Bundle Trust Board Meeting in Public Session 2 May 2023

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

1 Introduction, Welcome and Chair's Opening Remarks

Chair

2 Public Questions

Chair

2.1 Ward Accreditation

Director of Nursing/Deputy Chief Executive

3 Apologies for Absence

Chair

4 Declarations of Interest

Chair

5.1 Minutes of the meeting held on 4 April 2023

Chair

Item 5.1 Public Board Minutes April 2023v1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log April 2023.docx

6 Chief Executive Horizon Scan Including ICS

Chief Executive

Item 6 CEO Update, 020523.docx

7 Patient/Staff Story

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

7.1 BREAK

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

8.1 Assurance and Risk Report from the Quality Governance Committee

Deputy Chair of QGC - Chris Gibson

Item 8.1 QGC Upward report April 2023v1.doc

Item 8.1 QGC 2023 Feb ULHT NHSE Visit letter FINAL.pdf

Item 8.1 QGC APPENDIX A Ockenden Presentation.pdf

Item 8.1 QGC APPENDIX B Maternity Neonatal Safety Assurance Report March 2023 Final.docx

Item 8.1 QGC APPENDIX C Maternity Improvement Plan.xlsx

Item 8.1 QGC APPENDIX C MatSIP Headline Report March 2023 MNOG.docx

Item 8.1 QGC APPENDIX D MNOSG NED REPORT DEC 2022 - FEB 2023 report.pdf

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

9.1 Assurance and Risk Report in respect of People and Organisational Development

Director of People and OD

Item 9.1 POD - Upward Report - April 2023 (final draft).docx

9.2 Staff Survey Update

Director of People and OD

Item 9.2 National Staff Survey Board Reportv2.docx

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

10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee (inc Comm Ann Report)

Item 10.1 FPEC Upward Report April 2023v1.docx

Item 10.1 FPEC Annual Report 2022-23v3.1.docx

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

12 Integrated Performance Report

Item 12 IPR Trust Board - Front page.docx

Item 12 IPR Trust Board April 2023.docx

13 Risk and Assurance

13.1 Audit Committee Upward Report

13.2 Risk Management Report

Item 13.2 TB - Strategic Risk Report - May 2023.docx

Item 13.2 Appendix A - Risks rated 15-25 - April 2023.pdf

13.3 Board Assurance Framework

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

Item 13.2 BAF 2022-2023 v25.04.2023.pdf

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 6 June 2023

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

United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 4 April 2023

Via MS Teams Live Stream

Present

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

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Catherine Franklin, Matron, Child Health Management

Apologies
Dr Colin Farquharson, Medical Director

371/23	**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.
372/23	**Item 2 Public Questions** **Q1 from Vi King** **If the Trust have backlogs for fracture clinics. Please can I ask why Grantham is still not being utilised, to save people having to travel to Lincoln and Boston. I know orthopaedic clinics are 4 times a week but fracture clinic is only 3 days a week.**

	I know that "New Trauma" first appointments are at Lincoln or Boston. It doesn't make any sense not to have Grantham running 5 days a week for fracture clinics and orthopaedic clinics. **Please can you let me know when Grantham will be fully utilised to save the people of Grantham and surrounding areas having to travel.**
373/23	The Chief Operating Officer responded: There was no backlog for fracture clinics dues to these being part of the urgent care pathway with clinically prioritised appointments. It was noted that a meeting had taken place on 3 April with the surgical division to consider Grantham being utilised further. There would be changes made to job plans for specialist grade doctors in orthopaedics which would allow a 5-day service at Grantham. The Trust would commence with follow up appointments however exploration of new patient clinics was being undertaken however this would take between 12-14 weeks as notice of the changes to job plans would be required. The Chief Operating Officer noted that this would offer a more responsive service to the population of Grantham and surrounding area. The Chief Operating Officer would continue to provide direct updates to Ms King on the progress. The Chair was pleased to hear the positive response and supported the ongoing communication with Ms King as an advocate for the patients of Grantham.
374/23	**Item 3 Apologies for Absence** Apologies were received from Dr Colin Farquharson, Medical Director
375/23	**Item 4 Declarations of Interest** The Chair noted that, as of 31 March 2023, she had ceased to be the Chair at Lincolnshire Community Health Service NHS Trust (LCHS) and the register had been updated accordingly.
376/23	**Item 5.1 Minutes of the meeting held on 7 March 2023 for accuracy** The minutes of the meeting held on 7 March 2023 were agreed as a true and accurate record.
377/23	**Item 5.2 Matters arising from the previous meeting/action log** 301/23 – Assurance and Risk Report People and Organisational Development Committee – The Chair had written to Dr Chablani on behalf of the Board – Complete

378/23	311/23 – Gender Pay Gap Report – The Director of People and Organisational Development confirmed that the presented data had been offered in a way to reflect the suggestions made and was now available on the Trust website as part of the action plan – Complete
379/23	360/23 – Risk Management Report – The Director of Nursing advised in relation to the Echocardiographic Training Programme (ETP) there had historically been difficulties in recruiting experienced physiologist. Principle physiologist had been involved in system wide training and had contributed and engaged with multiple processes and programmes across the midlands in order to mitigate system wide pressure on recruitment and training. The Trust was engaging with the ETP.
380/23	The Director of Nursing was pleased to note the recent appointment of 3 substantive physiologists, following a recent recruitment round, as a direct result of the recruitment and retention premia agreed a number of months age.
381/23	This would help the service fragility and also reduce agency use once those joining the Trust were in post. This would allow the risk register to be updated, specifically risk 4789 – Complete
382/23	363/23 – Risk Management Report – The Chief Executive confirmed that the risk had been captured and would appear on the risk register report in due course – Complete
383/23	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board noting that the system continued to be busy noting that this was not just United Lincolnshire Hospitals NHS Trust (ULHT) but all sector partners.
384/23	It was noted that the holiday period was being entered and therefore the system was preparing from a buy time of year with the Easter break however this, in addition to normal operational pressures and employees across the system wanting leave, it was always a busy time of year.
385/23	This year the busy period would coincide with the next Junior Doctor strike which would follow straight on from the East break commencing at 7am on Tuesday 11 April and finishing at 7am on Saturday 15 April. This would be a very disruptive 4-day period with all parts of the system working to protect urgent and emergency care (UEC) and same day services.
386/23	The Trust was going all it could to protect elective care where possible, but it was inevitable that there would be delays and inconvenience. The Chief Executive offered apologies to the patients who would be impacted by this and hoped that people understood that the 4-day strike was outside the Trust's direct control.
387/23	There was a continuation through representative bodies to implore those involved to hold discussions to reach a negotiated settlement. All plans were in place to manage as best as possible what would be a difficult week across the system.
388/23	

389/23	The Chief Executive advised of the system financial position noting that the system would end the year with a £17m deficit with the 2023/24 plan still in final draft form. Negotiations continued across the country with NHS England (NHSE) with the initial system plan having been submitted with a £52m deficit. This had now reduced to between £39-40m, and all would be done to reduce this.
390/23	The system remained in the Recovery Support Programme (RSP) with the financial recovery plan part of this and amounted to £55m of savings. In order to exit the RSP 6 consecutive months of achieving the financial plan were required meaning all trajectories were agreed and allocated between different organisations.
391/23	The Chief Executive advised that the system oversight framework (SOF) ratings had been issued for quarter 3 with there being no change to the system being at SOF level 4. ULHT was at SOF3 with LCHS and Lincolnshire Partnership NHS Foundation Trust (LPFT) both in segment 1.
392/23	There had been a positive Quarterly System Review Meeting (QSRM) held the previous week with NHSE and all system partners and colleagues from NHS Midlands. The meeting had covered health inequalities, quality, finance, performance, mental health and learning disabilities.
393/23	The summary from the regional director had been that a huge amount of good progress and work had taken place in Lincolnshire with it noted that the system worked well together. There was current positive performance with current challenges being addresses. It was noted that the system was at the higher end of the QSRMs that had been undertaken with a very positive discussion held.
394/23	The Chief Executive updated on Trust issues noting that, as predicted, the Trust would end the year at a £13.6m deficit, as part of the system deficit.
395/23	The Chief Executive was pleased to report that Grantham had been accredited nationally as a surgical hub. This was great news for Grantham with the 2 new theatres. Work now focusing on maximising the work to be done at Grantham and increasing capacity and productivity.
396/23	The Trust's Workforce Race Equality Standard (WRES) plan had been rated as good by NHSE. Work continued around the culture and leadership programme and a number of cultural ambassadors had been appointed, with staff having stepped forward to support this.
397/23	This was supported by the staff networks and all of the Executive Leadership team who had now signed up to the NHS Midlands Staff Networks Executive Sponsors programme in order to learn how to make the most of the staff networks.
398/23	The Chief Executive advised members of the Board that an interim Director of Finance and Digital had been selected with work underway to finalise the process.
	The Chief Executive noted that this would be the last Board for the current Director of Finance and Digital wishing Mr Matthew every success at Nottingham University Hospitals NHS Trust (NUH). The Chief Executive noted that it was a testament to Mr

	Matthew's ability that he had been head hunted for the role, going through the recruitment process.
399/23	The Chief Executive was delighted as a friend but sad for the Trust that Mr Matthew would be leaving offering thanks and best wishes for the future.
400/23	The Chair endorsed all of the points made about the Director of Finance and Digital.
401/23	Dr Gibson noted that the Trust had been responsible for most of the 2022/23 predicted deficit noting that the 2023/24 deficit was predicted to rise and asked if the Trust was also responsible for this and what were the broad-brush factors leading to the increase in the system deficit.
402/23	The Chief Executive noted that a large proportion of the deficit would sit with the Trust however noted this continued to more. The last figure had been £21m of the £39m as being the responsibility of the Trust. When considering the savings that were required these remained in the usual topics with the number of beds open and staff costs, particularly agency that went with that.
403/23	Considering the financial recovery plan, for the system to come out of the RSP, the Trust had £28m of the £55m with a significant portion related to the need to reduce agency spend.
404/23	The Director of Finance and Digital noted the impact of non-recurrent efficiency from the 2022/23 year which had come in to the 2023/24 position for the Trust and added £7m into the underlying position which would need to be made good.
405/23	The overall allocation worked broadly on a flat real term position with no specific growth build into this as the conversion adjustment took effect.
406/23	The conversion adjustment was the move of NHS allocations back to a post Covid-19 set of allocations, this was not just about the Trust spending more but the difference between growth and expenditure. £20.8m was the current share of the deficit for the Trust.
407/23	The Chair noted that the Trust, as ever, would be in a challenging financial position however there was a better understanding of the position, what was driving this and what was required of the Trust to contribute to the system position in order to deliver good governance and manage public money.
408/23	The Board received the report reflecting that the year would be financially and operationally challenging with the Chair offering thanks for the work being undertaken in respect of the Junior Doctors strike.
409/23	The work around the elective surgical hub at Grantham was acknowledged and was another example of the intent of the Trust Board to build on the arrangements at Grantham to make this a vibrant centre of excellence for trauma and orthopaedics as described in the past.
410/23	

411/23	The Chair thanked the Director of People and Organisational Development, Equality, Diversity and Inclusion Team and Board members for the work related to the WRES action plan to achieve the good rating. This offered a positive indication from the regulators of their confidence that the Trust could take the work forward. The Chair welcomed the cultural ambassadors and noted the need for an engagement session with the Board to offer support and outline expectations. The Trust Board: • **Received the report and significant assurance provided**
412/23	**Item 7 Patient Story** The Chair welcome Cathy Franklin, Matron for Child Health Management to the Board.
413/23	The Director of Nursing introduced the Patient Story to the Board noting that this related to neonatal services and the journey to achieve local neonatal status in 2022.
414/23	The Trust Board watched the video detailing the improvement journey and achievements of the neonatal services and the story of Missy-Lou born at 22 weeks gestation and the support that had been received by her mum, Teri.
415/23	The Director of Nursing noted the wonderful story where Teri's face had lit up when talking about the care received, especially at a time which would have been traumatic and upsetting. This demonstrated the learning, comprehensive support and valuing and recognising staff and innovation that had been undertaken in the service. When you get things right the outcome is fantastic for babies and families, and this was clearly seen through Teri's feedback. Thanks were offered to the Matron for bringing the story to the Board.
416/23	Mrs Brown, as the Non-Executive Director Maternity and Neonatal Safety Champion was proud to be the champion for these services noting that neonate remained in the background at time but was in the forefront with the story. Mrs Brown thanked the team for the work they did.
417/23	The Chief Executive noted that the story was a fantastic advert for the Trust's neonatal service but also for the whole Trust. The Chief Executive had recently reflected to the NHS England Chief Executive that these outcomes were what kept the moment in difficult times, knowing the Trust had positively impacted on hundreds of people at the end of each day.
418/23	It was noted that the Matron and colleagues were the embodiment of why the organisation mattered and when things were done right how there were fantastic stories as a result. Thanks were offered for the story presented and encouragement to keep up with the great work.
419/23	The Matron, Child Health Management noted that it had been great to show the Board and members of the public the story noting that neonatal services were sandwiched between maternity and paediatrics but was a big service with a lot of

	positive outcomes. It was important to be able to showcase this with the Matron, Child Health Management expressing how proud she was of the wonderful team.
420/23	The Chair noted that the Matron, Child Health Management was right to be proud as a leader of a service that provide such a service with the Board collectively sharing the pride.
421/23	It was noted that this was the embodiment of what the Trust strived to do for patients every day, this was about children, babies and their families and was a story that demonstrated the confidence and reassurance gained by Teri due to the level of after care provided by the team.
422/23	The Chair also noted the investment in personal development, education and training noting that from a Board perspective this was important but reflected that this could easily drop off when people were busy. There was a clear strategy around this in the service with the Chair congratulating the Matron, Child Health Management for the leadership approach noting this was the expectation across the Trust.
423/23	The Director of Nursing noted that there had been no formal complaints to the services since January 2021 noting that this did not happen by accident.
424/23	The Chair was pleased to note this and offered the support of the Trust Board in the future should this be required. The Trust Board: • **Received the patient story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
425/23	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair of the Quality Governance Committee, Mrs Brown provided the assurances received by the Committee at the 21 March 2023 meeting.
426/23	Mrs Brown advised the Board that the Committee had supported the revised process for clinical harm reviews which had been ratified by the divisions and taken through the Executive and Trust Leadership Teams and on to the Committee.
427/23	It was noted that there remained a need to review the remit of the Clinical Harm Oversight Group however the Committee was confident of the process in place.
428/23	The Committee received notable improvement in incident management and was pleased to receive the final action plan from the Never Event Summit which had been held.
429/23	The serious incident summary report had been received and demonstrated and increase in the number of completed actions with the notable position of no overdue actions from never events, this was the first time, for some time that the Trust had achieved this position.

430/23	The Committee recognised that this demonstrated the improvement in governance and processes across the Trust with strong assurance received.
431/23	Mrs Brown noted that the safeguarding report had offered limited assurance on the outstanding internal audit actions in the emergency departments however was pleased to advise that an emergency department oversight group was being established, utilising the same approach used in maternity and led by the Director of Nursing.
432/23	The Board noted that the Trust remained above trajectory for Clostridioides difficile and MRSA with a task and finish group being set up to consider peripheral line care and management.
433/23	The Committee noted, through the medicines management report, the continued pressure of staffing and the impact this was having on the ability to meet required improvements, particularly 7-day service. There had however been some improvement in controlled drugs management and progress of the Electronic Prescribing and Medicines Administration (ePMA) rollout.
434/23	Medicines management was an area recognised as requiring further assurance going forward.
435/23	Mrs Brown was pleased to advise the Board, from a patient experience perspective, that month on month improvement had been seen in assurance levels being received. The Committee was pleased to be able to, after review by the governance team and Committee, uplift objective 1b to a green assurance rating.
436/23	There had been continued challenge in reaching the 78-week elective trajectory, but the Committee had been pleased to hear of the notable achievement of the elective hub accreditation at Grantham.
437/23	The Committee had received the proposed clinical audit plan for 2023/24 which was supported by the Committee. The finale draft of the Committee effectiveness annual report had been received and Mrs Brown was pleased to present this to the Board as an attachment to the report.
438/23	Mrs Brown advised the Board that the Committee had received the industrial action learning action plan which recognised learning from the previous industrial action. All of the new plans were being utilised to put the Trust in the best position possible with the Trust being recognised, both internally and externally, for doing well during the industrial action period.
439/23	The Chair noted the growing sense of increased levels of assurance through the Committee noting those areas where further assurance was required had clear oversight.
440/23	The referrals to the People and Organisational Development Committee were noted in respect of the Healthcare Safety Investigation Branch (HSIB) bulletin and also the impact of flu and the vaccination programme.

	The Trust Board: • **Received the assurance report and annual report** • **Noted the uplift in assurance 1b – Patient Experience**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
441/23	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker provided the assurances received by the Committee at the 21 March 2023 meeting.
442/23	Professor Baker noted that the Committee had received the report from the Workforce, Strategy and Organisational Development Group noting that there had been some challenges around attendance and quoracy of the group.
443/23	The Committee were keen to see this addressed noting that the terms of reference of the group would be considered at the April Committee however it was recognised this may be impacted by the Junior Doctor strike.
444/23	The Committee had noted an increase in long terms sickness as reported through the performance dashboard with the Committee noting the current review of the occupational health service.
445/23	Moderate assurance had been received in respect of the safer staffing report although the Committee had noted the report offered January data. The lag in reporting would be addressed going forward with the timing of reports.
446/23	Professor Baker advised the Board that the NHS and System People Plan report had demonstrated an increase in substantive posts with the Committee noting the work being undertaken to address the use and culture of use of agency staff.
447/23	The Committee received the Culture and Leadership Group upward report and was pleased to note the 16 cultural ambassadors with Professor Baker noting that exploration as to having joint roles as Freedom to Speak Up ambassador would be undertaken as there was an overlap in the roles.
448/23	The Committee had welcomed the positive discussion between the Trust and University of Lincoln and the join recognition of the strategic importance to both organisations. The discussions had been encouraging with Professor Baker congratulating all of those involved in the discussions.
449/23	Professor Baker noted the concern expressed around progress pertaining to research and innovation with the work being done to involve the Executive team around this noted.

450/23	The official opening of the education centres in Lincoln and Boston would take place on 28 June and 5 July respectively.
451/23	The Committee had considered the Integrated Improvement Plan (IIP) and the key performance indicators (KPIs) for 2023/24 with challenges around appraisal and mandatory training that had only offered limited assurance. It was noted that this was the responsibility of leaders across the organisation to progress.
452/23	The Savile action plan had been received which focused on the progress of the disclosure and barring service checks. It was noted that this was in place for new started however consultation with colleagues was ongoing regarding the change in process for currently employed staff.
453/23	The Chair noted, as the Health and Wellbeing Guardian on the Board that there had been contact with colleagues to retain oversight of the occupational health review. It was pleasing to note that the Committee was sighed on this.
454/23	It was also pleasing to note that agency staffing was being considered by the Committee with the Chair endorsing the points made about the work with the university, there remained work to do however it was pleasing to note the traction. The Trust Board: • **Received the assurance report and annual report**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
455/23	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini provided the assurances received by the Committee at the 23 March 2023 meeting.
456/23	Ms Cecchini advised the Board of the work undertaken by the estates team on the high voltage shut down required for essential maintenance to take place. This had demonstrated good collaborative working between the estates team and operational teams.
457/23	From a Health and Safety perspective the Committee had received an update on the Entonox issues with the Committee noting that the Health and Safety Committee would maintain oversight on the monitoring of this. The Committee had requested this be reported back once considered.
458/23	Ms Cecchini noted the finance position as reported by the Chief Executive. The Trust was on track to deliver the agreed deficit of £13.6m with limited assurance received in respect of the cost improvement programme. A large proportion of this had been non-recurrent with work to do as a committee in the coming year to ensure this remained on track.

459/23	The Board was advised that contracting discussions for the 2023/24 year remained ongoing with an update to be received at the Committee as this moved forward.
460/23	The Patient Level Information and Costing System (PLICS) report has offered a helpful update demonstrating increasing costs and throughout Covid-19 a reduction in activity, this offered a reasonably positive position that progress could be made on productivity.
461/23	The Committee had received and noted the capital position noting the likelihood of delivering the capital resource limit.
462/23	An improvement action plan in respect of the Better Payment Practice Code (BPPC) had been received and requested by NHSE due to the previous reporting of the outage of the finance system, the Committee would oversee the action plan.
463/23	Ms Cecchini noted the procurement update that had been received advising that the Committee awaited the pipeline for procurement.
464/23	The Information Governance (IG) Group upward report had identified some challenges around IG with the Information Commissioners Office (ICO) due to undertake a revisit audit at the end of May to review progress on the action plan.
465/23	Ms Cecchini noted that progress was being made with the actions however significant work was required, specifically around the information asset strategy and implementation of this.
466/23	It was noted that this would impact on the Data Security and Protection Toolkit (DSPT) submission. The Committee had noted concern around the level of IG training and due diligence of contractual and procurement compliance which would also impact achievement of the DSPT.
467/23	The Committee had noted a move from limited to moderate assurance in respect of performance however it was noted that whilst the metrics were not all where expected there had been some improvement for cancer and the 62-backlog recovery. There had also been reduced assurance in respect of the 78-week requirement due to the impact of the Junior Doctor strike.
468/23	A deep dive had been received on the work to improve outpatient capacity with a request made for these to be made available to members of the Board in the paperless board solution reading room. The report had offered significant assurance that there was a strong programme of work in place that was well resourced.
469/23	Ms Cecchini noted that whilst the Committee had received an update on planning this had been superseded.
470/23	The annual report on committee effectiveness had been received however this had been held back from submission to the Board as the Committee felt the need to include further narrative around the levels of assurance.

471/23	The Committee had undertaken work on risk appetite which would inform a wider Board discussion, the Committee had also followed up on the internal audit recommendations and Care Quality Commission (CQC) actions.
472/23	The IIP and KPIs for 2023/24 had been considered with limited assurance on delivery of the 2022/23 year however the Committee had noted the positive infrastructure changes which offered increased confidence as the Trust moved into the next year.
473/23	The Chair noted the volume of what had been considered by the Committee across the whole portfolio of Finance, Performance and Estates noting there was a sense of the nature of the debate and where the challenges were.
474/23	Overall, there was a sense of increasing levels of assurance, whilst slow these were building which was welcome given some of the difficult nature of the business coming through the Committee.
475/23	Increasing levels of assurance were being received through improved reporting and planning with the challenge remaining in the execution however there was good delivery being seen around some areas.
476/23	The annual report would be received to the May Board once the appropriate level of assurance had been included. The Trust Board: • **Received the assurance report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
477/23	No items
478/23	**Item 12 Integrated Performance Report** The Chair noted that the reports from the Committees had shown the due diligence which had been undertaken into particular trajectories and target areas.
479/23	In order to not repeat what had been reported the Chair invited Executive Directors to draw to the Boards attention anything which the Board needed to be alert to or for the Non-Executive Directors to raise any questions.
480/23	Mrs Brown noted the number of hours lost by East Midlands Ambulance Service NHS Trust (EMAS) continued to reduce noting that this had been challenged regionally however there had again been some improvement which was notable.
481/23	The Chair thanks Mrs Brown for recognising the improvements given the discussions which had taken place regarding this.
482/23	The Chief Executive noted that urgent and emergency care had been discussed at the QSRM with a view that NHS Midlands considered this to be the most challenging area for the system. There was recognition of the improvement in handover delays

	however both the Trust and EMAS would need to continue to work on category 2 ambulance response times where the standard mean was 30 minutes with Lincolnshire being some way off of this. This would be revisited in the future.
483/23	The Chief Executive noted that, the end of March 78-week position was 277 with the zero target not achieved. This was recognised as an issue across the country with cancellations related to the Junior Doctor strikes and other pressures. The National aim was to clear this by the end of April however the Easter period and further 4-day Junior Doctor strike would impact on this. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
484/23	**Item 13.1 Risk Management Report** The Director of Nursing presented the risk report to the Board noting that there were 2 very high risks considered by the Risk Register Confirm and Challenge meeting with ambulance handover delays reduced to a moderate risk.
485/23	The unexpected surge in the emergency demand was closed with agreement that this would be incorporate into a single demand and capacity risk.
486/23	A new risk had been validated as very high, related to the epilepsy service provision in paediatrics and a number of risks, identified in the executive summary, were due to be presented to the Risk Register Confirm and Challenge meeting. As a result, these may be reported to the next month through the Committees once the scoring had been confirmed.
487/23	The Director of Nursing advised that following the updates this left 11 quality and safety risks rated very high and 12 rated high, which had not changed since the last reporting period.
488/23	There were 3 very high risks reported to the People and Organisational Development Committee and 5 very high risks reported to the Finance, Performance and Estates Committee. One of which was a new risk regarding Subject Access Request compliance and access to health records in accordance with statutory requirements.
489/23	A number of risks were awaiting review at the next meeting with the Director of Nursing noting that this demonstrate the live and dynamic nature of the risk register with the movement of risks being seen.
490/23	All of the risks had been reviewed by each of the Committees with clear mitigation plans in place for each of the risks. The appendix to the report offered the detailed od the strategic risks which it was hoped would be recognised by members of the Board.
491/23	The Director of Nursing noted that the report continued to offer significant assurance to the Board.

492/23	The Chair endorsed the comment about the risk register being dynamic noting that the report offered sight of both current and future risks. The enhancement to the report was welcomed. The Trust Board: • **Accepted the risks as presented noting the significant assurance**
493/23	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the Board Assurance Framework (BAF) to the Board noting that all Committees had considered the BAF during the March meetings.
494/23	As noted in the upward report from the Quality Governance Committee a proposal to the Board had been made for objective 1b to move from an amber to green assurance rating.
495/23	The Chair noted that the BAF had been considered in detail by the Committees and noted that this would be the last time the 2022/23 BAF was received by the Board.
496/23	There had been incremental progress seen on the objectives which built on the emerging levels of assurance that plans were in place, being delivered and meeting strategic objectives.
497/23	Support was sought from members of the Trust Board to endorse the year end position. The Trust Board: • **Received the report noting the moderate assurance** • **Approved the rating of Objective 1b from amber to green**
498/23	**Item 14 Any Other Notified Items of Urgent Business** The Chair noted that the Director of Finance and Digital would be leaving the Trust Board at the end of the month with this being the last public Board meeting that would be attended.
499/23	The Chair noted a special connection with Mr Mathew having started in the Trust on the same day and reflected that this was an entirely different place. Testament was paid to Mr Matthew for his resilience, perseverance and professionalism, particularly in the early days.
500/23	The Trust had been in Financial Special Measures, under the old regime, which had been a challenging place with external turnaround support in place that had been hard to manage and navigate.
501/23	This was Mr Matthew's first director post in the NHS with the Chair noting what an amazing journey this had been so far, to the point of being identified for other things in other parts of the country. It was clear why his credibility, reputation and profile had taken Mr Matthew to a much bigger role.

502/23	The Trust had benefited from all of this with Mr Matthew being professional around the management of not just the money for the Trust but other portfolios including digital and for some time people and organisational development which he had been able to turn his hand to with ease.
503/23	The Chair wished Mr Matthew every success in the future noting the comments which had been offered in the MS Teams chat from other Board members.
504/23	The Director of Finance and Digital offered thanks for the kind works noting that he had had a brilliant time at ULHT nothing the timing of his departure had not been planned but was an opportunity that had presented itself.
505/23	The Director of Finance and Digital noted that the organisation was now unrecognisable compared to arriving in the Trust on 2 January 2018 noting that he was leaving with the Trust in a stronger place.
506/23	The Director of Finance and Digital wished all the best for the future to everyone noting that he was determined to see more joint working between acute Trusts to collaborative and hoped to be able to facilitate this between the Trust and NUH in the future.
507/23	The next scheduled meeting will be held on Tuesday 2 May 2023 via MS Teams live stream

Voting Members	**5 Apr 2022**	**3 May 2022**	**7 June 2022**	**5 July 2022**	**2 Aug 2022**	**6 Sept 2022**	**4 Oct 2022**	**1 Nov 2022**	**6 Dec 2022**	**7 Feb 2023**	**7 Mar 2023**	**4 Apr 2023**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	A	X	X	X	X	X	X	X	X	X	X	X
Sarah Dunnett	A	X	A	X	A	A						
Paul Matthew	X	X	X	X	A	X	X	X	X	X	X	X
Andrew Morgan	X	X	A	A	X	X	X	X	X	X	X	X
Mark Brassington												
Simon Evans	X	X	X	X	A	X	X	A	X			
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X
Philip Baker	X	X	X	X	X	X	X	X	X	X	X	X
Colin Farquharson	X	X	X	X	X	A	A	A	A	A	A	A
Gail Shadlock	X	X	X	X								
Dani Cecchini	X	X	X	X	X	X	X	X	X	X	X	X
Rebecca Brown						X	X	X	X	X	X	X
Neil Herbert						X	X	X	X	X	X	X
Paul Dunning						X	X	X	X	X	X	X
Michelle Harris										X	A	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	301/23	Assurance and Risk Report People and Organisational Development Committee	Letter of thanks to be sent to Dr Chablani for work undertaken in the role as Guardian of Safe Working	Chair	04/04/2023	Complete
7 March 2023	311/23	Gender Pay Gap Report	Consideration of additional layer of data to be utilised to better understand the local dynamics of the gender pay gap to be taken forward with the Equality, Diversity and Inclusion Group	Director of People and Organisational Development	04/04/2023	Complete
7 March 2023	340/23	Assurance and Risk Report from the Finance, Performance and Estates Committee	Update on medicines management to be offered to the Board in 3 months' time in order to ensure sight was not lost to due this having been an issue for some time	Medical Director	07/06/2023	
7 March 2023	360/23	Risk Management Report	Clarity on risk 4789 regarding echocardiographic staffing to be offered to Dr Gibson in respect of the Trust engaging in the Health Education England process as a potential solution for the long-standing issues experienced by the Trust.	Director of Nursing	04/04/2023	Complete
7 March 2023	363/23	Risk Management Report	Risk to be captured within the risk register in respect of current changes in the Executive Team	Chief Executive	04/04/2023	Complete

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*2 May 2023*
Item Number	*Item number 6*

Chief Executive's Report

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

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to be under operational pressure due to service demand. Services coped well with the Easter break and the four days of industrial action by junior doctors. The planning over recent weeks has been in readiness for the Bank Holidays in May, including the Coronation weekend.
b) The Hewitt Review was published on 4th April. This is an independent review by the Rt Hon Patricia Hewitt into Integrated Care Systems. The review identified six key principles that will help to create the context in which ICSs can thrive. These are : collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the space and time to lead; the right support; balancing freedom with accountability; and enabling access to timely, transparent and high-quality data. The review report is now with Ministers for consideration of the way forward.
c) The outcome of the pay offer to NHS staff on the Agenda for Change pay system is awaited. Trade Unions are currently consulting with their members, the RCN and Unison having already confirmed the outcome of their consultations. An extraordinary national NHS Staff Council meeting will be held on 2nd May, where a formal decision will be made as to whether the offer in principle will be accepted.
d) Discussions are continuing within the system and with NHS England over the operational plan for 2023/24. The final plan needs to be submitted on 4th May. One of the key issues that remains outstanding is whether the system is able to submit a balanced financial plan for the year.
e) The system ended 2022/23 with a deficit of £16.8m.
f) NHS England has published the findings of its review of delivery and continuous improvement in the NHS and launched its new approach to improvement, NHS Impact. NHS England has agreed three actions: to establish a national improvement board which will agree national priorities for improvement led delivery; to launch a single shared NHS Improvement approach which will be delivered through NHS Impact; to co-design and establish a Leadership for Improvement programme.
g) On 5th July the NHS will celebrate its 75th anniversary. The celebrations of this milestone are being co-ordinated by the national NHS Assembly. All parts of the Lincolnshire system will be involved in the celebrations.
h) Along with John Turner the ICB CEO, I have joined the Court of the University of Lincoln. The Court is one of the key ways in which the University engages with key local stakeholders to disseminate information about its activities and to engage others in its plans for the future.
i) Congratulations have been sent to Gareth Davies the MP for Grantham and Stamford who has been appointed to the ministerial role of Exchequer Secretary to the Treasury.

Trust Overview

a) At Month 12, the Trust reported a year end deficit of £13.6m against a start of the year plan of break-even. This year-end position was in line with a revised forecast agreed across the system.
b) The Trust put in place robust plans for dealing with the second round of industrial action by junior doctors which took place across the four days 11th-15th April. Including the first round of industrial action by junior doctors in March, the Trust has had to

cancel 165 electives and 1,474 outpatients. The Trust has incurred additional staff costs of c£250k in covering for striking staff, and has lost income of c£300k related to activity not carried out. The activity income should be recoverable when the postponed work is subsequently carried out.

c) The Trust was one of the key presenters at the national NHS People Promise Exemplar Programme Collaborative Event that was held on 20th April. This was in acknowledgment of the progress made in the staff survey results for 2022 and the work that is underway to change the Trust's culture, behaviours and leadership practices. The Trust also received positive coverage in NHS England's Chief Workforce Officer's weekly blog, in relation to our work around flexible working.

d) Barry Jenkins joins the Trust on 8th May as Director of Finance and Digital, to replace Paul Matthew. This is an interim appointment for a six month period. Barry is an experienced senior leader, with 13 years of Board level experience spanning the NHS and local government, including in mental health, community and acute care. His most recent appointment was at Buckinghamshire Healthcare NHS Trust where he was Chief Financial Officer.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	18 April 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** The meeting was cancelled due to industrial action however the Committee noted that the group would consider how this evolved as a result to the changes to the clinical harm review process. **Patient Safety Group Upward Report** The Committee received the report noting that the group had reviewed the incident analysis report and whilst there had been an increase in the percentage of overdue actions the number of older actions had reduced in line with the divisional work. The Committee noted that the internal audit report in relation to Central Alerting System and Field Safety Notices, which offered, limited assurance. Actions had been agreed with work underway to devise the action plan. Of particular note was the excellent national cardiac arrest outcome data, which was reported to the Committee that placed the Trust as one of the top performers in the country. **Serious Incident Summary Report inc Duty of Candour** The Committee received the report noting the position presented and received a verbal update on the first never event declared within the current financial year. The Committee noted the continued improvement with duty of candour noting there had been a positive drive forward with continued sustainable improvement. Thanks were offered to the clinical teams for the

	achievement. **High Profile Cases** The Committee received the report noting the content. **Claims and Inquests Report** The Committee received the report noting the quarter 4 data presented in the report and recognised that improved reporting would be possible with the new system. **Infection Prevention and Control (IPC) Group Upward Report** The Committee noted that the meeting had been cancelled due to industrial action. **NHSE IPC Visit Letter Outcome** The Committee received the outcome letter (appendix a) following the NHS England IPC visit to the Trust noting that the letter was not as positive as the verbal feedback which had been received during the course of the visit. The visit had been received positively, however it was noted that due to the change in the NHS England escalation matrix this had resulted in the Trust being placed into enhanced monitoring. This was due to a breach being observed in waste management, increased rates against trajectories for healthcare acquired infections and lack of progress in respect of sharps management. The Committee received the draft action plan which was due to be finalised in the coming month noting that where possible immediate actions had been taken. **Medicines Quality Group Upward Report** The Committee received the report noting the progress being made in relation to the medicines management project however recognised that some areas remain outstanding. Funding had now been identified to support the work in relation to self-administration of medicines for 2023/24 with the Committee noting slow progress at this time. It was noted that the medicines management training had been approved by the group with the completion of the relevant QIA and approval of the mandatory training group. This would now be available to staff through ESR. The Committee was pleased to note the continued roll out of ePMA which had been successful in the medicine division and was now progressing to the surgical division. The Committee noted that 7-day working for pharmacy services continued to be difficult however noted success with international

	recruitment although recognised long lead times. **Children and Young People Oversight Group Upward Report** The Committee received the report noting the significant progress made in the service since 2018 and the previous issues that had been experienced. The Committee noted the embedding of the CP-IS system as an agreed CQC action noting that a process was now in place to address any lack of compliance with this. It was noted that, to support the service, project support had been identified from the Improvement and Integration Directorate with a focus on the hidden child and transition, which had not yet progressed due to capacity. The Committee noted the successful appointment of a Lead Nurse role to support the paediatric epilepsy service with ongoing work to develop a broader strategy for epilepsy services. **Nursing Midwifery and AHP Advisory Forum Upward Report** The Committee noted that the meeting had been cancelled due to industrial action. **Maternity Neonatal Oversight Group Upward Report** The Committee welcomed the Divisional Head of Nursing and Midwifery to the meeting who presented the upward report and associated appendices (attached). It was noted that the Trust had successfully submitted full compliance to the Clinical Negligence Scheme for Trusts for year 4 with formal feedback awaited. The Committee noted the publication of the national 3-year plan, which supplemented the Ockenden and Kirk-Up reports rather than superseding them. Trust has already undertaken benchmarking against the Trust's maternity improvement plan to identify if any further actions are required. There was assurance that the 3-year plan aligned to the improvement plan already in place. Following the recent Neonatal peer review the group had considered the resulting actions with the Committee noting the positive visit which did not raise any significant concerns being raised. The Committee considered the recent reports of BAME women having poorer outcomes. A review of relevant Trust data had been undertaken which did not demonstrate an excess issue for the Trust. Community IT connectivity issues which the Committee was alerted to noted that a trial was in place to support community midwives in accessing information. Once the trial is complete, feedback would be

	offered to determine an ongoing solution.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report to inc PLACE lite report** The Committee received the report including the outcome of the PLACE lite report in respect of Grantham where some lower scores had been seen in relation to the environment, particularly for dementia friendly areas. Reassuringly the areas identified were already known with actions in place. The Committee noted the positive engagement with the Patient Panel and the co-design of the Patient Visiting Policy, which had been approved by the group. An assurance report from the medicine division demonstrated a reduction in the number of completed friends and family test responses however, it was noted that the outcome of responses remained static. The Committee noted the discussion regarding triangulation of data and the analysis to be taken from this across a number of areas including PLACE reports, IPC and staff experience which would support identification of actions to improve patient experience. **Patient Story** The Committee received a patient story which reflected on the moving of a patient across services and sites in order to deliver care and noted the work being undertaken to reduce moves and bring services to patients rather than patients to services. The Committee suggested benefit in this being presented to the Trust Leadership Team to support the need for change across the organisation.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report (inc. confidential enquiries quarterly report)** The Committee received the report, was pleased to note achievement of the VTE target, and continued improvement in the SHMI metric. The group had received an update in respect of the Patient Safety Incident Response Framework (PSIRF) with interest noted in respect of the new reporting structures. The group had considered the proposed CQUINS put forward locally and through specialised commissioning with a moderate level of assurance received that these would result in positive outcomes. The Committee received the National Confidential Enquiries report noting

	the outstanding actions, which had decreased over the course of quarter 4. There was assurance that divisions were better sighted on relevant actions.
	Assurance in respect of other areas: **Draft Quality Account** The Committee received the draft Quality Account noting the timescales for this to be finalised and published by the end of June. The Committee offered some feedback on the draft report, which would be considered in the production of the final report. It was noted that wider stakeholder engagement would be required as part of the process. The final report would be presented to the Committee in May. **CQC Action Plan** The Committee received the monthly update noting the movement of actions with some not yet closed as data was not sufficient to demonstrate achievement to enable these to be closed. The Committee noted that the Medicine Division were due to take responsibility for the Child Protection Information System (CP-IS) and sought assurance that this would be successful. It was noted that the appropriate support and resource was being requested and offered with the Committee due to receive an update from the Division at the May meeting. **Quarterly Quality Impact Assessments (QIA) Report** The Committee received the report noting that there was a more proactive approach being taken to QIA development, particularly focused on cost improvement and the integrated improvement plan. A full review of existing QIAs was being undertaken which should be completed by the end of April to determine those that were no longer required or required updating. The outcome of the review would be reported to the Committee in the next quarterly report. **Committee Performance Dashboard** The Committee received the report noting that the items had been covered through the reports to the Committee. There had been improvement seen in respect of NICE compliance and an ongoing area of focus continued to be postpartum haemorrhage greater than 2 litres. The Committee was also pleased to note that the Trust had reported the lowest ever levels of Summary Hospital-level Mortality Indicator (SHMI). **Industrial Action – Recommendation 2** The Committee received an update in respect of recommendation 2, critical incidents, of the industrial action plan, which had been presented

	to the Committee in March. It was noted that clarification had been provided and therefore the recommendation had now been signed off. The Committee noted that all actions had been addressed with the action plan now complete.
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	M	J	J	A	S	O	N	D	J	F	M	A
Chris Gibson Non-Executive Director	X	X	X	X	X	X	A	X	X	X	X	X
Sarah Dunnett Non-Executive Director (Maternity Safety Champion)	X	X	A	X								
Karen Dunderdale Director of Nursing	X	X	X	X	X	X	X	X	D	X	X	D
Simon Evans Chief Operating Officer	D	D	A	X	X	X	X					
Colin Farquharson Medical Director	X	X	X	X	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
Vicki Wells, Associate Non-Executive Director				X	A	X	X	X	X	X	X	X
Michelle Harris, Chief Operating Officer								A	X	X	X	X

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

NHS England
NHS England - Midlands
Regional Chief Nurse
Cardinal Square – 4th Floor
10 Nottingham Road
Derby
DE1 3QT
28 March 2023

Mr Paul Dunning
Medical Director
United Lincolnshire Hospitals NHS Trust
Lincoln County Hospital

Dear Mr Dunning,

NHS England IPC Visit 1st and 2nd February 2023

I would like to thank you for organising the review visit to the Trust on 1st and 2nd February 2023. The items and feedback outlined in the letter are confirmation of the feedback that was provided to you on the day of the visit. On the day of the visit, I was joined by Jane Finch Senior Health Protection Nurse, NHS Lincolnshire Integrated Care Board.

I would like to acknowledge the recent extreme pressures that you have had within the Trust over the Christmas and New Year period; you still had several wards with operating with the “your next patient” model, which included patients being cared for in ward areas that were not set up as patient areas. Understandably the staff were tired, but this did not stop them from providing compassionate care to our patients. Throughout the course of the visit we observed the care and kindness to patients, and to each other.

Following this visit myself and the ICB have reviewed the findings and agreed against the NHS England Midlands Infection Prevention and Control (IPC) Matrix; that the Trust are now categorised as enhanced monitoring and support, this is due to

- Ongoing regulatory breaches that were observed in waste management.
- Lack of progress on the agreed actions to improve sharps management.
- Increase in your HCAI rates against the trajectory as identified below.

HCAI data from December 2022 shows, 54 cases of *Clostridioides difficile* against a trajectory for the year of 56. The Trust has 15 cases of pseudomonas aeruginosa

bacteraemia against a trajectory of 13, breaching the annual threshold for this HCAI. The Trust are reporting 73 E. Coli bacteraemia against a trajectory of 107 for the year. The Trust is reporting 32 Klebsiella bacteraemia cases against an annual trajectory of 37. At the time of this letter, the UKHSA data shows 2 MRSA bacteraemia and 31 MSSA cases.

Overview of visit: The visit commenced with a Teams presentation and conversations with the Infection Prevention and Control Team and Matrons groups. The discussion with your team provided an update on the work that has been completed since the previous visit and the next actions that are in progress. The team was able to outline some key actions that they have taken and have articulated the difficulties that they have faced given the current capacity pressures, including:

- IPC everyone's business.
- Improvements in standards of cleaning and work provided by the Estates team.
- BBE challenge particularly amongst the doctors.
- Work being undertaken to promote the correct documentation regarding peripheral vascular lines and VIP scoring.

The visit took place over two days to ensure that the team were able to visit the three main hospital sites; , Lincoln County Hospital, Grantham and District Hospital and Boston Pilgrim Hospital. Each site followed the same structured process with two main areas chosen by the Trust and one area chosen by the visiting team as a quality control. The Trust choice included the ward which had recently had a Carbapenemase Producing Enterobacteriaceae (CPE) outbreak.

During the visit we were accompanied predominantly by Sandra Smirthwaite - Matron for IPC and Karen Bailey – Matron for Decontamination; various members of your multidisciplinary team joined us as appropriate, including the Deputy Director of IPC and the Microbiologist; Matrons and ward leaders for each of the areas that were visited. Detailed feedback was provided to each area immediately where good practice and areas of improvements were identified. The IPC team were taking full action notes to ensure that all actions were captured and enacted.

I would like to pass my thanks to the teams in these areas who, despite the significant pressures they have been under due to capacity and flow within the organisation, were able to show us around their areas and were open to the feedback was provided, addressing some of the actions that were identified immediately. At the end of the visit Trust level feedback was provided to yourself and members of your team.

The Document review will be provided as a separate document.

Key areas of good practice:

Significant improvement in urinary catheter care was evidenced in the clinical areas visited through the use of the urinary catheter pathway. The team were able to describe the actions that they have taken to achieve these improvements in urinary catheter insertion and care, it would be useful to capture this as a process and

explore if this work can be used to support improvement in other pathways. Documentation was reviewed in each of the clinical areas visited, it was identified that all patients with a urinary catheter had a documented reason for insertion and the insertion procedure details and ongoing care was completed in line with your organisational processes. There was excellent documentation related to urinary catheter care noted in all areas.

Improvements were observed in relation to cleanliness, with all wards and departments clean, dust free and tidy. There were improvements witnessed with storage facilities, to minimise clutter in areas and support the teams to maintain high levels of cleanliness. The team explained that where an area drops below a Four-Star rating there is an action plan put into place to support improvements and a reaudit is completed within the month. All appropriate documentation relating to cleaning is in place and available to review. Housekeeping rooms and trolleys are all fit for purpose.

There has been good progress made with the handwash basin replacement programme, this is an extensive piece of work and there is a long-term plan in place to support the completion of this work.

Throughout the course of the visit good IPC practices were witnessed and staff were observed to decontaminate their hands in line with the Your 5 Moments of Hand Hygiene. The team explained that work has commenced regarding the 'Gloves off' campaign, and good practices were observed in relation to this. The Trust have noted some issues with bare below the elbow, these were explained during the visit and had already been escalated to the regional Assistant DIPC for further discussion, the team were able to describe the actions that were being taken to resolve these issues.

The Decontamination Matron has grown into the role and has developed a good relationship with the IPC team, Facilities team and the Estates departments. They are also the interface between Facilities and Estates, which has supported the coordination of works that have been required such as during the CPE outbreak. The role has evolved through her appropriate training, it would be worth considering evaluating this role and sharing as good practice for other organisations to consider.

All the clinical equipment that was spot checked across the areas visited was seen to be visually clean and ready for use. Cleaning wipes were readily available for use to support staff to maintain standards.

The Facilities Department explained that they were over appointing to housekeeper roles due to the high turnover they were experiencing, this has ensured there are always staff who are trained and available within the organisation. The team explained that 60 staff have undertaken their NVQ training with the local college with rolling programme continuing. A discussion was had regarding the significant value of staff development, and it was reported that there are a number of housekeeping staff who have stepped into care roles following the training, this identifies another career development pathway within the organisation. There has been a cultural review with an external facilitator for the housekeepers, the report is currently

awaited. We were advised that funding has been agreed for leave etc at 21% of budget over establishment, this will support the teams to continue to deliver standards of cleanliness across the organisation.

Water Safety, Ventilation and Decontamination Groups are now embedded into the governance process, reporting to the IPC Group, this was also evidenced through the documentation provided.

Trust wide themes requiring action:

Waste management: The breach of the Waste Regulations that were identified from the February and April 2022 visits remain on this visit. These issues require urgent attention, it may require addressing through the contract process. The large waste storage containers were stored inappropriately unsecured adjacence to Bostonian Ward at the Pilgrim Hospital which has public access, a secure area is required in line with the waste regulations. There were five waste storage containers which were unlocked and containing clinical waste and one storage container which contained full sharps bins but did not have a working locking mechanism. All of the clinical waste storage containers and domestic waste storage containers were found to be dirty and unlocked. Waste storage containers should be on a regular cleaning programme, the details should be included within your contract with your waste provider and monitored as part of your contract management processes. Both these issues are a continuing theme from previous visits.

Sharps Safety As identified on both previous and this visit there continues to be non-compliance to regulatory requirements in relation to sharps management. It was confirmed that training and audit are required, and the Trust are aware of this with actions on the action plan however, I recommend that this should be reviewed, and actions expedited with the company and the IPC team to address this. Following discussion with yourselves, I am aware that you have sharps audit programme led by the company which you are wanting to repeat on an annual basis. This has not yet been booked for 2023.

There was a medical student in the ED who did not take a sharps bin to point of use as there were no small sharps bins available, so they used a tray for all the waste they had generated, this waste was observed mixed within the tray. It is noted that this was dealt with compassionately at time with a good response from the student. Following discussion, it was confirmed that the cannulation/ blood trolley should have been taken to the patient however, the medical student was not aware of this practice. On reflection with the team in the department, this was acknowledged and confirmed that this should be covered within the induction process for the area. I would recommend that area inductions are reviewed and ensure these differences in practice are in place as required especially in all areas where the local practice is different to the Trust policy. It would be worth considering including this difference in practice within the Trust sharps policy to support awareness and understanding. A sharps bin was in use, but the lid was not sealed, and the label was unsigned (EAU

Grantham) and some sharps bins were being used as storage containers rather than as sharps bins, these were located within a store room.

The Trust had completed a piece of work to replace drip stands, these were purchased as colour coded stands for different departments; however, these are already chipped, scratched and pealing making cleaning difficult. This appears to be damage from the pumps being clamped in place. Work is required with procurement to identify a stainless-steel drip stand which can have various pumps attached without causing damaged. I would suggest the current stands are blocked from the ordering system or a process is in place to repair the versions that are in use.

Intravenous cannula insertion and Visual Infusion Phlebitis (VIP) scoring was not completed in line with your organisational policy. Documentation was reviewed across all areas visited, which identified that insertion records were not completed when patients were cannulated outside of ward areas, such as when cannula are inserted in the emergency department, endoscopy, theatres and the delivery suite. The VIP scoring was observed to be completed with a tick and not documented as a score; this does not allow for accurate monitoring of the VIP scoring. There were cannula that were observed to have been in place for greater than five days, documentation for these was not completed. On discussion it was identified that the audit process focuses on ward areas and not the full patient pathway, I would recommend reviewing the auditing process to cover the full patient pathway to support those areas where the documentation was not being completed. I would also recommend reviewing the process and learning identified through the work that has been completed on the urinary catheter pathway as this appears to have been successful. Following discussion, I am aware that you have commenced enhanced divisional work regarding the MRSA bacteraemia which is being monitored through the IPCG.

During the visit we checked nine mattresses across all sites identifying five of these were contaminated. One of the mattresses was visually contaminated on the external surface despite the bedspace cleaning checklists being completed, this was dealt with by the ward manager while we were on the ward. Additionally, there were four mattresses with strike through, two of these were trolley mattresses in the ED. A process of regular checking is required particularly for those mattresses that are moved between departments. Good ownership of mattresses and beds is required with the support of the audit process.

Dental Department across sites: multi-patient use products were found in use as per product box (etching and glue) this needs further investigating along with an SOP of how to use to prevent contamination. Dental moulds cleaning fluid was found not locked not away as per COSHH regulations despite the facility to lock these away being available. There needs to be clear lines of departmental leadership across all small departments with an understanding of their role and responsibility.

On the maternity unit we observed shared baby clothes which were being stored in the sluice prior to being laundered off site and then loaned to different babies, it was noted that these were new clothes that have been donated to the unit but are then reused after laundering. This process requires a review and risk assessment.

Key themes where improvement has been identified and work needs to continue:

A number of sluice/ dirty utility rooms have open racking for storage. I note that this now only contains appropriate items; however, it is recommended that this continues to be monitored to prevent inappropriate items being moved back into the area.

There has been a significant amount of estates work across the organisation particularly in patient facing areas. However, there remains a backlog maintenance, which you have reported is approximately £80 million. I would recommend a wall survey to be completed to identify where there are areas that walls are not intact, as it is recognised that areas of wall which are not intact impacts the ability to clean. I would also recommend a review of all outstanding estates actions to ensure cohesive working between estates, IPC and health and safety to address the highest risk items and develop a joint risk assessment matrix to support the prioritisation.

The Governance processes around IPC have improved, the following areas of feedback are noted:

- The correct name of the group or committee needs to be used consistently for formal meetings; the use of group or committee seem to be used incorrectly.
- Papers need to provide assurance (verified evidence) not reassurance, to the DIPC and Board. Mitigations and actions require clear documentation with dates for completion, dates of update, completed date and who is the leading the action to demonstrate pace and who is responsible for the actual action.
- IPCG reports to Quality Committee appear to have a cycle of subject information; I recommend that the risks identified and agreed at IPCG are escalated to the next Quality Committee. I understand that you have risk as an agenda item on the IPCG meetings, however from the discussion I was advised that only new risks are escalated to the Quality Governance Committee. I would recommend that a paper covering all IPC risks continues to go to each Quality Governance Meeting, so the Board are sighted on the current position.
- I recommend continued monitoring/review due to the infancy or changes to the sub-groups of IPCG; which include the Ventilation Group, Water Safety Group and Decontamination Group with membership from IPC and Microbiology.

Improvements were identified in the Facilities and Estates department which included a change to the authorising engineer contract and funding of courses for internal staff with an external specialist providing validation. The help desk team now includes a data analyst who monitors and supports the management of the PPM recovery plan. There remains a staffing risk with Lincoln County Hospital where there have been several promotions leaving vacancies that are difficult to fill due to the pay

grades compared to the private sector. As a mitigation an external contract is currently in place rather than agency staff.

Water Safety services have come back in house which has made it easier to maintain standards. The water safety plan is overdue but remains in place while the new one is developed, SOPs and documentation in place. The Authorising Engineer is engaged, and audits were completed in November 2022 with action plan in place. Majority of dead legs removed, and basins & taps replaced last year except for areas where decants were delayed, plans in place for completing this work. New flushing posters have been launched across the Trust but only one was observed during on the visit, it is recommended that the roll out of these posters is reviewed to ensure that they are accessible across the organisation.

