancellations. Date confirmed in June to roll out at PH/LC with roadshows arranged to promote awareness and lessons learnt.
Clinical prioritisation – Focusing on clinical priority of patients using theatres.



Mar-23
73,514
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has increased from February 2023, with March showing an increase of 1,459 to 73,514.
This is more than double the pre-pandemic level reported in January 2020.

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

- ENT – 9096
- Ophthalmology – 6252
- Gastroenterology – 6127
- Gynaecology – 5260
- Dermatology – 5204

Actions
Improvement programmes as described above for RTT performance. In addition, all patients >52 weeks are monitored by the Trusts RTT team. Validation programme started 24th April, with phase 1 being technical validation of pathways; followed by phase 2 being an administrative review, involving contacting patients to review the need for treatment.

Mitigations:
The number of patients waiting over 78 weeks has decreased by 356 from February. There is a daily 78 week cohort meeting between the ICB and ULHT to monitor progress against target.
Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced, with an established process for this now in place for several specialties.

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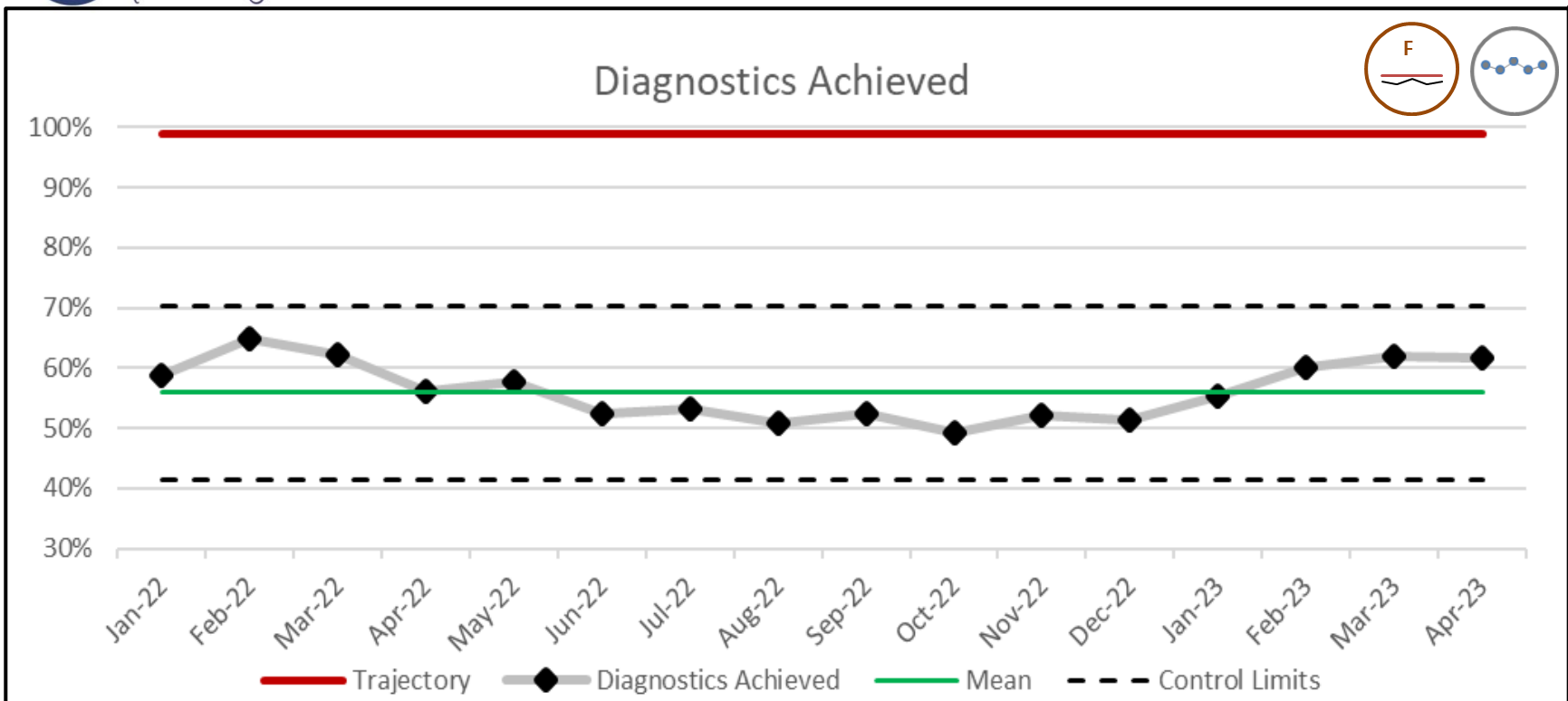

Apr-23
61.82%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 61.82% against the 99.00% target.

Issues:

- The majority of diagnostic breaches sit in Cardiac Echo with 5400 breaches recorded in April.
- MRI has 622 breaches. Additional outsourcing to help reduce the backlog from January 2023 hopefully reducing breaches to within limits by July
- There are 617 Dexa Breaches as the scanner is now up and running we should see a reduction of around 200 breaches each month
- Additional to the 5800 cardiac echoes there are additional 102 Stress/TOES and 148 echo-paediatrics.

Actions:
Where demand out strips capacity additional resource is being sort. All areas have completed a recovery trajectory to NHSE. Theis 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 should see 200 reduction each month as now up and running.

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

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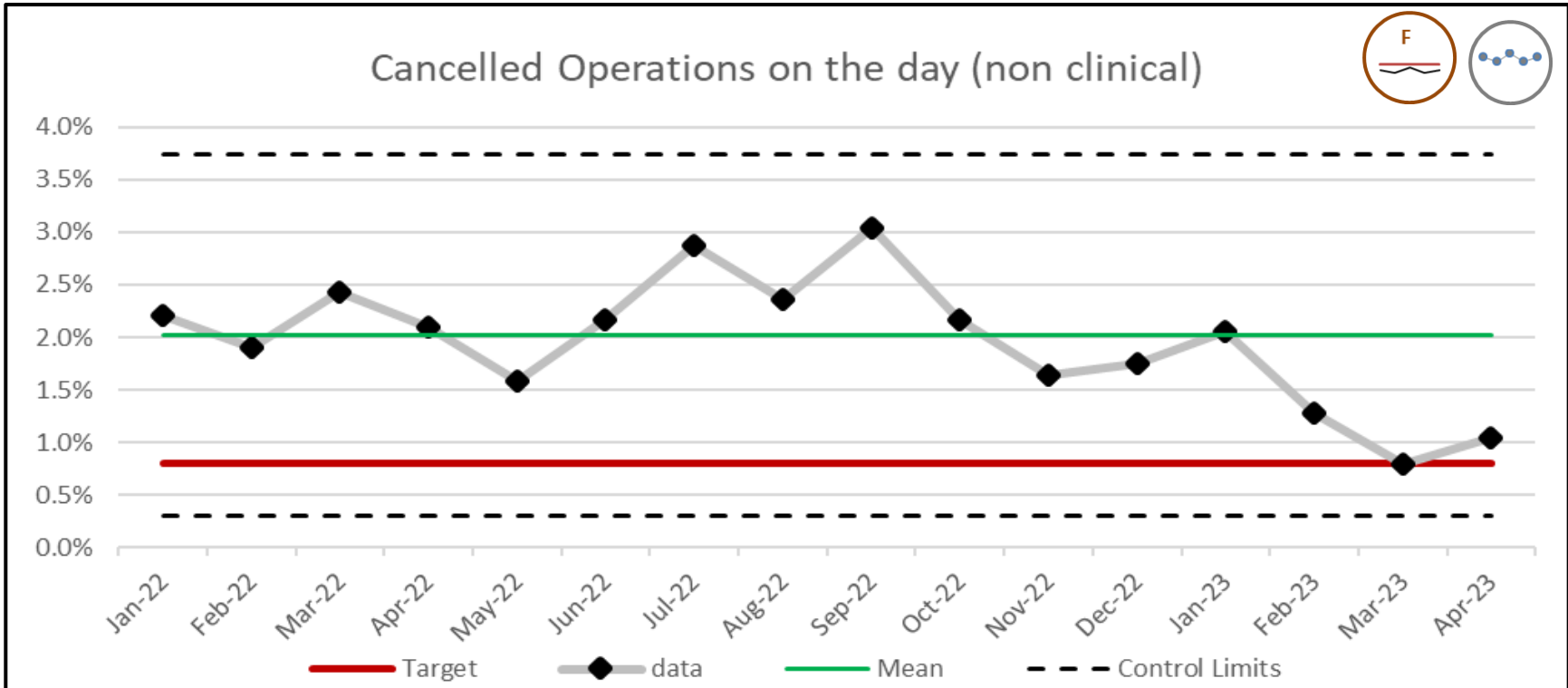


Apr-23
1.05%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

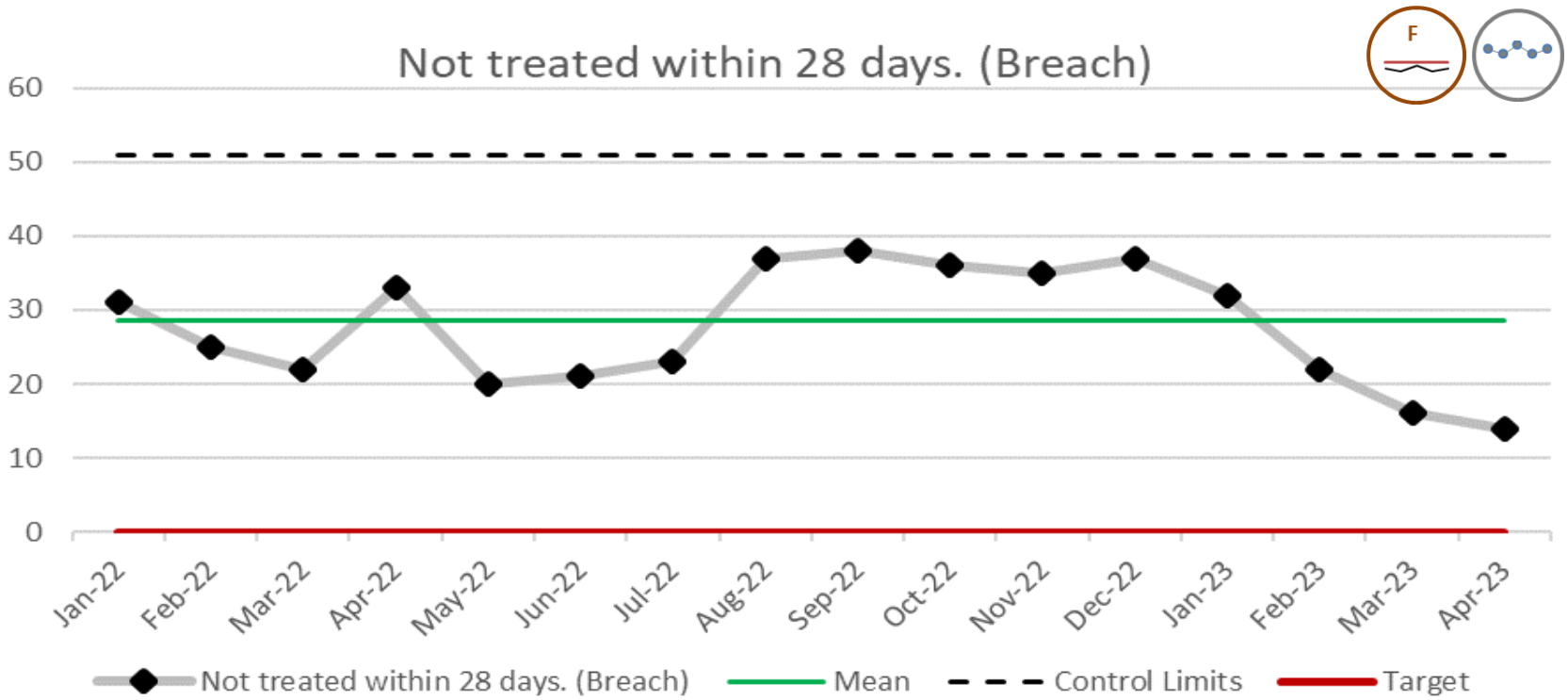
What the chart tells us
There was a slight increase of patients cancelled on the day from 0.79% in March to 1.05% in April which is slightly above the agreed trajectory of 0.8%.

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

1. Lack of time
2. Admission Moved Back
3. All other reasons accounted for one cancellation each (Transport/No L2 Beds/Equipment Issues/Industrial Action)

Actions:
Pre Assessment has been redirected to ensure all patients are being confirmed as fit to proceed before being offered a date for surgery.
Standby patient SOP being developed to provide patients who are 'ready to go' in case of last minute cancellations.
Dedicated team supporting Grantham Elective Hub

Mitigations:
Significant work within the divisions has resulted in the positive reduction in the number of patients cancelled on the day over the last two months. Whilst the percentage was slightly increased in March this was partly due to a significantly reduced number of elective procedures due to the 4 day industrial action (1129 patients through theatres in March vs 884 in April).



Apr-23
14
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 April where patients have not been treated within 28 days of a last-minute cancellation. This is a requirement for same day cancellations.

What the chart tells us:
There have been further reductions in April, with the total number of breaches at 14 which is a continuing reduction, though the agreed target of zero has not been achieved.

Issues:
There has been reduced availability of lists due to the 4 day industrial action during April which has significantly impacted the ability to run theatre lists.

Actions:
Waiting List teams are working to maintain planned list activity at a minimum of 90%.

All CBUs and surgeons have been asked to identify plans for increased utilisation at our elective hub site, which will improve capacity and therefore reduce this figure in order to achieve our target – this remains ongoing and utilisation is being monitored

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

This is also improved due to the reduction in cancellations on the day.

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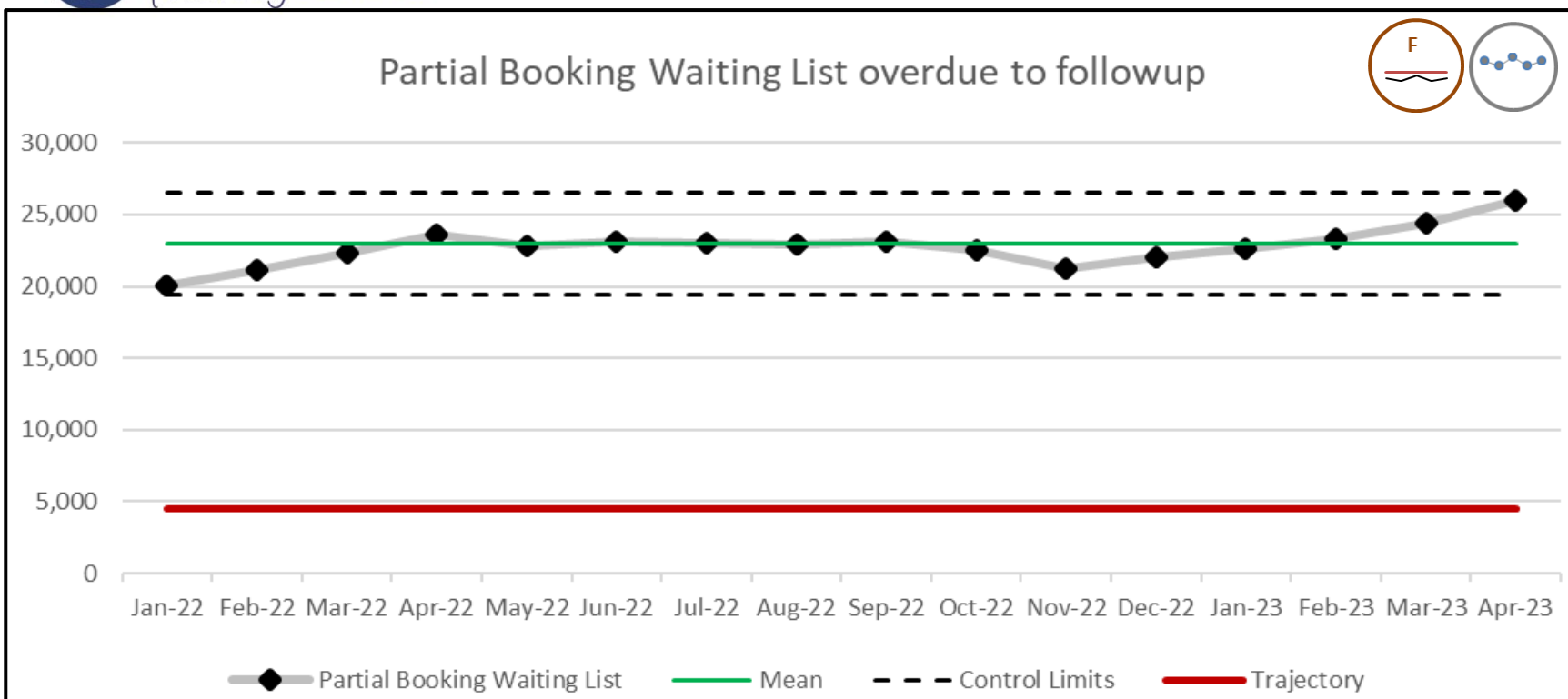

Apr-23
25,962
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 25,962 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 PBWL demand outweighs the current available capacity, rooms and resources. Industrial action plans further reduced capacity and outpatient activity.

Actions:
The PBWL meeting with the CBU's has been relaunched with a new agenda and template to improve attendance and focus. PIFU implementation has been refreshed and continues to be an area of focus. The continuing upward trend of overdue PBWL is being escalated to the DMD's for awareness and support.

Mitigations:
Clinics and patients have 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. The outpatient team continue to support organisational priorities in ED and urgent care cancelling outpatient clinics when required.

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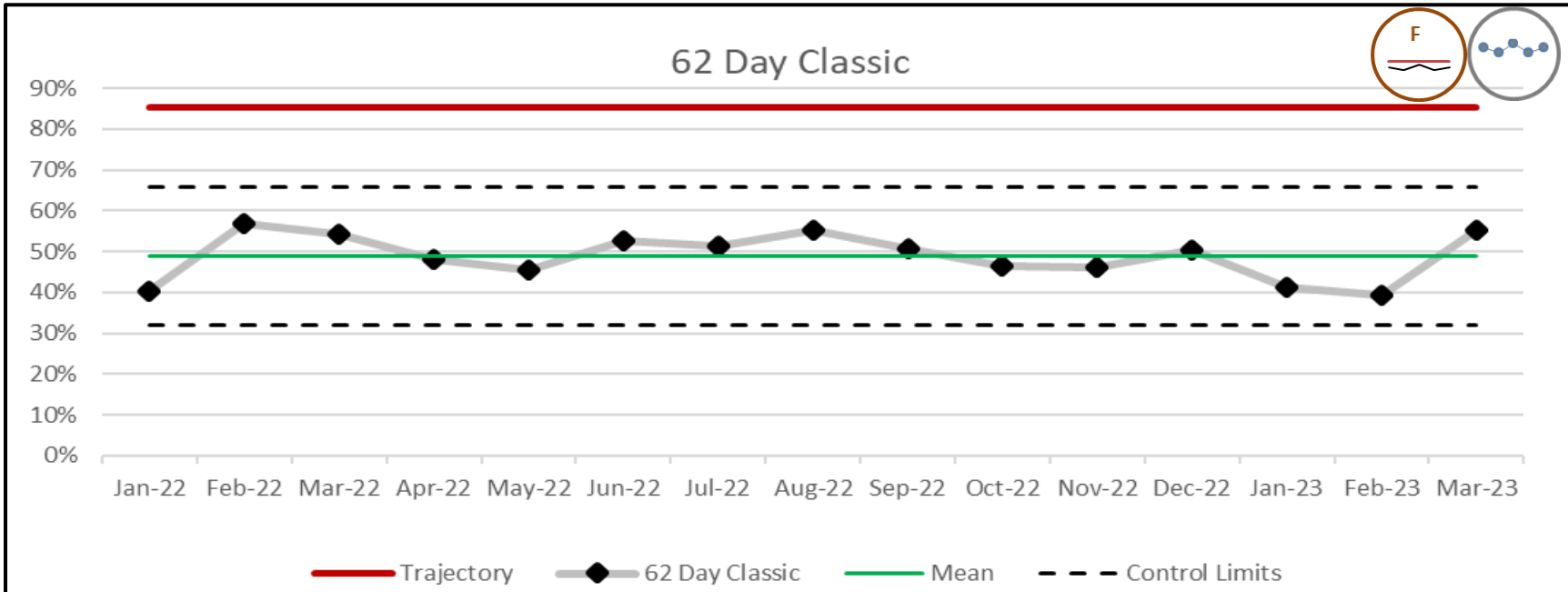


Mar-23
55.08%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 55.08% 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 capacity is also limited and impacts the ability to be able to populate lists at short notice.