The team advised that the Theatres ventilation upgrade has been agreed at Board for £2.5 million and the capital plan for 2023/24 is in place. There is an Authorising Engineer for Endoscopy currently in place, but the contract ends in June 2023 and the Trust are tendering currently. However, there is no Authorising Engineer for all other decontamination, so this is being reviewed to potentially bring these two roles together.

The Trust reported that there is 24/7 cleaning teams in place with a deep clean team working till 9pm daily.

Next steps

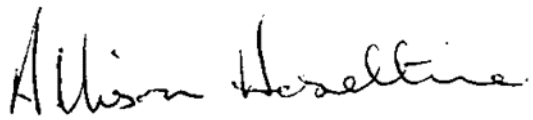
Following this visit and the issues that have been identified on multiple visits with no improvement, including regulatory requirements as outlined above the Trust will be categorised in enhanced monitoring and support this will enable us to focus resources to support the Trust with the improvement activities.

- As discussed during the visit a meeting with both you and Kirsty Morgan to go through the DIPC Development session has been arranged for 01 March 2023.
- I had intended to arrange a 1:1 meeting with Natalie before the end of March 2023, however this was not possible, I have requested that Kirsty Morgan arranges a 1:1 with Natalie.
- I would like to propose a follow up visit in approximately 6 months' time, date to be confirmed; ideally this visit will be completed in conjunction with ICB colleagues.
- We have previously recommended the delivery of a roles and responsibilities masterclass, which can be delivered on teams at one of your matrons' or equivalent managers meetings. We can deliver this session if this would be useful.
- I advise that there is a review of the existing action plan to ensure that the planned actions address the concerns that have been identified and are still relevant with actions are made more immediate; I would also like to offer Kirsty Morgan's support to review this action plan.

Please use this to continue to develop your IPC action plan around the “Hygiene Code” to address the concerns identified. This should work alongside your action/improvement plan and not as a separate action plan from the visit.

Finally, please share this report with your Trust Board and confirm by email to Kirsty Morgan, that this has been completed.

Yours sincerely



Allison Heseltine

Assistant Director of Nursing – NHS Midlands

Nina Morgan – Regional Chief Nurse – NHSE Midlands
Kirsty Moran – Assistant Director of IPC – NHS Midlands
Mel Mcfeeters – Deputy Director of Nursing, NHSE – Midlands
Oli Newbold – Director of S&T – NHS Midlands
Jane Finch - Senior Health Protection Nurse, NHS Lincolnshire Integrated Care Board.

United Lincolnshire Hospitals NHS Trust

Quality & Leadership

Our Improvement Journey at ULHT Maternity

Libby Grooby – Head Of Midwifery

Emma Upjohn – Deputy Head of Midwifery

ULHT Maternity Timeline

NHS
United Lincolnshire Hospitals
NHS Trust

Oct 2019

CareQuality Commission

Overall - Requires Improvement

	LCH	PHB
Safe	●	●
Effective	●	●
Caring	●	●
Responsive	●	●
Well-led	●	●

Dec 2020

Maternity Services Support Programme Commenced

Mar 2021

Maternity & Neonatal Oversight Group Established

Jun 2021

Maternity Incentive Scheme Year 3

Compliance declared with all 10 Safety Actions

Jul 2021

Staff Engagement Sessions with Director of Nursing

Dec 2021

Ockenden Submission

90% of actions successfully evidenced

Jan 2022

Midwifery Preceptorship & Retention Team Launched

Feb 2022

CareQuality Commission

Overall - Good

	LCH	PHB
Safe	●	●
Effective	●	●
Caring	●	●
Responsive	●	●
Well-led	●	●

2022

MIS Year 3 Monies reinvested to

- Band 7 Patient Safety Midwives Team
- Band 7 Mental Health Specialist Midwife
- Band 6 Antenatal and Newborn Screening Midwife
- Band 7 & 6 Infant Feeding Specialist Midwives
- Band 7 Multiples & PTB Midwife

Feb 2022

BFI Stage 2 Accreditation Achieved

Mar 2022

Saving Babies Lives v2

All elements fully implemented

April 2022

Workplace Innovation

Culture Change Programme Started

Jun 2022

Ockenden Insight Visit

Oct 2022

Maternity Services Support Programme Exited

Q4 2022

Perinatal Institute

Top 10 Trusts SGA Detection

Feb 2023

Maternity Incentive Scheme Year 4

Compliance declared with all 10 Safety Actions

2022

ICB Funded

- Band 7 Fetal Monitoring Midwife
- Band 7 Preceptorship Midwifery Team
- Band 7 Tobacco Dependency Midwife
- Band 3 x2 Tobacco Dependency Advisors

Leadership

Working with Trust Board

- Changing the dynamic
- Reinvesting CNST monies in Maternity in Specialists
- Establishing Maternity & Neonatal Oversight Group

Working with Staff

- Regular SLT engagement sessions with all maternity staff
- In depth staff consultation with Director of Nursing in July 2021
- Visibility of senior staff including Triumvirate on wards

Working with leaders

- Engaged Workplace Innovation to support culture change
- Emotional Intelligence training for all Band 7 and 8 midwives
- Developing a culture of continuous improvement all staff can be involved in

Quality & Improvement

Aim: Creating a culture of continuous staff-led improvement

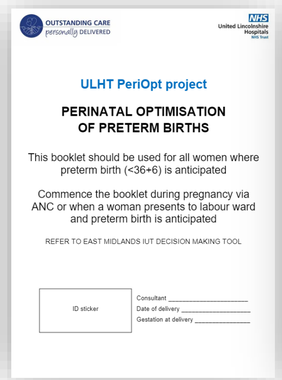
QI Training

- Interested staff can undertake Accredited QSIR Practitioner training
- All preceptorship midwives complete Improvement Fundamentals in a Day
- Working with other Trust teams on QIPs e.g. Communications, Improvement Academy, Digital, Data Analysts, Blood Transfusion and Pharmacy

Quality & Improvement

Working with External Agencies

- Lincolnshire LMNS / Better Births Team
- EMAHSN
  - Funding for Twins Trust Maternity Engagement Project
- Regional Perinatal Networks / Task & Finish Groups
  - Postpartum Haemorrhage – ULHT have adopted Obs Cymru guidance
  - Preterm Optimisation & Stabilisation – PeriOpt Booklet
  - Clinical escalation - iNeed


OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

ULHT PeriOpt project

PERINATAL OPTIMISATION OF PRETERM BIRTHS

This booklet should be used for all women where preterm birth (<36+6) is anticipated

Commence the booklet during pregnancy via ANC or when a woman presents to labour ward and preterm birth is anticipated

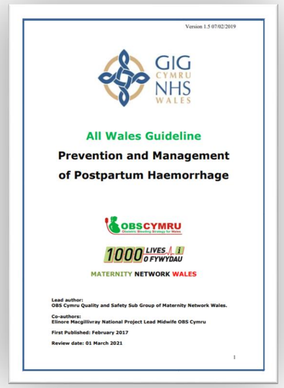
REFER TO EAST MIDLANDS IUT DECISION MAKING TOOL

ID sticker

Consultant _____

Date of delivery _____

Gestation at delivery _____


Version 1.5 07/02/2019

GIG CYMRU NHS WALES

All Wales Guideline

Prevention and Management of Postpartum Haemorrhage

OBSCYMRU

1000 LIVES A FYWYDAU

MATERNITY NETWORK WALES

Lead author:
OBS Cymru Quality and Safety Sub Group of Maternity Network Wales.

Co-authors:
Elinore Margillivray National Project Lead Midwife OBS Cymru

First Published: February 2017

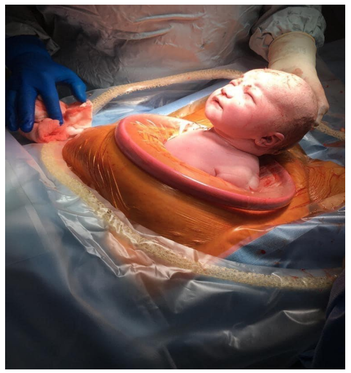
Review date: 01 March 2021

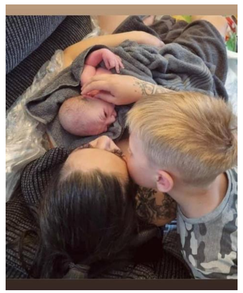
What next……

- Continue to work together as a system, collaborative working to support a safe service that meets the needs of our women

- Continue journey of improvement – striving to achieve excellence

- Staff engagement and support





United Lincolnshire Hospitals NHS Trust

Maternity & Neonatal Safety Assurance Report

Libby Grooby, Divisional Head of Midwifery

As at 20 March 2023

Maternity & Neonatal Safety Assurance Report – Key Highlights

Trust: United Lincolnshire Hospitals NHS Trust **Date:** As at 20 March 2023 (February data)

Executive Summary:

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

Outliers: Red Flags

KPI	National Rate	Trust Rate	Comments / Actions Being Taken
Maternity			
Smoking at time of delivery	<9.6%	12.27%↓	In house team appointed and now in post NRT now in use by the team Support staff recruited to
PPH ≥ 2L	<1.30%	2.15%↓	Improvement in month New guideline launched. Need to continue to monitor Maybe associated with the weighing of blood loss
PROMPT Training	>90%	88.74%↓	Drop off in month. CNST standard reached. All staff allocated onto training. Normal fluctuation, increased activity in month pulled staff from training although PROMPT is prioritised
3rd and 4th degree tears		3.37%	First month red Suggest deep dive for next MNOG
No of PN admissions up to 42 days		3.68%	See deep dive
Sickness		6.44%	Second month red, driven by increased short and long term sickness, spike in COVID Managed appropriately
Neonates			
Sickness - Neonates	Trust rate 4%	LCH 1.9%↑ PHB 10.7%↓	Registered / Unregistered - all being managed but has been escalated to PRM
Hypo-thermia	0	LCH 2↓ PHB 3↑	Relaunched warm bundle One BBA
QIS	70%	57%↓ LCH 72%↓ PHB	Clear trajectory and robust education programme and all new staff attend the network foundation programme for pre QIS training.

‘Deep Dives’

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

- Postnatal readmissions noted to be variable month on month with several months flagging red on the dashboard. Therefore a piece of work was undertaken to understand if there were any themes/trends, and so actions that could be taken to reduce.

PN readmission reports 22.docx

- The Team recently attended the Regional Ockenden event to present our improvement journey; this was a successful event **(see agenda)**

Learning Lessons

Overview for the reporting period:

As at 1 March 2023, there were 118 (108 last report) open incidents for Obstetrics & Community Midwifery, 42 (44 last report) of which are overdue.

There were 14 (9 last report) open incidents in Neonates, 2 (1 last report) of which is overdue.

As at 1 March 2023, there was one (303051) Serious Incidents (SI) open in Obstetrics and none in Neonates.

4 open cases being investigated by HSIB - IDs 288645, 295891, 296364 and 294094 with 279214 being overdue (final report now received- awaiting sign off from SIRG).

There were 2 closed SIs for Obstetrics –273369 and 285078 but none for Neonates and no closed HSIB cases.

ULHT SI Update – see below

Maternity Neonatal Safety Assurance Rep

SPC Charts to demonstrate data relating to Datix and SI actions

August 2022- March 2023 FH data.xlsx

SPC Chart for MNOG March 2023.xlsm

Specific Requirements	Number	Details	Learning / Actions Taken
Number of incidents graded as moderate or above (reported February 2023)	1 – Obstetrics 0 - Neonates	**1. 306484 -** Bulgarian lady who speaks no English, Induction of labour for OC with propess, progressed in labour to 5cm and Pathological CTG at 01:31 Cat 2 LSCS called. (To ground floor theatre as LW theatre closed for CS) History of Gastroschisis at birth herself so Consultant Obstetrician aware and present for surgery under GA and surgical team also present but left after birth. On preparing to close uterus a large longitudinal laceration of approx 8 cm on small intestine. Surgical team recalled, resection of lacerated bowel and resuturing. Remained in recovery for pain relief and observation and returned to LW at 08:10.	1. Taken to SI panel to discuss- previous history impacted on outcome/extended surgery. Review when in labour from surgical team held. Missed opportunity for MDT during pregnancy to plan care if LSCS required. Previous normal births x 2.
Other Incidents considered at SI / Rapid Review Panel **(November 2022)**	0 – Obstetrics 0- Neonates	1. **294754-** Downgrade from DI requested as patient issues now resolved. No ongoing bladder concerns. Actions added to Datix to ensure learning and actions completed.	
Serious Incidents - New	1 - Obstetrics 0 – Neonates	**1. 305131 (HSIB) -**38+4/40 Induction of labour. GDM diet alone. Last USS shows tailing growth. Propess inserted. 8pm Normal CTG. 10pm and 12pm- Reported pain -attempt to auscultate FH. Dr's called- CAT 1 LSCS- called for fetal bradycardia. Baby born with no signs of life.	MDT held 15.3.2023. HSIB investigation in process. Family meeting with HOM 10.3.2023.
Serious Incidents – Closed (February 2023)	2 – Obstetrics 0 – Neonates	1. **273369** - IOL - PIH, NVD live male, born in poor condition, neonatal team called and performed resuscitation, intubation and transfer to NNU. 2. **285078** - Patient day 1 post cat 1 LSCS. Drain insitu. Attempted to remove drain by 2 different midwives but unsuccessful, lots of resistance. Removal attempt by Reg on call - drain tubing snapped during traction leaving partial amount of tubing in abdomen. Nil visible at incision site.	1. HSIB report action plan ongoing. 2. Down grade requested and approved by ICB.

HSIB Investigations	4 current	1. **279214** – Awaiting sign off from SIRG. 2. **288645** – Report received. Action plan made. Family meeting offered. 3. **295891** – Draft Report received – 2 safety recommendations. MDT action plan review to be held. 4. **295364** – Draft Report Received. No recommendations. Final MDT to be held. 5. **294094-** Interviews completed awaiting draft report.	
Key themes & trends Identified from the above incidents and any additional actions being taken		1. **Placentas and histology.** 2. **Electronic fetal monitoring** 3. **Communication** 4. **Escalation** 5. **Clinical Assessment**	
Number of overdue actions from incidents / SIs / HSIB and actions being taken		As at 1 March 2023, in Obstetrics, there were 95 (106 last month) ongoing actions – 44 of these are overdue. In Neonates there were no outstanding actions. Weekly action plan meetings continue- teams/leads to identify any actions that may require support/resources or date extensions if unachievable.	

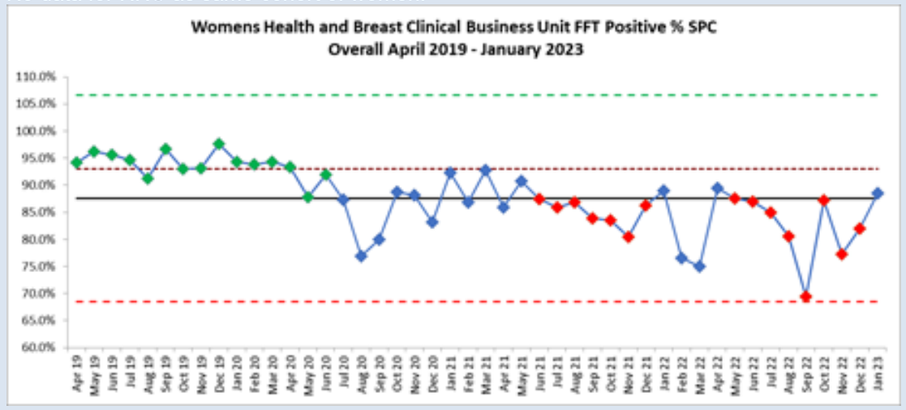
Service User Voice Feedback

Brief overview for the reporting period:

As at 1 March 2023, there were 11 open complaints in Obstetrics & Community Midwifery - L35010, P35499, L34516, P35859, P33675, P35825, P36171, L35148, L35814, L35854 and L34054, 3 of which are overdue. There are 0 open complaints in Neonates.

There were no PALS concerns received in Obstetrics or Neonates in and no open PALS contacts.

MVP have completed the 15 steps on Pilgrim site and partially on Lincoln site – formal feedback awaited.
Ockenden insight visit June 20/21st will provide further feedback.

Specific Requirements	Number	Details	Learning / Actions Taken
Number of complaints received in February	4 – Obstetrics 0 - Neonates	1. P35859 2. P35825 3. L35854 4. L35814	
Number of PALS received in February	0 – Obstetrics 0 - Neonates		
Number of compliments* ***Information taken from SUPERB (Single Unified Patient Experience Reporting Board)***	4 – Obstetrics 20 – Neonates	4 for Maternity PHB 20 for Neonates PHB	
Feedback received by Maternity & Neonatal Voices Partnerships		Initial feedback on the 15 steps was positive on both sites. Areas for improvement are around our notice boards and our inclusivity.	
Key themes & trends identified from the above activity and any additional actions being taken		• **Appointments –** This has been identified in 36% of our complaints. Unable to have clear actions until a piece of work has been undertaken to understand the detail behind why appointments is a theme. This piece of work is being undertaken. • **Communication –** This has not been highlighted in our complaints for the last 3 months. This is a positive improvement but will need monitoring to ensure sustainability.	
Number of overdue actions from complaints / PALS and actions being taken		As at 1 March, there were 2 open Obstetric complaint actions, both overdue. There are 0 open Neonatal complaint actions.	
Friends and Family Test		The highlight report for January 2023 shows a National average recommended rate of 93%, a Trust average of 90% and Maternity have achieved 97%. No data for NNU as same cohort of women.  We see a consistently low number of negative stories from the ‘Care Opinion’ ranging from 0-1 a month. However there is inconsistency in the positive stories ranging from 2 – 25 a month	

Staff Experience & Feedback

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

- Please also refer to the separate report from the Maternity NED 'Safety Champion.
- HoM team discussions have started on both sites monthly. This is on the back of the need to improve staff experience. Reassuring that issues raised are well known and these are

  Staffing in periods of high acuity
  Medway

  Plans in place to try ways of improving both.

Other in month Developments & Updates

For March

- Findings from SQAS - SQAS has completed its annual quality review and they are not planning to undertake a specific QA for our screening service. There will just be the planned walk through of our governance for our screening programmes.
- Birth Choice Clinic – Quarter 4 Report

  q4 2022 bcc report.docx

- Inequities Update Report

  Highlight report Jan 23.docx

- Quarterly PMRT Report for October to December 2022

  Quaterly report October-December 2(

- Single delivery plan and an updated Core Competency Framework is due to be released 30th March. The expectation was that this would condense Ockenden, Kirkup, NHS long term plan and Maternity transformation plans into a single plan. Early intelligence is that this is probably not the case. The SDP encompasses 4 elements in line with Kirkup:

  Listening and working with families with compassion
  Growing, retaining and supporting our workforce
  Developing a culture of safety and support
  Standards and structures that underpin safer, more personalised and more equitable care

  We are unsure of the level of guidance that will accompany this. Core competency Framework will be reviewed on release to ensure we include recommendations in our TNA. Consideration will need to be given to discussing increasing the uplift for midwives in line with the recommendations.

- Exciting developments are being made to the dashboard which will be shared in full at the next MNOG meeting.
- Safeguarding being considered as an important area that needs discussion at MNOG
- SBLv2 – assurance asks from region have increased. This is challenging to manage due to the time consuming audits that need to be completed.
- Theatre 8 is now back in use on the Pilgrim site but still requires some remedial work. 2nd theatre has been decommissioned and re provided in ground floor theatre. This has identified risks and a risk assessment has been completed.
- Issues with labour ward ventilation and the use of gas and air have been raised as a national issue. ULHT have undertaken an initial assessment of the situation and the results are variable. Therefore, further tests are being completed. In the meantime NHS guidance is being followed and a risk assessment has been completed. A guideline is also in process to support gas and air usage.

Update from Neonates –

- Workforce – recruitment continues on both sites, however recent applicants for PHB all overseas nurses requiring sponsorship. Total registered nurse vacancies at LCH = 3.76wte and 2.0wte at PHB.
- Trajectory for discontinuation of agency use – May 2023 whereby all new starters will be in post and supernumerary period ends.
- Attending recruitment open day to promote service and welcome applications from NQN
- Trajectory for ANNP cover completed – full complement of ANNPs, 6.0wte to provide full tier one cover by January 2025. Scoping the role of the ANNP to cover clinics in addition to tier one rota. This will provide a competitive advantage to promote the role within ULHT, aiding recruitment and retention.
- AHP workforce – recent Ockenden funding for AHP cover has proved successful. Physio to commence in post 20.3.23, 0.4wte across both sites. Clinical Psychologist appointed and awaiting start date. The post will be 0.5wte across both sites. Dietician 0.4wte across both sites – interviews taking place 5.4.23. Continuing to build a case of need for additional AHP hours.
- Data Clerk – sadly leaving at the end of March 2023. Role to be reviewed to focus on NNAP data collection and analysis. This role is pivotal to the service as NNAP data will drive the governance agenda to improve patient outcomes.
- Further funding bids through the Network to provide 0.6wte PDN and 0.4wte Risk Lead in process. This funding is provided as part of the tranche LTP in relation to the NCCR.
- Bronze Ward Accreditation received for LCH. Application for PHB in process.
- Peer Review final report has been received into the Trust. Action plan with measurable timescales to be developed to ensure compliance with recommendations made.
- NNAP data currently under review. Focus to be on improving outcomes as audit measures have changed identifying some shortfalls. Consultant and Matron working together to identify strategic measures to ensure compliance and continued improvement.
- BFI Lead post paused due to ICB recruitment freeze. Work to continue using link nurse roles more efficiently. Awaiting confirmation of authorisation to recruit from ICB.
- iNeed project - implementation in process. Roll out May 2023.
- NEWTT2 – approved by APPG – roll out May 2023.

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

Escalations from Maternity & Neonatal Safety Collaborative

- Continuing issues with connectivity in the community, which will not be helped by 4G sims in some areas. As a result, the service has been removed from Holbeach Children's Centre which is contrary to the family hub ideal.
- New national tool to encompass Ockenden, SBL etc.
- The work undertaken in the last 2 years through this meeting and MNOG has been phenomenal and the safety improvements put in place across ULHT has been amazing, resulting in low stillbirth rates, reduced numbers of babies going for cooling etc. However, it is acknowledged that there is still a lot of work to do with our teams to ensure they are happier at work in order to maintain this progress. There will be a focus on this in the next 6 months.

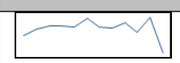
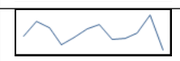
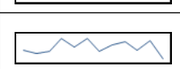
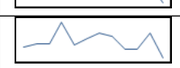
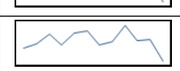
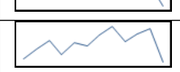
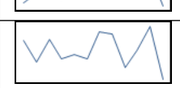
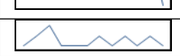
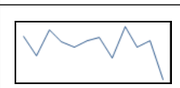
Appendix A

ULHT Maternity & Neonatal Quality Dashboard 2022/23

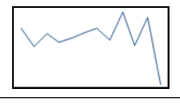
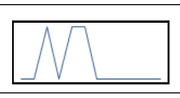
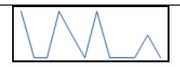
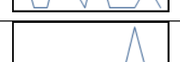
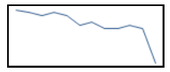
Activity Indicators ULHT																				
Metric	Threshold R	Threshold A	Threshold G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Total Number of bookings benchmarked to 5200				Careflow Maternity (CM)		487	522	474	468	482	428	427	486	436	486	461		5157		
Women booked by 9+6 weeks	<67.50%		>67.50%	CM/HES Data 2021		70.64%	67.24%	68.78%	68.16%	72.82%	73.36%	71.43%	71.81%	71.79%	67.90%	73.97%				
Women booked onto Continuity Pathway	<22%		>22%	CM/ULHT default plan		22.59%	20.69%	25.74%	19.44%	19.29%	24.53%	21.31%	25.31%	18.58%	24.69%	20.39%				
BMI >25 at Booking				CM/PHE 2018		53.18%	56.51%	55.06%	55.98%	56.22%	53.04%	53.63%	57.41%	55.50%	58.44%	55.97%				
BMI >35 at Booking				CM/PHE 2018		12.94%	13.22%	13.50%	13.68%	12.45%	11.68%	11.94%	13.37%	13.76%	15.64%	13.88%				
BMI >40 at Booking				CM/PHE 2018		5.95%	4.79%	5.27%	3.63%	5.19%	5.14%	4.68%	5.56%	5.50%	4.53%	4.77%				
Total number of Births				CM		367	363	362	393	385	384	405	389	377	386	333		4144		
Total Number of Live Births				CM		365	363	362	391	384	384	404	389	377	384	332		4135		
Unassisted Vaginal Birth Rate	<57%		>57%	CM/HES Data 2020		54.22%	55.65%	51.10%	50.38%	54.55%	51.04%	53.83%	52.70%	50.13%	54.15%	58.26%				
Home Birth Rate	<2.40%		>2.40%	CM/ONS 2020		1.09%	2.48%	2.76%	1.02%	1.30%	2.60%	2.22%	0.77%	2.92%	1.55%	1.20%				
Forceps and Ventouse	>12%		<12%	CM/HES Data 2020		10.08%	10.74%	9.67%	11.20%	9.09%	9.90%	7.90%	10.28%	11.14%	7.51%	7.21%				
Total Caesarean Section Rate				CM		34.88%	31.96%	38.40%	37.40%	35.58%	38.02%	37.04%	35.99%	38.20%	37.05%	32.73%				
Emergency Caesarean Section				CM		21.80%	20.11%	23.20%	20.36%	23.64%	21.09%	20.99%	21.34%	27.59%	23.83%	20.12%				
Elective Caesarean Section				CM		13.08%	11.85%	15.19%	17.05%	11.95%	16.93%	16.05%	14.65%	10.61%	13.21%	12.61%				
Women booked on Continuity Pathway received care in labour/birth by continuity Team	<70%		>70%	CM/NHSIE		40.00%	23.08%	34.04%	10.59%	29.41%	32.84%	34.07%	21.62%	21.69%	38.27%	20.00%				
Induction of Labour Rate	>40%		<40%	CM/HES Data 2021		38.46%	41.46%	38.76%	36.69%	36.13%	41.16%	33.75%	39.06%	41.71%	38.32%	39.88%				
Smoking at Booking				CM/MSDS 2021		13.76%	14.94%	18.99%	15.81%	13.07%	14.72%	13.58%	16.26%	12.16%	15.43%	12.36%				

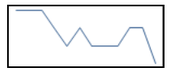
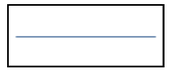
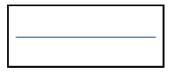
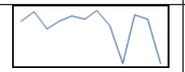
Smoking at the time of Delivery	>9.6%		<9.6%	CM/NHSD 2021		14.29%	11.48%	14.89%	17.31%	14.40%	16.36%	15.25%	13.28%	17.91%	14.96%	12.27%			
GDM at delivery				CM		13.74%	14.29%	13.48%	17.05%	21.73%	13.98%	19.25%	20.83%	18.45%	19.69%	13.80%			

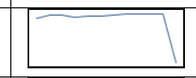
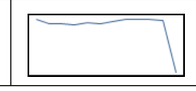
Maternal Morbidity Indicators ULHT

Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
PPH ≥1.0 litre	>8.60%		<8.60%	CM/Obs CYMRU		7.42%	10.08%	11.52%	11.37%	10.99%	14.78%	11.25%	10.42%	12.83%	8.92%	15.34%				
PPH ≥1.0 litre SVB	>4.90%		<4.90%	CM/Obs CYMRU		1.92%	3.92%	3.09%	0.78%	1.83%	2.90%	3.50%	1.56%	1.60%	2.36%	4.91%				
PPH ≥1.0 litre Instrumental	>18.40%		<18.40%	CM/Obs CYMRU		1.37%	0.84%	1.12%	3.10%	1.83%	3.17%	1.25%	2.08%	2.67%	1.31%	2.76%				
PPH ≥ 1.0litre EL/LCS	>8.50%		<8.50%	CM/Obs CYMRU		1.37%	1.68%	1.69%	4.39%	1.57%	2.37%	3.00%	2.60%	1.07%	1.05%	3.07%				
PPH ≥ 1.0litre EM/LSCS	>19.80%		<19.80%	CM/Obs CYMRU		2.75%	3.64%	5.62%	3.36%	5.76%	6.33%	3.50%	4.17%	7.49%	4.20%	4.60%				
PPH ≥2.0 litre	>1.30%		<1.30%	CM/Obs CYMRU		0.27%	0.84%	1.40%	0.52%	1.31%	1.06%	1.75%	2.34%	1.34%	1.84%	2.15%				
3rd and 4th degree Tear	>3%		<3%	CM/OASI post-bundle stats		2.47%	1.12%	2.53%	1.29%	1.57%	1.32%	3.00%	2.86%	0.80%	1.84%	3.37%				
Admission to ITU	>1		0	Inpatient Matron		0	1	2	0	0	0	1	0	1	0	1		6		
No of PN Readmissions up to 42 days of birth	>3.40%		<3.40%	Self serve NMPA 2021		4.12%	2.24%	4.78%	3.62%	3.14%	3.69%	4.00%	2.08%	5.08%	3.15%	3.68%				

Neonatal Mortality & Morbidity Indicators ULHT

Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Unexpected Term admissions to the NICU (based on Term births)	>5%		<5%	NNU/NHSIE ATAIN project		6.90%	4.68%	6.34%	5.21%	5.73%	6.41%	6.90%	5.46%	9.01%	4.90%					Reports 1 month behind.
No. of babies transferred for therapeutic cooling	>1		0	NNU		0	0	1	0	1	1	0	0	0	0	0		3		
Pre-Term Birth 23+0-36+6 wks	>6%		<6%	CM/SBL		4.90%	5.79%	8.56%	7.12%	9.35%	5.47%	5.93%	5.91%	5.84%	9.59%	6.61%				
No. of Antenatal stillbirths	≥1			CM		2	0	0	2	1	0	2	0	0	0	1		8		
No. of Intrapartum stillbirths	≥1			CM		0	0	0	0	0	0	0	0	0	1	0		1		
Rolling stillbirth rate (12 months)	>3.8 per 1000		<3.8 per 1000	CM/ONS 2020		3.43	3.23	3.03	3.28	3.08	2.44	2.67	2.20	2.21	2.44	2.22				
No. of NND	≥1			CM and NNU		0	0	0	0	0	1	0	0	0	1	0		2		Sept - 21 day old baby transferred

																				from home to ED
Rolling NND rate (12 months)	> 2.2 per 1000		<2.2 per 1000	CM and NNU/ONS 2020		0.64	0.65	0.65	0.44	0.22	0.44	0.22	0.22	0.22	0.44	0.44				
AN Steroids Eligible / Full course Administered	<100%		100%	NNU		5/1	4/1	5/3	9/2	15/5	6/1	3/2	4/1	3/1	10/3	4/4				
AN Magnesium Sulphate Eligible / Administered	<100%		100%	NNU		2/2	0/0	2/2	3/3	2/2	1/1	0/0	1/1	1/1	4/2	1/1				
SGA detection rate	< 41.2%		>41.7%	ANC/SBL Perintatal Institute		57.14%	69.38%	46.00%	55.77%	63.24%	59.18%	71.43%	50.94%		64.71%	58.69%				

Workforce Indicators ULHT																				
Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Midwife to Birth Ratio (funded)	01:27		01:26			01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26				
Midwife to Birth Ratio (Actual)	01:27		01:26			01:25	01:25	01:25	01:27	01:26	01:26	01:28	01:26	01:26	01:26	01:23				
1-1 in labour	<99%		>99%	CM/CNST		100%	100%	100%	100%	100%	100%	99.47%	100%	100%	100%	100%				
Sickness Rate	>4.3%		<4.3%	Workforce Intelligence		4.10%	3.83%	4.73%	5.65%	5.72%	3.54%	4.66%	3.95%	4.24%	4.81%	6.44%				
Co-ordinator Supernumerary	<96%		>99%	Inpatient Matron/CNST		90.00%	96.50%	96.00%	92.23%	93.75%	95.00%	97.55%	99.70%	100%	100%	100%				
Prompt Training Compliance	<90%		≥90%	CE team/ CNST		83.31%	81.64%	68.55%	69.54%	65.22%	69.67%	76.97%	93.44%	92.87%	90.44%	88.74%				
Mandatory Training Compliance	<90%		≥90%	CE team/ CNST		92.31%	83.52%	84.15%	81.58%	86.04%	84.67%	87.88%	91.29%	90.91%	90.60%	88.72%				

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

		Trained	Possible	%
PROMPT	Lincoln MW	156	172	90.70
	Lincoln Drs	26	34	76.47
	Lincoln Anaes	18	20	90.00
	Lincoln HCSW/MSW	37	44	84.09
	LCH Prompt	237	270	**87.78**
	Bank Only MW (Trustwide)	18	21	**85.71**
	Pilgrim MW	85	94	90.43
	Pilgrim Drs	21	25	84.00
	Pilgrim Anaes	24	24	100.00
	Pilgrim HCSW/MSW	25	28	89.29

	PHB Prompt	155	171	**90.64**
	Trust Compliance Prompt	410	462	**88.74**

Recovery Training Compliance

	LCH		**PHB**	
	Number	%	Number	%
Nov 21	85/121	70%	66/75	88%
Oct 21	24/64 Increased number of staff needing training after this to include COCOs	37.5%	20/44	45%
March 22	52/110	47%	50/67	75%
June 22	65/110	59.09%	61/67	91.04%
Sept 22	73/111	65.7%	61/67	91.04%
Feb 23	92/130	70%	62/70	89%

Postnatal Indicators ULHT

Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Skin to Skin Contact at Birth	<80%		>80%	CM/HES 2021		78.90%	78.79%	75.41%	76.21%	80.47%	75.78%	83.17%	80.72%	82.49%	82.03%	78.92%				
Breastmilk at first feed	<68%		>68%	CM/HES 2021		61.64%	64.19%	66.02%	65.22%	64.58%	60.16%	70.30%	66.32%	68.70%	64.58%	65.96%				Jul, Sep & Oct updated Dec 22

Risk Management Indicators ULHT

Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
No. of unit closures	≥1		0	Inpatient Matron		2	1	3	2	2	2	1	0	1	1	1		16		
Number of incidents logged & graded as moderate or above				Risk (Datix)		3	1	3	0	0	3	3	2	1	2	1		19		
No. of SI's Maternity	≥1		0	Risk (Datix)		0	1	1	1	0	0	0	1	0	0	0		4		
No. of Never Events	≥1		0	Inpatient Matron		0	0	0	0	0	0	0	0	0	0	0		0		
No. of HSIB cases	≥1		0	Risk (Datix)		0	0	1	0	0	0	3	0	0	1	0		5		HSIB cases corrected Dec 22
PMRT commenced within CNST timeframe	<95%		≥95%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
PMRT completed within CNST timeframe	<50%		≥50%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				

Duty of Candour (verbal)	<100%		100%	Risk (Datix)		100.00%	100.00%	N/A	N/A	N/A	N/A	N/A	N/A	100.00%	N/A				Reports one month behind
Duty of Candour (Written)	<100%		100%	Risk (Datix)		100.00%	100.00%	N/A	N/A	N/A	100.00%	100.00%	N/A	100.00%	N/A				Reports one month behind
No of current coroners cases / inquests pending				Legal		0	0	0	0	0	0	0	0	0	0	0		0	
No of coroners Regulation 28 (prevention of future death reports) made direct to the trust)				Legal		0	0	0	0	0	0	0	0	0	0	0		0	
No of Formal Complaints				Complaints		1	1	1	4	1	1	3	0	1	3	4		20	

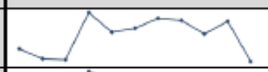
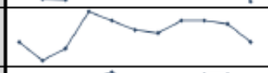
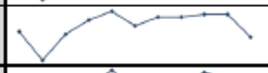
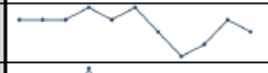
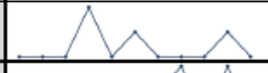
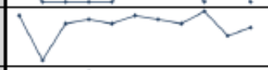
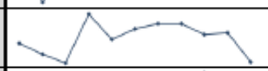
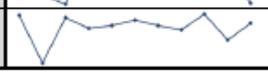
Perinatal Mortality Report – February 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	MBRRACE Notified	CNST Standards draft deadline date	DATIX Panel SI
PHB	SB	09/02/23	29+2	P1, low risk pregnancy, RFM 2/7, no FH on attendance.	86036	10/02/23	No current deadlines set	305776 Yes No
PHB	NND	04/02/23	18 days	Born by ELCS 37/40. Out of area visiting family, found by mum with no signs of life, unsuccessful resus attempts.	86035	10/02/23	No current deadlines set	A&E
LCH	Misc	12/02/23	20+5	P0+1, Prev 16/40 misc, GDM diagnosis 15/40, suture 16/40, 20/40 bulging membranes, APH so suture removed, spont birth.	N/A	N/A	N/A	306140 No No

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2022/2023

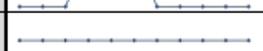
Lincoln County Hospital

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit	Live Births	2909	2925	2812	242.4	243.8	234.3	233.1	220	210	209	257	237	241	251	249	235	248	207		2564	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	345	326	371	28.8	27.2	30.9	30.3	27	21	25	37	34	31	30	34	34	33	27		333	
	No of First Episode Admissions	283	282	299	23.6	23.5	24.9	24.0	22	12	21	26	29	24	27	27	28	28	20		264	
	% of First Episode Admissions against Live Births			N/A			11%	10.2%	10.0%	5.7%	10.0%	10.1%	12.2%	10.0%	10.8%	10.8%	11.9%	11.3%	9.7%		N/A	
	No of Admissions to TC	152	202	220	12.7	16.8	18.3	19.0	16	18	17	14	12	18	23	27	18	25	21		209	
	All Ex-utero transfers	73	62	69	6.1	5.2	5.8	5.5	6	6	6	7	6	7	5	3	4	6	5		61	
	Ex-utero transfers <27 weeks	1	2	1	0.1	0.2	0.1	0.4	0	0	0	2	0	1	0	0	0	1	0		4	
	In-utero transfers	4	13	11	0.4	1.1	0.9	0.7	1	0	1	0	0	1	1	2	0	2	0		8	
	In-utero transfers <27 weeks	0	8	6	0.0	0.7	0.5	0.5	1	0	0	0	0	1	1	1	0	2	0		6	
	NNU Term Admissions	143	168	170	11.9	14.0	14.2	13.6	16	5	14	15	14	16	15	14	17	11	13		150	
	Live Term Births	2654	2725	2584	221	227	215	216	211	200	191	241	215	226	231	231	220	222	192		2380	
	% NNU Term Admissions (Live Term births) - Target <5%	N/A	N/A	N/A	5.4%	6.2%	6.5%	6.3%	7.6%	2.5%	7.3%	6.2%	6.5%	7.1%	6.5%	6.1%	7.7%	5.0%	6.8%		N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2022/2023

Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	68%	63%	69%	72.5%	70.9%	72.5%	58.9%	57.2%	81.3%	80.4%	62.2%	70.0%	81.1%	86.9%	76.2%		N/A	
		TC	N/A	N/A	N/A	83%	80%	45%	43.2%	38.8%	30.6%	48.3%	37.5%	40.3%	41.3%	44.0%	51.7%	44.8%	45.2%	52.7%		N/A	
		Total (NNU & TC)	N/A	N/A	N/A		67%	61%	63.9%	59.7%	57.9%	55.2%	50.4%	67.0%	66.8%	55.8%	63.6%	86.4%	72.4%	68.0%		N/A	
	Hypothermia on Admission - Ep.1 (<36.5◦c)	NNU	34	33	28	2.8	4.4	2.3	1.1	0	0	1	0	0	2	2	3	2	2	0		12	
		TC			15			1.3	2.1	0	3	0	1	1	3	6	1	1	5	2		23	
	(% of first episode admissions)	NNU %			N/A			0.1	4.2%	0.0%	0.0%	4.8%	0.0%	0.0%	8.3%	7.4%	11.1%	7.1%	7.1%	0.0%		N/A	
		TC %			N/A			0.1	10.5%	0.0%	16.6%	0.0%	7.1%	8.3%	16.7%	27.2%	3.7%	5.9%	20.0%	9.5%		N/A	
	Transferred for Therapeutic Cooling		5	0	4	0.4	0	0	0.2	0	0	0	0	1	1	0	0	0	0	0		2	
	HIE (all grades)		8	2	6	0.7	0.2	0.5	0.3	0	0	0	1	1	1	0	0	0	0	0		3	
	Neonatal Deaths (following admission to NNU)		0	1	1	0	0.1	0.1	0.0	0	0	0	0	0	0	0	0	0	0	0		0	
	Neonatal Deaths (delivery room)								0.1	0	0	0	0	0	0	0	0	0	1			1	
	Unit Closures (any)		0	2	0	0	0.2	0.0	0.0	0	0	0	0	0	0	0	0	0	0	0		0	
	No. of Exceptions		8	13	22	0.9	1.1	1.8	1.1	3	0	1	1	1	2	1	2	0	1	0		12	
	Medication Errors (moderate and above)															0	0		0	0			
	No of Serious Incidents (SI)		1	1	1	0.1	0.1	0.1	0.0	0	0	0	0	0	0	0	0	0	0	0		0	

United Lincolnshire Hospitals NHS
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Neonatal Quality and Safety Dashboard - 2022/2023

Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Staffing	Appraisals - % (Target 100%)	Registered and unregistered	N/A	N/A	N/A			86%	89.0%	80.0%	87.2%	86.1%	86.1%	91.7%	92.0%	93.3%	89.4%	91.0%	88.9%	93.3%		N/A	
		ANNPs	N/A	N/A	N/A	75%	75%	71%	79.0%	83.0%	83.0%	71.0%	71.0%	71.0%	85.0%	85.0%	71.5%	83.0%	83.0%	83%		N/A	
	Sickness - % (Target - Trust avg <4%)	Registered and unregistered	N/A	N/A	N/A	6.5%	5.1%	6.8%	7.0%	10.5%	11.2%	9.6%	13.1%	6.4%	4.1%	7.2%	1.0%	4.5%	7.4%	1.9%		N/A	
		ANNPs	N/A	N/A	N/A	4.0%	0.6%	4.9%	9.7%	3.5%	3.9%	5.7%	26.0%	2.9%	8.4%	18.9%	14.9%	10.1%	7.7%	4.6%		N/A	
	Mandatory training % (Core Learning) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	94%	91%	90%	94.5%	91.0%	95.0%	96.0%	96.0%	96.0%	97.0%	92.0%	94.0%	95.0%	94.0%	93.0%		N/A	
		ANNPs	N/A	N/A	N/A	96%	97%	90%	94.0%	95.0%	93.0%	96.0%	96.0%		92.0%	94.5%	88.0%	94.5%	96.0%	95.0%		N/A	
	Mandatory training % (Core Learning Plus) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	92%	86%	86%	90.1%	85.0%	86.0%	90.0%	95.0%	93.4%	93.0%	89.9%	88.0%	92.0%	90.5%	88.0%		N/A	
		ANNPs	N/A	N/A	N/A	96%	89%	86%	86.6%	90.0%	91.0%	91.0%	91.0%		80.5%	83.0%	84.5%	82.5%	83.5%	88.6%		N/A	
	BLS (Target >95%)		N/A	N/A	N/A	93%	63%	77%	82.3%	31.0%	80.0%	88.0%	88.0%	89.0%	88.0%	89.0%	91.0%	90.0%	83.0%	88.0%		N/A	
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	N/A	N/A	64%	64.2%	63.6%	66.5%	68.0%	69.3%	69.5%	65.3%	63.6%	63.7%	62.8%	57.0%	57.0%		N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	3.9	4.6	2.3	1.6	2.6	1.6	1.6	1.6	1.6	1.0	1.6	1.6	1.6	1.3	1.3		N/A	
	% staff with in-date NLS (Target 100%)		N/A	N/A	N/A	100%	95%	90%	99.7%	97.2%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%		N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2022/2023

Pilgrim Hospital, Boston

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit	Live Births	1762	1612	1798	146.8	134.3	149.8	142.7	145	153	153	134	147	143	152	140	142	136	125		1570	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	209	172	218	17.4	14.3	18.2	16.6	18	19	20	10	16	14	16	9	19	18	24		183	
	No of First Episode Admissions	175	137	191	14.6	11.4	15.9	14.6	14	18	16	9	15	12	14	9	19	16	19		161	
	% of First Episode Admissions against Live Births			N/A			11%	10.3%	9.7%	11.8%	10.5%	6.7%	10.2%	8.4%	9.2%	6.4%	13.4%	11.8%	15.2%		N/A	
	No of Admissions to TC	72	65	80	6.0	5.4	6.7	7.2	10	7	8	7	4	8	5	6	14	7	3		79	
	All Ex-utero transfers	30	28	23	2.5	2.3	1.9	2.0	2	2	4	1	2	2	2	1	1	3	2		22	
	Ex-utero transfers (<32 weeks)	12	7	9	1.0	0.6	0.8	0.5	1	0	1	0	2	0	0	0	0	2	0		6	
	All in-utero transfers	20	14	8	2.0	1.2	0.7	0.8	2	2	1	0	1	0	0	0	2	1	0		9	
	In-utero transfers (<32 weeks)	15	13	5	1.5	1.1	0.4	0.8	2	2	1	0	1	0	0	0	2	1	0		9	
	NNU Term Admissions	87	65	113	7.3	5.4	9.4	8.5	9	11	7	4	6	7	11	6	15	6	12		94	
	Live Term Births	1638	1510	1672	136.5	126	139	133	137	142	140	124	134	133	146	135	135	125	112		1463	
	% NNU Term Admissions (Live Term births) Target <5%	N/A	N/A	N/A	5.3%	4.3%	6.7%	6.4%	6.6%	7.7%	5.0%	3.2%	4.5%	5.3%	7.5%	4.4%	11.1%	4.8%	10.7%		N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2022/2023

Pilgrim Hospital, Boston

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	46%	44%	42%	33.6%	34.2%	25.4%	64.2%	35.1%	40.7%	36.3%	27.4%	10.4%	20.6%	27.8%	47.3%		N/A	
		TC	N/A	N/A	N/A	50%	39%	51%	54.6%	55.8%	80.6%	53.3%	66.1%	40.3%	36.7%	46.8%	22.5%	81.5%	58.1%	58.9%		N/A	
		Total (NNU & TC)	N/A	N/A			42%	45%	40.6%	41.4%	43.8%	60.6%	45.4%	40.6%	36.4%	33.9%	14.4%	40.9%	37.9%	51.2%			
	Hypothermia on Admission - Ep.1 (<36.5ºc)	NNU	35	39	30	2.9	3.3	2.5	1.4	4	1	1	0	0	2	1	1	2	2	1		15	
		TC			5			0.4	0.2	0	0	0	0	1	0	0	0	0	1	0		2	
	(% of first episode admissions)	NNU %			N/A			0.2	10.4%	28.6%	16.6%	6.3%	0.0%	0.0%	16.7%	7.1%	11.1%	10.5%	12.5%	5.3%		N/A	
		TC %			N/A			0.1	3.6%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%		N/A	
	Transferred for Therapeutic Cooling		2	2	1	0.2	0.2	0.1	0.1	0	0	1	0	0	0	0	0	0	0	0		1	
	HIE (all grades)		2	3	2	0.2	0.3	0.2	0.1	0	0	1	0	0	0	0	0	0	0	0		1	
	Neonatal Deaths (following admission to NNU)		0	0	2	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0	0		0	
	Neonatal Deaths (delivery room)								0.1	1	0	0	0	0	0	0	0	0	0			1	
	Unit Closures (any)		0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0			0		0	
	No. of Exceptions		24	23	22	2.0	1.9	1.8	1.1	1	1	1	3	2	2	0	0			0		10	
	Medication Errors (moderate and above)															0	0			0			
	No of Serious Incidents (SI)		0	0	1	0	0	0	0.0	0	0	0	0	0	0	0	0			0		0	

United Lincolnshire Hospitals NHS
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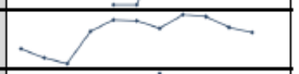
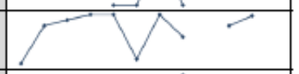
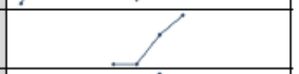
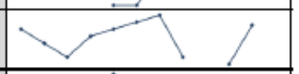
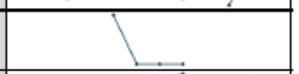
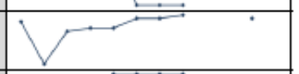
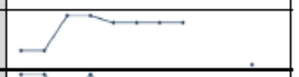
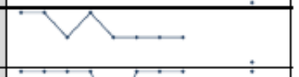
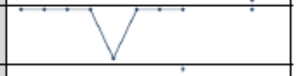
Neonatal Quality and Safety Dashboard - 2022/2023

Pilgrim Hospital, Boston

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Staffing	Appraisals - % (Target 100%)	NNU	N/A	N/A	N/A			83%	74.8%	89.0%	85.0%	65.0%	58.0%	70.0%	75.0%	75%	74%			82%		N/A	
		Outreach												67.0%	67.0%	100%	100%						
	Sickness - % (Target - Trust avg <4%)	NNU	N/A	N/A	N/A	5.5%	6.3%	6.3%	10.6%	6.3%	3.9%	2.3%	11.0%	14.0%	13.8%	11.8%	15.4%	14.9%	12.0%	10.7%		N/A	
		Outreach												0.0%	0.0%	3.2%	0.0%						
	Mandatory training % (Core Learning) (Target >95%)	NNU	N/A	N/A	N/A	95%	96%	98%	97.7%	94.6%	98.0%	98.5%	99.0%	99.0%	95.0%	99.0%	97.0%		98.0%	98.9%		N/A	
		Outreach												92.0%	92.0%	95.0%	97.0%						
	Mandatory training % (Core Learning Plus) (Target >95%)	NNU	N/A	N/A	N/A	92%	94%	96%	95.8%	97.0%	95.0%	93.0%	96.0%	97.0%	98.0%	99.0%	93.0%		92.0%	97.6%		N/A	
		Outreach												97.0%	90.0%	90.0%	90.0%						
	BLS (Target >95%)	NNU	N/A	N/A	N/A	97%	99%	96%	93.3%	95.0%	82.0%	92.0%	93.0%	93.0%	96%	96%	97%			96%		N/A	
		Outreach												67.0%	67%	67%	67%						
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	62%	67%	70%	74.3%	73.0%	73.0%	75.5%	75.5%	75.0%	75.0%	75.0%	75.0%	75.0%			72.0%		N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	2.0	0.6	1.5	1.2	2.0	2.0	1.0	2.0	1.0	1.0	1.0	1.0			0.0		N/A	
	% staff with in-date NLS (Target 100%)	NNU	N/A	N/A	N/A	96%	100%	98%	99.1%	100%	100%	100%	100.0%	92%	100%	100%	100%			100%		N/A	
		Outreach							83.5%						67%		100%					N/A	

Maternity & Neonatal Safety Improvement Project

Updated March 2023

Evidence available		U:\Midwifery\Action plans & evidence\Maternity Safety Improvement Plan
Version	**Date Updated**	**Update**
Version 1.0	01/10/2022	Plan creation completed and all fields completed
Version 1.1	04/10/2022	Reviewed at MNSC to archive embedded actions with evidence filed
Version 1.2	07/10/2022	Actions OS52 and OS53 added, transferred from Datix
Version 1.3	12/10/2022	Reviewed with PSIT who will forward evidence
Version 1.4	21/10/2022	Actions OS54 and OS55 added, transferred from Datix
Version 1.5	04/11/2022	Summary page updated with action headers
Version 1.6	11/11/2022	November RAG updated, headline report for MNOG
Version 2.0	16/01/2023	LMNS Action tab archived following agreement with ULHT and LMNS
Version 2.1	14/03/2023	RAG updated, completed and evidenced actions turnd blue ready for MNSC. Saved as PDF for sharing with staff on intranet

Maternity & Neonatal Safety Improvement Project Strategy: Executive Summary

Background & Introduction

Since the publication of the National Maternity Review in 2016 and the implementation of the Maternity and Neonatal Safety Collaborative, ULHT have been on a journey of improvement to optimise safe, personalised evidence-based care for women and families of Lincolnshire. The publication of the Long-term plan further supports the importance of ensuring maternity services optimise positive outcomes to contribute to a healthy population.

The Trust recognises that implementing change at pace and scale within the challenges of limited resources requires approaching innovation, change and quality improvement intelligently. Effectively implementing the national recommendation and locally identified areas for improvement is therefore essential to improving outcomes for women, babies and families across the county and for generations to come. To support this approach, key roles have been developed to enhance capacity and Quality Improvement (QI) training has been offered to clinical staff to enhance our safety and quality improvement ambitions.

ULHT is situated with the Midlands region and is the sole provider of maternity services within Lincolnshire Local Maternity and Neonatal system (LMNS). Since the inception of the LMNS, ULHT has also sought to work collaboratively with stakeholders within the LMNS. Extensive engagement with our Maternity Voices Partnership ensures that our services are responsive to and co-produced with the women and families of Lincolnshire.

Aims of the Strategy

The Maternity & Neonatal Safety Improvement Project Strategy outlines the Trust's ambitions to ensure our maternity service offers safe, evidenced-based, high-quality and personalised and aligned to national drivers (e.g. CNST, Saving Babies Lives, Continuity of Carer) and locally identified areas for improvement (e.g. Learning from Serious Incidents). A key element of the Trust's Maternity & Neonatal Improvement Project Strategy is the desire to learn from other organisations (e.g. Ockenden, CQC). Key quality improvement projects and actions support operational delivery - further details are provided in the full Maternity & Neonatal Improvement Project Strategy document.