Actions:

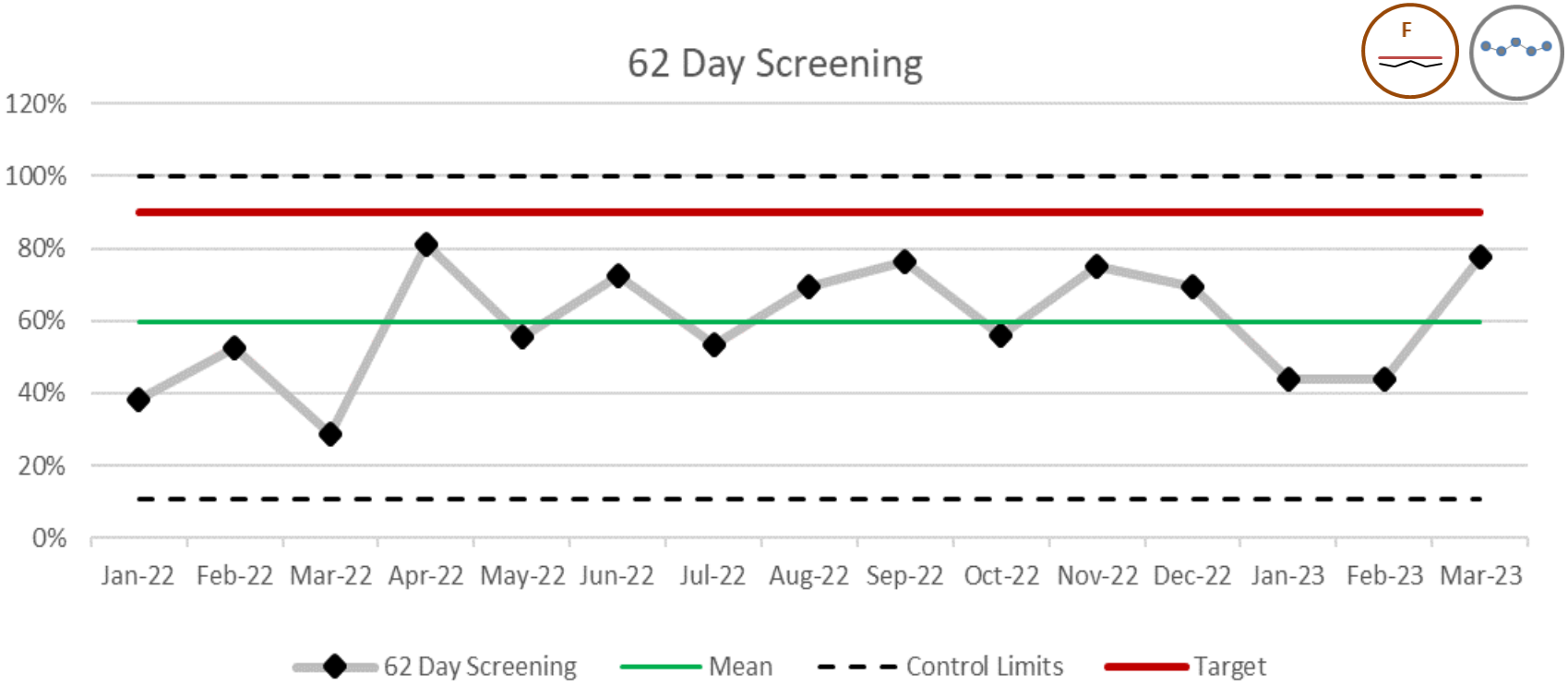
In Oncology, recruitment is ongoing to secure locums, NHS locums or substantive posts. 2 Medical Oncologist posts are out to advert as locums. We appointed to one post and area awaiting a start date. A 6 month Oncology SpDr post went out to advert from which we have 2 appointable candidates. One has already started and one is awaiting the PLAB2 exam.
Theatre capacity is improving and will be further alleviated now that the new theatres have opened at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.

Please also see Actions on accompanying pages.

Mitigations:

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

Please also see Mitigations on accompanying pages.



Mar-23
77.61%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

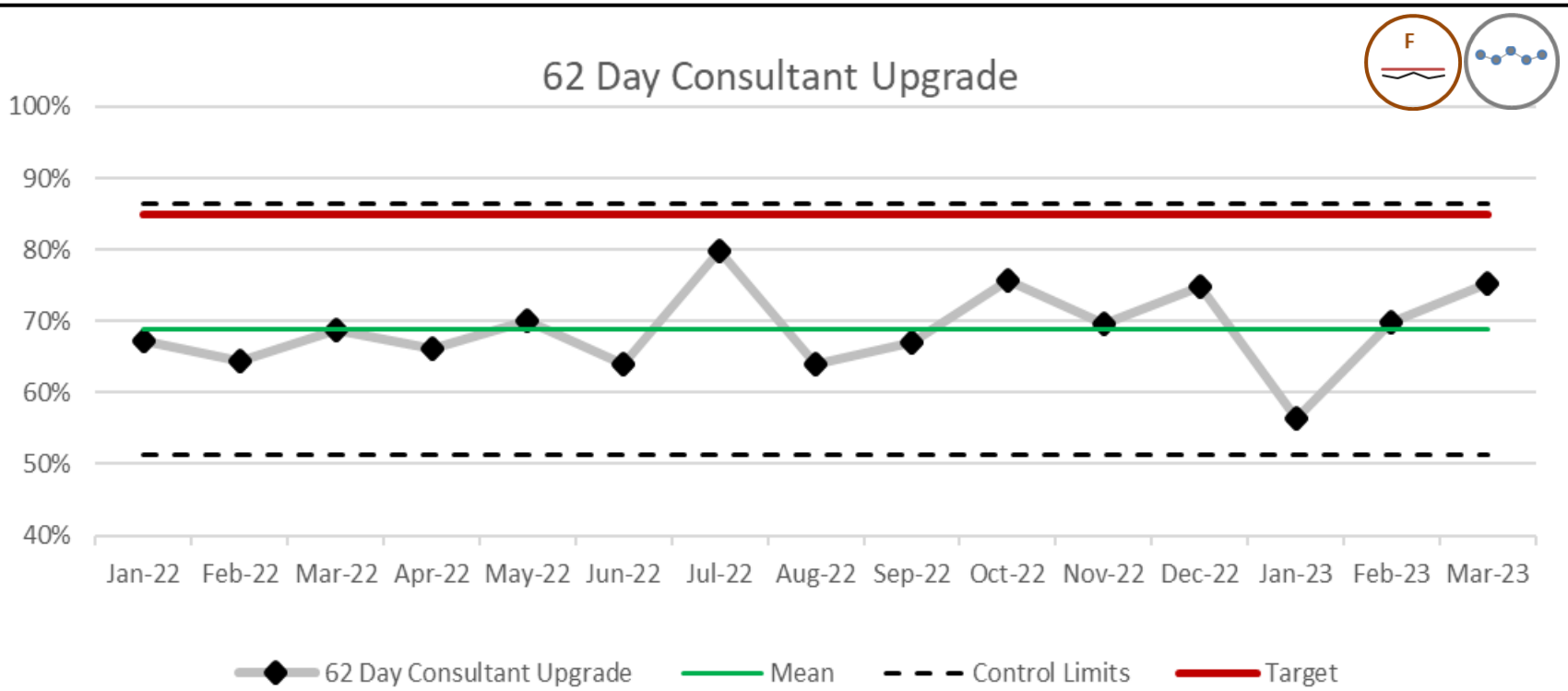
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 77.61% 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.



Mar-23
75.23%
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 75.23% 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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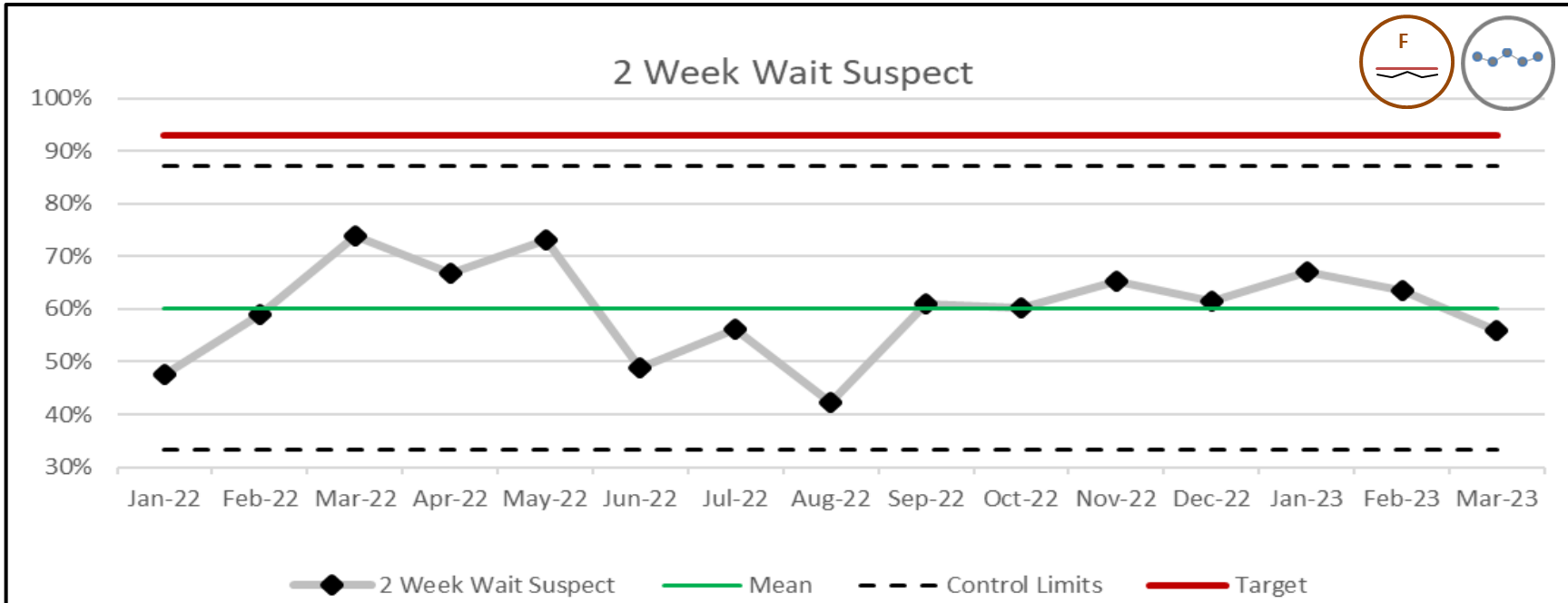


Mar-23
56.01%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of patients seen by a specialist within two weeks of 2ww referral for suspected cancer.

What the chart tells us:

We are currently at 56.01% against a 93% target.

Issues:

Patients not willing to travel to where our service and/or capacity is available.
Nurse Triage / CNP capacity issues in colorectal specialty.
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with 35% of the Trust's March 14 Day breaches within that tumour site.
Also of concern was skin performance which accounted for 40% of the Trust's 14 day breaches.
The Gynae tumour site accounted for 13% of March breaches.

Actions:

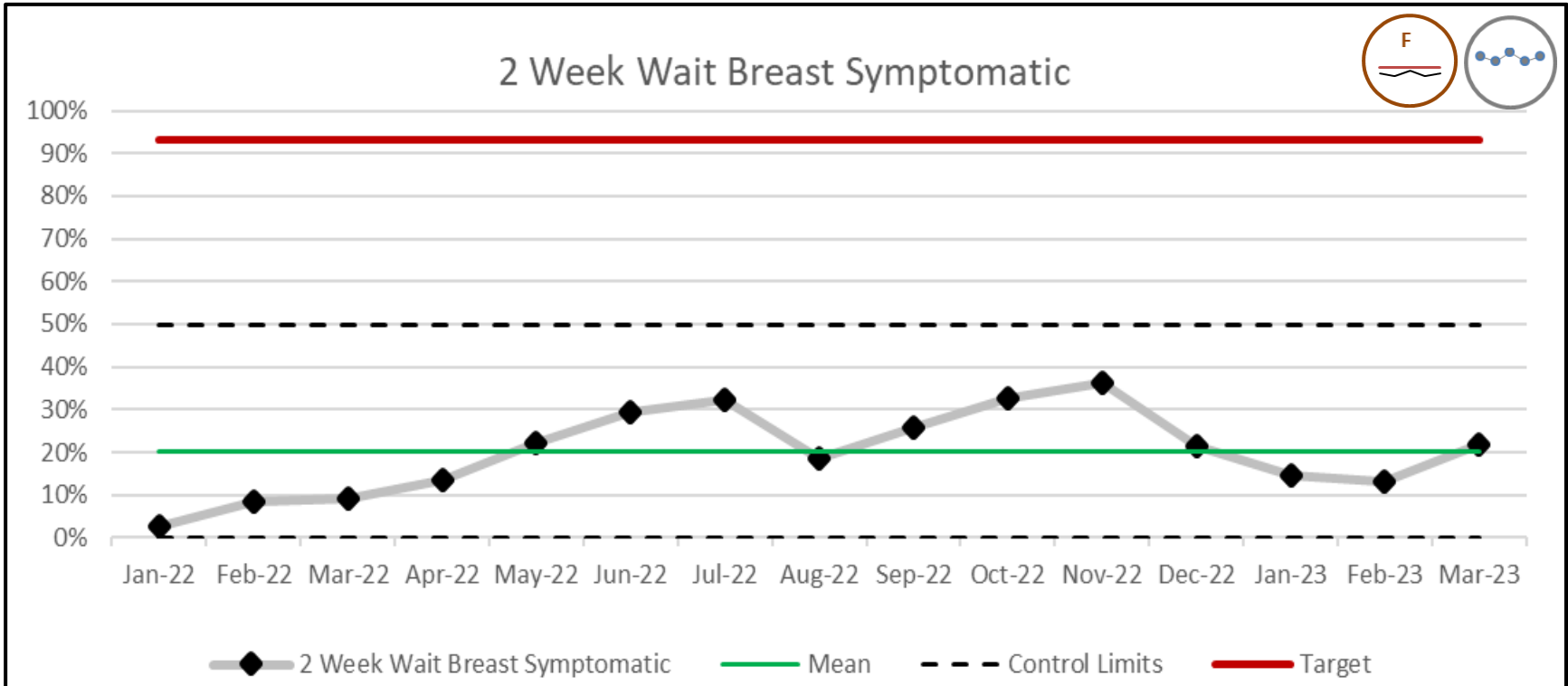
In Gynaecology, a number of work streams have been identified through the oncology strategy meetings – the most recent meeting took place on 28th April. Referral triage by the CNS team and referral redesign work is still underway to address 1st OPA capacity challenges.
The Radiology Recruitment Strategy is in place to address the Breast Service One-Stop appointment alignment issues. In addition, 2 x Registrars are undergoing assessments that will allow them to hold their own clinics thereby improving capacity.
Respiratory consultant capacity is a continuing issue alongside an increased number of referrals. ICB Analysis of the FReD Referrals is in progress and an ongoing BC for an increase in consultant workforce to 10-15 consultants is underway.
UGI Referral and Triage processes are being reviewed and a Gap Analysis supported by the ICB has been completed. The ICB is supporting discussions regarding the management of incomplete referrals. A bid is being developed for UGI CNS to triage at the start of UGI pathway and discussions are underway with Endoscopy and Outpatient teams to streamline processes at the front of the pathway and support effective triage and booking of appointments.
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, a Demand and Capacity deep dive has resulted in a number of improvements being adopted to smooth out booking processes and increase capacity.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-23
21.67%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 21.67% against a 93% target.

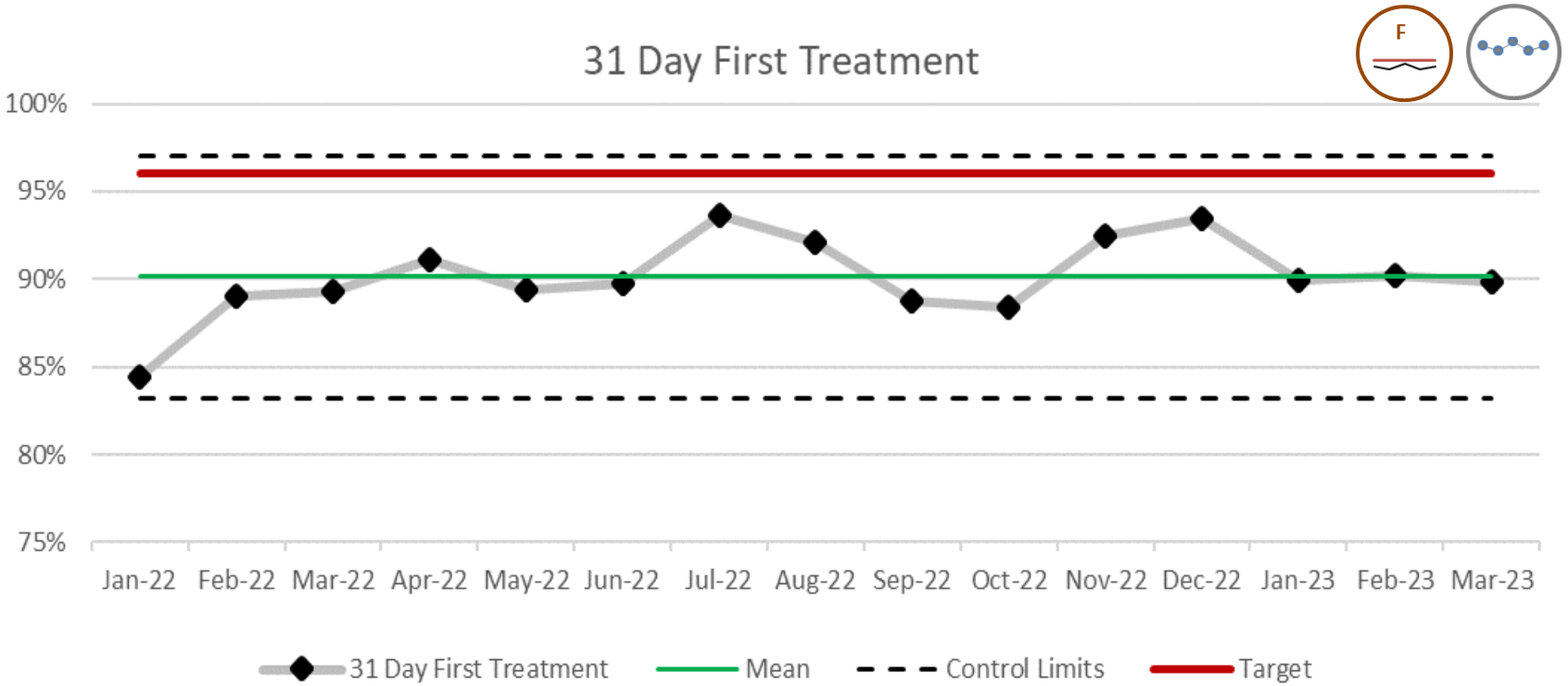
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

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



Mar-23
89.89%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

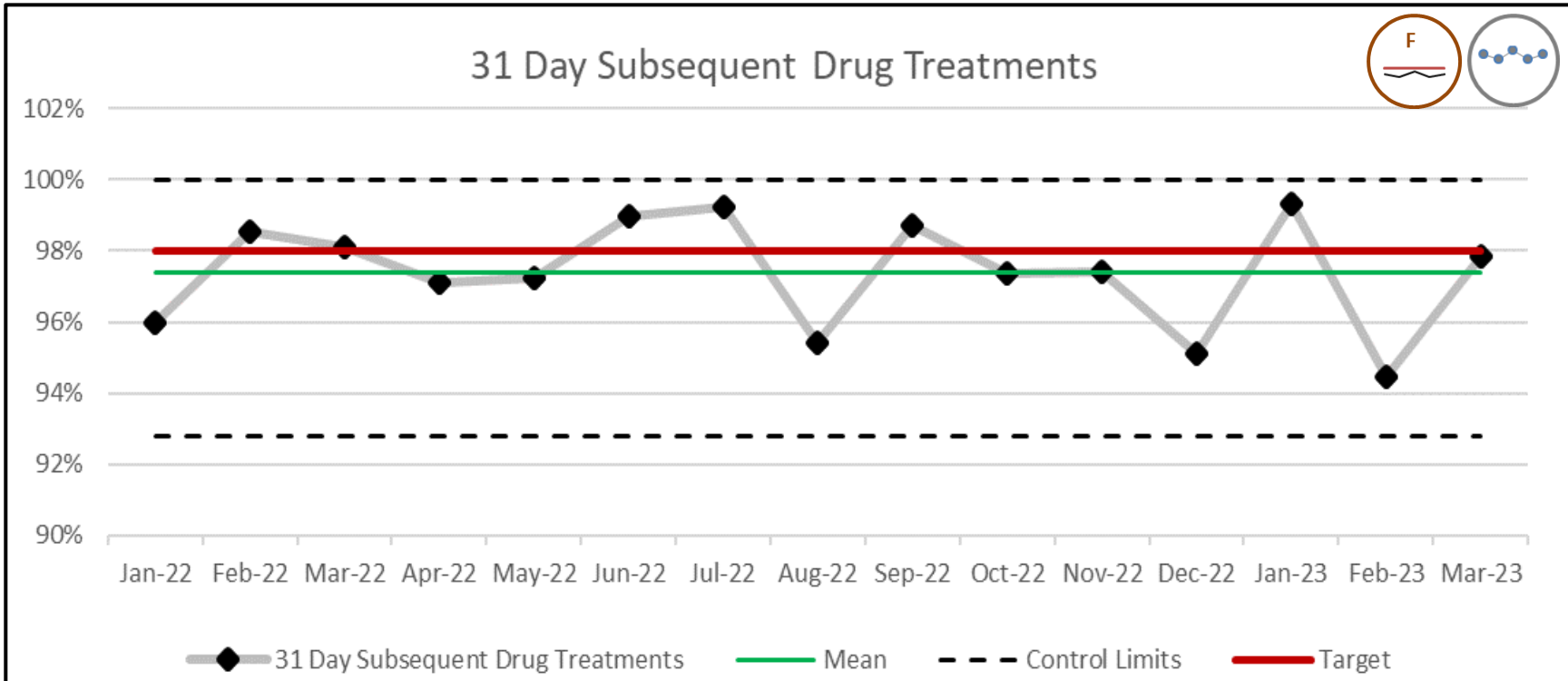
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 89.89% against a 96% target.

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

Actions:
Recruitment in Oncology is ongoing to secure locums, NHS locums or substantive posts. 2 Medical Oncologist posts are out to advert as locums. We appointed to one post and area awaiting a start date. A 6 month Oncology SpDr post went out to advert from which we have 2 appointable candidates. One has already started and one is awaiting the PLAB2 exam.
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. Multiple Bank Holidays have resulted in reduced Brachy capacity – work is underway with theatre teams with an aim to provide a Tuesday service.

Mitigations:
Theatre capacity is improving and will be further alleviated now that the new theatres have opened at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity.
In Head and Neck, Surgeon recruitment required. Locum consultant currently taking on non-cancer Thyroid cases to release capacity for cancer.



Mar-23
97.84%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

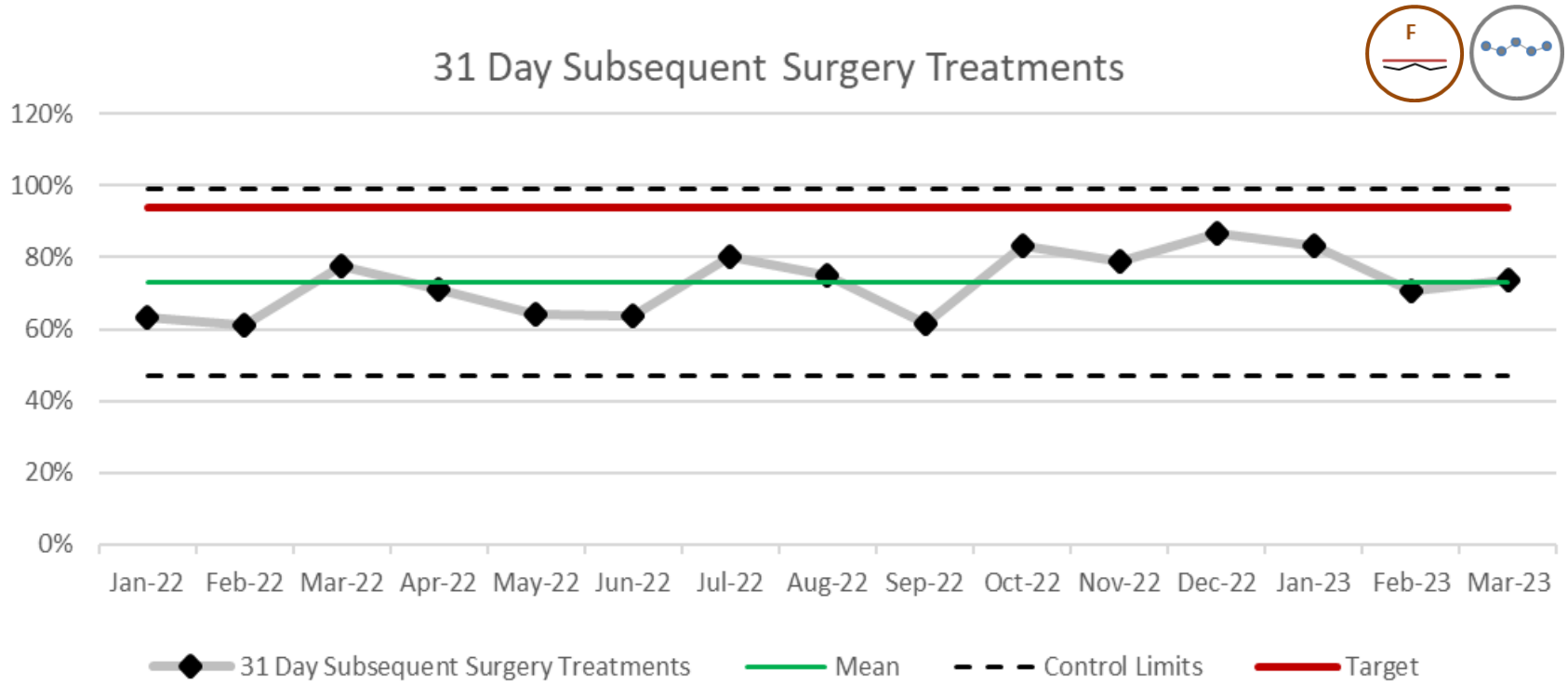
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was drugs.

What the chart tells us:
We are currently at 97.84% against a 98% target.

Issues:
The failure of the 31 Day standards was primarily attributed to lack of AA and theatre capacity.
In March, 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.



Mar-23
73.68%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

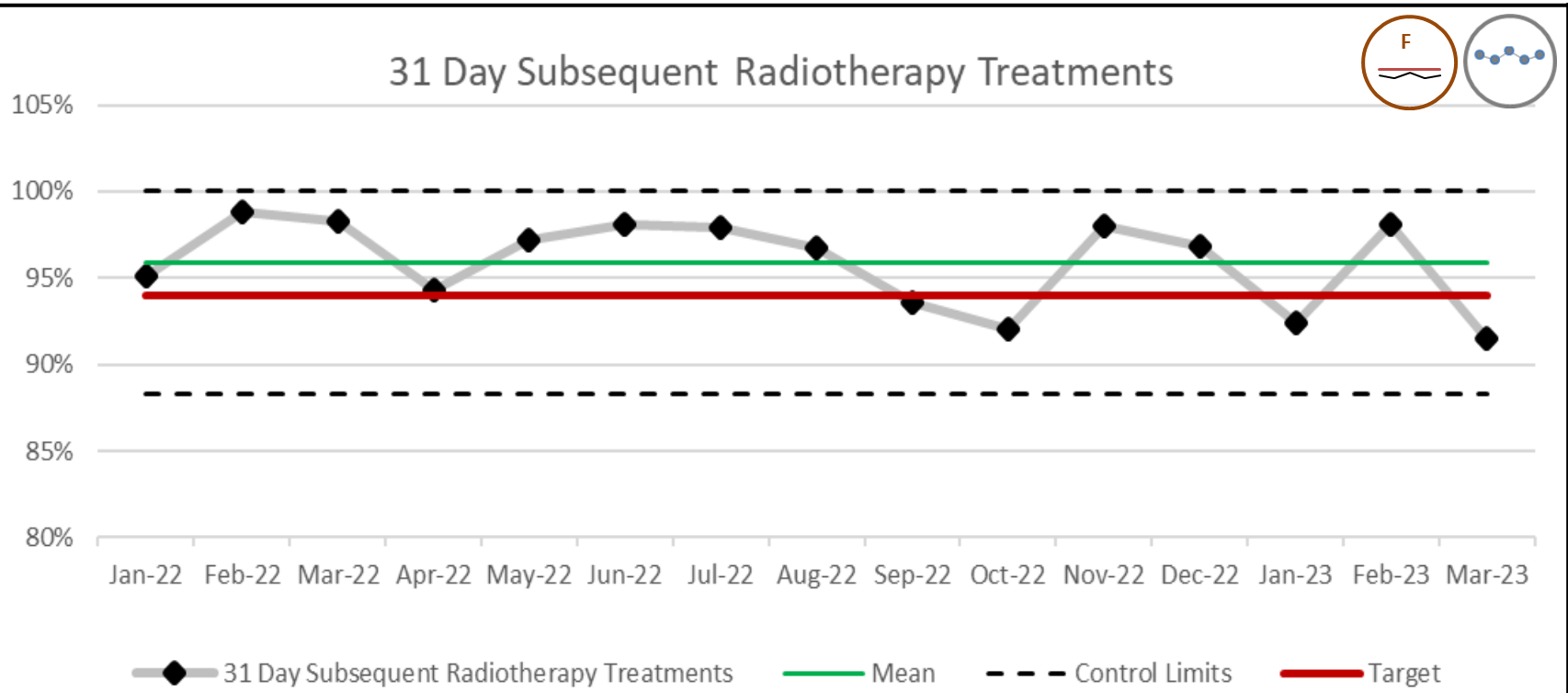
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was surgery.

What the chart tells us:
We are currently at 73.68% against a 94% target.

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

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

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



Mar-23
91.54%
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 91.54% against a 94% target.

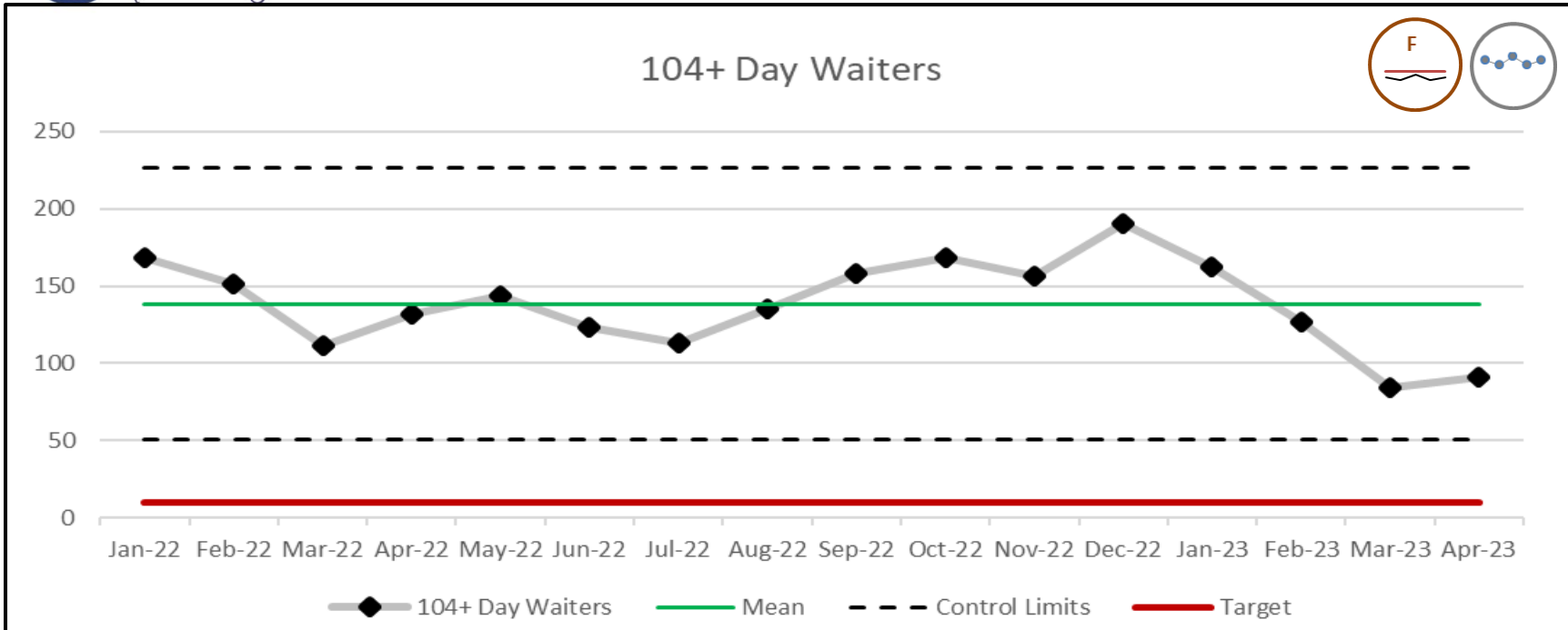
Issues:
Radiotherapy & Brachytherapy – Recent Linac breakdowns have resulted in delayed treatment start dates. Multiple Bank Holidays have resulted in reduced Brachy capacity – work is underway with theatre teams with an aim to provide a Tuesday service.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-23
91
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 11th May the 104 Day backlog was at 91 patients. The agreed target is <10.

There are three tumour sites of concern:-
Colorectal 36 (majority awaiting diagnostics, outpatients and clinical review)
Urology 14
Upper GI 12

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 19% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Actions:

See Actions on previous pages

Mitigations:

See Mitigations on previous pages

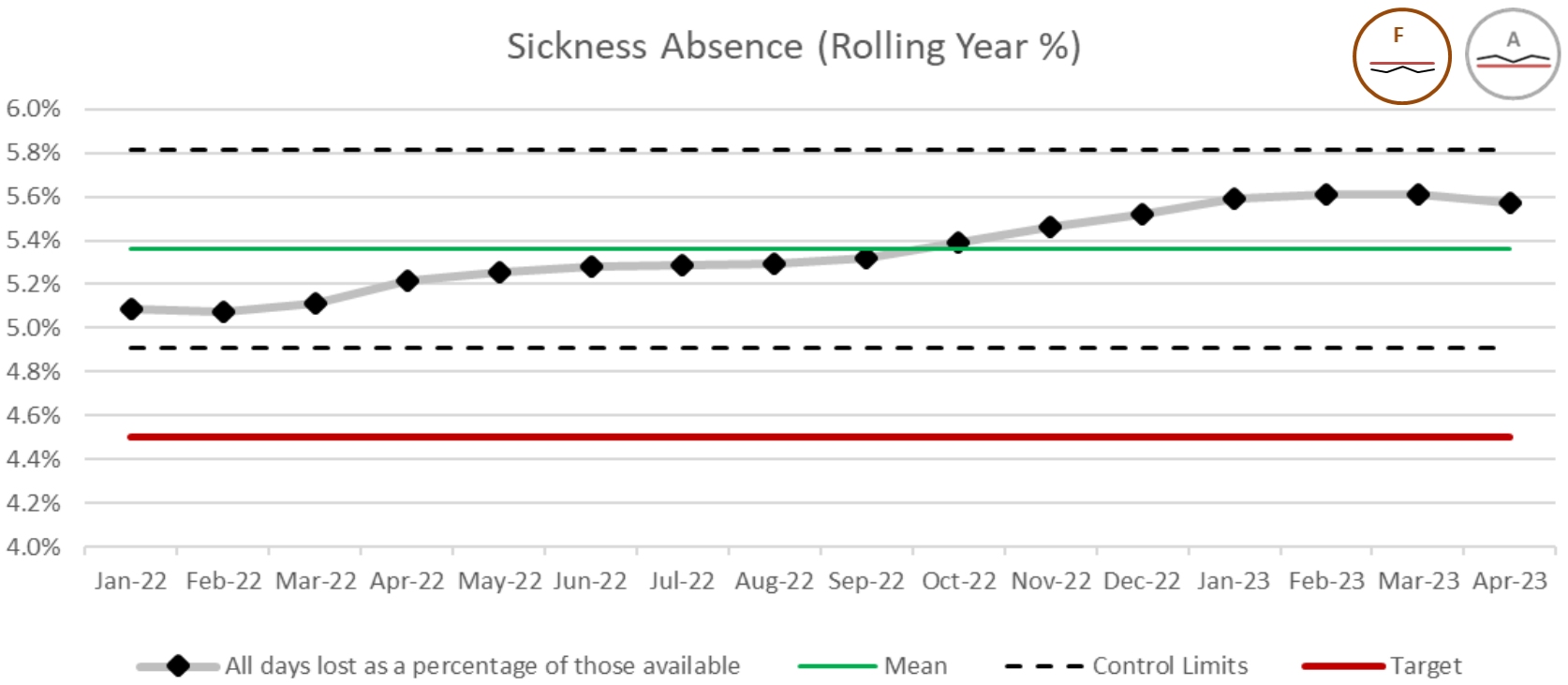
PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Feb-23	Mar-23	Apr-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	88.81%	89.18%	90.17%	90.17%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	7.72%	6.91%	7.69%	7.69%		P	B	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.61%	5.61%	5.57%	5.57%		F	A	
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	13.55%	12.82%	13.23%	13.23%		F		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	65.39%	65.95%	67.19%	67.19%		F	A	

See Executive Scorecard section for relevant failing metrics above.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-23
5.57%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
5.57 % of sickness absence rolling year.

What the chart tells us:
5.57% is above the target of 4.5%.

Issues:
Sickness accounts for 75.96% of all unplanned absence.
Consideration needs to be given to the other reasons that make up the other 24.04% of unplanned absence.
AMS compliance remains a challenge

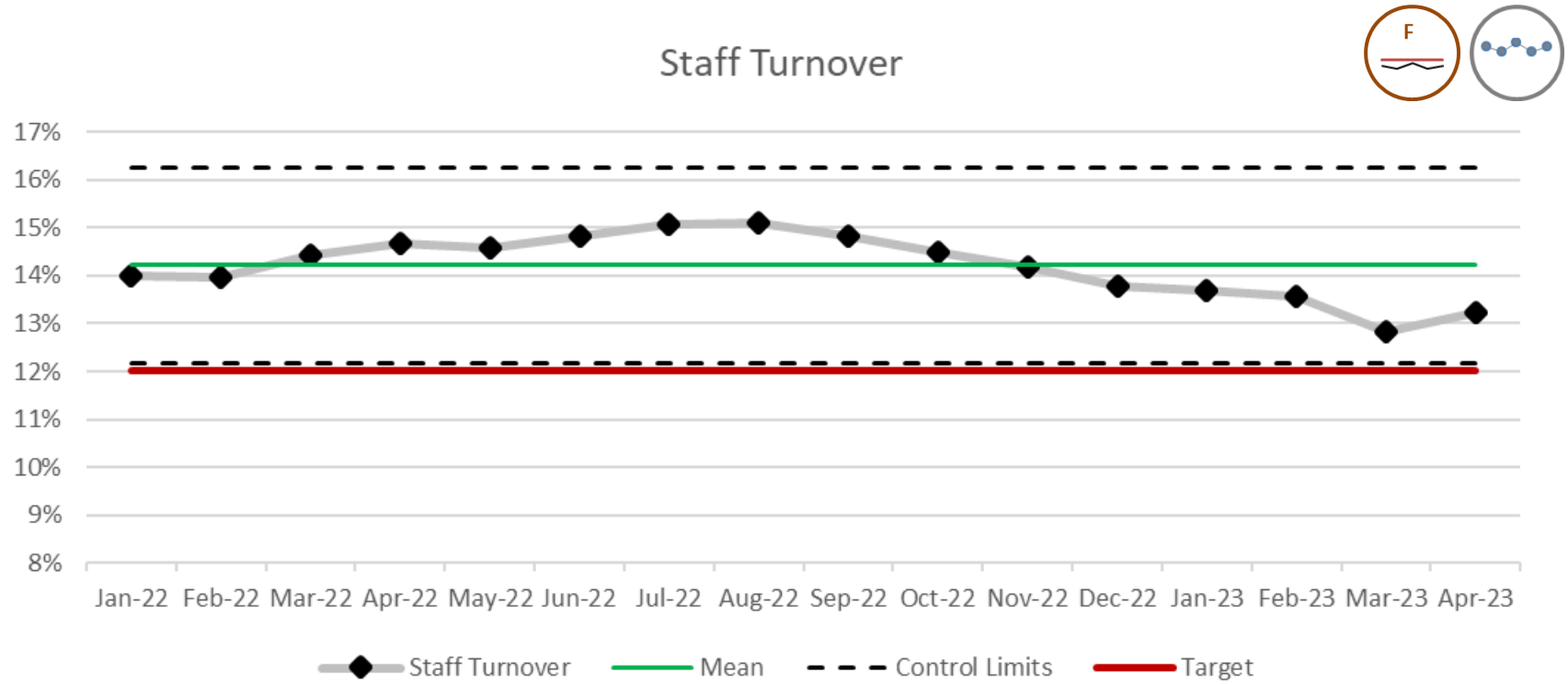
Actions:

- People Management Essentials (PME) training to be mandated.
- PME roll out will provide further foundation as regards the importance / expectations around absence management and the recording of this within the 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.
  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. They also are responsible for the Wellbeing service and Health and Well Being Champions who help to support staff to remain in the workplace.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-23
13.23%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
12%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
13.23% of turnover over a rolling 12 month period.