The overarching aims of the strategy are to:

Optimise safety	**Optimise experience**	**Improve leadership**	**Offer choice and personalised care to women**	**Provide assurance**
- Reduce neonatal hypothermia - Reduce delays in treatment/review/delivery - Improve management of neonatal hypoglycaemia - Improve fetal monitoring - Induction of Labour Pathway - Improve Transitional Care arrangements - Managing complex pregnancy - Care after birth - Reduce smoking in pregnancy - Midwifery Workforce - Clinical Workforce - Saving Babies Lives v2 - Availability of Equipment - Safe Use & Storage of Medicines - PPH - Skills & Drills	- Responding to Service User feedback - Improve communication - Reducing delays in discharge - Environment	- Monitoring Fetal Wellbeing - Escalation	- Risk Assessment throughout Pregnancy - Birth Choices Pathway - Informed decision making - Personalised Care and Support Planning	- Empowerment of Staff & Use of Professional Judgement - Safety Culture Milestones - Reporting, Investigation and Learning Lessons from Incidents & Complaints - External Notification - HSIB / Early Notification Scheme - Staff Training - Maternity Services Data Set (MSDS) - Perinatal Mortality Review Tool - Maternity NED Safety Champion - Culture including Attitude & Behaviours - Staff Health & Wellbeing

Oversight & Assurance

The Trust's Maternity & Neonatal Oversight Group (MNOG) has agreed the need for a single, combined Improvement Plan which brings together in one place all of the required improvement actions and associated assurances. This plan is provided in the remainder of this document which will remain 'live' as new improvement actions are identified and added. Completed actions will be archived once assurance has been provided to MNOG that actions and changes in practice have been embedded and, where required, ongoing monitoring arrangements are in place to ensure they remain effective.

Maternity & Neonatal Improvement Plan

RAG RATING MATRIX	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress / on track
Red	Not yet completed / significantly behind agreed timescales

Optimise Safety

No	Recommendation	Source (e.g. CNST, Ockenden, CQC, HSIB)	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	Progress (as at 14th March 2023)	Previous RAG Jan-23	Current RAG Mar-23	Actual Completion Date Denotes Action Completed	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
Reduce the number of cases of Hypothermia												
OS3	Introduce blanket warming cabinets on to labour ward, include reference to their use in the prevention and management of hypothermia guideline and embed into practice.	ATAIN	Deliver to Labour Wards following safety checks.		Clinical Engineering	31/10/2021	Delivered and in place on Labour Wards at Lincoln & Pilgrim.			31/10/2021		Hypothermia case reviews
			Review use via the low temperature admission case review		ATAIN Lead	31/05/2022	Underway - new midwife assigned to complete case review. ST AY discuss Stevie Dickinson 4/10/22 ATAIN leads to take on audit					
Improve Fetal Monitoring / CTG Interpretation												
OS5	Continue to focus on improving fetal monitoring / CTG interpretation including staff awareness and individual and group training needs with an emphasis on recognition and escalation of an abnormal CTG.	Thematic Review of SIs & Complaints, November 2021 and SIs 265231, 253843, 264475	Implement the improvement actions agreed following the recent internal SBLCBV2 audit, as outlined with the monthly Maternity & Neonatal Assurance report, dated September 2021.		FM Leads	30/06/2022	Underway. - EFM Risk assessment in I{ booklet - Fresh eyes audit -					Part of ongoing Fresh Eyes audit programme Maternity & Neonatal Safety Collaborative will retain oversight of this area of work with escalation of issues to MNOG, as required
OS5	Continue to focus on improving fetal monitoring / CTG interpretation including staff awareness and individual and group training needs with an emphasis on recognition and escalation of an abnormal CTG.	Thematic Review of SIs & Complaints, November 2021 and SIs 265231, 253843, 264475	Implement CTG on-line training - RCOG EFM package (E lfh).		FM Leads	01/07/2022	Feasibility of introducing this training is being explored. 9/9/22 IIA package mandatory, EFM package optional at present, awaiting confirmation to make ?mandatory. EFM whole day in place, EFM competency document in place					
OS6	Review feasibility of introducing physiological interpretation of CTG at ULHT.	ATAIN & ATAIN Quarterly Report and SI 265231	Benchmark HIE numbers against Trusts using physiological interpretation. Trusts to benchmark against; GSTT, Kingston.		FM Leads / Consultant Midwife	30/06/2022	This is a significant piece of work - review and benchmarking to be completed following appointment of FM leads. 9/9/22 ~~Kingston excluded due to STAN~~. Last 10 cases review planned to apply hypothetical physiological interpretation to evidence differenert course of action, expected 9/12/22 16/9/22 Data received from GSTT 14/3/22 - Neoventa package for physiology interpretation identified to support implementation in view of current barriers at ULHT. Kingston data reinstated despite use of STAN. Kingston have 0% rate of HIE and					
			Identify barriers to implementation.									
Improve the Management of Hypoglycaemia												
OS8	Provide up to date, evidence based education to Midwives regarding hypoglycaemia.	ATAIN	Review current hypoglycaemia education provided to Midwives		Patient Safety Lead Midwife / Consultant Midwife		Safety Lead has reviewed MTD teaching. Updated teaching programme provided to staff from November 2021 onwards.					Efficacy to be audited through ATAIN audits
			Arrange meeting to plan education strategy for hypoglycaemia management		Clinical Educators							
Reduce Delays in Treatment / Delivery / Review												
OS9	Introduce traffic light escalation communication	ATAIN	Present QI at LW forum.	Reduction in incidents / harm Improved quality & safety	Patient Safety Lead	31/01/2022 revised date 31/3/23	Work underway - update requested. 21/9/22 iNeed escalation project to be launched 3rd Oct, implemented by 31st March 2023					Once launched seek feedback to be sought from staff
			Step 1: Introduce QI to co-ordinators and role out to LW pan Trust.									
			Step 2: Role out to AAU and PN & AN wards.									

OS10	Audit time of decision made to deliver to delivery for EMCS.	ATAIN	20 notes audit for CS pan Trust.		LW Midwife (KA) / Patient Safety Lead Midwife	31/10/2021	Completed - 82% within NICE recommendations, most were Cat 3, therefore plan to complete looking at Cat and Cat 2 only as part of the ongoing audit plan.			31/10/2021		Part of ongoing audit programme
Induction of Labour Pathway												
OS13	Investigate quality improvement projects to include an MDT approach to IOL.	Feedback from staff to DON	QI projects to include the development of an MDT approach to IOL.	Reduction in last minute IOLs	IOL Midwife / Clinical Lead	31/03/2022	Trialled and discontinued.					Part of ongoing audit programme
OS14	Service already in place that optimises timing and information provision and support to women offered an IOL, to be rolled out to women who are being booked for IOL in their 37th week of gestation.	ATTAIN (Quarterly Report) and SI 243511	Audit to be completed to include a review of discussions around IOL to ensure they include a documented discussion about risks and benefits, in order for mothers to make a fully informed decision.				Audit completed.					
			IOL Checklist to be developed.				IOL checklist and journal developed and in use but needs embedding.					
OS15	Review with digital team regarding documentation / audit trail for women who have unsuccessful IOL.	Deep Dive - Unsuccessul IOL 2021 (May 2022)	IOL MW to plan comms around correct data entry, repeat audit following implementation of recommendations	Improve quality of IOL data	Amy Garratt Safety MW	30/09/2022	Poster completed and displayed around unit					Ongoing audit programme
OS16	Make the use of the IOL checklist mandatory to ensure standardisation of information giving and consent prior to women attending for IOL and also to evidence women are being given the		Audit 40 sets of notes 6 months after implementation of checklist	Improve shared decision making and informed consent	Amy Garratt Safety MW	31/08/2022	In process					Ongoing audit programme
OS17			Implement checklist at PHB and audit 40 sets of notes 6 months following	Improve shared decision making and informed consent	Amy Garratt Safety MW	28/02/2023	Monthly audit of 20 notes (10 LCH, 10 PHB) from January. Ensuring timely feedback and improvement.					Ongoing audit programme
OS18	Consider cervical assessment prior to formal IOL as recommended by NICE to help assess the readiness of the cervix to decide the most suitable method of IOL and ensure women are being counselled appropriately		Recommended within checklist, include in audit of 40 sets of notes as above	Improve shared decision making and informed consent	Amy Garratt Safety MW	31/08/2022	As above, some difficulties implementing checklist and therefore auditing. To be icnluded in new monthyly audit plan.					Ongoing audit programme
OS19	Discuss every option for continuation of IOL - offer mechanical IOL at each review point if changes to Bishop Score demonstrates mechanical IOL is possible.		Included in rewritten IOL guideline, due to be ratified at next guideline group	Improve shared decision making and informed consent	Amy Garratt Safety MW	TBC for GG lead	Publication of guideline 06/02/2023					Guideline group inc in quarterly report on guideline position
OS20	Ensure the utilisation of 'Induction of Labour: Managing Delays' to ensure escalation of delays is appropriate and not extensive.		Review 3-6 months after implementation of SOP, Obtain baseline data around delays	Reduce delays in IOL process	Amy Garratt Safety MW	TBC for GG lead	Publication of SOP 06/02/2024					Ongoing audit programme
OS21	Provide education updates for staff to ensure knowledge of care, management, support options, risks and benefits and optimising techniques surrounding induction of labour		Practice reference document and Padlet, include in Safety & Risk MMT training	Improve shared decision making and informed consent	Amy Garratt Safety MW	31/08/2022	Review with education team for MMT 2023/24					Mandatory training presentation
OS22	Repeat audit following implementation of recommendations		Repeat deep dive 6 months following implementation	Improve shared decision making and informed consent	Amy Garratt Safety MW	31/08/2022	Decision made for monthly audit of 20 notes (10 LCH, 10 PHB) from January. Ensuring timely feedback and improvement.					Ongoing audit programme
OS23	Audit real time IOL action timelines (i.e. admission, commencement, for transfer to labour ward, interval to when transferred to LW etc.). This will provide clear data that may highlight target areas for improvement and also can support the anecdotal perception that delays are fairly common, particularly at LCH		Review 10 IOL real time action timelines, 2 per day for one week	Reduce delays in IOL process	Amy Garratt Safety MW	30/11/2022						Ongoing audit programme
OS23.1		National Survey	Explore feasibility of post-discharge check in calls as routine for all patients.		Safety Midwife							
OS23.2			Development and roll out of updated, meaningful and accessible resources for women and their families and staff utilising a variety of media and communication		Safety Midwife							
OS23.3			Roll out of an electronic booking system		Safety Midwife							
OS23.4			Mapping of the IOL patient journey including delays		Safety Midwife							

OS23.5			Improved patient journey with benefits to quality, safety and efficiency		Safety Midwife							
OS23.6			Clinical support from IOL midwife to practice alongside midwives and deliver IOL cares – role modelling and teaching others best practice		Safety Midwife							
OS23.7			Address inequities in information-giving and consent process		Safety Midwife							
OS23.8			Review best practice in other units and identify whether elements of this can be utilised to improve the ULHT service		Safety Midwife							
OS23.9			Develop decision tools based on best evidence to support appropriate and standardised practices around timing of IOL in various circumstances		Safety Midwife							
OS23.10			Development of ongoing patient feedback mechanism		Safety Midwife							
Improve Transitional Care Arrangements												
OS25	Avoid unnecessary separation of mother and baby for babies that could be safely cared for in TC.	TC	Undertake deep dive into the notes of these babies and identify the scope for QISR.		NNU Manager	30/11/2021	Audit complete.					TC Audits in place Monthly maternity & neonatal assurance report MNOG
OS28	Transitional care services are in place that support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme (ATAIN).	CNST Year 4 Safety Action 3	The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	Improved quality & safety Improved experience and wellbeing	NNU Matron / NNU Managers	30/06/2022 CNST revised date 5/1/23	TC audit to be recommenced and findings shared quarterly via the Maternity & Neonatal Assurance Report. TC action plan to be developed, as part of the wider Maternity & Neonatal Improvement Plan, and progress overseen by the Board level NED Maternity & Neonatal Safety Champion and via MNOG. 21/9/22 Joint ATAIN/TC action plan approved at MNOG, evidence requested from NNU that audit findings are shared with LMNS/MNOG					
Ensure the Provision of Dedicated Staff for Elective Caesarean Section Lists												
OS29	Ensure that where there are elective caesarean section lists there are dedicated obstetric,	ACSA	Create gap analysis from ACSA standards and current service.	Improved quality & safety	Project Manager for Surgery	01/09/2021	Complete.			01/09/2021		Part of ongoing audit programme
			Arrange meeting to discuss actions required to meet 1.7.2.5 and engage relevant services.		General Manager for Women's & Children's Services	01/09/2021	Complete.			01/09/2021		
			Gain update report from maternity unit level 1 theatre regarding theatre lights and timescale for completion.		Patient Safety Lead Midwife	01/09/2021	Lights have been changed and theatres are ready for use pending minor electrical work. Go live linked to wider refurbishment plan and timescales.			01/09/2021		
			ELCS list to be generated and kept for audit purposes.		Anaesthetic Consultant Lead for Obstetrics	01/09/2021	Ongoing requirement - in place.			01/09/2021		
			Draft Business Plan for staffing uplift.		General Manager for Women's and Children's Services	31/10/2022	Postponed due to COVID. Recommended and Working Party set up and work underway.					
			Undertake scoping exercise for availability and costs of training for MW to attend specific recovery training.		Consultant Midwife	01/09/2021	Complete. Please also refer to action 13 on the 'Provide Assurance' Tab.			01/09/2021		
Managing Complex Pregnancy												
OS31	The maternity risk management strategy and / or relevant guideline or SOP should be reviewed to ensure they are clear on the criteria for informing / calling the consultant for direct support for complex cases. There should be ongoing audit of the effectiveness to ensure the agreed requirements are being met	Thematic Review of SIs & Complaints, November 2021	Compliance to be audited.		Quality & Audit Midwife / Clinical Lead for Maternity Services	30/04/2022	To be added to audit plan and utilising the standards set out within the new RCOG guidance. Requirements of consultants to be reinforced through job planning.					On audit plan
Attention After Birth												

OS32	Support HCSWs on Labour Ward to provide increased postnatal care.	CQC - survey	Support HCSWs on Labour Ward to provide increased postnatal care.	Improved quality & safety Staff satisfaction and wellbeing	Labour Ward Managers	31/03/2022	Training needs identified. Work to be undertaken to develop training support offer. 4/10/22 EE supports HCSWs to provide BF support, undertake all mandatory training and some elements of PROMPT training and MMT					Skills Audit PDSA Cycle
Reducing Smoking in Pregnancy												
OS33	Ensure that every person admitted to hospital who smokes will be offered NHS-funded tobacco dependency treatment by 2023/24. This includes all expectant mothers throughout their antenatal care, as well as exploring how to help partners of pregnancy women so any new-born baby goes home to a smoke free home.	NHS Long Term Plan [Public Health Challenges including smoking also raised as part of the Feedback from Staff to the DON]	Initial Pilot: - available to up to 40% of smokers; - to be delivered in the areas with the highest prevalence of smoking at the time of booking - recruit 1x Specialist Stop Smoking Midwife and 2x Maternity Support Tobacco Dependency Advisors; - implement best practice VBA training.	Reduced risk & improved outcomes	LMNS led with ULHT support	31/03/2022	This initiative is being progressed as a 'system'. Business Case and full milestone plan developed. Update provided to the Maternity & Neonatal Oversight Group on Wednesday, 6 October 2021. There is staff understanding and recognition of the challenges. Stop Smoking Midwife appointed and in post.					Monitored via MNOG and SBLCBv2
			Phase Two: - target to increase to 70% of maternal smokers by March 2023 - recruitment 2x additional Maternity Support Tobacco Dependency Advisors			31/03/2023						Monitored via MNOG and SBLCBv3
			Phase Three: - target to increase to 100%; - introduce new NHS smoke free pregnancy pathway.			31/03/2023						Monitored via MNOG and SBLCBv4
Clinical Staff Workforce												
OS36	Review medical staff / consultant cover	Feedback from staff to DON	Review to include a review of support to junior doctors and review of the midwifery role within the ANC.	Improved quality & staff Improved staff morale & wellbeing	Divisional Clinical Director - Family Health	31/12/21	A review of consultant cover and support to junior doctors is underway. This will include consideration of HEE feedback. See also CNST Year 4 Safety Action 4 - obstetric medical workforce. Some uplift to consultant establishment expected post Ockenden. Linked to the above work, a review of the ANC pathways and role of the midwife in the ANC has been undertaken. Arising from this work there is increased Consultant cover on the ANC at					
Availability of Equipment												
OS40	Ensure the availability of & access to key equipment	Feedback from staff to DON	Concerns highlighted specifically relate to CTG, beds and IT.	Improved quality & safety Improved experience Increased job satisfaction	Divisional Managing Director - Family Health	31/03/2022	There is a bed replacement programme in place. Plans and timescales for maternity element of bed replacement programme needs communicating to staff CTG issue relates to connectors inadvertently being lost / disposed of at a considerable cost to the Division. Ward Managers have confirmed there are sufficient supplies. This issue will continue to be monitored with further reminders and awareness as required. Additional IT equipment ordered. Additional IT equipment requirements will be addressed through the Digital Maternity Assessment (DMA).					Review of Incidents Risk Register at MNOG
Safe Use & Storage of Medicines												
OS41	Trust to ensure that the temperature of the treatment rooms within maternity at LCH are monitored to ensure that medicines are stored at the correct temperature and that there is restricted access to these rooms.	CQC 2021 Inspection	Wall Thermometer to be ordered and escalation procedure to be reinforced.	Improved quality & safety	Midwife (YC)	30/11/2021	Wall thermometer in place. Daily check added to daily checklist. Staff aware of escalation process			30/11/2021		
			Introduce daily checking of treatment room temperatures.									
			Audit the process to ensure compliance.		Inpatient Matrons	31/03/2022	Update required.					Ongoing audit

OS42	The Trust must ensure that all medicines are stored safely and securely.	CQC 2021 Inspection Report	Plan out action in response to audit to close any gaps identified (i.e. order digital thermometers).	Improved quality & safety Improved safety and security of medicines	Head of Midwifery / Matrons	31/03/2022	Action plan from Lincoln site still outstanding - to be completed ASAP. There is not a separate SOP for raised ambient temperatures (Trust Medicines Management policy is followed). If temps are elevated, Pharmacy input is sought.				Action Plan	
			Identify any risks from audit undertaken (i.e. rooms where ambient temperature is routinely 25 degrees or above and take advice from pharmacy around mitigations.		Head of Midwifery / Matrons	31/03/2022	Lincoln action plan received. Pharmacy and QM for medicines contacted to arrange a meeting to review in greater detail.				Action Plan	
			Understand mitigations to environmental challenges in storage of medicines (i.e. age of estate at Lincoln maternity with a lack of air-conditioning/ventilation).		Divisional Managing Director - Family Health	30/04/2022	Project Manager now in place and full design team to be appointed over next couple of weeks. This is for the refurbishment of maternity only, not to support with estate issues in the interim. Linked to above action, feed into this following meeting with Pharmacy and QM for Medicines.				Action Plan	
			Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.		Divisional Managing Director - Family Health	31/03/2022	Issues can be escalated through PRM if cannot be resolved locally (estates issues can be escalated through this route).			31/03/2022	PRM Escalations Risk Register	PRM
Postpartum Haemorrhage (PPH)												
OS43	Streamline MRHP process and ensure it aligns with latest guidance.	SI 263178	Benchmark Maternity PPH guidance against Trust wide MRHP.	Improved safety	Patient Safety Lead Midwife	28/02/2022	Review and simplified and re-issued.			28/02/2022		Maintained under Guideline Process Ongoing monitoring of PPH via dahsboard and PPH review process
Skills & Drills												
OS44	Use skills and scenarios to improve human factors and situational awareness elements of clinical scenarios	SI 254930	Documentation compliance review of PPH proforma for 3 months	Improve Safety	Maternity Safety Team	31/03/2023	Plan audit framework. Plan training to increase awareness of proforma as a prompt rather than audit tool. Included within Newsflash and PPH monthly newsletter. 14/9/22 Transferred from datix actions 21/9/22 PPH QIP in process					Documentation compliance audit
OS45		SI 254930, SI 254930	Increase number of theatre-based skills & drills to include use of PPH proforma		Education Team	31/03/2023	Funds secured for a SimMom which will facilitate high-quality simulation training 14/9/22 Transferred from datix actions.					TNA/Annual Education Plan
OS46		SI 259852, SI 263178	Increase number and frequency of drills in maternity theatre setting.		Education Team	31/03/2023	6.1.2022- Impacted by covid/level of activity in theatre. Plans in place. Trust wide labour ward forum scheduled for 21/1/2022. Only 2 in past 12 months due to covid/activity and poor attendance to be quorate. 14/9/22 Transferred from Datix actions					TNA/Annual Education Plan
OS47		SI 259852	Clinical Education Team to support live drills and scenarios to support maintaining situational awareness during a postpartum haemorrhage. The Obstetric Multidisciplinary Team are to be provided with the understanding and tools to support maintaining situational awareness during a postpartum haemorrhage		Education Team	31/03/2023	6.1.2022- Impacted due to covid/activity. Preparations in place for skills and drills. To be implemented when activity/staffing allows. Education team informed or anticipated plan and completion date. - live drills are back on prompt face to face training day, situational awareness included in this,. 14/9/22 Transferred from datix actions					TNA/Annual Education Plan
OS48		SI 269764	Roll out of telephone triage drills-type exercises with maternity staff triaging calls from women		Education Team	31/03/2023	14/9/22 Transferred from datix actions					TNA/Annual Education Plan
OS49		SI 271935	MDT training to be included within Live Skills and Drills.		Education Team	31/03/2023	human factors training. Situational awareness on prompt which is attended by anaesthetists, prompt now F2F so live skills and drills is included there - extend deadline 14/9/22 Transferred from datix actions					TNA/Annual Education Plan
OS50		SI 261928	The Trust re-evaluate current training in neonatal resuscitation to ensure there is a focus on clinical leadership, roles and responsibilities, communication within the team and record keeping. Embed NLS skills drills/interactive learning session on labour wards (both sites) using new document – at least fortnightly as continuous learning		Education Team	31/03/2023	6/10/22 Transferred from Datix action					

OS51		SI 271061	Education and Training regarding signs and symptoms of placental abruption, Incorporate Placental Abruption within skills and drills, to include multiple scenarios of clinical presentation.		Education Team	31/03/2023	21/10/22 Transferred from Datix actions					

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Optimise Experience

No	Recommendation	Source (e.g. CNST, Ockenden, CQC, HSIB)	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	Progress (as at 14th March 2023)	Previous RAG Jan-23	Current RAG Mar-23	Actual Completion Date Denotes Action Completed	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
Responding to Service User Feedback												
1	The Trust can demonstrate that there is a mechanism for gathering service user feedback, and that it works with service users through the Maternity Voices Partnership to co-produce local maternity services including ensuring a 'voice' fr marginalised women.	Ockenden / CNST Year 4 Safety Action 7 / SI 269764	Clear co-produced plan, with MVP that demonstrates co-production and co-design of service improvements, changes and developments.	Improved experience	MVP Lead / Consultant Midwife	30/06/2022	Work has commenced.				Co-produced plan - see additional CNST evidential requirements	MVP via MNOG
Improve Communication												
2	Introduce training to improve communication	Thematic Review of Maternity SIs & Complaints, November 2021	Mandatory study session to be arranged for the whole department on communication / documentation with a focus on the communication issues identified during the Thematic Review.	Improved experience and informed decision making	Clinical Lead for Maternity, Trust wide / Clinical Lead for Labour Ward, LCH	30/06/2022	To be delivered as part of Divisional training programme from April 2002 onwards and to be included in existing events and forums (e.g. governance, audit, CTG meetings) to ensure as wider a coverage of staff as possible. Training to cover patient stories as well as communication issues identified from the thematic review. 9/9/2022 iNeed escalation project underway, expected completion date 31st March 2023 utilising EBC L+S Toolkit - Human factors session including iNeed on MMT					Annual Education Plan
3	Improve the information available for women and families on the process for referral and communication between hospitals		Drafting of new and updating of existing Patient Information Leaflets, where relevant, to include information for women and families on what will happen where referral or communication between hospitals occurs.	Improved experience	Patient Safety Lead Midwife	30/06/2022	In place and ongoing. Information leaflets are available on the maternity webpage and are also available in different languages.					Patient Leaflets monitored by Patient Experience Team for rview dates
Reducing Delays in Discharge												
6	Review pharmacy and TTO processes	CQC - Maternity Survey	Complete process / patient journey mapping.		Inpatient Matron	30/11/2021	Completed. Linked to pharmacy Business Case. Check w LB					Pharmacy governance
Environment												
7	Continue to make improvements to the environment.	Feedback from Staff to DON / PLACE Lite / Divisional Improvement Plan / CQC 2021 Inspection - Initial Feedback	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	Improved environment and experience for women and staff Privacy & Dignity requirements are fully met	Head of Midwifery / Deputy Director of Estates & Facilities	30/06/2023	Ward Refurbishment Programme due to commence in January 2022 but will take time to complete. New break room now established on Nettleham. New furniture & fittings ordered from charitable funds. Furniture loaned in the meantime Some immediate works completed further to recent CQC feedback including improvements to privacy & dignity and replacement of ageing furniture and fixtures and fittings. 9/9/22					Monthly Matrons Quality Audit
Induction of Labour												

OE8	Improve womens involvement in Induction of Labour, Improved patient journey with benefits to quality, safety and efficiency	National Survey Results Dec 2022	Explore feasibility of post-discharge check in calls as routine for all patients.	Improve experience of IOL	IOL/Safety Midwife	31/05/2023						
OE9			Development and roll out of updated, meaningful and accessible resources for women and their families and staff utilising a variety of media and communication		IOL/Safety Midwife	01/04/2023						
OE10			Roll out of an electronic booking system		IOL/Safety Midwife	31/05/2023						
OE11			Mapping of the IOL patient journey including delays		IOL/Safety Midwife	31/05/2023						
OE13			Clinical support from IOL midwife to practice alongside midwives and deliver IOL cares – role modelling and teaching others best practice		IOL/Safety Midwife	31/01/2023						
OE14			Address inequities in information-giving and consent process		IOL/Safety Midwife	31/05/2023						
OE15			Review best practice in other units and identify whether elements of this can be utilised to improve the ULHT service		IOL/Safety Midwife	Completed	Action completed as part of establishment of IOL role					
OE16			Develop decision tools based on best evidence to support appropriate and standardised practices around timing of IOL in various circumstances		IOL/Safety Midwife	Completed	Checklist created and already in practice					
OE17			Development of ongoing patient feedback mechanism		IOL/Safety Midwife	01/04/2023						

Maternity & Neonatal Improvement Plan

RAG RATING MATRIX	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress / on track
Red	Not yet completed / significantly behind agreed timescales

Improve Leadership

No	Recommendation	Source (e.g. CNST, Ockenden, CQC, HSIB)	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	Progress (as at 14 March 2023)	Previous RAG Jan 23	Current RAG Mar 23	Actual Completion Date Denotes Action Completed	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
Escalation												
6	Strengthen escalation process (including acting on concerns & feedback to staff)	Feedback from staff to DON SIs 255356, 263178, 264990	Band 7 Co-ordinators identified as a key enablers but need support.	Increased staff support and wellbeing Improved quality & safety Improved staff survey feedback	Head of Midwifery / Interim Matron	31/03/2022 Workplace Innovation programme running untilearly 2023	First meeting held with Band 7 Co-ordinators on 14/7/2021. Agreed that there is a need to ensure all staff have an understanding of each other roles and communication of agreed escalation procedures and actions. Maternity escalation plan discussed with B7s – suggestions made to improve guideline based on birth rate acuity data – further meetings to be held. August meeting was not well attended due to leave and operational pressures. Further meeting arranged for September 2021. Some teething problems . Links to ongoing work around culture. Further support / development required for Band 7s.					Workplace Innovation Programme MNOG Maternity and Neonatal Assurance Report

Maternity & Neonatal Improvement Plan

RAG RATING MATRIX	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress / on track
Red	Not yet completed / significantly behind agreed timescales

Choice & Personalised Care

No	Recommendation	Source (e.g. CNST, Ockenden, CQC, HSIB)	Actions / Key Milestones	Expected Impact	Lead	Forecast Completion Date	Progress (as at 14 March 2023)	Previous RAG Jan 23	Current RAG Mar 23	Actual Completion Date Denotes Action Completed	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
Risk Assessment Throughout Pregnancy												
CPC1	A risk assessment should be completed at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance	Ockenden & CQC	Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance.	Improved choice and personalised care Improved quality & safety Improved experience	Consultant Midwife / Patient Safety Lead Midwife / Quality & Audit Midwife	30/09/2022	Risk assessments completed. PCSP Task and Finish co-production group established with support from PMO and CCG to develop and implement PCSPs. Project Manager assigned and new Lead in post, project now restarted					Ongoing audit plan
#												
CPC6	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care.	Ockenden	SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.		Matrons	31/01/2022	In place.			31/01/2022	Filed 22/9/22	Ongoing audit plan PCSP ongoing project Ockenden Assurance at MNOG
CPC7	Women's choices following a shared and informed decision-making process must be respected.	Ockenden	SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.		Patient Safety Lead Midwife	30/04/2022	In place.				Filed 22/9/22	Ongoing audit plan PCSP ongoing project
CPC8			CQC survey and associated action plans				Failed IOL and subsequent Cat 3 LSCS is being audited at present. This will be reported into the Maternity & Neonatal Oversight Group and if compliance is demonstrated, the action will be completed.					Ongoing audit plan PCSP ongoing project Ockenden Assurance at MNOG
Birth Choices Pathway												
CPC12		BCC Audit	Increase the data that is recorded on the Birth Choices Clinic (BCC) database to enable deeper analysis of time.	Informed consent Improved choice and personalised care Improved satisfaction & experience	Consultant Midwife	31/03/23						Ongoing audit plan
CPC13		BCC Audit	Explore previous CS midwife-led counselling pathway to free up ANC time, upskill midwifery team, reduce need for BCC inut and improve service users satisfaction (based on Oxford midwife-led Birth After Ceaesarean care pathway.		Consultant Midwife	31/03/23						PCSP project Monitored through Maternity Assurance Report
CPC14		BCC Audit	Implement bi-monthly BCC forums / sharing meetings between consultant obstetricians and midwives, or ensure the involvement of the consultant midwife in existing consultant obstetrician meetings to support more cohesive working		Consultant Midwife	31/12/22						PCSP project Monitored through Maternity Assurance Report
CPC15		BCC Audit	Finalise method for recording planned BCC activity on PAS and explore / review how this activity is currently funded / costed.		Consultant Midwife	31/10/22						

CPC16		BCC Audit	Finalise route of adminstration support to reduce admin workload on consultant midwife.	Consultant Midwife	31/12/22							
CPC17		BCC Audit	Review method for gathering feedback from women.	Consultant Midwife	ongoing	Plan for quarterly text to be sent inviting completions of forms			23/9/22			Ongoing audit plan

Maternity & Neonatal Improvement Plan

RAG RATING MATRIX	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress / on track
Red	Not yet completed / significantly behind agreed timescales

Provide Assurance

No	Recommendation	Source (e.g. CNST, Ockenden, CQC, HSIB)	Actions / Key Milestones	Expected Impact	Lead	Forecast Completion Date	Progress (as at 14 March 2023)	Previous RAG Jan-23	Current RAG Mar-23	Actual Completion Date Denotes Action Completed	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
Empowerment of Staff & Use of Professional Judgement												
2	Ensure the empowerment of staff to use professional judgement.	Feedback from staff to DON	Ensure the need for guidelines is fully understood whilst supporting staff to use professional judgement.	Improved staff morale Improved experience for women	Head of Midwifery	31/03/2022 31/03/2023	Work is underway in response previous feedback to refocus on midwifery expertise through: undertaking some 'back to basics' training, re-arranging the birthing room to facilitate a low risk birthing environment in a high risk labour ward etc. This will be led by the PMAs who suggested a 'Midwifery Month'- a time to refocus on midwifery expertise. This topic is now covered on the preceptorship programme. This also links to the cultural work which is underway and empowering Band 6/7s. This will include surveys and focus groups to obtain feedback from staff. This will be a 9-month programme - commenced April 2022					Workplace Innovation Programme Ongoing culture surveys Work Afterthoughts
Culture including Attitude & Behaviours												
4	Improve staff morale and address issues with attitude and behaviours in some areas During the CQC 2021 inspection, the CQC commented that: "Not all staff appeared engaged, morale was mixed, and we found an inconsistent safety culture with not all staff happy to challenge".	Feedback from staff to DON / CQC Inspection 2021 - Initial Feedback		Improved staff morale	Divisional Triumvirate	31/03/2023	Linked to staff survey improvements and OD work which is underway - see also 2. above. Results of previous staff and culture surveys to be fed back to staff as part of planned Comms Campaign. Repeat of culture survey planned at a date to be confirmed. Previous surveys to be feedback to staff with support from Jackie Lloyd					Workplace Innovation Programme Ongoing culture surveys
Perinatal Mortality Review Tool												
9	Trusts to utilise the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard.	CNST Year 4 Safety Action 1	All eligible perinatal deaths from 1st September 2021 should be notified to MBRRACE **within two working days** and completed **within one month** of the death.	Strengthened learning & improvement Improved communication with parents	Bereavement Midwife / Patient Safety Midwife	30/06/2022	Underway - reporting requirement now 7 days instead of 2. Currently compliant.					PMRT Quarterly Report via MNOG
			A review using the PMRT for 95% of all eligible deaths of babies that have occurred from 8/8/21 will have been started within 2 months of each death (including home births).			30/06/2022						PMRT Quarterly Report via MNOG
			>50% of deaths suitable for PMRT that occurred from **8/8/21** are reviewed using the PMRT by MDT and completed to at least the point where a draft report has been generated by the tool by **4 months of each death and published within 6months**.			30/06/2022						PMRT Quarterly Report via MNOG

			For 95% of all deaths from 8/8/21, the parents will have been told that a review of their babies death will occur, and their perspective/questions sought. Any anticipated delays will be explained to parents and a timetable for likely completion. If delays are expected, any questions that can be answered should be. Especially if the questions have bearings on future pregnancies			30/06/2022						PMRT Quarterly Report via MNOG
			Quarterly reports submitted to Trust Board from 8/8/21 that includes details of each death and consequent action plans. These reports should be discussed with the maternity safety champion and Board level safety champion.			30/06/2022						PMRT Quarterly Report via MNOG
10	Trusts & Health Boards and PMRT and governance teams to continue to improve the way in which the PMRT Tool is supported, resourced and implemented	Learning from Standardised Reviews When Babies Die (National Perinatal Review Tool), Third Annual Report, October 2021	Provide adequate resourcing of multidisciplinary PMRT review teams, including administrative support and ensure the involvement of independent external members in the team.	Strengthened learning & improvement Improved communication with parents	Head of Midwifery	30/06/2022	Benchmarking exercise underway against the recommendations. PRMT group convened and strategy being developed. 21/9/22 New Lead in post ?Advert out for Band 3 PMRT admin role LMNS member currently acting as external, plan to buddy up with another Trust improve external support 16/01/23 Awaiting Band 3, external member from LMNS, not yet buddied up with another trust					PMRT Tool Quarterly Report via MNOG
			Use the PMRT parent engagement materials to support engaging parents and families in the review process, including them being made aware a review is taking place and being given flexible opportunities at different stages to discuss their views, ask questions and express any concerns. Many parents may want to give positive feedback about the care they received.			30/06/2022	Benchmarking exercise underway against the recommendations. PRMT group convened and strategy being developed. Every parent is offered opportunity to be involved in review process, leaflet out to print around parental involvement 21/9/22 New lead in post					PMRT Tool Quarterly Report via MNOG
			Use the local PMRT summary reports and this national report as the basis to prioritise resources for key aspects of care and quality improvement activities identified as requiring action.			30/06/2022	Benchmarking exercise underway against the recommendations. PRMT group convened and strategy being developed. 21/9/22 new lead in post PMRT lead to pull report of key aspects of care for QI activities 16/12/23 PMRT summary report pulled					PMRT Tool Quarterly Report via MNOG Datix actions
			Improve the quality of recommendations developed as a consequence of reviews by developing actions targeted at system level changes and audit their implementation and impact.			30/06/2022	Benchmarking exercise underway against the recommendations. PRMT group convened and strategy being developed. 21/9/22 New Lead in post PMRT Lead to pull report of recommendations and rate quality of actions, assess for duplications on SIP					PMRT Tool Quarterly Report via MNOG Datix actions
			All PMRT actions to be recorded on Datix from September 2022 and monitored via Thursday Datix action meeting			31/12/2022	21/9/22 Decision required around timeframe for historical actions not currenlty on DATIX					PMRT Tool Quarterly Report via MNOG Datix actions
13	The Trust should ensure mandatory training is completed by medical staff in line with Trust policy,	2019 CQC Inspection	Report on core training compliance by staff group within the Divisional PRM slides.	Improved staff knowledge and	Head of Midwifery	31/01/2022	PRM report with staffing breakdown from most recent meeting is available.			01/03/2022	PRM Pack	Reporting on training performance

	completed by medical staff in line with Trust policy, in particular mental capacity and deprivation of liberty safeguarding training.	Inspection	Review the use of the Maternity Services Education Strategy to determine if this is effective in supporting improved training compliance.	knowledge and competency Improved quality & safety Strengthened assurance	Divisional Managing Director - Family Health	30/04/2022	There is a need to revisit the education strategy post-covid recovery and define milestones.				Revised Education Strategy Training Performance Data	performance generally is monitored at Divisional level through the established governance route: Divisional Clinical Cabinet
			Achieve Resuscitation core training level of 95% for medical staff.		Divisional Clinical Director - Family Health	30/04/2022	In-house trainers to deliver BLS training.				Training Performance Data	
			Achieve 80% training compliance (average across all core training subjects) for medical staff.		Divisional Clinical Director - Family Health	30/04/2022	Performance at 08/032022: PBH: 75.1% & LCH: 68.05%.				Training Performance Data	
			Achieve 95% Trust target for core training compliance for medical staff.		Divisional Clinical Director - Family Health	31/08/2022	Ongoing.				Training Performance Data	
14	The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff	CQC Inspection 2021 - Immediate Feedback & Written Report	Clear trajectories and monitoring of compliance to be agreed for midwives who training / sign off of competence is outstanding.	Improved staff knowledge and competency Improved quality & safety Strengthened assurance	Head of Midwifery / Deputy Head of Midwifery / Consultant Midwife	31/10/2021	Trajectories agreed and communicated to CQC although there has been some slippage on those timescales - see below.			31/10/2021		Performance against agreed trajectories is monitored monthly through MNOG
			Trust to deliver against agreed trajectories.			31/03/2022 (original date) 30/04/2022 & 30/11/2022 (revised dates)	Training is due to be completed at PBH by the end of April 2022 and at LCH by the end of November 2022. In respect of LCH, this is due to the continuity of carer midwives now being included within the training numbers.					
			Competencies to be included as part of roster planning.			31/10/2021	In place. The majority of midwives on the labour ward are B6 and therefore have, for the most part, obtained the necessary competencies as part of their training at B5 level. Assurance has been provided to the Maternity & Neonatal Oversight Group that management and oversight of the roster ensures that there are sufficient numbers of competent staff on shift to recover women following a general anaesthetic. By way of further assurance, it was agreed by the group that future update reports should include a random sample of reports from e-roster to evidence this point.			31/10/2021		
			Monitoring of compliance against the agreed actions and trajectories to be undertaken through the Maternity & Neonatal Oversight Group as part of the monthly Maternity & Neonatal Assurance Report			31/03/2022	In place & ongoing.			31/03/2022		
External Notification - HSIB / Early Notification Scheme												
15	The Trust has reported 100% of qualifying cases to HSIB and EN for 2021/22.	CNST Year 4 Safety Action	Reporting of all qualifying cases to HSIB for 2021/22.	Strengthened opportunities for	Safety Leads	30/04/2022	Ongoing - requirements met.					Monthly maternity & neonatal assurance

	HSIB and EN is 2021/22.	Safety Action 10	For qualifying cases which have occurred during the period 1 April 2022 to 5 December 2022 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and	opportunities for learning and improvement Improved communication with women and families		CNST Revised Date 5/1/23	Ongoing - requirements met.					neonatal assurance report / MNOG
			2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.				Ongoing - requirements met.					
Reporting, Investigation and Learning Lessons from Incidents & Complaints													
16	Mechanisms for learning lessons to be reviewed and strengthened, as required	Thematic Review of SIs & Complaints, November 2021	Actions plans generated from SIs to be more robust and follow SMART principles with follow-up through audit to ensure changes are embedded into practice.	Strengthened opportunities for learning and improvement	Risk Midwife / Patient Safety Lead Midwife	Ongoing	Changes to the SI report and action template will address this requirement. There is more robust QA of SI reports and action plans through the SI Rapid Review Panel. 4/10/22 Actions reviewed by external reviewer						
			Changes in practice to be disseminated in local educational meetings or specific learning lessons event rather than as email communications.			Ongoing	Survey underway to ascertain staff preferences as to how learning is shared.						
			Lessons learned event to be convened covering the themes and learning from the Thematic Review.			Ongoing	Themes and learning from the Thematic Review will be disseminated through existing forums and educational events to ensure as wider a coverage of staff as possible.						
			Introduce and / or strengthen any existing dedicated postnatal mortality & morbidity study days.			Ongoing	In place and ongoing.						
			Ensure the completion of all overdue SI actions as a priority.			Ongoing	Weekly action plan meetings continue to be held with the senior team and specialist midwives and include review of HSIB, PMRT, SI, DI and Complaint actions. Where appropriate, overdue actions are being aligned to relevant work streams within the Maternity & Neonatal Improvement Plan.						
17	Trust to provide assurance that staff are reporting incidents appropriately.	CQC Inspection 2021 - Immediate Feedback	Review current arrangements to ensure they are robust.		Risk Midwife / Patient Safety Lead Midwife	30/11/2021	Current mitigations in place: • DATIX reporting is stable, regular process, • Information from the dashboard is pulled from Medway and cross referenced with DATIX to support appropriate reporting, • Daily sit rep completed and sent to DoN which includes reports of harm which prompt DATIX review, • Risk midwife undertakes daily review of activity and DATIX to support accurate reporting.						Monthly Matrons Audits Safety Huddles
18	The Trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	CQC Inspection 2021 - Final Report	Review the mechanisms for sharing learning from incidents / SIs etc. to ensure they are reaching all relevant staff groups.		Assistant Director of Clinical Governance / Patient Safety Specialist	ongoing	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups. 23/9/22 Survey by Safety Culture team, results awaitied						Risk newsletter started Sep 2022
Safety Culture Milestones													
19	Undertake Safety Culture Climate Surveys.	Safety Culture Work Programme and Thematic Review of SIs & Complaints, November 2021	Undertake analysis of data provided to Family Health on previous Safety Climate Surveys undertaken through the East Midlands Maternity Network.	Improved Safety Culture Improved staff morale Improved Quality & Safety	Safety Culture Lead / Head of Midwifery	31/10/2021	Analysis completed and report submitted to MNOG in October 2021.			31/10/2021			
			Feedback findings and actions to staff.			30/11/2021	Feedback provided to staff by Divisional team.			30/11/2021			
			Repeat surveys are periodic intervals.			31/03/2022 Survey to be repeated at end of WI programme	Further survey planned for early 2022 facilitated through the East Midlands network. Date not yet provided. The network will communicate directly with the FH Division. 21/9/22 Workplace Innovation programme underway, agreed with Regional Lead EMAHSN that this is an acceptable sustitute for culture survey						

20	Introduce and participate in Safety Walk Rounds.	Safety Culture Lead & Team to join existing walk rounds.	Safety Culture Lead	31/12/2021	Walk rounds currently paused due to operational and COVID restrictions but arrangements in place to join once restrictions are lifted. Needs review of PSIT involvement. 12/10/22 Safety Culture Leads join Quality Matrons Assurance visits					
21	Ensure the continued engagement of the maternity team with the Safety Culture work including the 'Its Safe to Say' Campaign	Increase awareness of the 'Its Safe to Say' Campaign as part of the planned Comms Plan.		31/12/2021	Launch complete - outputs to be aligned with the Culture and Leadership Programme.			31/12/2021		
22	Complete the planned roll-out of Human Factors Training.	Safety Culture Lead to provide insight in to human factors training following incident reviews.		31/12/2021	In progress - part of PSIRF roll-out but support being provided on request. 12/10/22 PSIT involved in some Sis			12/10/2022		
		Safety Culture Lead to support Family Health Division with Human Factors training.		31/12/2021	Human Factors training booked for 2022/23.			31/12/2021		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Maternity Safety Improvement Plan

HEADLINE REPORT for Maternity & Neonatal Oversight Group

Jules Bambridge
Lead Midwife for Patient Safety

March 2023

v2.1 Maternity Neonatal Safety Impr

The Maternity Safety Improvement Plan (MatSIP) is a dynamic live document for the collation and monitoring of improvement actions arising from national maternity reports and assurance requirements as well as internally identified improvement actions e.g. actions identified through Serious Incidents.
As of 16th January 2023 the MatSIP is broken down into 6 sections

Section	Total Actions	**Red** Not yet completed / significantly behind agreed timescales or non-compliance expected	**Amber** In progress / on track / completion expected	**Green** Completed & ongoing and / or not yet fully embedded (awaiting evidence of embedding)	**Blue** Completed & embedded with evidence, to be signed off at MNSC prior to closure
Optimise Safety	**54**	7 (⬇2)	12 (⬇ 2)	36 (⬆5)	7 (⬆7)
Optimise Experience	**14**	2 (⬌)	7 (⬇3)	5 (⬆3)	0
Improve Leadership	**1**	0 (⬌)	1(⬌)	0 (⬌)	0
Deliver MNP Ambition	**0**	No longer applicable, archived			
Choice & Personalised Care	**10**	4 (⬆3)	2 (⬇ 3)	4(⬌)	0
Provide Assurance	**39**	6 (⬇5)	2 (⬇3)	4 (⬇15)	8 (⬆7)
TOTAL	**118**	**19**	**24**	**49**	**15**
Archived Actions	105	Completed, embedded and signed off by MNSC for closure			

Patient-centred ◆ Respect ◆ Excellence ◆ Safety ◆ Compassion

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

	Action No	Action Milestone	Responsible Lead	Due Date	Comments
1	OS6	Benchmark HIE numbers against Trusts using physiological interpretation. Trusts to benchmark against; GSTT, Kingston.	FM Leads	30/6/22	This is a significant piece of work - review and benchmarking to be completed following appointment of FM leads. 9/9/22 Kingston excluded due to STAN. Last 10 cases review planned to apply hypothetical physiological interpretation to evidence different course of action, expected 9/12/22 16/9/22 Data received from GSTT **23/03/23 ACTION REVIEWED BY EFM TEAM, SCOPING EXERCISE NOW COMPLETE AND PROJECT PLAN IN DEVELOPMENT : FOR ARCHIVING**
2		Identify barriers to implementation.			
3	OS40	Trust to ensure that the temperature of the treatment rooms within maternity at LCH are monitored to ensure that medicines are stored at the correct temperature and that there is restricted access to these rooms. - Audit the process to ensure compliance	Inpatient Matrons	31/3/22	**23/03/23 NOW BEING MONITORED VIA CQC ACTIONS, CAN BE ARCHIVED FROM SAFETY IMPROVEMENT PLAN**
4	OS41	Trust to ensure that the temperature of the treatment rooms within maternity at LCH are monitored to ensure that medicines are stored at the correct temperature and that there is restricted access to these rooms. Audit the process to ensure compliance	HoM / Matrons	30/4/22	
5	OS42	The Trust must ensure that all medicines are stored safely and securely. - Plan out action in response to audit to close any gaps identified (i.e. order digital thermometers)			
6		- Identify any risks from audit undertaken (i.e. rooms where ambient temperature is routinely 25 degrees or above and take advice from pharmacy around mitigations			
7		- Understand mitigations to environmental challenges in storage of medicines (i.e. age of estate at Lincoln maternity with a lack of air-conditioning/ventilation).			
8	OE2	Mandatory study session to be arranged for the whole department on communication / documentation with a focus on the communication issues identified during the Thematic Review.	Clinical Lead for Maternity Trustwide / Clinical Lead for Labour Ward LCH	30/6/22	To be delivered as part of Divisional training programme from April 2002 onwards and to be included in existing events and forums (e.g. governance, audit, CTG meetings) to ensure as wider a coverage of staff as possible. Training to cover patient stories as well as communication issues identified from the thematic review. 9/9/2022 iNeed escalation project underway, expected completion date 31st March 2023 utilising EBC L+S Toolkit 11/11/22 Ongoing iNeed project, currently undertaking qualitative review of escalation processes to be repeated in March 2023 following full implementation of iNeed tookit **23/03/23 COMMUNICATION NOW COVERED IN HUMAN FACTORS ELEMENT OF MANDATORY TRAINING: FOR ARCHIVING**
9	PA10	Provide adequate resourcing of multidisciplinary PMRT review teams, including administrative support and ensure the involvement of independent external members in the team.	HoM / PMRT lead	30/6/22	Benchmarking exercise completed. PRMT group convened and strategy being developed. 21/9/22 New Lead in post, plan for Band 3 admin post LMNS member currently acting as external, plan to buddy up with another Trust

10		Use the local PMRT summary reports and this national report as the basis to prioritise resources for key aspects of care and quality improvement activities identified as requiring action.	HoM / PMRT lead	30/6/22	improve external support, PMRT Lead to pull report of recommendations and rate quality of actions, assess for duplications on SIP and identify QIP 16/01/23 Update from PMRT Lead – Temporary administrative support in place, external remains ICB until buddying confirmed, summary report pulled but still requires review of key aspects of care in order to collaborate actions and identify QI. PMRT action plans will be taken to monthly action plan meeting to ensure quality of recommendations made.
11		Improve the quality of recommendations developed as a consequence of reviews by developing actions targeted at system level changes and audit their implementation and impact.	HoM / PMRT lead	30/6/22	
12	OS18	Consider cervical assessment prior to formal IOL as recommended by NICE to help assess the readiness of the cervix to decide the most suitable method of IOL and ensure women are being counselled appropriately.	IOL MW	31/08/22	23/3/23 Awaiting update from IOL lead
13	OS23	Audit real time IOL action timelines (i.e. admission, commencement, for transfer to labour ward, interval to when transferred to LW etc.). This will provide clear data that may highlight target areas for improvement and also can support the anecdotal perception that delays are fairly common, particularly at LCH	IOL MW	30/11/22	23/3/23 In progress
14	OS29	Elective LSCS - Draft Business Plan for staffing uplift.	General Manager for Family Health	31/10/22	23/3/23 Awaiting update
15	PA14	Recovery training - Clear trajectories and monitoring of compliance to be agreed for midwives who training / sign off of competence is outstanding.	Hom/DHoM	31/10/21	
16	OE 6	Review pharmacy and TTO processes	Inpatient Matron/Ward Manager	31/11/21	Ward manager has contacted Pharmacy to reinstate this project
17	CPC1	Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance.	Patient Safety Midwife	30/9/22	Project well under way, first draft of PCSP Pregnancy Journal now printing
18		Finalise method for recording planned BCC activity on PAS and explore / review how this activity is currently funded / costed.	Consultant Midwife	31/12/22	23/3/23 Progress update awaited
19		Finalise route of adminstration support to reduce admin workload on consultant midwife.	Consultant Midwife	31/12/22	23/3/23 Draft process in place

United Lincolnshire Hospitals NHS Trust

NED Maternity & Neonatal Safety Champion's Report: Dec - Feb 2023

Executive summary:

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

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

are all in place.

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

Activities undertaken this quarter:

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

- 14th December – LMNS
- 14th December – 1:1 HOM
- 11th January – 1:1 Consultant Midwife
- 20th January – MNOG
- 26th January – Military Project Lincolnshire – Military Voices
- 27th January – 1:1 Maternity Voices Chair
- 8th February - LMNS
- 21st February – Board Development session – Strategic Planning (Integrated Improvement Plan 2023/4)
- 23rd – 24th – NED Induction NHS Providers
- 24th Feb – 1:1 with MVP Chair

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

- Estates update in readiness for the meeting with Head of Estates
- Staff drop in clinics
- Session with new midwives
- Regional Community of NED Champions

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
• Building on continuity of care teams, targeting towards areas greatest need • Consolidated improvement plan and ensuring evidence	• Communication during labour • Military families issues with maternity records, isolation and navigation of new services	• Continued concerns about the Medway IT system/ environment including storage space. Challenges especially on the Lincoln site – the need to keep staff informed of progress – LMNS chair raised concern on the distribution of

objectively reviewed prior to sign off. • Wider Trust improvement projects motivating e.g. productive ward • Increased staff communications and dedicated organisational development support being provided • Wider system work on health inequalities, including weight management, diabetes, and physical exercise. • Gathering and robustly reviewing (internally and externally) evidence to ensure best practise and achievement of CNST.	• The success of the Military Maternity project for all families that have been involved. • Environmental issues at both maternity sites. • Opportunity for families to weigh their babies if bottle-feeding.	services due to poor connectivity. • Staff engagement and involvement in future IT system requirements (e.g., plug in v wireless laptops) • Concern that the Family Health Division did not have the support roles in post required to enable the strategy planning deadlines and delivery.

Good practice, improvements & innovation to share:

- Additional workforce funding available
- Innovative new roles for hard to recruit areas
- System support through the LMNS team
- CNST planned achievement
- Exit from regional maternity monitoring
- Review of the MNOG and implementation of amended governance.
- Military Voices show case event

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

Ongoing

- Status and timing of capital plans at Lincoln site
- Status, timing, and disruption of capital works at Pilgrim site
- Status and implementation of new maternity IT system – whilst this is closer funding and implementation dates have not been agreed as yet.
- Making *every contact count* across the wider Lincolnshire maternity and neonatal system (e.g., weight management, sexual health advice, dental support etc) and links with wider system strategies on equalities, health and well-being and early years
- Thinking about ways to capture feedback/experience through whole perinatal pathway and across services
- Understanding the impact of COVID on pathways (e.g., vaccination take-up; preterm deliveries etc).

New this month

1. The increasing disruption for patients and staff due to the current maternity IT system.

Activities planned:

- Develop relations with system/neighbouring Trust MNSC NEDs
- Liaising with regional team re Maternity Safety Champion NED regional meeting
- Site visits

- Attending Maternity and Neonatal Oversight Group.
- Exploring a system-wide strategic planning session

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

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:	11 April 2023 – Cancelled due to industrial action
Chairperson:	Professor Philip Baker, Chair
Author:	Claire Low, Director People and Organisational Development

Purpose	This report summarises the matters due to be considered by the People and OD Assurance Committee at the cancelled 11 April 2023 meeting. The report details the strategic risks 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 works 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** Concerns in regards attendance and quoracy were noted by the Committee at the previous meeting in March 2023. Additional escalation in terms of the importance of attendance has been undertaken with the members of WSODG. Latterly attendance improved for the April meeting and the Group was quorate. The terms of reference due to be submitted to the Committee in April will be submitted in May for approval. **Committee Performance Dashboard** There were no items of escalation in regards the performance dashboard from the WSODG to the Committee. The main areas of focus for the WSODG and the Committee are: Vacancies, Turnover rate, Sickness rate, Statutory and Mandatory Training compliance rate, and Appraisal compliance rate. The performance dashboard will be reviewed at the Committee meeting in May. **Submission to NHSE/I - Workforce Plan and numbers** The Trust met all deadlines in regards to the Workforce Plan submission and received positive feedback from regional colleagues. This report has been deferred for review at the Committee meeting in May. **Safer Staffing** There were no items of escalation in regards Safer Staffing from the WSODG to the Committee.

	Safer Staffing will be reviewed at the Committee meeting in May. **Trauma and Orthopaedic Deep Dive Report** This paper has been deferred for review at the May Committee meeting.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Pulse Survey feedback** Although a fuller paper was available for review at the April Committee meeting the Committee did receive an update in respect of the Quarter 4 Pulse Survey feedback as part of the National Staff Survey paper that was presented and received by the Committee for information at the March Committee meeting. **Culture and Leadership Group Upward Report** The Committee received a report at the March Committee meeting and while a paper was on the agenda for the April Committee meeting the Culture and Leadership Group were not due to meet between March and April therefore there is no upward report. The Director of People and Organisational Development will work with the Deputy Trust Secretary to ensure an appropriate reporting cycle is in place for this meeting. **Freedom to Speak Up Report** The Committee were due to receive a quarter four update report outlining key findings in relation to confidence to speak up from the staff survey results, which has shown a small increase in staff feeling they have a voice that counts. General work update continues to highlight the good work being undertaken including an increase in the number of Champions which now stands at 21 across all sites, including Louth. This paper has been deferred for review at the May Committee meeting. **GMC Junior Doctor Survey Update** This paper has been deferred for review at the May Committee meeting. This is a particularly pertinent issue for review in the current context of Junior Doctor strikes.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Research and Innovation Update** This paper has been deferred for review at the May Committee meeting.

	University Teaching Hospital Group Upward Report Positive discussions continue to take place with the University and progress of the University Teaching Hospital Group will be reviewed at the Committee meeting in May.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee were due to receive the monthly report which will continue to have limited assurance due, in the main, to the continued challenge with achievement of appraisal and mandatory training figures. It was recognised at the Committee Meeting in March that work was taking place in both these areas to enable progress. The Integrated Improvement Plan will be reviewed at the Committee meeting in May. **Risk Report including Risk Register** The Committee will review the Risk Report and Risk Register at the May Committee meeting. **Audit Recommendations** The Committee will receive any outstanding audit recommendations at the May Committee meeting. **Review of relevant external reports/inquiries** The Committee were due to receive a report outlining the Trusts response to the Healthcare Safety Investigation Branch (HSIB) investigation into staff wellbeing across the urgent and emergency care systems and the impact that this has on patient safety. The report from Occupational Health identified some gaps within the Trust in particular safe spaces or dedicated areas where staff can express how they feel in a safe secure environment. The report also identified areas of good practice within the Trust including training a pool of over 50 staff to have the skills to undertake debriefs in key areas such as A&E urgent care ITU and Maternity. This paper has been deferred for review at the May Committee meeting. **CQC Action Plan** At the March Committee meeting the Committee noted the intention for a review of the action plan, which would be discussed through the Trust Leadership Team and presented back to the Committee. The action plan will continue to be reported in-line with its reporting cycle.

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	Not applicable
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 position remains as at March 2023. A review of the papers due to be considered at the cancelled April 2023 Committee Meeting continues to provide assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*02 May 2023*
Item Number	*Item 9.2*

National Staff Survey – Action Plan

Accountable Director	*Claire Low, Director of People and Organisational Development*
Presented by	*Claire Low, Director of People and Organisational Development*
Author(s)	*Damien Macdonald-Bloomfield, Head of Organisational Development*
Report previously considered at	*Not applicable*

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	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish collaborative models of care with our partners	
4b Becoming a university hospitals teaching trust	
4c Successful delivery of the Acute Services Review	

Risk Assessment	*NA*
Financial Impact Assessment	*NA*
Quality Impact Assessment	*NA*
Equality Impact Assessment	*NA*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *None – update report on National Staff Survey*

Executive Summary

This report provides the Trust Board with an update on the work being conducted in relation to the National Staff Survey results.

The NHS Staff Survey 2022 was conducted by Picker with 65 acute and acute community trust organisations. Our aggregate positive score places us at position 57 out of 65. The overall positive score is the average positive score for all positively scored survey questions [ULHT was rated 60/60 in 2021 and 58/58 in 2020].

Since 2021, our overall positive score has increased by approximately 3.5%, ranking us second out of 65 for the highest increase in our overall positive score. Among the 65 acute and community trust organisations that conducted the NHS Staff Survey 2022 with Picker, this is the number.

Following the lift of the embargo on 9 March 2023, the Organisational Development Team will be responsible for ensuring that the results of the survey are shared at trust and divisional levels.

The divisional action plans will completed by the end of May 2023, and a communications road map will enable ongoing engagement and communication throughout the year and into the 2023 National Staff Survey.

The Workforce Strategy and Organisational Development Group will monitor progress against divisional action plans on a monthly basis, allowing for reporting to the People and OD Committee.

Purpose

To provide an update to the Trust Board on work being undertaken in regards to the results of the 2022 National Staff Survey.

Key messages

The survey results were released on 9 March 2023, since then the Organisational Development Team have been collaborating with Communications colleagues to send out trust-wide communications to inform all staff groups of the high-level results.

This year's survey was conducted by Picker, with 65 acute and acute community trust organisations. Our aggregate positive score places us at position 57 out of 65. The overall positive score is the average positive score for all positively scored survey questions [ULHT was rated 60/60 in 2021 and 58/58 in 2020].

Our overall positive score has increased by approximately 3.5% since 2021, and we are ranked 2/65 for the highest overall positive score increase. This is out of the 65 acute and community trust organisations that ran the NHS Staff Survey 2022 with Picker.

Staff Survey Results and Action Plan

In April 2023, divisional communications commenced. Each division's results have been compiled into data packs, and Divisional Heads of HR with their OD Managers are collaborating with divisional teams to determine the top two or three actions they will pursue in response to the data. When necessary, divisions will host additional listening events, such as focus groups or workshops, in order to comprehend any areas where the data raises concerns.

These action plans will be returned to the Organisational Development Team by the end of May 2023 who will combine into one over-arching plan, allowing the Workforce Strategy and Organisational Development Group to monitor monthly progress.

In preparation for the reopening of the survey in the third quarter of fiscal year 2023/24, the Organisational Development Team is collaborating with communications colleagues to develop a comprehensive roadmap. This map will highlight key engagement plans that will take place throughout the year. A major emphasis will be placed on recognising accomplishments using our already established brand of **"you said, we did"** style activities to demonstrate that we are acting on feedback.

The People Promise Manager is preparing a report for various meetings and committees in June 2023, when the action planning has completed, outlining the over-arching plan and timetable for addressing the results. This will also connect the national staff survey activity to the broader organisational development strategy being formulated by the new Head of Organisational Development.

The Organisational Development team have already undertaken some analysis of the results and have identified the following key themes from the survey feedback:

- Health and Wellbeing
- Staff Development
- Acting on concerns
- Free text, offers a focus on development themes
- Caring and compassionate leaders that listen

Based on the key themes the Organisational Development team have identified 10 strategic recommendations/actions they are proposing will be taken forward alongside the divisional

specific action plans. These are outlined below as a draft proposal which need full approval by the Trust through ELT and TLT.

- **Compassionate leadership:** Build on **ELT** live sessions by introducing ***"we hear you, we see you sessions"*** which would run at divisional level by our **SLT** members on a quarterly basis across each ULHT site - in person sessions.
- **Act on concerns:** Based on these session, turn feedback into action, sharing through our ***"you said, we did"*** actions and results (we each have a voice that counts).
- **Development:** We commit that every colleague will receive a 90-minute appraisal within the next financial year; plans will be put in place for resource and time required to achieve this.
- **Development**: Every appraisal will have a focused conversation around development and career aspirations including, short, mid and end of career options.
- **Health and Wellbeing:** We commit that every employee who becomes unwell will receive the appropriate support including a compassionate and caring call back within the first 48hrs. This call back will offer support available such as EAP. Wellbeing strategy being developed with a Wellbeing Manager appointed.
- **Reward and Recognition:** Launch our one stop, reward and recognition platform Viv-up as per TLT paper being considered on the 4th May 2023.
- **Develop our leaders:** In order to achieve the above we recommend that we upskill and refresh all our managers and leaders in respect of our Leaders Basics Brilliantly workshop, which we recommend is mandated across the Trust for every existing and new leader to experience over the next 24 months - the investment is two days per leader.
- **Act on concerns:** Link to our 2023/24 "United Against" campaigns covering, aggression, harassment, bullying and other forms of inappropriate behaviour
- **Development:** Leading functional teams during times of conflict and difficulty by upskilling our leaders to hold effective mediated conversations. This course has been developed using TKI conflict handling, OD and our trust Occupational Health Team.
- **Embed:** People Promise into BAU through further education in respect of the People Promise pillars and what this means to them; launch our Restorative and Just Culture education programme and train our leaders to use this tool.

Conclusion:

Work is taking place at both divisional and trust level to identify and deliver the key actions that will make a difference to our staff based on their feedback through the staff survey.

These actions will be the key drivers to support continued staff engagement and the continued increase in our positive scoring at the next National Staff Survey.

Divisional action plans will be complete by end of May 2023 and the 10 strategic recommendations/actions identified through analysis of the trust level data will be further developed and refined and agreed at ELT and TLT to ensure appropriate senior level support and commitment.

The Workforce Strategy and Organisational Development Group will monitor progress against divisional action plans on a monthly basis, allowing for reporting to the People and OD Committee.

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	20 April 2023
Chairperson:	Dani Cecchini, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Mortuary Update – QGC Referral** The Committee received the update noting that actions underway in respect of response to concerns raised by the Human Tissue Authority. It was noted that the required improvements had been made however additional work would be undertaken during the financial year to improve the family room and viewing area. The Committee received a verbal update in respect of access to the mortuary which was the specific area of focus of the referral with the Committee noting that there was controlled access to mortuary services.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts and CIRG Upward Report** The Committee received the suite of finance reports noting the month 12 revenue position which closed at £13.6m deficit, in line with the plan agreed at month 9 and the capital programme expenditure of £47.4m, fully utilising the full capital allocations available. The Committee noted the efficiency report and the £18m of efficiency that had been delivered in 2022/23 however recognised that a large proportion of this was non-recurrent. The contract position was noted with the expectation that this would be signed by the end of April for the 2023/24 year with a specialised commissioning contract also due to be signed, subject to agreeing the final position.

	The Committee received and noted the Capital, Revenue and Investment Group upward report noting that the mortuary business case had been considered. **2023/24 Revenue and Capital Financial Plan including System Financial Recovery Plan Trajectories** The Committee received the financial planning reports including the system financial recovery plan trajectories. The Committee noted the £20.8m Trust deficit for 23/24 subject to a £32m total CIP. There was a £4m full year effect CIP from 22/23 meaning delivery of £28m CIP was required in 23/24. The Committee understood the capital resource available to the Trust to be used and this was insufficient to manage the estate backlog and statutory compliance issues. Further work would be undertaken at Board level in order to support prioritisation of works. The Committee noted the moderate assurance offered understanding what drove the position and level of assurance. **Strategic Procurements** The Committee noted that the report offered a table of the upcoming procurements noting that this would support scheduling of items to be received to the Committee and subsequently the Board. The Committee requested the inclusion of expiry dates of contracts to support these being presented at the appropriate time and to ensure capacity for these to be considered.
	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Hospital Group Upward Report** The meeting was cancelled due to industrial action **Clinical Records update – QGC Referral** The Committee noted the verbal update offered with the reinstatement of the Clinical Records Group (CRG) and revision of the terms of reference which had been approved by the Information Governance (IG) Group. The Committee noted that reporting from CRG to IG Group would take place with upward reporting through to the Committee
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting the moderate assurance offered. The Committee noted the increased pressures in urgent care experienced during March with an increase in EMAS conveyances and a 14% increase in type 1 activity.

	It was noted that the increased pressures dovetailed with the inability to create the correct flow and balance demand due to the number of open escalation beds. The Committee was aware of the need to address the open escalation beds across the Trust in order to ensure that the organisation operated in the safest manner. System work was underway to consider right sizing of beds however this would need to be brought to conclusion before the Trust would be able to reduce beds to the 968-core bed base. The planned care updated detailed the achievement of 0.79% in March for cancelled operations noting that this demonstrated the work, control and dedication that the TACC team had developed. The Committee noted that whilst the 78-week zero target had not been achieved at the end of March this was as a result of the Junior Doctor strike and patient choice with lost capacity reported. The Committee noted the expectation in May to formally launch the elective hub at Grantham with continued support being received from Professor Briggs. Improvements were being seen across diagnostics with grip and control being seen and further improvements in compliance against DM01. The Committee noted the position in cancer services with a high level of confidence that the increase would be brought back down in respect of the 104-day backlog. Teams were in place to support patients to receive appropriate care and treatment. As a result of the assurances offered to the Committee and the level of confidence to achieve cancer trajectories the Committee supported the uplift of objective 3d to amber from red.
	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: **Committee Governance Arrangements** The Committee consider the governance arrangements of the reporting groups to enable clear sight of assurances in respect of the relevant strategic objectives and legislative/regulatory requirements. The Committee requested that during the course of May and June that the reporting groups consider their terms of reference and work programmes to offer to the Committee in June for approval. There would be a need within the terms of reference to include a descriptor of how system groups would feed in. **Committee Effectiveness – Final Annual Report** The Committee received and approved the final report for the Board noting the need for the minor addition of the ambition to review the assurance rating for objective 3d. **Planning Update 2023/24** The Committee received the report noting the progress that had been made in respect of 2023/24 planning noting the focus that needed to be provided during the year of efficiency and productivity. The Committee noted the importance of the patient level costing information in the ability to understand and demonstrate productivity. The focus on agency reduction was noted with the Committee seeking to understand the link of this with bed closures. It was noted however that there were 3 areas of focus, these being recruitment and retention of substantive staff, reduction of agency in line with service delivery requirements and improved rota management of staff. **CQC Action Plan** The Committee received the update noting that actions were covered through other reports received by the Committee and noted that a group would be established to support progress of urgent care associated actions. The Committee also noted the need to receive assurance on the delivery of actions through the reporting groups. **Improvement Steering Group Upward Report** The Committee received the upward report from the Improvement Steering Group noting a number of positive achievements at the end of 22/23.

	Achievements had included £1.6m delivered against a target of £1.8m reduction in agency spend with £241k set to be recovered during March. It was also noted that there had been a reduction in ambulance handover times for patients waiting over 59 minutes and a reduction in stay as a result of the productive theatres programme. The Committee noted that the achievements demonstrated that with the right infrastructure in place delivery could be achieved. With the infrastructure there was confidence to deliver. **Committee Performance Dashboard** The Committee received the report noting that items had been considered through the reports received however specifically noted that compliance target of 0.8% for cancelled operations. The Trust had demonstrated, in March, compliance of 0.79%, the lowest reported since December 2021.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. The Committee agreed that Objective 3d Improving cancer services access should, as a result of the assurances and continual improvements received, be uprated to Amber.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	M	J	J	A	S	O	N	D	J	F	M	A
Dani Cecchini, Non-Exec Director	X	X	X	X	X	X	X	X	X	X	X	X

Gail Shadlock, Non-Exec Director	A	A	X									
Director of Finance & Digital	X	X	X	X	D	X	X	X	X	X	X	X
Chief Operating Officer	D	X	X	X	X	X	X	X	X	X	X	X
Director of Improvement & Integration	X	D	X	D	X	X	X	D	X	X	X	X
Sarah Buik, Associate Non-Executive Director				X	X	X	X	X	X	A	X	X

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

United Lincolnshire Hospitals NHS Trust

Annual Report to the Trust Board from the Finance, Performance and Estates Committee 2022/23

ROLE OF THE COMMITTEE

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

The Finance, Performance and Estates Committee will:

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

A modern, clean and fit for purpose environment:

- Developing a business case to demonstrate capital requirement
- Delivering environmental improvements in line with Estates Strategy
- Continual improvement towards meeting PLACE assessment outcomes
- Reviewing and improving the quality and value for money of facilities services including catering and housekeeping
- Continued progress on improving infrastructure to meet statutory Health and Safety compliance
- Implementing year 1 of the estates strategy
- Use of the Premises Assurance Model (PAM)

Efficient use of resources:

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

Enhanced data and digital capability:

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

Improving Cancer Services access:

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

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

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

Urgent Care:

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

Establish collaborative models of care with our partners:

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

Successful delivery of the Acute Services Review:

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

MEETINGS

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

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

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

MEMBERSHIP AND ATTENDANCE

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

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

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

Members	**21 April 2022**	**30 May 2022**	**23 Jun 2022**	**21 July 2022**	**25 Aug 2022**	**22 Sep 2022**	**20 Oct 2022**	**24 Nov 2022**	**22 Dec 2022**	**25 Jan 2023**	**23 Feb 2023**	**23 Mar 2023**
Non-Executive Director (Mrs Cecchini, Chair)	X	X	X	X	X	X	X	X	X	X	X	X
Non-Executive Director (Ms Shadlock)	X	A	A	X								
Associate Non-Executive Director Mrs Buik)					X	X	X	X	X	X	A	X
Director of Finance and Digital	X	X	X	X	X	D	X	X	X	X	X	X
Chief Operating Officer	X	D	X	X	X	X	X	X	X	X	X	X
Director of Improvement and Integration	X	X	D	X	D	X	X	X	D	X	X	X

X denotes attendance
A denotes Apologies given

D denotes Deputy in attendance

REVIEW OF BUSINESS

The Finance, Performance and Estates Committee work programme for 2022/23 is set out as an appendix to this report.

The Finance, Performance and Estates Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2022/23:

- Objective 3a A modern, clean and fit for purpose environment
- Objective 3b Efficient use of our resources
- Objective 3c Enhanced data and digital capability
- Objective 3d Improving cancer services access
- Objective 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards
- Objective 3f Urgent Care
- Objective 4a Establish collaborative models of care with our partners
- Objective 4c Successful delivery of the Acute Services Review

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

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

Objective 3a – **AMBER**
Objective 3b – **AMBER**
Objective 3c – **AMBER**
Objective 3d – **RED** (September)
Objective 3e – **AMBER** (September)
Objective 3f – **RED** (September)
Objective 4a – **AMBER**
Objective 4c – **GREEN** (July)

At the end of the year the strategic objectives were rated as follows:

Objective 3a – **AMBER**
Objective 3b – **RED**
Objective 3c – **AMBER**
Objective 3d – **RED**
Objective 3e – **AMBER**
Objective 3f – **RED**
Objective 4a – **AMBER**
Objective 4c – **AMBER**

During the course of the year the Committee has reduced the level of assurance ratings presented within the Board Assurance Framework to reflect the position of delivery against the strategic objectives.

Objective 3b – Efficient use of resources was reduced from amber to red as a result of non-delivery of the statutory financial duty.

The Committee noted the intention and ambition to review, in the first part of the 2023/24-year, Objective 3d - Improving cancer services access to consider moving the objective from red to amber due to the continued achievements being reported.

Objective 4c – Successful delivery of the Acute Services Review was reduced from green to amber to reflect that assurance were felt to be in place however assurances were uncertain.

OVERVIEW

The Finance, Performance and Estates Committee has continued to, over the last twelve months, work to improve the assurance it can give to the Board on finance, operational performance, estates and digital services. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan, as defined by the terms of reference through this annual report.

The Committee has been well attended by members and the Chair has been actively involved in the agenda setting alongside the Director of Finance and Digital.

Other key areas of focus of the Committee have included:

- Estates
- Health and Safety
- Emergency planning
- Digital services
- Information Governance
- Constitutional standards
- Service Recovery

The Committee receives monthly assurance/exception reports from the reporting groups offering assurance on areas relevant to the remit of the Committee. There remained a continued focus in 2022/23 on reporting from the Estates Directorate with continued improvements seen in reporting.

Appointments to Authorising Engineers had been completed in year with the Committee seeing the benefit of these roles through reports received. The Health and Safety Annual Report had been received and approved by the Committee demonstrating the continued improvements and the ongoing work to achieve a 5-star

rating from the British Safety Council in respect of the Trusts Occupational Health and Safety arrangements.

The Committee noted through reporting that further focus was required in respect of fire safety following the lifting of all enforcement notices in the previous year. The Committee had requested that a clear action plan be put in place to address the concerns raised and noted that there was an improved, open and transparent relationship with Lincolnshire Fire and Rescue.

Work continued in respect of the utilisation of the Artificial Intelligence System to support prioritisation of patients and to ensure patients were appropriately categorised and to support the reduction of waiting lists. The reduction of waiting lists had also been supported through a validation process which had, overall, seen a reduction in the waiting lists however there was, at this time, no productivity gain.

The Committee continued to monitor the delivery of the Integrated Improvement Plan noting that the delivery of projects had progressed during the course of the year supported by the implementation of the Improvement Steering Group. In addition, the committee has received deep dive briefings into progress made in respect of the theatres and outpatient improvement plans. These have served to provide assurance that an appropriate infrastructure is in place to support these initiatives whilst recognising some slippage in progress to date.

Throughout the year the Committee has periodically received updates in respect of cyber security that have offered assurance on the levels of cyber security being achieved by the Trust.

Development of the Electronic Patient Record had also been considered by the Committee through receipt of the outline business case to support implementation. The Committee supported the business case onward to the Trust Board for approval and to seek national approval to progress and fund.

Reporting had also been received in respect of Information Governance with the Committee noting ongoing concern with regard to Freedom of Information and Subject Access Request compliance. There was however a focus on supporting an increase in resource for Information Governance in order to deliver the required improvements which had been agreed by the Trust Leadership Team.

The Committee towards the end of the financial year had given focus to the planning ahead to ensure the planning activity was in place noting that financial planning would be undertaken at system level with internal planning focussing on engagement with the Divisions to deliver against budgets agreed and saving and improvement programmes.

On a monthly basis the Committee continued to receive updates in respect of actions required for Low Surface Temperature works with the Committee receiving assurance that those actions within the remit of the Trust had been completed. The Committee continued to monitor the action plan for actions relating to third party premises.

Risks

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

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

Performance Review

The Committee reviews performance against the agreed Key Performance Indicators (KPIs) and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover operational performance and efficient use of resources.

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

Performance discussions focused on operational performance and the Trusts' ability to recover following the impact of Covid-19. The Committee noted variable progress in performance over the year noting that this continued to be impacted by delays as a result of Covid-19 and the increase in operational pressures being experienced across the NHS.

It was noted however that there had been some positive movement in year in performance in areas such as colorectal services and a reduction in patients being seen through cancer pathways who did not require cancer services.

Performance in Same Day Emergency Care had also seen 30% of all medical admissions being cared for and going home the same day. There had also been a positive position in planned care for 104 week waits with the Trust performing joint best in the region.

Concerns remained however in respect of the continued deterioration in urgent and emergency care, due to increases in demand and continued flow and discharge issues, Care Close to Home not delivering the level of impact expected and

challenges in restoring capacity in outpatient services to pre-Covid-19 levels and above.

The Committee noted throughout the year the financial position of the Trust with a breakeven plan submitted for the System. Following the financial regime during Covid-19 this had now reverted to contracted payments resulting in a more challenged position due to the continued Covid-19 costs being incurred by the Trust.

Work continued to reduce the costs associated with Covid-19 with the Committee supporting, during the financial year, a number of business cases which would see elements of Covid-19 costs moved within the envelope of the Trust.

The Committee noted the during the year the Trust reported a deficit position with a readjusted financial plan submitted by the System to recognise the ongoing movement in the financial position.

Worked continued to identify Cost Improvement Programmes (CIP) to reduce spend however in year it was noted that these mainly focused on transactional CIP rather the transformational with a significant value of non-recurrent schemes impacting negatively on the financial position for 2023/24.

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2nd May 2023*
Item Number	*Item 12*

Integrated Performance Report for February 2023

Accountable Director	*Jon Young, Deputy Director of Finance & Digital*
Presented by	*Jon Young, Deputy 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

SHMI

The Trust SHMI has slightly decreased this month and is currently at 102.93. 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. The Trust HSMR is 94.03.

eDD

The Trust achieved 88.3% with sending eDDs within 24 hours for March 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 February data

Screening Inpatient child– Screening compliance for inpatient child increased to 88.0%. Six of the eight missed / delayed screens were children found to have a viral cause for illness. There were 2 children delayed in getting treatment, both of these were due to very difficult cannulations.

IVAB Inpatient Child - The administration of IVAB for inpatient children reduced to 80%. 8 out of 10 children that required treatment received this in a timely manner. 2 children had delayed antibiotics. One child was very difficult to cannulate and another child was found to have a tissued cannula and had to wait for another before antibiotics could be given.

IVAB ED child - The administration of IVAB for children in ED was at 33.3% a decrease from the last reporting period. There were 4 patients in ED this month that were delayed in receiving antibiotics. 2 children were difficult to cannulate leading to the delay. One child was waiting to be seen by paediatrics before a decision was made and the other was waiting to be transferred to the ward and seen by paediatrics before a decision was made. Sepsis training has been delivered for new Doctors starting in February. Simulation training has been reintroduced in ED areas.

Duty of Candour (DoC) – February Data

Verbal compliance for February was at 94% against a 100% target and 88% for written against a target of 100% within the reporting period. The Clinical Governance team continue to notify clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion. Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's and performance is included in monthly divisional governance reports.

Operational Performance

At the time of writing this executive summary (17th April 2023), the Trust has 39 positive COVID inpatients with no patients requiring Intensive Care intervention. The March peak was 48 patients. The current Influenza inpatients are 0 with the peak in March being recorded at 5 patients. RSV peaked at 14 patients in March but as of the date of this report there are zero. There are currently 2 patients reconfirmed Norovirus with a further prevention/intervention at PHB.

This report covers March'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

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

4-hour performance was incompliant against the 4-hour target with a reduction in performance at 57.03%. Which is a 1.18% negative variance against February's position.

There were 721 12-hr trolley waits, reported via the agreed process in March. This represents an increase of 19 patients from February 2023 (702). Sub-optimal discharges/timely recognition to meet emergency demand remains the root cause of these delays.

Performance against the 15 min triage target demonstrated a deterioration of 0.39%. 78.23% in March verses a target of 88.50%. A deeper review is required of patients who leave the department or refuse treatment that compromise this performance target.

There were 616 >59minute handover delays recorded in March, an increase of 300 from February, representing a 94.93% decline. March experienced a 5.4% increase in ambulance arrivals.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 5.01 days against an agreed target of 4.5 days a deterioration of 0.12 days compared to January. The average bed occupancy for March against "Core G&A" was in excess of 98%, with PHB demonstrating the highest level of occupancy against core. March saw the highest number of acute beds open at 1067 verses funded core G&A of 968 acute beds.
System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3. Pathway 1 saw an increased length of stay by 1.2 days compared to February 2023. Pathway 2 saw an increase of 2.1 days and Pathway 3 an increase of 4.6 days.

Elective Length of Stay decreased further from 4.30 days in February to 3.02 in March.

Referral to Treatment

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

February demonstrated an improvement in performance of 0.4%. February outturn was 49.56% versus 49.16% In January. 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 2,766 patients waiting over 65 weeks, which is a decrease of 721 patients on the reported January position. The position requires close monitoring and scrutiny.

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

At the end of March, the Trust reported zero patients waiting longer than 104 weeks. Discussions are taking place with NHSE weekly in regard to 104- and 78-week waiters with an expectation of 277 patients over 78 weeks by end of March 2023 including first definitive treatment due the impact of the Junior Doctors strike action. The previous position was zero.

Waiting Lists

Overall waiting list size has decreased since January. February reported 72,055 compared to January's position of 72, 772 a decrease of 717. 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 17th April, ASI recovery has demonstrated a deterioration (1,499 verses 564 in February) 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 March reported ongoing improvement 61.83% verse 60.12% in February. Compliance against the national target of 99%. A positive variation of 1.71% improvement on the February outturn but still a negative variance of 37.62% 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 866 in March compared to 1163 in February. Endoscopy backlog due to outpatient recovery, in particular, colorectal. This will be supported by the continued utilisation of Medinet.

Cancelled Ops

This performance target requires special mention. The compliance target for this indicator is 0.8%. March demonstrated 0.79% compliance. This is the first time this target has met the national target of 0.80% - Congratulations!

The target for not treated within 28 days of cancellation is zero. March experienced 16 breaches against the standard verses 22 in February.

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 39.27% (against 85.4% target.) This demonstrates a deterioration of 0.03% in performance since the last reporting period and is 46.13% below the nationally agreed compliance target. However, the position against the Trust recovery trajectory is just in line.

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

104+ day waiters have reduced and are achieving the agreed trajectory. There are currently 84 patients waiting >104 days against a target of <10. The current figure is a further decrease of 43 patients since the last reporting period. The highest risk speciality is colorectal with 52 pathways greater than 104 days, this a further reduction of 31 since the last reporting period. 3 times weekly meetings are in place to offer challenge and confirm.

Workforce

Mandatory Training – The mandatory training rate for February has seen a slight increase (by 0.38%) to 89.18% against 95% target. Work is ongoing to ensure that all areas and individuals are given the time to complete core learning modules. The recent strike action has inhibited progression in terms of core compliance rates and will continue to do so whilst a risk of for further cancellation of training continues to occur over the coming months if further industrial action occurs. The Mandatory Training Action Plan has now been approved and work is underway to improve our mandatory training compliance, including the review of all core and topics to ensure these are still required. A 6-month progressive compliance target has been agreed with the final target of 95% to be achieved by October 2023.

Sickness Absence – The March sickness absence rate of 5.61% 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 discuss 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 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 65.95% non-medical and 99.44% 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 continues to see downward trend with March turnover being 12.82% against a Target of 12%. Operational pressures, staffing and culture challenges mean that a regular proportion of staff are looking for other avenues outside the Trust. 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 0.8% decrease in vacancy factor in March to 6.9%, this was due to us having a significant number of starters joining the Trust. 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 in coming months due to sizeable business cases for Community Diagnostics and Housekeeping being signed off which will increase our funded establishment, however despite this due to significant recruitment our net staffing position will continue to grow.

Finance

The Trust submitted a revised financial plan for 2022/23 of a break-even position; the plan is inclusive of a £29.0m cost improvement programme.

The Trust delivered a deficit of £0.3m in March (£0.3m adverse to plan) and a year-end deficit of £13.6m deficit (£13.6m adverse to plan).

CIP savings of £18.9m have been delivered YTD (£10.1m adverse to planned savings of £29.0m).

Capital funding levels for 2022/23, agreed through Trust Board & FPEC, show a plan of £47.5m; capital expenditure incurred in 2022/23 equated to £47.5m.

The March 2023 cash balance is £41.3m, which is a decrease of £47.0m against the March 2022 year-end cash balance of £88.3m.

Paul Matthew
Director of Finance & Digital
April 2023

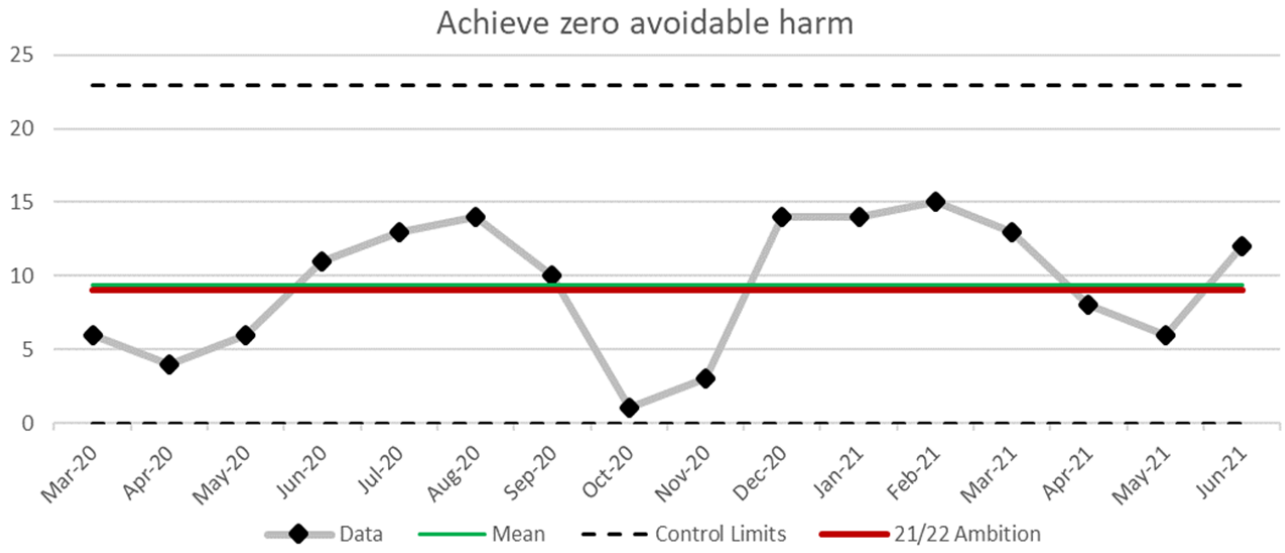
Statistical Process Control Charts

to make appropriate decisions.

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

An example chart is below:



Statistical Process Control Charts

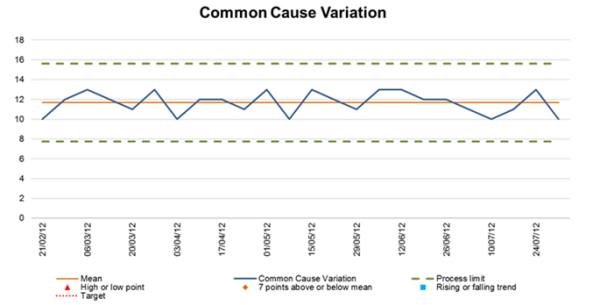
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- A trend – may be identified where there are 7 consecutive points in either a patter that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

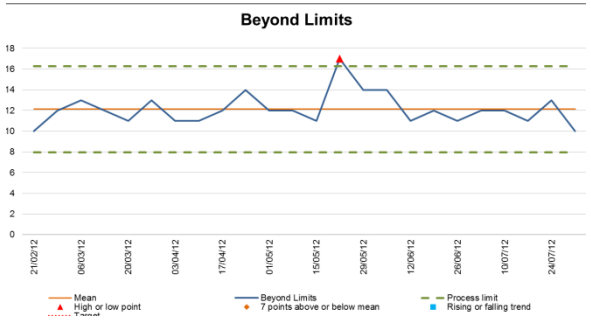
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



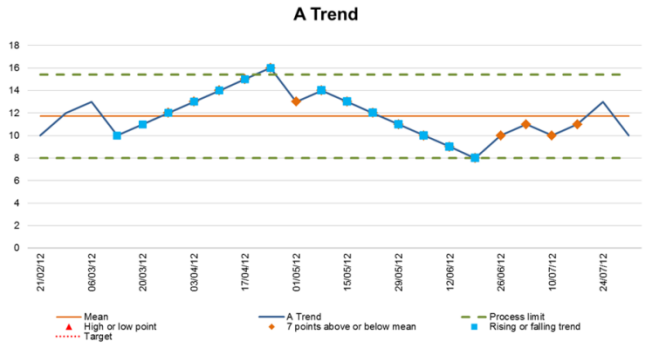
Extreme Values

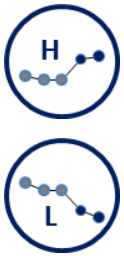
There is no Icon for this scenario.



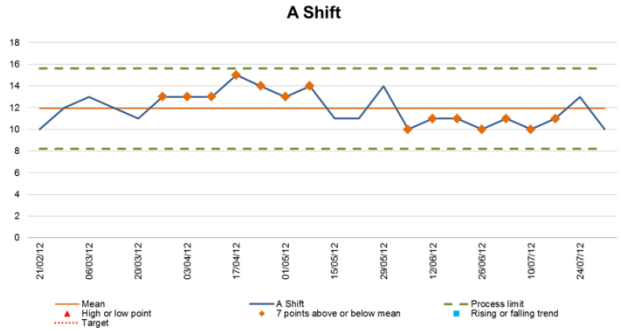
Statistical Process Control Charts

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

Where the target has been met or exceeded for at least 3 of the most recent data points in a row, or sitting is a string of 7 of the most recent data points, at least 5 out of the 7

Where a target has been missed consistently

Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

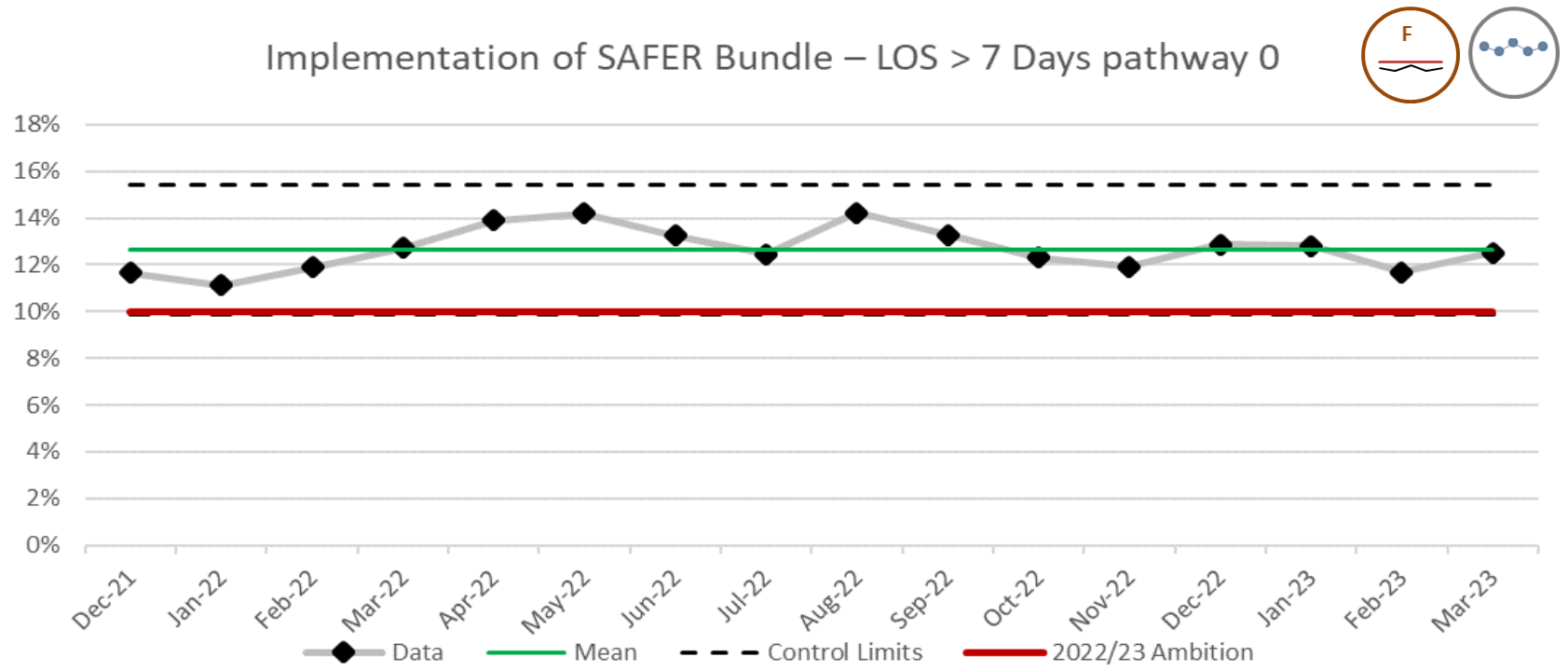
EXECUTIVE SCORECARD

Measure ID	Domain	Measure	Measure Definition	SRO	2022/23 Ambition	Tolerance	£'000	Jan-23	Feb-23	Mar-23	Latest month pass/fail to ambition/ tolerance	Trend variation
1	Patients	Implementation of SAFER Bundle – LOS > 7 Days pathway 0	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients.	COO	10.00%	1.00%		12.81%	11.68%	12.50%	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 (102.68) (75th of 121)	3rd Quartile (103.12 (71st of 121)	3rd Quartile (102.92 (69th of 121)	P	B
3	Patients	Reduction in moderate and severe harm and death incidents	Serious incidents (including Never Events) of harm - Moderate, severe and death - per 1000 OBD	DoN	0	0.17		0.39	0.06	0.34	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		0.03	0.09	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	0.03	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	(610)	(276)	(258)	F	
9	Services	Percentage of patients spending more than 12 hours in department	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	COO	1.00%	5.00%		13.88%	15.01%	15.45%	F	
10a	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	COO	503	100		7,563	6,935		F	A
10b	Services	Patients waiting 65 weeks or more	Number of patients waiting 65 weeks or more (RTT pathways)	COO	TBD	TBD		3,487	2,766			A
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%		55.58%	68.25%		F	A
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	DoPOD	9.00%	1.00%		8.30%	7.72%	6.91%	P	
13a	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	DoPOD	90.00%	2.00%		64.24%	65.39%	65.95%	F	A
13b	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	DoPOD	95.00%	2.00%		89.25%	88.81%	89.18%	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%		80.56%	75.83%	74.90%	F	

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-23
12.50%
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 March was 1.3 days a reduction of 0.1 days .Also consistent with March performance in 2021 and 2022.

Issues:

Numbers of stranded and super stranded patients has increased across all 3 Acute Sites.
Higher acuity of patients requiring a longer period of recovery post Winter Impact, and complexity of post hospital care.
Medical outliers have reduced overall but reduced medical staffing has led to delays in senior reviews.
The number of positive covid cases requiring a longer length of stay has increased slightly.

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

Actions:

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

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

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

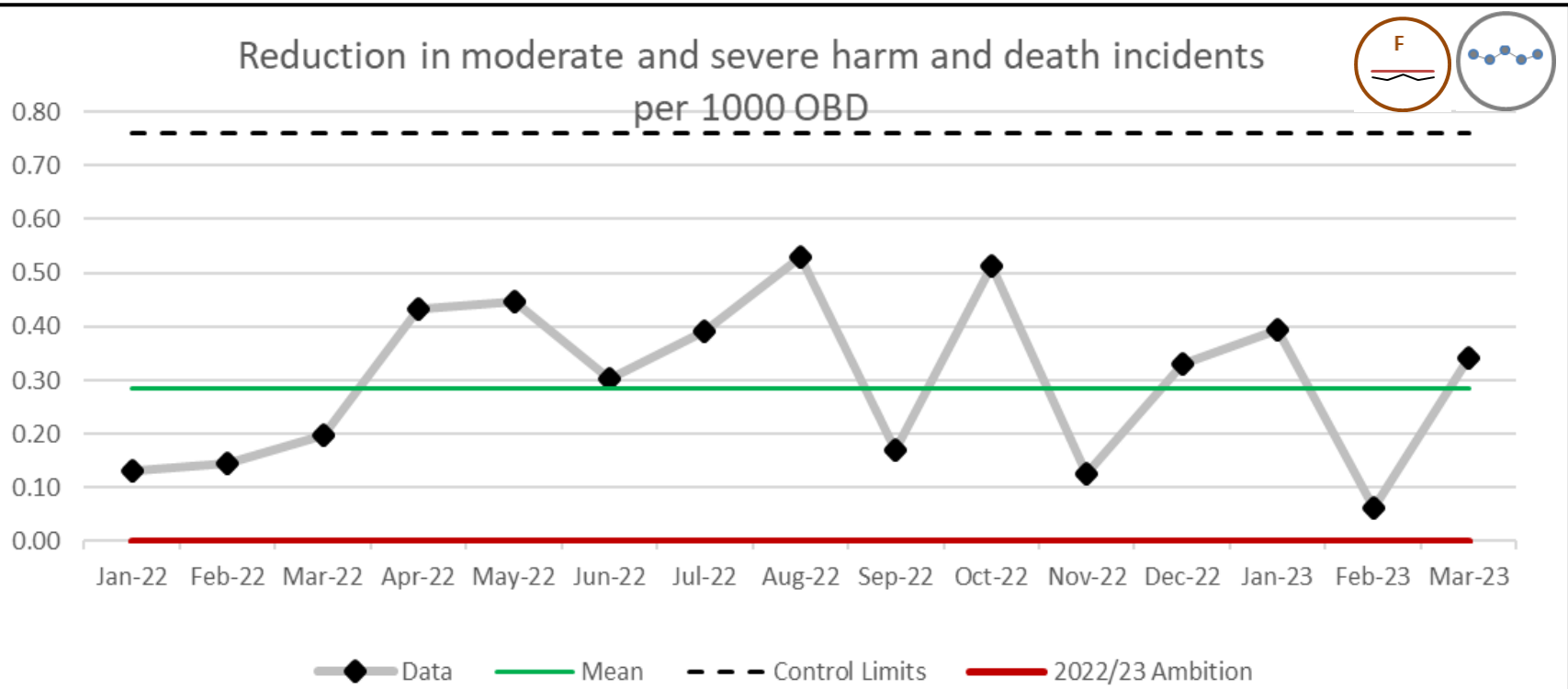
Mitigations:

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-23
0.34
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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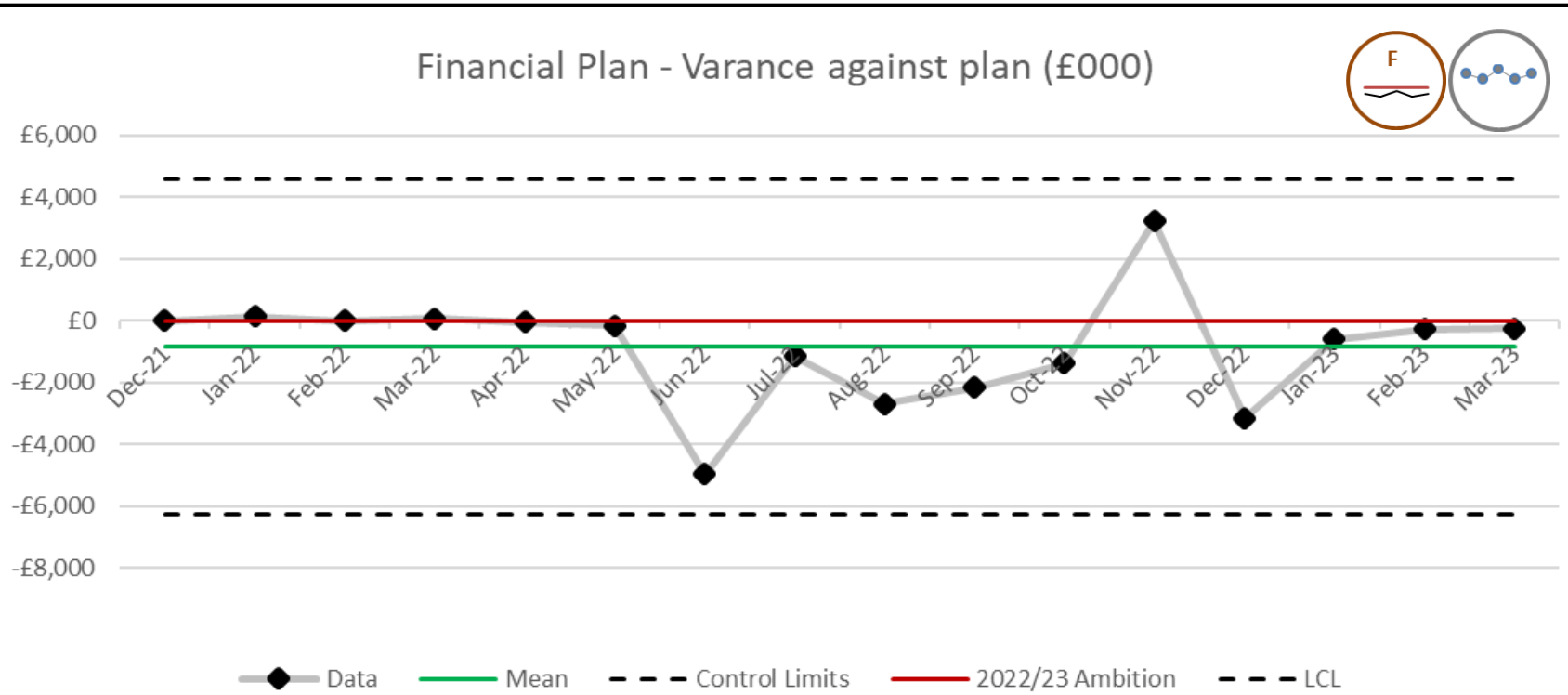

Mar-23
Variance to plan (£258) k
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
£0
Achievement
Metric is failing the target
Executive Lead
Director of Finance

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

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

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

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

Mitigations:
Continued focus upon the delivery of cost improvement, monitoring of the TLT action plan, agreement to transact the Risk and Gain Share in relation to Care Closer to Home, and agreement of a forecast deficit of £13.6m as part of a revised ICS forecast for 2022/23; the Trust delivered its revised forecast deficit of £13.6m and the ICS has improved upon its revised forecast deficit.

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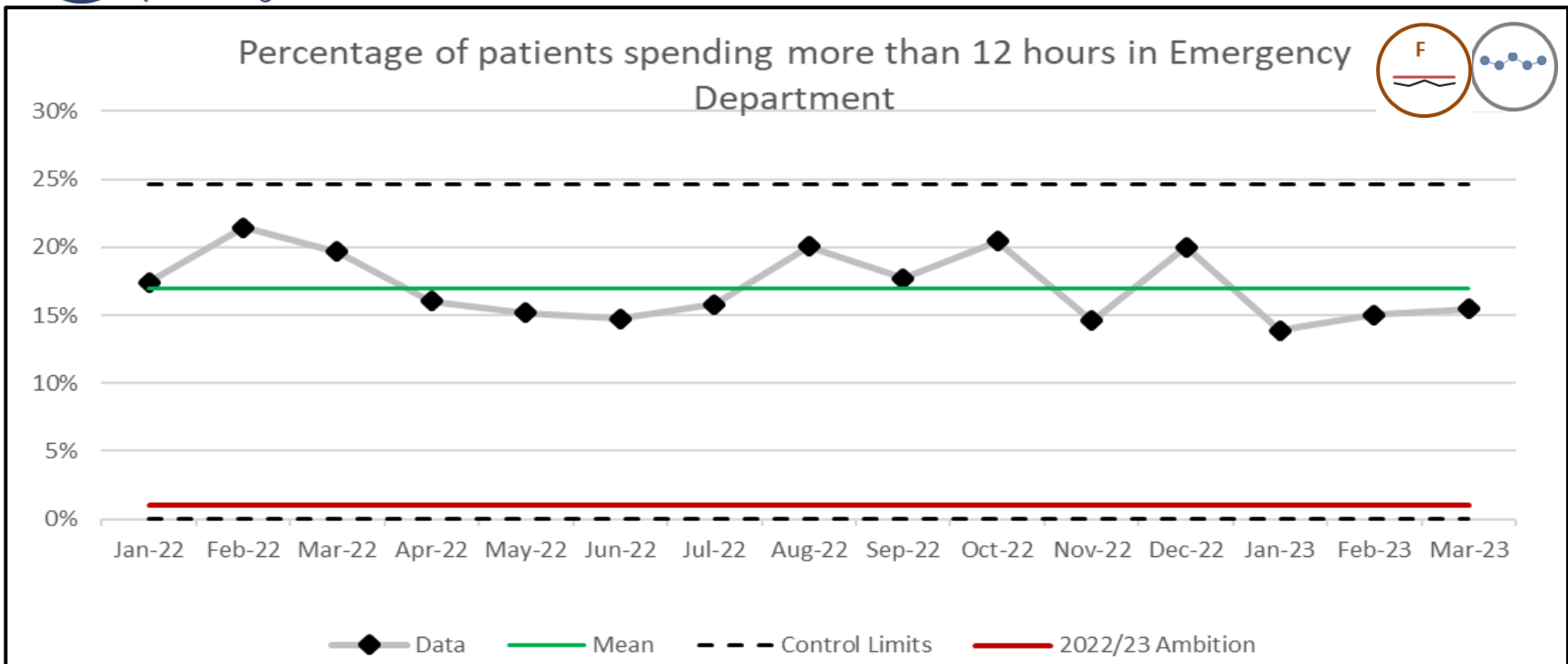

Mar-23
15.45%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
1% with 5% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

February experienced a slight increase in the numbers of patients with an aggregated time of arrival greater than 12 hours against total attendance. 1964 compared to 1656 in February.
What this chart doesn't tell us also is that March saw an increase of 1693 patients into the department compared to February. Equivalent of 13.93%.