What the chart tells us:
Turnover rates have stabilised and decreased slightly month on month but are still higher than 12% target. There has been a small in-month increase which was expected due to the financial year end leavers e.g. Fixed-Term contracts etc.

Issues:
Turnover rate was expected to increase at this time due to year end leavers (fixed term contracts) and retirements.

Recent Analysis of exit survey data shows reasons as follows

- 20% retirement age
- 16% lack of work life balance
- 13.5% relocation
- 10% lack of development opportunities
- 7% incompatible work relationships
- 6.5% promotion
- 5% ill health

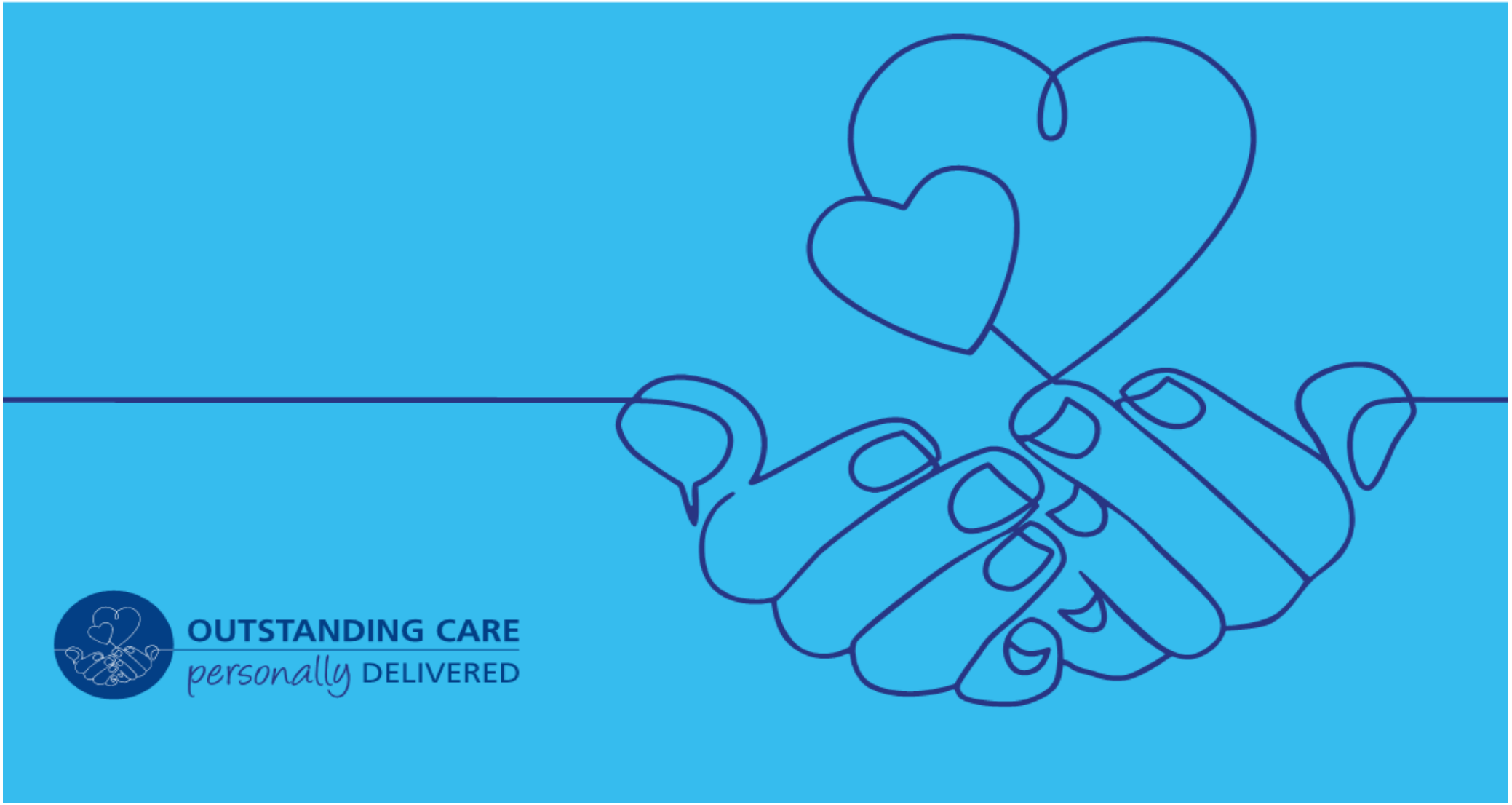
Actions:

- A People Promise Manager dedicated to ULHT who is focussing on retention issues including career conversations and flexible working
- 16 Culture Ambassadors have been recruited and inducted and have commenced their development programme
- Recruitment levels are on track to reduce vacancies which will assist with retention

Mitigations:
Staff survey results are being disseminated across the Trust and focus groups have been arranged to gain feedback on the findings and establish divisional action plans to address any of the areas of concerns highlighted and share best practice. This should help improve employee engagement levels by undertaking a 'you said we did' campaign which in turn should help reduce turnover.

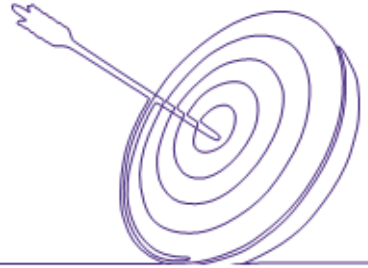
Financial Position Month 1 (2023/24)
Finance Report
5 Year Priority – Efficient Use of Resources

United Lincolnshire Hospitals NHS Trust



Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)



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NHS Trust

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	57,151	56,719	(432)	57,151	56,719	(432)
Other operating Income	3,447	3,590	143	3,447	3,590	143
Employee Expenses	(41,555)	(41,358)	197	(41,555)	(41,358)	197
Operating expenses excl employee expenses	(20,745)	(20,703)	42	(20,745)	(20,703)	42
OPERATING SURPLUS/(DEFICIT)	**(1,702)**	**(1,752)**	**(50)**	**(1,702)**	**(1,752)**	**(50)**
Net finance costs	(474)	(443)	31	(474)	(443)	31
Other Gains / Losses	0	29	29	0	29	29
Surplus / (Deficit) for the period	**(2,176)**	**(2,167)**	**9**	**(2,176)**	**(2,167)**	**9**
Below Line Adjustments	52	52	0	52	52	0
Adjusted financial performance surplus / (deficit)	**(2,124)**	**(2,114)**	**10**	**(2,124)**	**(2,114)**	**10**

- **Revenue position** - The Trust's financial plan for 2023/24 is a deficit of £20.8m; the table above shows that in April the Trust delivered an adjusted deficit of £2.1m i.e. the reported revenue position is in line with the planned deficit of £2.1m

- **CIP position** - The Trust's CIP plan for 2023/24 is to deliver savings of £28.1m; the Trust delivered savings of £1,691k in April, or £531k (45.8%) favourable to planned savings of £1,160k.

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

NHS
United Lincolnshire Hospitals
NHS Trust

Cash

- The April 2023 cash balance is £45.6m; this is an increase of £4.3m against the March year-end cash balance of £41.3m.

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

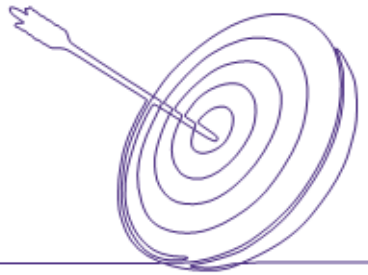
BPPC

- The BPPC performance for April was 95% / 81% by value / volume of invoices paid (appendix 5d); this compares to the full year performance in 2022/23 of 79% / 70%.

Capital position

- The Trust's capital plan for 2023/24 amounts to c£37.9m; the Trust delivered capital expenditure of c£0.2m in April, or £0.4m lower than planned capital expenditure of c£0.6m.

Finance Spotlight Report
(Key areas of focus - Income)



United Lincolnshire Hospitals NHS Trust

The Income position is £0.3m adverse to plan; this includes:

- **NHS patient care income contract** – £390k adverse to plan; including

Pass through drugs and devices are £144k favourable to plan.

Provision has been made for £542k for income risk in relation to contract activity.

- **Other operating income from patient care activities** – £42k adverse to plan

- **Other operating income** - £143k favourable to plan; including

Non-patient care services income over performance of £83k.

Research & Development income over performance of £33k.

Finance Spotlight Report
(Key areas of focus - Expenditure

United Lincolnshire Hospitals NHS Trust

- **Actual pay expenditure of £41.4m in April** is £0.2m favourable to planned expenditure of £41.6m.

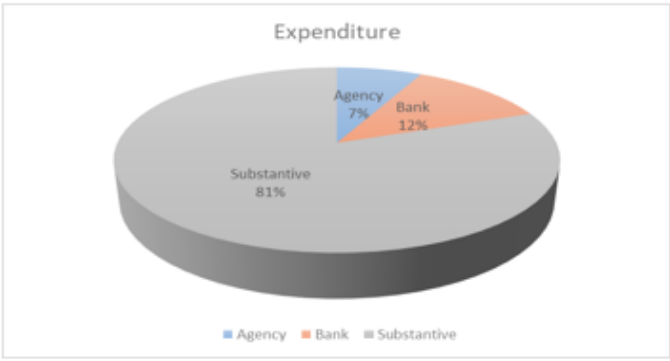
- **The April pay position includes**:

Pay award - An accrual for the 2023/24 pay award in line with the financial plan; as per national guidance, no accrual has been included in relation to the increased settlement.

- Actual pay expenditure of £41.4m in April included £33.3m (81%) on substantive staffing and £8.0m (19%) on temporary staffing:

  £3.1m on agency staffing (down by £0.9m on expenditure of £3.9m in April 2022).

  £5.0m on bank staff.



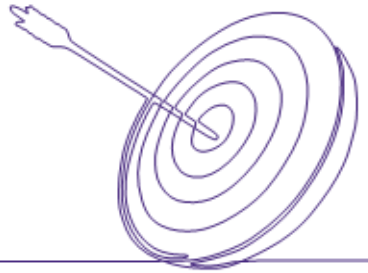
- **Actual Non-Pay expenditure of £20.7m in April** is £42k favourable to planned expenditure of £20.7m

- **The April non pay position includes:**

Inflation where suffered, plus a central accrual for inflation where April estimates are based upon the 2022/23 price base.

Activity volumes are lower than planned in April, but inflation suffered is higher than national planning guidance followed re financial planning for 2023/24.

Finance Dashboard



United Lincolnshire Hospitals NHS Trust

NHSI's Use of Resources assessments aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care. The assessment is in 5 resource areas;

Clinical Services
People
Clinical Support Services
Corporate Services, Procurement, Estates and Facilities
Finance

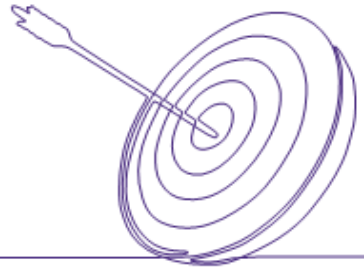
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last three full financial years and the current 2022/23 position are as follows

Finance and use of resources rating	Full Year ending:					Actual
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	31/03/2023	APR 2023
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	0.28
Capital service cover rating	4	4	4	1	3	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.91)	(9.38)
Liquidity rating	4	4	1	1	3	3
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(3.50%)
I&E margin rating	4	4	2	2	4	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]	[illegible]
Agency rating	4	4	4	4	[illegible]	[illegible]
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	0.00%
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	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	30-Apr-23		31-Mar-24
		Plan	Actual	Forecast
	£000	£000	£000	£000
Intangible assets	11,383	5,905	11,048	9,660
Property, plant and equipment	298,860	287,085	297,516	317,869
Right of use assets	11,807	11,644	11,595	9,638
Receivables	2,157	1,848	2,231	1,848
Total non-current assets	**324,207**	**306,482**	**322,390**	**339,015**
Inventories	8,067	7,000	6,408	7,000
Receivables	52,874	28,520	46,585	26,375
Cash and cash equivalents	41,269	60,876	45,673	16,201
Total current assets	**102,209**	**96,396**	**98,666**	**49,576**
Trade and other payables	(91,839)	(89,466)	(84,372)	(79,801)
Borrowings	(3,129)	(3,109)	(3,097)	(3,161)
Provisions	(20,143)	(7,025)	(18,202)	(4,825)
Other liabilities	(1,260)	(4,130)	(5,348)	(1,130)
Total current liabilities	**(116,371)**	**(103,730)**	**(111,019)**	**(88,917)**
Total assets less current liabilities	**310,045**	**299,148**	**310,037**	**299,674**
Borrowings	(12,189)	(12,105)	(11,990)	(9,117)
Provisions	(2,636)	(3,124)	(5,035)	(2,992)
Other liabilities	(11,069)	(11,027)	(11,027)	(10,566)
Total non-current liabilities	**(25,894)**	**(26,256)**	**(28,052)**	**(22,675)**
Total assets employed	**284,151**	**272,892**	**281,985**	**276,999**
Financed by				
Public dividend capital	724,041	723,888	724,042	738,236
Revaluation reserve	42,584	28,529	42,489	41,888
Other reserves	190	190	190	190
Income and expenditure reserve	(482,663)	(479,715)	(484,735)	(503,314)
Total taxpayers' equity	**284,151**	**272,892**	**281,985**	**276,999**

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 £45.7m has increased £4.4m from March but is expected to reduce during the year in line with the planned deficit and a reductions in creditors / provisions.

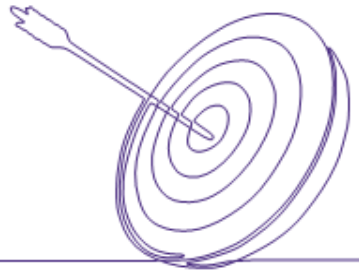
Note 3: Receivables remain higher than for much of 2022/23 with payment for a number of CVs and the non-consolidated element of the 2022/23 pay award remaining to be paid – total circa £24m. See Appendix 5a-b

Note 4: The overall level of Trade and other payables at £79.8m remains above historic levels. This includes the estimated cost of the pay award circa £14.9m.
BPPC and aged creditor performance is reported at Appendix 5c-d.

Note 6: The planned capital programme for 2023/24 will result in asset additions of £37.9m. This is to be funded through internal cash resources but with an injection of £14.2m 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



NHS
United Lincolnshire Hospitals
NHS Trust

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

Note 1: Cash held at 30 April was £45.7m against a plan of £60.9m. This represents an increase of £4.4m against the March year-end cash balance of £41.3m.

Note 2: The variance against plan of £8.7m is being driven predominantly by the level of receivables (22/23 CVs and Pay award) which is significantly higher than was anticipated.

Note 3: Cash balances are expected to reduce as we move through 2023/24. Principle drivers being:

- The planned deficit of £20.8
- Release / utilisation of provisions associated with current litigation and contractual obligations – circa £15m.
- A further reduction in capital creditors (April £9.9m) from the year end high of £21.2m.
- A 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	*06/06/2023*
Item Number	*Item 12.1*
Year 4- Trust Integrated Improvement Plan 2023/24	
Accountable Director	*Sameedha Rich-Mahadkar, Director of Improvement and Integration*
Presented by	*Sameedha Rich-Mahadkar, Director of Improvement and Integration*
Author(s)	*Sarah Ferguson, Deputy Director of Strategy & Planning* *Georgina Grace, Head of Strategy & Planning* *Lindsey Marshall, Strategy Support Manager* *Stephen Knight, Senior Communication Manager*
Report previously considered at	*Private Trust Board May 2023*

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

Risk Assessment	*Not completed*
Financial Impact Assessment	*Not completed*
Quality Impact Assessment	*Not completed*
Equality Impact Assessment	*Not completed*
Assurance Level Assessment	*Significant*

Recommendations/ Decision Required	• *This paper outlines Year 4 of the Trust's Integrated Improvement Plan (IIP).* • *The IIP has been built on the 'bottom up, top down' design approach, through a clinically led lens, which we began last year.*

- *It has been developed in collaboration with Divisional Teams, Executive Teams and Corporate colleagues to ensure it was inclusive and reflected the needs of the whole organisation.*
- *Trust Board are asked to approve 23/24 Integrated Improvement Plan.*

Summary of ULHT Integrated Improvement Plan

Our Strategy for 2023/24

NHS
United Lincolnshire Hospitals
NHS Trust

OUTSTANDING CARE
personally DELIVERED

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Introduction

We have a lot to be proud of at United Lincolnshire Hospitals NHS Trust. Our staff and volunteers have responded brilliantly to the unprecedented challenges posed by COVID-19 recovery, the relentless demand we have seen in emergency medicine and to address the backlog created by the pandemic.

Our people continue to work selflessly and tirelessly to keep our hospitals open and our patients safe, driving towards our vision to provide outstanding care, personally delivered to our Lincolnshire population.

We are moving into a new era of partnership and collaboration, following the creation of the Integrated Care Board (ICB) in July 2022. The constituent parts of the NHS are now working together across Lincolnshire, rather than competing in an internal marketplace.

We each have a role in the local Lincolnshire Integrated Care System (ICS) to provide better care for patients, improved health and wellbeing for everyone, and sustainable use of resources. This is really crucial given our financial position and the national drive for improved productivity and efficiency – it is important we are good custodians of public monies. We need to continue our improvement journey to achieve a CQC rating of 'good' and 'outstanding' in all areas, in the wider context of the Lincolnshire ICS.

Lastly, we are proud to lead talented and inclusive people, in serving some of the most culturally diverse and socially deprived parts of the country. We thank our colleagues for everything they do to continue to provide safe and compassionate care for all our patients and their communities.

Our organisation

United Lincolnshire Hospitals NHS Trust (ULHT) serves one of the largest geographical areas in England with a population of around 768,364, and a workforce of circa 8,531.

Our services are delivered by four core clinical divisions: Medicine, Surgery, Family Health, and Clinical Support, with support from our corporate services.

At ULHT we provide a comprehensive range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services, primarily operating across four hospital sites; Lincoln, Boston, Grantham and Louth.

We have a number of community hospitals providing additional capacity, closer to our patients' homes; John Coupland Hospital in Gainsborough, Johnson Community Hospital in Spalding, Skegness and District Hospital and our newly established Community Diagnostic Centre at Grantham.

Our vision

Our Integrated Improvement Plan for 2023/24 sets out our commitment to continual improvement and a realistic map for the next stages of our improvement journey. Our purpose is plain and simple. Putting patients first is our key focus. That's why we're all here.

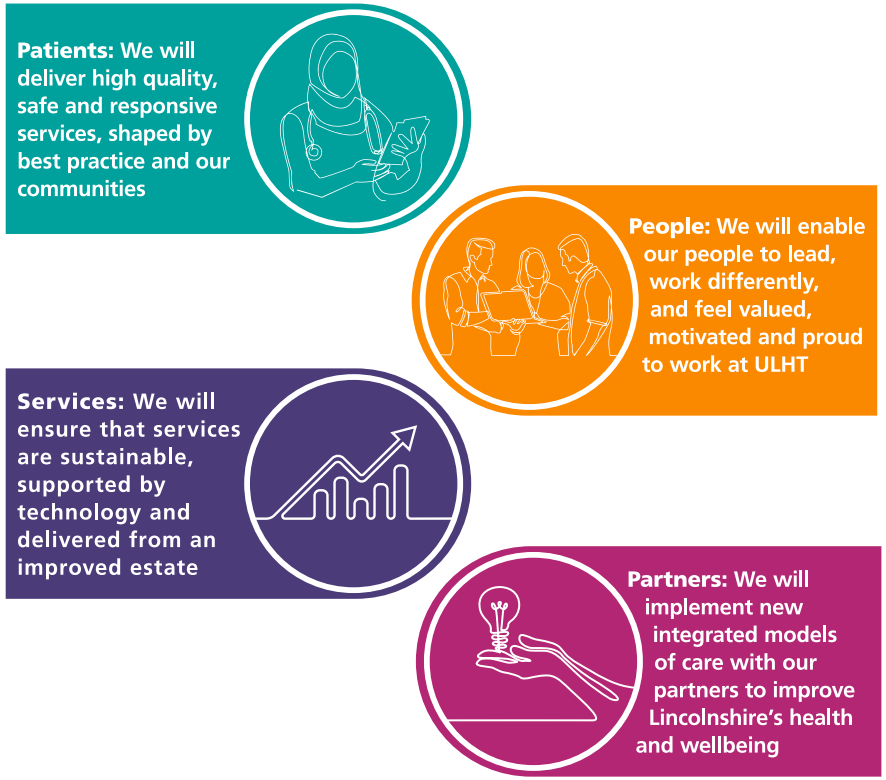
We have five values which demonstrate what we stand for, and how we behave.

The strategic objectives are simple and focus on our patients, our people, our services and our partners. The annual Integrated Improvement Plan will detail the work we will progress and actions we will take this year, under these key objectives.

We pledged to have continuous quality improvement and productivity and efficiency, to be at the heart of what we do to support us to deliver better patient outcomes, improve operational and financial sustainability.

Our Values

Our Strategic Objectives



Our achievements during 2022/23

Achievements for our patients

For our patients we have;

Developed a new £5.6m Resuscitation department in the Emergency Department at Lincoln

Established safer Maternity services with removal of all CQC conditions, a move out of the national Maternity Safety Support Programme and recruitment of 34 additional midwives

Reduced waiting times in Emergency Departments:

- Patients waiting less than 12 hours in ED improved from 84.93% (Feb 2022) to 88.25% (Jan 2023)
- Number of ambulance handovers delays exceeding 59 minutes reduced from 800 (Feb 2022) to 497 (Jan 2023)

Improved patient safety indicators:

- Improvement in patient mortality (SHMI) from 111.2 (Feb 2022) to 102.7 (Jan 2023)
- Consistently achieved greater than 98% compliance with IPC objectives

Established the Patient Improvement Advisory Group with patient volunteers to provide scrutiny and ensure the patient voice is heard when considering improvement ideas and projects

Achievements for our people

For our people we have;

Increased our overall workforce numbers by an additional 1,000 people

Second highest improver in all acute Trusts in the NHS staff survey results, particularly in:

- Colleagues feeling supported to develop their potential from 41% to 50%
- Colleagues feeling the organisation respects individual differences from 58% to 65%
- Colleagues feeling satisfied with opportunities for flexible working patterns from 45% to 51%

Reduced staff turnover rates from 14.7% to 13.6%

Reduced medical vacancies from 8.88% to 4.72%

Recruited more than 350 registered nurses

Reduced support staff vacancies from 13.53% to 7.89%

Delivered a saving against nursing agency spend of circa £1.6 million

Implemented Royal College of Physicians safe staffing review resulting in a saving of circa £900,000

Launched our Cultural Intelligence Programme to improve equality, diversity and inclusion

Our Talent Academy has supported:

- Utilisation of 95% of apprenticeship levy
- 49 members of staff to complete their apprenticeships
- 156 people to commence an apprentice programme
- Recruitment of 103 Reservists

Implemented HealthMedics for leave requests for everyone in our medical workforce

Achievements for our services

For our services we have;

Successfully eliminated patient waits of 104 weeks or more. Almost eradicated patient waits greater than 78 weeks

Invested £5.3 million in two new theatres at Grantham

Became one of eight elective Surgery Hubs to receive accreditation nationally at Grantham and District Hospital

Secured and delivered £135.8m of capital investment over the last three years against an overall target of £120m over five years

Provided mutual aid to other Trusts, ensuring equitable access to treatment for patients requiring Urology or Orthopaedic surgery

Reduced the number of operations cancelled on the day of surgery from 2.9% (July 2022) to 1.28% (Feb 2023)

Rolled out electronic prescribing to 17 areas

Secured an initial £6.2m to commence work on the enabling infrastructure for our Electronic Health Record implementation

Delivered a reduction in non-elective length of stay for Pathway 0 patients to 4.56 days against a target of 5.96 days

Reduced 7,000 missing outcomes from patient appointments by 42% and have driven up Patient Initiated Follow Up to above 3.5% (across all divisions). Surgery Division are up to 4%

New theatres at Grantham and District Hospital

Achievements for our partners

For our partners we have;

Established a Tobacco Cessation Service within the Trust

Developed a strong relationship with the University of Lincoln to build our partnership in research and innovation to become a University Teaching Hospital Trust

Seen more than 300 patients as a result of the expansion of our virtual ward capacity, supporting reduced waiting times and pressure on emergency services

Completed the Orthopaedic Acute Service Review (ASR) with full sign off obtained from Lincolnshire's Health Overview and Scrutiny Committee

Continued partnership working with our Integrated Care System, Lincolnshire Community Health Services NHS Trust and GP colleagues to implement the outcomes from the Stroke and Grantham ASR

Our objectives for 2023/24

Our patient objectives

By 2025, we will deliver high quality, safe and responsive services, shaped by best practice and our communities.

What this will look like:

- We will have improved discharge processes
- Patients will not come to harm in our care
- Patients will receive high quality, safe care

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

What we will achieve in 2023/24:

- Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm and reviewing external reports and assessments of our services
- Improve our medication management safety and reduce medication related incidents resulting in harm, supported by implementation of an e-Prescribing system
- Establish an open and honest patient safety culture rather than attributing blame and liability, which will enable improved clinical outcomes, through implementation of Patient Safety Incident Response Framework (PSIRF) by September 2023

Patient Objective 1b: Improve patient experience.

What we will achieve in 2023/24:

- 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
- Implementation of our 'you care, we care to call' programme across 38 wards
- Improved learning from patient feedback, with a focus on addressing discharge processes and inclusion of 'experts by experience'
- Embedded processes to address risk of hidden child and support transition across all services

Patient Objective 1c: Improve clinical outcomes.

What we will achieve in 2023/24:

- Ensure we provide clinically safe services, through an increased volume of Diamond Accredited Wards
- Improve clinical effectiveness through increased compliance with national and local standards
- Improve clinical effectiveness and best practice principles by prioritising Cardiovascular pathways
- Relaunch and embed our Commissioning for Quality and Innovation (CQUIN) programme to ensure best practice and improve clinical outcomes

Our people objectives

By 2025, we will enable our people to lead, work differently, and feel valued, motivated and proud to work at ULHT.

What this will look like:

- We will have an improved benchmark position for vacancy and turnover rates when compared to peer and national medians
- We will have an improved position in all domains of the national NHS Staff Survey
- We will be rated "Outstanding" for "Well Led" by the Care Quality Commission

People Objective 2a: A modern and progressive workforce.

What we will achieve in 2023/24:

- Proactively support staff to remain well and at work, however should the need arise, support them through illness and their return to work
- Develop and support our people and the wider system, maximising access to training opportunities, making full use of the apprenticeship levy
- Vacancy levels below 4% across all staff groups
- Reduce our staff turnover rate to 6% across all staff groups

People Objective 2b: Making ULHT the best place to work.

What we will achieve in 2023/24:

- Support Divisions to achieve 95% of our people having completed all relevant statutory and mandatory training by March 2024
- Support our Divisions to provide all staff with an appraisal and clear objectives
- 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

People Objective 2c: Well led services.

What we will achieve in 2023/24:

- An external audit against CQC Well Led measures, to be completed by September 2023 and an action plan to be developed for further improvements
- Compliance with national agency utilisation target of 3.7% of total system pay bill for agency and locum workforce
- 53% of our staff recommending ULHT as a place to receive care

Our services objectives

By 2025, we will ensure that services are sustainable, supported by technology and delivered from an improved estate.

What this looks like:

- Deliver a balanced finance plan with a framework in place to identify targeted improvement schemes
- Secure capital funding to deliver Trust strategies, including the Trust Green Plan
- Our staff will have access to real-time data via electronic systems
- Our patients will be able to access services in timeframes that are safe and responsive

Services Objective 3a: A modern, clean and fit for purpose environment

What we will achieve in 2023/24:

- Support capacity maximisation ensuring modernisation and utilisation of space and reduction in backlog maintenance through implementing the estates strategy
- Reduce our net carbon footprint
- Deliver our capital programme

Services Objective 3b: Efficient use of our resources

What we will achieve in 2023/24:

- Deliver our key cost improvement programmes across our targeted, transformation and transactional framework
- Deliver our financial plan
- Develop plans and strategies for our fragile services, through service review process and transformational programmes of work

Services Objective 3c: Enhanced data and digital capability

What we will achieve in 2023/24:

- Upgrade of our technological infrastructure to support technology advancements
- Provide our people with real-time data to support delivery of high quality care
- Enhance our organisational digital capability and skills through training
- Implementing 2023/24 actions of becoming a "Paper Lite Digital Hospital" and delivery of our Digital Strategy and implementation of an Electronic Prescribing system

Services Objective 3d: Improving cancer services access

- Meet all constitutional standards for performance for cancer care
- Improve access to our services to meet the needs of our population
- Increase the proportion of cancers diagnosed early

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

- Elimination of 78 weeks/ 65 week waits across all specialties
- Meet all constitutional standards for performance on elective care
- Maximisation of capacity and efficiencies to reduce waiting times

Services Objective 3f: Urgent Care

What we will achieve in 2023/24:

- Meet all constitutional standards for performance for non-elective care
- Improve flow and discharge with a reduced length of stay and robust process to support discharge efficiencies
- Reduce our bed occupancy to support flow through our emergency departments

Our partners objectives

By 2025, we will implement new integrated models of care with our partners to improve Lincolnshire's health and wellbeing.

What this looks like:

- We will be a leading partner for the ICS and be making a positive impact on our population health outcomes and the local economy
- We will be growing a culture of research and innovation
- We will embed a deeper understanding of our role to reduce health inequalities

Partners Objective 4a: Establish collaborative models of care with our partners

What we will achieve in 2023/24:

- Development of Core20PLUS dashboard to enable greater understanding of the Lincolnshire population and support a reduction in health inequalities
- A Joint Forward Plan with our ICS and embed population health data and the health and wellbeing strategy
- Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme

Partners Objective 4b: Becoming a University Hospitals Teaching Trust

What we will achieve in 2023/24:

- Develop a joint research strategy and a joint research office via a virtual platform
- Develop a joint future workforce plan for resources to enable development of future clinical workforce, including the training of principle investigators
- Achieve 'Teaching' hospital status

Partners Objective 4c: Successful delivery of the Acute Services Review

What we will achieve in 2023/24:

- Develop a ULHT clinical service strategy and establish a rolling programme of specialty clinical service strategies
- Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships
- Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire

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United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*6 June 2023*
Item Number	*Item 13.1*

Strategic Risk Report

Accountable Director	*Dr Karen Dunderdale, Director of Nursing & Deputy Chief Executive*
Presented by	*Dr Karen Dunderdale, Director of Nursing & Deputy Chief Executive*
Author(s)	*Helen Shelton, Assistant Director of Clinical Governance*
Report previously considered at	*Lead assurance committees for each strategic objective*

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

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

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

Executive Summary

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

- The are 17 quality and safety risks rated Very high (20-25), with an increase of 2 due to the Paediatric risks around Diabetes and Epilepsy being split into Acute and Community risks, these relate to:

    - 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;
    - Outpatient appointment processes in Haematology;
    - Non-recurrent funding in Cancer services;
    - ICU capacity for elective surgery.

- Since the last report one Very High has been discussed at the April RRC&C meeting with the following outcome:

- Lessons learned to improve patient safety – **Reduced from a Very High (20) to now a closed risk.**

- There are 7 Very High Risks (20-25) reported to the People & Organisational Development Committee this month, an increase of 4 from the previous reporting period:

    - 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; - **New Validated Risk**
    - Pharmacy service not able to withstand prolonged staff absence; - **New Validated Risk**
    - Pharmacy workload demands; - **New Validated Risk**

- Service configuration (Haematology) – **New Validated Risk**

- There were 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, an increase of 1 from the last reporting period:
  - 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;
  - Fabric and capacity of the mortuary service – **New Validated Risk**

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 372 active and approved risks reported to lead committees this month. This is 24 more than were reported last month.

2.2 There were 30 risks with a current rating of Very high risk (20-25) and 24 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)
23 (6%)	**72** (19%)	**221** (59%)	**29** (7%)	**30** (8%)

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

2.3 There were 13 Very high risks and 10 High risks recorded in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and 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	25/04/2023
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.	26/04/2023
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.	24/04/2023
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.	24/04/2023

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.	24/04/2023
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.	25/04/2023

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.	24/04/2023
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	18/04/2023

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	18/04/2023
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	24/04/2023

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.	06/04/2023
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.	18/04/2023
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.	18/04/2023

Strategic objective 1b: Improve patient experience

2.4 There were 1 Very high risks and 2 High risks recorded in relation to this objective.

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4998	Appointments system - frequent delayed appointments due to not being actioned promptly enough after e-outcome completion. As a consequence of secretaries micromanaging clinic appointments and e-outcomes to fit in time critical patients this has resulted in a back log of typing. Circa 8 weeks backlog.	Very high risk (20)	* Recruitment and retention of outpatient staffing to support clinics * Training of outpatient staff in Haematology appointments. * Division out to bank sec assistants and agency to support back log of typing	19/04/2023

Strategic objective 1c: Improve clinical outcomes

2.5 There were 4 Very high risks and 2 High risk recorded in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5075	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.	Very high risk (20)	The triumvirate to include surgery and TACC are planning to meet to review potential options.	06/04/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4828	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust. Update 4th July 22- 26th July, ePMA functionality version 10.21 will be upgraded. ePMA pilot from 13/09/22, full Trust wide roll out from mid Oct.	25/04/2023
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.	05/04/2023

Strategic objective 2a. A modern and progressive workforce

2.6 There was 4 Very high risk and 4 High risks recorded in relation to this objective. A summary of the Very high risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4991	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	Very high risk (20)	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	24/04/2023
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.	06/04/2023
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	24/04/2023

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."	19/04/2023

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. 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	24/04/2023
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.	06/04/2023
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.	06/04/2023

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

2.8 There were 3 approved Very high risks (20-25) and 2 High risk (15-16) recorded in relation to this objective, the same position as reported last month. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4648	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk. - Fire safety protocols development and publication. - Fire drills and evacuation training. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Planned preventative maintenance programme by Estates	25/04/2023
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - PPM reporting for FEG and FSG By Estates Teams - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk	25/04/2023
5104	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.	Very high risk (20)	Risk reduction plan to assure HTA during March that risk controlled above mitigate their concerns over the Trusts mortuary estate.	26/04/2023

Strategic objective 3b: Efficient use of our resources

2.13 There were 2 approved Very high risks (20-25), this remains stable from last month's report; and 4 High risks (15-16), also remaining stable from last month's 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	24/04/2023
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.	26/04/2023

Strategic objective 3c: Enhanced data and digital capability

2.14 There was 1 approved Very high risk (20-25) recorded in relation to this objective, this is remains stable from the previous report. There were also 3 High risks (15-16), the same as in the previous report. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties.	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.	25/04/2023

	Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."		Early identifications of chasers and urgent requests to reduce the likelihood of complaints."	

Strategic objective 3d: Improving cancer services access

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

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

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

Strategic objective 3f: Urgent Care

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

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

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

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

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

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

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

3. Conclusions & recommendations

3.1 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;
- Outpatient appointment processes in Haematology;
- Non-recurrent funding in Cancer services;
- ICU capacity for elective surgery

3.2 There are 7 Very High Risks (20-25) reported to the People & Organisational Development Committee this month, an increase of 4 from the previous reporting period:

- 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).

3.3 There were 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, an increase of 1 from the last reporting period:

- 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;
- Fabric and capacity of the mortuary service.