Issues:

March experienced a 13.93% increase in Type 1 attendances to ED compared to February 23. This increase in Emergency Department attendances resulted in 13.92% (470) additional 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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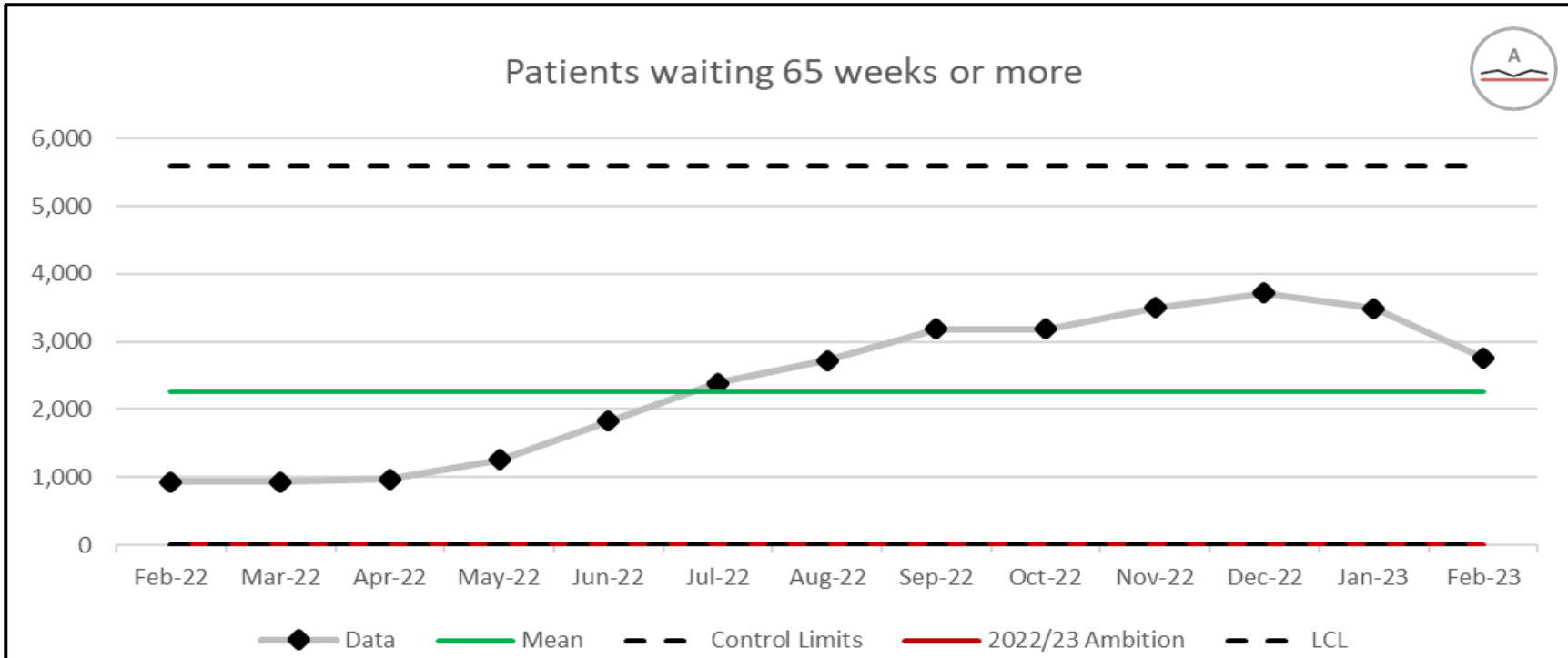

Feb-23
2,766.00
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
2022/23 Ambition/Tolerance
TBD
Achievement
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 2,766 incomplete 65-week breaches for February 2023, a decrease of 721 from January 2022's 3,487

Issues:
Whilst ULHT's position is strong with 104 week wait patients, with 4 patients reported for February; performance is less assured with 65 week waiters. Both admitted and non-admitted patients sit within this backlog, however, the most significant pressure remains in the non-admitted pathways. The doctors scheduled industrial action will have a detrimental effect on performance

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

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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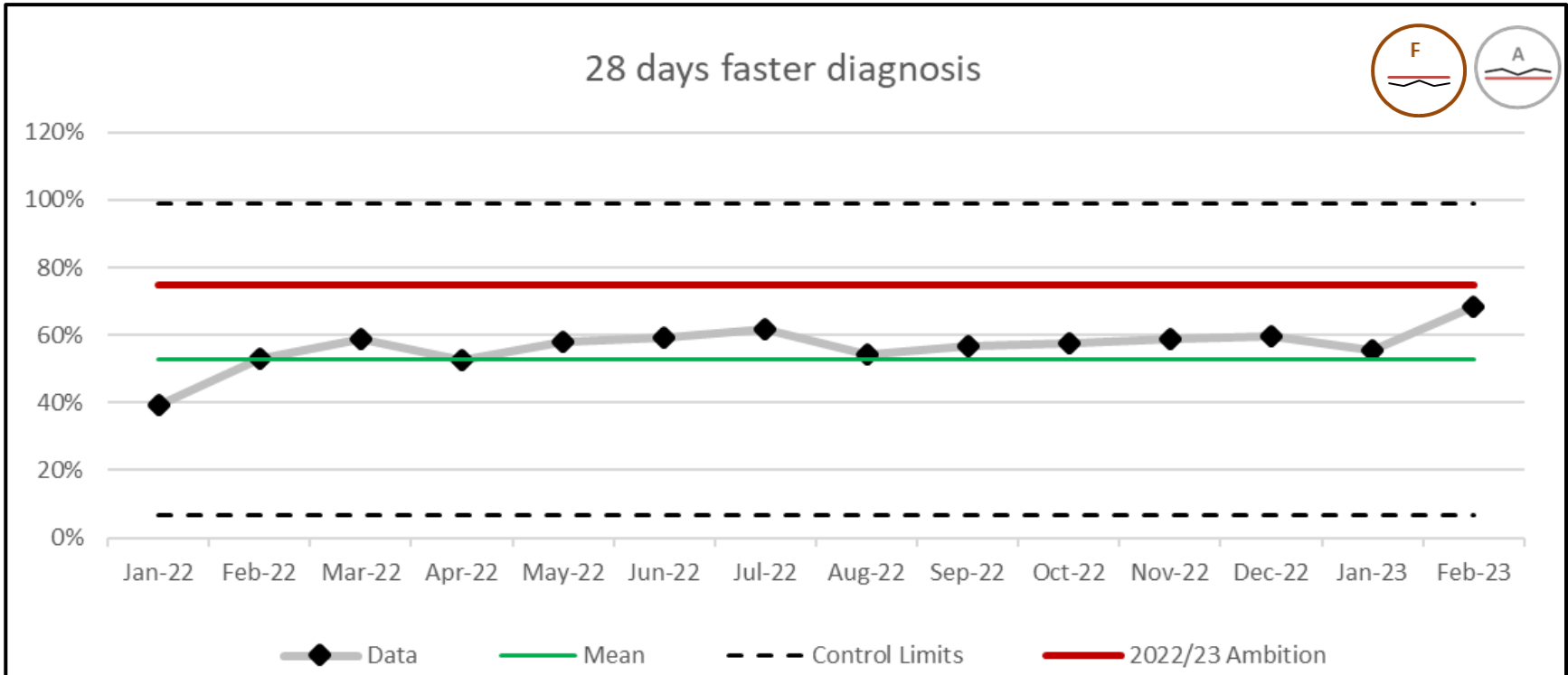

Feb-23
68.25%
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
2022/23 Ambition/Tolerance
75% with 5% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

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 68.25% against a 75% 2022/23 ambition with a 5% tolerance.

Issues:

The impact of ongoing pathway, staffing and capacity challenges.

Patients not willing to travel to where our service and / or capacity is.

2ww OPA capacity in high volume tumour sites such as skin, breast and lung (see 2ww Suspect).

Diagnostic capacity challenges and clinical review capacity.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program.

Recruitment to vacant CNP post focus on clinical reviews below 28 days is currently on hold until potential re-banding and substantive funding is in place.

Recruitment is underway in Respiratory, ENT and Haematology specialties to improve Consultant availability and clinical review capacity.

Theatre capacity for Urology diagnostics remains a challenge – work to increase this capacity and reduce bottlenecks is ongoing. Daily Diagnostic Huddles have been implemented within the Urology CBU. Diagnostic capacity for TPGA is due to implemented at GK imminently and in Louth from June 2023.

Mitigations:

A new electronic and streamlined admin process is in place in respiratory and being embedded at LCH – this is now also being reviewed for PHB too.

A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention / support. However, the Pre-Diagnosis Team workload continues to be impacted by an increasing backlog.

All tumour site CBUs 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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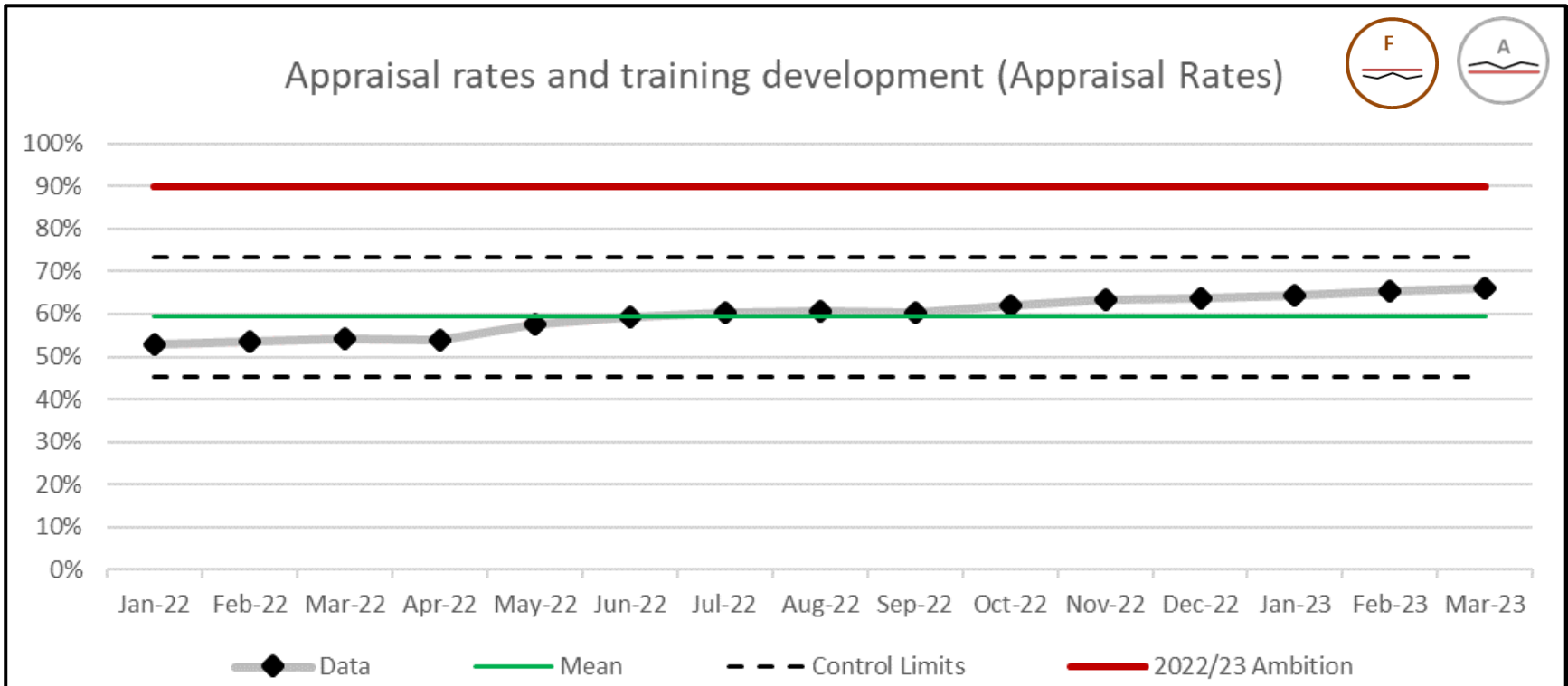

Mar-23
65.95%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
2022/23 Ambition/Tolerance
90% with 2% tolerance
Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
% completion is currently 65.95% **(non-medical)**

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

Issues:

- Currently there is no real accountability for a lack of appraisal compliance across the Trust's leaders.
- A lack of protected time for the completion of appraisals.

Actions:

- People Management Essentials (PME) training to be mandated.
- PME roll out will provide further foundation as regards the importance / expectations around appraisals and the recording of this within 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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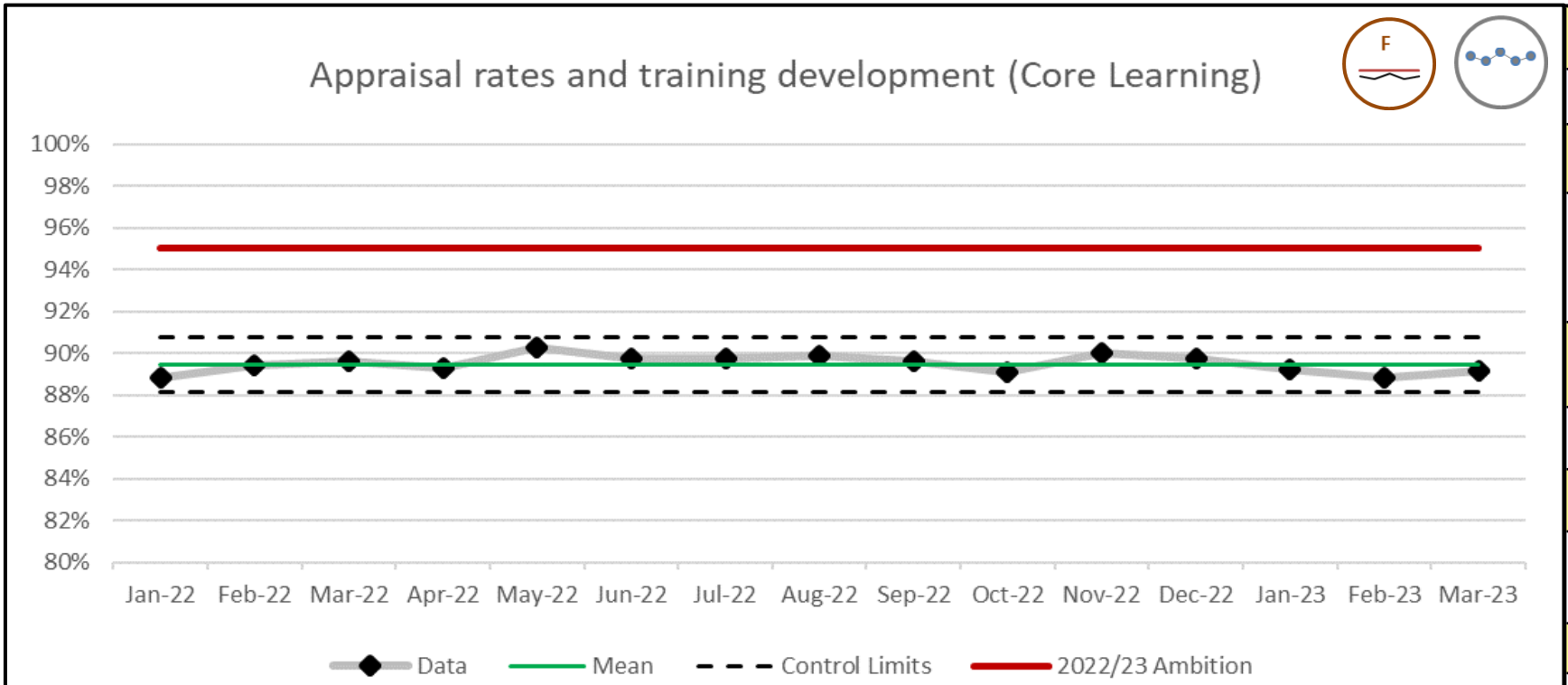
NHS United Lincolnshire Hospitals NHS Trust



Mar-23
89.18%
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 89.18

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

Issues:
- Protected time for core learning continues to be an issues, particularly clinical staff.
- Core / Core + offer inappropriately defined not entirely indicative of need.
- Core offer too large.

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 aligned to the national Core Skills Training Framework (CSTF).
- Core + offer being reviewed and then work to make this offer more person specific will commence.

Mitigations:
Improvement Action Plan

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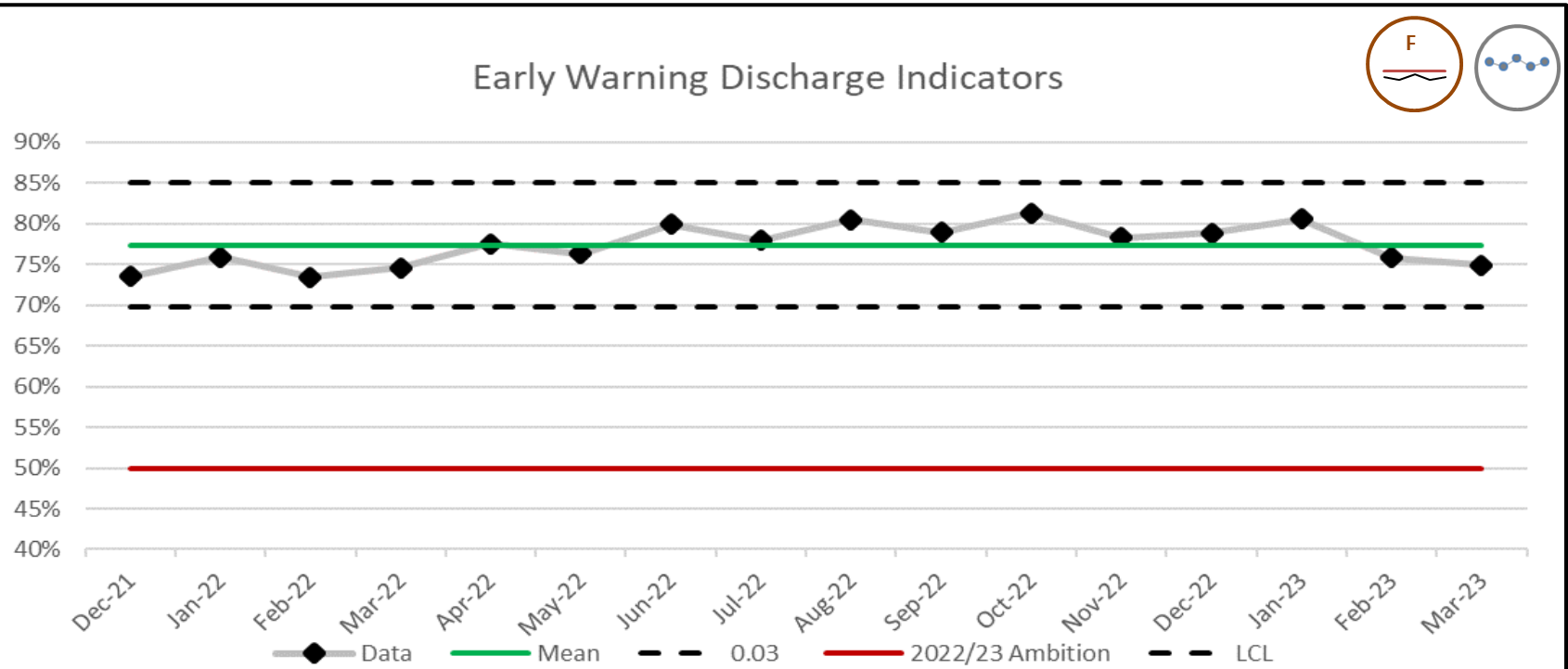

Mar-23
74.90%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
50% with 10% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

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 74.90% against a 50% 2022/23 ambition with a 10% tolerance. This is a decrease in performance of 0.90% compared to February 23.

Issues:

Numbers of stranded has increased but super stranded patients have decreased in number.
Increasing length of stay of all pathways 1-3. The most significant increase in volume of bed days is Pathway 1 Domiciliary care but since the advent of the joint D2A process and additional funding benefits are being realised slowly but there remains insufficient capacity to meet the increasing demand.
The Transfer of Care Hub continue to gain more traction on moving discharges forward at an improved pace.

Actions:

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

Mitigations:

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

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

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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	Jan-23	Feb-23	Mar-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	8	5	5	70	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.00	0.01	0.01	0.03		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.02	0.01	0.04		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1			0			
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.08	0.13	0.04	0.12	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	0	0	5	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	3	2	0	9	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	11	4	4	67	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	93.70%	94.03%	95.49%	94.47%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	5	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.02	5.32	5.85	5.83	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	21.0%	11.8%	10.7%	13.12%	P	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-23	Feb-23	Mar-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	100%	0%	None due	52.67%		
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	93.98	93.79	94.03	94.41	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	102.68	103.12	102.92	105.35	F	L
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	100.00%	99.67%	P	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	91.50%	89.30%	88.30%	89.93%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	90.0%	94.00%		91.07%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	84.8%	87.53%		86.30%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	94.0%	92.00%		93.61%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	100.0%	80.00%		79.88%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	92.0%	93.00%		90.75%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	90.0%	90.00%		86.18%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	96.0%	96.00%		94.08%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	89.0%	33.30%		60.56%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.44	2.22	2.43	2.72	P	
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	94.00%	94.00%		87.18%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	90.00%	88.00%		80.55%	F	

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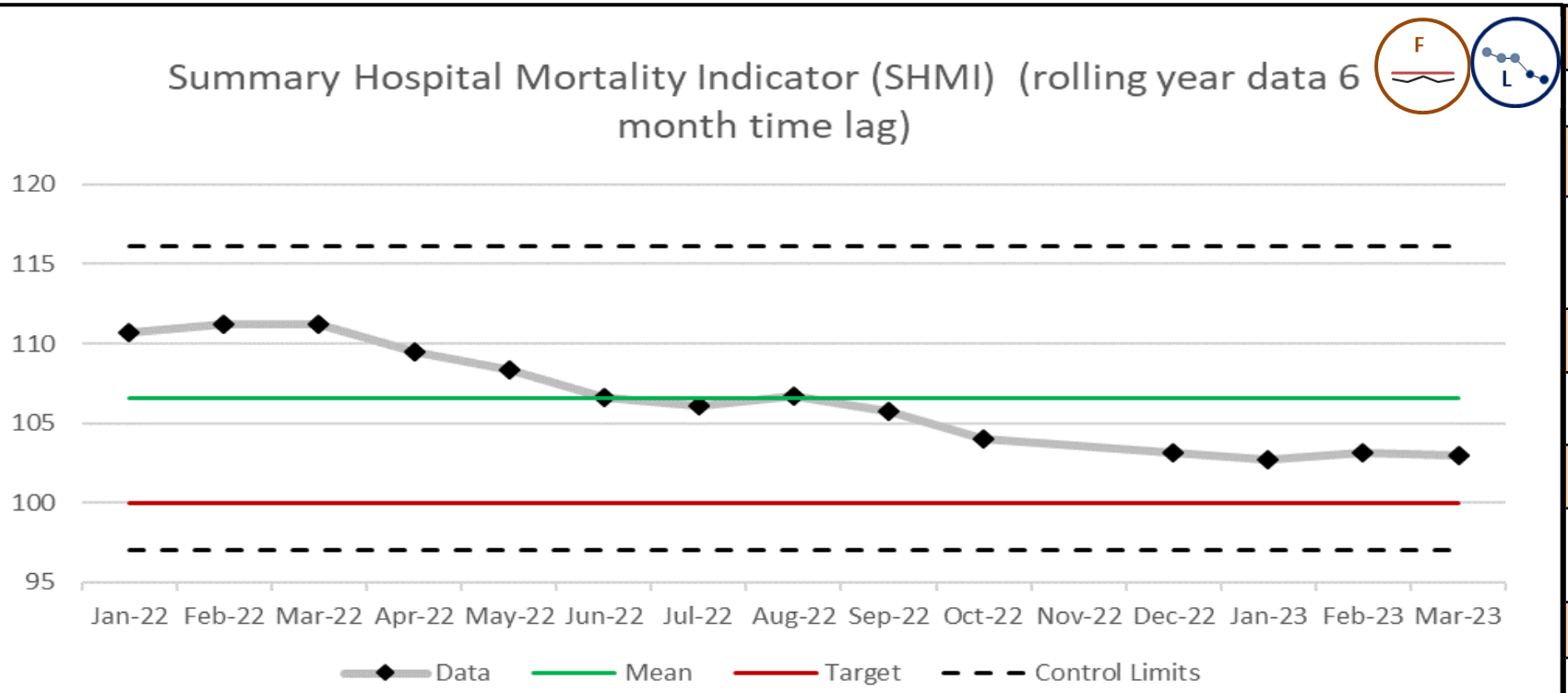

Mar-23
102.92
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
To remain in "as expected" range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

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

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

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

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

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

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

HSMR is 94.03 (rolling 12 months)

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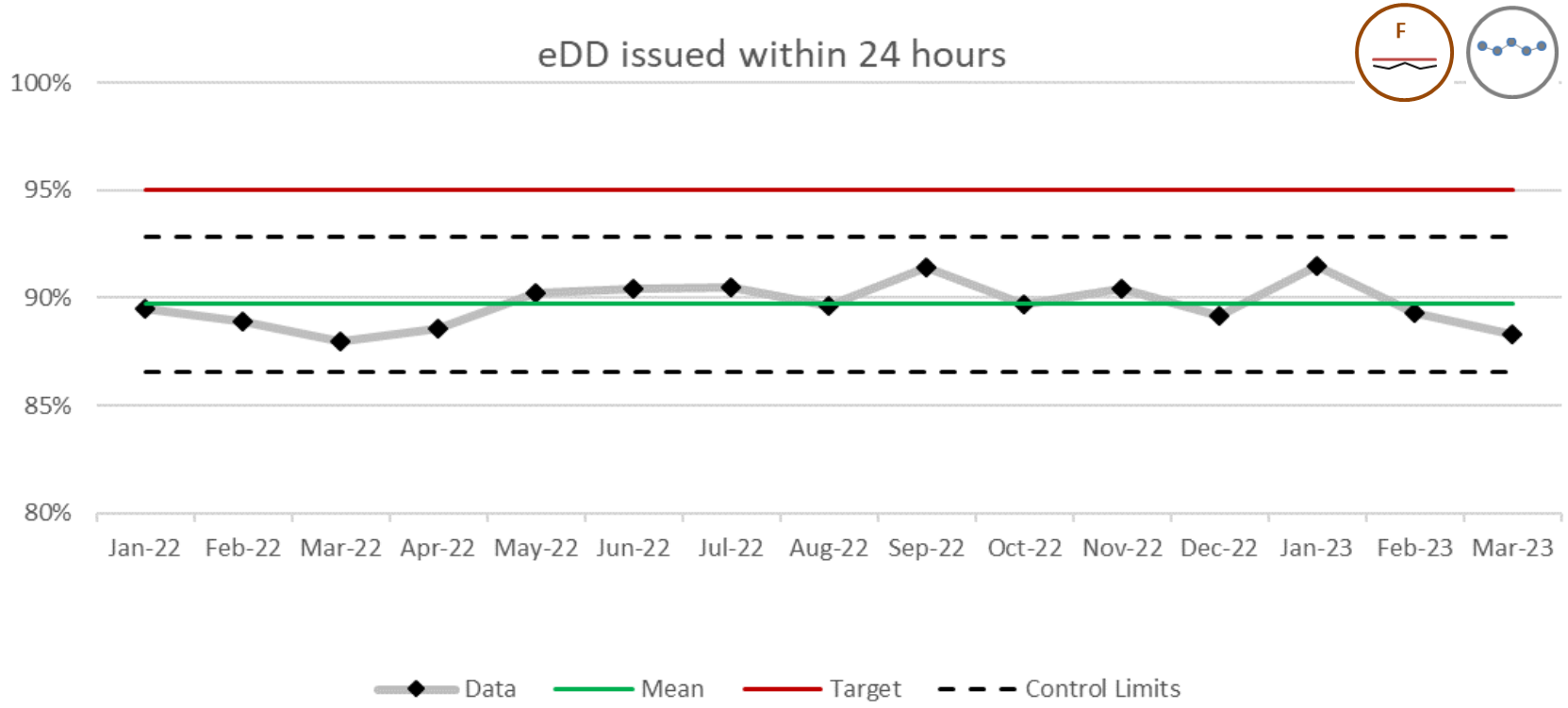

Mar-23
88.30%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 88.30%.

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

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

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

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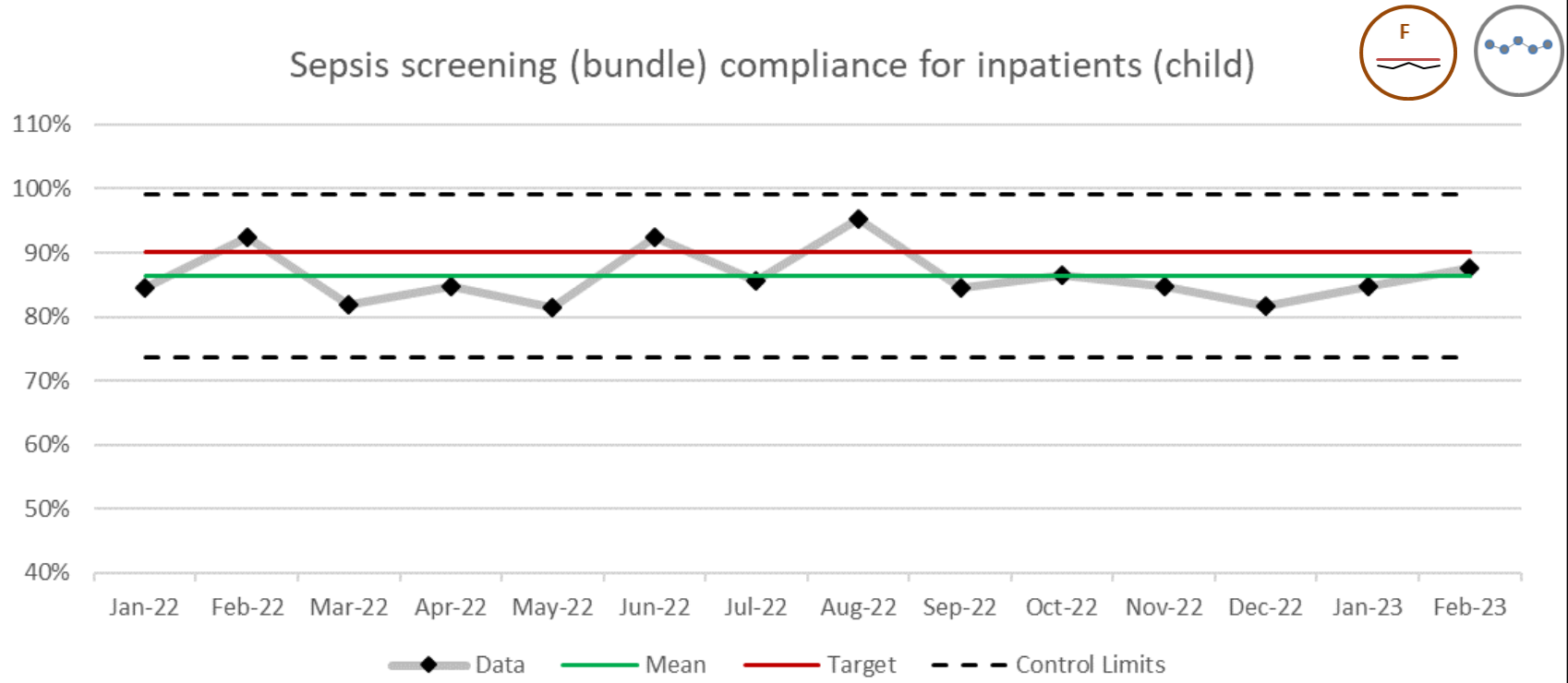

Feb-23
87.53 %
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The metric for inpatient child screening has failed to achieve the metric at 87.53%
This represents 56 of 64patients or 8 patients who were not screened within 60 minutes of raised PEWS.

Issues:
Six of the missed / delayed screens were children found to have a viral cause for illness.
The patients were from all 3 areas, 3 from Safari ward, 2 from Rainforest and 3 from 4A.
There were 2 children delayed in getting treatment, both of these were due to very difficult cannulations.

Actions:
The paediatric sepsis practitioner has met with the Matron to discuss the delays. Pilgrim site have not been returning their harm reviews and the matron has addressed this with the ward sister.
Paediatric Sepsis Sim training for ward staff has taken place and there is more planned after the next Drs handover.
Harm reviews that have been completed have found no harm to patients.

Mitigations:
The ward educator at Lincoln continues to undertake harm reviews that are relevant to their area. An allocated nurse at Pilgrim will also do this moving forward.
Some of the issues are associated with medical staff and teaching continues for this staff group.
Issues currently discussed at Paediatric Governance as well as in deteriorating patient meetings.

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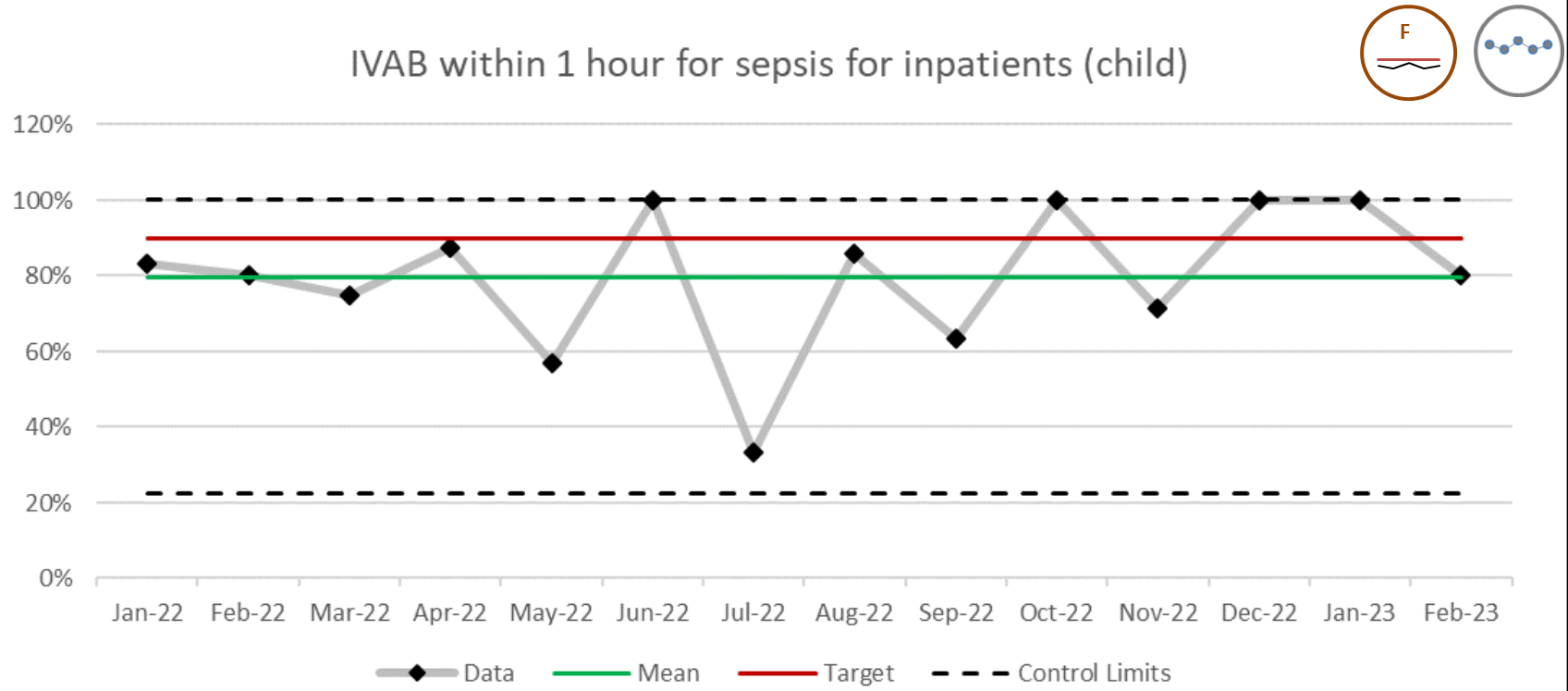

Feb-23
80.00 %
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
8 out of 10 children that required treatment received this in a timely manner. 2 children had delayed antibiotics.

Issues:
One child was very difficult to cannulate and another child was found to have a tissued cannula and had to wait for another before antibiotics could be given.

Actions:
1 x child given IM ceftriaxone to reduce delay as much as possible.
Harm reviews completed for delayed screens and no harm found.

Mitigations:
Sepsis simulation training is taking place monthly involving both nursing and medical staff.
Harm review details are being discussed at monthly Paediatric governance meetings. IM administration is also to be discussed at the next Sepsis focus group meeting.

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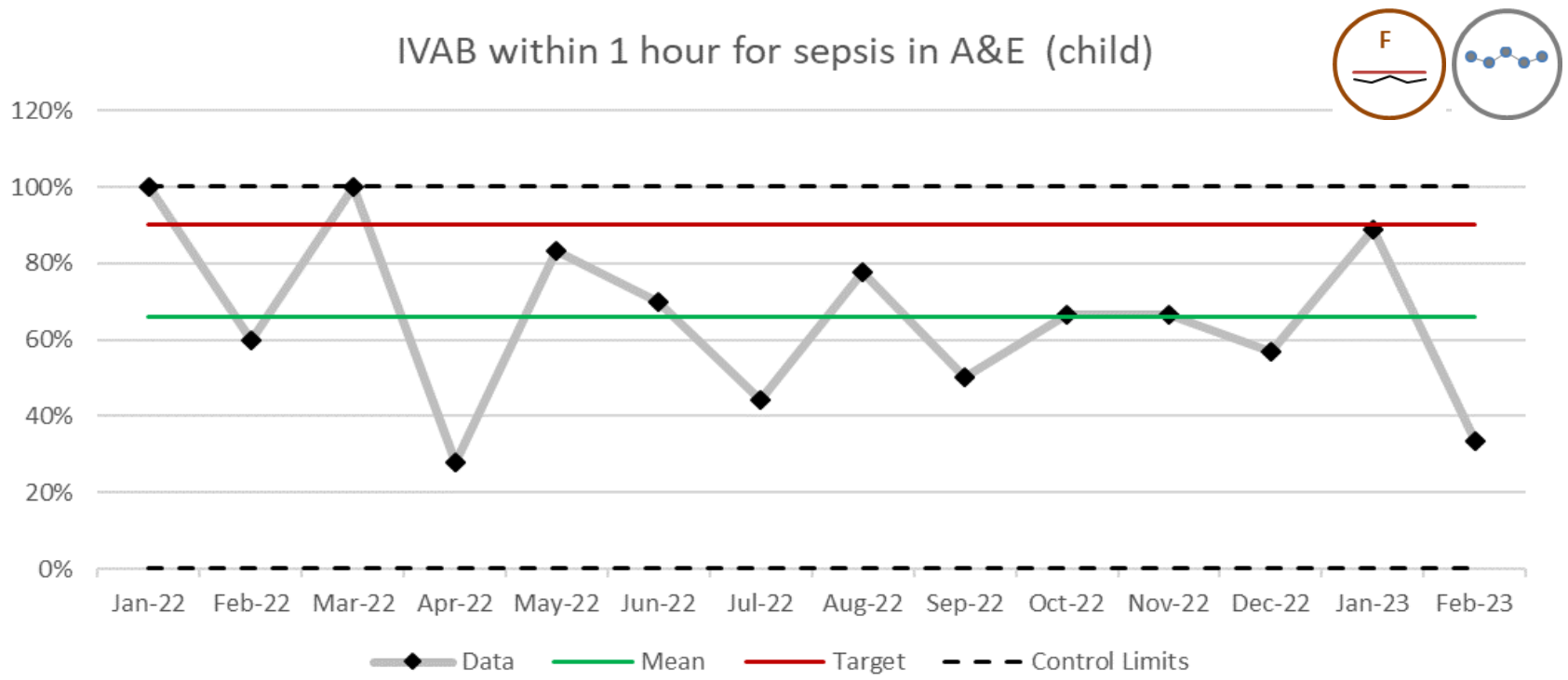


Feb-23
33.30%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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 33.3%, which is 2 of 6 patients, and is well below the 90% target. 4 patients was delayed in receiving antibiotics.

Issues:
There were 4 patients in ED this month that were delayed in receiving antibiotics. . All of the delays were on one site. 2 children were difficult to cannulate leading to the delay. One child was waiting to be seen by paediatrics before a decision was made and the other was waiting to be transferred to the ward and seen by paediatrics before a decision was made.

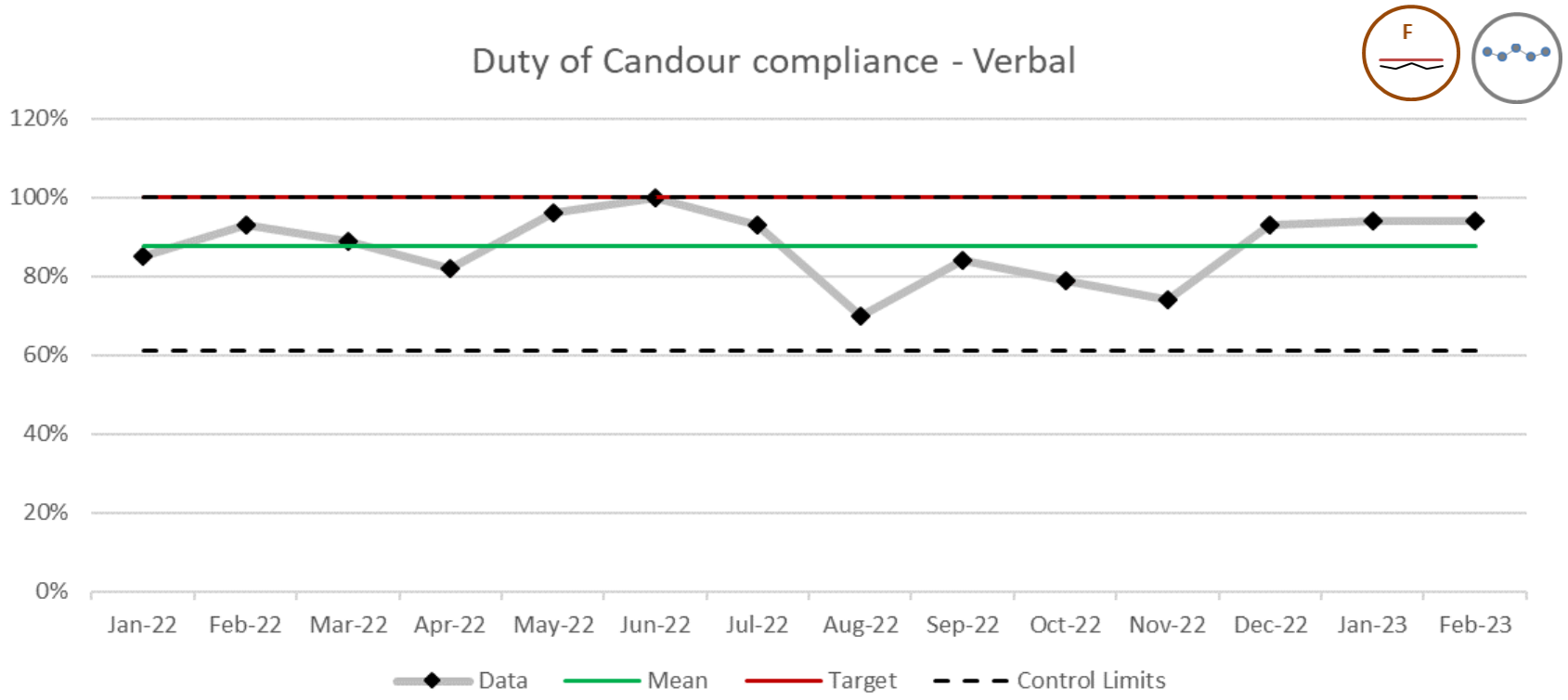
Actions:
Sepsis training has been delivered for new Doctors starting in February. Simulation training has been reintroduced in ED areas with the first one in Jan 23
Harm reviews have been completed for all delayed treatment and no harm found.
IM administration is to be discussed at the next Focus group meeting.
Delays also discussed at Paediatric governance.

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-23
94.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
Compliance with the 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.

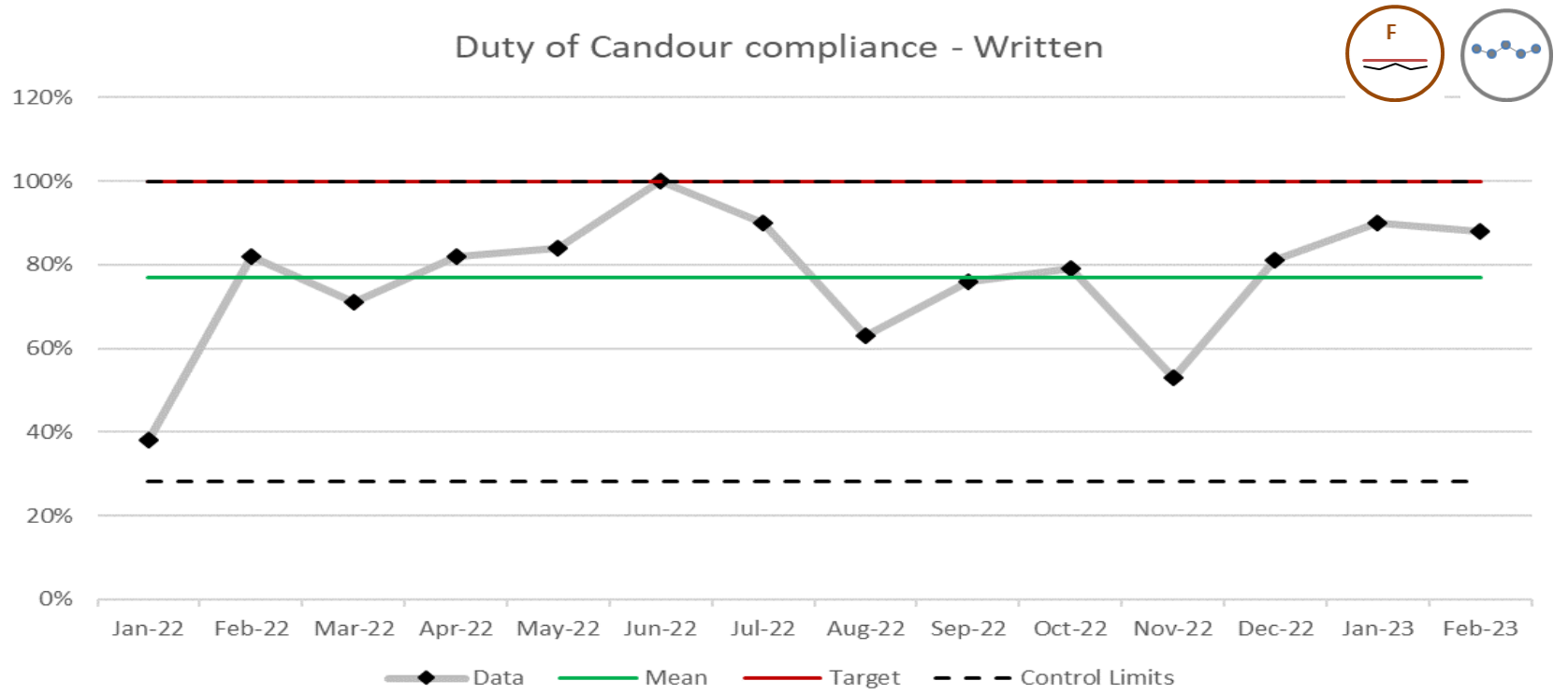
Actions:
Risk & Governance Coordinators are sighted on each day's notifiable incidents and are working closely with the Divisional teams to eliminate the backlog and improve the timeliness of completing Duty of Candour.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-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 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.

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

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

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jan-23	Feb-23	Mar-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.26%	0.27%	0.53%	0.32%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	60.67%	58.21%	57.03%	60.26%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	647	702	721	9604	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	77.99%	78.62%	78.23%	79.06%	88.50%			
	65 Week Waiters	Responsive	Services	Chief Operating Officer	TBC	3487	2766		28,998				
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	49.16%	49.56%		49.19%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	72,772	72,055		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	41.23%	39.27%		47.88%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	66.95%	63.51%		60.53%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	14.41%	13.08%		23.57%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	89.97%	90.17%		90.84%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	99.31%	94.48%		97.30%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	83.33%	70.83%		74.38%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	92.39%	98.13%		95.93%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	44.00%	43.75%		63.30%	90.00%			

OUTSTANDING CARE personally DELIVERED

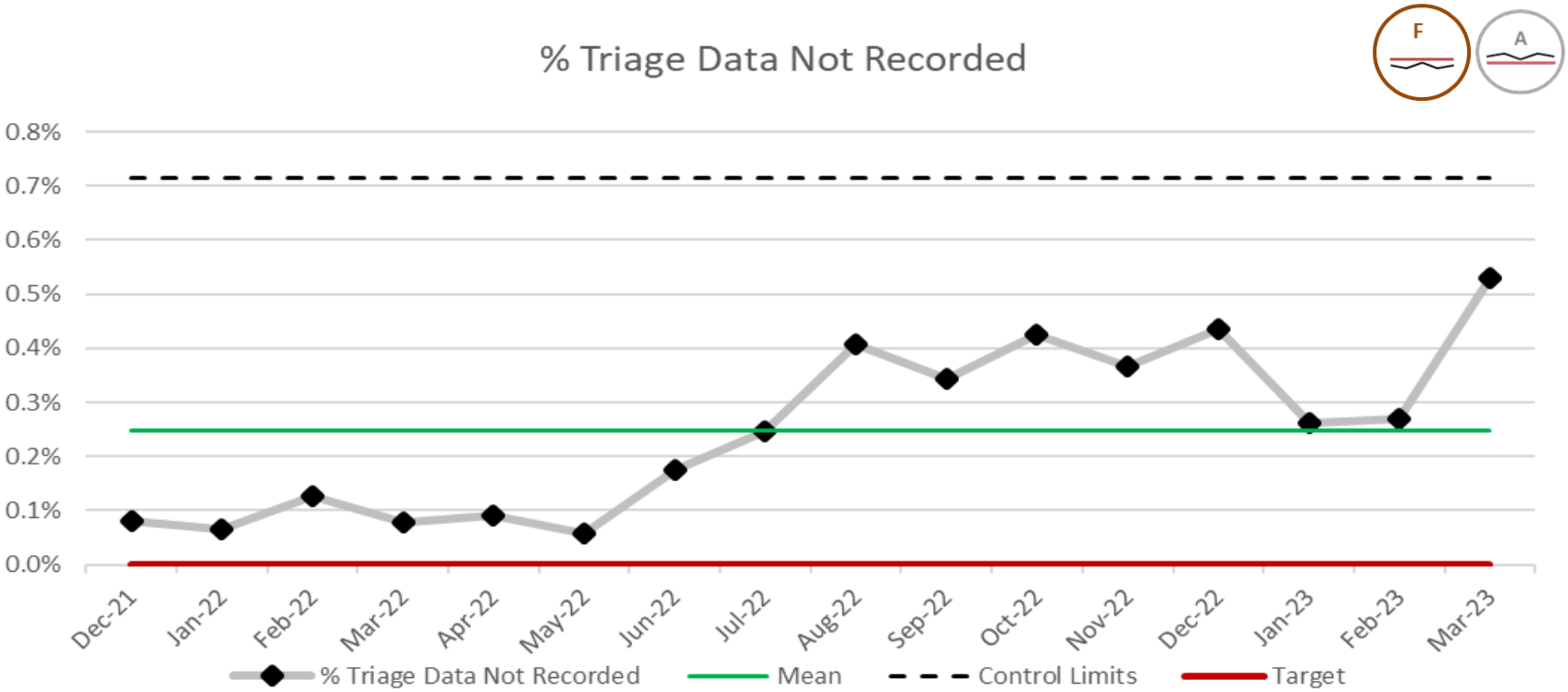
NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jan-23	Feb-23	Mar-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%	56.32%	69.92%		68.84%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	55.35%	60.12%	61.83%	54.38%	99.00%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	2.05%	1.28%	0.79%	1.98%	0.80%	P		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	32	22	16	350	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	88.46%	65.56%	90.67%	76.69%	90%	P		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	67.95%	37.78%	80.00%	57.20%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,638	3,475	3,917	3,787	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	497	316	616	737	0	F		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	162	127	84	1,692	120	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.52	4.30	3.02	3.11	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	5.05	4.89	5.01	5.02	4.5	F		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	22,664	23,309	24,397	22,898	4,524	F		
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	32.60%	31.35%	32.33%	34.89%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	43.47%	43.87%	43.05%	39.84%	45.00%	F		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-23
0.53%
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:
March 23 reported a non-validated position of 0.53% of data not recorded verses target of 0%.
What the chart doesn't tell us is that 81.5% of those without a triage recorded "did not wait" to be seen.

Issues:

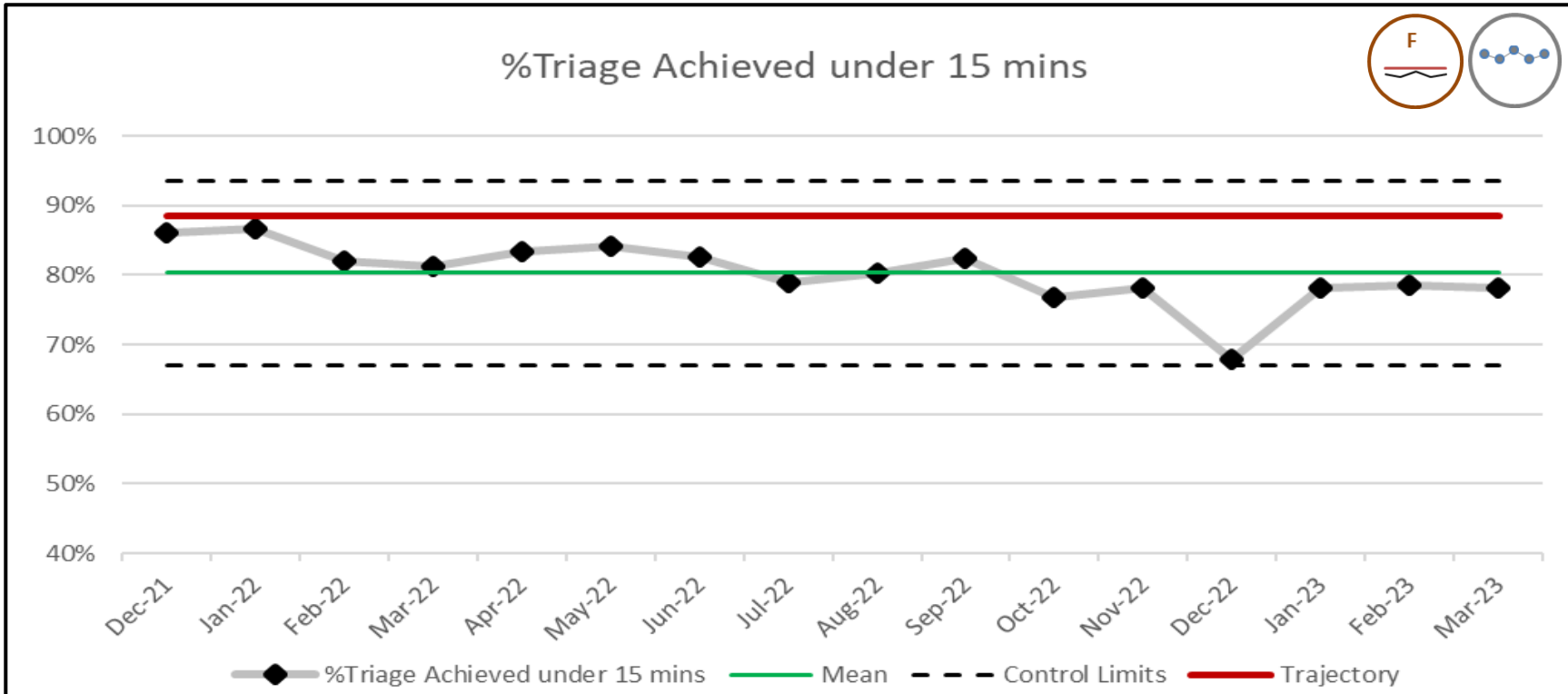
- Recognition of patients that "Did Not Wait/Refused Treatment" prior to triage being conducted.
- Recognition of patients who were transferred from one site to another for continued emergency care/direct admission to specialty.
- Manchester Triage trained staff (MTS) to consistently operate two triage 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).



Mar-23
78.23%
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%.
March outturn was 78.23% compared to 78.63% in February (validated).
This target has not been met.

What the chart doesn't tell us, is that the ED attendances increased by 1693 more patients. Yet the performance only decreased by 0.40% compared to February.

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:

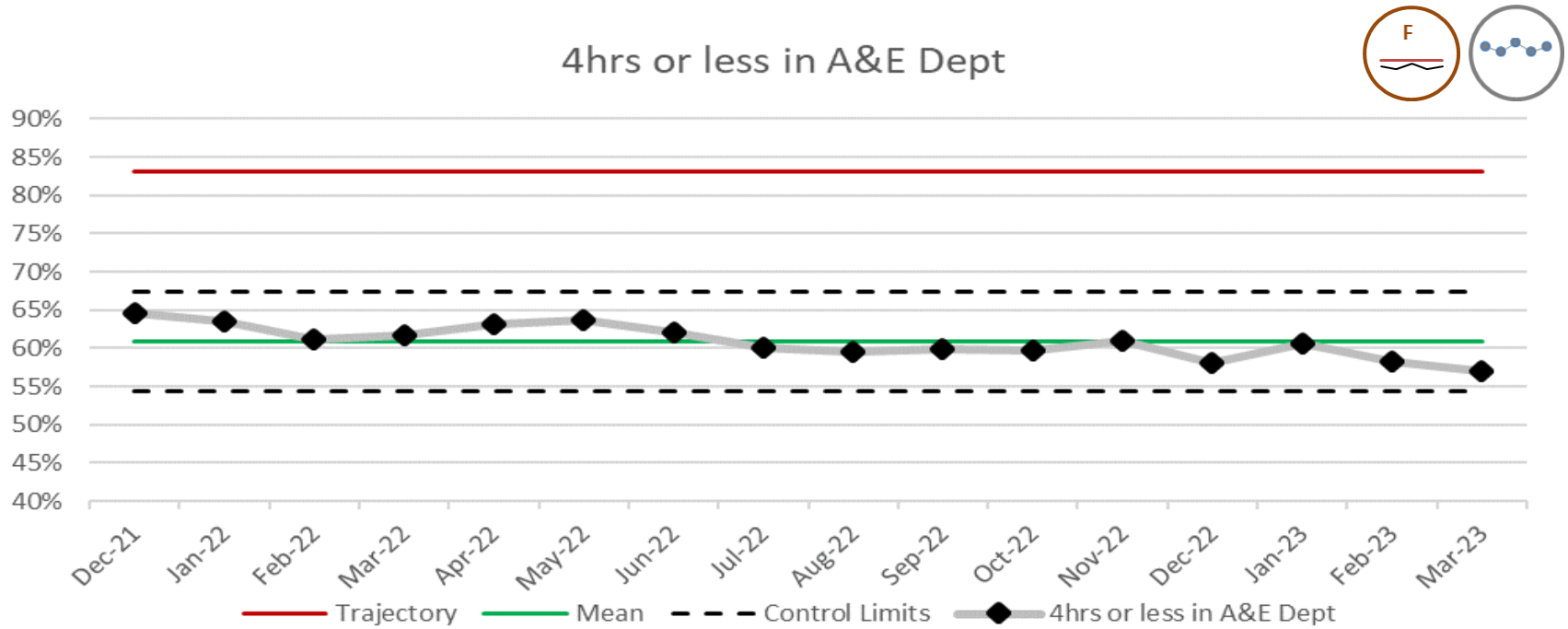
Most actions are repetitive but remain relevant.
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
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



Mar-23
57.03%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

The 4-hour transit target performance for March was 57.03% compared to 58.21% in February, which is a decline of 1.18%.
The target compliance is 83.12% and is an historic target that has been unchanged in 2 years.

Issues:

ED saw a 13.93% increase in Type 1 Attendances compared to February 2023 and 10.35% more than seen in March 2022. The total number seen in March 2023 (13838) Type 1 patients, has not been seen previously at ULHT, the only time this value has been close was October 2022 at 13517 patients.

Ward Based Discharges were an average of 26 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 >60% 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:

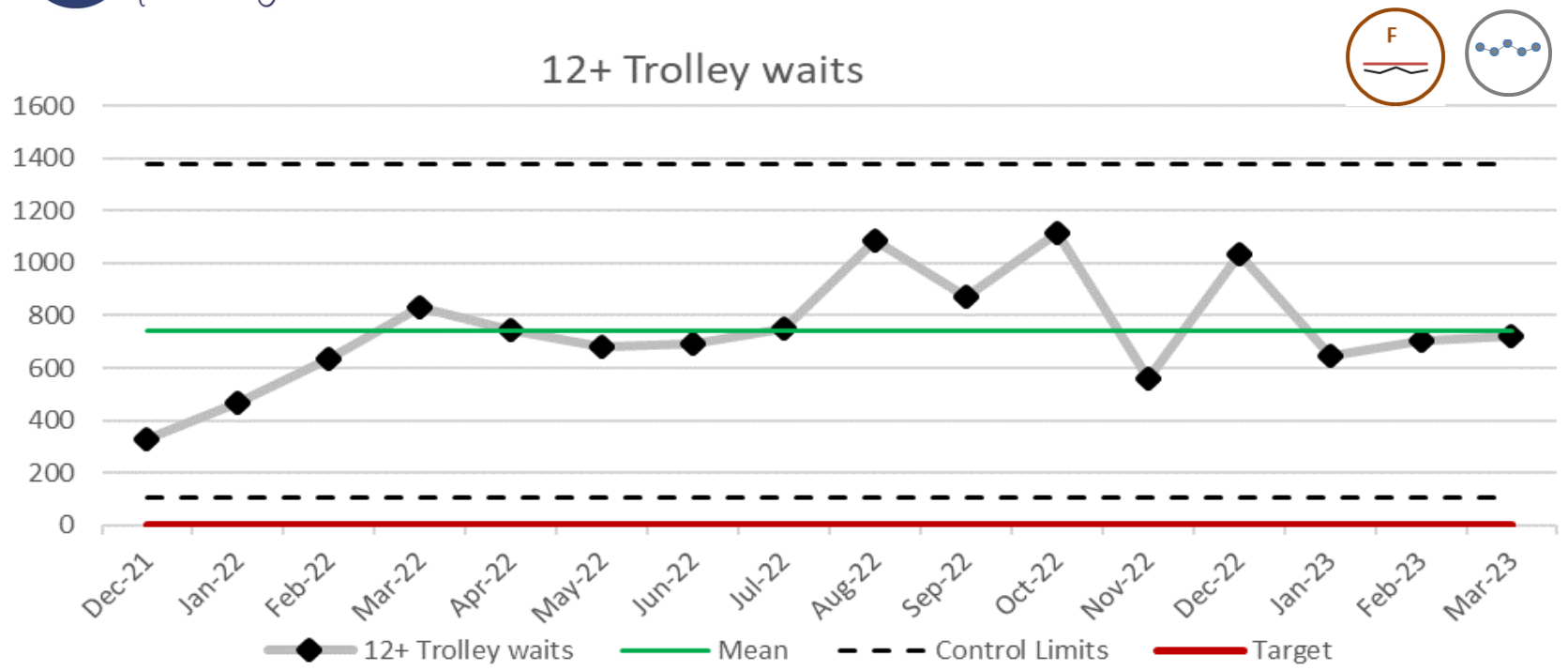
Reducing the burden placed upon the Emergency Departments further will be though the continued expansion of Same Day Emergency Care (SDEC) Services, maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients, the System flow and discharge 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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-23
721
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. This is an increase of (19), compared to February. This represents a decline of 2.70%. This equates to 5.21% of all type 1 attendances for March.
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 March 529 patients remained in ED >24hours, with the longest at 56hours.

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:

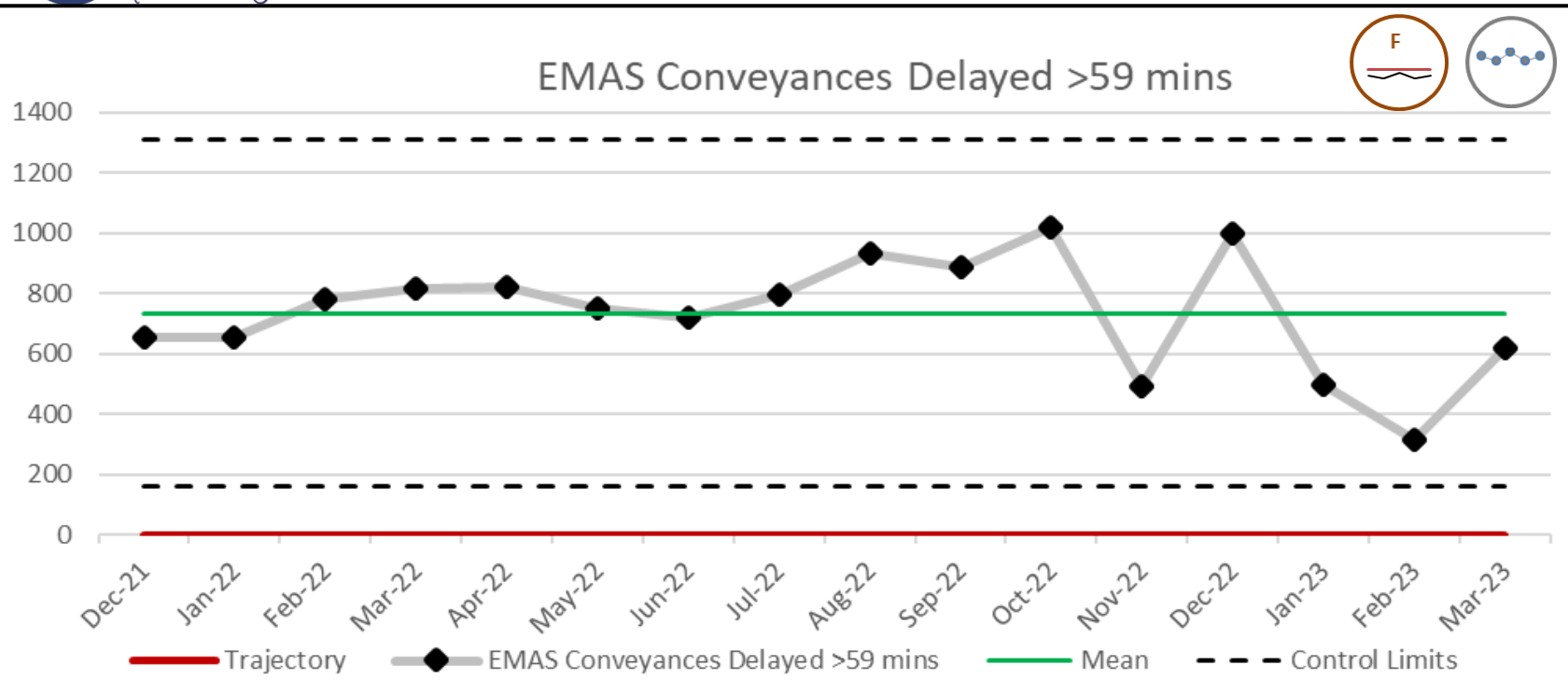
The Trust continues to work closely with national regulators in reviewing and reporting these breaches.
Due to the number of 12hrs trolley waits breaches currently, harm reviews are completed by the UEC team, DATIX are completed and escalations to the CCG and NHSE/I are in place.
A daily review of all 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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-23
616
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:

March demonstrated a sharp decline in performance waits greater than 59 minutes'. 616 compared to 316 in February. This represents a 94.93% decline. What the chart does not tell us is that ULHT saw 5.4% more ambulance arrivals to ED. Also the number of "walk-in" to the department increased by 14.80% causing the occupancy of the departments beyond thresholds

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:

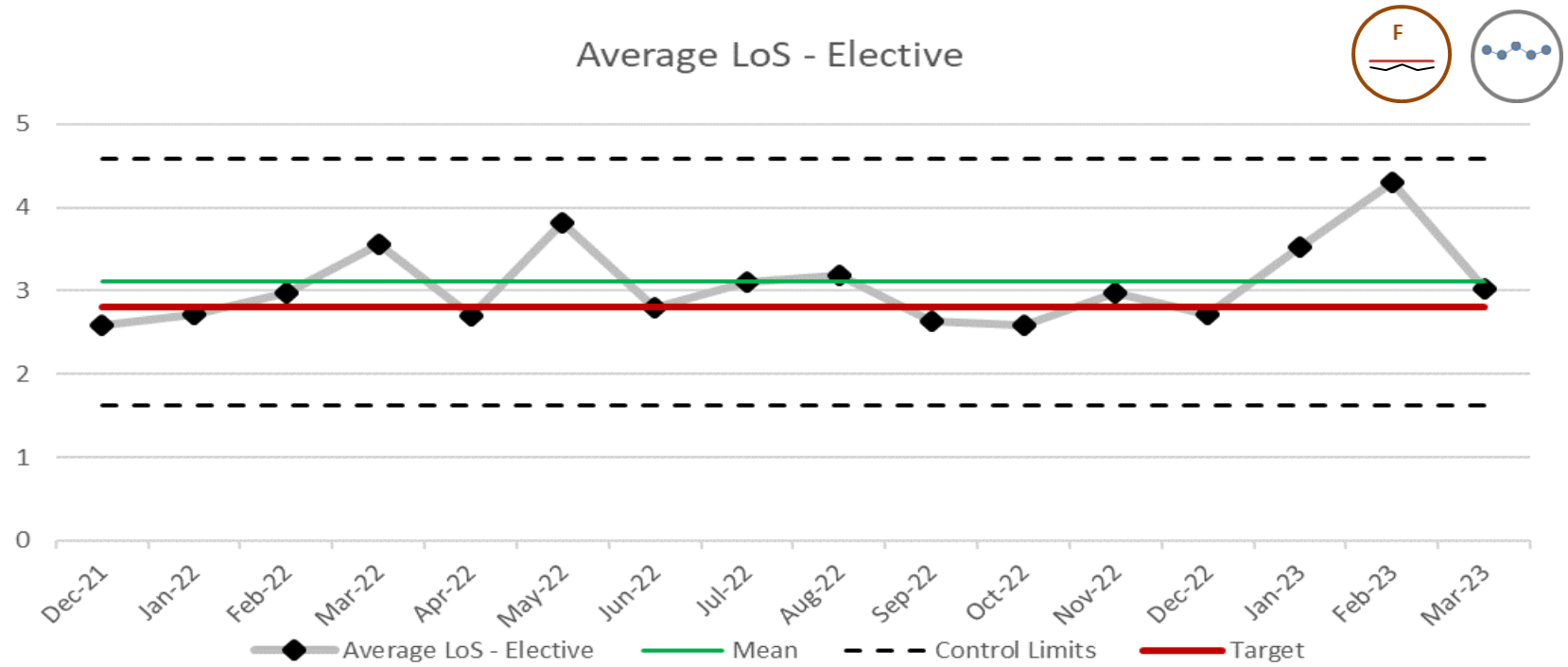
All ambulances approaching 30 minutes without a plan to off load is escalated to the Clinical Site Manager and then in hours Tactical Lead to secure a resolution and plans to resolve are feedback to the DOM. Out of hours, the responsibility lies with the Tactical on Call Manager.
Daily messages to EMAS 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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-23
3.02
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 3.02 days compared to 4.30 days in February. This is an improvement of 1.28 days and represents a negative variance of 0.22 days against the agreed target.

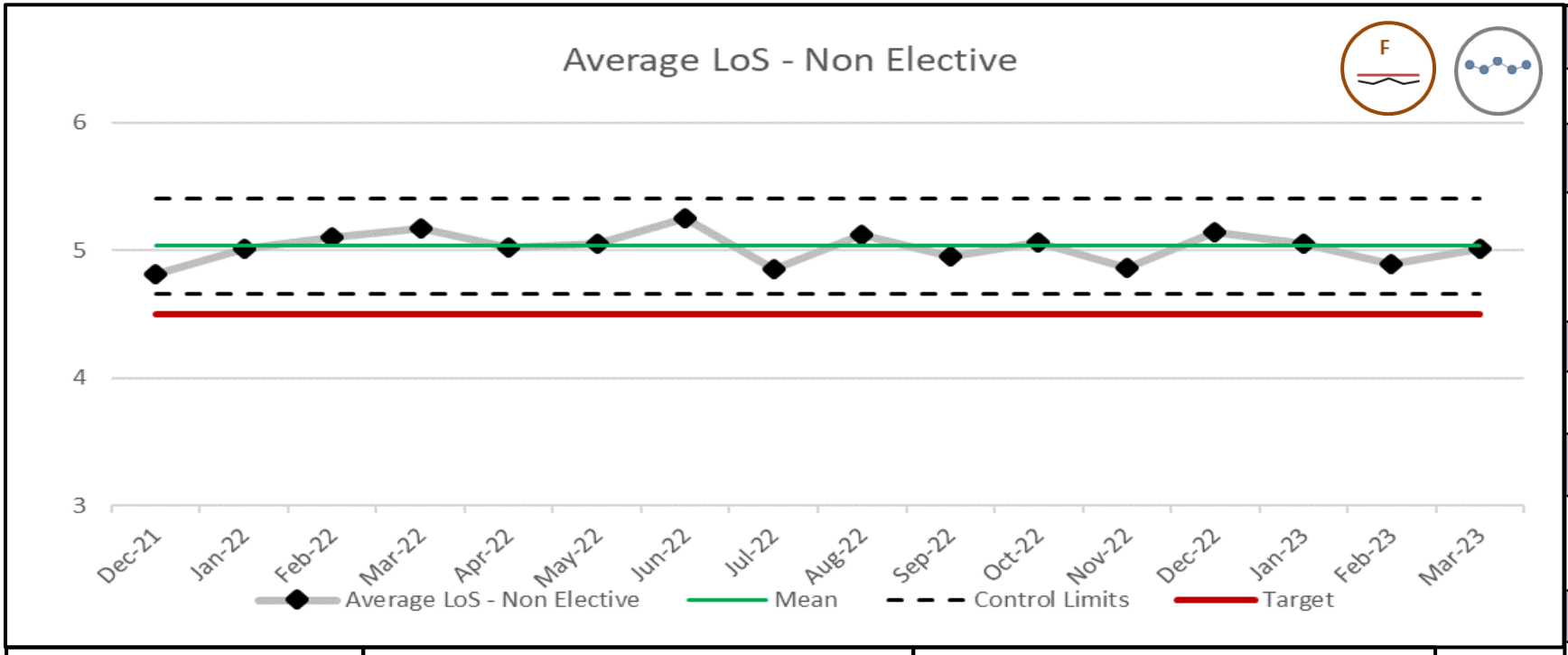
Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Mar-23
5.01
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 5.01 days in March.
This is a decline of 0.12 days and a 0.61 days negative variance against the agreed target.
What the chart doesn't tell us is that the decline is across all Pathways. (Additional days)
P0 – 0.1
P1 – 1.2
P2 – 2.1
P3 – 4.6

Issues:

Super –stranded patients has seen an increase of 12 from Februarys 145 daily average to March at 157 patients.

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:

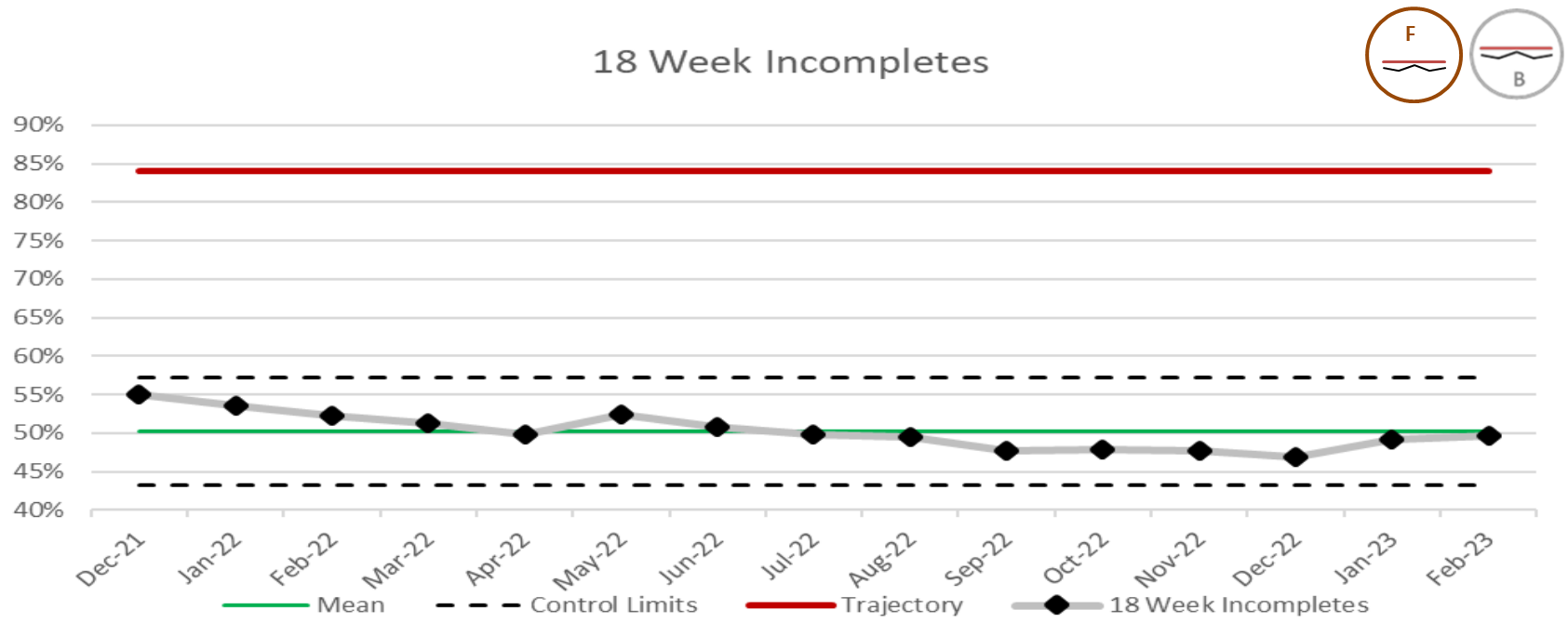
These actions are repetitive but still appropriate
Focused discharge profile through daily escalations.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
The move to Lateral Flow Testing as opposed to PCR 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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Feb-23
49.56%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background

Percentage of patients on an incomplete pathway waiting less than 18 weeks.

What the chart tells us:

There is significant backlog of patients on incomplete pathways. February 2023 saw RTT performance of 49.56% against a 92% target, which is 0.4% up from January 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 – 5642 (decreased by 86)
- Gastroenterology – 3809 (increased by 80)
- Dermatology – 2902 (decreased by 105)
- Respiratory Medicine – 2542 (decreased by 140)
- Gynaecology – 2492 (decreased by 83).

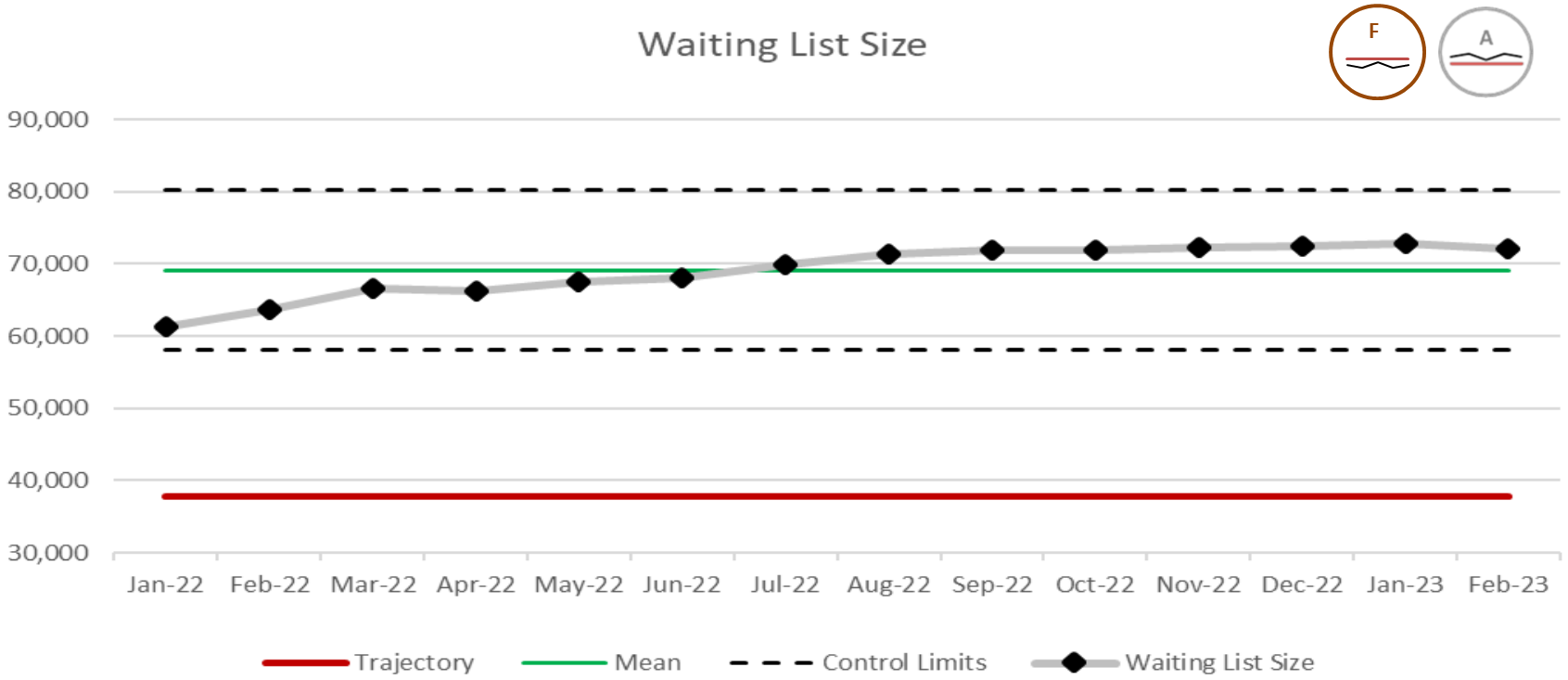
Actions:

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

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

Mitigations:

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



Feb-23
72,055
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 decreased from January 2023, with February showing a decrease of 717 to 72,055
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 – 8844
- Ophthalmology – 6226
- Gastroenterology – 6076
- Dermatology – 5111
- Gynaecology – 5100

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

Mitigations:
The number of patients waiting over 78 weeks has decreased by 421 from January. 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.

OUTSTANDING CARE personally DELIVERED

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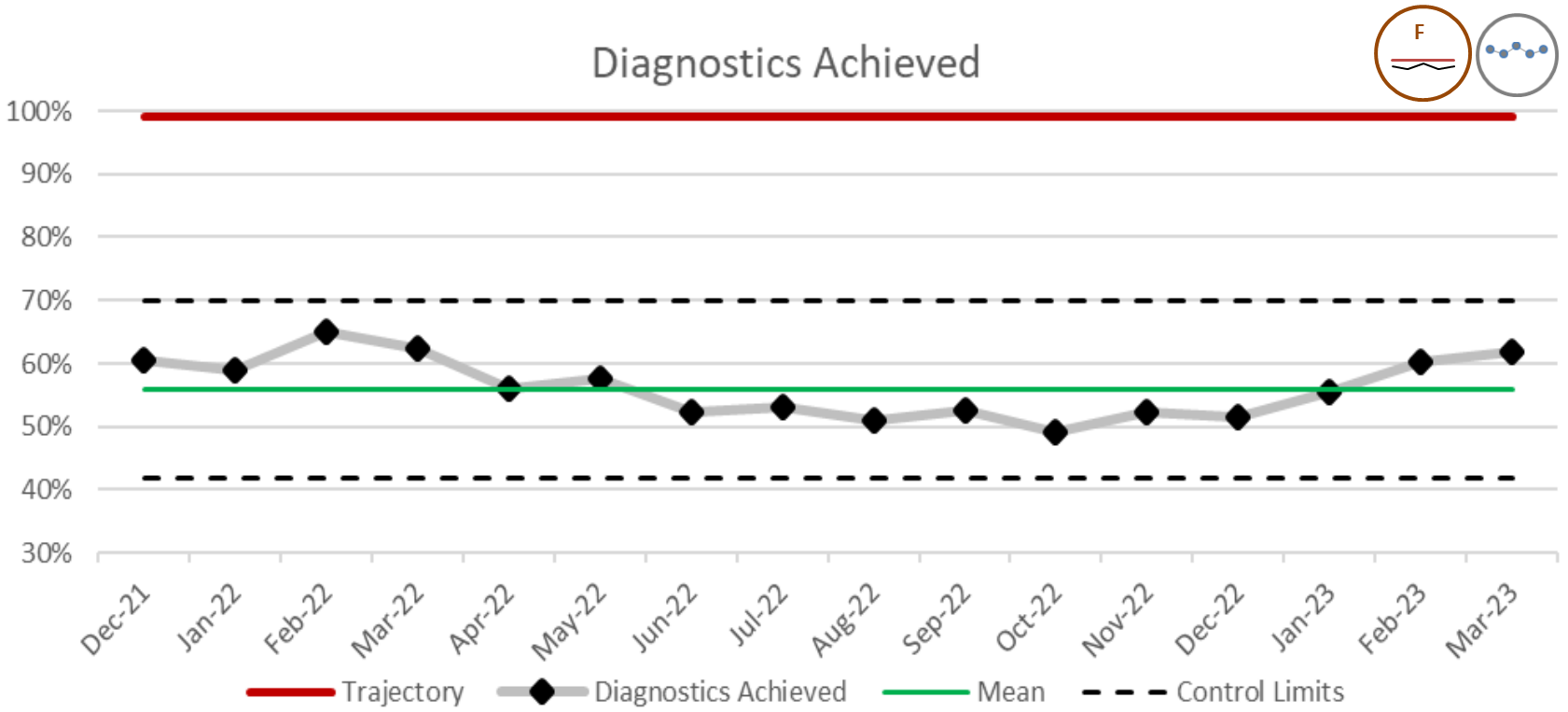

Mar-23
61.83%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 61.83% against the 99.00% target.

Issues:
The majority of diagnostic breaches sit in Cardiac Echo with 5710 breaches recorded in March.
MRI has 1125 breaches. Additional outsourcing to help reduce the backlog from January 2023 hopefully reducing breaches to within limits by July.
There are 866 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 94 Stress/TOES and 171 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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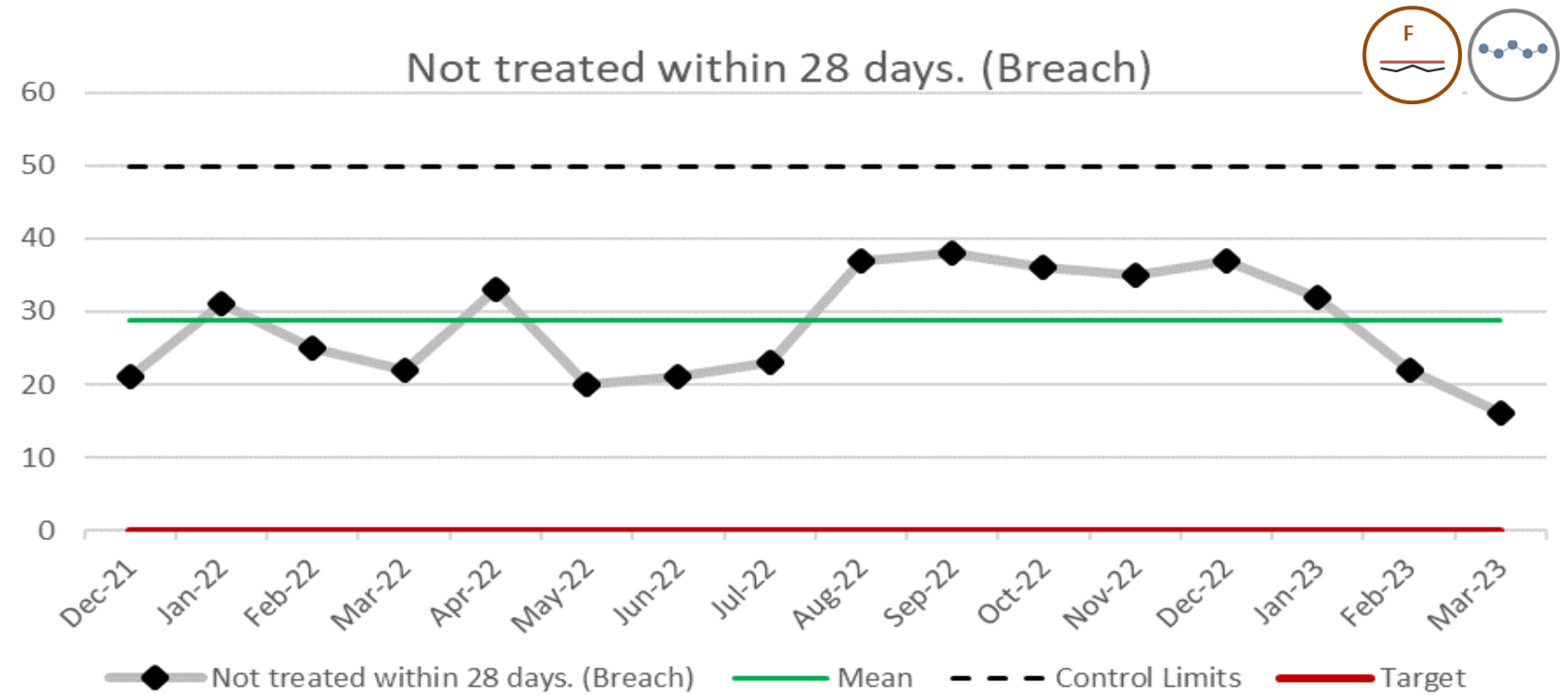


Mar-23
16
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
This chart shows the number of breaches during March 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 March, with the total number of breaches at 16 which is a continuing reduction, though the agreed target of zero has not been achieved.

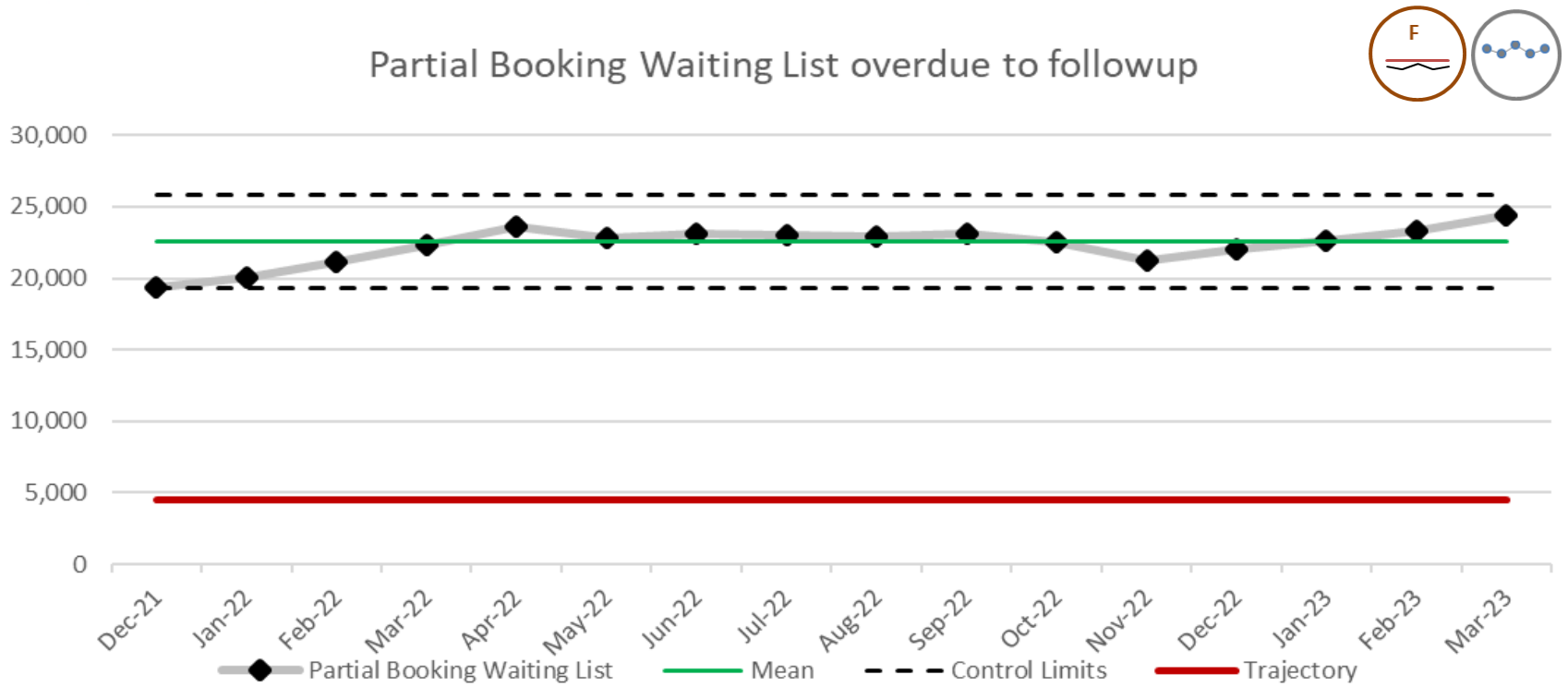
Issues:
There has been reduced availability of lists due to industrial action as well as end of year leave taking for surgeons, both of which reduce capacity.

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.

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.



Mar-23
24,397
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 24,397 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased until April 2022, at which point it remained stable with small decreases / increases per month. Since November 2022 the PBWL has started to increase on an upward trend.

Issues:
The organisation is continually pressured in a number of areas especially in urgent / emergency care, requiring patient flow to be prioritised. Rooms and resources have impacted outpatient activity levels. Industrial action plans have reduced outpatient activity.

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

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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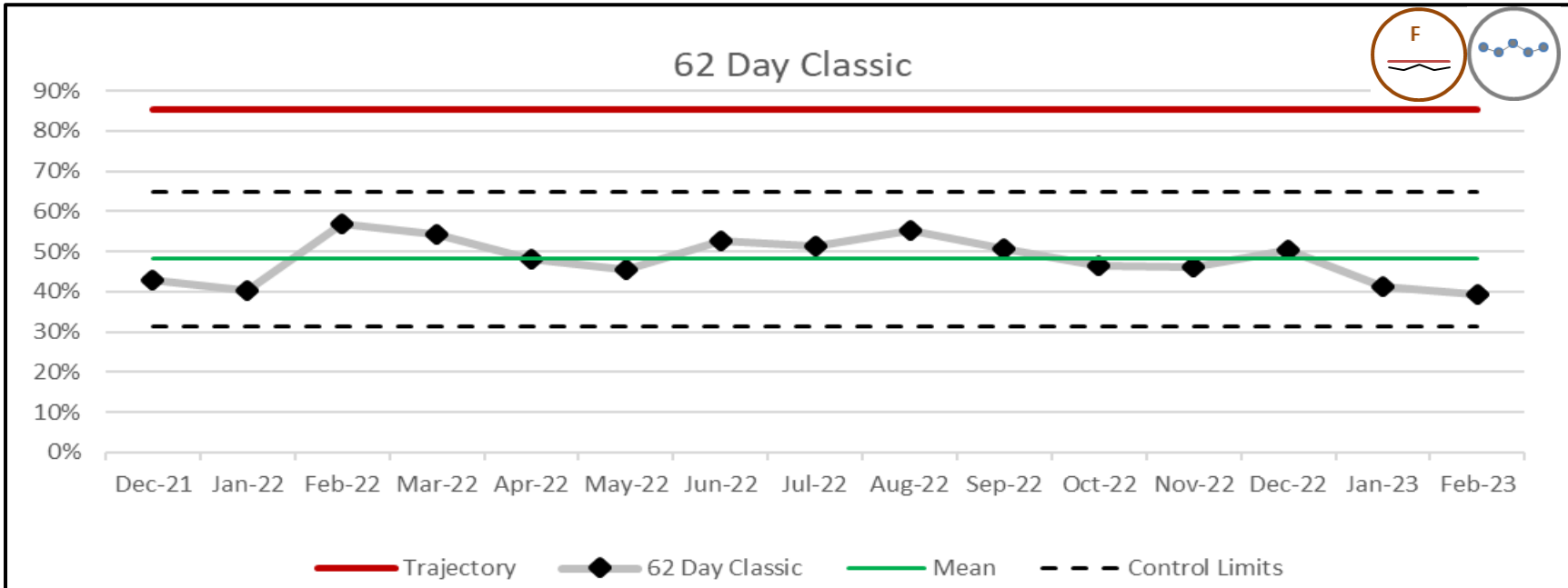


Feb-23
39.27%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 39.27% 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 and Lung.
Limited theatre capacity continues to impact cancer pathways across the Trust.
Anaesthetic assessment capacity is also limited and impacts the ability to be able to populate lists at short notice.

Actions:

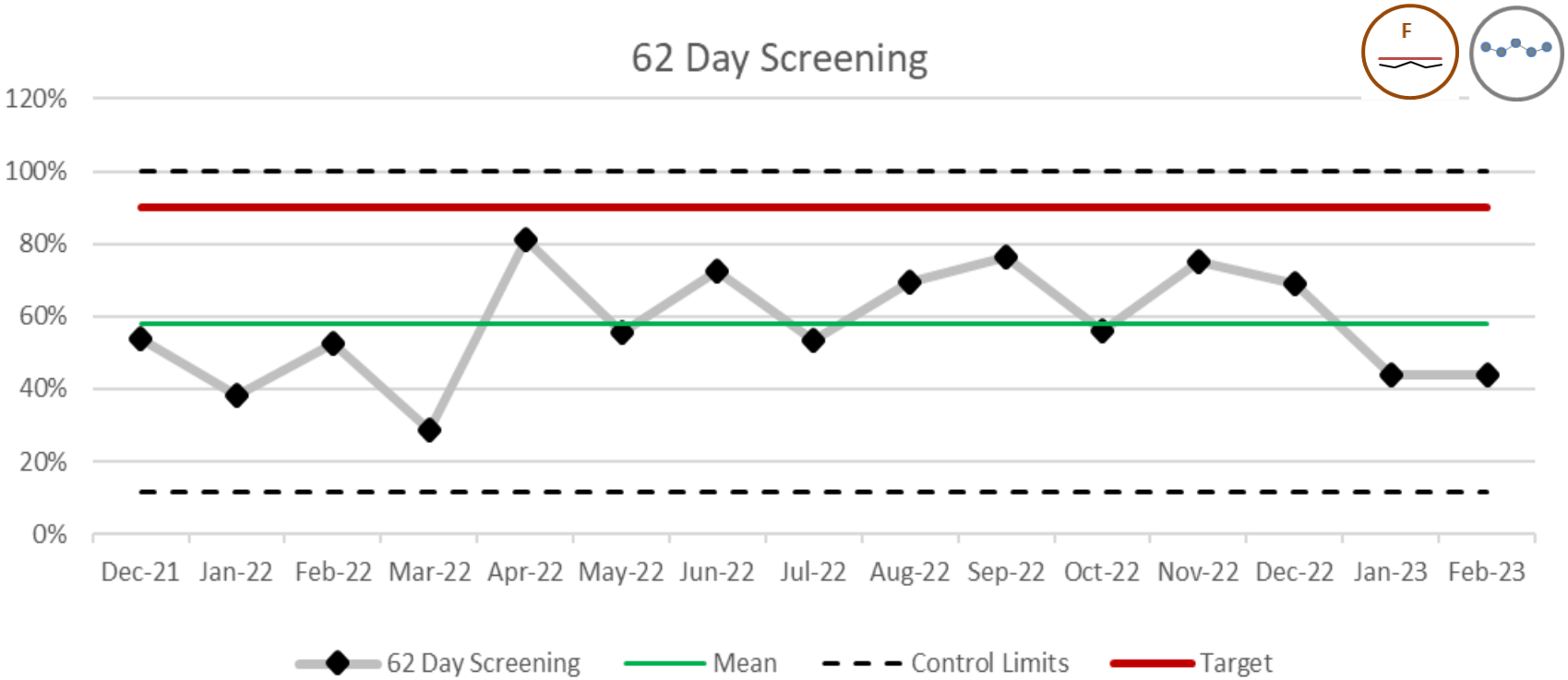
In Oncology, recruitment is ongoing to secure locum, NHS locum or substantive posts. 3 Medical Oncologist posts are out to advert as locums. A 6 month Oncology SpDr post went out to advert from which we have 2 appointable candidates. Confirmation as to whether both can be appointed is awaited.
Theatre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

Please also see Actions on accompanying pages.

Mitigations:

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

Please also see Mitigations on accompanying pages.



Feb-23
43.75%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

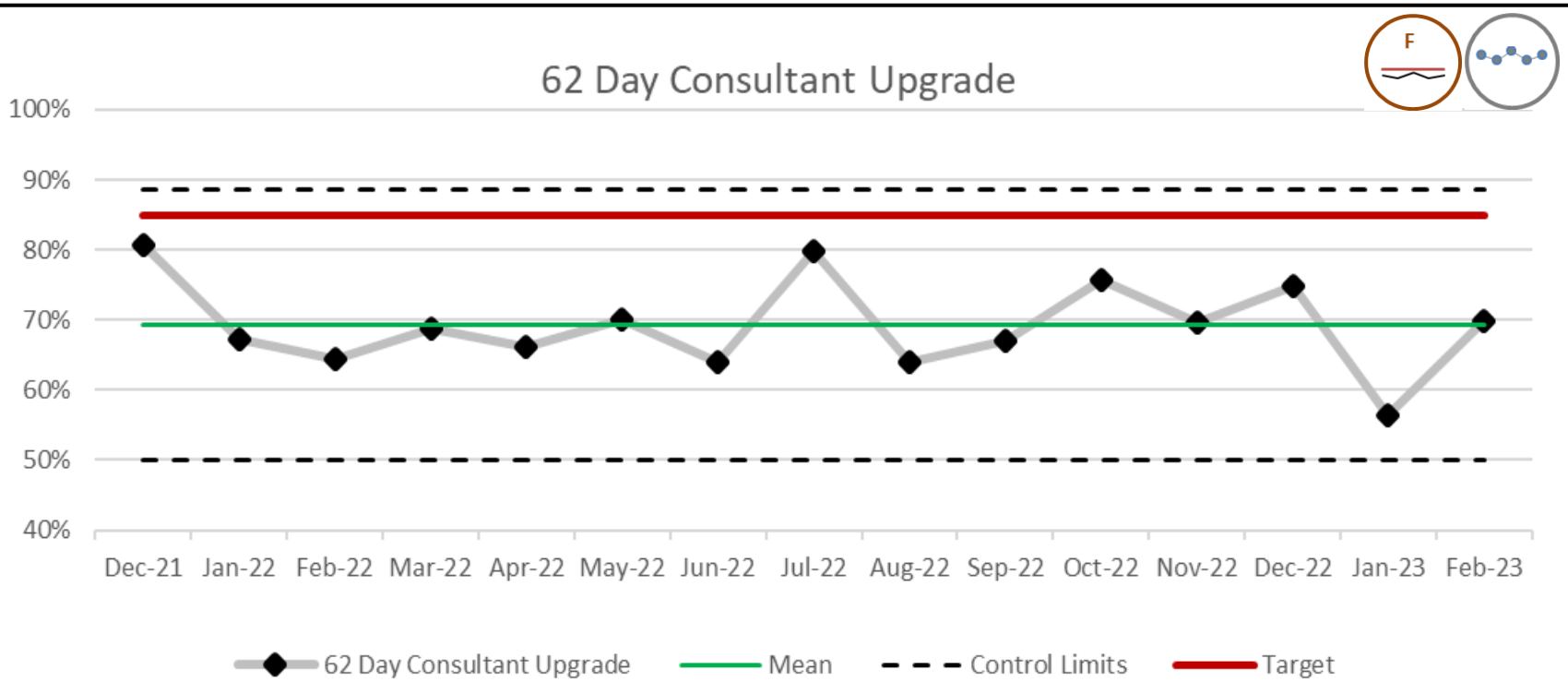
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 43.75% 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.



Feb-23
69.92%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days of a consultant's decision to upgrade their priority.

What the chart tells us:
We are currently at 69.92% against an 85% target.

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

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

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

OUTSTANDING CARE personally DELIVERED

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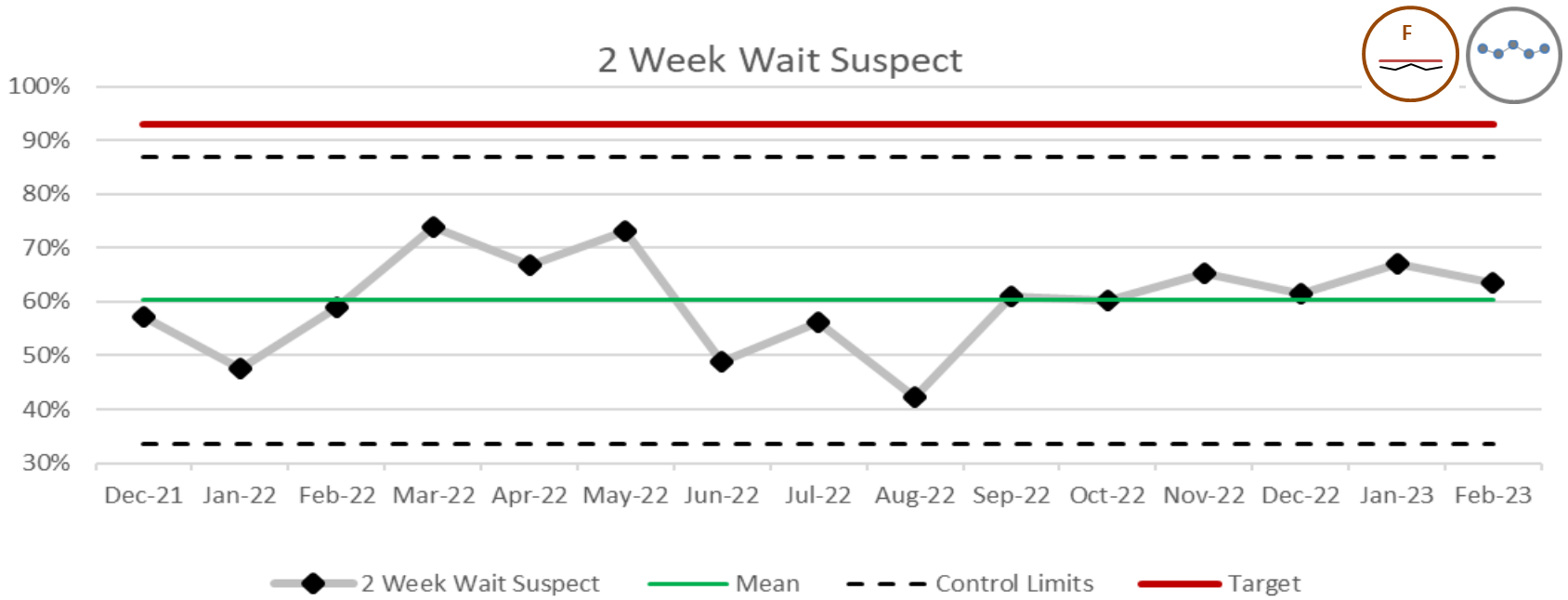

Feb-23
63.51%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 63.51% 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 43% of the Trust's February 14 Day breaches within that tumour site.
Also of concern, although an improving picture in February, was skin performance which accounted for 28% of the Trust's 14 day breaches.
The Gynae tumour site accounted for 10% of February breaches.
Lung accounted for 11% of the Trust's breaches and over 70% of 2ww referrals did not have their first OPA until after day 14 of the pathway.

Actions:

In Gynaecology, A number of work streams have been identified through the oncology strategy meetings – the next meeting is due 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.
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.