3.4 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							**3a. A modern, clean and fit for purpose environment**																			
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).	Quarterly dialog with HTA and Trust ULHT Improvement action plan	16/04/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Risk reduction plan to assure HTA during March that risk controlled above mitigate their concerns over the Trusts mortuary estate.	[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.	5	31/03/2024		16/05/2023
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)	25/04/2023	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	[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 storage of items within corridors was highlighted: "Article 14(2) Emergency Routes and Exits There are combustible materials and items that pose an ignition risk are located on escape routes within the hospital. It required that Corridors and stairways that form part of an escape route should be kept clear of obstruction and hazard free at all times. Items that maybe a source of fuel or pose an ignition risk should not normally be located on any corridor or stairway that will be used as an escape route." In light of identified storage issues and subsequent non-compliance with these requirements, there is now a high potential for immediate enforcement notice with a view to prosecution in accordance with the regulator's compliance code. Task & finish group set up to address storage issues at local and at senior levels. Fire Safety Advisors working with local managers; IR1s reported when storage issues are identified, with escalation to divisional leads where necessary	4	30/06/2022	31/03/2024	25/05/2023
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.	25/04/2023	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	[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 escalation to senior managers. Setting up task & finish group to look at storage issues. Reviewed all fire risk assessments in Diagnostics across all 3 sites; other FRAs for public areas have also been reviewed. Reviewed all external security patrols and implemented alterations to routes to ensure possible higher risk areas are also patrolled. New tagging points added to patrol routes. Implementation of further required actions continues to progress.	10	31/03/2022	31/03/2025	25/05/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5136	Physical or psychological harm	Parkhill, Michael	Pattinson, Paul	Estates Investment and Environment Group	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.	28/03/2023	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.	[26/04/2023 12:02:44 Rachael Turner] This is a risk to midwives. Pilgrim is currently in progress and re-sampling is in place. In Lincoln the ventilation is a big issue due to asbestos. This risk may need to be split. Looking at improving the monitoring at both sites to provide assurance and measure levels. This risk was validated at Risk Register Confirm and Challenge at a score of 16 High Risk. [06/04/2023 12:48:08 Paul White] Presented by Estates at Risk Register Confirm & Challenge 29 March. Agreed that perspectives from other areas is required before bringing back to April meeting for validation.	10	28/03/2024		28/06/2023
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	21/10/2022	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	[21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	21/01/2023
Strategic Objective						**3b. Make efficient use of our resources**																				
4664	Finances	Matthew, Mr Paul	Young, Jonathan	Workforce Strategy Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	National policy: - Agency spending cap set by Government ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Annual budget setting process cascades and apportions the Trust temporary staffing spend limits to the Divisions and Directorates. - Monthly financial management & monitoring arrangements are in place to identify variation temporary staffing financial plans at all levels of expenditure from department up to Trust. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Financial Review Meeting (FRM)	24/04/2023	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	[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	31/03/2023	24/05/2023
5020	Finances	Wall, Mrs Tracey	Thomson, Cheryl	Workforce Strategy Group	WORK	02/09/2022	20		Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	26/04/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very High risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[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 [12/10/2022 17:24:16 Helen Hartley] No changes made at governance	10	02/09/2023		31/05/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4957	Finances	Young, Jonathan	Young, Jonathan			28/06/2022	16	Professional Guidance	Corporate	Finance and Digital	Finance	Trust-wide	The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. The national planning assumption is that all COVID costs incurred in Acute settings in relation to COVID will cease from 1st June 2022 aligned to the anticipated reduction in COVID patients to extremely low levels.	National policy: - Government financial planning assumptions due to COVID ULHT policy: - Financial plan set out the Trust Budget allocations in respect of COVID spend - Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). ULHT governance: - Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. - Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base. - The Planning and Recovery Steering group will provide oversight of the COVID costs.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FRM.	02/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Alignment of the Directorate and Divisional budgets to the national strategy for the removal of COVID costs from 1st June 20222. By exception reporting of all COVID costs not removed from financial positions.	[02/02/2023 14:25:19 Rachel Thackray] The Trust is forecasting £5.8m COVID related costs for 22/23. This is a much improved position from the 21/22 spend however this is still a pressure, although much reduced, in the financial position. All schemes that have been reduced or ceased have been through a QIA assessment. Risk to be reassessed in April 2023. The Trust incurred c£13m of direct costs in relation to COVID with a further indirect cost e.g. staff sickness. The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	8	31/03/2023	31/03/2023	03/04/2023
4665	Finances	Matthew, Mr Paul	Young, Jonathan	Financial Turnaround Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £25m CIP target for 22/23. If the Trust fails to deliver The CIP Plan it will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to achieve their financial plans.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial plan inclusive of CIP. (Transformational) - Establishment of the service framework to prioritise Speciality improvement reviews. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process from 1st April. (Transactional) ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process - Programme Management Office (PMO) & dedicated Programme Manager. - Introduction of the Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes - Refresh of the FRMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I The Trust monitors internally against its CIP targets inclusive of specific Divisional and Scheme targets Divisional focus against Transactional schemes is reviewed at the relevant FRM Trust focus against Targeted and Transformational schemes is reviewed at the Improvement Steering Group	02/02/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Refresh of the CIP framework and training to all stakeholders. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust IIP and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	[02/02/2023 14:13:16 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme for 22/23 a shortfall of £11m against its revised plan, which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. [02/02/2023 14:12:00 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. The Trust has delivered its CIP plan for the past 3 years, albeit a reduced requirement during the 2 financial years that cover COVID. The Trust is embedding a new Improvement framework with CIP included within it and is also working with system partners to make financial improvements due to pathway changes. This will take time to embed and alongside the operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the CIP target. Reviewed at RRC&CG - agreed score of 16.	4	31/03/2023	31/03/2023	02/05/2023
5019	Finances	Wall, Mrs Tracey	Spendlove, Mrs Clare			02/09/2022	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is a continued reliance on bank and agency staff for nursing workforce in Urgent & Emergency Care there is a risk that there not sufficient fill rate in each department which will impact on patient safety and have a negative impact on the CBU budget	Robust nursing plan for every post meetings Daily operational matrons identified for Lincoln and Pilgrim Daily safer staffing lead identified for escalation Establishment review DON Monthly roster clinics / workforce dashboard Daily staffing meetings 3x day Monthly director of nursing quality dashboards. Temporary staffing solutions group - purpose is to reduce agency spend attendance.	Plan for every post meetings Budget reports	24/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Robust recruitment plan International recruitment	[24/04/2023 12:58:59 Carl Ratcliff] Recruitment plan in place and continues - will plan when next risk reduction can take place [06/03/2023 13:55:09 Rachael Turner] RRC&C members in agreement of risk score reduction to a High Risk (16). [22/02/2023 16:47:51 the reporter] -Establishment reviews have taken place -Fill rates have improved into temporary staffing therefore the likelihood of not having nursing staffing in both Pilgrim and Lincoln is reduced -The organisation has taken ownership that a rapid handover is available. -Divisional approval of risk reduction confirmed. -Email sent to RCRC&C members for approval of risk score reduction. [22/02/2023 14:03:50 Paul White] Improvement in fill rates when shifts are put out. Reduced likelihood because of existing mitigations in place affecting staffing and there is a proposed end . Presented at Confirm & Challenge meeting 22 Feb by TW. Agreed in principle with reduction in score from 20 to 16. Group members to be given until 1 March to raise any concerns. [09/02/2023 16:12:57 Helen Hartley] Met with Tracey Wall, Cheryl Thomson and Rachel Thackray - reduced to 16 and added mitigations [27/01/2023 11:39:06 Helen Hartley] Reviewed today but another meeting in diary early February to discuss in more detail potential to lower. [23/11/2022 11:25:56 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed but may be reduced on next review taking account of mitigating controls. [10/11/2022 13:40:02 Helen Hartley] No change at governance [07/11/2022 07:03:20 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:24:02 Helen Hartley] No change at governance	8	02/09/2023	31/07/2023	31/05/2023
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	13/03/2023	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.	[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		13/06/2023
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. 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.	25/04/2023	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.	[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. *Fortnightly meeting with HR are taking place re staff SARs. *Resource currently directed at new requests to minimise risk of complaints for requests from 2023 onwards as this would impact ICO involvement. [01/03/2023 16:45:25 Fiona Hobday] Risk updated following Confirm and Challenge meeting. Meeting with ICO 6/2/22 with Trust Secretary, SIRO and Head of IG- overall regulator were comfortable with position explained to them and work ongoing to resolve backlog issue. Staff resource has been reallocated to split between backlog and new requests- performance being monitored between both and resource will be redirected as needed. Backlog has reduced over last month and oldest request now dates back to July 22 as opposed to May 22 which was the position at the start of Feb 23. Action plan documented- to be sent to ICO imminently as part of an update. Awaiting formal response from ICO following meeting.	6	30/06/2023	30/09/2023	31/05/2023
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 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.	[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	07/06/2023
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 it runs the risk of not meeting national best practice. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. 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.	[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	31/05/2023
4641	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	Emergency Planning Group	23/11/2021	16	Risk assessments	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	19/05/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	Risk reviewed, description amended to reflect broader range of threats to the digital infrastructure. Current score increased to 16. Have purchased a significant number of Radios, to allow communication in the event of failure. We've completed a Network Core Switch replacement at Pilgrim new Data (DC3) at Pilgrim to provide resilience at site backup across site has been improved. Recovery Vault is in the process of implementation The Metro-Cluster is in the process of implementation.	4	31/03/2023	31/03/2023	18/08/2022

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Strategic Objective							**1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population**																			
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	24/04/2023	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.	[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		24/05/2023
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.	06/04/2023	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.	[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	06/05/2023
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. HoS/clinical 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	24/04/2023	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	[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	24/05/2023

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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 orders, manage	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	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	19/04/2023	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.	[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	04/05/2023
4991	Service disruption	Low, Claire	Shankland, Lindsay	Workforce Strategy Group		08/08/2022	20		Corporate	People and Organisational Development	Operational HR	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience.	ULHT policy: - Workforce planning processes - Recruitment & Selection Policy & Procedure - Rota management systems & processes - Locum temporary staffing arrangements - Workforce management information - Core learning / Core+ programmes? ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Vacancies & turnover rate. Staff survey results relating to job satisfaction / retention. Core learning compliance rates?	24/04/2023	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.	[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 circa 300 net extra are clinical. Agency providers are now across 4 key areas. Talent acquisition team are now in place to help recruit to difficult to recruit roles. Refugee doctor project still in place. Due to work taking place, proposal for the risk score to be reduced to a score of 12 (moderate). This will go to RRC&C meeting for validation. [10/03/2023 11:43:15 Rachael Turner] No change this month, work currently underway for progress update in April. [31/01/2023 15:11:35 Rachel Thackray] Developing workforce planning report to be submitted to HEE by 31 March 2023, this has a monthly breakdown of anticipated recruitment plans across staff groups with an aim to take us to a vacancy factor of approx 2%. This will be monitored at an organisational and system level monthly. Staff survey results from November 2022 show increased positive scores across all factors which should influence retention issues. Risk reduction plan - Presentation to ELT on 10/11/22 to update international recruitment plan, revised projection on increasing nurse recruitment to get to zero vacancy position by March 2023 Currently 250 nurse vacancies - task and finish group created by Head of Recruitment to work in conjunction with divisional leads to pull together a recruitment activity plan for the remainder of 2022/23 and 2023/24. Plan for recruitment of 285 nurses by the end of the financial year.	4	31/03/2023	31/03/2023	24/05/2023

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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. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung Clinical oncology - head and neck, skin, upper GI (RT only). Lack of cover for leadership roles (Chemotherapy lead and clinical lead)	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements	Monitoring tumour site performance data	24/04/2023	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	[24/04/2023 10:37:32 Maddy Ward] Oncology service review carried out in March in association with strategy, planning, improvement and integration directorate [03/04/2023 09:37:11 Rose Roberts] workforce paper to be started after haem have been reviewed, discussed at risk confirm and challenge, confirmed as high risk. [16/01/2023 12:13:46 Sarah Chester-Buckley] Interviews being set up for leadership role. [15/12/2022 13:42:46 Alex Measures] leadership posts out to advert [16/11/2022 15:56:34 Rose Roberts] Posts being mitigated by employing high cost locums, risk with this mitigation is that locums need only give one weeks notice. Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements. 220622 Agency Clinical oncologists recruited. So improved cover for Head and neck and melanoma. Ongoing	4	31/03/2023	31/03/2023	24/05/2023
4862	Service disruption	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 N 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	4	30/12/2022	30/06/2023	31/05/2023
4762	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	Nursing, Midwifery and AHP Forum, WORK	14/01/2022	15	Risk assessments	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	18/04/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[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 support new starters. 13/06/22- Beds are currently capped at 8 level 3 due to insufficient medical staffing. We are able to meet numbers but skill mix remains a concern.	6	30/06/2021	30/09/2022	18/05/2023

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4905	Physical or psychological harm	Cooper, Mrs Anita	LES (Deleted User)		Workforce Strategy Group	22/04/2022	12	Workforce Metrics, Risk assessment, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on acute wards, delayed discharges, delayed referral to response times. Patient reviews delayed for botox treatment. Paediatric services-delayed response to new diabetes referrals and unable to see current diabetes patients in clinic-could lead to patient harm.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Prioritisation guidelines help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff-(normally B6 N&D staff)	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service.	10/03/2023	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.	[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	30/06/2023	31/03/2023	28/04/2023
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)	24/04/2023	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	[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. Promise Manager now in post from September 2022 working on staff retention. 1. Pulse Staff Survey - Q2 (July'22) 2. Reset approach (communication, engagement of and management) for sign off - ELT (June'22) 3. Local action planning process - now live 4. 7 Big Ticket Priorities proposed following NHS Staff Survey	4	31/03/2023	31/03/2023	24/05/2023

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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.	24/04/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	[10/03/2023 11:46:11 Rachael Turner] No change. Work currently in progress to provide an update in April. [31/01/2023 15:18:02 Rachel Thackray] Current risk assessment in place and working group set up to prepare for potential ongoing industrial action, links in with operational planning to ensure a joined up approach. [07/11/2022 11:13:23 Rachel Thackray] There is a likelihood that there will be some form of industrial action before the Christmas period in 2022. Therefore, it is necessary to increase the likelihood of this risk from low to extremely likely. As such he Associate Director of Workforce is working with the Emergency Planning team to revise the current action plan in place involving staff side reps and the Senior Management Team. The communications team will also be involved. There is a meeting taking place on the 8 November 2022 to implement a Task and Finish group. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review).	4		31/03/2023	24/05/2023
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	06/04/2023	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.	[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	06/05/2023
4993	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group	08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide		WDES (Workforce Disability Equality Standard): limited awareness and implementation of reasonable adjustments and other forms of support which results in limited equality and equity of opportunity for staff classified as having a 'disability'; impedes Trust's ambitions to create an inclusive culture and foster belonging; difficulties in attracting as well as retaining talent	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	[31/01/2023 15:22:04 Rachel Thackray] WDES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. WDES action plan prioritised for engagement, development and delivery 2. July 2022: ULHT review datasets, declaration rates (from 1/7/22 ULHT required to submit metrics and narrative data via the DCF online platform by Aug'22). 3. End October 2022: deadline for ULHT to publish WDES 2022 annual report (include metrics report and WDES action plan)	4	31/03/2023	31/03/2023	28/04/2023
4992	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group	08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide		WRES (Workforce Race Equality Standard): low compliance/ limited improvement and action to address indicators i.e. increase senior representation and better lived experience of BAME staff working in ULHT. Risk is this results in low number of applications for vacancies which then remain unfilled (difficulty attracting talent); poor turnover rates (difficulty in retaining talent) and a poor employer brand locally, regionally, nationally and overseas. This will impact on the culture of the organisation and the ability to recruit with increased turnover. Wider risk with regards to broader protected characteristics linked to the delivery of the EDI objectives.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	[31/01/2023 15:23:43 Rachel Thackray] WRES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. EDI Group and regular reporting established (for assurance) 2. Anti racism strategy and delivery plan socialised with stakeholders and live 3. NHS Staff Survey results - deep dive and analysis of lived experience of staff with protected characteristics 4. Draft EDI objectives 2022-25 - socialised and ready for sign off (end June) 5. ULHT workstream lead - addressing BAME disciplinary gap (Lincs Belonging Strategy) 6. People Promise Manager successfully appointed from end May'22	4	31/03/2023	31/03/2023	28/04/2023

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Strategic Objective							**1a. Deliver Harm Free Care**																			
4832	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	24/04/2023	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.	[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		24/05/2023
4879	Physical or psychological harm	Harris, Michelle	Lynch, Diane	Patient Safety Group		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU			If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - 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	24/04/2023	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	[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	24/05/2023
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 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	18/04/2023	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	[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	18/05/2023
5101	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	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways 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;	19/04/2023	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	[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	18/05/2023
5016	Physical or psychological harm	Wall, Mrs Tracey	Thomson, Cheryl	Workforce Strategy Group	Patient Safety Group	02/09/2022	25		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	26/04/2023	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	[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	31/05/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (Initial)	Source of Risk	Division	Clinical business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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	24/04/2023	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	[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	24/05/2023
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		Trust-wide	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.	06/04/2023	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.	[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	06/05/2023
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-May 2022 Total -344 Moderate harm -7 Severe-4 Death-1	24/04/2023	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.	[24/04/2023 13:05:08 Sarah Addlesee] •Update April 2023 Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG). •A monthly Falls Prevention Quality Council has commenced as part of the collaborative working across Quality, Divisional and Improvement teams to ensure an integrated approach to falls prevention work. •An audit of practice against the Falls Prevention and Management Policy is planned to be undertaken during May 2023 supported by the Audit and Clinical Effectiveness team. Outcomes and recommendations will be presented to FPSG. •Divisional falls prevention forums are in place to support shared learning. •Business Case for Falls Prevention Service to be further developed and resubmitted following feedback from CRIG. •Falls Prevention and Management Policy and Enhanced Care Policy are being reviewed and consulted on. [06/03/2023 09:35:09 Sarah Addlesee] •Update Feb 2023 Falls incidents continue to be analysed and trends and themes identified organisationally which will continue to be areas of focus to improve. •The new Adult Inpatient Risk Assessment documentation has been rolled out, this includes a daily assessment for falls which prompts preventative actions to be implemented and escalation processes. Regular training and support is being provided by the Quality Matron and Clinical Education teams post introduction. There has been a reduction in the overall number of falls in February 2023- (129) ,there continues to be severe –(2) and moderate –(2) reported in February. •Collaborative working continues with Quality, Divisional and Improvement teams to ensure an integrated approach to falls prevention improvement work. A revised Falls Prevention working group has been formed and will provide updates to the Falls Prevention Steering Group (FPSG) who will provide oversight and monitoring of progress being made. •The Falls Prevention and Management Policy and Enhanced Care Policies are being reviewed. [14/10/2022 10:29:24 Rachael Turner] Risk reviewed-no change.	4	31/12/2021	31/03/2023	09/02/2023
4828	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	25/04/2023	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	[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 210622 No change due to major pressure on the system due to covid backlog. 230922 An externally procured validation team have been identified and they are due to start end of October. Risk transferred to Operations from Outpatients following discussion re ownership.	8	31/03/2023	31/03/2023	25/05/2023

ID	4877	4789	5100	5102	4843
Risk Type	Physical or psychological harm	Physical or psychological harm	Physical or psychological harm	Physical or psychological harm	Physical or psychological harm
Executive lead	Harris, Michelle	Harris, Michelle	Rivett, Kate	Rivett, Kate	Cooper, Mrs Anita
Risk lead	Carter, Mr Damian	Ratcliff, Carl	Heath, Dr Durga	Navdeva-Grigorova, Tanya	Hansford, Lisa
Lead Oversight Group	Patient Safety Group	Patient Safety Group	Children & Young Persons Oversight Group	Children & Young Persons Oversight Group	Medicines Quality Group
Reportable to	Clinical Effectiveness Group		Clinical Effectiveness Group	Clinical Effectiveness Group	
Opened	28/03/2022	16/01/2022	14/03/2023	15/03/2023	19/01/2022
Rating (Initial)	20	20	20	20	20
Source of Risk	Risk assessments	Risk assessments			Risk assessments
Division	Corporate	Medicine	Family Health	Family Health	Clinical Support Services
Clinical business Unit		Cardiovascular CBU	Children and Young Persons CBU	Children and Young Persons CBU	Pharmacy CBU
Specialty		Cardiology	Paediatric Medicine	Paediatric Medicine	Pharmacy
Hospital			Trust-wide	Trust-wide	
What is the risk?	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	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	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	Quality and safety risk from inability to deliver diabetes pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors	Screening, management and review mechanisms of patients requiring or in receipt of Intravenous Immunoglobulin (IVIg) is inadequate.
Controls in place	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	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	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. 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.	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)
How is the risk measured?	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	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	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;	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	Reported incidents involving use of Intravenous Immunoglobulin (IVIg)
Date of latest risk review	25/04/2023	24/04/2023	18/04/2023	04/05/2023	29/03/2023
Likelihood (current)	Extremely likely (5) >90% chance	Extremely likely (5) >90% chance	Extremely likely (5) >90% chance	Extremely likely (5) >90% chance	Quite likely (4) 71-90% chance
Severity (currently)	Severe (4)	Severe (4)	Severe (4)	Severe (4)	Severe (4)
Risk level (current)	Very high risk (20-25)	Very high risk (20-25)	Very high risk (20-25)	Very high risk (20-25)	High risk (15-16)
Rating (current)	20	20	20	20	16
Risk reduction plan	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	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	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	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.	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.
Progress update	[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 patient in order to maximise list utilisation Risk lead updated to Head of Operations.	[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. [01/12/2022 10:58:41 Carl Ratcliff] New working group in place lead by COO Plans being worked up to open CDC when contract agreed Extra room now found at LCH - start to sue next week R/R paper submitted to COO for approval Need to obtain recovery graph to show impacts of each / all action [04/11/2022 12:28:16 Carl Ratcliff] Approval now in place to use CDC at Grantham to cover 300 pts in back log. Process being agreed with procurement / operations to start. Plan for other half of waiting list being worked up for agreement. Booking team now transferred to Cardiology team to manage. Deep dive	{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)	[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)	[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.
Risk level (acceptable)	8	4	8	4	4
Initial expected completion date	31/03/2023	31/03/2022	14/03/2024	15/03/2024	01/10/2021
Expected completion date	31/03/2023	01/02/2024	15/03/2024	15/03/2024	28/04/2023
Review date	25/05/2023	31/05/2023	18/05/2023	18/05/2023	29/06/2023

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
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.	18/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[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		18/05/2023
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 deemed locally as 24 hours.	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) 71-90% chance	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		Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	24/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[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
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.	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.	29/03/2023	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.	[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	29/06/2023

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
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	27/04/2023	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.	[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 and additional areas of focus including domiciliary NIV. To commence end of January 23. Monthly NIV audit continues-Timeliness of the commencement of NIV is improving, issues relating to availability of NIV bed and appropriate referrals a current issue to bed pressures. Escalated and reported through escalation structure. Agreed risk remains high but reduced, requires to remain at 16 until for confirmation of Trust wide achievement of BTS standards. New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB are on hold with provisions in place to allow NIV to be delivered in the bay where there are x 4 monitored beds (IPC agreed) Risk discussed at Risk Register Confirm & Challenge Group in May 2022. Still inconsistencies with timeliness against BTS standards, particularly at Lincoln, and inability to ring-fence beds but an	4	30/09/2022	31/12/2022	27/07/2023
5067	Reputation	Shelton, Helen	White, Paul	Patient Safety Group	Patient Safety Group, WORK	23/12/2022	8	Risk assessments	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	26/04/2023	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.	[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	26/07/2023
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	Clinical Governance	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	21/03/2023	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.	[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	30/06/2023
5143	Service disruption	Parkin, Mr Lee	Parkin, Mr Lee	Trust Leadership Team	Estates Infrastructure and Environment Group, Estate Strategy Group, Health and Safety Group, Information Governance Group, Outpatient Improvement Group, Patient Safety Group	13/04/2023	25	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Pilgrim Hospital, Boston		decisions made regarding admin block in phb will impact on the current health records service by the removal of lift in h block. this will impact on h/recs service delivery across all specialties and may also impact on possible physical harm to staff. possible delay to treatment plans due to no administrative information being available for appointments.	there is addition of dumb waiter(2). there is a current weight limit for this of 10kg per box (h/safety) and there is also an improvement notice on h/recs services.claim against dumb waiter injury already served to trust (liability accepted)	service currently supplies 60,000 sets of notes per year via lift, potential removal of lift would severely reduce this activity and add extra physical harm risk to staf, but may also impact on daily clinical support.	13/04/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	only option to use dumb waiters, one of which is in another area with limited access.	[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	31/05/2023	31/05/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital
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
Strategic Objective							**1b. Improve patient experience**					
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
4724	Physical or psychological harm	Rimmer, Lucy	LES (Deleted User)	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide
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
5075	Physical or psychological harm	Capon, Mrs Catherine	Dolling, Matthew	Patient Safety Group	Estates Infrastructure and Environment Group	13/01/2023	20		Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital

ID	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
4688	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	18/04/2023	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, practical,	[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	18/07/2023
Strategic Objective	**1b. Improve patient experience**													
4701	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.	03/04/2023	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.	[04/04/2023 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	03/07/2023
4724	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.	10/03/2023	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.	[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	28/04/2023
Strategic Objective	**1c. Improve clinical outcomes**													
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	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.	25/04/2023	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	[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	29/12/2023	25/05/2023
5075	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.	06/04/2023	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.	[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		06/05/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (Initial)	Source of Risk	Division	Clinical business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4731	Physical or psychological harm	Harris, Michelle	Parkin, Mr Lee	Medical Records Group	Digital Hospital Group, Information Governance Group, Patient Experience Group, Patient Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Draft policy produced further discussion with changes required with Divisional Clinical Lead - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	05/04/2023	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.	[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	31/07/2023	04/04/2023
4928	Service disruption	Ratcliff, Carl	Smith, Charles	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	24/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[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 Existing new patients currently being validated by support manager. TOE list capacity being utilised for PBWL patients. Plans in plan for PIFU for cardiology (next meeting end of August 2022).	8	30/06/2022	31/07/2023	27/04/2023

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*6 June 2023*
Item Number	*Item 13.2*

Draft 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* • *Confirm the proposed AMBER rating of objective 3b – Efficient use of resources*

- *Confirm the proposed RED rating of objective 3d – Improving cancer services access*

Executive Summary

The relevant objectives of the 2023/24 BAF were presented to all Committees during May with the exception of the Audit Committee in draft format having been updated to reflect the Integrated Improvement Plan.