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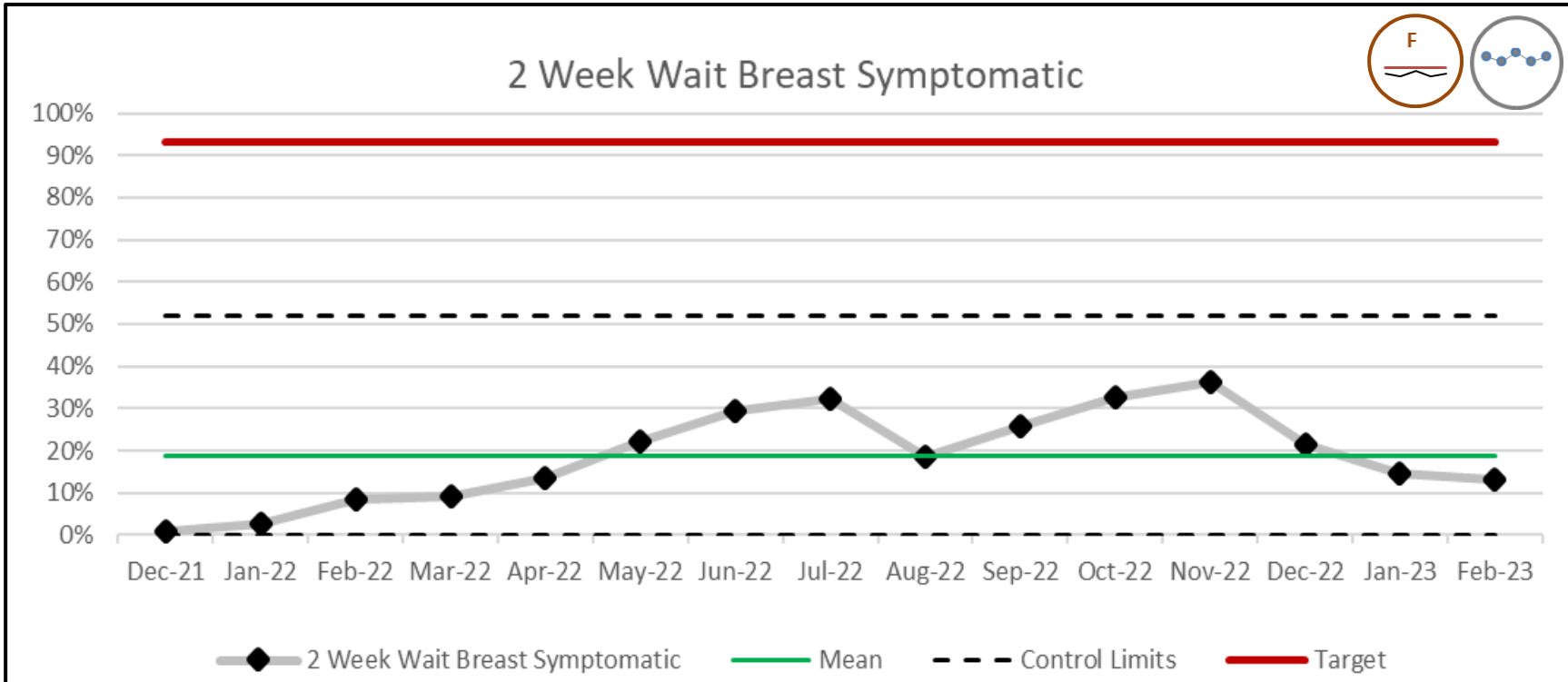

Feb-23
13.08%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 13.08% 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%.

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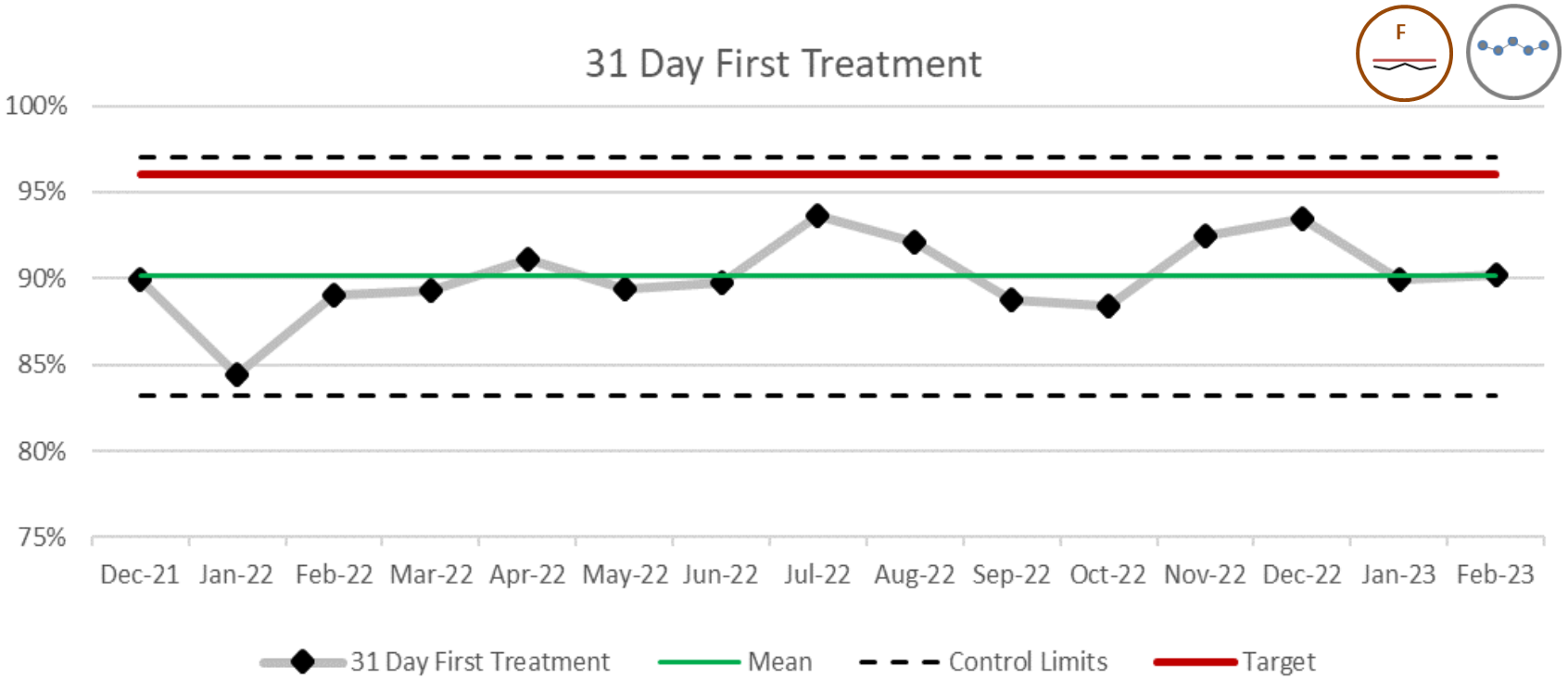


Feb-23
90.17%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

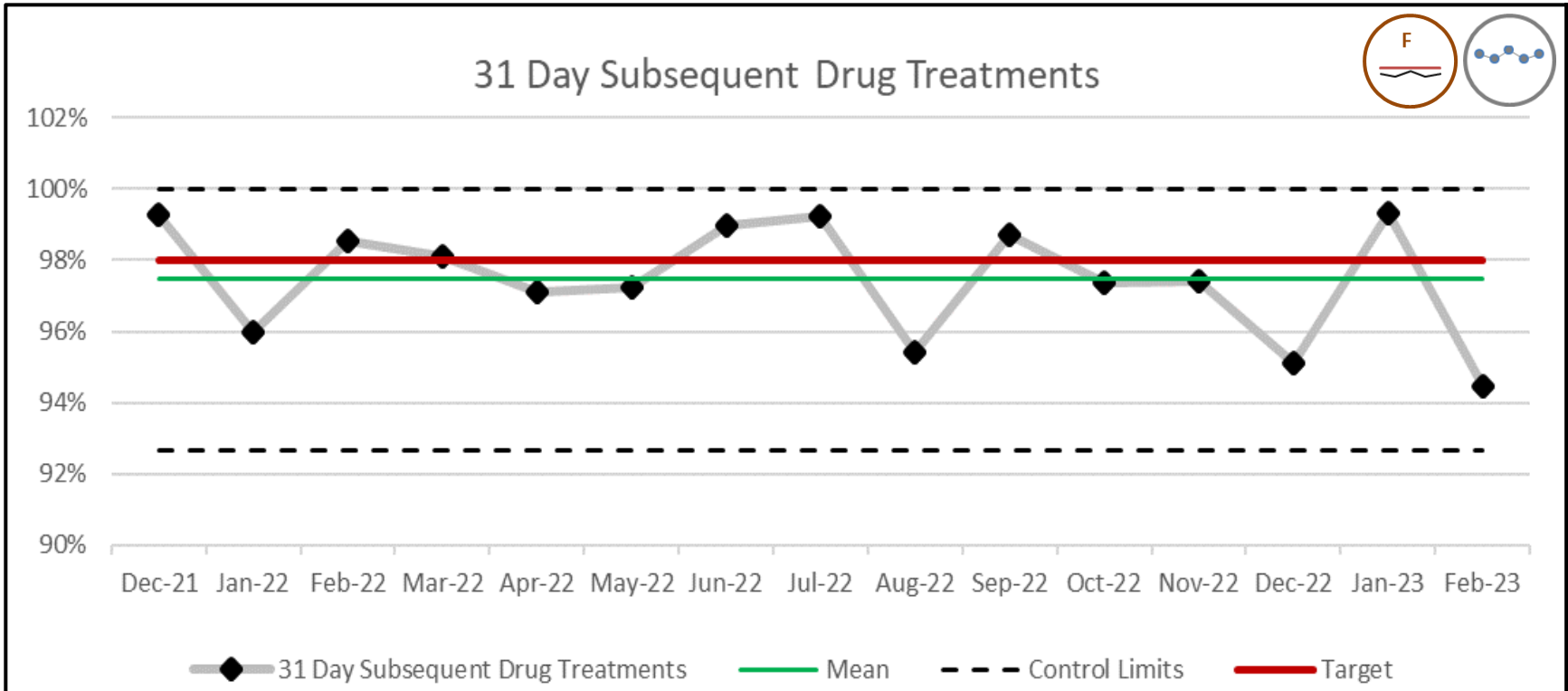
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 90.17% against a 96% target.

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

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

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



Feb-23
94.48%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

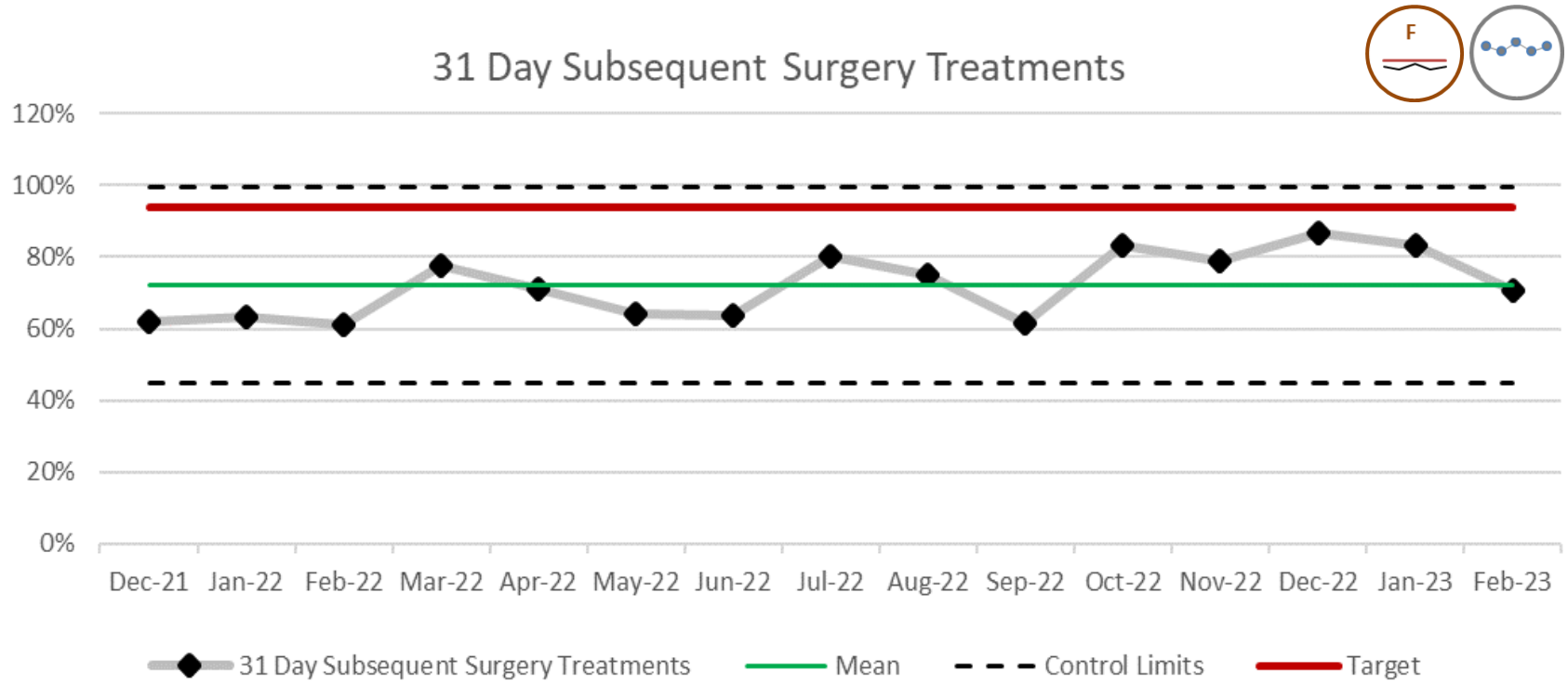
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was drugs.

What the chart tells us:
We are currently at 94.48% against a 98% 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.



Feb-23
70.83%
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 70.83% 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.

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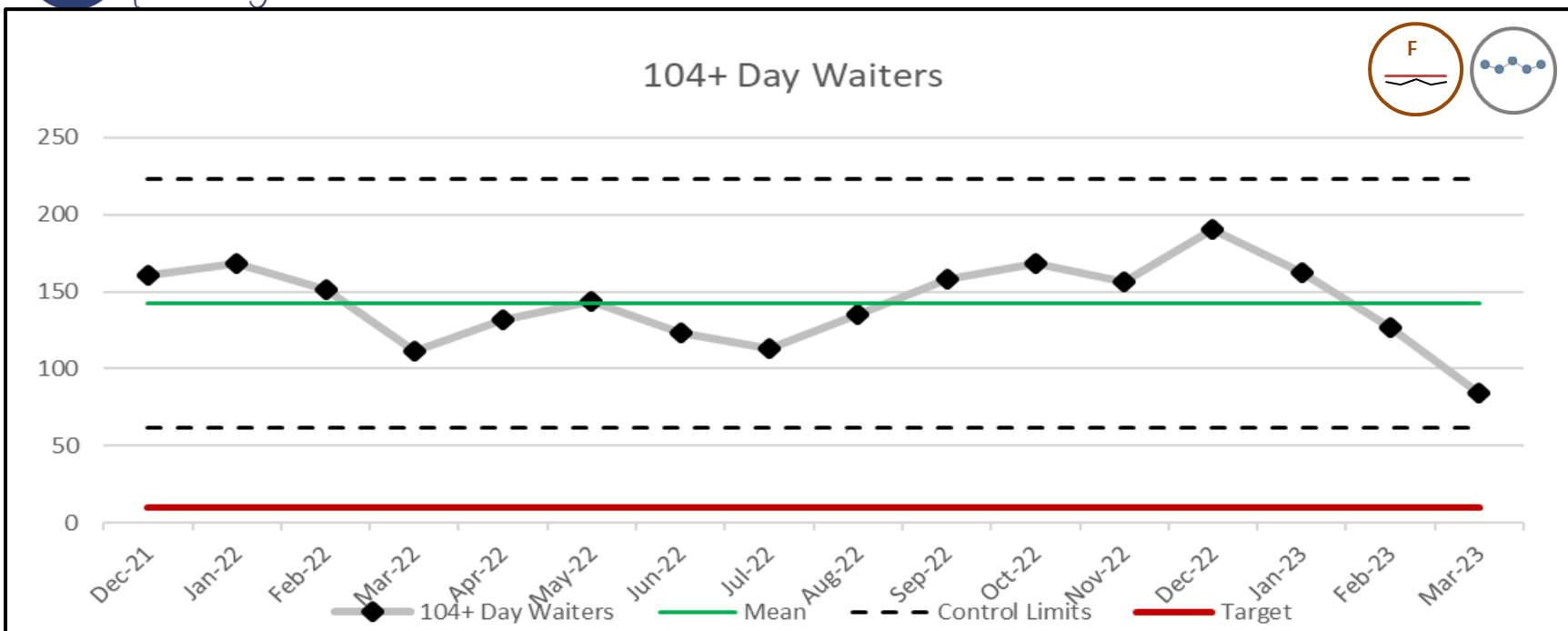
NHS United Lincolnshire Hospitals NHS Trust



Mar-23
84
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 13th April the 104 Day backlog was at 84 patients. The agreed target is <10.

There are two tumour sites of concern
Colorectal 52 (majority awaiting diagnostics, outpatients and clinical review)
Lung 10

Issues:

The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Gynaecology, and Lung.
Approximately 28% 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	Jan-23	Feb-23	Mar-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	89.25%	88.81%	89.18%	89.55%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	8.30%	7.72%	6.91%	9.58%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.59%	5.61%	5.61%	5.40%		F	A	
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	13.67%	13.55%	12.82%	14.30%		F		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	64.24%	65.39%	65.95%	61.41%		F	A	

See Executive Scorecard section for relevant failing metrics above.

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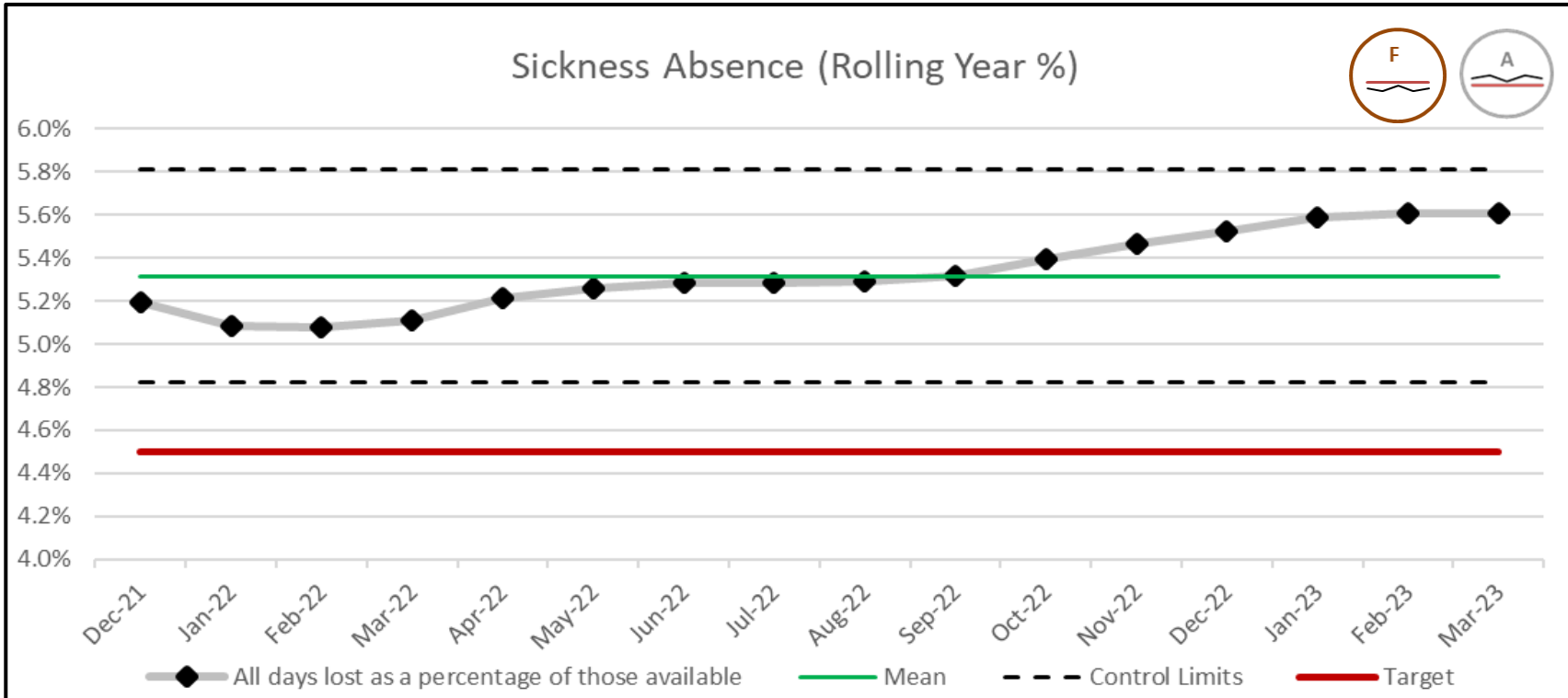
NHS United Lincolnshire Hospitals NHS Trust



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

Background:
5.61 % of sickness absence rolling year.

What the chart tells us:
5.61% 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.

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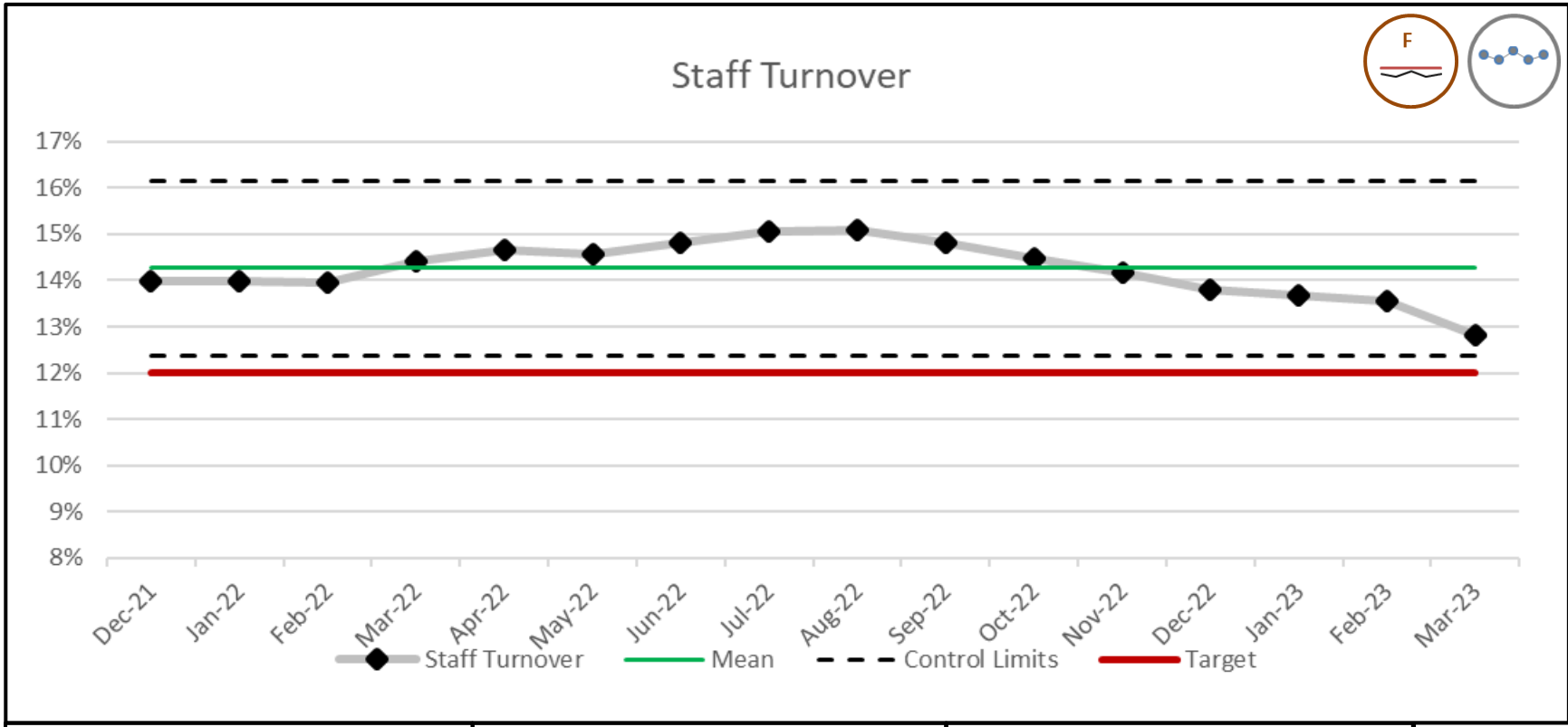
NHS United Lincolnshire Hospitals NHS Trust



Mar-23
12.82%
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:
12.82% of turnover over a rolling 12 month period.

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

Issues:
Recent Analysis of exit survey data shows reasons as follows

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

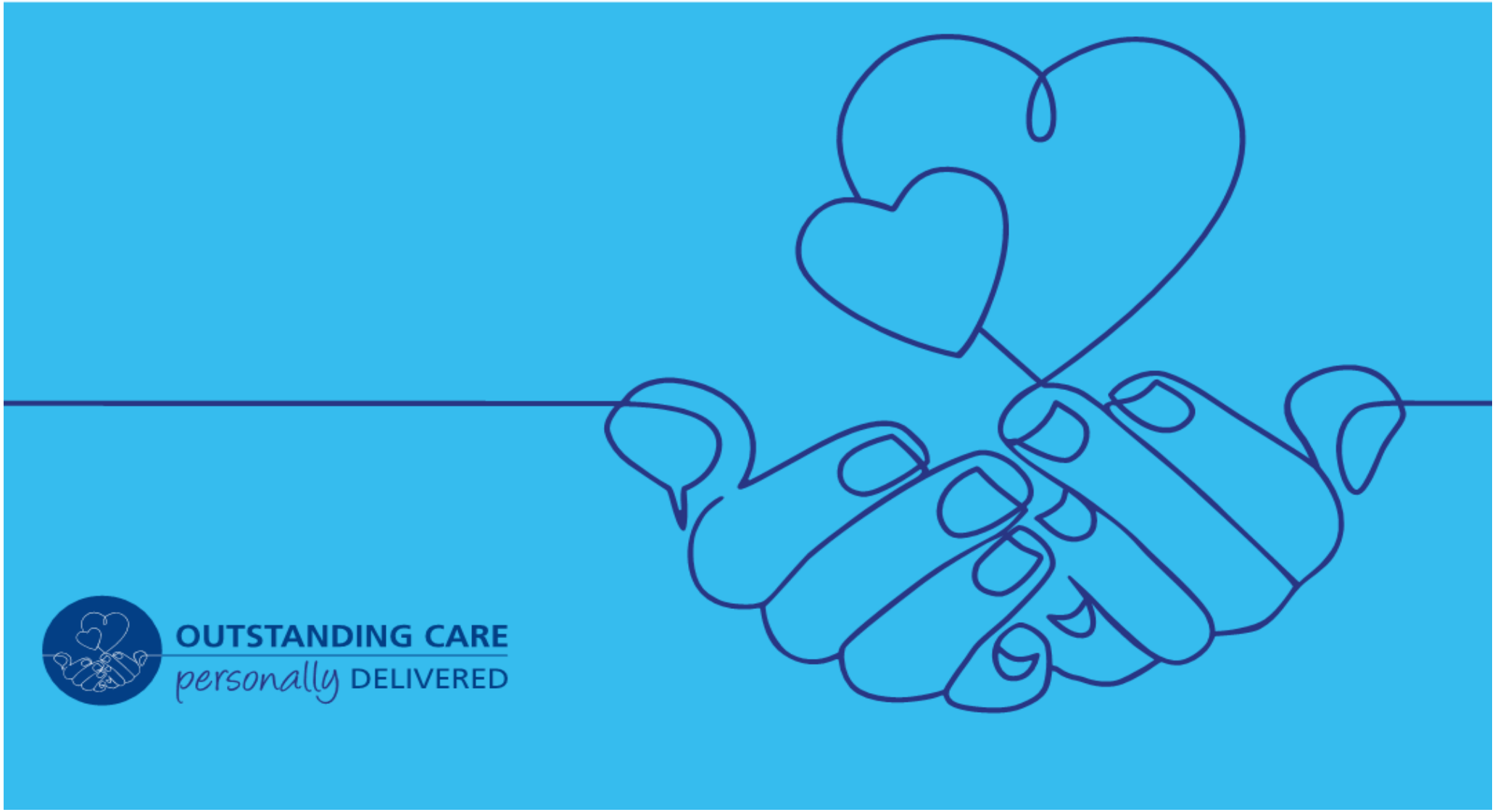
Actions:

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

Mitigations:
See actions

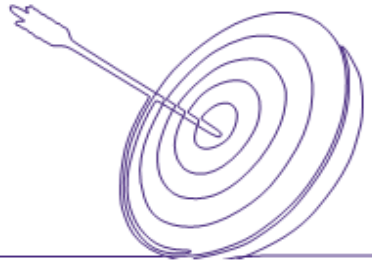
Financial Position Month 12 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust



Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)

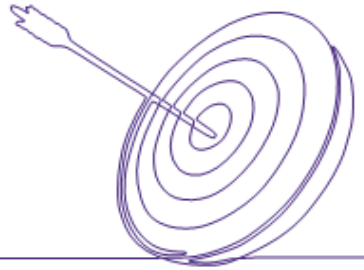


United Lincolnshire Hospitals NHS Trust

Adjusted financial performance	Current Month			Year to Date		
	£'000	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	52,450	103,001	50,551	629,555	708,886	79,331
Other operating income	3,243	7,202	3,959	37,394	48,179	10,785
Employee expenses	(36,973)	(81,763)	(44,790)	(439,127)	(515,916)	(76,789)
Operating expenses excluding employee expenses	(18,082)	(32,639)	(14,557)	(220,845)	(254,520)	(33,675)
OPERATING SURPLUS / (DEFICIT)	**638**	**(4,199)**	**(4,837)**	**6,977**	**(13,371)**	**(20,348)**
NET FINANCE COSTS	(643)	(1,156)	(513)	(7,657)	(5,974)	1,683
Other gains/(losses) including disposal of assets	0	(30)	(30)	0	44	44
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(5)**	**(5,385)**	**(5,380)**	**(680)**	**(19,301)**	**(18,621)**
Add back all I&E impairments/(reversals)	0	5,079	5,079	0	5,079	5,079
Remove capital donations/grants/peppercorn lease I&E impact	5	(1)	(6)	680	548	(132)
Remove net impact of consumables donated from other DHSC bodies	0	49	49	0	49	49
Adjusted financial performance surplus/(deficit)	**0**	**(258)**	**(258)**	**0**	**(13,625)**	**(13,625)**

- While the Lincolnshire system's financial plan for 2022/23 was to deliver a break-even position, the ICS enacted the NHSE protocol agreement after Month 9 reporting to deviate from that planned position; the ICS forecast reported at Month 10 (and agreed within the NHSE protocol) was a £21m deficit which included a forecast deficit of £13.6m for the Trust.
- The table above shows that the Trust delivered an adjusted deficit of £0.2m in M12 and delivered an adjusted deficit of £13.6m in 2022/23; the Trust has therefore delivered its agreed forecast outturn position; as a result of receiving additional income for prescribing volume and price concessions, the ICS as a whole has delivered a £16.8m deficit.
- CIP savings of £18.9m have been delivered, or £10.1m (34.9%) adverse to planned savings of £29.0m.

Finance Spotlight Report
(Key areas of focus - Income)



United Lincolnshire Hospitals NHS Trust

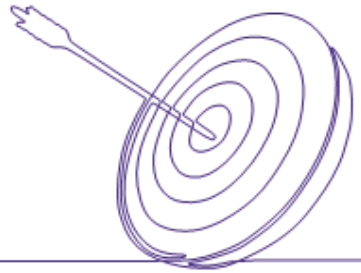
The year end income position is £90.1m favourable to plan; this most notably includes:

- **NHS Patient Care income contract - £46.6m favourable variance**; this includes £12.0m of funding to compensate the Trust for beds that have not yet closed as a result of the CC2H scheme/escalation beds, £9.4m pay award funding (net of NI reduction), over performance of £4.8m re Variable Drugs (Lincs and NHSE), £4.2m across a number of other smaller contract variations (18) with NHS Lincolnshire ICB, £3.6m elective service recovery funding, £3.5m of winter funding, £2.7m of digital/cyber/EPR funding, £2.3m ESRF funding, £1.1m of NHS England prior year income for the true-up, £1.0m funding in respect of delayed discharges, £0.7m from Lincs ICB in relation to variable diagnostics, £0.5m mutual aid income for T&O work undertaken for Leicestershire ICB, £0.5m of other variable charges to providers and devolved administrations, and £0.3k additional CV with NHSE. Settlements have been reached with Lincolnshire ICB for variable elements to the contract and with Leicestershire ICB regarding mutual aid in order to remove year end risk.
- **Additional employers pension contributions – £16.7m favourable variance**; notional income from NHSE for which there is offsetting notional expenditure in Pay.
- **Additional pay award funding – £14.6m favourable variance**; as per instructions from NHSE, the M12 position includes £14.6m of accrued income and an equal and opposite expenditure accrual in Pay.

The balance (or £12.2m) of the favourable movement is made up of the following items:

- **Education & Training - £4.2m favourable variance**; including £0.6m notional income re the apprenticeship levy.
- **Income in respect of employee benefits accounted for on a gross basis – £1.8m favourable variance**
- **Radiology fire - £1.6m favourable variance**; the financial plan did not include the I&E impact of the Radiology fire; this variance offsets an adverse variance of £1.6m in expenditure (mainly in Non Pay in relation to hire of clinical equipment).
- **Non-Patient Care services - £1.2m favourable variance**
- **Donated consumables (Covid) – £1.2m favourable movement; offset by donated expenditure**
- **Research & Development – £0.2m favourable variance**
- **Other miscellaneous movements – £2.0m favourable variance**

Finance Spotlight Report
(Key areas of focus - Pay)



NHS
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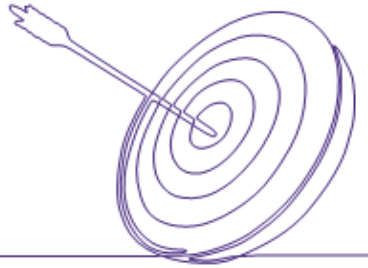
- **The year end pay position is £76.8m adverse to plan including under delivery on Pay CIP of £9.3m.**
- Actual pay expenditure in March of £81.9m was £43.0m higher than £38.9m in February.
- The £43.0m increase in Pay expenditure in March is driven by additional employers pension costs, accrued expenditure in relation to the additional pay award settlement for A4C staff and a technical adjustment in relation to Bank Staff.

  - **Substantive pay is £35.5m adverse to plan**
    - Expenditure of £63.0m in March is £32.0m higher than expenditure of £31.0m in February
    - This increase includes £16.7m of notional expenditure in March in relation to additional employers pension contributions (for which there is an equal and opposite offset in income), £14.9m of accrued expenditure in March in relation to the additional pay award settlement for A4C staff (£0.3m higher than the £14.6m funding accrued), and £1.2m transferred from capital to revenue in March; the overall increase in substantive pay in March was mitigated in part by a reduction of £1.1m in relation to annual leave carry forward.

  - **Agency pay is £24.1m adverse to plan**
    - Expenditure of £4.0m in March is £0.5m higher than expenditure of £3.5m in February (3 more days).

  - **Bank Pay is £17.3m adverse to plan**
    - Expenditure of £14.9m in March is £10.6m higher than expenditure of £4.3m in February driven by a technical adjustment in relation to Bank Staff.
    - The extra contractual rate card increase is estimated to have increased Medical Extra Duty costs by £2.1m since it was implemented on 12 December.

Finance Spotlight Report
(Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

Non Pay

- The year end non-pay position is £33.7m adverse to plan and this includes a number of specific drivers:
  - £11.0m re technical adjustments i.e. £5.1m re impairments, £2.4m re provision for future removal/destruction costs associated with the medical record storage contract, £1.3m re stock expensed to revenue, £1.3m re donated consumables (Covid), £0.7m re capital to revenue transfers and £0.2m re a one off adjustment re Bad Debt.
  - £5.6m re higher than planned pass-through expenditure.
  - £4.1m re unplanned expenditure offset by additional income e.g. £1.6m re System Digital & Cyber, £1.5m re the radiology fire, £0.5m re mutual aid, and £0.5m re validation.
  - £2.8m re Depreciation and Amortisation driven by Lincolnshire system schemes i.e. Shared Care Record and eMsk.
  - £2.7m re under delivery of the Cost Improvement Programme
  - £1.0m re excess inflation
  - £6.5m re other movements e.g. the cost of additional beds, continuation of Covid costs, contractual disputes etc.
- Non Pay expenditure of £32.5m in March was £8.6m higher than £23.9m in February driven by an increase of £2.4m in depreciation and amortisation, recognition of £5.1m of impairments and £1.3m of donated consumables (Covid).

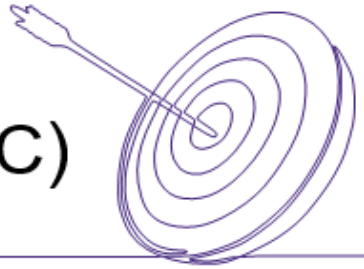
CIP

- The original financial plan assumes that the Trust will deliver CIP savings of £25m (3.6%) in 2022/23; the plan resubmission increased the total CIP savings requirement by £4.0m i.e. a CIP savings requirement of £29.0m in total.
- Actual savings of £18.9m (65.1%) have been delivered such that delivery is £10.1m (34.9%) adverse to plan.

Capital

- Capital funding levels for 2022/23 agreed through Trust Board & FPEC show a plan of c£47.5m; actual capital spend incurred in 2022/23 equates to c£47.5m of which £25.4m was incurred in March.

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



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Cash

- The March 2023 cash balance is £41.3m; this is a decrease of £47.0m against the 2021/22 year-end cash balance of £88.3m.

- 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.

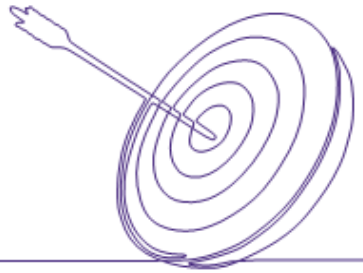
BPPC

- The final BPPC performance for 2022/23 was 79% / 70% by value / volume of invoices; this compares to the full year performance in 2021/22 of 89% / 83%.

- Performance during March itself was 81% / 71%. This is comparable to the period prior to the August Cyber attack, but remains below levels before the finance system migration in December 2021.

- The Trust has received a letter from Julian Kelly re-iterating the 95% target and directing the Trust to improve performance from April.

Finance Dashboard



NHS
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

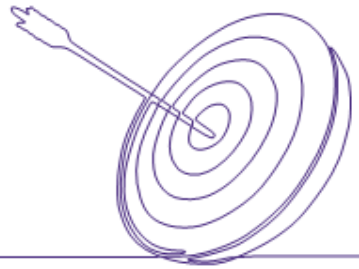
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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	Forecast
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	MAR 2023	31/03/2023
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	1.48
Capital service cover rating	4	4	4	1	3	3
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.92)	(10.92)
Liquidity rating	4	4	1	1	3	3
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(1.80%)
I&E margin rating	4	4	2	2	4	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]	0.00%
Agency rating	4	4	4	4	[illegible]	1
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	(1.80%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	3

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

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

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

Note 1: The closing balance sheet for 2021/22 has been restated for the impact of the introduction of IFRS16.

The impact in balance sheet terms is to recognise 'Right of Use' assets with the offset being an increase in Borrowings (£12.28m) and the I&E reserve (£0.19m).

Both the plan and actual for 2022/23 are stated on an IFRS 16 basis.

Note 2: Cash at £31.8m has reduced £6.4m from January but is expected to increase before the year end with the drawdown of £19.9m capital PDC in March.

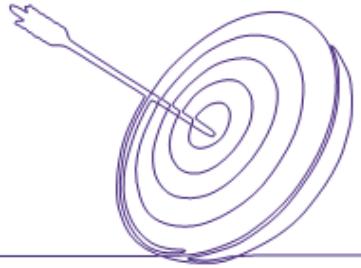
Note 3: Receivables have increased in recent months but continue to be supressed below pre-pandemic levels and will remain so throughout the remainder of 2022/23 with the continuation of block contract payments.

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

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

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

Cashflow reconciliation – April 2022– March 2023



United Lincolnshire Hospitals NHS Trust

	31-Mar-22	31-Mar-23	
		Plan	Actual
	£000	£000	£000
Operating surplus / (deficit)	549	6,977	(13,372)
Depreciation and amortisation	15,736	19,192	22,001
Impairments and reversals	7,340	-	5,079
Income recognised in respect of capital donations	(27)	(50)	(82)
Amortisation of PFI deferred credit	(503)	(503)	(503)
(Increase) / decrease in receivables and other assets	11,261	(8,617)	(37,595)
(Increase) / decrease in inventories	504	-	(2,060)
Increase/(decrease) in trade and other payables	9,745	(8,554)	2,951
Increase/(decrease) in other liabilities	(457)	-	130
Increase / (decrease) in provisions	5,860	(5,010)	10,883
Net cash flows from / (used in) operating activities	**50,008**	**3,435**	**(12,568)**
Interest received	34	240	1,175
Purchase of intangible assets	(994)	-	(4,143)
Purchase of property, plant and equipment	(35,132)	(51,875)	(42,692)
Proceeds from sales of property, plant and equipment	148	-	156
Net cash flows from / (used in) investing activities	(35,944)	(51,635)	(45,504)
Public dividend capital received	26,610	20,318	19,863
Other loans repaid	-	(403)	(403)
Capital element of finance lease rental payments	-	(2,413)	(2,416)
Interest paid	(1)	-	-
Interest element of finance lease	-	(119)	(121)
PDC dividend (paid)/refunded	(6,418)	(7,800)	(5,872)
Net cash flows from / (used in) financing activities	20,191	9,575	11,044
Increase / (decrease) in cash and cash equivalents	**34,255**	**(38,625)**	**(47,028)**
Cash and cash equivalents at 1 April - brought forward	54,042	88,297	88,297
Cash and cash equivalents at period end	**88,297**	**49,672**	**41,269**

Note 1: Cash held at 31 March was £41.3m against a plan of £49.7m. This represents a decrease of £47.0m against the 2021/22 year end cash balance of £88.3m.

Note 2: The variance against plan of £8.4m is driven by a combination of the I&E operating deficit (£20.3m), and an increase in receivables beyond plan (£29.0m) offset in part by increases in payables (£11.5m), provisions (£15.9m) and capital purchases (£5.0m).

Note 3: Underlying cash balances remain above 2019/20 levels primarily due to:
- The continued block payment regime
- Increased levels of provisions to offset risks associated with current litigation and contractual obligations.

The 2022/23 Capital programme has however utilised £8.5m of historic cash reserves.

Note 4: Despite pressures / risks associated with the outturn deficit, no immediate cash pressures are anticipated. In the immediate short term the cash position appears favourable due to the high level of year end capital creditors.

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*May 2023*
Item Number	*Item 13.1*

Strategic Risk Report

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

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

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

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

Executive Summary

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

- There were 16 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month, an increase of 5 since the last reporting period:
    - Patient flow through Emergency Departments;
    - Recovery of planned care admitted pathways;
    - Recovery of planned care non-admitted (outpatients) pathways;
    - Recovery of planned care cancer pathways;
    - Reliance on paper medical records;
    - Reliance on manual prescribing processes;
    - Potential for serious patient harm due to a fall;
    - Processing of echocardiograms;
    - Learning lessons from previous patient safety incidents;
    - Delivery of paediatric diabetes pathways;
    - Delivery of paediatric epilepsy pathways;
    - Medicines reconciliation compliance; - **New Validated Risk**
    - Consultant capacity for Haematology outpatient appointments; - **New Validated Risk**
    - Outpatient appointment processes in Haematology; - **New Validated Risk**
    - Non-recurrent funding in Cancer services; - **New Validated Risk**
    - ICU capacity for elective surgery. - **New Validated Risk**

- The People & Organisational Development Committee was cancelled this month due to the industrial action, therefore risks remain the same as the last reporting period with 3 Very high risks (20-25), of note these are under review as part of a HR/OD risk workshop in April 2023:

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

- There were 5 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, the same as 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

- There are also several High and Very high risks that are awaiting review and validation from the Risk Register Confirm & Challenge Group (RRC&CG), including:
- Increase of demands of PICC Service causing delays to patient treatment and flow.

- Lack of emergency buzzers on Ward 5B Pilgrim
- Staff exposure to Nitrous Oxide
- Mortuary service capacity concerns following HTA inspection
- Staffing at night pressures in ED due to increase footfall.
- Delays in Health Records
- Medicines Management Training not currently on ESR

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 348 active and approved risks reported to lead committees this month. This is 5 more than were reported last month.

2.2 There were 24 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)
21 (7%)	**60** (19%)	**219** (57%)	**24** (7%)	**24** (9%)

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

2.3 There were 11 Very high risks and 7 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	21/02/2023
5016	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding. This may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust.	Very high risk (25)	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED.	12/04/2023
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.	27/01/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5101	Quality and safety risk from inability to deliver epilepsy pathways that meet National standards due to resourcing and capacity factors.	Very high risk (20)	High risk due to one paediatrician managing all children with epilepsy, lack of designated nursing support. This has been a factor in several incidents of a serious nature in paediatrics. Reduction plan: 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	14/03/2023 **Risk developed to enable amalgamation of two individual risks that pertain to delivery of epilepsy services (ID4972 and ID 5073)**
5103	Quality and safety risk from inability to deliver 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. 1. Business case being developed to address shortfall, agreed in principal at CRIG. This is for a dietician, psychologist, admin and additional nurses. 2. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance 3. An increase in clinic capacity	15/03/2023 **Risk developed to enable amalgamation of two individual risks that pertain to delivery of diabetes services (ID4974 and ID 5051)**
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.	07/03/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4877	If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	29/03/2023
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. **Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration to clarify the risk description.**	29/03/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4624	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	Very high risk (20)	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	06/03/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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. 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. **Reviewed at confirm and challenge confirmed as v high risk.**	03/04/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4622	If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients.	Very high risk (20)	- Establishment of Patient Safety Improvement Team - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previoulsy called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ - Prepare for implementation of new Patient safety Incident Response Framework (PSIRF) in 2022 (replacement for Serious Incident Framework)	07/03/2023 **Recommended to RRC&CG to be reduced to Moderate (12) and merged with Patient Safety Strategy delivery risk – awaiting feedback from group members**

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	22/03/2023

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
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.	29/03/2023
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
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 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.	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. 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.**	03/04/2023

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. **Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration to clarify the risk description.**	29/03/2023

Strategic objective 2a. A modern and progressive workforce

2.6 There was 1 Very high risk and 3 High risks recorded in relation to this objective. A summary of the Very high risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4991	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	Very high risk (20)	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	14/03/2023

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

2.7 There were 2 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	14/03/2021
4439	If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Very high risk (20)	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	14/03/2023

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

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

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4648	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk. - Fire safety protocols development and publication. - Fire drills and evacuation training. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Planned preventative maintenance programme by Estates	03/03/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - PPM reporting for FEG and FSG By Estates Teams - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk	03/03/2023

Nitrous oxide risk

2.9 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)).

2.10 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.

2.11 These factors 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. Estates will continue to look at improving the current ventilation systems and where possible retrofit a solution e.g. upgrade of existing supply motors, and the Health and Safety Team will ensure effective monitoring where practicable.

2.12 The Estates perspective on this risk as noted above was presented and discussed at the RRC&CG meeting in March. It was agreed that further input was required from specialists in other areas and that an update would be brought back for validation at

the April meeting. Once agreed, it will be added to the FPEC section of the risk register, with reporting to QGC whilst it remains High risk.

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	02/03/2023
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.	12/04/2023

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.	01/03/2023

	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."		Workforce change is required which will be a much longer process. 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.

2.20 A comprehensive review and update of the People & OD directorate risk register is currently taking place, with support from the Clinical Governance risk team. A workshop has been booked to complete this work on 25th April. This work is likely to result in a more detailed breakdown of specific workforce risks, providing clearer links between the risk register and planned work on workforce planning; leadership and management; and equality and inclusion.

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

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

3. Conclusions & recommendations

3.1 There were 16 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month:

- Patient flow through Emergency Departments;
- Recovery of planned care admitted pathways;
- Recovery of planned care non-admitted (outpatients) pathways;
- Recovery of planned care cancer pathways;
- Reliance on paper medical records;
- Reliance on manual prescribing processes;
- Potential for serious patient harm due to a fall;

- Processing of echocardiograms;
- Learning lessons from previous patient safety incidents;
- Delivery of paediatric diabetes pathways;
- Delivery of paediatric epilepsy pathways;
- 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 The People & Organisational Development Committee was cancelled this month, therefore they have only been sited 3 Very high risks (20-25) which were reported at the previous month's meeting:

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

3.3 There were 5 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month:

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

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

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective							**1a. Deliver Harm Free Care**																			
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	07/03/2023	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	[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	28/04/2023
5103	Physical or psychological harm	Rivett, Kate	Naydeva-Grigorova, Tanya	Children & Young Persons Oversight	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	15/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Due to inadequate service, the service has been forced to be reduced and prioritising the children most in need, in doing so, not meeting BPT or audit requirements. Reduction plan: 1. Business case being developed to address shortfall, agreed in principal at CRIG. This is for a dietician, psychologist, admin and additional nurses. 2. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance 3. An increase in clinic capacity	[15/03/2023 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	13/04/2023
5101	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight	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;	14/03/2023	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	[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	13/04/2023
5016	Physical or psychological harm	Wall, Mrs Tracey	Thomson, Cheryl	Workforce Strategy Group	Patient Safety Group	02/09/2022	25		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	22/02/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	[22/02/2023 12:01:19 Paul White] Present at Confirm & Challenge by TW, reduction in score from 25 to 20 discussed and agree along with incorporation of details from previously separate 'surge in demand' risk. [27/01/2023 11:17:57 Helen Hartley] Risk reviewed and updated. [23/11/2022 11:28:16 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed. [10/11/2022 13:40:59 Helen Hartley] No change at governance [07/11/2022 07:03:00 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:20:43 Helen Hartley] No changes made at governance	10	02/09/2023	31/03/2024	22/03/2023
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	03/04/2023	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	[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	03/05/2023
4622	Physical or psychological harm	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group		09/04/2018	20	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	If the Trust doesn't have an effective approach to learning lessons when things go wrong with patient care it may result in missed opportunities to significantly improve patient safety and potentially to serious harm.	National Policy: - NHS National Patient Safety Strategy - NHS National Reporting and Learning System (NRLS) ULHT Policy: - Incident Management Policy & Procedures - Complaints Policy & Procedures - Patient Safety Improvement Team (Clinical Governance) - Patient Safety Specialists - Patient Safety Partners ULHT governance: - Trust Board assurance through Quality Governance Committee (QGC) / Patient Safety Group (PSG)	- Recurring themes in patient safety incidents, complaints, PALS & claims - Recurring themes in audits / reviews of risk / incident / complaints / claims management - Monitoring implementation of the National Patient Safety	07/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	National Patient Safety Strategy implementation plans, including: - Preparations for introduction of the new national Patient Safety Incident Response Framework (PSIRF) - Upgrade to Datix CloudIQ to enable information upload to the new national Learning from Patient Safety Events (LFPSE) system - Recruitment and induction of Patient Safety Partners (PSPs) - Establishment of Patient Safety Improvement Team within Clinical Governance	[07/03/2023 15:14:31 Rachael Turner] Patient Safety Team now in place, patient safety meetings are in place to identify patient safety risks. Patient Safety Risk themes have been added to the Trust risk register these include DKA Risk 4785, Ophthalmology Risk 4746, and Pressure Ulcers Risk 4626. PSIRF Implementation now in place. Datix Q-Project manager has been recruited. Work is currently underway for Datix information to be uploaded to LFPSE. Currently working with Incident Team and is keeping to schedule. Patient Safety Partners and have been recruited and inducted. Learning to improve newsletters are produced to highlight patient safety. This risk will be presented at the RRC&C meeting in March with a proposal for this risk to be closed.	4	31/01/2019	23/04/2023	31/03/2023

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
4947	Physical or psychological harm	Simpson, Mr Andrew	Saddick, Ahtisham	Medicines Quality Group	Clinical Effectiveness Group	17/06/2022	20	Policy/Protocol Issues	Clinical Support Services	Pharmacy CBU			There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	NICE guidance NG5 states that in an acute setting, that we should accurately list all of the patient's medicines (including prescribed, over-the-counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another – for example, if they are admitted to hospital.	We conduct monthly medicines reconciliation audits, which consistently have shown us failing to meet NICE targets and we are operating significantly below the national average. This audit is presented at the MQG.	29/03/2023	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	29/04/2023
4624	Physical or psychological harm	Davies, Angela	Adelseee, 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	06/03/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	[06/03/2023 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.	4	31/12/2021	31/03/2023	09/02/2023
4878	Physical or psychological harm	Harris, Michelle	Carter, Mr Damian	Patient Safety Group	Outpatient Improvement Group	28/03/2022	20	Risk assessments	Corporate	Operations		Trust-wide	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care non-admitted pathway & booking systems / processes (outpatients) - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Outpatient Recovery Group; Reports through Divisional PRMs (for performance), and FPEC and System Planned Care Group - Clinical Harm Oversight Group	2ww first O/Ps back within national target Urgent 1sts 90% <13 weeks by 31.03.23 Time critical follow ups (452/2657 overdue) – target to eliminate (mainly neurology, cardiology, rheumatology) by 31.03.23 RTT non-admitted: Clear >104wws by 31.03.22 Clear >78wws by 31.03.22 (with few remaining by 30.06.22) Clear >65wws by 30.09.22 Clear >52wws by 31.12.22	21/02/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[21/02/2023 17:44:30 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen in Outpatients and subsequently patients are not waiting so long. Recent Outpatient Sprint to improve DNAs, missing outcomes etc. have also seen fewer patients waiting. The trust is on track to clear all incomplete patient pathways >78 weeks by the end of March 2023, with the exception of patient choice. [13/12/2022 13:31:41 Rachel Thackray] As per previous update, no change to risk grading [21/10/2022 09:42:00 Rachel Thackray] Work continues on the Outpatient Improvement Programme (ORIG) to improve clinic utilisation, reduce demand and increase activity back to 19/20 levels and above. Key progress since last update includes; 1. Contract awarded for Validation contract – Start date November 2022 2. Commencement of personalised Outpatient plan – Start date December 2022 3. Super September completed and yielded 40% reduction in non-admitted pathways that were validated 4. Plan to reinstate tertiary clinics to increase capacity 5. Dedicated support to reduce missing outcomes 210622 No change due to major pressure on the system due to covid backlog. 230922 An externally procured validation team have been identified and they are due to start end of October. Risk transferred to Operations from Outpatients following discussion re ownership.	8	31/03/2023	31/03/2023	22/05/2023
4877	Physical or psychological harm	Harris, Michelle	Carter, Mr Damian	Patient Safety Group		28/03/2022	20	Risk assessments	Corporate				If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care admitted pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	02/03/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[02/03/2023 18:51:14 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen and subsequently patients are not waiting so long. Recent Theatre Productivity work has started to yield improvements and led to a significant reduction in late starts. This is particularly evident at Grantham through the SuperSprint and has seen lost minutes due to late starts reduce by 50% [26/01/2023 15:06:57 Corporate Dashboards] Risk moved from Surgery to Corporate as this is an operational risk, not divisional. [21/10/2022 09:40:36 Rachel Thackray] Work continues on three main improvement programmes to address capacity for Surgery 1. HVLC/GIRFT – Looking at best use of theatres by ensuring HVLC procedures are completed as daycases rather than Electives. This maximises productivity of lists and reduces length of stay to ensure bed availability for surgery. Compliance with HVLC has started to increase over recent weeks 2. Theatre efficiency/productivity – The trust deployed a company called Foureyes insight to work with the surgical division and implement a 16 week improvement programme around best use of theatres to drive efficiency and productivity. This piece of work has now concluded and yielded improvement in utilisation and internal processes. This now needs to be embedded as business as usual 3. Clinical prioritisation – Looking at the prioritisation of patients for surgery based on their clinical need to ensure limited theatre resource is used for the patients that most need it. The output of this work has seen good list usage for our most urgent patients and an appropriate mix of lower priority patient in order to maximise list utilisation Risk lead updated to Head of Operations.	8	31/03/2023	31/03/2023	02/04/2023

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4789	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl	Patient Safety Group	Clinical Effectiveness Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	27/01/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	[27/01/2023 10:16:42 Charles Smith] 27/01/23 - Charles Smith DGM - CDC work had to go via tender, expected to start ~01/02/23. Delivery of 3000 from backlog. Midlands visit action plan/meridian recommendations largely implemented. R&R has preliminary sign-off from trust. Trajectories have total WL eradication in 2024 if no changes, 6w and 13ww cohorts within 12/12. FUrther workforce challenges with Mat leave and new resignations. Position remains difficult in terms of capacity and fragility of workfoce. [01/12/2022 10:58:41 Carl Ratcliff] New working group in place lead by COO Plans being worked up to open CDC when contract agreed Extra room now found at LCH - start to sue next week R/R paper submitted to COO for approval Need to obtain recovery graph to show impacts of each / all action [04/11/2022 12:28:16 Carl Ratcliff] Approval now in place to use CDC at Grantham to cover 300 pts in back log. Process being agreed with procurement / operations to start. Plan for other half of waiting list being worked up for agreement. Booking team now transferred to Cardiology team to manage. Deep dive review completed by NHSE/I with actions in place - monitored with weekly meeting in Division to complete actions. Echo backlog remains high. Meridian re-engaged to support service. Number of measures being undertaken to increase capacity. Progress being reported into planned care board. Discussed at Risk Register Confirm & Challenge Group on 25 May 2022. Agreed that this is a broader quality of care and experience risk potentially impacting on a large number of patients, rather than a specific risk of serious harm. 23.08.22 Proposals been completed for internal improvement and also use of CDC - both will start in October. Funding and approvals being sought- will update once completed	4	31/03/2022	01/02/2024	20/04/2023
4843	Physical or psychological harm	Cooper, Mrs Anita	Hansford, Lisa	Medicines Quality Group		19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Screening, management and review mechanisms of patients requiring or in receipt of Intravenous Immunoglobulin (IVIg) is inadequate.	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Reported incidents involving use of Intravenous Immunoglobulin (IVIg)	29/03/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Single staff reliance for local panels, 1x haematology consultant, 1x neurology consultant and 1x chief pharmacist only. Antimicrobial and High Cost Drugs Management Pharmacist undertaking administrative functions to ensure all referrals are screened and are done so in a timely manner. Shared care arrangements and prescribing accountabilities are unclear and need review.	[29/03/2023 10:06:27 Maddy Ward] We have raised the risk today to quite likely and the medical director needs to review the process for review of these patients by an immunologist. [20/12/2022 14:25:21 Alex Measures] No further progress 19/07/21 - Shared care document was sent to NUH for review. However, NUH business unit manager expressed difficulties to advance on the SCA due to staff shortages in immunology division. Dr Neill Hepburn will discuss with NHS England regarding next step. 150622 ongoing until get an immunologist in the trust.	4	01/10/2021	28/04/2023	29/06/2023
4935	Service disruption	Farquharson, Colin	Martinez, Francisca	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.	09/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		09/02/2023
4779	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl		Clinical Effectiveness Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	27/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[27/01/2023 10:23:30 Charles Smith] 27/01/23 - CS DGM - Ongoing area of concern due to workforce and ACP gaps (being recruited to but time required to train). TIA still a concern but stable numbers. [16/12/2022 14:35:47 Carl Ratcliff] Additional work in palce to find external support / validate PWL and push patients through system [22/11/2022 17:25:10 Carl Ratcliff] Aim to have outliers back in right place and work continues to improve OPD work. Limited consultant numbers still mean there is a risk to OPD planned care work Plans in place to address backlogs across all areas. Significant area of risk for TIA. 23.08.22 Remains an issues although noting covid cases have dropped. Will be resolved once the improvement work on wards in completed to remove outliers and pts are in the correct place with appropriate bed numbers	4	31/03/2022	31/03/2023	28/01/2023
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
4958	Physical or psychological harm	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group		30/06/2022	12	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	The Trust may not be able to fully and effectively implement the requirements of the National Patient Safety Strategy, resulting in potential missed opportunities to significantly improve patient safety and possible non-compliance with national standards	National policy: - NHS Pateint Safety Strategy: Safer culture, safer systems, safer patients ULHT policy: - Patient Safety Improvement Team (Clinical Governance) - Patient Safety Specialists ULHT governance: - Patient Safety Group (lead) / Quality Governance Committee (assurance)	Frequency and severity of patient safety incidents reported. Monitoring implementation of the National Patient Safety Strategy.	07/03/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Patient Safety Strategy implementation plans, including: - Preparations for introduction of the new national Patient Safety Incident Response Framework (PSIRF) - Upgrade to Datix CloudIQ to enable information upload to the new national Learning from Patient Safety Events (LFPSE) system - Recruitment and induction of Patient Safety Partners (PSPs)	[07/03/2023 15:04:50 Rachael Turner] Risk re-opened as work currently ongoing. This risk will go to RRC&C Meeting in May with a proposal to reduce the risk from a High (16) to Moderate(9). Patient Safety Strategy: PSIRF Implementation now in place. Incident Response Framework: Project manager has been recruited. Work is currently underway for Datix information to be uploaded to LFPSE. Currently working with Incident Team and is keeping to schedule. Patient Safety Partners and have been recruited and inducted. [23/12/2022 15:01:46 Paul White] Risk reviewed & decision made to combine with risk 4622 as per previous update. This entry can be closed. [08/12/2022 11:26:42 Paul White] Consideration to be given to combining this with risk 4622 (learning lessons to improve patient care). [08/12/2022 11:25:13 Paul White] Updated timescales from NHSE regarding LFPSE implementation - deadline extended to Sept 23. [14/10/2022 10:32:27 Rachael Turner] Risk reviwed-no change As a result of delays to the procurement of Datix Cloud IQ, along with an estimated implementation timeline of 6 months to upgrade the system, there is now an increased likelihood of not being ready to integrate with the LFPSE system by the April 2023 due date. Rating increased from 12 to 16. Update 08/09/2022 - communication received this week from RL Datix to say that DatixWeb (the Trust's current version) has now been approved for connection to the LFPSE system). This development will mitigate the system integration aspects of the risk.	4	31/03/2023	31/03/2023	28/02/2023
4646	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Clinical Effectiveness Group	NIV Working Group	14/12/2021	20	Policy/Protocol Issues, Risk assessments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	13/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[13/01/2023 13:14:40 Donna Gibbins] Case of need agreed and SFBC being written following approval at establishment review for staffing establishment. Recruitment complete for LCH Respiratory wards with minimal vacancies once all staff in place. Task and finish group arranged for phase 2 of the respiratory project to review NIV standards at PHB and additional areas of focus including domiciliary NIV. To commence end of January 23. Monthly NIV audit continues-Timeliness of the commencement of NIV is improving, issues relating to availability of NIV bed and appropriate referrals a current issue to bed pressures. Escalated and reported through escalation structure. Agreed risk remains high but reduced, requires to remain at 16 until for confirmation of Trust wide achievement of BTS standards. New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB are on hold with provisions in place to allow NIV to be delivered in the bay where there are x 4 monitored beds (IPC agreed) Risk discussed at Risk Register Confirm & Challenge Group in May 2022. Still inconsistencies with timeliness against BTS standards, particularly at Lincoln, and inability to ring-fence beds but an improving position. Agreed that risk remains high but has reduced. Recommendation for rating to change from 20 to 16.Overall compliance monitored with a monthly NIV report. Case of need for funding of ward nurses in new environment agreed to ensure BTS standards are delivered, SFBC now required- commenced and in process, ew costings awaiting due to agreed pay rise on agenda for change	4	30/09/2022	31/12/2022	07/04/2023
4722	Physical or psychological harm	Cooper, Mrs Anita Ogunyemi, Olubuymi		Patient Safety Group, WORK		13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If there is insufficient enhanced care support available at the level required for the number of patients on Ashby Ward who require it (the ward has a high level of complex rehabilitation patients and regularly has 3 or more patients requiring enhanced care due to high risk of falls; cognitive impairment; wandering - security of self and other patients) then it may lead to safety and security incidents resulting in serious harm to patients	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Quality Governance Committee (QGC) assurance through lead Patient Safety Group (PSG) - CSS Division, CBU / speciality governance arrangements - Capital & Revenue Investment Group (CRIG) management of business case process	Patients requiring enhanced care on Ashby Ward Patient falls incidents on Ashby Ward Patient security incidents on Ashby Ward	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
Strategic Objective							**1b. Improve patient experience**																			
4998	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Outpatient Improvement Group	Patient Experience Group	22/08/2022	12		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		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.	* Weekly meeting with Service and Support Manager in Cancer Services and Outpatients. * Service and Support Managers in Cancer Services are man-marking patients to appoint. * Reminded consultants to ensure e-outcomes are completed.	* New referrals and PBWL show ongoing capacity issues. * RTT and cancer performance below target. * Increased Datix, Complaints and PALS * Outcome from Staff Survey results	22/02/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	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	[15/12/2022 13:37:21 Alex Measures] choice and access now taken over oncology haematology, initial procedures put in place constantly under review during these early periods following the takeover Choice and access now moved appointment system to GDH. Expected improvement review in 3 mths.	4	01/04/2023	01/04/2023	31/03/2023
4701	Reputation	Grooby, Mrs Libby Upjohn, Emma		Estates investment and Environment Group	Patient Experience Group	13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	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

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
4724	Physical or psychological harm	Rimmer, Lucy	Bradley, Mrs Lesley	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	10/03/2023	Extremely likely (5)	>90% chance	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	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	Clinical Effectiveness Group, Digital Hospital Group, Patient Safety Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	29/03/2023	Extremely likely (5)	>90% chance	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	28/04/2023
4731	Physical or psychological harm	Harris, Michelle	Parkin, Mr Lee	Medical Records Group	Clinical Effectiveness Group, Digital Hospital Group, Information Governance Group, Patient Experience Group, Patient Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Draft policy produced further discussion with changes required with Divisional Clinical Lead - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	05/04/2023	Extremely likely (5)	>90% chance	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.	[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	4	30/06/2018	31/03/2023	04/04/2023
4932	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Workforce Strategy Group	Clinical Effectiveness Group	24/05/2022	16	Workforce Metrics	Clinical Support Services	Cancer Services CBU		Trust-wide	Services will be stopped and/or disrupted due to non-recurrent funding (Macmillan/RDC/SDF funding streams). These include CNS, CCC, Waiting List Clerk, Trainee ACP's/ACP's, Advanced Practitioner Radiographer, PTL administrator, PTL Tracker, Deputy nurses-leadership roles. 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 job roles list	03/04/2023	Extremely likely (5)	>90% chance	Very high risk (20-25)	20	CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology. Risk reduction plan escalated to ICB as it is a system wide impact.	[03/04/2023 09:40:42 Rose Roberts] We are awaiting EMCA review to see if need the posts. McMillan posts have been funded. Reviewed at confirm and challenge confirmed as v high risk. [14/03/2023 11:21:33 Rachael Turner] Division has reviewed and have proposed that risk score is increased to a rating of 20 (Very High). This risk will be raised at RRC&C Meeting in March for validation. [30/01/2023 16:12:51 Rose Roberts] Contracts end March 2023, if not in receipt of further funding non specific symptom (NS pathway will have to stop. Pre diagnosis service will have to stop. Currently we have a tick box on all 2 ww referrals which allows complex and vulnerable patients to be identified for support from this team, circa up to 40 pt per week. The other contracts that end end of March for transitional care specifically for colorectal and urology, would stop. [15/12/2022 13:32:54 Alex Measures] case of need completed for all four divisions within the trust, paper submitted to CRIG awaiting date for presentation Reduced to moderate as finance are now fully aware of the situation. Ongoing	8	31/10/2022		03/05/2023
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	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.	29/03/2023	Extremely likely (5)	>90% chance	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		29/04/2023

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
4928	Service disruption	Ratcliff, Carl Smith, Charles	Patient Safety Group		Clinical Effectiveness Group	28/04/2022	16	Professional Guidance	Medicine	Cardiovascular CBU	Cardiology		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across Cardiology arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	27/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[27/01/2023 10:20:57 Charles Smith] 27/01/2023 - CS - DGM - Further 2x Cons departures (Ads out). C&A not able to support PIFU implementation yet. Further loss of agency Cons at PHB to remove reliance on agency (cost). NHS national ask is to reduce FU work, this will have negative impact so currently negotiating via D&C process. [16/12/2022 14:40:47 Carl Ratcliff] Work underway to fill all clinics but no major concerns with perf [22/11/2022 17:29:18 Carl Ratcliff] RTT for cardiology starting to improve, however backlogs still place and risk not yet reduced. Specialty review work will lead t plan to bring RTT performance back into line but could take 6/12 Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Additional details to be added to risk reduction plan. 10.08.2022- New consultant starting September 2022- 2 x clinics per week for new patients only Existing new patients currently being validated by support manager. TOE list capacity being utilised for PBWL patients. Plans in plan for PIFU for cardiology (next meeting end of August 2022).	8		30/06/2022	31/07/2023	27/04/2023
4905	Physical or psychological harm	Cooper, Mrs Anita Bradley, Mrs Lesley			Clinical Effectiveness Group, Workforce Strategy Group	22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on acute wards, delayed discharges, delayed referral to response times. Patient reviews delayed for botox treatment. Paediatric services- delayed response to new diabetes referrals and unable to see current diabetes patients in clinic-could lead to patient harm.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Prioritisation guidelines help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff-(normally B6 N&D staff)	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service.	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							**2a. A modern and progressive workforce**																			
4991	Service disruption	Low, Claire Shankland, Lindsay	Workforce Strategy Group			08/08/2022	20	Corporate	People and Organisational Development	Operational HR		Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience.	ULHT policy: - Workforce planning processes - Recruitment & Selection Policy & Procedure - Rota management systems & processes - Locum temporary staffing arrangements - Workforce management information - Core learning / Core+ programmes? ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Vacancies & turnover rate. Staff survey results relating to job satisfaction / retention. Core learning compliance rates?	14/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very High risk (20-25)	20	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	[14/03/2023 13:54:10 Rachael Turner] Increase in headcount, 7.7% now and plans to get this even lower. Roughly 4% improvement. 450 more staff increase and 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. [31/01/2023 15:11:35 Rachel Thackray] Developing workforce planning report to be submitted to HEE by 31 March 2023, this has a monthly breakdown of anticipated recruitment plans across staff groups with an aim to take us to a vacancy factor of approx 2%. This will be monitored at an organisational and system level monthly. Staff survey results from November 2022 show increased positive scores across all factors which should influence retention issues. Risk reduction plan - Presentation to ELT on 10/11/22 to update international recruitment plan, revised projection on increasing nurse recruitment to get to zero vacancy position by March 2023 Currently 250 nurse vacancies - task and finish group created by Head of Recruitment to work in conjunction with divisional leads to pull together a recruitment activity plan for the remainder of 2022/23 and 2023/24. Plan for recruitment of 285 nurses by the end of the financial year. 1. New to care recruitment being extensively used for HCSW role with 14 appointed & a further 40 offered. 2. Nursing associate recruitment embedded 3. Medical Support Worker role now looking to be embedded as business as usual. 4. Agency providers increased to a minimum of three for key roles, rather than 1 previously. 5. Restructure process started within wider HR team will result in significant greater capacity for recruitment activities and overall oversight and proactivity. 6. Restructure process started, to introduce internal agency aspect to ULHT recruitment	4		31/03/2023	31/03/2023	14/04/2023
4741	Service disruption	Cooper, Mrs Anita Chester-Buckley, Sarah	Workforce Strategy Group			13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung Clinical oncology - head and neck, skin, upper GI (RT only). Lack of cover for leadership roles (Chemotherapy lead and clinical lead)	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements	Monitoring tumour site performance data	22/02/2023	Extremely likely (5) >90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	[16/01/2023 12:13:46 Sarah Chester-Buckley] Interviews being set up for leadership role. [15/12/2022 13:42:46 Alex Measures] leadership posts out to advert [16/11/2022 15:56:34 Rose Roberts] Posts being mitigated by employing high cost locums, risk with this mitigation is that locums need only give one weeks notice. Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements. 220622 Agency Clinical oncologists recruited. So improved cover for Head and neck and melanoma. Ongoing	4		31/03/2023	31/03/2023	22/03/2023

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
4862		Ratcliff, Carl	Rumble, Callum	Workforce Strategy Group	WORK	22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting. We do not have the substantive staff nor the locum or agency bookings, to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals on top of high volume OP workload, delayed pathway progress / commencing treatment such as chemotherapy. Due to lists / skillset required, there is not the ability within the organisation to cross cover between sites leading to Grantham particularly being	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The Business Unit have this week (06/09) put a bid in to the EMCA to gain funding of 250K to support a General Medicine to work in Respiratory so that our Substantive teams can be released to support Respiratory Cancer Capacity - This bid is currently being reviewed. We have worked in the background to book x 2 Agency Locum General Medicine Consultants 1 at Boston and 1 at Lincoln which will take us over budget, but supports the respiratory patients of lincolnshire and the welfare of consultant staff.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	24/02/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Close working with Agency to try and recruit agency locums to temporarily fill gaps. Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff. Additional funding applied for from Cancer alliance/ICB for Gastro and Resp to allow for additional Gen Med Locum to reduce burden on current workforce. Remote working in place to support outpatients where possible. Agency spend supporting out of hours workload - for example, covering the substantive consultants on calls to allow them to focus on Cancer work instead of on call - supporting patient care.	[24/02/2023 13:48:15 David Marsh] Recruitment in progress, 5 substantive consultants in post (3 x Lincoln, 2 Boston). Agency locums in place covering a variety of roles/sites. New NHS Trust Locum Respiratory Consultant from overseas started in January at Lincoln. Now working independently. Division looking at developing ACP roles and Nodule Nurse post. [01/12/2022 11:15:13 Carl Ratcliff] plan for 3 consultants now being on boarded New plan to develop ACP nodule role Most recent update: Dear Carl, Following the catch up earlier, Claudia, Ashley and I have compiled our thoughts on what could go down to support the services..... Option Take down Benefits Risks: 1 Do Nothing None Cancer patients continue to wait prolonged periods for care. • Inpatient services at LCH and PHB continue to become extremely depleted • Welfare of current consultant workforce continues to suffer, potentially leaving to sickness / prolonged absence • Boston have only x2 Consultants, currently utilising support from already depleted LCH Team. (If annual leave / sickness, we have only 1 consultant on the Pilgrim site) 2 Grantham inpatient respiratory services (Preferred) Releases x1 Agency Locum Consultant who can ?potentially? go over to Lincoln (as per previous agreement) • Releases a consultant to cover the rota to a 'safe' level Non-compliance with ASR due to taking out inpatient respiratory services at GDH • 1 consultant from the Acute on Call rota at Grantham. • Dr E could decide to leave ULHT due to not agreeing with request 3 Respiratory to come off the outlier rota for General Medicine Capacity to support the ward referrals / CT triage Impact on other specialties / or risk for outliers not to be seen daily (sick and new only) 4 Cancellation of non DCC roles for substantive workforce (Governance / Audit Lead / Community	4	30/12/2022	01/04/2023	01/03/2023
4762	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	Nursing, Midwifery and AHP Forum, WORK	14/01/2022	15	Risk assessments	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	09/01/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[09/01/2023 14:29:40 Caroline Donaldson] Staffing position remains the same - still an issue. Advert out for posts. Second Clinical Educator post has been recruited to. Level 3 beds still capped at 8 (both sites). [29/11/2022 15:15:09 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. No change to previous progress note. [20/10/2022 14:04:40 Caroline Donaldson] 20/10/2022 Discussed with Lead Nurse. Still ongoing workforce issues. Interviews are in progress for additional clinical educator post and approach has been made to the Clinical Education team to support with that. Individualised action plans are being drawn up and put in place for new members of nursing staff in order to support them. 16/09/2022 Skill continues to be an issue. Additional clinical educator to be appointed to support training needs of team. Level 3 beds still capped at 8. Risk continues and includes skill mix as well as numbers of staff. Mitigation - ongoing recruitment, block booking of Agency staff, daily review of staffing undertaken, liaison with University of Lincoln to support new starters. 13/06/22- Beds are currently capped at 8 level 3 due to insufficient medical staffing. We are able to meet numbers but skill mix remains a concern.	6	30/06/2021	30/09/2022	09/02/2023
Strategic Objective							**2b. Making ULHT the best place to work**																			
4990	Reputation	Low, Claire	Shankland, Lindsay	Workforce Strategy Group		08/08/2022	20		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally.	1. National and local lessons learnt for engaging staff effectively with surveys 2. Dedicated 'staff experience/engagement' role proposed to lead programme of work (including corporate and local action planning)	1. Pulse Staff Survey response rate (quarterly) 2. NHS Staff Survey response rate (annual)	14/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. National mandate for NHS organisations to run Pulse Survey every quarter (1,2&4) 2. Comprehensive and robust positioning to complement NHS Staff Survey and part of a wider staff listening and engagement plan 3. You said campaign to drip feed/communicate how staff intelligence is improving working environment and services - now live	[14/03/2023 14:01:55 Rachael Turner] Staff survey results demonstrate significant improvement, the Trust are now second nationally in improving. Update to be provided at next reviews [31/01/2023 15:15:19 Rachel Thackray] Staff survey responses from November 2022 indicate a perceptible positive shift across most questions. Improvement evident in position within our group on Picker moving from last place to 57/65. [09/11/2022 14:55:58 Rachel Thackray] Staff survey currently live with a good uptake and comms on a daily basis. HRBPs working with divisional leads to promote areas with low uptake. Promise Manager now in post from September 2022 working on staff retention. 1. Pulse Staff Survey - Q2 (July'22) 2. Reset approach (communication, engagement of and management) for sign off - ELT (June'22) 3. Local action planning process - now live 4. 7 Big Ticket Priorities proposed following NHS Staff Survey	4	31/03/2023	31/03/2023	14/04/2023
4439	Service disruption	Low, Claire	Shankland, Lindsay	Emergency Planning Group	WORK	16/11/2018	20		Corporate	People and Organisational Development	Operational HR		If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Workforce plans & rota management procedures. Temporary staffing arrangements. Business Continuity Policy with associated procedures & guidelines. Local service-specific business continuity plans & recovery procedures. Executive oversight (Chief Operating Officer) through Emergency Planning Group.	Frequency of industrial action events. Publicised staff polls / surveys by professional bodies on possible industrial action.	10/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	[10/03/2023 11:46:11 Rachael Turner] No change. Work currently in progress to provide an update in April. [31/01/2023 15:18:02 Rachel Thackray] Current risk assessment in place and working group set up to prepare for potential ongoing industrial action, links in with operational planning to ensure a joined up approach. [07/11/2022 11:13:23 Rachel Thackray] There is a likelihood that there will be some form of industrial action before the Christmas period in 2022. Therefore, it is necessary to increase the likelihood of this risk from low to extremely likely. As such he Associate Director of Workforce is working with the Emergency Planning team to revise the current action plan in place involving staff side reps and the Senior Management Team. The communications team will also be involved. There is a meeting taking place on the 8 November 2022 to implement a Task and Finish group. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review).	4	31/03/2023	31/03/2023	10/04/2023
4993	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	WDES (Workforce Disability Equality Standard): limited awareness and implementation of reasonable adjustments and other forms of support which results in limited equality and equity of opportunity for staff classified as having a 'disability'; impedes Trust's ambitions to create an inclusive culture and foster belonging; difficulties in attracting as well as retaining talent	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	[31/01/2023 15:22:04 Rachel Thackray] WDES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. WDES action plan prioritised for engagement, development and delivery 2. July 2022: ULHT review datasets, declaration rates (from 1/7/22 ULHT required to submit metrics and narrative data via the DCF online platform by Aug'22). 3. End October 2022: deadline for ULHT to publish WDES 2022 annual report (include metrics report and WDES action plan)	4	31/03/2023	31/03/2023	28/04/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4992	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	WRES (Workforce Race Equality Standard): low compliance/ limited improvement and action to address indicators i.e. increase senior representation and better lived experience of BAME staff working in ULHT. Risk is this results in low number of applications for vacancies which then remain unfilled (difficulty attracting talent); poor turnover rates (difficulty in retaining talent) and a poor employer brand locally, regionally, nationally and overseas. This will impact on the culture of the organisation and the ability to recruit with increased turnover. Wider risk with regards to broader protected characteristics linked to the delivery of the EDI objectives.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	[31/01/2023 15:23:43 Rachel Thackray] WRES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. EDI Group and regular reporting established (for assurance) 2. Anti racism strategy and delivery plan socialised with stakeholders and live 3. NHS Staff Survey results - deep dive and analysis of lived experience of staff with protected characteristics 4. Draft EDI objectives 2022-25 - socialised and ready for sign off (end June) 5. ULHT workstream lead - addressing BAME disciplinary gap (Lincs Belonging Strategy) 6. People Promise Manager successfully appointed from end May'22	4	31/03/2023	31/03/2023	28/04/2023
Strategic Objective							**3a. A modern, clean and fit for purpose environment**																			
4647	Reputation	Harris, Michelle	Davey, Keiron	Fire Safety Group	Fire Safety Group	14/12/2021	20	External Inspections	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees	- Compliance audits against fire safety standards - Progress with fire safety improvement plans - PPM compliance assurance (current lack of required detail for internal and regulator assurance)	03/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very High risk (20-25)	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	[03/03/2023 13:44:13 Rachael Turner] Fire safety team currently working with estates colleagues to identify any areas of lower assurance are included within PPM schedule. Fire Drills commencing non clinical areas March 2023 No change, risk grading remains the same [06/12/2022 14:55:09 Rachel Thackray] Fire safety team currently working with estates colleagues to identify any areas of lower assurance are included within PPM schedule [02/11/2022 12:40:28 Rachel Thackray] No change, risk grading remains the same LFR previously served ULH with an Enforcement notice and action plan (since removed) in which the storage of items within corridors was highlighted: "Article 14(2) Emergency Routes and Exits There are combustible materials and items that pose an ignition risk are located on escape routes within the hospital. It required that Corridors and stairways that form part of an escape route should be kept clear of obstruction and hazard free at all times. Items that maybe a source of fuel or pose an ignition risk should not normally be located on any corridor or stairway that will be used as an escape route." In light of identified storage issues and subsequent non-compliance with these requirements, there is now a high potential for immediate enforcement notice with a view to prosecution in accordance with the regulator's compliance code. Task & finish group set up to address storage issues at local and at senior levels. Fire Safety Advisors working with local managers; IR1s reported when storage issues are identified, with escalation to divisional leads where necessary. Lack of PPM assurance identified - escalated to Estates management team for action, including improvements to the Micad system.	4	30/06/2022	31/03/2024	03/04/2023
4648	Physical or psychological harm	Harris, Michelle	Davey, Keiron	Fire Safety Group	Emergency Planning Group, Health and Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	03/03/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very High risk (20-25)	20	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[03/03/2023 13:47:32 Rachael Turner] Compartmentation survey commenced with remedial actions identified for inclusion within capital plan 23/24/25, Fire drills commenced in non clinical areas March 2023. [06/12/2022 14:53:59 Rachel Thackray] New security provider undertaking internal patrol routes with escalation to porters when storage discovered. [02/11/2022 12:39:13 Rachel Thackray] Regular audits conducted by fire safety team by Fire Safety team within corridors, and IR1s being submitted to line managers for action. Escalation to matrons has now begun via IR1s. Rating increased on review to 20 - combustible storage in common areas frequently found (including life lobbys); emerging lessons learned from recent arson incident at LCH (including spread of smoke beyond the room of origin). Actions undertaken recently - IR1s issued to local managers and owners of storage risk, including escalation to senior managers. Setting up task & finish group to look at storage issues. Reviewed all fire risk assessments in Diagnostics across all 3 sites; other FRAs for public areas have also been reviewed. Reviewed all external security patrols and implemented alterations to routes to ensure possible higher risk areas are also patrolled. New tagging points added to patrol routes. Implementation of further required actions continues to progress.	10	31/03/2022	31/03/2025	03/04/2023
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	21/10/2022	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	[21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	21/01/2023
Strategic Objective							**3b. Make efficient use of our resources**																			

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

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5019	Finances	Wall, Mrs Tracey	Spendlove, Mrs Clare			02/09/2022	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is a continued reliance on bank and agency staff for nursing workforce in Urgent & Emergency Care there is a risk that there not sufficient fill rate in each department which will impact on patient safety and have a negative impact on the CBU budget	Robust nursing plan for every post meetings Daily operational matrons identified for Lincoln and Pilgrim Daily safer staffing lead identified for escalation Establishment review DON Monthly roster clinics / workforce dashboard Daily staffing meetings 3x day Monthly director of nursing quality dashboards. Temporary staffing solutions group - purpose is to reduce agency spend attendance.	Plan for every post meetings Budget reports	12/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Robust recruitment plan International recruitment	[06/03/2023 13:55:09 Rachael Turner] RRC&C members in agreement of risk score reduction to a High Risk (16). [22/02/2023 16:47:51 the reporter] -Establishment reviews have taken place -Fill rates have improved into temporary staffing therefore the likelihood of not having nursing staffing in both Pilgrim and Lincoln is reduced -The organisation has taken ownership that a rapid handover is available. -Divisional approval of risk reduction confirmed. -Email sent to RCRC&C members for approval of risk score reduction. [22/02/2023 14:03:50 Paul White] Improvement in fill rates when shifts are put out. Reduced likelihood because of existing mitigations in place affecting staffing and there is a proposed end . Presented at Confirm & Challenge meeting 22 Feb by TW. Agreed in principle with reduction in score from 20 to 16. Group members to be given until 1 March to raise any concerns. [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		22/05/2023
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**																			
4657	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team.	Monthly reporting completed. Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	01/03/2023	Extremely likely (5) >90% chance	Severe (4)	Very High risk (20-25)	20	Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[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. [02/02/2023 09:01:03 Fiona Hobday] Risk taken to Confirm and Challenge meeting in Jan 23- agreed score should increase to 20. [30/01/2023 14:01:47 Rachael Turner] Risk requested to be increased to a score of 20 at Confirm and Challenge group as we are not meeting statuary requirements and continue to have a large backlog. This risk also impacts on Complaints and PALS. Agreed at C&C group for risk score to be increased. [06/12/2022 15:51:15 Maria Dixon] Ongoing communications with ICO. Changes to clinical review part of process. Some additional temporary resource brought in. This is a significant ongoing piece of work that is going to take at least 12 months to overcome. Office 365 implementation Trust-wide in progress, to enable search of emails / systems. Still has limitations & requires staffing capacity to manage demand for SARs	6	30/06/2023	30/06/2023	02/05/2023
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

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4658	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework it runs the risk of not meeting national best practice. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. 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

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*2 May 2023*
Item Number	*Item 13.2*

Board Assurance Framework (BAF) 2022/23
Close down report

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 3d – Improving cancer services access*

Executive Summary

The relevant objectives of the 2022/23 BAF were presented to all Committees during April including the Audit Committee but with the exception of the People and Organisational Development Committee which had been stood down.

The Board are asked to note the updates provided within the BAF identified by green text.

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

The following assurance ratings have been identified:

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

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

Work is now underway to devise the 2023/24 Board Assurance Framework which will be finalised following formal approval of the Year 4 Integrated Improvement Plan (IIP) for the 2023/24 year.

Once the IIP has received formal Board approval the draft 2023/24 Board Assurance Framework will be taken through the Committee cycle for review and update ahead of being presented to the Board.

It is anticipated that the Board will receive, and commence using, the 2023/24 Board Assurance Framework from June 2023.

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

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SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Programme of work in place to implement the requirements of the National Patient Safety Strategy (culture and systems) Human Factors faculty in place and face to face training restarted. Commencing next steps of cultural work with external agency. Pascale survey work continues to be undertaken. Safe to Say Campaign launched. (PSG)	Further work required in conjunction with People and OD to develop the Just Culture framework. Issues linking National Patient Safety Training to ESR are impacting on our ability to meet National training requirement.	To be considered as part of the Trust Culture and Leadership Programme	Safety Culture Surveys Action plans from focus groups and Pascal survey findings. Regular update reports to the Patient Safety Group and upwardly reported to QGC and through TLT. Theatre Safety Group reporting progress against a Quality Improvement plan to PSG. Regular upward reports received from Divisions.	None identified	Not applicable		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	None identified.	Not applicable	Upward reports from QGC sub-groups 6 month review of sub-group function Annual review of QGC takes place.	None identified	Not applicable		
						Effective sub-group structure and reporting to QGC in place (CG)	None identified.	Not applicable	Sub-Group upward reports to QGC	None identified.	Not applicable		

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

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1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care	5016 4624 4877 4878 4879 4789 5101 5103 4947 4740 4622	CQC Safe	Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG. Training has been delivered to approximately 40 members of staff to undertake SJR's. Bespoke training and support offered from the Mortality team to the Divisions. (PSG)	Gaps in the number of structured judgement reviews undertaken - this is not across all Divisions, good practice exists and is demonstrated through the mortality group. Impact of Covid-19 on coding triangles	Following the success in UTOO for ACP's contributing to the SJR reviews, further training is going to be rolled out to the MDT.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Dr Foster data on depth of coding. Dr Foster data is now available.	Gap identified in the ability to draw learning from SJR's due to ongoing delays with completion Inconsistent approach to Mortality and Morbidity meetings across specialties.	Local data sources are used where possible. Gaps in learning mitigated by ME process and escalation of concerns via incident management processes. New Deputy MD reviewing MORaLs and M&M meetings with a view to making recommendations.	Quality Governance Committee	**Green**
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG)	Clinical harm review processes not all documented & aligned with incident reporting Recognition of a skills gap for investigations at different levels of the organisation	Implementation of a Clinical Harm Delivery Group reporting into the Clinical Harm Oversight Group which is a sub-group of QGC. Appointment of a Clinical Harm and Mortality Manager Investigation training will be addressed as part of the implementation of the PSIRF and National Patient Safety Strategy. Plan to refocus PRM with a specific focus on quality and safety.	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports Strong divisional reporting to MORALs	None identified.	Not applicable		
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Improvement seen across all divisions in terms of development of NatSIPs/LocSIPs, however audit is required in order to provide assurance of implementation.	Individual Divisional meetings now in place; quarterly reporting to PSG Additional support provided to medicine from the Patient Safety Improvement Team	Audit of compliance	Pilot audit tool developed and currently being trialled prior to full rollout.	Review occurring through the Divisional meetings with quarterly reporting to PSG.		

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			~~safety of care~~ Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19			Medicines Quality Group in place with a focus on improving medication safety / appropriate prescribing / appropriate management of drugs and controlled drugs Robust medicines management policies and procedures in place Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit. The Medicines Management Action group in place to oversee the programme of works from the IIP programme. MQG will retain oversight of the relevant IIP programme of work (MQG)	Lack of e-prescribing leading to increase in patient safety incidents due to medication errors Gaps identified within the recent internal audit undertaken by Grant Thornton Lack of adherence to Medicines management policy and procedures Lack of 7 day clinical pharmacy service	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Deputy Medical Director led Action / Delivery Group in place and meeting fortnightly to progress actions and reporting to the MQG.	Upward Report from the Medicines Quality Group to QGC Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group Omitted doses audit Prescribing Quality reports Robust Divisional reporting and attendance into MQG monthly IIP upward report into MQG monthly Internal Audit report	Medicines Quality Group have not been receiving reports regarding progress with the medicines management IIP however this is planned to commence from November; Lack of upward reporting from the DTC and the Medical Gas Audit Pharmacy audits only occurring in areas they are providing a clinical service to.	Divisional representation at Medicines Quality Group reinforced by Medical Director and Director of Nursing and template for divisional reporting of BAU medication safety activities in to Medicines Quality Group developed and in place		
						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training occurs through MNOG.		

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

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

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						Quality Accreditation and assurance programme which includes weekly and monthly audits which include feedback on patient experience from patients in the clinical areas.(PEG)	Further development of alignment of findings in audit data to patient experience surveys overarching plan and other sources of patient experience information. Annual Ward / Dept quality review visits may be paused due to operational pressures in times of extremis. Head of pt experience can access the audit data. Deep dives into areas of concern as identified in quality metrics dashboard meetings. patient experience data collected through the audits is referenced in the overarching action plan, so that the data is triangulated. Update reports to PEG and QGC as required. Weekly and monthly audits continue to take place including during times of extremis. Audit tools are refreshed at least annually or sooner, to reflect current practice. quality accrediation now embedded with a number of ward areas acheiving Diamond Award status, the award panel has a patient representative on the Panel.		Reports to PEG and upwardly to QGC Ward / Dept review Visits are cancelled when the organisation is in extremis. However, weekly spot check audits and monthly matron audits continue. Scheduled review visits for the year, which include the patient experience team as part of the visit team. Pt Experience team have sight of hotspots / concerns and can in-reach to provide support.				

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	4998	CQC Caring	Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG) Working with Hard to Reach groups. Diversity of representation at the patient panel Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging You Care - We Care to Call (YCWCC) Campaign being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. You Care - We Care to Call (YCWCC) Campaign being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. Experts by Experience group gaining traction and engagement, working with the QI Team to identify a patient E by E group who they can work with as part of codesign / service redesign. LD E by E practitioner about to be recruited.	Reaching out project (Hard to Reach groups) still being developed but linking in with Healthwatch in the meantime		Upward reports and minutes to the Patient Experience Group Sensory Loss group upwardly reports to Patient Panel.	Diversity of patient engagement and involvement is limited.		Quality Governance Committee	**Green**
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting. Audit planned for Jan 23 and to report to PEG in Feb/March 23	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work. Audit planned for Jan 23 combined with EOL visiting audit.	Report to PEG through complaints & PALs reports; upward reports were received from Visiting Review working group which has now disbanded; the planned audit will report back to PEG and propose any further recommendations. With visiting restrictions now removed the previous issues cited within complaints and PALs have not been seen. This will continue to be monitored through the winter months. from Visiting Review working group. New Visting Policy being written, incorporating feedback	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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									and steer from national team around visitors / carers / Head of Pt Exp part of this natonal work and spo bringing back the infomration to ULHT. B31:E40				
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Pt Equalities Lead role being discussed at Trust level re potential for this new role into the Trust. Both Pt experience managers will be Cultural Ambassadors as part of the Trust culture change workstream. Head of Pt Exp is a member of the EDI group and works with the EDI lead on pt issues.	EDI 1/4rly report to PEG;	EDI Reports still developing in maturity regarding patient experience	Head of Pt Experience working with EDI lead to ensure data is relevant and triangulated.		
						Robust process for monitoring Mixed Sex Accommodation Breaches in place.	No control gaps identified.	No control gaps identified.	Regular reporting to Patient Experience Group and Quality Govenance Committee.	No assurance gaps identified.	No assurance gaps identified.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)			PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme recommenced September 22. Annual report will go to TB and then to PEG.	PEnding first formal issue of the outputs on the National Staff Survey early link in with Comms will be required to share the outputs with all Trust Staff before general release on the 9th March.		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. Staff experience surveys - Pulse survey quarterly and annual staff survey			Discharge experience reports to PEG quarterly staff experience reports and updates received at PEG. Patient Experience Team working with Lead Nurse for Discharge to support and ensure experience data is collected, analysed and acted upon.	Lead Nurse for discharge to attend PEG in October. Deferred to Nov. Deferred to Dec. Attending in April. Annual staff survey results to April PEG	Staff experience data will be used to identify thems and triangulate to pt experience data / complaints.		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4932 4828 4731 7932 5075	CQC Responsive CQC Effective	Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust.	Acknowledged that there is good engagement from nursing and AHPs. Although improving, work continues to encourage engagement from medics.	Review of Terms of Reference to be undertaken. Invites to speakers to come direct from Mr Simpson as Chair of the Group in future.	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	Isolated pockets where upward reports are not always submitted.		Quality Governance Committee	**Green**
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports have begun to demonstrate changes in practice as a result of GIRFT work. The committee want to see further evidence of this before removing this gap.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (CAG) with quarterly reports to QGC (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed and workshops planned with leads, led by the Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates meaning that reporting to QGC is not as up to date as expected.	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate Meeting to take place with Medical Director and Audit Leads to discuss role and expectations, however attendance has been impacted by operational pressures.		
						National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable		
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	Not applicable		

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						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down although this is due to recommence.	National reports to be presented at Governance Meetings once produced		
						Specialised services quality dashboards (SSQD) Regular reports to CEG with relevant owners in attendance where improvements are required.	None identified	None identified	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	None identified	None identified		
						Process in place for implementing requirements of the CQUIN scheme.	Plans now in place for delivery of 2022/23 CQUINs, although assurances not yet received that these are fully implemented.	CQUIN delivery group commenced again.	Quarterly reports to CEG and upwardly reported to QGC	None identified.	None identified.		
						Process in place for ensuring high quality of record keeping including Medical Records Group.	Medical Records Group not meeting regularly.	Refocus of the Medical Records Group planned by the new Chair.	Programme of record keeping audits taking place.	Audits do not demonstrate compliance with record keeping standards.	Divisional governance leads to pick up within each area.		
						Process in place for monitoring of and implementation of NCEPOD requirements.	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.				
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)			System PP - Each 'pillar assigned system lead Progress/assurance reported to People Board (quarterly) Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan Priorities agreed for 2022/23	None identified			

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						Workforce planning and workforce plans	Overall vacancy rate declining	A new pillar for workforce planning and transformation is being created as part of the People Directorate restructure. The Trust have an Associate Director of Transformation and Workforce planning in post who is leading workforce planning in conjunction with HRBP's, finance and improvement team. This is established and regular reviews are now in place.	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend.	Some areas remain hard to fill however full and comprehensive workforce plans are in place 'plan for every post' and workforce scorecards are in place and are reported through to the Operational Workforce and Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board.	Work continues with the regional roll out of the KPMG workforce tool and from a ULHT perspective a group has been created to support the submission of the Q4 workforce planning submission. First draft of the workforce submission has been submitted with further work now been undertaken on the final submission which is due to our system colleagues on 13.03.23. Intensive work has been undertaken to triangulate the workforce requirements coupled with capacity and finanical reductions on temporary staffing required from a ULHT perspective contributing to the system cost improvement plan.		
						Recruitment to agreed roles - plan for every post	Availability of workforce	Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up and completion of actions. Recruitment key performance metrics feature as part of the People & OD scorecard which is tabled at the Workforce Strategy and Operational meeting and then is reported upwards by expectation to People & OD Committee via the highlight report.	None identified			
						Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established (8B - 12 month) Temp/12 month fixed term People Promise Manager appointed (Liz Smith - ULHT) from end May 2022 Task and Finish Group Statutory and Mandatory Training Task and Finish Group Appraisal	Talent management - on hold	Restructure and resource in to People and OD Directorate	Executive CQC Assurance Panel Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training	Appraisal compliance levels not at expected level Mandatory Training compliance not at agreed level	A paper was tabled at PODC in February to outline the plan to progress review of what constitutes mandatory and role specific training with focused work to commence when the Head of Education commences employment at the beginning of April. Recommendations were approved by PODC.		

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2a	A modern and progressive workforce	Director of People and Organisational Development	Possible disruption caused by system wide strike action and capacity of Pillar leads	4991 4741 4862 4762	CQC Safe CQC Responsive CQC Effective	Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural change when the ability of the ULHT teams to engage when we are operationally challenged Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects)	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations Working with each improvement programme and Divisions to develop identify and align improvement plans	Internal training reports produced by Improvement academy Improvement programmes identifying personalised training needs for ULHT staff Divisions training plan (aligned to the IIP) presented at FPAM	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams.	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement)	People and Organisational Development Committee	**Amber**
						Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Support and training from HRBPs External consultancy briefings with divisional leads	Sickness/absence data	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. Stats are reported through FPAM.		
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service (pending P&OD restructure)	Training and Development department	Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education Recruitment to Head of Education and Training infrastructure. Interim resource in place	System LEAD (Learning, Education and Development) Board to provide system oversight (agreed) Apprenticeship uptake and utilisation of levy through WSODG	None identified			
						Creation of robust Workforce Plan •Values based recruitment and retention •Maximising talent management opportunities •Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn' Promote benefits and opportunities of Apprenticeships	Vacancy of accountable officer	Appointed post holder due to commence March 2023. Interim cover in place. Task and Finish Group established	Improved vacancy rates reported through WSODG and escalated as required through the scorecard to PODC.	None identified			
						Improve the consistency and quality of leadership through:- Reset leadership development offer and support (Leadership SkillsLab and PME) •Improved mandatory training compliance •Improved appraisals rates using the WorkPal system •Developing clear communication mechanisms within teams and departments	Training and Development and review of existing OD infrastructure	Recruitment to Head of Education and Training infrastructure. Interim resource in place. Realignment of OD priorities, due to go live April 2023	Workforce and OD Group IPR - Appraisal compliance Culture and Leadership Group Priority updates to PODC	None identified			

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						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			
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	4990 4439 4993 4992	CQC Well Led	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		People and Organisational Development Committee	**Amber**
						Alignment with People Promise Reset and alignment of Trust values & staff charter (with safe culture) Reset ULH Culture & Leadership	Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Group Culture and Leadership Programme Group upward report NSS results (Feb 2023)	Delivery of agreed output	Trust wide communications were issued on the 9th March in relation to the results of the staff survey with follow up work being undertaken by Head of OD working with the Head of HR and separate Directorates to highlight the 'top three' areas of improvement and the plan to address these.		
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.			Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) Leadership SkillsLab - launched June'22	Training and Development department	Leadership SkillsLab - launched June'22	National Quarterly Pulse surveys (mandated from July'22) Number of staff attending leadership courses	Limited oversight of outputs of Pulse Surveys	Work on-going in terms of launch of next pulse survey and promotion.		
						Lincs Belonging Strategy EDI Delivery Plan 2022-25			Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified			
						Staff networks			Council of Staff Networks	None identified			

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						Employee Assistance Programme implemented May 2022			System Health & Wellbeing Board Linc People Board (NB. Wellbeing Pillar) Employee Wellbeing Group (pending)	Wellbeing activity (for reporting to Workforce, Strategy and OD Group)	Core data is now included in the POD scorecard which is tabled at the Operational working group.		
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian			Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee	None identified			
						Embed compassionate and inclusive leadership (aligned to People Promise)	Training and Development department		Culture and Leadership Group	None identified			
			Risk register configuration not fully reflective of organisations			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				

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2c	Well led services	Chief Executive	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	Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6		Audit Committee	**Amber**
						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy management reviewed and updated	Move of policies in to SharePoint reliant on progress with Trust intranet. Timeline delayed through Covid Divisional breakdown of policies requiring review being shared with PRMs	Review of document management processes - Complete New document management system - SharePoint - In place Reports generated form existing system - Complete All policies aligned to division and directorates - Complete Single process for all polices clinical and corporate - Complete	Fortnightly ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
						Ensure system alignment with improvement activity							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.		

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3a	A modern, clean and fit for purpose environment	Director of Finance and Digital	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4648 - Fire Safety 4647 - Fire Safety 4858 - Water	CQC Safe	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.	Finance, Performance and Estates Committee	**Amber**
						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.		
						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				

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

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						COVID costs - The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID.	The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	Financial plan set out the Trust Budget allocations in respect of COVID spend Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. QIA of risk of removal of all COVID schemes, outcomes reviewed at TLT for decision Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base.	Cease or approved COVID costs continuation as part of the Trust investment prioritisation process.	Correlation between the response to COVID and the new cost base. Ability to remove COVID costs at pace. Prevalence of COVID patients in the Trust.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FPAM.		
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Ranked in 4th place nationally of ICS usage of Care Portals.				
						Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	EPR OBC to be approved by Frontline Digitalisation NHSE/I OBC requirements (including financial) being worked through with Frontline Digitalisation NHSE/I OBC approved at Aug FPEC and Sept Board Updated 'affordable' OBC to go to Jan / Feb 2023 FPEC / Board FPEC supported new version of OBC on 1st Feb. Now going to Trust Board for approval on 7th Feb. OBC approved by Board and submitted to Frontline Digitalisation on 7th Feb. Now moving through to regional Fundamental Gateway Review on 21st April.		

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

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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)	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 Outpatient programme for 23-24 agreed algined to GIRFT principals	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		
						HVLC/GIRFT Programme - Theatre productivity and efficiency	Ability of the ULHT teams to engage in the programme. Emergency pressures & junior doctor strikes resulting in elective cancellations Full robust Theatre programme with focus on KPIs aligned to GIRFT standards	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			

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						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				
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 UEC - sprint work on has now commenced front door realting to EMAS direct access, therapies at front door & pedaitric pathway review . Productive ward programme now has sprint focus on discharge lounge, web V completion & Predictive discharge dates	Large complex programme which required system working to reduce pathway 0 waits and deliver right care right time principals	Large programme of work so additional resource has been provided through a consultancy previously hwoever will now be by the irmprovement delivery team	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 doctor strikes will impact discharge and length of stay and occupancy gains preventing delivery of discharge/ bed closures.	Reporting through Urgent Care Improvement& Recovery Steering Group and Improvement Steering Group and FPEC 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				

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SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and other planning priorities puts an added constraint on time, capacity and headspace to engage with the ICS agenda. Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor institutions		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority specialities for service reviews by July 2022. Heat Map finalised and used to identify the Specialties that were to be prioritised first for Specialty Review. Initial 17 data packs completed in readiness for Specialty Reviews during Feb/Mar 2023. Pilot within Cardiology undertaken in Nov 2022.	Finance, Performance and Estates Committee	**Amber**
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements in 22/23- (1) continued improvements in patient safety and experience (2) reduce long waiting times for treatment (3)make our people feel valued and supported by improving our culture and leadership	Embedding and sustaining cultural change when we remain operationally challenged with staffing issues etc. Ability to demonstrate quick impact on the cultural change due to various interventions as part of our Outstanding Care Together programme will be limited (as these are multi year/multi factorial projects)	ELT/TLT oversight Board / system reporting	Updated IIP reported at relevant Board Committees	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh - completed. Year 4 IIP under development and due to be completed within Mar 2023 following a robust Business Planning Session in Q4 of 2022/23 (including Divisional IIP completions).		
						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.		

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4b	Becoming a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	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	People and Organisational Development Committee	Red
						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.		
						Improve the training environment for students	Understanding of our offer of the facilities required for a functioning clinical academic department	Revision of the library and training facilities to ensure that facilities are fit for purpose for all staff who will require access to training facilities, library, ICT equipment to be able to perform their role. This will be aligned to the UHA Guidance, and will include those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unknown timescales of completion	A new R&I group has been set up being led by Director of R&I/Deputy Medical Director, this will provide more oversight and rigor in developing an R&I agenda with representation from key stakeholders and clear milestones for delivery		
						Developing a joint research strategy with the University of Lincoln	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU, with a local version between ULHT and UoL created as we move forward and understand the finer details of the partnership. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy.	RD&I Strategy and implementation plan agreed by Trust Board	Drafts in place which broadly cover joint research and teaching approach across the organisations, unable to outline in strategy financial commitment. UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group		

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						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	Evidence bound by UHA requirements	Portfolio of evidence is being captured and is available on the shared drive Identified leads to liaise with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Roadmap developed to identify required evidence for portfolio	Clear understanding of rigidity of UHA requirements Letter to CEO of UHA agreed at TLT on 15/09/2022 and being sent by IID Director to ask for meeting to discuss approach.	Discussions being held to clearly identify opportunity for movement within guidance and steps being taken for a name change application		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Two potential candidates have been identified for the Clinical Academic recruitment.		
4c	Successful delivery of the Acute Services Review		Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data) Engage with services to develop plans as to how best to approach a clinical review, First Implementation Oversight Group meeting scheduled for September	Heat maps now drafted, with service reviews linked with improvement and clinical strategy development Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	Process being developed to identify services for review. This includes the development of a HEAT Tool to identify areas where services are not meeting targets, such as RTT, Cancer, Finance data. Initial discussions with divisions have been had with a view to ensure that the services most needing priority review are identified. Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning at TLT on 13/10/22 for review and sign off. Publish ULHT clinical service strategy end of 2022/23 Working with Divisions to identify ASR implementation requirements with draft outline plans in place for Orthopaedics and Stroke. Stroke Capital/Estates Group meetings now diarised and being led by the Business Case Team. Orthopaedics ASR taken to HOSC in Dec 2022 and confirmed as complete through ULT upward reporting. Stroke ASR are working on a 'Perfect Week' to further progress and have commenced relevant staff consultation processes required.	Finance, Performance and Estates Committee	**Amber**

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

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

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

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

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

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