The Board are asked to note the updates provided within the BAF identified by green text and recognise the ongoing work with Executive Directors to ensure appropriate population of the draft BAF for 2023/24.

Following review through the Committees the Finance, Performance and Estates Committee are proposing that objective 3b – Efficient use of resources be rated amber from red and for objective 3d – Improving cancer services be rated red from amber.

The following assurance ratings have been identified:

Objective		Rating at start of 2023/24	Assurance Rating (May)
1a	Deliver harm free care	**Green**	**Green**
1b	Improve patient experience	**Green**	**Green**
1c	Improve clinical outcomes	**Green**	**Green**
2a	A modern and progressive workforce	**Amber**	**Amber**
2b	Making ULHT the best place to work	**Amber**	**Amber**
2c	Well led services	**Amber**	**Amber**
3a	A modern, clean and fit for purpose environment	**Amber**	**Amber**
3b	Efficient use of resources	**Red**	**Amber**
3c	Enhanced data and digital capability	**Amber**	**Amber**
3d	Improving cancer services access	**Amber**	**Red**

3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	**Amber**	**Amber**
3f	Urgent Care	**Red**	**Red**
4a	Establish collaborative models of care with our partners	**Amber**	**Amber**
4b	Becoming a University Hospitals Teaching Trust	**Red**	**Red**
4c	Successful delivery of the Acute Services Review	**Amber**	**Amber**

Following formal approval of the Year 4 Integrated Improvement Plan (IIP) for the 2023/24 year a final review and alignment to the BAF will be undertaken alongside work with the Executive Directors to ensure accurate descriptions of controls and assurances are in place.

Once work has been completed the BAF will be offered to the Committees in the usual format for review through the June meetings and onwards to the Board as the final draft in July.

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2023/24 - May 2023

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

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

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

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						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	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.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamination and other estates- related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Estates and Facilities policy schedule document to be presented to the IPCG		
						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 with specific concern relating to poor environmental infrastructure such as ventilation systems	IPC policies have been updated / developed / written in line with the timetable. •Estates and Facilities/Decontamination Lead has made good progress continued to progress work including a Decontamination sub group of the IPCG • Good progress with achieving and sustaining standards of environmental cleanliness as well as audit and monitoring processes to achieve compliance with the National Standards of Healthcare Cleanliness 2021 Provision of suitable hand hygiene products installed across the Trust	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Some aspects of reporting continue to be subject to further development	Reporting to and monitoring by the IPCG and other related forums		

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

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1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	5016 4804 5057 4624 4877 4878 4879 4789 4935 4750 4779 4868 4974 4646	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	Lack of upward reporting from the DTC, Medical Gases, Sedation and Chemotherapy Group. Limited 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 Committee	**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. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training occurs through MNOG.		

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						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA (Ensuring early detection and treatment of deteriorating patients) (PSG)	Work required to develop the maturity of the group. New Chair identified and full review of membership and remit required. Maturity of some of the sub-groups of DPG not yet realised. This will be considered as part of the review of DPG.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE; DKA	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas Number of incidents occurring regarding lack of recognition of the deteriorating patient	DPG meeting not meeting as frequently due to loss of Chair. New Chair identified and commenced in post October 2022.			
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	Paper presented to CRIG and funding agreed - currently sat in reserves and awaiting drawdown by Estates and Facilities who will manage the trainers	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting to Mental Health, Neuro Diversity and Autism group	DMI training to commence delivery in November 2022. 05.01.2023 - Training commenced delivery in November but not fully rolled out as only 1 trainer in post. New Training jobs are out to advert this month with a view to being in post for March / April 2023 when full rollout will begin	Datix being monitored by safeguarding team to ensure review of any restraint incidents Funding agreed by CRIG. new roles to be managed within Estates and Facilities. 05.01.2023 - New Training jobs are out to advert this month with a view to being in post for March / April 2023 when full rollout will begin 07.02.23 - all posts now advertised and shortlisted - interviews early March - likely appointment dates May 2023		
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG) One central monitoring process now in place.	Review of compliance metrics required.	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							

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						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads(CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				
						Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm and reviewing external reports and assessments of our services							
						Improve our medication management safety and reduce medication related incidents resulting in harm, supported by implementation of an e-Prescribing system							
						Establish an open and honest patient safety culture rather than attributing blame and liability, which will enable improved clinical outcomes, through implementation of PSIRF by September 2023							

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						Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group - the group continues to develop its maturity Meeting may be stood down due to operational pressures at time of operational extremis.	The Group meets monthly and has a work plan and schedule. If the meeting is stood down, then the papers are reviewed and Chairs report provided.	Upward reports to QGC monthly and responds to feedback Review of ToR in May 2022 and annually as part of the work schedule. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report Divisional Reports have developed in reporting maturity and include a patient story / risks and issues / actions. This is a well embedded part of the PEG meeting.	Themes from the Divisional assurance reports and the Complaints reports and others sources of information are being triangulated, so oversight across the themes is clear, this is work in progress.	Overall report being developed and monitored through PEG.		
						Patient and Carer Experience (PACE) plan 2022 - 2025 (PEG)	The PACE Delivery Plan to be actioned and embedded over the life of the delivery plan.		Patient Experience & Carer Plan progress report to Patient Experience Group as per schedule.	Ongoing assurances provided to PEG re: actions. Assurance is variable due to the number of actions being delivered. But overall oversight of the plan = moderate assurance	The delivery plan will be monitored through PEG		
						Quality Accreditation and assurance programme which includes weekly and monthly audits which include feedback on patient experience from patients in the clinical areas.(PEG)	Further development of alignment of findings in audit data to patient experience surveys overarching plan and other sources of patient experience information. Annual Ward / Dept quality review visits may be paused due to operational pressures in times of extremis.	Head of pt experience can access the audit date. Deep dives into areas of concern as identified in quality metrics dashboard meetings Update reports to PEG and QGC as required. Weekly and monthly audits continue to take place including during times of extremis.	Reports to PEG and upwardly to QGC	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year, which include the patient experience team as part of the visit team. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support.		

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	4701 4724	CQC Caring	Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging. Recruitment for new panel members will happen through Nov / Dec 22. Sensory Loss group upwardly reports to Patient Panel. You Care - We Care to Call (YCWCC) Campaign pilot being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. Communication working group set up to look at a range of communication issues affecting patient experience.	Upward reports and minutes to the Patient Experience Group	Diversity of patient engagement and involvement is limited.	Partnership working established with Healthwatch to reach out to Eastern European community; staff BAME network approached for community links and contacts. Expert reference groups progressing well: Breast mastalgia group has completed its co-design but will meet again in the future as part of service evaluation, Cancer group meeting quarterly, Dementia Carers group has had first meeting and will meet alternate months. Cardiology and QI groups being developed	Quality Governance Committee	**Green**
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting. Audit planned for Jan 23 and to report to PEG in Feb/March 23	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work. Audit planned for Jan 23 combined with EOL visiting audit.	Report to PEG through complaints & PALs reports; upward reports were received from Visiting Review working group which has now disbanded; the planned audit will report back to PEG and propose any further recommendations. With visiting restrictions now removed the previous issues cited within complaints and PALs have not been seen. This will continue to be monitored through the winter months. from Visiting Review working group.	Patient information currently subject to review and work is ongoing.	Audit of visiting experience planned for Jan 23 will provide an understanding across all aspects of visiting now that all COVID precautions have been stepped down. This will also tie in with national work on Care Partners and visiting guidance under the Health & Care Advisory Board which the Head of Patient Experience is a member of.		

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						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports will need to develop in maturity regarding patient experience	Head of Pt Experience to discuss with EDI lead to ensure data is relevant and triangulated.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic; national programme recommenced September 22	PLACE Lite continues & reports to PEG plus the annual report will be received at PEG, due Jan 23		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements.	Discharge experience reports to PEG quarterly.	Lead Nurse for discharge to attend PEG in October. Deferred to Nov. Deferred to Dec.	Patient Experience Team to meet with Lead Nurse for Discharge to support and ensure experience data is collected, analysed and acted upon.		
						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							
						Implementation of our 'you care, we care to call' programme across 38 wards							
						Improved learning from patient feedback, with a focus on addressing discharge processes and inclusion of 'experts by experience'							
						Embedded processes to address risk of hidden child and support transition across all services							

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4731 4828 4972 4905	CQC Responsive CQC Effective	Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust.	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics.	Review of Terms of Reference to be undertaken. Invites to speakers to come direct from Mr Simpson as Chair of the Group in future.	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	Isolated pockets where upward reports are not always submitted.		Quality Governance Committee	**Green**
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (CAG) with quarterly reports to QGC (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed and workshops planned with leads, led by the Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates meaning that reporting to QGC is not as up to date as expected.	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate Meeting to take place with Medical Director and Audit Leads to discuss role and expectations, however attendance has been impacted by operational pressures.		
						National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable		
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	Not applicable		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down although this is due to recommence.	National reports to be presented at Governance Meetings once produced		

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						Specialised services quality dashboards (SSQD)	SSQD data collection now commenced again post Covid. Areas with outliers identified with some plans for improvement, however not all required areas currently have plans.	Continued support from the Clinical Effectiveness Team and requirement to attend CEG and provide update on progress.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	Actions plans not yet received for all necessary areas.	Continued requirement to attend CEG to provide updates.		
						Process in place for implementing requirements of the CQUIN scheme.	Plans now in place for delivery of 2022/23 CQUINs, although assurances not yet received that these are fully implemented.	CQUIN delivery group commenced again.	Quarterly reports to CEG and upwardly reported to QGC	Some gaps identified in reporting processes.	Being dealt with via the CQUIN delivery group		
						Process in place for ensuring high quality of record keeping including Medical Records Group.	Medical Records Group not meeting regularly.	Refocus of the Medical Records Group planned by the new Chair.	Programme of record keeping audits taking place.	Audits do not demonstrate compliance with record keeping standards.	Divisional governance leads to pick up within each area.		
						Process in place for monitoring of and implementation of NCEPOD requirements.	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.				
						Ensure we provide clinically safe services, through an increased volume of Diamond Accredited Wards							
						Improve clinical effectiveness through increased compliance with national and local standards							
						Improve clinical effectiveness and best practice principles by prioritising Cardiovascular pathways							
						Relaunch and embed our CQUIN programme to ensure best practice and improve clinical outcomes							

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SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)			System PP - Each 'pillar assigned system lead Progress/assurance reported to People Board (quarterly) Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan Priorities agreed for 2022/23	None identified	The People Board are currently reviewing the Pillar lead roles with the changing dynamics of the People Board. It is envisaged that 23/24 review will be taken in terms of the People Team taking the lead roles aligned to the People Promise. A new system Workforce Committee has been created aligned to the Finance Recovery Board to ensure oversight and assurance are provided on all workforce related cost improvement plans are delivering and on track.		
						Workforce planning and workforce plans	Overall vacancy rate declining	A new pillar for workforce planning and transformation is being created as part of the People Directorate restructure. The Trust have an Associate Director of Transformation and Workforce planning in post who is leading workforce planning in conjunction with HRBP's, finance and improvement team. This is established and regular reviews are now in place.	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend.	Some areas remain hard to fill however full and comprehensive workforce plans are in place 'plan for every post' and workforce scorecards are in place and are reported through to the Operational Workforce and Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board.	Work continues with the regional roll out of the KPMG workforce tool and from a ULHT perspective a group has been created to support the submission of the Q4 workforce planning submission. First submission was made at the end of March still potential for a review due to be submitted on 4th May linked to 'The Plan to Zero'. It is not envisaged at this moment in time that our submission will change.		
						Recruitment to agreed roles - plan for every post	Availability of workforce	Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up and completion of actions. Recruitment key performance metrics feature as part of the People & OD scorecard which is tabled at the Workforce Strategy and Operational meeting and then is reported upwards by expectation to People & OD Committee via the highlight report.	None identified			

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2a	A modern and progressive workforce	Director of People and Organisational Development	Possible disruption caused by system wide strike action and capacity of Pillar leads	4362 & new high risk on POD register	CQC Safe CQC Responsive CQC Effective	Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established (8B - 12 month) Temp/12 month fixed term People Promise Manager appointed (Liz Smith - ULHT) from end May 2022 Task and Finish Group Statutory and Mandatory Training Task and Finish Group Appraisal	Talent management - on hold	Restructure and resource in to People and OD Directorate	Executive CQC Assurance Panel Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training	Appraisal compliance levels not at expected level Mandatory Training compliance not at agreed level	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.	People and Organisational Development Committee	**Amber**
						Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural change when the ability of the ULHT teams to engage when we are operationally challenged Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects)	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations Working with each improvement programme and Divisions to develop identify and align improvement plans	Internal training reports produced by Improvement academy Improvement programmes identifying personalised training needs for ULHT staff Divisions training plan (aligned to the IIP) presented at FPAM	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams.	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement)		
						Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Support and training from HRBPs External consultancy briefings with divisional leads	Sickness/absence data	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. 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.		
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service (pending P&OD restructure)	Training and Development department	Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education Recruitment to Head of Education and Training infrastructure. Interim resource in place	System LEAD (Learning, Education and Development) Board to provide system oversight (agreed) Apprenticeship uptake and utilisation of levy through WSODG	None identified			

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						Creation of robust Workforce Plan •Values based recruitment and retention •Maximising talent management opportunities •Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn' Promote benefits and opportunities of Apprenticeships		Associate Director of People Planning and Workforce Transformation commenced March 2023. Task and Finish Group established	Improved vacancy rates reported through WSODG	None identified			
						Improve the consistency and quality of leadership through:- Reset leadership development offer and support (Leadership SkillsLab and PME) •Improved mandatory training compliance •Improved appraisals rates using the WorkPal system •Developing clear communication mechanisms within teams and departments	Training and Development and review of existing OD infrastructure	Recruitment to Head of Education and Training infrastructure. Interim resource in place. Realignment of OD priorities in line with the restructure have gone live in April 2023	Workforce and OD Group IPR - Appraisal compliance Culture and Leadership Group Priority updates to PODC	None identified			
						Providing a stable and sustainable workforce by:- •Ensuring we have the right roles in the right place through strong workforce planning •Reducing vacancy rates and ensuring that posts are filled through a positive and values recruitment approach •Reducing our agency staffing levels/spend •Strengthening the Medical Workforce Job Planning processes	Low completion rates and compliance with job planning	System support being considered for job planning	WSODG TSSG Medical Staffing Group	None identified			
						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%.		Health and wellbeing Manager appointment and the creation of a Health and Wellbeing Group has been completed and their first meeting was held end of April. This will feed into the Workforce Operational Group. On going training and support for Health and Wellbeing champions.	None Identified			
						Employee Assistance Programme implemented May 2022			System Health & Wellbeing Board Linc People Board (NB. Wellbeing Pillar) Employee Wellbeing Group (pending)	Wellbeing activity (for reporting to Workforce, Strategy and OD Group)	Core data is now included in the POD scorecard which is tabled at the Operational working group.		

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						Develop and support our people and the wider system, maximising access to training opportunities, making full use of the apprenticeship levy			Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Aligned to restructure of the Talent Academy within the POD broader restructure.	None identified			
						Vacancy levels below 4% across all staff groups			Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Aligned to restructure of the Talent Academy within the POD broader restructure.	None identified			
						Reduce our staff turnover rate to 6% across all staff groups							
						Compliance with National agency utilisation target of 3.7% agency and locum workforce							
						NHS People Plan & System People Plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future			People Board	None identified			
						Alignment with People Promise Reset and alignment of Trust values & staff charter (with safe culture) Reset ULH Culture & Leadership	Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Group Culture and Leadership Programme Group upward report NSS results (Feb 2023)	Delivery of agreed output	Paper being presented to Board in May 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 further update will follow meeting being held in May.		
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.			Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care				

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) Leadership SkillsLab - launched June'22	Training and Development department	Leadership SkillsLab - launched June'22	National Quarterly Pulse surveys (mandated from July'22) Number of staff attending leadership courses	Limited oversight of outputs of Pulse Surveys	Work on-going in terms of launch of next pulse survey and promotion.	People and Organisational Development Committee	**Amber**
						Lincs Belonging Strategy EDI Delivery Plan 2022-25			Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified			
						Staff networks			Council of Staff Networks	None identified			
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian			Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee	None identified			
						Embed compassionate and inclusive leadership (aligned to People Promise)	Training and Development department		Culture and Leadership Group	None identified			
						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.	Support and training from new Education Department	Workforce Operational Group	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.		
						Support our Divisions to provide all staff with an appraisal and clear objectives		Support and training from new Education Department	Workforce Operational Group				
						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				

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						53% of our staff recommending ULHT as a place to receive care							
2c	In year improvement within Quality and Safety, with an ambition by 2025 to increase by 5% on our current league table for NHS Acute Organisations for indicators	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 Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 23/24 financial settlements	4384 - ERF Clawback (116% activity delivery risk) 4957 - COVID costs 4664 -Agency	CQC Well Led CQC Use of	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 plam 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	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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		Digital	The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. 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.	costs 4665 - FRP delivery 4666 - Inflation pressures	Resources	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		
						COVID costs - The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID.	The national expectation is that the costs of COVID ceased from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	Financial plan set out the Trust Budget allocations in respect of COVID spend Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. QIA of risk of removal of all COVID schemes, outcomes reviewed at TLT for decision Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base.	Cease or approved COVID costs continuation as part of the Trust investment prioritisation process.	Correlation between the response to COVID and the new cost base. Ability to remove COVID costs at pace. Prevalence of COVID patients in the Trust.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FPAM.		
						Meet all National asks for performance, set out in the planning guidance, for day cases, outpatients and diagnostics							
						Engagement with plans to address capacity for our fragile services, through service review process and transformational programmes of work							
						Compliance with our budget, supported by the delivery of agreed costs improvement plans							
						Utilisation of Capital allocation to enhance our services and support efficiency improvements							

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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	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.			Finance, Performance and Estates Committee	**Amber**
						Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	EPR OBC to be approved by Frontline Digitalisation NHSE/I OBC requirements (including financial) being worked through with Frontline Digitalisation NHSE/I OBC approved at Aug FPEC and Sept Board Updated 'affordable' OBC to go to Jan / Feb 2023 FPEC / Board FPEC supported new version of OBC on 1st Feb. Now going to Trust Board for approval on 7th Feb. OBC now with Regional / Frontline Digitalisation Fundamental Criteria Review.		
						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.		
						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					

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						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							
						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							
						Implementation of an Electronic Prescribing system							
3d	Improving cancer services access	Chief Operating Officer	Insufficient clinical capacity, insufficiently optimised pathways, Dependency on services (primary care, pathology) that are unable to deliver required access or level of service		Cancer Standards 62 day, 14 day and 28 Day FDS	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Cancer Care Integrated Improvement Programme and Assoc Governance System Cancer Improvement Board	Recovery post COVID and risk of further waves Specialty Capacity strategies not in place Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) East Midlands Cancer Alliance Increased Oversight	Cancer board assurance and performance reports Deep Dive information and reports on gap analysis Routine Performance and pathway data provided by Sommerset system	Process information below the cancer stages are not always captured Some digital systems are not linked and not all wait information is recorded e.g. MIME system	Targeted Improvement (3 x weekly) of key concern specialties increase the scrutiny of reporting and pathway performance led by COO Colorectal now seeing a well managed recovery and the Surgical Division is now reviewing the Prostate Cancer Pathway. Breast continues to see improvement. The 62 day backlog continues to be aligned to the agreed recovery trajectory.	Finance, Performance and Estates Committee	**Red**
						Meet all National asks for performance, set out in the planning guidance, for cancer care							
						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							
						Elimination of 65 week waits across all specialties							
						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		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Planned Care Integrated Improvement Programme and Assoc Governance System Planned Care and Diagnostic Group	Recovery post COVID and risk of further waves Specialty strategies not in place Elective Theatre Programme Transformation team not yet established.	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Recovery plans at specialty level. To date have delivered required reductions in 104 week waits Outpatient Improvement Group Foureyes Theatre Improvement Programme GiRFT and High Volume Low Complexity Programme Group	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and NHSE Review data	Inconsistent approach to waiting list validation CBUs do not have traction or insight into the non admitted or admitted waiting lists Maximum Outpatient and theatre capacity not apparent as yet. Demonstration of change at pace is lacking.	National edict to see and treat all patient waiting greater then 78 weeks by 31 March 2023 in place. Twice daily monitoring and reporting is now in place. The largest DM01 risk is Echo Cardiology. A plan is now in place to offer and recruitment and retention premium. The recommendations and action plans suggested following the Regional Diagnostic Team external review is realising some benefits. Local, System, Regional and national assurance meetings in place to monitor progress and delivery. Use of independent sector, mutual aid and insourcing/outsourcing providers to ensure delivery. ICB and COO holding the Trust to account for delivery against national deadline. Internal design, development and agreement of a 'production plan'. Review of all consultant Job Plans is in train.	Finance, Performance and Estates Committee	**Amber**
						Outpatient Recovery & Improvement Programme (ORIG)	Focused on 3 activities to support outpatient specialties to be able to reduce backlogs and provide enough capacity to meet demand 1. Clinic slot utilisation key metric being tracked to drive up access to outpatient services and reduce the backlogs 2. e-RS -All directory of services (DOS) reviewed and services to be uploaded to ensure polling for primary care 3. Missing outcomes backlog addressed and reduced with sustainable plans OP Sprint above completed - next phase of OP work in Q4 to continue to address slot utilisation, improve Patient Initiated Follow Up , no patients waiting over 78 week & root cause issues of missing outcomes & DNA in Trauma & Orthopaedics	ORIG working with division to get back to pre-covid clinic templates and develop recovery plans Specialty based capacity and demand modelling to ensuring outpatient resource focused in correct areas-focus on division specific areas of improvement required	OP Data Activity tacker from Performance Team reviewed weekly monthly in divisional FPAM	Escalations & issues through ISG when required	Reporting through Improvement Steering Group & FPEC		

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						HVLC/GIRFT Programme - Theatre productivity and efficiency	Ability of the ULHT teams to engage in the programme Emergency pressures resulting in elective cancellations Culture mindset change takes time.	Full robust Theatre programme with focus on KPIs now meeting weekly to oversee and drive changes	Theatre dashboard has been created and reviewed by operational teams for booking & scheduling - aim for 90% 6-4-2/scheduling now in place Weekly Capacity meetings held to ensure theatre utilisation	Increased in NEL demand may impact staffing levels, elective bed capacity, and therefore could impact on elective activity. KPIs potentially impacted: OTD cancellations and actual utilisation against planned levels	Reporting through Improvement Steering Group/FPEC/HVLC		
						Clinical prioritisation Group	Ability to list appropriate mix of P2/3/4 due to effective preop Unnecessary on the day cancellations Increased non-admitted waiting list waiting to convert to admitted	Preop workstream via FEI Review and management through prioritisation group and Surgical PRM Management through ORIG/HVLC/Surgical PRM			Reporting through FPEC/HVLC		
						Meet all National asks for performance, set out in the planning guidance, for elective care							
						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							
						Elimination of 65 week waits across all specialties							
						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 has been provided through a consultancy Impower & ECIST to assist in identification of areas to improve and on the ground support	Metrics dashboard developed for discharge and flow linked to bed reductions trajectory	Data metrics to demonstrate impact on of the interventions is being developed. There is a risk to the delivery of non-elective length of stay target and increase in daily discharges due to the reliance of other specialties and external agencies outside of the control of the hospital There is a risk that winter pressures and will outstrip length of stay and occupancy gains preventing delivery of discharge/ bed closures.	Reporting through Urgent Care Improvement& Recovery Steering Group and Improvement Steering Group monthly		
						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							

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						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							
						Elimination of 65 week waits across all specialties							
						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**												
			Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement			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.		
						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	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 anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) The process of building the Trust Clinical Strategy has commenced taking information from Specialty Reviews to inform accordingly, and building on outputs from the Business Planning process.	Finance, Performance and Estates Committee	**Amber**
						Development of Core20PLUS dashboard by June 2023 to enable greater understanding of the Lincolnshire population and support a reduction in health inequalities							
						Establishment of the Tobacco Cessation service to proactively support better health for the Lincolnshire population							
						A Joint Forward Plan by June 2023 and continued utilisation of JSNA, population health data from Optum and the health and wellbeing strategy, to influence our collective approach							
						Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme							
						Developing a business case to support achievement of University Hospital Teaching Trust Status	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee	Further understanding of the costs involved to increase size of R&I department and also to develop an R&I facility	R&I team reworking business case with a phased approach		

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4b	Develop a strong professional relationship with the University of Lincoln (UoL) and the Medical School	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increase clinical academics by 20 and RCF funding worth £200k within the last 2yrs Further clarification and implications of the changed guidance on univ hospital status required. Funding for Clinical Academic posts and split with UOL to be agreed	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Contract agreed with UOL for Clinical academic posts. UoL have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - linked to roadmap and Research Event to identify specialties. RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position - now amalgamated into the monthly Steering Group with ad hoc meetings between SRO's where needed to discuss funding for Clinical Academics. ULHT have a recruitment roadmap in place which will include some pump prime from vacancies. Additionally a joint Research Event is being planned for Q3 of 2022/23 with the University to identify future areas of collaboration with research and Clinical Academic recruitment. Event planned for Q3 of 2022/23 cancelled by the University as they wanted to review outputs from a previous event they hosted in August 2022 to understand if there was any potential alignments that could be made for onward joint collaborations.	People and Organisational Development Committee	Red
						Improve the training environment for students	Understanding of our offer of the facilities required for a functioning clinical academic department	Revision of the library and training facilities to ensure that facilities are fit for purpose for all staff who will require access to training facilities, library, ICT equipment to be able to perform their role. This will be aligned to the UHA Guidance, and will include those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unknown timescales of completion	A new R&I group has been set up being led by Director of R&I/Deputy Medical Director, this will provide more oversight and rigor in developing an R&I agenda with representation from key stakeholders and clear milestones for delivery		
						Developing a joint research strategy with the University of Lincoln Develop a joint research strategy by September 2023, which identified shared research focus areas	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU, with a local version between ULHT and UoL created as we move forward and understand the finer details of the partnership. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy.	RD&I Strategy and implementation plan agreed by Trust Board	Drafts in place which broadly cover joint research and teaching approach across the organisations, unable to outline in strategy financial commitment. UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group		
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	Evidence bound by UHA requirements	Portfolio of evidence is being captured and is available on the shared drive Identified leads to liaise with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Roadmap developed to identify required evidence for portfolio	Clear understanding of rigidity of UHA requirements Letter to CEO of UHA agreed at TLT on 15/09/2022 and being sent by IID Director to ask for meeting to discuss approach.	Discussions being held to clearly identify opportunity for movement within guidance and steps being taken for a name change application		

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
						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.		
						Successfully recruit 6 Clinical Academics							
						Improve research and innovation throuhg 4 collaborative research projects							
						Develop a joint future workforce plan for resources to enable development of future clinicla workofrce, including the trianing of principle investigators							
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							

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
						Developing and maximising our Elective Hub in Grantham							
						A Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire							

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	*Public Trust Board*
Date of Meeting	*6 June 2023*
Item Number	*Item 13.3*

Code of Governance Update

Accountable Director	*Chief Executive, Andrew Morgan*
Presented by	*Trust Secretary, Jayne Warner*
Author(s)	*Trust Secretary, Jayne Warner*
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	*Insert risk register reference*
Financial Impact Assessment	*None*
Quality Impact Assessment	*None*
Equality Impact Assessment	*None*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *Board are asked to note the updated Code of Governance* • *Consider the proposal for Audit Committee to maintain oversight of the requirements of the code as part of their quarterly Compliance Report*

Executive Summary

An updated code of governance for NHS provider trusts has been published following consultation in 2022. This came into effect from 1 April 2023. This replaces the 2014 NHS foundation trust code of governance and sets out an overarching framework for the corporate governance of trusts, supporting delivery of effective corporate governance, understanding of statutory requirements where compliance is mandatory and provisions with which trusts must comply, or explain how the principles have been met in other ways.

The new code covers both foundation trusts and NHS trusts. We will be undertaking a review of our compliance with the new code in the coming months for reporting any implications through the Audit Committee and the Board and to support planned updating of the Standing Orders and SFIs. Below are links to new Code and key associated documents.

Final copies of the Code, Addendum, and Guidance on good governance and collaboration.

The new code will replace the NHS Foundation trust code of governance, which was last updated in 2014. For the first time, the code will apply to all trusts. The code sets out principles to help trusts deliver effective corporate governance, and provisions with which trusts must comply, or explain how the principles have been met in other ways. Statutory requirements (where compliance is mandatory) are clearly indicated.

The code applies from April 2023.

The code has been updated to reflect:
• its application to NHS trusts, aligning with the proposed extension of the NHS Provider licence to them
• changes to the UK Corporate Governance Code in 2018
• the establishment of integrated care systems under the Health and Care Act 2022
• the evolving NHS System Oversight Framework, under which trusts will be treated similarly regardless of their constitution as an NHS trust or foundation trust.

The code is structured in five main sections containing the principles and provisions:
A - Board leadership and purpose;
B - Division of responsibilities;
C - Composition, succession and evaluation [of the board];
D - Audit, risk and internal control; and
E - Remuneration.

The provisions are drawn together in a “disclosures” section: a checklist against which compliance can be self-assessed and which must be reported against in trusts’ annual reports.

Finally, there are three appendices which cover the role of the trust secretary, provisions relating to councils of governors (for foundation trusts only), and the regulatory requirements related to the code and provider licence.

This new guidance seeks to clarify the expectations around collaboration on all provider trusts and to set out the governance characteristics that trusts should have in place to facilitate effective collaboration. It sets the expectation that providers collaborate with partners to agree shared objectives through integrated care partnerships (ICPs) and deliver

five-year joint plans and annual capital plans through collaborative arrangements. It links to the NHS Oversight Framework.

The guidance includes a section explaining how NHSE will use this guidance in cases of non-compliance, noting that in the first instance integrated care board (ICB) leaders should seek informal resolution of issues locally, with NHSE intervention following if required, and in discussion with ICB leaders.

The guidance details expectations on providers to consistently:
• engage in shared planning and decision-making
• take collective responsibility with partners for delivery of services across various footprints
• take responsibility for delivery of improvements and decisions agreed through any relevant forums.

Illustrative minimum behaviours are described in each case. A table further describes five characteristics of governance arrangements to support effective collaboration, with key lines of enquiry (KLOEs) for each in the form of questions about providers' participation, engagement, dialogue, information-sharing and decision making, among other things. The five characteristics expected of providers are:
• developing and sustaining strong working relationships with partners
• ensuring decisions are taken at the right level
• setting out clear and system-minded rationale for decisions
• establishing clear lines of accountability for decisions
• ensuring delivery of improvements and decisions.

The appendix to the guidance includes illustrative scenarios of ways in which providers can collaborate effectively.

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*6 June 2023*
Item Number	*Item 13.4*

NHS Provider Licence Modifications 2023

Accountable Director	*Chief Executive, Andrew Morgan*
Presented by	*Trust Secretary, Jayne Warner*
Author(s)	*Trust Secretary, Jayne Warner*
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	*Insert risk register reference*
Financial Impact Assessment	*None*
Quality Impact Assessment	*None*
Equality Impact Assessment	*None*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *The Board are asked to recognise the changes to the NHS Provider Licence and the extension of requirements for Provider Trusts* • *Approve for publication the 2022/23 year end self certification for Conditions G6 and FT4*

- *Consider the proposal for Audit Committee to maintain oversight of licence conditions as part of their quarterly Compliance Report*

The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients.

All NHS foundation trusts and NHS trusts are required to hold a licence. NHS controlled providers and independent providers of NHS services are required to hold a licence unless exempt.

Modifications to the licence

The NHS provider licence was first introduced for NHS foundation trusts in 2013 and extended to NHS trusts from April 2023. It was introduced for independent providers in 2014.

The licence has now been modified following a statutory consultation to bring it up to date to reflect current statutory and policy requirements.

The annual self-certification provides assurance to NHSE that NHS providers are compliant with the conditions of their NHS provider licence. On an annual basis, the licence requires NHS providers to self-certify that they have:

a. effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);

b. complied with governance arrangements (condition FT4); and

c. for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).

Whilst non-FT trusts were not required to hold a provider licence for the 22/23 year, directions from the Secretary of State require NHSE to ensure that NHS trusts comply with conditions equivalent to those in the licence as it deems appropriate. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions.

The Health and Care Act 2022 requires us to hold an NHS Provider Licence from 1 April 2023. Full details of the standard conditions of this licence are at https://www.england.nhs.uk/the-nhs-provider-licence/

It is recommended that to support the Trust in maintaining compliance with the modifications made to the licence with effect from April 2023 that a summary position statement is built into the quarterly compliance report already received by the Audit Committee.

ULH Statement of Compliance for 2022/23

A template is available for trusts to assist with recording of each of the self certifications to illustrate compliance. Whilst it is not mandatory to complete, and it is not necessary to submit to NHSE the template has been completed in case the Trust is subject to NHSE request. NHSE's self-certification requirements deadline for conditions G6 and FT4 is 30 June 2023.

Declaration 1 General Condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

The Board is required to confirm it is compliant with the following certification or explain why it cannot certify itself as compliant.
Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

The Trust does not have any conditions placed on its Licence and has not entered into any formal undertakings with NHS England. The Trust was judged to be in SOF 3 within the NHS system oversight framework and therefore can access support to assist with the Trust's improvement priorities.

In 2022/23 evidence was provided by the Trust which allowed removal by the CQC of all remaining enforcement notices from the Trust. The CQC undertook a Well Led inspection which found that the Trust was good for the Well Led domain. The Trust is tracking the delivery of all improvements required by the CQC through an improvement plan. The delivery against each of these actions plans is assured through the Quality Governance Committee.

On this basis it is recommended that the Board can confirm its compliance with licence condition G6.

Declaration 2 Condition FT4 - Corporate Governance Statement

The Board is required to indicate it is compliant with the following statements or if not state why it is non-compliant.

1) The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

The Trust has set its strategic objectives and has an established route through which its Board, Committees, Divisional structures monitor and receive assurances. Each of the Board Committees has terms of reference agreed by the Board. Each ToR includes details of their delegated responsibilities for scrutinising and assuring the Board on mandated governance reports and statements. The Audit Committee membership is drawn from the respective Board Committee Chairs facilitating the ability to cross refer between committees matters where the tracking of improvements in internal control have been identified by Internal Audit, External Audit, Counter Fraud or Management.

For each Committee there are assigned Executive Director committee leads.

Across the wider systems of internal control, the Trust's internal auditors have not identified any significant weaknesses within the Trust's internal financial control. The BAF and risk register reflect the management of the risks to the systems of internal control with the oversight of this being undertaken by the Audit Committee.

Based on the above it is recommended that the Board can confirm its compliance.

2) The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time.

The Board through its development programme has continued to develop its understanding of the changing system landscape and the Trust takes an active role within the ICS. The Board receive updates as required on changes to NHS corporate governance.

Based on the above it is recommended that the Board can confirm its compliance.

3) The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.

The Board Committees align to the Trust's strategic objectives along with the mandated committees (Audit, Remuneration and Charitable Funds). The annual review of their respective effectiveness has been completed and assurance provided to the Board through their upward reports.. There are clear lines of reporting for each Committee which include each Committee Chair providing an assurance report to the Board after each of their meetings. Lines of accountability are clearly assigned to the respective Executive Directors noting that for each Committee there are assigned Executive Director committee leads.

Based on the above it is recommended that the Board can confirm its compliance.

4) The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.

Through reports to the Board and through its Committees assurance has been provided on the Trust's efficient and economic operation, the lead committee with oversight is the Finance, Performance and Estates Committee. The Trust has complied with NHS Financial Frameworks. The Trust submitted and met its revised financial forecast and has complied with the requisite requirements including ICB review of the Trust's actions to manage its financial plan. The Trust has delivered a substantial proportion of its the efficiency programme. The national internal audit programme concluded that the Trust has robust systems of internal financial control.

The Finance, Performance and Estates Committee has a lead role for the oversight of operational performance and whilst the Trust recognises the significant risks within this area, the Board is sighted on the respective operational performance plans.

The Quality Committee is the lead Committee for providing assurance to the Board on the Trust's compliance with health care standards. Noting that for a number of areas, such as the CQC improvement plans are also reported directly to the Board. The Board receives and reviews the BAF at each of its meetings, this review is supported by the prior consideration of the BAF segments within each responsible committees complemented by overall review at the Audit Committee.

The Board's cycle of business ensures that it receives all mandated reports allowing it to meet its obligations in respect of its required declarations. The Committee workplans link to these requirements allowing the Board to receive greater depth of commentary at its meetings.
Based on the above it is recommended that the Board can confirm its compliance.

5) The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

The Board and Remuneration Committee has received regular updates on the Executive, Director structure and portfolios including the rationale for any changes. All changes have been endorsed by the Committee. In respect of the quality of care then there are clear executive and committee accountabilities for oversight. The Board both directly and through its committees ensures that a focus is maintained on the delivery of safe services. The Board receives assurances against the Integrated Improvement Plan and the BAF and Risk Register at each of its meetings. Based on the above it is recommended that the Board can confirm its compliance.

6) The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

The Trust has an established process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members' continuation as fit and proper persons is completed by the Trust Secretary and reported to the Trust Chair. The Board and its Committees through the receipt of Workforce reports have oversight of the actions being taken to mitigate the workforce risks in relation to recruitment and retention complemented by the Board's review of workforce BAF risks. There is scheduled reporting to the Board through

the People and OD Committee on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All improvement schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services.

Based on the above it is recommended that the Board can confirm its compliance.

On this basis it is recommended that the Board can confirm its compliance with licence condition FT4.